

**Commissioning services for women and
children who are victims of violence or abuse
– a guide for health commissioners**

**Department of Health guidance produced in
response to the report of the Taskforce on health
aspects of Violence against Women and Children**

Equality Impact Assessment (EqIA)

January 2011

Commissioning services for women and children who are victims of violence or abuse – a guide for health commissioners

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Context

1.1. A cross-Government strategy to tackle Violence against Women and Girls (VAWG) was launched on 24 November 2009. Its purpose was to raise awareness of the damage VAWG causes to society, the individual woman survivor and to her children; to reduce the incidence of such violence; and to improve services for and experiences of VAWG survivors. As part of this work, the Department of Health set up a Taskforce looking at how health services for VAWG survivors may be improved. **Responding to Violence against women and children: the role of the NHS** is the report of that Taskforce¹ and contains its recommendations to Government and the basis on which these are made. The report was published on 11 March 2010.

1.2. The Department of Health's Taskforce on Violence Against Women and Children recommends that we provide more guidance to health commissioners on how to commission services for women and children who are victims of violence or abuse. The document **'Commissioning services for women and children who are victims of violence or abuse – a guide for health commissioners'**

¹ Add ref when available

is the Department of Health's response to that recommendation. It supplements the more general commissioning guidance produced as part of the cross-Government strategy on violence against women with a more hands-on guide aimed directly at the NHS. This Equality Impact Assessment accompanies the commissioning guidance.

1.3. The Health Taskforce set up four subgroups covering:-

- domestic violence including its impact on children who witness it
- sexual violence against women;
- violence against girls including child sexual abuse;
- harmful traditional practices such as forced marriage, female genital mutilation and honour-based violence; and human trafficking.

1.4. Based on the subgroups' assessment and proposals the Taskforce has recommended NHS action covering:

- Prevention
- Identification and management
- Key services and successful pathways
- Improving availability and quality of services
- Information sharing
- Workforce issues
- Systems and incentives.

1.5. The Taskforce recommendations are at Annex A. The guidance to which this Equality Impact Assessment relates is the Department of Health's action to implement recommendation 10.

1.6 This work fits within the overall Government VAWG strategy and this EqIA should be seen as part of the EqIA of that strategy managed by the Home Office and linked with work by partnering Government departments (DCSF, Home Office, DCLG, GEO). Within the Department of Health, the work comprising the response to the Taskforce on Health Aspects of Violence against Women and Children (of which this commissioning guidance for health commissioners is a part) is also part of the wider agenda to tackle violence (the Tackling Violence and Abuse Framework, for which a separate but linked EqIA is in production).

1.7 Equality Impact Assessment is an essential part of meeting the Department of Health's general duties towards equality. It considers what effect the Department's activities have on eliminating unlawful or unjustifiable discrimination, promoting equality of opportunity and meeting other requirements of the equality duties, such as promoting positive attitudes towards disabled people. It also enables us to show how positive effects can be maximised, and negative effects minimised or eliminated, by modifying policies and practices.²

²

Department of Health, Equality Impact Assessment: Guidance for policy makers, 2008

Significance of equality in violence

2.1 Violence against women is defined by the United Nations as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women”. It includes domestic violence, forced marriage, ‘honour’ crimes, prostitution, sexual violence, trafficking for sexual exploitation, stalking and female genital mutilation... Around half of all women and girls have been victims of violence over their lifetime.³

2.2 Although violence affects people of both genders, some types of violence are experienced more by women than by men (see section 6). The British Crime Survey and other Home Office data show that women are much more likely to be victims of domestic violence, sexual violence, forced marriage and ‘honour’ based violence and most forms of trafficking. Women and girls suffer these forms of violence disproportionately because of their gender. Violence is linked to issues of power and control, and these are associated with gender stereotypes in some cultures where violence may be seen as normal and acceptable in some circumstances. The violence endured by women from partners and family members is a violation of human rights with profound health and economic consequences. The immediate aftermath of violence can be very damaging, and abuse suffered in childhood can have a profound impact on people in later life and on their families.

2.3 Violence affects women and children of all ages, with those at each end of the age spectrum being particularly vulnerable. Physical violence is more likely to be experienced by younger women, teenagers and children, but older women are also affected by it and are also more likely to suffer neglect and financial abuse. Emotional abuse may be experienced at any age. Violence may be experienced in all socio-economic groups, and in all ethnic groups. There is similar prevalence of intimate partner violence in same sex relationships as in opposite sex ones. People with disabilities are more likely to experience violence as a result of their disability. Trans people may also be more prone to experience violence as a result of their gender identity, and they and gay and lesbian people may be suffer violence or threats of ‘outing’ from other family members because of their personal characteristics as well as from partners.

2.4 The Taskforce has considered harmful traditional practices which amount to violence against those who suffer them, who are overwhelmingly female. These practices are not condoned by any major faith but are prevalent in some communities and associated with the culture practised therein. Challenging these practices may be seen as a challenge to the communities which practise them, and to the social structures within them.

³ HM Government (2009) *Together We Can End Violence Against Women and Girls: A Strategy*, Home Office: London.

The need for an Equality Impact Assessment

- 3.1 The Department of Health's interim response to the Taskforce's recommendations includes a commitment to action where appropriate to take forward work to improve the NHS offer to survivors of violence (see section 8). This will impact on DH policy development and also on the DH role as system leader for the NHS and other healthcare. This in turn will affect frontline healthcare services. In conjunction with the Taskforce programme DH has therefore carried out an assessment of the impact of implementing the agreed recommendations, looking at actual and potential service users of different backgrounds and characteristics.
- 3.2 A [full] Equality Impact Assessment has been carried out because the remit of the Taskforce, and therefore of the Department of Health response, is to tackle an issue which is all about challenging and removing gender inequality. By definition it will concentrate on the impact on women and children as survivors of violence which they experience largely as a result of their gender or age. But it is recognised that a minority of victims experiencing similar violence is male. It is hoped that good practice will be developed as a result of the Taskforce recommendations which will enhance services for all survivors of violence or abuse.

