Improving services for women and child victims of violence: The Department of Health Action Plan

A Department of Health Action Plan produced in response to the report of the Taskforce on health aspects of Violence against Women and Children

Equality Impact Assessment (EqIA)

November 2010

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Context

1.1. The document '***Improving services for women and child victims of violence: The Department of Health Action Plan'*** is the Department of Health's response to the recommendations of the Taskforce on the Health Aspects of Violence Against Women and Children. It sets out how the Department of Health will improve the way health services support the many victims that continue to experience suffering due to violence and abuse. Violence against women and children is acknowledged as a major violation of women and children's' human rights and Government intervention is necessary to enable the NHS to make progress in meeting the unmet health needs of women and children who are victims of violence. This Equality Impact Assessment accompanies the action plan and supplements the report of the Taskforce.

1.2. The Taskforce was set up as to look at how health services for VAWG survivors may be improved and was part of the Cross-Government Strategy to tackle Violence against Women and Girls (VAWG), launched in November 2009. The Task Force reported in March 2010[1]

1.3. The Taskforce found that the NHS is failing to identify some victims of VAWG, sometimes missing an opportunity to break the cycle of violence. In addition, NHS care for some vicitims of VAWG is poor and the health impacts of violence are under-treated in many victims.

1.4. The Taskforce on Violence Against Women and Children made 23 recommendations, including:

- That 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;
- That NHS staff should have the competencies and skills to equip them to appropriately identify, treat and refer women and child victims of violence;
- That NHS staff who may be victims of violence and abuse are supported;
- That quality of the forensic workforce and services for victims of sexual assault are improved;
- That the right specialist services are commissioned.

1.5 Under the previous administration, an interim Government response to the taskforce report was published in March 2010. This document outlined the initial response to each of the recommendations in the

[1] Responding to violence against women and children – the role of the NHS. The report of the Taskforce on the Health Aspects of Violence Against Women and Children. March 2010.

report at that time, and committed to producing an implementation plan in autumn 2010. When the new administration came into power, the issues were re-examined and a work programme, which took into account the policies and priorities of the Coalition Government, was agreed with ministers.

1.6 The initial scoping exercise that determined which taskforce recommendations would be taken forward, recognised two important constraints in the current NHS environment: scarce resources and the approaching structural changes. The recommendations that are being taken forward were chosen due to their beneficial impact, recognising the constraints both in terms of finance and time by the VAWC programme budget for 2010/2011 (£2.9 million).

1.7 The DH VAWC action plan takes forward fifteen high-level recommendations set out by the taskforce (see Annex A). It sets out how the Department in partnership with the NHS Confederation, Home Office and Royal Colleges will take action by spring 2011 to address many of the high-level recommendations proposed by the taskforce.

1.8 This EqIA should feed into the EqIA of the new Cross-Government VAWG strategy, managed by the Home Office and linked with work by collaborating Government departments (DfE, 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 is also part of the wider agenda to tackle violence.

1.9 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

Significance of equality in violence

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

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. 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 suffer violence or threats of ‘outing’ from other family members because of their personal characteristics as well as from partners.

The need for an Equality Impact Assessment

3.1 The Department of Health’s interim response to the Taskforce’s recommendations included a commitment to take forward work to improve the NHS services on offer to survivors of violence. This will impact on DH policy development, which in turn will affect frontline healthcare services.. DH has therefore carried out an assessment of the impact of implementing the Action Plan, looking at actual and potential service users of different backgrounds and characteristics.

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

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 concerned with 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 because 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 work on VAWC, 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. However, it is hoped that any improvement in services for women and children will result in improvements for all survivors including men.

Promotion of equality

3.4 This work has the potential to promote equality of opportunity for women, with their children, to live on equal terms with their partners. It should particularly improve 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 that currently prevent them from seeking and getting help.

Taking this forward

4 The Department of Health published the Government's interim response to the Health Taskforce's recommendations for action by Government and by the NHS in March 2010. The Department of Health Action plan 'Improving services for women and child victims of violence' will be published along with this Equality Impact Assessment.

