

# **Violence Against Women**

A literature review



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A literature review commissioned by the  
National Group to Address Violence Against Women

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I consider myself privileged to have been part of the movement to challenge violence against women in Scotland during the last 20 years, and in that time I have met many women who were survivors of male violence. Their stories are with me still, and I thank them for the lessons learned.

## **Definition**

*“The term “violence against women” means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:*

- a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;*
- b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;*
- c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.”*

*UN Declaration on Violence Against Women, 1992  
CEDAW, Recommendation No 19, 1993  
Beijing Platform for Action 1995*

## **Executive summary**

- Violence against women is widespread, and may affect women of any age, class, race, religion, sexuality, or ability. Factors which may increase women's vulnerability to some types of violence include age, disability, and poverty. Across all forms of violence and abuse, women are most at risk from men they know.
- Significant numbers of women experience more than one type of violence. Prevalence surveys which address violence against women in all its forms may yield more information than 'single issue' surveys about the meaning and impact of violence in women's lives. Few studies have been designed specifically to record the experiences of marginalised groups of women, including black and minority ethnic women, women with disabilities, lesbian women, women working in prostitution and homeless women. Attempts to document the experiences of marginalised groups of women must go beyond merely ensuring their 'inclusion', numerically speaking, in general population studies.
- Recurring themes in women's descriptions of male violence include the use of tactics of control, humiliation and degradation, the abdication of responsibility by the male abuser, and the attribution of blame to the woman. These are found regardless of the woman's relationship to the perpetrator, and regardless of whether the experience is a discrete event or part of a pattern of abuse.
- Violence against women has a significant impact on the health and socio-economic status of women. It affects the health and wellbeing of children and young people who witness violence against their mothers and other women. The costs to society of responding to violence against women, and the overall economic impact, are significant and measurable. However, there is a need for improved data collection systems across all agencies involved in responding to women who have experienced violence.
- Although there has been an increase in the number and range of services available to women who have experienced violence, there is relatively little evaluative research. The available research suggests that women value advocacy and support, and want service providers to be more proactive in offering these. Research into interventions tends to focus on discrete aspects of violence against women, reflecting the way in which women's experiences are compartmentalised by service providers and policy makers. Although some comparative research has been undertaken, no studies were identified which evaluated interventions to respond more broadly to women's experiences of violence.

- Research on interventions with rape survivors is primarily focussed on medico-legal responses, with some literature on therapeutic interventions, but little on interventions by primary care workers. Rape crisis provision is still poor across Scotland, and there is a lack of independent evaluation of the approach. There is a similar lack of evaluation of sexual assault referral centres (SARCs), although a forthcoming report from the Home Office should address this.
- Much of the literature on women working in prostitution is taken up with questions of definition and agency, and in this, it reflects early debates about how far women 'choose' to stay with violent partners. There is also a significant body of literature which considers crime management interventions. There is little on interventions which support women abused in prostitution, or assist them in leaving.
- Research on interventions with adult survivors of childhood sexual abuse is primarily found in the mental health literature. Although some work has been carried out which explores the links between childhood sexual abuse and chronic physical health problems, no research was identified which addressed how healthcare staff should acknowledge this or respond to it. No research into the criminal justice response to adult survivors of childhood sexual abuse was identified.
- By comparison, research on interventions with domestic abuse survivors cuts across several sectors, including criminal justice, acute and primary care health services, social work services and outreach and advocacy services.
- The scarcity of research on interventions for black and minority ethnic women, women with disabilities, lesbian women, and older women affected by male violence against women is perhaps a reflection of the dearth of services for these groups.
- Research on violence against women cuts across academic boundaries, and is found in several fields, including law, social sciences and health. This is a reflection of the diverse range of responses violence against women demands. However, multidisciplinary research is rare, and consequently opportunities for 'cross-fertilisation' are missed.
- Services for children and young people affected by violence against women are still relatively scarce. Although not addressed directly in this review, an early trawl of the literature identified little research on effective interventions. The existing body of research focuses primarily on the impact of domestic abuse on children and young people.
- It is acknowledged that the involvement of women survivors of male violence in contributing to the development and design of services increases effectiveness and accountability. However, there are still few examples of how this is achieved in practice.

- In describing the acts of abuse perpetrated by different men, at different points in their lives, women survivors of male violence consistently make the connection between child abuse, rape, domestic violence and commercial sexual exploitation. There are demonstrable links between different forms of violence against women, in the nature of the violence, the consequences of it, and the interventions required. Whether or not these links are made visible in policy and practice is to some extent governed by how far violence against women is regarded as symptomatic of wider gender inequalities in society, and how far initiatives to tackle violence against women are located within this context.

## **1. Background**

In Western society, the most recent efforts to acknowledge, explain and challenge male violence against women coincide with the re-emergence of the feminist movement in the early 1970s. Feminist activists identified male violence against women as central to the perpetuation of women's oppression, seeing sexual assault, rape, sexual harassment, domestic violence and other forms of male violence as part of a continuum of violence against women and children (Kelly, 1987; Radford et al, 2000). Violence against women is experienced by women of all ages and social classes, all races, religions and nationalities, all over the world. It is overwhelmingly perpetrated by men (Krug et al, 2002).