Positive and Negative Impact

- 3.3 There is expected to be considerable positive impact for women as a result of this work, which will be compounded for women and children of different backgrounds and characteristics whose specific needs have been considered. There is also some potential for perceived negative impact for men since their needs as victims will not be specifically considered as part of this work (but see 3.2 above).

Promotion of equality

- 3.4 This work has the potential to promote equality of opportunity for women and their children to live on equal terms with their partners, instead of subject to their power and control. It should improve particularly the support and services available to women with disabilities and from particular ethnic groups by tailoring services to meet their needs and remove or circumvent the barriers which currently prevent them from seeking and getting help.

Taking this forward

- 4 The Department of Health has published the Government's interim response to the Health Taskforce's recommendations for action by Government and by the NHS in March 2010. It will be accompanied by guidance for NHS commissioners on commissioning services for survivors of violence against women and children, and this Equality Impact Assessment. The interim Government response sets out the next steps

the Department will be taking and governance arrangements for overseeing implementation. Following this initial response, the Department will publish a full implementation plan, accompanied by a full Equality Impact Assessment and economic impact assessment, later in 2010.

4.1 The commissioning guidance will cover:

- Scope for identifying victims and survivors of VAWC to enable early intervention and prevention of recurring violence
- Working in partnership with other statutory and voluntary agencies to provide specialist services tailored to women's and children's particular needs
- Measuring effectiveness of services, using feedback from service users to ensure that their needs are recognised and met
- Making use of all opportunities within processes such as World Class Commissioning, Joint Strategic Needs Assessment, patient involvement and empowerment, and Quality, Innovation, Productivity and prevention to make sure that women's and children's views and needs are taken into account in planning, delivering and evaluating services
- Sample case studies to spread good practice. ,

Methodology

5.1 The Taskforce used evidence from a variety of sources to establish the prevalence and incidence of violence against women and children and in particular issues and variations applicable to people of different characteristics and backgrounds. Evidence was gathered from the following sources:

5.2 Published data on crime and violence from the British Crime Survey, Home Office reports on Forced Marriage, violence and homicide, and the Department of Health handbook.

5.3 Findings from the Home Office consultation 'Together we can end Violence against Women and Girls', held from March to May 2009. This was a cross-Government consultation. It included a series of focus groups run by the Women's National Commission covering women of different ages, ethnic backgrounds, sexual orientation, geographical locations, occupations and with different disabilities and health issues.

5.4 The Women's National Commission was also commissioned to run a further series of focus groups to consider health services' role in helping survivors of violence to inform the Taskforce. Thirteen focus groups were held from September to November 2009; details are at Annex A, including the different characteristics and backgrounds of those who took part.

5.5 The Taskforce commissioned two consultants to co-ordinate and undertake gathering views from children and young people about their experience of seeking and/or receiving help from the NHS after suffering sexual violence or abuse. Wherever possible feedback was gathered from

children within their existing therapeutic relationships, but some young people participated in focus groups. More details are at Annex B. This work was done in accordance with Article 12 of the UN Convention on the Rights of the Child.

- 5.6 An open survey attracting responses from the general public was run by NHS Choices, and views were gathered from a range of NHS staff from many different professional groups at a deliberative event and from staff focus groups in South Birmingham PCT and West Essex PCT; the latter focused on NHS staff as victims of violence. SHAs were trawled for examples of current good practice.
- 5.7 A literature review was commissioned from the University of Nottingham to identify research showing prevalence, incidence and evidence of effective interventions. The findings were supplemented by contributions from Taskforce subgroups, which were co-chaired and staffed by a wide range of experts with specialist knowledge of research and practice in the field. Detailed references are given in each of the subgroup reports.
- 5.8 The Taskforce also considered separately the issue of elder abuse.
- 5.9 For this commissioning guidance, DH also drew upon an panel of external experts – commissioners, academics, practitioners and third sector workers – to inform and test the document.

The Evidence Base

Prevalence and risk

- 6.1 Headline evidence of the prevalence of violence against women and children is:
- 6.1.1 One in four women will be affected by domestic violence in their lifetime.
 - 6.1.2 On average, two women in England and Wales are killed every week by a current or former male partner.
 - 6.1.3 Domestic violence accounts for 16% of all violent crime, rising to 24% in certain local authority areas.
 - 6.1.4 It is the major cause of injury to women under 60 years of age and a major risk factor for psychiatric disorders, chronic physical conditions and substance abuse
 - 6.1.5 2.6% of people aged 66 and over living in private households reported in 2007 that they had experienced mistreatment involving a family member, close friend or care worker during the past year- which equates to about 227,000 people across the UK⁴.

⁴ The term 'mistreatment' covers both abuse (psychological, physical, sexual and financial) and neglect.

- 6.1.6 At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs⁵
- 6.1.7 There were 12,165 rapes on females in 2008/9. There were 968 rapes on males in the same period.⁶
- 6.1.8 There were 19,740 sexual assaults on females in 2008/9.⁵
- 6.1.9 According to British Crime Survey (self completion module) in 2008/9 3% of women and up to 1% of men had experienced a sexual assault, the majority of which were less serious sexual assaults. This may be an underestimate due to underreporting.
- 6.1.10 Around 50% of women service users in specialist mental health services have endured child sexual abuse, and many have also suffered further violence and abuse in adulthood.
- 6.1.11 Over half the women in prison say they have suffered domestic violence and one in three has experienced sexual abuse⁷.
- 6.1.12 British Crime Survey 2009 data show that women experience much higher levels of sexual assault than men. For adult experience of any sexual assault (including attempts) women have about 7 times the reported levels than men. For recent experiences women have about 6 times the reported levels as men.
- 6.1.13 16% of children under 16 experienced sexual abuse during childhood (11% boys and 21% girls).
- 6.1.14 There were 21,618 child sex offences in 2008/9 (these include rape, gross indecency and incest), in which one in seven victims were under ten and 1,000 were aged 5 and under⁸
- 6.1.15 Disabled children are three times more likely to be sexually abused than able bodied children⁹
- 6.1.16 Nine out of ten people with learning disabilities experienced harassment or violence within a year¹⁰. 32% experienced harassment or attacks on a daily or weekly basis. 23% had been assaulted.
- 6.1.17 Children under the age of 12 were most likely to have reported being raped by someone they knew well (a friend or family member)¹¹.
- 6.1.18 More than one third (36%) of all rapes recorded by the police are committed against children under 16 years of age¹².
- 6.1.19 Almost a quarter of sexual abuse reports to UK police forces in 2008 were for children under 10 years¹³
- 6.1.20 ChildLine, the 24 hour confidential helpline for children and young people, counselled on average one child aged seven and under for

⁵ Department of Health 2002

⁶ British Crime Survey 2009

⁷ Reducing re-offending by ex-prisoners Social Exclusion Unit 2002.

