Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Cydraddoldeb a Chyfiawnder Cymdeithasol ar Atal trais ar sail rhywedd drwy ddulliau iechyd y cyhoedd

This response was submitted to the Equality and Social Justice Committee consultation on The public health approach to preventing gender-based violence

PGBV 15

Ymateb gan: Coleg Brenhinol y Seiciatryddion Cymru a Chanolfan Gweithredu Iechyd Meddwl y Cyhoedd | Response from: Royal College of Psychiatrists Wales and Public Mental Health Implementation Centre

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Royal College of Psychiatrists Wales

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness and intellectual disabilities, and the mental health of individuals, their families and communities.

In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych Wales represents more than 600 Consultant and Trainee Psychiatrists working in Wales.

The Public Health Approach to Preventing Gender-Based Violence

Background

Women and girls are disproportionately affected by gender-based violence (GBV); this term also acknowledges the power inequalities that underpin multiple forms of violence against women globally.[1] "Gender-based" refers to gender roles and status across society which in turn perpetuate violence against women although "gender affects violence by and toward *both* women and men".[2]

1. Different types of violence

The terms GBV, domestic violence, Intimate Partner Violence (IPV) and Violence Against Women and Girls (VAWG) convey similar concepts and are used interchangeably. However, there are important distinctions between them and their implications at different levels.[3]

It is important to note that the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015[4] defines GBV to include harassment and genital mutilation as well as "honour-based violence." Specifically, the Act defines that GBV includes behaviours "arising from values, beliefs or customs related to gender or sexual orientation", female genital mutilation forced marriage.[4]

Intimate Partner Violence (IPV) is a behaviour by a current or previous intimate partner that causes physical, sexual, or psychological harm, including acts of sexual coercion, controlling behaviour, physical aggression, and psychological abuse.

Domestic violence involves all acts of physical, sexual, psychological, and economic violence that occur within the family, domestic unit, or between intimate partners. These can be former or current partners and does not necessarily involve sharing the same residence.[1]

2. Prevalence of different types of violence

Research on GBV commonly investigates the type of behaviour and its frequency (prevalence and incidence).[12,13] These data are captured in self-reported surveys or administrative datasets but are largely influenced by underreporting linked to fears and avoidance of blame.[12,13] Additionally, issues arise relating to aggregated data based on multiple forms of violence rather than individual datasets.[13(p3)] GBV is a major issue both globally and locally. About one-third of women worldwide have experienced sexual and/or physical violence at some point in their lives, while more than 10% of women were victims of such violence at the hands of an intimate partner in the past year.[14] The prevalence of GBV among countries in the European Union (EU) is similar to the global average, with approximately

one-third of women experiencing sexual and/or physical violence at some point in their lives.[15] The annual incidence of such abuse among women in EU countries has been estimated at 8%.[15]

According to the Crime Survey for England and Wales, it is estimated that 1 in 20 (5%) adults aged 16 or over experienced domestic abuse between October 2021 and March 2022.[5] This type of violence disproportionally affects women. In England and Wales, 70% of victims of domestic abuse are women.[6] However, domestic abuse remains heavily underreported, with only 13% of those who experienced it the mentioned period reporting it to the police.[19] Domestic abuse is also costly with an estimated £66 billion in England in 2017 with this likely being an underestimate of the actual cost.[7–9] Almost three-quarters of the £66 billion cost (£47 billion) relate to the emotional harms experienced by victims; there are also costs to the economy relating to reduced productivity, time off work and costs to services.[8]
In 2019/20 it was estimated that just over 2,000 people experienced honour-based abuse in England and Wales and in 2017/18, 271 newly recorded cases of FGM were recorded in Wales.[7,8,10] Finally, there are approximately 100 victims of forced marriages in Wales every year.[8,11]
During COVID-19, government restrictions including lockdown and physical distancing led to the "shadow pandemic" of violence, as first described by the United Nations.[16] During the March 2020 lockdown, referrals to domestic violence and abuse services in England and Wales declined when compared to period before and after as well as the same period the year before.[17] However another study[18] found that during COVID-19 (March 2020-September 2020), there was a 190% increase (54 to 157) in self-referrals to local support services in Bridgend relating to child and domestic abuse concerns – based on data from a local domestic abuse charity (CALAN). Similarly, a 198% increase (44 to 131) in third party referrals was seen in the same time period.[18]
Overall, these figures highlight the urgent need for increased awareness, prevention, and response measures to address GBV and provide support to those affected by it.