Individual characteristics and circumstances alone cannot explain why this should be the case. Feminist commentators suggest that the context for violence against women is a cultural and political framework in which women are not equal partners with men. Violence against women is both the result of gender inequality and the means by which it is perpetuated (Brownmiller, 1976; Dobash and Dobash, 1979; Radford et al, 2000). This analysis of violence against women as a reflection of the power imbalance in society has largely informed the development of work to challenge violence against women in the United Kingdom, and in Scotland, over the last 30 years.

The first Women's Aid groups in Scotland opened refuges in Glasgow and Edinburgh in 1973 (Scottish Women's Aid, 2002), and by 1976, the Scottish Office had provided some funding towards a national office (Cuthbert and Irving, 2001). Rape Crisis centres soon followed, with centres opening in Glasgow in 1976 and Edinburgh in 1978 (Christianson and Greenan, 2001). Since then women's organisations and individual women in Scotland have continued to develop responses to violence against women, campaigning for recognition of the issues and for change and improvement in statutory responses to women who had experienced violence.<sup>1</sup> On the whole, work to challenge violence against women in Scotland split early on into separate campaigns against domestic violence and against rape, although in both areas of work the links between different forms of abuse continued to be made. The inclusion of child sexual abuse, and the legacy for adult survivors, into the sexual violence agenda dates from the early 1980s, as survivors began to make contact with Rape Crisis and other support services. By the early 1990s, separate services for survivors of child sexual abuse had begun to develop (Kerr, 1990).

By 1987, there was a strong and vibrant women's movement in Scotland developing new ways to challenge male violence against women, despite sometimes very limited resources. The 1987 Scottish Women's Liberation Movement Conference, "Working Against Violence Against Women" was attended by over 260 women (and about 150 children) who discussed a wide range of issues related to violence against women, including the need for

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<sup>1</sup> A timeline giving key dates is provided in Appendix 1.

“intensified campaigning on the issue of child sexual abuse; awareness-raising and action on racism and classism, heterosexism and oppression in disability; creating international links; addressing the problems of women organising in rural areas” (Jennings, 1990, in Henderson and Mackay, 1990: 115).

As awareness of the prevalence and impact of violence against women increased, institutional responses to the issue gradually shifted. Throughout the 1970s and early 1980s, for example, the police response to allegations of rape was characterised by aggressive questioning of complainers based on an assumption that women were lying. Following research into the investigation of sexual assault in Scotland (Chambers and Millar, 1983), a significant policy shift began, with the publication in 1985 of guidelines to chief constables on responding to women alleging rape (Scottish Office, 1985). The first ‘female and child unit’, designed to provide a more sympathetic response to sexual offences complainers, was established in Glasgow in 1987.

Guidelines on police responses to domestic violence were published in 1990 (HMIC, 1997), and a ‘specialist officer’ approach to domestic abuse was adopted by Lothian and Borders Police from the early 1990s. This specialist approach has continued to develop since then. Strathclyde Police, the largest of the Scottish forces, established divisional ‘family protection units’ towards the end of 2002, providing a specialist response to rape and sexual assault complainers and child abuse complainers as well as to women reporting domestic violence.

These developments have been supported by the involvement of women’s organisations in delivering training to police officers. The involvement of Women’s Aid in awareness training for police officers is acknowledged to have increased understanding of women’s experiences of domestic violence (HMIC, 1997), and Rape Crisis Centres fulfilled a similar function in providing input to police training on rape and sexual assault (Christianson and Greenan, 2001). The Glasgow-based Women’s Support Project was involved in providing training to experienced officers at Tulliallan Police Training College on the links between domestic violence and child protection from 1998, and this training has been continued by Women’s Aid.

There have also been changes in the wider criminal justice response to crimes of violence against women. The process of restricting the use of sexual history evidence in sexual offences trials, begun in 1985<sup>2</sup>, has been taken a step further with the passing of the Sexual History (Procedures and Evidence) (Scotland) Act 2002, more than 20 years after Rape Crisis centres began campaigning on the issue<sup>3</sup>. The progress of the current Vulnerable Witnesses Bill through the Scottish Parliament is the latest outcome of a process of campaigning for improved treatment by the courts of women

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<sup>2</sup> With the Law Reform (Miscellaneous Provisions) (Scotland) Act 1985.

<sup>3</sup> See Appendix 1.

complainers, and other 'vulnerable' groups, which has been ongoing for more than two decades.

Since the passing of the Matrimonial Homes (Scotland) Act 1981 there have also been gradual legislative changes which have increased the protection available for women from their violent partners/ex-partners. Most recently, the Protection from Abuse (Scotland) Act 2001 is slowly beginning to have an impact, providing more women with the option of having powers of arrest attached to a common law interdict (Cavanagh, Connelly and Scoular, 2003). Despite ongoing, and justified, concern at the high attrition rates associated with the prosecution of all crimes of violence against women through the courts (see, for example, Hester, Hanmer et al, 2003; Jamieson, 2001; Kelly, 2003), the general trend is forward-moving, if slow.