⁸ NSPCC figures from Freedom of Information request for police reports

⁹ Sullivan and Knutson, 2000. This is a respected USA study. UK figures are unknown but estimated to be similar.

¹⁰ Mencap, *Living in Fear*, 2000

¹¹ Home Office Research Study 196. Home Office. p.7

¹² Home Office Statistical Bulletin (July 2006 / 12/06)

¹³ NSPCC, January 2009

- sexual abuse every day in 2007/8. Most of the children counselled for sexual abuse were aged twelve to fifteen years (61%). Fifty-nine per cent of children said the abuse was from a family member and 29% said abuser was someone else known to them.
- 6.1.21 Three-quarters (72%) of sexually abused children did not tell anyone about the abuse at the time. 27% told someone later. Around a third (31%) still had not told anyone about their experience(s) by early adulthood.
- 6.1.22 88% of teenage girls and 83% of teenage boys have experienced sexual bullying at school
- 6.1.23 Sexual bullying starts when children are in primary school
- 6.1.24 45% of teenage girls have had their bottom or breasts groped against their will
- 6.1.25 55% of adolescent girls believe that they were at least partly to blame for their unwanted sexual experiences¹⁴
- 6.1.26 1 in 3 girls and 16% of boys reported some form of sexual partner violence.
- 6.1.27 The UK Forced Marriage Unit (FMU) handles around 400 cases of forced marriage each year but this is likely to represent only the tip of the iceberg as the unit sees over 1,600 reports of forced marriage each year.¹⁵
- 6.1.28 Forced marriage can happen to both men and women although most cases involve young women and girls aged between 13 and 30. There is no “typical” victim of forced marriage. Some may be under 18 years old, some may be over 18 years old, some may have a disability, some may have young children and some may be spouses from overseas.
- 6.1.29 The majority of cases of forced marriage reported to date in the UK involve South Asian families. There have also been cases involving families from East Asia, the Middle East, Europe and Africa.
- 6.1.30 Women and girls may have an increased risk of forced marriage if they have disclosed sexual abuse.
- 6.1.31 The United Nations Population Fund estimates that at least 5,000 women worldwide are victims of ‘honour’ killings each year.¹⁶
- 6.1.32 An estimated 100 - 140 million girls and women worldwide are currently living with the consequences of FGM. In Africa, about three million girls are at risk from FGM each year.¹⁷ Estimates of prevalence in the UK are not clear. FGM is most frequently carried out on young girls between infancy and the age of 15.¹⁸ An epidemiological study commissioned by FORWARD in 2007 estimated that 66,000 women in the UK are affected by FGM with 24,000 young girls at high risk of FGM.

¹⁴ AAUW (2001); Chiodo et al (2009); Fineran & Bennett (1999); Hands & Sanchez (2000); Murnen & Smolak (2000); Renold (2002); Timmerman (2005) and Altemor (2009); Owens et al. (2005); Katz & McManus (2008); Stonewall (2007); NSPCC (2006)

¹⁵ FCO 2009 Information available at <http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/>

¹⁶ (United Nations Commission on Human Rights, 2002).

¹⁷ WHO 2008

¹⁸ WHO, 2008.

- 6.1.33 Human trafficking into the UK is most commonly for the purpose of commercial sexual exploitation. However, trafficking also leads to forced labour and domestic servitude. The majority of victims are women and girls but men and boys are also victims of trafficking. [DN I've made clear in the guidance that I'm talking just about trafficking for sexual exploitation, so you may want to delete the last two sentences.]
- 6.1.34 The NGO Anti-Slavery International estimates there may be at least 5,000 trafficking victims in the UK.¹⁹

Equality Impact of VAWC

Gender

6.2 Violence against women happens largely because of their gender and is a form of gender inequality and a cause of health inequalities between genders. The types of violence experienced disproportionately by women and girls, and by children of both genders as part of the same expression of inequality, are domestic violence, by partner and family members; sexual violence; harmful traditional practices (forced marriage, female genital mutilation and violence committed in the name of honour); and some forms of human trafficking.

6.2.1 The impact of gender inequality is such that female survivors stop believing in their right to equal treatment and in their ability to cope as individuals:

"That attitude of 'why don't you just leave?' I got from my doctor really isn't helpful; abusers grind you down over time so you really believe you can't cope without them. Where do you go? He's telling you he will kill you if you go. It's not easy, I went back to my partner 8 times, it was only when he took the children away for two days and he was threatening not to bring them back that I finally left and stayed away. Women need support whether or not they stay with their abusers. Health services need to understand that and not judge women or blame them."²⁰

"A girl can get hit because she has her own opinions and her boyfriend don't like it. Lots of boys just hit girls because they don't like what they say."²¹

6.2.2 Women and girls who have suffered gender-related violence can be badly affected by healthcare experiences which remind them of that violence and may refuse treatment as a result:

"When I was on the ward I tried to commit suicide six times. I kept saying about the sexual abuse but they wouldn't listen. I had to have an internal examination because of the abuse but it was by a male doctor. They said they didn't have a woman to do it. It was awful; it felt like being raped all over again. I felt dirty."²²

¹⁹ Home Affairs Select Committee Report, 2009

²⁰ Focus groups run by the Women's National Commission, Autumn 2009

²¹ Children's focus groups run for DH, Autumn 2009

²² Focus groups run by the Women's National Commission, Autumn 2009

*“I can’t get the dental healthcare I need because I’m too scared to go to the dentist. Because of the way dentists work, this can be really terrifying for women ... Lying in that chair with the light in your face, with a man leaning over you putting things into your mouth, it’s really traumatic if you’ve been sexually abused orally”.*²³