4.1 The Action Plan will cover:

- Awareness raising of violence against women and children in health professionals, including advice for communications professionals;
- Improving access to information for women and children experiencing violence and abuse, to aid safe and swift access to services and advice;
- Improving skills and improving training of NHS staff to equip them to appropriately treat and refer victims of violence and abuse;
- Supporting NHS staff who might be victims of violence and abuse;

- Improving quality of the forensic workforce and services for victims of sexual assault;
- Ensuring effective commissioning of specialist services for women and children who are victims of violence;
- Improving data collection on violence and ensuring the appropriate sharing of data;
- Strengthening the evidence base on violence against women and children.

Methodology

5.1 This EqIA for the action plan 'Improving services for women and child victims of violence. The Department of Health Action Plan' has been informed by a number of sources. The steering group for the taskforce was made up of experts in mental health, nursing, domestic violence, harmful traditional practices, as well as senior representatives from the police, local government , the civil service and the NHS. A list of the steering group member is available in Annex D.

5.2 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:

- 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.

- 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 that included a series of focus groups run by the Women's National Commission. These covered women of different ages, ethnic backgrounds, sexual orientation, geographical locations, occupations and with different disabilities and health issues.

- The Women's National Commission, an arm's length body working in association with a number of community and voluntary groups, 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.

- The Taskforce commissioned two consultants to co-ordinate and gather 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.

- An open survey attracting responses from the general public. This 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.

- 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.
- The Taskforce also considered separately the issue of elder abuse.
- The Department of Health Action Plan has been informed by the NHS VAWC Implementation Group, Royal Colleges and third sector organisations.

The Evidence Base

Prevalence and risk

6.1 Headline evidence of the prevalence of violence against women and children includes:

Gender

- in 2009/10, more than one in four women in England and Wales (4.4m) had been affected by domestic violence since the age of 16[4] In 2009/10 there were 293,000 incidents of domestic violence recorded by police in England and Wales[5]
- On average, two women in England and Wales are killed every week by a current or former male partner.
- Domestic violence accounts for 16% of all violent crime, rising to 24% in certain local authority areas.
- There were 12,165 rapes of women in 2008/9. There were 968 rapes on males in the same period.[6]
- There were 20,000 sexual assaults on females in 2009/10[5].
- 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.
- Over half the women in prison say they have suffered domestic violence and one in three has experienced sexual abuse[7].
- British Crime Survey 2009 data show that women experience much higher levels of sexual assault than men do. For adult experience of any sexual assault (including attempts), women have about seven times the reported levels than men. For recent experiences, women have about 6 times the reported levels as men.

Age

- 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 occurs[8]
- Around 50% of women service users in specialist mental health services have endured child sexual abuse, and many have suffered further violence and abuse in adulthood.
- Sixteen % of children under 16 experienced sexual abuse during childhood (11% boys and 21% girls)[9].

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[4] Flatley, J et al. Crime in England and Wles 2009/10. Home Office 2010
[5] Ibid
[6] British Crime Survey 2009
[7] Reducing re-offending by ex-prisoners Social Exclusion Unit 2002.
[8] Department of Health 2002

- 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 under[10]
- Disabled children are three times more likely to be sexually abused than able bodied children [11]
- Children under the age of 12 were most likely to have reported being raped by someone they knew well (a friend or family member)[12.]
- Almost a quarter of sexual abuse reports to UK police forces in 2008 were for children under 10 years[13]
- Around one fifth (20.9%) of all rapes recorded by the police in 20089/10 were committed against children under 16 years of age[14].
- ChildLine, the 24 hour confidential helpline for children and young people, counselled on average one child aged seven and under for 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.
- 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.
- 88% of teenage girls and 83% of teenage boys have experienced sexual bullying at school
- Sexual bullying starts when children are in primary school
- 45% of teenage girls have had their bottom or breasts groped against their will
- 55% of adolescent girls believe that they were at least partly to blame for their unwanted sexual experiences[15]
- 1 in 3 girls and 16% of boys reported some form of sexual partner violence.
- 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
- 2.6% of people aged 66 and over living in private households reported in 2007 that they had experienced mistreatment involving a family