Local authorities engaged with the issue of violence against women initially at a service level, through the provision of emergency accommodation and social work services. Throughout the late 1980s and early 1990s, however, local authorities played an increasing role in raising awareness and challenging the norms which underpin violence against women. Much of this work was undertaken by women's units, equalities units, and later, community safety units. Undoubtedly the most high profile example of this was the development in 1992/1993 of the Zero Tolerance poster campaign by Edinburgh District Council Women's Unit (Mackay, 2001).

Local government reorganisation in the mid 1990s provided another impetus for the development of local partnerships to tackle violence against women, and this was further supported by the publication of guidance on developing such partnerships (CoSLA, 1998). Although some of these early partnerships took the form of domestic violence fora, a few (for example in Edinburgh and Glasgow) adopted a broader position on violence against women.

There have always been supportive individual clinicians and practitioners in the various areas of the health service women have approached for health care as a result of violence. Some have developed local initiatives which have contributed valuable information to the knowledge base within their own discipline or their own locality – for example, a local training programme for midwives in Inverclyde Hospital (Scobie, 1999), and a domestic abuse monitoring exercise in the A&E department at Law Hospital (Guthrie, 1998). Institutional developments in the health service, however, were inclined to be piecemeal and inconsistent through most of the 1980s and early 1990s. The publication of the SNAP<sup>4</sup> report on domestic violence in 1997 focussed attention on the failure of the health service in Scotland to adequately address the health needs of women experiencing domestic violence. At a practice level, the Castlemilk Demonstration Project ran from 1996-98 from Castlemilk Health Centre, and was managed by the Department of Public Health in Greater Glasgow NHS Board. The project aimed to "improve the safety of women in the home through the development of an interagency approach"

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<sup>4</sup> Scottish Needs Assessment Programme

(Cosgrove, 1998: i) and alongside this also explored ways to improve the responses of primary health care staff to domestic violence.

The Women's Public Health Team at Greater Glasgow NHS Board continues to develop innovative, replicable work on the impact of gendered violence on women's health. They have worked to address the training needs of health staff in relation to domestic violence, and have also been active in addressing the development of services for survivors of sexual assault and childhood sexual abuse. Elsewhere in the health service, initiatives to address domestic abuse have far outnumbered broader interventions. An exception is the EVA Project, a multi-disciplinary project currently funded by NHS Lanarkshire to provide services and improve service provision for women who have experienced violence at any point in their lives (EVA, 2001).

The recent publication of NHS guidance for health staff on responding to domestic abuse continues the more general trend, although there are signs that other areas are beginning to attract attention. A Scottish Executive short life working group on the care needs of adult survivors of sexual abuse has recently produced a consultation report, and in Glasgow, a recent survey explored the responses of clinical psychologists to survivors of sexual abuse and sexual assault (Biggam and Johnson, 2003).

Against this background of 25 years of campaigning and service development, the Scottish Office announced the establishment, in 1998, of the Scottish Partnership on Domestic Violence, subsequently renamed the Scottish Partnership on Domestic Abuse. Chaired by Anne Smith QC, the group comprised representatives from the key Scottish office departments, the judiciary, the police, the legal profession, and the voluntary sector. The group was remitted to develop an action plan leading to a national strategy on domestic abuse, which was published in November 2000.

The aims of the National Strategy to Address Domestic Abuse in Scotland are based on the '3 P's' first used in the Zero Tolerance campaign:

- Prevention – active prevention of domestic abuse of both women and children
- Protection – appropriate legal protection for women and children who experience domestic abuse
- Provision –adequate provision of support services for women/children

The Strategy identified key policy and practice areas to be developed and improved in order to achieve these aims. It also placed a requirement on local authorities and health boards to establish local partnerships to tackle domestic abuse. The Scottish Executive provided £18 million through the Domestic Abuse Service Development Fund to support the work of these local partnerships, and established the National Group on Domestic Abuse to monitor the implementation of the strategy. The National Group includes representatives from the police, the judiciary, women's support organisations and local authorities. It is chaired by the Minister for Communities.

There are now 32 local partnerships, covering all local authority areas in Scotland. Some of these predate the National Strategy, having developed either from local domestic violence fora, or from multi-agency groups set up to tackle violence against women in a broader sense. Of the 32 groups, only four currently have a focus on aspects of violence against women other than domestic abuse.

In November 2002, the Scottish Parliament debated the issue of 'violence against women'. The then Minister for Social Justice, Margaret Curran MSP, announced that the National Group to Address Domestic Abuse would widen its remit to include all forms of violence against women, and would be renamed the National Group to Address Violence Against Women.

The National Group has commissioned this literature review to inform the development of the agenda on violence against women. Accordingly, this report will:

- review the available literature on the prevalence and impact of violence against women, and on interventions
- the review will consider sexual violence, sexual harassment, domestic violence, and commercial sexual exploitation
- identify examples of good practice
- identify gaps in research, policy and practice on violence against women in Scotland

The review will primarily focus on work carried out in Scotland and the U.K., with some reference to international work, in particular in Canada. With the exception of some 'benchmark' works, the literature search has been limited to a five-year period from 1998-2003.

The subject of 'violence against women' is huge. There are acknowledged links between violence against women and violence against children. However, time constraints mean that this review cannot adequately consider the impact of violence against children, although some attention is given to the impact of childhood sexual abuse on adult women survivors. For similar reasons, the review does not cover the sizeable body of literature on sex offenders, although some consideration is given to work with men who abuse their partners, in the context of exploring a multi-agency response to domestic abuse. Nor does the review cover the body of literature on prevention initiatives.