*“If you have been a victim of domestic violence, you don’t want to be on a hospital ward with men. It’s shocking that we still have mixed wards; the last thing you want is to be with men. The whole thing about mixed sex wards is violence in itself. I won’t go into hospital if it’s a mixed ward they want to put me in.”*²⁴

6.2.3 Because their bad experiences are gender-based, it is important for survivors to receive services from people whom they do not associate with their violence. This will usually mean women’s services provided by women, but there is a need for sensitive response to each person’s individual circumstances:

*“I went to the doctors about things to do with sexual abuse I’d experienced, but because it was always a male doctor, I never said anything. They have no record of what’s happened even though I’m in there weekly, with something or another. I think it has to be a woman doctor that women see, otherwise it’s really difficult to speak about this, especially if you’ve been raped by a man. It’s scary enough talking about it, especially if you’ve not spoken about it before, so yes it has to be a woman.”*²⁵

*“No-one ever believed me that I was sexually abused by my mother. I tried to tell when I was a teenager, and again when I was an adult I attempted to tell my GP, also a woman, but she drew herself away from me, and no longer is as friendly as she previously was when I went to see her with my ongoing depression. Why do health professionals always assume that as a woman you want to be seen by a woman, because I don’t. Women need to be given a choice. I feel safer with a man and have found it incredibly hard to be trustful of women.”*²⁶

6.2.4 Gender-based violence can occur in all social groups and it is important not to make assumptions about prevalence:

*“One of my colleagues who was a GP had a perception that if she was working in a middle class area, she didn’t need to know about domestic violence because it doesn’t happen to middle class women. We need to give people information that it affects all women, it’s across all classes, educated men are doing this too, it’s about power... This should have been part of the training.”*²⁷

Age

6.3 Age is an additional risk factor for some forms of violence, with those at both ends of the age spectrum more vulnerable in different ways. About two thirds of sexual offences happen to adult victims, and one third to children and teenagers (see headline figures above).

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Focus groups run by the Women’s National Commission, Autumn 2009

- 6.3.1 A review²⁸ of studies of prevalence of partner violence found that the range of those women in the general population experiencing partner violence over their lifetime was 13-31%, and the range of those women in the clinical population, interviewed in healthcare settings, was 13-41%. The range of women in the general population experiencing partner violence over the previous year was 4.2-6%, and the range for women in the clinical population was 4-19.5%.
- 6.3.2 The studies found higher prevalence in the general population amongst younger women and those who were separated or single. Prevalence of physical assault alone decreased with age. Financial abuse and neglect are more likely to be suffered by older women, but physical violence still occurs: in 2009 five older women in the Metropolitan Police area were killed by their adult sons.
- 6.3.3 Older women may have little awareness of the criminality of sexual violence²⁹:

“Amongst older women there is still little awareness that rape in marriage is violence and a criminal offence and it’s very difficult for anyone to go to a health professional and report it or to get help from the sexual abuse. There needs to be more awareness raising amongst older women, and support from social care and health support workers.”

“There isn’t enough understanding about dementia to see whether they are suffering violence. There is no training to take them seriously. I have supported a woman where the man who has dementia is raping his wife regularly. It is treated as a medical condition but if you looked at it, it was something he was doing before, no-one took any action against him and no-one offered her any support. Because she was an older woman, and his carer, her experience of rape by her husband was just ignored.”

- 6.3.4 Children and teenagers face particular pressure in disclosing violence if they fear they will not be believed:

“I told someone but they didn’t believe me and I suppose after that I really started to think that maybe I’d imagined it and it was my mind playing tricks with me”³⁰

“I was very young when my dad started abusing me sexually.....it takes a long time to figure out that such behaviour is wrong and when I did (figure it out) I didn’t know who to tell or who would believe me”³¹

²⁸ Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, *et al.* How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technol Assess* 2009;**13**(16).

²⁹ Focus groups run by the Women’s National Commission, Autumn 2009

³⁰ Children’s focus groups run for DH, Autumn 2009

³¹ *Ibid.*

6.3.5 Children also need special understanding of their needs, and for staff working with them to appreciate the circumstances in which they are seeking help in order to tailor it to their needs:

“There needs to be a reframing around issues in abuse. Children need to know it is ok to kick and scream whereas at the moment they grow up being told that in general it is wrong so they feel bad for doing it. In certain circumstances it is ok to challenge behaviour. Things that children are taught like ‘say no to strangers’ – well actually in our case [women who have suffered incest] the abuse comes from people you know and the people who might be able to help are strangers so it’s completely irrelevant stupid advice.”³²

6.3.6 A failure to recognise abuse by partners or family members can lead to inappropriate targeting of services³³ resulting in higher levels of undetected and untreated abuse elsewhere.

Ethnicity

6.4 Evidence from women survivors of violence highlight particular issues for women from different cultural communities, sometimes but not always linked to ethnic groups.

6.4.1 It is not unusual for perpetrators to accompany victims seeking help from services to prevent them from disclosing, but for women and girls from some minority ethnic groups this is compounded by family or community practices to safeguard their wider ‘honour’. Women and girls from some communities are at greater risk of forced marriage once sexual abuse is disclosed.

“Midwives are supposed to ask about domestic violence now, but I don’t know any woman using our service who has been asked safely about this, without having family members present. They need training to ask BME women on their own, even if they have female family members there, sisters, sister in laws, it’s still not ok to ask and expect women to feel safe to say yes, I’m being abused.”³⁴

“Even if the perpetrator isn’t with you, he sends one of his family members with you. And in the name of honour you can’t even talk about it. Especially if they say, I’m going to interpret because she can’t speak English. That’s why it’s so important that at my surgery we have a language line, because they don’t really like to have people translating because they might misinterpret, so they set up this language line, which has access to all different languages.”³⁵

“I told my doctor about being at risk of forced marriage and she seemed shocked that things like this happened in the twenty first century, she kept asking, are you sure? I was like, I know what my family are doing to me. The doctor just gave me a load of numbers even though I explained I couldn’t ring anyone, I am monitored all the time.