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[9] Cawson P. and May-Chahal C. Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. 2005.
[10] NSPCC figures from Freedom of Information request for police reports
[11] Sullivan and Knutson, 2000. This is a respected USA study. UK figures are unknown but estimated to be similar.
[12] Home Office Research Study 196. Home Office. p.7
[13] NSPCC, January 2009
[14] Flatley, J et al. Crime in England and Wles 2009/10. Home Office 2010
[15] AAUW (2001); Chiodo et al (2009); Fineran & Bennett (1999); Hands & Sanchez (2000); Murnen & Smolak (2000); Renold (2002); Timmerman (2005) and Altenor (2009); Owens et al. (2005); Katz & McManus (2008); Stonewall (2007); NSPCC (2006)

member, partner, close friend or care worker during the past year- this equates to about 227,000 people across the UK[16.]

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

Learning disability

- Nine out of ten people with learning disabilities experienced harassment or violence within a year[17]. Thirty-two% experienced harassment or attacks on a daily or weekly basis. Twenty-three% had been assaulted.

Forced Marriage

- The UK Forced Marriage Unit (FMU) handles around 400 cases of forced marriage each year. In 2008 there were an estimated 5000-8000 cases of either actual or threatened forced marriage in England alone[18].
- 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.
- 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.
- Women and girls may have an increased risk of forced marriage if they have disclosed sexual abuse.

'Honour violence'

- The United Nations Population Fund estimates that at least 5,000 women worldwide are victims of 'honour' killings each year.[19]
- There were 477 recorded incidents of 'honour'-based violence recorded by the Metropolitan Police Service in 2010[20]

FGM

- 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[21].
- 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.[22] 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[23].

Trafficking

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[17] Mencap, *Living in Fear*, 2000
[18] Kazirmirski et al 2009
[19] (United Nations Commission on Human Rights, 2002).
[20] Metropolitan Police Service 2010
[21] WHO 2008
[22] WHO, 2008.
[23] A statistical study to estimate the prevalenc of Female Genital Mutilation in England and Wales. Summary Report. Foundation for Women's Health, Research and Development (FORWARD). 2007.

- 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. [
- The NGO Anti-Slavery International estimates there may be at least 5,000 trafficking victims in the UK.[24]

Equality Impact of VAWC

Gender

7.1 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.

7.1.1 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."[25]

"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."[26]

7.1.2 Women and girls who have suffered gender-related violence can be badly affected by healthcare experiences that 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."[27]

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[24] Home Affairs Select Committee Report, 2009
[25] Focus groups run by the Women's National Commission, Autumn 2009
[26] Children's focus groups run for DH, Autumn 2009
[27] 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".[28]

"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."[29]

7.1.3 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."[30]

"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."[31]

7.1.4 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."[32]

Age

7.2 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).

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[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Focus groups run by the Women's National Commission, Autumn 2009

7.2.1 A review[33] 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 those women in the clinical population was 4-19.5%.

7.2.2 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.

7.2.3 Older women may have little awareness of the criminality of sexual violence[34]:

"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."

7.2.4 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"[35]

"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"[36]

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[33] 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).
[34] Focus groups run by the Women's National Commission, Autumn 2009
[35] Children's focus groups run for DH, Autumn 2009
[36] Ibid.

7.2.5 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."[37]

7.2.6 A failure to recognise abuse of young people by family members or partners can lead to inappropriate targeting of services[38] resulting in higher levels of undetected and untreated abuse elsewhere.

Ethnicity

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

7.3.1 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."[39]

"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."[40]

"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

[37] Focus groups run by Women's National Commission, Autumn 2009
[38] '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
[39] Focus groups run by Women's National Commission, Autumn 2009
[40] Ibid.

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. 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."[41]

"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."[42]

7.3.2 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. However, in some cases, where the perpetrator may be an older female relative, survivors may feel safer with male or younger staff that they do not associate with the abuse. This may particularly affect women and girls from some Asian communities.