There are bound to be omissions in a review covering a subject area as vast as this. This report must therefore be seen as indicative, aiming to identify and examine some of the key issues in some depth rather than provide a comprehensive guide to all that has been researched and written about violence against women.

A word on terminology – throughout the research literature, the phrase 'violence against women' is used interchangeably with 'domestic violence' and 'domestic abuse', i.e. in contexts where what is being discussed is violence

against women by an intimate partner or ex-partner. For the sake of clarity, in this report, 'violence against women' is used as a generic term, indicating the whole spectrum of abuse which may be experienced by women. Where the report refers specifically to violence perpetrated against women by intimate partners, the terms 'domestic violence' or 'domestic abuse' are used.

## 2. *The extent of the problem*

*“Whilst clear categories and definitions are important for statistical and research purposes, we must never forget that these are abstract analytic concepts developed for a specific purpose - to count the extent of violence. They do not reflect experiential reality, which is always more complex....”*

*Liz Kelly, Domestic Violence: Enough is Enough conference, London, October 2000*

What, why and how to measure the true extent of violence against women are questions which have stimulated much debate among practitioners, policy makers and researchers (Desai and Salzman, 2001; Dobash and Dobash, 1998; Hester, Kelly and Radford, 1996). In relation to domestic abuse, at both national and local level, much effort has gone into trying to identify how a common approach to data collection might be achieved. Attempts to evaluate new service developments and public education initiatives are hampered by the lack of available ‘benchmarks’. Differences in data systems and data collection, uncertainty about how to overcome ‘double counting’, and concerns about the legal aspects of data sharing, are some of the issues currently under debate.

### 2.1 Recorded crime

Statistical Bulletins produced by the Scottish Executive are the main source of official information on violence against women in Scotland. Information about recorded crime is collected quarterly and published annually. The data is ‘offence based’ rather than ‘incident based’ - several offences may be involved in one incident, there may be more than one offender and there may be more than one victim. The figures therefore provide a record of the levels of crime occurring in Scotland, but not the numbers of individuals affected by it (Scottish Executive, 2003). Since what is being counted is ‘offences’ rather than individuals, gender disaggregation is not possible, with one notable exception.

‘Crimes of indecency’ is the category which includes figures relating to sexual violence. Prior to 2001, this was broken down into sub headings of ‘sexual assault’, ‘lewd and indecent behaviour’ and ‘other’. From 2001, the sexual assault category was split into ‘rape and attempted rape’ and ‘indecent assault’. The purpose of this was to allow easier counting of offences covered by the police Statutory Performance Indicator of serious violent crime. An interesting by-product, given that in Scotland the legal definition of rape is gender specific, is that there will now be the possibility of analysing reporting trends in this one area of sexual violence against women.

For the year from 1<sup>st</sup> January to 31<sup>st</sup> December 2002, there were 913 crimes of rape or attempted rape in Scotland. It is noted that this represents an increase of 21% on 2001, and is the highest level of rapes and attempted rapes ever recorded in Scotland (Scottish Executive, 2003). No particular

reason is offered for this Scottish-wide phenomenon. However an increase of 37% in crimes of indecency recorded by two Scottish forces, in Lothian and Borders and in Tayside, is attributed variously to increased reporting of 'historical' abuse, a rise in indecent assault reports as a result of proactive work with children and young people, and a more proactive approach to working with women's support organisations to encourage reporting by their service users (Scottish Executive, 2003).

Incidents of violence against women may involve a range of crimes and offences including serious assault, petty assault, sexual offences and breach of the peace. Women's Aid groups and other women's support organisations have been aware of an increasing use of mobile phones by abusive men as a means of harassing and intimidating women. An increase of 23% in offences involving 'threats or extortion' as a result of this increase in threatening phone calls or text messages is noted by Lothian and Borders Police. Again, because the focus is on the incident rather than the people affected by it, it is not possible to see how far this might relate to violence against women.

Specific statistics on domestic abuse have been collected by the Scottish police forces since 1999. These give more detail about recorded incidents of domestic abuse. 36,010 incidents were recorded in 2002, the majority of which (59%) did not go on to be recorded as a crime or an offence. 90% of the incidents involved a female victim and a male perpetrator (Scottish Executive, 2003). A particular concern raised in the most recent report is the level of repeat victimisation – where the information was available, about half of the cases involved repeat victimisation (Scottish Executive, 2003).

The data from different police forces raises some questions about differences in police recording. Some forces do not record a crime or offence if no further action is taken after the initial report, for example if the victim does not wish to pursue the matter, while other forces will record. As a result, Central Scotland shows only 24% of incidents leading to the recording of a crime or offence, while Grampian shows 98% of incidents being recorded as a crime or offence. The report notes that "these recording practices are under continuing review with the intention of achieving consistency across Scotland" (Scottish Executive, 2003: 27)

## **2.2 Agency statistics**

There is, then, some information available on the incidence of violence against women as encountered by the criminal justice system. Clearly this does not provide a full picture of the extent of the problem. If the numbers of workers seeking training on how to respond to women who have experienced violence is anything to go by, there are many more women seeking help, support or information from agencies outwith the criminal justice system. Women present to housing departments, social work departments and health professionals looking for a range of services. However, this is not reflected in the statistical information available from these agencies. In some instances, the options available to staff when recording the reason for a referral do not

include 'violence'. Where it is recorded, it may not be in a format which enables collation. Health professionals, for example, will record the information that a patient has disclosed violence or abuse, but this will be in a narrative form in the patient's record. Even where these records are held on a computer system, it is not possible to extract only information about 'violence as a reason for referral' without an appropriate coding system.