3. Impact of victimisation on health

There are risks to health including injuries, reproductive health problems (e.g. increased risk of acquiring STIs), and chronic health conditions.[20] GBV is often considered in relation to a 'syndemic' of interacting diseases which synergistically exacerbate one another and are underlined by social conditions.[21,22] Syndemic relationships are often considered between GBV, mental health and HIV.[21,23] Both physical and mental health consequences can have intergenerational impacts that can span across the life course.[20] Mental disorders are also among some of the strongest risk factors for interpersonal violence (ranging from 1.8 times increased likelihood among hyperkinetic disorder to 7.4 times among people with substance use disorders).[24,25]

4. A public health approach to GBV

The World Health Organization's (WHO) Violence Prevention Alliance describes how a public health approach to violence "seeks to improve the health and safety of all individuals by addressing underlying

risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence".[8,26]

A public health approach to GBV involves addressing the issue as a public health concern rather than solely a criminal justice or individual problem.[27] This approach recognises that GBV is a widespread and complex problem that requires a multi-sectoral response that includes prevention, surveillance and monitoring (epidemiology), early intervention, collaboration, and empowerment.[8,27] Overall, a public health approach to GBV seeks to address the root causes of violence and to promote safety, health, and well-being for all individuals and communities.[27]
The WHO's Violence Prevention Alliance[26] specify four steps for a public health approach to violence prevention:

1) Surveillance/epidemiology
2) Identifying risk and protective factors
3) Developing and evaluating interventions
4) Implementation and scaling up effective policy and programmes, including addressing any implementation gaps

5. Welsh policies and priorities

The Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015 enforces a statutory duty for local authorities to provide basic training and awareness for all staff, enhanced training for those with closer contact and a duty to prepare and implement local strategies.[4] This was a landmark achievement as the first UK legislation to explicitly address violence against women.[7,28] However, concerns have been raised about the interactions between this Act and the Housing (Wales) Act 2014 regarding the rights of women who are homeless following domestic abuse.[4,29,30]

Q1) What works in preventing gender-based violence before it occurs (primary prevention) and intervening earlier to stop violence from escalating (secondary prevention)?

From a broader perspective, there is evidence (ref) for interventions aiming to:

- Empowering women and girls
  - Promoting the empowerment of women and girls through education, economic opportunities, and political participation can help to reduce their vulnerability to violence and increase their agency.

- Engaging men and boys
  - There is promising evidence of interventions that engaging with men and boys can prevent GBV.
  - These types of interventions can be successful in challenging traditional notions of masculinity and promote more equitable and respectful relationships between men and women.

- Addressing structural factors
  - Addressing the root causes of gender inequality and discrimination, such as poverty, racism, and homophobia, can help to prevent GBV by reducing the social and economic marginalisation of vulnerable populations.

Moreover, there is a wide array of interventions in the health sector that can prevent GBV from occurring in the first place (ref)

- Training and education
  - Develop the capacity of health services with the required skills to address prevention of VAWG both from a health and a multi-sectoral approach.[31]
  - VAWG and its impact should be embedded in medical school and psychiatry training alongside teaching on Trauma Informed Approaches (TIA)
  - All doctors in training and those who provide mental health care to understand their duty and have confidence to ask about, and respond safely to, VAWG, including domestic violence and abuse, sexual harm, FGM, HBV.
  - Mandatory training for all health care professionals to make sensitive routine enquiry into the risk of harm to people of all ages as well as the risk they pose to others, including around DVA and coercive control and how to respond to disclosures.

- Data collection
  - A mandatory field on measures of GBV including domestic violence and abuse, should be included within the NSH Digital Minimum Mental Health Data Set.
  - Data collection in all healthcare organisations should include data on domestic violence and abuse (present/absent/not asked).

- National data for Wales should be disaggregated to different local areas, where possible, to support the undertaking of local needs assessments by public health bodies and local authorities.

- Support sharing of intelligence on GBV across sectors (e.g., police, schools, healthcare settings, charities) to increase understanding of size of the problem locally and nationally; however, this must consider specific privacy/confidentiality concerns of marginalised groups (see Q2 response)

- Leadership
  - We need multidisciplinary senior leadership (including medical) to implement trauma informed approaches and effective strategy around domestic abuse and multi-agency working (National Pathfinder Toolkit, June 2020)
  - It is essential to create health policies and protocols that recognise VAWG and streamline specific actions and pathways to address it.[31]

- Finance
  - The prevention of GBV is a heavily underfunded area. While 'Tackling violence against women and girls' strategy involved £43 million during the 2021/2022 period, Women's Aid estimates that £409 million is required to properly address GBV during the 2022/2023 period.[31,32]
  - Health budgets should explicitly allocate resources to the prevention of GBV.

