Healthcare Policy and Strategy Directorate
Patients and Quality Division

The Scottish Government

CEL 41 (2008)

29th September 2008

Dear Colleague

GENDER-BASED VIOLENCE ACTION PLAN

Summary

1. The Annex to this letter sets out expectations for Boards to develop a 3 year action plan (2008 – 2011) to address gender based violence and supersedes previous guidance issued in 2003 – '*Domestic Abuse Guidelines for Healthcare Workers in NHS Scotland*'.

Action

2. Chief Executives must ensure that:

- this letter and the attached guidance are brought to the attention of, and implemented by, all appropriate staff and in particular ensure that they develop and deliver a 3 year action plan with specific and measurable goals across the priority areas identified; and
- contact details for a senior member of the Executive team appointed to lead on this area of work are passed to Katie Cosgrove by 17 October (see panel for contact details).

3. This plan will address the following 4 key areas:
    - Implementation of Routine Enquiry of abuse within priority settings
    - Dissemination of revised guidance on abuse for staff.
    - Production of an employee policy on gender-based violence.
    - Multi-agency collaboration.

4. Undertaking this work will assist Boards meet their legislative obligations to promote gender equality as detailed in the Equality Act 2006. To facilitate this process we have agreed a package of support including the appointment of a national team, the development of a suite of resources and tools, and funding to promote the plan internally within each board

5. An evaluation of this work will take place over the 3 year implementation period.

Yours sincerely

DEREK FEELEY

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GENDER-BASED VIOLENCE ACTION PLAN
GUIDANCE FOR HEALTH BOARDS

A. INTRODUCTION

1. This guidance details our aims and objectives in relation to tackling gender-based violence over the next 3 years, the contribution of health boards towards realising these, and the support available to do so. Some further explanatory notes on gender-based violence and routine enquiry of abuse are included in Appendices 1 and 2 of the guidance.

B. BACKGROUND

2. Addressing gender-based violence falls within our legislative obligations to promote gender equality as detailed in the Equality Act (2006), and within our responsibility to implement both the cross governmental *Strategic Framework on Violence Against Women* and the *Strategic Approach for Survivors of Childhood Sexual Abuse. The National Domestic Abuse Delivery Plan for Children and Young People* developed under the auspices of *Getting It Right for Every Child (GIRFEC)* also includes *a* range of actions that have implications for the NHS, in particular the inclusion of a programme of routine enquiry of domestic abuse.

3. As a profound public health issue it is also an important part of our endeavour to address health inequalities as identified in *Better Health, Better Care* and in *Equally Well,* the report issued by the *Ministerial Task Force on Health Inequalities.*

4. Gender-based violence encompasses the spectrum of abuse experienced disproportionately by women and perpetrated predominantly by men i.e. domestic abuse, rape and sexual assault, childhood sexual abuse, sexual harassment, stalking, commercial sexual exploitation, and harmful traditional practices such as female genital mutilation (FGM), forced marriage and so-called 'honour' crimes. Given the range of health problems associated with abuse, its impact on health services is substantial and cuts across the majority of health service settings. The NHS has a pivotal role in the appropriate identification and management of this issue since virtually all survivors of abuse, both female and male, will interact with health services at some point, either on their own or on their children's behalf.

5. NHSScotland is committed to making tangible, sustainable progress in tackling this issue. To do so we intend to adopt an incremental approach over the next 3 years, concentrating on the areas and settings where presentations of people affected by gender-based violence are highest, and which work closely with the most vulnerable people within our communities. The priority areas for attention will therefore be **mental health, sexual & reproductive health, A&E, primary care, addictions, and maternity services**. Appropriate linkage with work on **child protection** and **homelessness** will also be prioritised given the overlaps with these areas.

6. Most health boards have made some inroads in relation to domestic abuse but progress on other forms of abuse is more fragmented. The focus of this

guidance is to consolidate these gains and establish a co-ordinated and consistent national approach to the identification and management of gender-based violence. It outlines the **minimum** requirements essential to realise the goal of an NHS that understands and discharges its responsibility in this important area.

C. AIM AND OBJECTIVES OF GUIDANCE

Aim

7. Our aim is to adopt a systems approach to ensure that the NHS in Scotland fully recognises and meets its responsibilities around gender-based violence as a service provider, employer and partner agency.