Recognising the need to address this difficulty with data collection, the Scottish Executive undertook a three day snapshot in December 2003 to gauge the extent to which women are presenting to agencies as a result of domestic abuse. Participating agencies across Scotland included Women's Aid, accident and emergency departments, primary care teams, social work teams and homelessness units. A report on the outcomes is expected shortly.

Women's voluntary organisations are the other main source of data about the numbers of women experiencing violence. The 40 affiliated local groups in the Scottish Women's Aid network received 72,029 requests for information and support between April 2002 and March 2003, a 10.3% increase on the previous year. In addition, 5,873 women requested refuge, this need for emergency accommodation implying a recent history of abuse by a partner (Scottish Women's Aid, 2003). The Women's Support Project, a Glasgow based organisation working with women affected by any form of violence or abuse, received 1550 requests for support between April 2002 and March 2003 (Women's Support Project, 2003). Statistics will be available shortly from Rape Crisis Scotland, the national office for the network of Rape Crisis Centres in Scotland. A new database is due to come on stream to allow routine collation of statistics from all local groups.

The under-reporting of violence against women to **any** agency is well documented. A survey of women in Edinburgh found that although over half of the respondents had experienced some form of violence, only 21% of those who had experienced physical or sexual violence had approached a support agency for help (Henderson/CEC<sup>5</sup>, 1997). Sources other than agency statistics must be examined in order to assess the true extent of violence against women.

## **2.3 Crime surveys**

Survey results on the prevalence of violence against women may vary depending on a range of factors including the definitions used, the methodology used, and the context of the survey (Johnson, 1998; Walby and Myhill, 2001). However, it is estimated that between one in two and one in ten women will experience some form of violence at some point in their lives, with between 0.4% and 10% of women experiencing violence in any 12 month

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<sup>5</sup> References to the 'Hidden Figures' report by Shirley Henderson, published by City of Edinburgh Council in 1997, are given in this format to distinguish them from references to the report by Sheila Henderson, also published in 1997, on Service Provision to Women Experiencing Domestic Violence Against Women in Scotland, published by the Scottish office Central Research Unit.

period (see, for example, Budd, Mattinson and Myhill, 2000; Henderson/CEC, 1997; Macpherson, 2002; Mirrlees-Black, 1999; Mooney, 1993; Myhill and Allen, 2002; Statistics Canada 1993, cited in Johnson, 1998; World Health Organisation, 2002).

National crime surveys have provided some extension of the data available from official statistics. The Scottish Crime Survey (SCS) has run independently of the British Crime Survey (BCS) since 1993, and was repeated in 1996 and 2000. The SCS 2000 survey included a self-completion questionnaire which asked about domestic violence. 6% of women responding had experienced either threats or force from a partner during 1999; 19% of women had experienced threats or force from a partner at some point in their lives (Macpherson, 2002). Similar self-completion modules on rape and sexual assault were included in the BCS in 1998 and 2000. A report based on findings from both of these surveys noted that 0.9% of women had experienced some form of sexual victimisation in the previous 12 months; 9.7% in their lifetime. Partners were the perpetrators in 32% of cases (Myhill and Allen, 2002).

Walby and Myhill note that reporting of violence against women in these generic crime surveys increases over time and as survey methodology is refined and developed, and consider whether the methodology applied by some of the national surveys on violence against women might improve reporting rates still further (Walby and Myhill, 2001). They identify some problems with generic crime surveys, including limited time available to build a rapport with survey participants, or to ask “nuanced questions”<sup>6</sup> about women’s experiences of violence. They also consider whether, in generic surveys, less priority might be given to selection and training of interviewers. Finally, they raise the question of how far women see what has happened to them as ‘a crime’ and whether questions of definition influence how far women report their experiences (Walby and Myhill, 2001). They are not convinced that this is a major problem and cite the 1996 BCS survey on domestic violence, in which “significant numbers of people did in fact report domestic violence even when they said they did not consider it a crime” (Mirrlees-Black, 1999, cited in Walby and Myhill, 2001: 508).

Crime surveys tend to focus on a single aspect of violence against women, and by the nature of their perspective – violence as crime –are inclined not to consider in depth areas of women’s experience which are harder to frame as ‘crime’. They may not address the particular issues related to violence against women from marginalised groups, including black and minority ethnic women, women with disabilities, lesbian women, and women working in prostitution. Women from these groups may be subject to higher levels of some types of violence than women in the general population, and the violence they experience may impact on their lives in different ways (Barnard et al, 2001; Farley, 1998; Henderson/CEC, 1997; Johal, 2003; Kelly, 2000; Saxton et al, 2001; Siddiqui, 2003).