7.3.3 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."[43]

"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."[44]

7.3.4 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*
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> *"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*

[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Focus groups run by Women's National Commission, Autumn 2009

nearest to her, who have put her in this position, and she might even have mixed feelings of anger towards them."[45]

"When [doctors] see women that have had FGM … they call everyone to come and have a look at our genitalia, it's very shameful."[46]

"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."[47]

7.3.5 FGM leads to an increased risk of Caesarean section, post-partum haemorrhage and perinatal mortality[48].

7.3.6 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." [49]

Disability

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

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

"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

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

[46] WNC, Women's Focus Groups, Home Office Consultation Response, p.32

[47] Ibid.

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

[49] Focus groups run by Women's National Commission,, Autumn 2009

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 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"[50]

7.4.2 Disabled children are three times more likely to suffer abuse than able-bodied children.
7.4.3 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."[51]

7.4.4 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."[52]

7.4.5 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

7.5 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.

7.5.1 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

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[50] British Crime Survey, 1999
[51] Focus groups run by Women's National Commission, Autumn 2009
[52] Ibid.

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."[53]

"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"[54]

7.5.2 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

7.6 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.

7.6.1 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."[55]

7.6.2 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 that denies their preferred identity.

7.6.3Trans 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

7.7 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.

7.7.1 There may be cultural views, which influence community attitudes and may lead to difficulties of access and take-up for people in some groups. There may be tensions on issues such as extra-marital sex, which has grounding in some religious teaching, and on issues such as underage

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[53] Focus groups run by Women's National Commission, Autumn 2009
[54] Children's focus groups run for DH, Autumn 2009
[55] Focus groups run by Women's National Commission, Autumn 2009

marriage, women's consent and control over their lives, which may be culturally-based.

7.7.2 There are some areas and circumstances in which religious background may be a particular risk of child sexual abuse[56].

Human Rights

7.8 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, for both women survivors and their children who experience or witness it.

Next Steps

8. The Taskforce has produced a report with 23 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.

8.1 The Government's interim response to this report contained an indication of the extent to which each recommendation is accepted. The Action Plan details how the Department of Health will implement those recommendations.

Equality Impact Assessment

9.1 A negative impact is unlikely. The policy has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist for women and children who are experiencing or have experienced violence. The improvements in services arising from this work should mitigate for any possible increase in barriers and inequalities for men.

Outline Equality Action Plan

10.1 VAWC affects women and children from all communities, able-bodied and disabled, different sexual orientations and all ages. In this Equalities impact assessment the main actions in the action plan have been considered along with mitigating factors that could be harnessed to address any negative impacts on equality.

10.2 Awareness raising

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[56] Ryan report, 2009; Commission of Inquiry into Dublin Archdiocese, 2009

A communications strategy has been developed in response to the recommendations of the Taskforce. The NHS awareness campaign developed was widely consulted on with the third sector and other stakeholders such as Government departments and NHS Partners. Stakeholders stressed the importance of tailoring materials to local populations and ensuring that materials should be accessible and tailored to the needs of different groups such as different ages, ethnicities and abilities.

10.3 Workforce education and training
'Honour' crimes, female genital mutilation (FGM) and forced marriage disproportionately affect women and children from certain communities. It is important that staff in the NHS are aware of these issues and how to treat or refer someone who divulges that they have been abused.

The evidence suggests that FGM is not always dealt with appropriately, maintaining the dignity of the victim; and often victims reporting pressure to marry or 'honour'-based violence are not referred immediately to someone who can help them. This is especially important with forced marriage as there is often only one opportunity to help the victim.

In order to address these issues, we will ensure that equality issues are adequately covered in healthcare training curricula, including a E-learning package commissioned by the Department of Health for general practitioners. We will ensure that these include 'honour crimes' and forced marriage.

The age, gender, ethnicity, and disability status of staff taking qualifications on VAWC will be monitored to ensure that the course is available to all appropriate staff. In addition, any materials available to staff, visitors or patients in healthcare settings on VAWC should be in appropriate media and accessible to different communities.