Objectives

8. The scale of the task and the existing pressures upon health services require the adoption of an incremental approach to change, hence the decision to prioritise the areas of **Mental Health, Sexual & Reproductive Health, A&E, Addictions, Primary care, Addictions, and Maternity services.** Linkage with work on Homelessness and Child Protection will also be included in this approach. Our objectives are:

- To improve the health care identification and assessment of gender-based violence within priority areas;
- To increase the institutional capacity of health boards to respond to abuse;
- To develop indicators and establish healthcare outcome measures on the detection and management of abuse related health problems;
- To develop comprehensive standards of care in relation to the different forms of gender-based violence within priority areas;
- To ensure that gender-based violence is integrated into the relevant strategic and planning frameworks;
- To develop a clear policy within boards for employees who have experienced, or are experiencing abuse, or are perpetrators of abuse; and
- To ensure the NHS contributes effectively to multi-agency efforts to address abuse.

D. RESPONSIBILITY OF HEALTH BOARDS

9. To realise the above aim and objectives, each health board will develop and deliver a 3 year action plan detailing how it will achieve the following **4** key deliverables:

(i) *Implementation of Routine Enquiry of abuse within the priority settings*
(ii) *Dissemination of revised guidance on abuse to staff*
(iii) *Production of an employee policy on gender-based violence*
(iv) *Multi-agency collaboration*

Executive Leadership

10. Each board will be expected to appoint a senior member of the Executive team to assume responsibility for establishing an appropriate infrastructure to direct the work and deliver the required change. While we would suggest this is the

Designated Director for Patient Focus Public Involvement, given their existing equalities responsibilities, there may be other more suitable leads.

11. A senior operational manager within each board and CHP should be assigned responsibility for ensuring effective implementation of the plan.

12. An annual report, aligned to a board's Gender Equality Scheme, reflecting year on year progress will be produced.

Action Plan

13. Each health board must prepare a 3-year action plan on gender-based violence with specific goals and timescales across each of the 3 years. **Each plan must ensure that the differential needs of both service users and staff in relation to other forms of inequality, including ethnicity, disability, age, sexual orientation, and faith are identified and recognised.** (Already a requirement under Equality Impact Assessment HDL (9) 2005).

14. It is acknowledged that health boards are at variable stages of development in relation to addressing gender-based violence and that they face different challenges in terms of geography and demographics. These factors will be reflected in the construction of individual plans. All, however, should specify their stage of development in relation to the following requirements for their plan, and indicate whether this will be a strengthening or advancement of existing work or the introduction of new processes.

15. To ensure tangible and demonstrable improvements each plan will focus on detailing the commitment and actions of the board in relation to the **4** key deliverables. This will include:

(i) Implementation of Routine Enquiry of abuse within the priority settings

Notes on routine enquiry are included at the end of this guidance.

A staged approach to the implementation of routine enquiry is essential, reflecting the need for careful planning around its introduction, and the need to tailor it to serve the nature and requirements of different services and settings. The following schedule is therefore proposed:

- *Year 1*: The focus will be primarily on planning to prepare for its implementation; including assessment and audit of services and staff training and development needs.
- *Year 2*: The focus will be on the introduction, or strengthening of routine enquiry in maternity, addictions and mental health services.
- *Year 3*: Routine enquiry will be introduced, or strengthened, in A&E, primary care and sexual & reproductive health services.

Detailed guidance will be provided to support the development of the plan. To facilitate implementation, and create an environment conducive to disclosure, the plan should include the following areas:

- *Policy development*
  In line with national guidance, each Board needs to ensure that there are clear operational policies on gender-based violence including protocols, best practice guidance, and risk assessment.

- *Audit and planning*
  An assessment of the current stage of development and identification of clear goals for introduction of routine enquiry over the three years within the priority settings.

- *Staff development & support*
  The provision of appropriate learning and education resources is crucial to ensuring sensitisation of staff to survivors of abuse. A tiered approach to training should be adopted, identifying different needs across different groups of staff. Incorporation of this training as part of the Equality & Diversity element of KSF is desirable. The significance of gender-based violence should be included, where appropriate, within other relevant training modules e.g. in child protection.