³² Focus groups run by Women’s National Commission, Autumn 2009

³³ ‘Stranger Danger’ campaign in the USA, which led to an increase in abuse by people known to the child victims as attention was diverted to tackling abuse by strangers

³⁴ Focus groups run by Women’s National Commission, Autumn 2009

³⁵ Ibid.

My doctor didn't believe me – I was sitting there crying my eyes out and I just wanted her to help me. In the end, two days later I just left the house off my own back with no help from the health services or anyone.”³⁶

“There is a reason why the highest rate of suicide is amongst Asian women. It's a knock on effect of where health services, especially mental health services, are failing them. Depression and stress is higher in Asian women and it's the same thing, it's linked to the violence. It's a reflection of women's perception of the help that is available to them, because there's no help.”³⁷

6.4.2 There is often an assumption – supported by most women who have suffered sexual violence at the hands of men – that immediate services should be provided for them by female staff. But in some cases, where the perpetrator may be an older female relative, survivors may feel safer with male or younger staff whom they do not associate with the abuse. This may particularly affect women and girls from some Asian communities.

6.4.3 Women who are refugees or asylum seekers may have difficulty in accessing any sort of healthcare:

“I tried to register with a GP and I showed them my Home Office ID card and they said no. But the NHS is free, it says on my card it is for asylum seekers. They told me that you cannot register with a GP when you are an asylum seeker. I showed her the 'NHS is free' form and then my ID and I gave her proof of address, and still she said no, I have to have passport. But I don't have a passport because I am an asylum seeker. She said well, we don't register asylum seekers.”³⁸

“We were in hospital with a woman who had experienced violence; they rang the crisis team who refused to help her because she is not registered with a GP. She doesn't have a permanent address or any documentation, but until we register her, the crisis team won't have anything to do with her. The hospital couldn't do anything; they gave her painkillers and sent her home. This is not a good enough response from the NHS to vulnerable women who have experienced violence.”³⁹

6.4.4 Women who have suffered female genital mutilation have to suffer the additional indignity of lack of understanding from NHS staff who may not have come across the condition before or who mistakenly think it is an acceptable practice in some cultures:

Messages from staff on Female Genital Mutilation

“As the girl starts to grow up, especially after starting her menstrual cycle, she starts facing problems which affect her emotional and psychological wellbeing. Emotionally she might feel that she has been a victim of her parents, the nearest to her, who have put her in this position, and she might even have mixed feelings of anger towards them.”⁴⁰

³⁶ Ibid.

³⁷ Ibid.

³⁸ Ibid.

³⁹ Focus groups run by Women's National Commission, Autumn 2009

⁴⁰ FGM is always with us Results from a PEER Study p.39 (FORWARD)

“When [doctors] see women that have had FGM ... they call everyone to come and have a look at our genitalia, it’s very shameful.”⁴¹

“When I had my first child 6 months ago, they didn’t help me, they said to me ‘you people, you’ll be back next year anyway, I don’t know why you are complaining.’ I had to fight for the midwife to check me, they refused to give me any painkillers, it was really traumatic.”⁴²

6.4.5 FGM leads to an increased risk of Caesarean section, post-partum haemorrhage and perinatal mortality⁴³.

6.4.6 Women who are victims of trafficking may be dependent on their traffickers for getting any medical help, access to which may be tightly controlled to prevent disclosure of abuse:

“One of our clients has been trafficked. Her husband brought her over here on a marriage visa. But he was not really her ‘husband’. He was a trafficker. For four years she was a prisoner and when she had to go to the doctor her “husband” would go as an interpreter. She was threatened to stop her escaping; they said that they would hurt her children back home if she tried to run away. She was beaten and bruised really badly. Her “husband” told the doctor that she was mental. He made up a background of mental illness. The doctor didn’t ask any questions about the bruising and always saw her with her trafficker as an interpreter. It took four years for her to escape. But they found her and she was beaten and raped and taken back to be held prisoner, there was no safety from the police or anyone else. If her doctor or someone in the hospital had spoken to her separately during all those years of abuse, she would have told them and would have got away quicker. But it looked as if the ‘husband’ was giving her support by taking her to the doctor. Health services need to be sensitive to patients coming along for appointments with other people, they are worried about cultural sensitivities but should see women alone and with a professional interpreter.”⁴⁴

Disability

6.5 The presence of mental, physical or learning disability is an additional risk factor for violence.

6.5.1 Disability can sometimes be the prime cause of violence amounting to hate crime:

6.5.2 *“Katie, who has cerebral palsy, was in an abusive relationship with a much older man without learning disabilities for seven years. Her partner raped her, physically assaulted her and frequently stole her benefits. This abuse occurred specifically because of Katie’s learning and other disabilities and in a manner, which we view as a hate crime. He called Katie a “spac”, a “retard” who deserved to be abused, that she was useless and did not deserve any respect. Katie has been receiving assistance from the Respond helpline for the last six years, but is still trying to deal with the effects of this violence. For*

⁴¹ WNC, Women’s Focus Groups, Home Office Consultation Response, p.32

⁴² Ibid.

⁴³ ‘Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries’, *Lancet*, (June 2006), Volume 367, Pp.1835 – 1841.

⁴⁴ Focus groups run by Women’s National Commission,, Autumn 2009

Katie the opportunity to attend an appropriate service that understands the often complex needs of people with learning disabilities who are the victims of sexual violence was an essential part of her recovery”⁴⁵

6.5.3 Disabled children are three times more likely to suffer abuse than able-bodied children (see 6.1.14).

6.5.4 Mothers of disabled children may be more likely to encounter partner violence, and their options for escaping it may be more restricted:

“The real problem for disabled women who have to flee their home in the middle of the night to escape violence is that they need a certain package of care, like PA, dialysis or respite facilities, but the care doesn’t go with you. You often have to move very quickly to get into a refuge like my mother and I did when we had to flee violence when I was 12. You have to start again and it can take months and months to get in place the care that you need and you could be totally dependent on PA or a carer.”⁴⁶

6.5.5 Women with disabilities may find that their attempts to get help are misinterpreted, and they may be put off from seeking help at all:

“As a disabled woman you do get bullied by health services. They threaten you at the hospital with taking your children away. If you ask for respite for your child they turn it into a welfare issue, they stereotype you as a woman and a mother as not being able to cope because you ask for help, help that you are entitled to.”⁴⁷

6.5.6 A learning or physical disability or illness adds to a young person’s, or an adult’s, vulnerability to forced marriage and may make it more difficult for them to report abuse or to leave an abusive situation. Their care needs may make them entirely dependent on their carers.