10.4 Improving quality of services
It is essential that services for victims of VAWC are of high quality and fit-for-purpose.
There is evidence that certain groups such as those with learning disabilities are at a higher risk of abuse. In designing services, it is important that 'less-heard' communities are consulted and in order to achieve this, appropriate communities, service user-groups and local third sector organisations should be consulted in exercises such as joint strategic needs assessment. Data on the demographics of clients should be collected to ensure that all victims have equity of access to services.

10.5 Evidence
Because all communities do not have the same ability to interact with health services, data needs to be collected on service use to ensure that there is no discrimination (institutional, direct or indirect) levelled at any sections of the population/community. This evidence can then be used to better plan services.

In addition, there are gaps in our knowledge on VAWC, for instance there is a need for an examination in the prevalence of same-sex intimate partner violence. Research should be commissioned to equip policy-makers to make good decisions that result in a good quality, culturally appropriate, age-appropriate services for victims.
10.6. Recommendation 22 from the Taskforce outlines the need for a national steering group to oversee the implementation of the recommendations from the Taskforce. This recommendation has been implemented and this Action Plan has been produced by that implementation group.

10.7 The Department of Health will use the Action Plan to support the improvement of the health response to violence against women and children.

10.8 The Action Plan details actions for awareness raising , improving education and training on violence against women and children for the NHS workforce, improving the quality of services for women and child victims of violence and strengthening data collection and evidence on violence against women and children.

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

Area of Action (from Action Plan)	Action	Equality Issue	Equality Action	Action lead
Awareness raising	Deliver an NHS awareness raising campaign to coincide with End Violence Against Women Day on 25 November 2010.	This campaign is aimed at preventing violence against women and does not address sexual or intimate partner violence against men. Violence against women affects women from many communities, women with disabilities, different sexual orientations and women of all ages.	Ensure that all awareness raising resources consider equality issues. Any improvement in access to, and quality of, services should represent an indirect improvement for male victims. Communications strategies should make it clear that materials must be tailored to the local population and should be accessible and tailored to the needs of different groups such as different ages, ethnicities and abilities.	DH Health services/NHS organisations
Awareness raising	Information for victims - Boost website content on VAWC building on work done by NHS choices	Some communities might not have English Language skills People with disabilities might have problems accessing suitable material on the internet	Ensure website content is accessible and appropriate to different audiences e.g. those with learning difficulties, those with impaired vision	DH Policy Team
Workforce education and training	Sponsor the development of a basic qualification for forensic physicians	VAWC affects women and children from all communities, able-bodied and disabled, different	Ensure that equality issues are adequately covered in the training, including the need for qualified	DH Policy Team

Area of Action (from Action Plan)	Action	Equality Issue	Equality Action	Action lead
		sexual orientations, and all ages	interpreters	
Workforce education and training	E-learning package on VAWC	VAWC affects women and children from all communities, able-bodied and disabled, different sexual orientations, and all ages	Ensure equality issues are adequately covered in the syllabus, including 'honour crimes' and forced marriage. Monitor ethnicity, age, gender and disability in staff taking this qualification.	DH Policy Team
Workforce education and training	Potential for an E-learning tool to provide a basic qualification on forensic sexual assault work.	VAWC affects women and children from all communities, able-bodied and disabled, different sexual orientations and all ages	Ensure equality issues are adequately covered in the syllabus, including 'honour crimes' and forced marriage. Monitor ethnicity, age, gender and disability in staff taking this qualification. Any improvement in access to, and quality of, services should represent an indirect improvement for male victims.	DH Policy Team
Workforce education and training	Feed into the strategy on health, work and well-being to ensure the impact of violence and	VAWC affects women and children from all communities, different sexual orientations, able-	Ensure any materials used in the workplace are accessible to different communities.	Health organisations/NHS DH Policy Team