  Within each area there should be clear indication of the availability of support and supervision for staff dealing with gender-based violence. Given the nature of the issues covered, particularly when providing therapeutic interventions, the potential for vicarious trauma should be recognised and mechanisms identified for assisting staff in such situations.

- *Data collection and analysis*
  The establishment of data collection mechanisms will be required as part of the Routine Enquiry programme. The plan should clarify responsibility for ensuring this is implemented and how the data will be retrieved and analysed. Baseline information on current practice across the country will be gathered to provide comparators for measurement.

- *Consultation with service users*
  There should be evidence of how the views of service users will be elicited in relation to routine enquiry.

- *Integration into key strategies*
  Clarification on where and how this process will be incorporated within the strategic and operational planning of the priority areas identified.

- *Involvement of GPs*
  GPs have a central role in the detection and management of abuse, particularly given the fact that many initial presentations in the targeted areas will be to GPs. Eliciting the support and involvement of GPs in routinely asking questions about abuse at such presentations and inputting to reporting systems will considerably assist the provision of an integrated

and coherent approach. A process for encouraging this participation should be identified.

(ii) Dissemination of revised guidance on abuse to staff

Guidance on gender-based violence is being produced for all staff across the NHS. It is incumbent upon boards to ensure that staff are apprised of this development and are assured access to this guidance to inform good practice.

The plan should detail how this will be undertaken. The priority areas identified in relation to routine enquiry should be targeted specifically to ensure clarity around expectations. It is anticipated, however, that information and guidance on gender-based violence will be made available to all staff across the organisation over the 3 years.

(iii) Production of an employee policy on gender-based violence

Given the prevalence of abuse, and the size of the workforce within NHS Scotland, many employees will have current, or previous, experience of one or more forms of gender-based violence. There are also likely to be perpetrators of abuse employed throughout the NHS in Scotland. Each board should produce an employee policy to support staff experiencing abuse, and to clarify how they will deal with perpetrators who are employees.

The plan should detail how and when the policy will be produced and how this will be disseminated to staff. It should also detail the process for monitoring its uptake across the organisation.

(iv) Multi-agency collaboration

The NHS has a central role both at a single and multi agency level in addressing gender-based violence. In the priority areas identified, collaborative working will produce the most effective outcomes, building on the structures already in place. At a strategic level we expect that local boards will work with multi-agency partnerships on abuse, and community safety and community planning processes to maximise this contribution.

The plan should include details of existing multi-agency work on abuse, including involvement in specific Multi-Agency Partnerships on Violence against Women, as well as other partnership where this issue will be relevant e.g. Community Planning, Community Safety and Homelessness Partnerships.

E. SUPPORT AVAILABLE TO HEALTH BOARDS

16. The scale of the institutional challenge in adopting a systems approach to gender-based violence is considerable, not least because of the complex and varied nature of the abuse. Over the next three years we expect that the incremental

process adopted will yield tangible and measurable year on year improvements within the priority areas identified.

17. To support boards in undertaking this work the following resources will be available:

- **National team**

A national team will work to support health boards develop their plans particularly in relation to Routine Enquiry and will comprise:

- 1 x wte Programme Manager,
- 3 x wte Regional Advisors (North, West and East),
- 1 x wte Communications Manager.
- 1 x 0.5 wte Information and Performance Manager
- 1 x wte researcher
- 1 x 0.5 wte admin officer

The team will provide advice and guidance to implement the programme, and will also provide a focal point for gathering and distributing best practice guidance on the different forms of abuse.

The team will additionally work with national boards particularly NES and QIS to co-ordinate activity around this issue and identify opportunities for embedding it within current planning and development. Since this programme will directly support health boards in meeting their legislative obligations on equality, particularly regarding the Public Sector Duty for Gender, the team will work closely with the Equalities and Planning Directorate within NHS Health Scotland to harmonise the approach to this work avoiding duplication of effort and resources.

- **National guidance**

Guidance on different forms of abuse is being produced to augment existing materials; this includes detailed guidance on routine enquiry. These will address the issues of *who should implement enquiry, when to do so, how to conduct routine enquiry, and where.* They will also include guidance on recording and handling disclosure. Templates for protocols, risk assessment and employee policies to assist in development of local policies will be provided.