Sexual Orientation

6.6 While people in same-sex relationships experience partner violence at a similar rate to people in opposite-sex relationships, lesbians and gay people may additionally experience abuse from other family members or other members of society because of their sexual orientation.

6.6.1 This attitude may be shown by healthcare staff too:

“I’m a mental health patient, when I go to the psychiatric hospital I am abused by staff. There’s a lot of homophobia in hospitals. I got attacked in hospital and the staff didn’t take any notice. One nurse said to me ‘you’re butch, you can defend yourself’. There is a lot of abuse on the wards for being a lesbian; it’s a big stigma if you’re an older woman. Government needs to clamp down on this. When you are trying to get better, this makes you worse, it sets you back. It’s very strong on the mental health wards yet staff don’t do anything to stop it.”⁴⁸

⁴⁵ British Crime Survey, 1999

⁴⁶ Focus groups run by Women’s National Commission, Autumn 2009

⁴⁷ Ibid.

⁴⁸ Focus groups run by Women’s National Commission, Autumn 2009

"I really believe, and I know I've said this before, but the health staff need to know that being gay doesn't mean that you deserve what has happened to you"⁴⁹

6.6.2 Services should be sensitively delivered to take account of an individual's needs:

"Getting any of the health or caring services to acknowledge your sexuality is almost impossible. All they say is, it doesn't matter, we treat everyone the same. I don't want to be treated the same, I have my own particular needs as a lesbian and I don't want people denying it"

Gender Identity

6.7 Trans people may also experience additional abuse because of their gender identity. There is a need for more research in this area to determine the prevalence of violence in this group.

6.7.1 This may come from family members or other members of society:

"Trans people have to put up with constant low-level verbal abuse. This constant abuse is demoralising, and intimidating; this mental and emotional abuse is worse and more difficult to recover from than physical violence."⁵⁰

6.7.2 Trans people may also be threatened with being 'outed' to friends and colleagues, or they may have hormone treatment medication hidden or thrown away as a subtle form of abuse which denies their preferred identity.

6.7.3 Trans people may have problems accessing appropriate services: for instance a person transitioning from male to female may not be allowed access to women-only services although these would be appropriate.

Religion or Belief

6.8 Religion and belief are not themselves associated specifically with violence. However religion or belief may have an effect on children's vulnerability and women's ability to disclose violence and to seek help, in some religious contexts where equality of women and men is not practised.

6.8.1 There may be cultural views which impact on community attitudes and may lead to difficulties of access and takeup for people in some groups. There may be tensions on issues such as extra-marital sex, which has a grounding in some religious teaching, and on issues such as underage marriage, women's consent and control over their lives, which may be culturally-based.

⁴⁹ Children's focus groups run for DH, Autumn 2009

⁵⁰ Focus groups run by Women's National Commission, Autumn 2009

6.8.2 There are some areas and circumstances in which religious background may be a particular risk of child sexual abuse, such as in the Roman Catholic church.⁵¹

Human Rights

6.8 Gender-based violence and violence against children in their many forms violate the human rights of their victims. They may in extreme cases face death and serious injury, their liberty may be restricted to the point where they are held under house arrest or not allowed out unaccompanied, violence carries with it degradation and inhumane treatment. Private and family life is severely disrupted by the immediate and long term effects of violence, both for women survivors and their children who experience or witness it.

Next Steps

7 The Taskforce has produced a report with 22 recommendations, at Annex A, for action by the Department of Health, the NHS at regional and local level, regulators, training providers, frontline staff, and partners in statutory services and third sector organisations.

7.1 The Government's interim response to this report contains an indication of the extent to which each recommendation is accepted. The recommendation to issue commissioning guidance is accepted for immediate implementation. The response outlines action to implement the full set of recommendations where appropriate, or to discuss further what is practicable.

7.2 A full implementation plan will be published later in 2010 and a full Equality Impact Assessment and economic Impact Assessment will accompany that plan (see below).

Outline Equality Action Plan

8 The Taskforce recommendation 10 is: Clear, outcomes focused commissioning guidance on services for violence against women and children should be issued by the Department of Health, with a particular emphasis on involving women and children in commissioning.

8.1 The Department of Health will implement that recommendation by the publication of '**Commissioning services for women and children who are victims of violence or abuse – a guide for health commissioners**'.

8.2 The Department of Health will encourage health commissioners to make use of the guidance in reviewing, planning, commissioning and evaluating

⁵¹ Ryan report, 2009; Commission of Inquiry into Dublin Archdiocese, 2009

local services and in engaging local women, teenagers and children in planning and evaluating the services which they may use.

8.3 The guidance gives advice for HEALTH COMMISSIONERS on their role in commissioning services; measuring the effectiveness of services; processes, including World Class Commissioning principles, Joint Strategic Needs Assessment, patient engagement and empowerment, quality and productivity, and regional commissioning.