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<sup>6</sup> Walby and Myhill, 2001:507

The authors of a report which addresses the intersection of domestic violence and ‘minoritisation’<sup>7</sup> make the point that whilst it is important to acknowledge that domestic abuse happens across all ethnic and socio-economic groups, by doing so there is a danger of making the specific experiences of ‘minoritised’ groups invisible (Batsleer et al, 2002). Similar difficulties have been noted in relation to women with disabilities (MacLeod, 1995, Nosek and Howland, 1998)). For both of these groups of women, the standard obstacles to reporting which may be experienced by many women – fear of the consequences, fear of not being believed, lack of access to information about services which might assist – are compounded by additional barriers, such as lack of information in appropriate languages or formats, lack of cultural awareness within agencies and greater dependency on the abuser, who may be the main carer or interpreter for the woman.

The experiences of older women may not be considered. Although older women are deemed to be at less risk of violence than younger women and girls (Statistics Canada, 1993; VAWS, 1996; Henderson/CEC 1997), they consistently express more anxiety about their safety than younger women (Henderson/CEC, 1997; Home Office, 2003; SCS, 2002). There has been little specific research on the extent of violence against older women, and the possibility that older women are less likely to report violence cannot be discounted. The Scottish Executive has commissioned research into older women’s experiences of domestic violence which was completed in May 2003 and is due to be published in Spring 2004.

Poverty may also make women more vulnerable to violence. It limits choices and forces women into types of employment which carry more risks of violence, for example prostitution, or work in the service industries. It may also put women in the position of having to take on shift work or work which is far from home, reliant on public transport, and they may be more at risk for this reason (Barnard et al, 2001; Byrne et al, 1999; Statistics Canada, 1993).

## **2.4 Counting the gaps**

There can be difficulty in extracting from a general crime survey the significance of the event in a woman’s life and a sense of the interconnectedness of the issues. The prevalence of experiences of stalking and sexual harassment, the involvement of women in pornography, prostitution and organised or ritual abuse, and the extent to which women experience violence in more than one context and at more than one point in their lives has been largely unexplored until relatively recently. Some areas of women’s experience remain invisible in any attempt at ‘counting’. Those

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<sup>7</sup> The study involves women who are African, African-Caribbean, Irish, Jewish and South Asian. Ruling out the term ‘minority ethnic’ on the grounds that it has come to be associated only with people of colour, the authors note “...we use the term minoritisation as an inclusive term which not only highlights relationships across structures of racialisation, but also reflects how these processes are based on unequal power relations” (Batsleer et al, 2002:42).

studies which have been done indicate that significant numbers of women have been affected by these issues.

Stalking, defined as 'persistent and unwanted behaviour', affected 17% of women at some point in their lives in a study of stalking and harassment in Scotland (Morris, Anderson and Murray, 2002). When asked about experiences they would categorise as 'stalking', only 10% of women reported a lifetime experience. This is closer to the findings from the U.S. national survey on violence against women, which asked respondents about stalking which 'involved a high level of fear'. In this study, 8% of women reported a lifetime experience of behaviour which fitted the description they were given (Tjaden and Thoennes, 1998).

The trafficking of women for sexual exploitation has gained increasing attention over the last few years, as awareness has increased of global trafficking in persons. The hidden nature of trafficking makes it difficult to assess accurately the numbers of women involved. Using a range of data sources, including a survey of police forces and a review of data on immigration patterns, organised crime and prosecutions for prostitution related offences, a recent study on the extent and nature of trafficking of women in the UK estimated that between 142 and 1420 might be trafficked into and within the UK per annum (Kelly and Regan, 2000).

There are similar difficulties with estimating the numbers of women working in prostitution. Routes Out Of Prostitution (ROOP), a Glasgow based project working to address prostitution as an issue of violence against women, estimates that over 1000 women in Glasgow are involved in prostitution (ROOP, 2003). This, however, is in the context of acknowledging that the 'visible' face of prostitution is on the streets, and that the numbers of women working in indoor prostitution are largely unknown and difficult to monitor (Kelly and Regan, 2000).

Women working in prostitution report much higher levels of violence than other women in the population – 82% of respondents in a San Francisco study had experienced physical assault while working in prostitution and 68% had experienced sexual assault<sup>8</sup> (Farley and Barkan, 1998). A study of women working in Edinburgh, Glasgow and Leeds found that two thirds of the women interviewed had experienced violence from clients (Barnard et al, 2001).

The San Francisco study also found that 57% of the respondents had experienced sexual assault in childhood. This is at the higher end of estimates of the prevalence of experiences of child sexual abuse in the general population, which range from one in four (Creighton and Russell, 1995) to one in eight (Baker and Duncan, 1985). Although Kelly et al (1991) found that 59% of the young women they surveyed had experienced some form of sexual abuse before they reached 18, their definition of sexual abuse included the spectrum of behaviours from flashing to rape. Narrowing the definition to exclude flashing and other 'less serious' abuses, the prevalence

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<sup>8</sup> Of the 130 respondents, 75% were women.

rate drops to 1 in 20 young women. This highlights some of the difficulties inherent in comparing studies. Few prevalence studies have been done in this area, and those that have use a wide range of definitions, methodologies, and sample profiles. The study by Kelly et al was designed to address some of these issues, and to identify what adaptations to methodology might help to provide a clearer picture of childhood experiences of abuse. The authors recommend taking a broad approach to 'defining', maintaining that narrowing the definition used in a survey too much excludes the possibility of gathering valuable qualitative data, for example in relation to the seriousness of the abusive experience for the individual at the time, and also in relation to the long term consequences (Kelly, Regan and Burton, 1991).