Area of Action (from Action Plan)	Action	Equality Issue	Equality Action	Action lead
	abuse is recognised and the need to support staff who may be victims	bodied and disabled and all ages. A number of healthcare staff will be suffering domestic violence. However, the needs of male staff might be overlooked	Ensure staff have access to services that could help if they are victims. Although these actions are predominantly aimed at women victims (and their children), steps should be taken to ensure that services are available for men.	
Improving quality of services	Provide funding jointly with the Home Office in 2010/11 to improve access to and quality of Sexual Assault Referral Centre (SARC) services	Access to and quality of services must be improved for all services users.	Improve awareness of SARCs among health and police service staff and ensure that they know how to refer to the service. Ensure that equality issues are considered in agreeing the data collected for quality monitoring in SARCS.	Health services/NHS organisations DH Policy Team
Improving quality of services	Involve service users in service needs assessment, planning, design and evaluation through processes such as Joint Strategic Needs Assessment; Quality, Innovation, Productivity and Prevention	Some communities/people that need to be consulted might be missed in these processes.	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	Health services/NHS organisations

Area of Action (from Action Plan)	Action	Equality Issue	Equality Action	Action lead
			younger adults, teenagers and children), disability, sexuality, gender identity, and ethnicity	
Evidence	Develop a needs assessment toolkit on sexual violence to assist local areas in identifying all relevant data sources	Some communities may have communication problems and this could lead to a lack of data collected on these victims.	Ensure that appropriate data is collected to ensure equity in services and that no group is discriminated against	NHS/ Health organisations DH Policy Team Local Public Health teams
Evidence	Research studies	VAWC affects women and children from all communities, able-bodied and disabled, different sexual orientations and all ages.	Commission research to advise policy makers – ensure that these address equality issues.	DH

Further action

11.1 The Department of Health will ensure that its webpage with resources including the Department of Health Action Plan , is kept up to date.

11.2 The Steering Group on the Implementation of the Taskforce recommendations on the health aspects of violence against women and children will oversee the execution of actions from the Action Plan.

11.3 The Department of Health will look at ways in which existing quality assurance and monitoring mechanisms may be used to provide feedback on how health services for victims of violence and abuse are being improved or whether there is a need for further action. These mechanisms will be designed within the new NHS structure following the consultation on the White Paper 'Liberating the NHS' and the White Paper on the Public Health Service, expected Autumn 2010. In addition, mechanism such as the National Patient Survey, NHS Complaints monitoring, and also the Quality Framework and CQC registration and monitoring processes will be used. These provide ways of checking whether providers are fulfilling their responsibilities and whether patient services and experiences are improving as a result.

For the Record

Name of person completing the EqIA:	Allison Duggal
Date EqIA completed:	November 2010
Name of Director endorsing the EqIA:	Mark Davies
Date EqIA endorsed:	15 November 2010

ANNEX A
Health Taskforce Recommendations (those in italics are not being taken forward in the Action Plan).

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	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: • 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. Universities and other providers of education and training, employers, regulatory and professional bodies should work together to make this happen.
4	*Midwives and health professionals should be trained to provide information to mothers from communities that 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 appropriately. This means that: • 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 SARCs, and these should be effectively communicated to those managing and working in SARCs 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: • 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.

ANNEX B

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 forms[57], and of these:

- Ten % 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.
- Twenty-nine % of women identified as being disabled.
- Two% of women identified as transgender.
- Five% of women identified as lesbian, 1% of women as bisexual, 76 % of women as heterosexual and 4% of women as 'other'.
- Forty-four % 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.
- Twenty two % 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'.

[57] 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).

Annex D

Taskforce on the Health Aspects of Violence Against Women and Children – membership of taskforce steering group

Oonagh Aitken	National Adviser, Children and Young People, Local Government Association Group
Professor Sir George Alberti (Chair)	Clinical Advisor to NHS London, Senior Research Investigator at Imperial College London and Emeritus Professor of Medicine at Newcastle University
Obi Amadi	Lead Professional Officer, Unite (the Union) – Health Sector (incorporating Community Practitioners' and Health Visitors' Association)
Louis Appleby*	Co-chair, Sexual Violence Against Women sub-group, National Director for Mental Health in England and Professor of Psychiatry at the University of Manchester
Dr Susan Bewley	Consultant Obstetrician/Maternal Fetal Medicine, Guy's & St Thomas' NHS Foundation Trust
Dinesh Bhugra	President, Royal College of Psychiatrists
Dame Carol Black	National Director for Health and Work
Eleri Butler	Violence Against Women Policy Manager, Women's National Commission
Miss Sarah Creighton*	Co-chair, Harmful Traditional Practices and Trafficking sub-group, Consultant Gynaecologist, University College London Hospital
Moira Dumma	Chief Executive, NHS South Birmingham
Mike Farrar/ Deputy Dr Ann Hoskins	Chief Executive, NHS North West/ Director of Children, Young People and Maternity, NHS North West
Gene Feder*	Co-chair, Domestic Violence sub-group, Professor of Primary Health Care, University of Bristol
Dr Clare Gerada	Vice Chair of Council, Royal College of General Practitioners