8.4 The use of the guidance could address current inequalities in the provision of services for women and children who are victims of violence or abuse in the following ways:

Deliverable outcome	Equality issue	Equality Action	Action lead
Partnerships with local authorities for joint commissioning and funding services provided by local third sector organisations	This guidance is aimed at addressing violence and abuse of women and children and does not address sexual or intimate partner violence against men. Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities.	Services provided by organisations with expertise in tailoring services to needs of users to take account of specific needs of those of different ages, disabilities, ethnicity, sexual orientation, gender identity, religion or belief, as well as gender. Also maximising available funding by pooling resources. Although this guidance does not cover men affected by violence and abuse, it is hoped that improvements in services for women and children will have a beneficial effect on services for men.	Health commissioners with partners
Meet legal obligations	There are legal obligations in the Human Rights Act, the Equality Act 2010, CEDAW and the UN Convention on the Rights of the	Promote gender equality in line with equality legislation; and protect children and vulnerable adults from harm in line	Health commissioners

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	Child.	with safeguarding legislation	
Measure effectiveness by outcome measures: best services to promote recovery; best interventions to prevent re-victimisation; cost-effective training for staff	The quality of services must be ensured for all sectors of the community, including for example, those with physical and learning disabilities, those from different ethnic backgrounds, people whose first language is not English etc.	Include measures of outcomes for different groups (age, disability including different types of physical, learning and mental health, different relevant ethnic backgrounds, sexual orientation, gender identity, religion or belief)	Health commissioners
Measure performance and outputs	Equal access to services must be ensured for all sections of society no matter their ability, ethnicity, gender, age etc. Outcomes should be suitable and of high quality for victims/patients from all sections of society	Include measures of engagement and take-up of services of service users from different backgrounds and with different characteristics	Health commissioners
Structure of governance and leadership to promote effective service response	Access and quality of services should be maintained (as above)	Ensure via recruitment and training governance arrangements and leadership in place to ensure needs of service users of different backgrounds and characteristics are met effectively	Health commissioners
Social return on investment	Access and quality of services should be maintained (as above)	Ensure outcomes and returns are analysed with reference to diverse backgrounds and characteristics to check for equitable investment that maximises social benefits for all	Health commissioners with partners

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Patient Reported Outcome Measures	Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities. Care must be taken to avoid bias in obtaining patient satisfaction with services.	Include specific questions about age, disability including different types of physical, learning and mental health, different relevant ethnic backgrounds, sexual orientation, gender identity, religion or belief to provide data on outcomes and satisfaction of different groups as baseline for action to improve where there is dissatisfaction	Health commissioners
Outcome measures for children	Violence affects children and young people from many communities, such as those children with disabilities, different sexual orientations and ethnicities.	As above, including age breakdowns for children and teenagers	Health commissioners
Outcome measures for third sector organisations	Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities.	As above	Health commissioners
Case studies providing examples of demographic data collection and analysis as basis for service planning, delivery and evaluation	Access to services should be equitable. Access should not reflect a bias towards a particular community e.g. ethnicity or preferred language.	Services provided by organisations with expertise in tailoring services to needs of users to take account of specific needs of those of different ages, disabilities, ethnicity, sexual orientation, gender identity, religion or	Health commissioners

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		belief, as well as gender.	
Involve service users in service needs assessment, planning, design and evaluation through processes such as World Class Commissioning; Joint Strategic Needs Assessment; Quality, Innovation, Productivity and Prevention	Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities.	Work with local third sector organisations and service user groups to identify specific needs and risks of diverse groups especially those who are 'seldom heard', and recognise risks associated with age (particularly older and younger adults, teenagers and children), disability, sexuality, gender identity, and ethnicity	Health commissioners and partners
Meet legal obligations	Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities.	Ensure compliance with section 242 of the NHS Act 2006 on involvement of service users	Health commissioners
Comply with Equality Duty when in force	Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities.	Ensure that people with the protected characteristics as defined in the Equality Act when enacted are treated equitably in line with that legislation	Health commissioners
Service standards	Violence against women and children affects women and children from many communities, such as women and children with disabilities,	Ensure that service standards used include meeting the needs of all service users of every background and characteristic	Health commissioners

	different sexual orientations and ethnicities.		
Take action as above to plan, deliver and evaluate services; publish reviews and issue further guidance on specific areas of dealing with gender- and age-based violence and abuse; ensure that service commissioners and providers meet equality and diversity requirements in carrying out their functions	Violence against women and children affects women and children from many communities, such as women and children with disabilities, different sexual orientations and ethnicities.	Ensure comprehensive system of informing, advising, planning, delivering, evaluating service provision that meets the needs of people from all backgrounds and characteristics and holding services commissioners and providers to account for doing so.	Health commissioners, Government, regulators

Further action

- 8.5 The Department of Health will ensure that its webpage with resources for commissioners, including this guidance, is kept up to date.
- 8.6 The Department of Health will look at ways in which new and existing quality assurance and monitoring mechanisms may be used to provide feedback on how services are being improved or whether there is a need for further action.
- 8.7 This exploration of monitoring mechanisms as a way of identifying the impact of the guidance and any need for further action will form part of the further DH VAWC implementation plan.

For the Record

Name of person completing the EqIA:	Rosalind Mead
Date EqIA completed:	19 February 2010
Name of Director General endorsing the EqIA:	Una O'Brien
Date EqIA endorsed:	

ANNEX A

Health Taskforce Recommendations

1	NHS staff should be made aware of the issues relating to violence and abuse against women and children, and of their role in addressing those issues.
2	PCTs, their partners in Local Strategic Partnerships and NHS Trusts should ensure that women and children who are experiencing violence or abuse are provided with information that helps them to access services quickly and safely
3	<p>All NHS staff should have- and apply- a clear understanding of the risk factors for violence and abuse, and the consequences for health and well-being of violence and abuse when interacting with patients. This should include:</p> <ul style="list-style-type: none"> • appropriate basic education and training of all staff to meet the needs of women and children who have experienced violence and abuse; • more advanced education and training of 'first contact' staff and those working in specialties with an increased likelihood of caring for women and children who have experienced violence or abuse; and • Staff awareness of the associations and presentations of violence and abuse and how to broach the issue sensitively and confidently with patients. <p>Universities and other providers of education and training, employers, regulatory and professional bodies should work together to make this happen.</p>
4	Midwives and health professionals should be trained to provide information to mothers from communities which practise Female Genital Mutilation. Ideally this should take place during the antenatal assessment. The use of targeted questioning in those communities where FGM is practised should be employed as part of an integrated local pathway of care for FGM.
5	PCTs and NHS Trusts should have clear policies on the use of interpretation services that ensure women and children are able to disclose violence and abuse confidently and confidentially
6	PCTs and NHS Trusts should work together with other agencies to ensure appropriate services are available to all victims of violence and abuse.
7	Every NHS organisation should have a single designated point of contact to advise on appropriate care pathways and referrals for all victims of violence and abuse, providing urgent advice in cases of immediate and significant risk.
8	NHS Organisations should have health and well being policies specifically for staff who are victims of domestic and sexual violence. A clear pathway should be implemented in every NHS funded organisation so that staff and managers know where and how to access support.
9	NHS organisations should ensure that information relating to violence and abuse against women and children is treated confidentially and only shared