The use of narrow definitions of violence against women excludes more than qualitative data. It is difficult to count something which has not been named; but until it is counted, how do we know it exists? For survivors of ritual abuse, the narrow focus in most surveys on the type of assault, e.g. 'rape' or 'physical assault', may exclude the possibility of naming the context in which the assault takes place, and thereby help to perpetuate the belief that such abuse does not exist (Matthew, 2001, 2002; Scott, 2001). A small scale survey which sought to assess agency awareness of ritual abuse asked respondents how many survivors of ritual abuse were known to have made contact with their agency between August 2002 and August 2003. 25 agencies responded; between them they reported contact with 96 survivors of ritual abuse (TRASH, publication pending).

It is clear that although single issue studies can be helpful in assessing the need for a specific service or policy development – for example, the need for development in housing policy to meet the needs of women fleeing domestic abuse – they do not allow the linkages between different types of gendered violence against women at different times in the lifecycle to be fully explored. In order to assess the full extent of 'violence against women' in a society, a different, broader approach may be required.

## **2.5 National surveys**

The Canadian national survey in 1993 asked questions about a wide range of experiences, and framed the questions around the theme of women's safety. The results were significantly higher than those found in other surveys. In 1993, Canadian police recorded 15,200 sexual assaults against women; the General Social Survey (GSS)<sup>9</sup> recorded 316,000 sexual assaults against women. Based on responses from 12,300 women, the Violence Against Women Survey (VAWS) estimated that there had been 572,000 sexual assaults against women in Canada that year. The pattern for assaults against women by their partners was similar – 46,800 'assaults against wives' were recorded by the police, 107,500 assaults were recorded by the GSS, and 201,000 assaults were estimated by the Violence Against Women Survey. Citing these figures in 1998, Johnson notes:

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<sup>9</sup> A Canadian national crime survey.

“The specialized survey of violence against women captures almost twice as many incidents as the traditional crime-victim survey, four times as many cases of wife assault as are reported to the police, and about 38 times as many cases of sexual assault as police statistics.” (Johnson, 1998: 39-40)

She attributes this increase in large part to a meticulous design process, in which every effort was made to create an approach which would encourage women to discuss their experiences of violence as fully and as safely as possible with the interviewers. The design team consulted with academic researchers, frontline practitioners, policy makers and women survivors of male violence. A random sample telephone survey was deemed to be the best approach, for a population with 99% access to a phone. The questionnaire design involved a rolling programme of consultation through focus groups, moving from general discussion through detailed analysis and testing of the content of the questionnaire. Consideration was given to how the questionnaire would be administered, including the selection and training of interviewers. It was held to be important that the interviewers be women, removing one perceived barrier to disclosure. Potential interviewers went through standard job screening to assess their suitability for the post and then underwent a second interview with a clinical psychologist to assess their ability to deal with the particular stressors associated with a large scale survey about violence and abuse. Interviewers were provided with eight days training which focussed on issues such as responding to disclosure and distress and ensuring that interviewees were in a safe place to participate in the interview. During the initial stages of phone contact, interviewers provided women with a ‘toll-free’ number to call if the interview was interrupted, or to discuss anything raised for them by the interview (Johnson, 1998).

The results of the Canadian survey are significant, not just because of the numbers of women who reported violent experiences, but because of the links made between different experiences of violence at different times in women’s lives, and in what is revealed about the context, meaning and impact of violence in women’s lives. Of the 12,300 women surveyed, 51% had experienced at least one physical or sexual assault since age 16 and almost 60% had been assaulted more than once. 25% of the women surveyed had been physically and/or sexually assaulted by partners or ex-partners – 20% of the women who were assaulted by a partner were sexually assaulted. In all, 45% of the women surveyed had been assaulted by someone known to them, compared with 23% who had been assaulted by strangers. 38% of women had been sexually assaulted by a man known to them (Status of Women Canada, 2002).

Since 1983, Canada has had no specific offences of rape, attempted rape or indecent assault. Instead, there are three levels of ‘sexual assault’ ranging in severity from “unwanted sexual touching” to “sexual violence resulting in serious physical injury sustained by the victim” (Status of Women Canada, 2002: 20). Over 90% of all incidents reported to the police are recorded as level 1 assaults – minor physical injuries or no injuries to the victim, with a maximum possible sentence of 10 years. The 1993 survey found that only 6% of all sexual assault incidents had been reported to the police, and only

4% of incidents involving 'unwanted sexual touching' (Status of Women Canada, 2002). The survey explored reasons for low reporting, which were similar to those reported in UK surveys – the incident was considered too minor (44%), women didn't think the police could do anything (12%), or they wanted to keep it private (12%). Interestingly, given how many sexual assaults were committed by men known to women, fear of the perpetrator, and not wanting the perpetrator arrested or jailed, were given as reasons for not reporting by only 3% of the women.