- **Training support**

Local training consortia will support Health Boards in undertaking training around the implementation of routine enquiry. Negotiation with the National Training Strategy Steering Group has been undertaken to ensure guidance is provided to local consortia on expectations of them in relation to this development. At a local level the regional advisors will facilitate and support this process.

- **Scottish Health Network on Gender-Based Violence**

This network will be managed by the team to provide a national forum for health staff to share best practice, disseminate research and information, and obtain support and guidance.

- **Funding**

Financial assistance of up to £10K p.a. over 3 years will be made available to each health board to support the dissemination of materials and staff events to promote this work.

- **Research**

Research into healthcare utilisation by survivors of abuse, and on effective interventions will be undertaken to maximise the role of the NHS in responding to survivors. The four Pathfinder projects on Domestic Abuse, developed under GIRFEC with a remit to improve the safety of people experiencing domestic abuse, will also be involved in researching the most effective health service contribution in developing multi-agency responses to abuse and risk management.

F. MEASUREMENT OF PROGRESS

18. Tangible and measurable improvements in planning and service delivery on gender-based violence are expected over the 3-year implementation period. Performance will be measured in each of the four performance areas in the plan and Boards are expected to produce evidence demonstrating progress.

19. Given the variation across health boards in relation to addressing gender-based violence, and the differential nature of the challenges they face in relation to size, geography and demographics, the national team will work with each board to agree local trajectories for each of the four performance areas.

20. A national framework will be established with Analytical Services Division to monitor the work and an independent evaluation commissioned. This will incorporate the views of service users & staff in relation to the acceptability and effectiveness of this approach. It will also be the first major national study in the UK to examine this issue in depth and should provide valuable information on how to progress work around abuse within the healthcare context.

21. It is anticipated that this will serve not only to chart advances made in responding to gender-based violence, but also to inform and enhance knowledge around effective interventions and best practice.

G. REPORTING AND ACCOUNTABILITY

22. Regular reports on the progress and status of the work will be submitted to the Mutuality, Equality and Human Rights Board at the SGHD (established late summer 2008). In relation to the specific implementation of Routine Enquiry, progress will also be reported to the National Domestic Abuse Delivery Plan Implementation Group, which has a remit to oversee the execution of the Plan.

23. As noted earlier, Boards are required to submit an annual report on progress around the gender-based violence action plan, which should be aligned with their reporting on their Gender Equality Scheme.

EXPLANATORY NOTES **Appendix 1**

GENDER-BASED VIOLENCE

- **What is Gender-based Violence?**

Gender-based violence is an umbrella term encompassing the spectrum of abuse aimed at individuals and groups based on their specific gender role in society. It is experienced disproportionately by women and perpetrated predominantly by men and may manifest in many ways. It includes all forms of violence against women including commercial sexual exploitation, harmful traditional practices such as female genital mutilation, forced marriage and so-called 'honour' crimes, sexual harassment, stalking, childhood sexual abuse and domestic abuse in same sex relationships.

Abuse of power is the cornerstone of gender-based violence. It reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. Action taken to address gender-based violence needs to recognise the gendered implications of this for both females and males. Similarly, the intersection of other inequalities needs to inform our response to gender-based violence. Discrimination in relation to ethnicity, (dis)ability, sexual orientation, age, migrant or refugee status etc can increase and intensify vulnerability to abuse and requires awareness of the varying needs of different groups.

- **How common is Gender-Based Violence?**

Gender-based violence is endemic in society. It permeates all social strata and is a major cause of disability and distress, particularly amongst women. Domestic abuse affects between 1in 3 and 1 in 5 women over their lifetime. It is estimated that 23% of women and 3% of men experience sexual assault as adults, and that approximately 7% of women and 0.4% of men experience rape. According to the British Crime Survey, in 54% of cases of rape the perpetrator is a current or ex-partner of the woman. In relation to childhood sexual abuse, prevalence rates are also high – around 21% of girls and 11% of boys. The Foreign & Commonwealth Office deal with around 400 cases of forced marriage annually, and the Home Office estimates that 66,000 women living in the UK have undergone female genital mutilation.

- **Implications of Gender-Based Violence for Health and Healthcare**

The physical, emotional and psychological consequences of gender-based violence can be profound and damaging, and are a significant predictor of poor health. The experience of abuse, in all its manifold forms, is a strong risk factor for a range of poor health outcomes and compromised functioning.