Ruth Hussey/ Sarah Lewis	Regional Director of Public Health and Medical Director, NHS North West/Regional Strategic Health Manager for Crime and Disorder, NHS North West
Ann Jackson	Learning and Development Facilitator, Royal College of Nursing
Shirlene Jones	Head of Nursing, Emergency and Urgent Care Centre, Whipps Cross University Hospital
Christopher Long*	Co-chair, Domestic Violence sub-group, Chief Executive, Hull Teaching PCT
Vince McCabe	Managing Director, West Essex Community Health Services
Astrid Osbourne	Head of Midwifery and Supervisor of Midwives [interim], Queen Mary's South London Healthcare NHS Trust; Consultant Midwife, University College London Hospital
Dr Rosalyn Proops*	Co-chair, Sexual Violence Against Children sub-group, Child Protection Officer, Royal College of Paediatrics and Child Health
Dawn Rees*	Co-chair, Sexual Violence Against Children sub-group, National CAMHS (Child and Adolescent Mental Health Service) Strategic Relationships and Programme Manager
Dr Karen Rogstad*	Co-chair, Sexual Violence Against Women sub-group, Royal College of Physicians, London, Consultant Physician in GU Medicine, Sheffield Teaching Hospitals NHS Foundation Trust
Dr Robina Shah	Chair, Stockport NHS Foundation Trust and National Lead for Disability Hate Crime, Ministry of Justice and Department of Health
Surinder Sharma*	Co-chair, Harmful Traditional Practices and Trafficking sub-group, National Director of Equality and Human Rights, Department of Health
Professor Anthony Sheehan	Chief Executive, Leicestershire Partnership NHS Trust
Dr Sheila Shribman	National Clinical Director, Children, Young People and Maternity, Department of Health
Liz Stephens	President, Royal College of Midwives
Dr Lindsey Stevens	College of Emergency Medicine
Antony Sumara	Chief Executive, Mid-Staffordshire NHS Foundation Trust
Paul Sutton	Chief Executive, South East Coast Ambulance Service NHS Trust
Rita Symons	Director of Strategy and Commissioning, NHS South Birmingham
Professor Ian F. Wall	President, Faculty of Forensic and Legal Medicine, Royal College of Physicians
Jo Webber	Deputy Policy Director, NHS Confederation
Dr Jan Welch	Clinical Director, The Haven Camberwell
Dave Whatton	Chief Constable, Cheshire Constabulary
Mary Whyham	Chair, North West Ambulance Service NHS Trust

Annex E

Membership of the Implementation Group on the Taskforce on the Health Aspects of Violence Against Women and Children

Melanie Walker (Chair)	Chief Exec, Newham PCT
Dr Jan Welch	Clinical Director, Haven Camberwell
Dr Louise Howard	Women's Mental Health, Institute of Psychiatry, King's College London
Dorcas Akeju	Chair of Liverpool FGM Group and FGM National Clinical Group
Professor Dunkley- Bent	London Southbank University
Rosalyn Proops	Royal College of Paediatrics and Child Health
Rita Symons	Director of Strategy and Commissioning, South Birmingham PCT
Dr Gene Feder	Primary Health Care, University of Bristol
Prof Sir George Alberti	Former Chair of Health Taskforce on VAWC
Dr Susan Bewley	Consultant Obstetrician/Maternal Foetal Medicine
Dr Lindsey Stevens	Royal College of Emergency Medecine