	<p>appropriately. This means that:</p> <ul style="list-style-type: none"> • There should be consistency and clarity about information sharing and confidentiality; • Staff should be equipped through training and local support from local leads on violence against women and children and Caldicott Guardians to share information appropriately and with confidence. In the case of safeguarding children, advice should come from the named doctor and nurse for safeguarding. • Women and children disclosing violence or abuse should feel assured that their information will be treated appropriately; • The Government should clarify the grounds for public interest disclosure in relation to 'serious crime'.
10	Clear, outcomes focused commissioning guidance on services for violence against women and children should be issued by the Department of Health, with a particular emphasis on involving women and children in commissioning.
11	Consistent and practical data standards should be agreed relating to the health aspects of violence and abuse against women and children to underpin analysis of quality, activity, outcomes and performance management by commissioners and NHS and third sector providers.
12	NHS commissioners should assess local needs and local services for victims of sexual violence and/or sexual abuse and ensure appropriate commissioning arrangements are in place.
13	Commissioners / PCTs with their partners in Local Strategic Partnerships should ensure that appropriately funded and staffed services are put in place along locally agreed care pathways.
14	The Department of Health and the Home Office should make it clear to the immigration agencies and the NHS that direct treatment needs should be provided to women and children experiencing violence and abuse whatever their immigration status.
15	PCTs, Local Strategic Partnerships and Trusts should ensure there is sustained and formalised co-ordination of the local NHS response to violence against women and children. This should be in the form of a Violence Against Women and Children Board in each area. These arrangements should link appropriately to local structures in place for safeguarding children and vulnerable adults.
16	PCTs and NHS Trusts should nominate local 'violence against women and children' leads, supported by the Violence Against Women and Children Board, to work with women and children and the NHS to drive change and improve outcomes.
17	The Government, PCTs, Local Authorities and statutory bodies should ensure that partnerships with the third sector are outcome focused, funded appropriately to meet service users' identified needs, involve women and

	children and are supported, promoted and encouraged locally and nationally.
18	Arrangements should be put in place to ensure leadership on this issue across the system- from Ministers and the Department of Health and system leaders, through to SHAs, PCT and Trust boards. Boards should nominate a senior member to ensure that effective services for victims are put in place in line with this report.
19	Regulators of health and social care services (in particular the CQC) should embed the issue of violence against women and children in its work programme, including registration. The Care Quality Commission should consider undertaking a special review of how well the NHS deals with the issues highlighted in this report after implementation of the initial Government response.
20	The Government should ensure that clear processes for clinical governance, supervision and regulation should be put in place for SARC, and these should be effectively communicated to those managing and working in SARC and the National Support Team on the Response to Sexual Violence.
21	The Department of Health should work with the relevant regulators and professional bodies to ensure that clinical staff undertaking forensic medical care are: <ul style="list-style-type: none"> • appropriately trained, skilled and experienced; • employed by the NHS; • integrated into NHS clinical governance; • work within a quality standards framework agreed by the Forensic Science Regulator and the Faculty of Forensic and Legal Medicine; and • commissioned in sufficient numbers to meet the needs of women and children.
22	A national steering group should be established to oversee implementation of this Taskforce's recommendations.
23	The Department of Health should review the evidence base with a view to identifying significant gaps in the evidence and commissioning further research.

Note – the recommendations refer to PCTs, as they were published before the *Liberating the NHS*. They should be read as referring to health commissioners.

**List of focus groups run by Women's National Commission, Autumn
2009**

- FG A:** Women who have experienced domestic violence
FG B: Women who have used statutory mental health services
FG C: Women from Black Asian Minority Ethnic (BAME) communities who have experienced domestic or sexual violence, forced marriage and so-called 'honour' based violence
FG D: Women who have experienced rape, sexual abuse or incest
FG E: Women who have experienced domestic violence
FG F: Women from Black Asian Minority Ethnic (BAME) communities who have experienced domestic or sexual violence, forced marriage and so-called 'honour' based violence
FG G: Women who have experienced domestic violence
FG H: Older women
FG I: Women from Black Asian Minority Ethnic (BAME) communities who have experienced domestic and sexual violence, forced marriage and so-called 'honour' based violence
FG J: Women refugees and asylum seekers
FG K: Disabled women
FG L: Women who have experienced rape, sexual abuse or incest
FG M: Women from Black Asian Minority Ethnic (BAME) communities who have experienced domestic and sexual violence, forced marriage and so-called 'honour' based violence
FG N: Women who have experienced incest

Of the 211 women consulted, 185 women chose to anonymously complete the WNC equalities monitoring forms⁵², and of these:

- 10% of women were aged 16-24; 28% of women were aged 25-34; 28% of women were aged 35-44; 17% of women were aged 45-54; 9% of women were aged 55-64 and 8% of women were over 65 years of age.
- 29% of women identified as being disabled.
- 2% of women identified as transgender.
- 5% of women identified as lesbian, 1% of women as bisexual, 76 % of women as heterosexual and 4% of women as 'other'.
- 44% of women identified as Black, Asian or from another minority ethnic group; 4% of women identified as mixed parentage, and 48% of women identified as white.
- 22% of women stated they were not religious; 1% of women identified as Buddhist; 2% of women as Hindu; 26% of women as Muslim; 3% of women as Sikh; 21% of women as Christian; 2% of women as Jewish, and 6% of women identified as 'other'.

⁵² Note that numbers do not add up to 100 as not all questions were always answered.

ANNEX C

Information collected from children and young people, Autumn 2009

Sixty-five children contributed their views to the consultation. They were receiving services from:

- A range of non-health agencies offering recovery services in the community to children who are victims of sexual abuse, including new technology abuse, sexual violence and exploitation including trafficking (45 children)
- Mental health residential units and third sector agencies offering services to children who have been diagnosed with mental health issues warranting interventions ranging from tier 1 to tier 4 services (28 children).