- Research:
  - Research on VAWG is still an emerging field.[33] There is still an incomplete understanding of the full array of health consequences and limited evidence on what works to prevent and tackle VAWG 'in terms of research and evidence.[33] Local research is needed to understand and meet the needs of the people who have experienced violence and those at risk.

Secondary prevention involves identifying and intervening in cases of GBV among individuals who have already experienced it. There are several ways in which the healthcare sector can address GBV from a secondary prevention approach. By taking this approach, healthcare providers can help reduce the impact of GBV on individuals and communities.

- Early identification:
  - Identifying warning signs of violence and providing support to individuals and families at risk can help prevent violence from escalating.[31]
  - The WHO have stressed the relevance that healthcare professionals have in early identification of IPV and the need to integrate elements related to GBV into clinical training.[34]
  - Women subject to IPV are usually treated within the health system, yet they do not always show obvious signs of abuse and many of them go undetected.[35]
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- Although NICE guidelines recommend training related to identification of GBV, this training remains minimal in most health educational curricula.[36]

- Effective support for victims
  - Effective support for women and girls subject to GBV includes the timely provision of counselling, legal support and referrals to appropriate services.
  - System-level integration to effectively refer individuals who have experienced GBV to appropriate services within the health sector.[31]
  - Enhancing and streamlining the referral network with organisations outside of the health sector, particularly the justice sector.
  - The forms of support that generate the most satisfaction for patients who have experienced GBV are trained counsellors/psychologists, Independent Sexual Violence Advisors (ISVAs), IDVAs, support services and specialist helplines.[31]
  - Personalised interventions with tailored goals, specific to the needs of patients who experienced GBV are the most effective.[37]

- Working with perpetrators
  - We support the promotion of the clear understanding that mental health conditions do not cause domestic abuse. Mental health professionals, as well as all healthcare clinicians do however have responsibility and should be trained and confident in routine enquiry and responding to disclosures from those who may be perpetrating abuse, including when to ask advice on any potential need to break confidentiality.
  - Holding perpetrators accountable for their actions through effective prosecution and sentencing can serve as a deterrent to future violence and provide a sense of justice for survivors.

Tertiary prevention involves the longer term or future care following violence including treatment, support, and protection (ref). For example, this may include measures such as providing emergency shelters and long-term support services (ref). However, this may also intersect with secondary prevention; each level is not mutually exclusive.[8,38]

Q2) How effective is a public health approach to preventing gender-based violence and what more needs to be done to address the needs of different groups of women, including LGBT+, ethnic minorities, young and older people at risk of violence at home and in public spaces?

Some subgroups of the population are disproportionally affected by GBV due to protected characteristics including age, ethnicity, disability, sexuality, and religion. To address this disproportionate burden, GBV research and policy must therefore look beyond gender and utilise an intersectional approach.[39] Specifically, gender inequalities and discrimination may intersect with structural determinants including other types and levels of discrimination, oppression and violence which heighten vulnerabilities.[39,40] For example, racism and discrimination (e.g. relating to migration status), gender binarism, sexism and heterosexism.[12]

Inequalities relating to power, marginalisation and historical oppression are interwoven and worsen outcomes among population groups.[40] For example, the prevalence of GBV is particularly high among transgender people; in the US one study estimated prevalence of physical intimate partner violence (in the past 12 months) to be as high as 89% in secondary school settings.[21,41]

Other disproportionately affected groups include:

- LGBT populations including women who identify as lesbian, bisexual, transgender or intersex[8,21,42]
- Indigenous women and racially minoritised communities/ethnic minorities[8,42,43]
- Refugees, asylum seekers and migrants (documented and undocumented) e.g. victims of human trafficking, conflict settings/humanitarian crises[8,42,43]
- Sex workers[44]
- Younger girls and older women[8,42]
- People living in poverty or rural communities
- People who use drugs
- Women and girls living with HIV and disabilities[8,42,45]
- People with severe mental illness[46–48]

Often, the marginalised status of these groups magnifies barriers of reporting resulting in underreporting of data.[49] For instance, undocumented migrants may experience fears of immigration enforcement following sharing health data with authorities (e.g. police, Home Office) or those who may face No Recourse to Public Funds (NRPF).[50–52] This is at a tension with efforts for surveillance and epidemiology – the first critical step in a public health approach. However, a 'firewall' approach to sharing data could overcome this initial barrier, which has already been accepted in principle by the Welsh Government and would be a step forward to Wales actions to be a 'Nation of Sanctuary'.[51–54] Additionally, in Wales, it has been identified that tailored approaches for vulnerable migrant women is

required particularly for those with precarious with support that is “appropriately resourced, high quality, needs-led, strengths-based, intersectional and responsive”.[55]

Furthermore, vulnerable groups may face barriers related to access and appropriateness of interventions. [36] LGBT+ individuals may face additional barriers to accessing services and may be more vulnerable to violence due to discrimination and stigma. Ethnic minorities may have unique cultural beliefs and practices that need to be considered when designing prevention programs. Younger and older people may require specific education and resources that are appropriate for their age group. This means that the approach needs to recognise the ways in which different forms of oppression act to create unique experiences and vulnerabilities for different groups of people. Initiatives need to be designed in collaboration with the affected communities to ensure that they are culturally sensitive, inclusive, and effective.