For example, experience of abuse contributes to a number of physical health problems including chronic pain, gastrointestinal difficulties, and heart and circulatory conditions either through exacerbation of the problem or making the management of these conditions problematic. An increasing body of evidence also records factors associated with delayed effects of abuse, such as hypertension and arthritis.

The adverse impact of abuse on mental health is well documented. Around 35%-40% of women experiencing domestic abuse report depressive symptoms; this rises to 50.2% in women with the additional experience of childhood abuse. Similarly, women who are abused are 15 times more likely to misuse alcohol, 9 times more likely to use drugs and five times more likely to attempt suicide than women with no history of abuse. Childhood sexual abuse is associated with depression, anxiety, eating disorders, self-harm, suicidal ideation and drug/alcohol addictions. Initial stressors resulting from child abuse and neglect may lead to poorer self-esteem and self-protective behaviours and high stress, setting the scene for greater vulnerability to abuse in adulthood, as evidenced in the higher rates of health risk behaviours such as smoking, alcohol and drug use, risky sexual behaviour and unwanted teenage pregnancies. Vulnerability to further exploitation is also manifested; for example, a high proportion of women involved in street prostitution have been sexually abused as children.

In relation to domestic abuse, pregnancy can be a vulnerable time for women since it frequently acts as a trigger for violence. Abuse during pregnancy increases the risk of poor maternal and infant health outcomes and is associated with obstetric complications including higher rates of miscarriage, abruption placenta, and uterine infection. Health risks to neonates include low birth weight, foetal bruising, fractures and haematomas and preterm birth.

- **The Cost of Gender-Based Violence**

Clearly the experience of abuse has significant implications for health and healthcare. A body of evidence charts the greater utilisation of health services among survivors of abuse e.g. some studies report that between 50-60% of inpatients and 40-60% of outpatients of mental health services have been physically or sexually abused as children.

The financial cost of dealing with gender-based violence is huge. One national study of domestic abuse alone estimated the cost to the NHS in England at £1.2billion per year. In relation to rape, another study assessed the costs of lost outputs and long-term health issues following rape to be about £76,000 per rape. Leaving aside the incalculable harm caused to individuals, the costs borne by the NHS in dealing with this issue are substantial.

Appendix 2

ROUTINE ENQUIRY OF ABUSE

Given the prevalence of abuse, its adverse health impact and the reluctance of survivors to disclose without direct questioning because of the stigma surrounding abuse, the NHS must be proactive in seeking to identify and address this issue. The implementation of routine enquiry has been advocated at a UK level by the Home Office and the Department of Health. Professional bodies, such as the Royal College of Midwives and the Royal College of Psychiatry also endorse this approach. Increased detection will afford survivors the opportunity to access support and services, allowing for earlier intervention and improved health outcomes.

Definition of Routine Enquiry

- It is important to distinguish what is meant by the various terms used to describe the process of asking about abuse.

- In public health terms, routine **screening** has a focus on early identification and the capacity to reach patients whether or not symptoms are immediately apparent. It also refers to the application of a standardised test according to a procedure that does not vary from place to place. The rigidity of this model is not appropriate for domestic and other forms of abuse.

- **Routine Enquiry -** Involves asking **all** people presenting to a service direct questions in relation to abuse. This can be at a particular point in their use of a service, or on all occasions at which they present

- **Selective Enquiry** - refers to direct/indirect questions to **some** people with whom there may be some suspicion of abuse, or who meet certain criteria indicating additional vulnerability to such abuse e.g. homeless women, or women with mental health problems.

A staged approach to implementation of Routine Enquiry will be undertaken, reflecting the need for careful planning around the introduction of routine enquiry, and the need to tailor it to serve the nature and requirements of different services and settings. Over the three years of the plan, clear systems for implementing routine enquiry of domestic and other forms of abuse will be established.

In relation to **domestic abuse,** this will be introduced in all the priority settings. Given the evidence on prevalence, dynamics and impact of abuse, this will apply to **all women** who present. This can be at a particular point in their use of a service, or on more than one occasion. In relation to mental health, addictions and sexual and reproductive health services, routine enquiry of **sexual abuse** will also be incorporated for **all** service users, both female and male.