Ultimately, an intersectional approach must be applied alongside a public health approach for social justice and health equity.[12]

Q3) What is the role of the public sector and specialist services (including the police, schools, the NHS, the third sector and other organisations that women and girls turn to for support) in identifying, tackling and preventing violence against women, and their role in supporting victims and survivors?

The public sector and specialist services play a crucial role in identifying, tackling, and preventing violence against women, as well as supporting victims and survivors. There is also a need to have sufficient monitoring systems in place to sustainability reduce violence including data on:

- Number experiencing different risk factors for violence perpetration/ victimisation including from higher risk groups
- Number experiencing different types of violence across the life course including from higher risk groups
- Proportion including from higher risk groups receiving evidence-based interventions to prevent violence, intervene early to stop it and for mental/physical effects of violence

The police and the justice system are responsible for responding to incidents of violence, protect victims from further harm and holding perpetrators accountable. [56] Health services are key to provide medical and psychological support to victims and survivors of GBV[14]. On the other hand, schools are key in change attitudes and behaviours that accept and normalise GBV from an early age. [57] The Third Sector and other organisations can raise awareness about the issue of GBV, provide support and resources to survivors, act as a bridge with statutory services, especially among marginalised populations, and advocate for policy and systemic changes that can help prevent violence against women and other marginalised gender groups. [58] These actions must be in collaboration between different organisations and sectors to ensure a coordinated response to violence against women.

A multi-agency response to GBV is a core component for a public health approach for primary, secondary, and tertiary prevention. As well as the sectors listed above, specialist health services that should be involved in a Health-in-All policies approach to GBV include sexual health services, HIV services, mental health services, support services (e.g. substance misuse, violence/abuse support, homelessness, childcare) and criminal justice contact.[59] Previous research has shown that some women who experience multiple disadvantages are still unable to access support across a range of issues across both England and Wales.[59,60]

The multi-agency Wales Violence Protection Unit is built on longstanding partnership between public health and policy.[16] However, some specialist services are more established and resourced than others.[61] For instance, currently there is only one organisation in Wales with expertise supporting forced migrant survivors with limited capacity and resource.[62]

As well as the sectors listed above, specialist health services that should be involved in a Health-in-All policies approach to GBV include sexual health services, HIV services, mental health services, support services (e.g. substance misuse, violence/abuse support, homelessness, childcare) and criminal justice

contact.[59] Previous research has shown that some women who experience multiple disadvantages are still unable to access support across a range of issues across both England and Wales.[59,60]
Specialist trauma-informed services must be co-designed with communities who are disproportionally affected by GBV to ensure that they are culturally competent and do not further exacerbate harms; for example, mainstream services are often not fully equipped to manage the complexities and intersecting issues that people may experience and trauma they may hold.[59]
We support recommendations of embedding co-production throughout the process from conducting needs assessments to commissioning services.[59]
The WHO[14] also outlines the role of the health sector to include:

1) Advocacy
2) Comprehensive services with health providers sensitised and trained in providing holistic and empathetic care
3) Early identification of women and children experiencing violence (prevent recurrence)
4) Promoting egalitarian gender norms
5) Generating evidence on magnitude of the problem through data collection (e.g. population-based surveys), surveillance and monitoring

Some of these actions are already being rolled out across Wales (e.g. statutory duty of NHS Wales nurses to report safeguarding concerns). However, some policies continue to act as a barrier to support (e.g. migrant women and girls and NRPF).[52] The multi-agency Wales Violence Protection Unit is built on longstanding partnership between public health and policy.[16] However, some specialist services are more established and resourced than others.[61] For instance, currently there is only one organisation in Wales with expertise supporting forced migrant survivors with limited capacity and resource.[62]
Overall, the public sector and specialist services have a critical role to play in identifying, preventing, and responding to violence against women, and in supporting victims and survivors. It is essential that they work together to create a comprehensive, coordinated response that prioritises the safety and well-being of women and girls.

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