In their review of the development of national surveys on violence against women, Walby and Myhill attempt to define 'state of the art methodology'. They identify several issues to be considered, including the context of the survey; interviewing practices; training for interviewers and ensuring a 'good fit' between interviewer and interviewee; the sampling frame; the mode of enquiry, and situating the event in relation to others (Walby and Myhill, 2001). They conclude that dedicated surveys on violence against women are likely to be more effective than general crime surveys which include questions about violence against women, since they pay greater attention to maintaining the safety of interviewees, building rapport and focussing on the meaning and impact of the violence as much as on the act itself.

In their 2002 report on assessing violence against women, Status of Women Canada<sup>10</sup> identify a set of indicators to be used as benchmarks against which to measure progress on tackling violence against women. These are designed to parallel the Economic Gender Equality Indicators released in 1997 by the F/P/T<sup>11</sup> Ministers Responsible for the Status of Women. The violence against women indicators follow six themes:

- Severity and prevalence of violence against women
- Impact of violence against women
- Risk factors associated with violence against women
- Institutional and community based responses
- Victims' use of services
- Public attitudes and perceptions

The authors stress that these indicators are limited by the quality of the data available, and note that as data collection methods improve, so must the indicators expand and adapt over time (Status of Women Canada, 2002). However, it is undoubtedly the case that the baseline data gathered in Canada through the national surveys of violence against women provide an invaluable benchmark against which to measure the effectiveness of policy development and legislative change (Hague, Kelly and Mullender, 2001).

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<sup>10</sup> Status of Women Canada is a department of the Canadian government responsible for...

<sup>11</sup> Federal/Provincial/Territorial

## **2.6 Extent of the problem - conclusions**

In summary, a review of the research on the prevalence and incidence of violence against women tells us that:

- violence against women is widespread, affecting women of any age, class, race, religion, sexuality, or ability
- women are most at risk from men they know
- factors which may increase women's vulnerability to some types of violence include age, disability, and poverty
- when asked, significant numbers of women describe patterns of abusive behaviour and repeat victimisation, rather than discrete assaults
- women experience violence at different points in their lives, and significant numbers of women experience more than one type of violence
- surveys which address violence against women in all its forms may yield more information than 'single issue' surveys about the meaning and impact of violence in women's lives
- few studies have been designed specifically to record the experiences of marginalised groups of women

### **3. Consequences of violence against women**

#### **3.1 For women**

##### **3.1.1 Fear of violence**

Given the prevalence rates for violence against women, it is perhaps not surprising that women feel less safe than men. However, women's perceptions of their own safety are significantly at odds with the realities of where the risk to them is located. Despite consistent research reports that women are most at risk from men known to them, the myth of the dangerous stranger prevails. Women feel most at risk on the streets, at night - 16% of women in the 2000 Scottish Crime Survey said they felt 'very unsafe' when walking alone after dark; 40% of women felt 'very or a bit unsafe'. By comparison, only 3.5% of men reported to the same survey that they felt 'very unsafe' walking alone after dark, despite the fact that they are more than three times more likely than women to experience an assault (Scottish Executive, 2000). Men are also more likely to be assaulted by strangers – only 17% of the 'stranger assaults' reported in a recent survey in England and Wales were committed against women. Conversely, 73% of the assaults designated 'domestic' were reported by women (Simmons and Dodd, 2003).

Elizabeth Stanko offers an interesting juxtaposition of the experiences of women and men and how those experiences impact on their feelings about safety and danger:

"Women's lives rest upon a continuum of unsafety. This does not mean that all women occupy the same position in relation to safety and violence. Many other features of their lives...will mean that their circumstances differ. Somehow, though, as all women reach adulthood, they share a common awareness of their particular vulnerability. Learning the strategies for survival is a continuous lesson about what it means to be female." (Stanko, 1990: 85)

In contrast, she says:

"For men, there are no tips about personal safety in crime prevention handbooks. It is assumed that men either know about avoiding dimly-lit alley ways and bus stops, or that they are able to protect themselves. While we may assume men already know how to protect themselves, they don't seem to be very successful: men's recorded levels of victimisation are much higher than women's." (Stanko, 1990: 109).

Women live with a consciousness of being 'at risk' of violence which is not experienced by most white heterosexual men, although Stanko acknowledges the connections between racist and homophobic violence and violence against women. It is this consciousness of ever present risk, she argues, which underpins the strategies women adopt to deal with the threat of violence in their daily lives, whether at home, at work, or on the street.

### 3.1.2 Health consequences of violence against women

The World Health Organisation defined violence as a public health issue in 1996, noting that it impacted especially on the health of women and children (WHO, 1997). Subsequently, a plan of action on violence against women drawn up by WHO identified areas of work needed in order to prevent violence and reduce violence-related morbidity and mortality among women. This work included the development of multi-country research, the need to document and test the efficacy of existing health interventions, and the need to raise awareness among health professionals of the impact of violence against women (WHO, 1997).

The latest outcome of this action plan is the *World report on violence and health*, a review of world literature and research on violence, including violence against women. This comprehensive report explores all aspects of the health consequences of violence against women, including injuries, pregnancy and reproductive health, chronic physical health issues, and the effects on mental health and wellbeing (Krug et al, 2002).

The 1996 national U.S. survey on violence against women found that in around a third of all rapes and physical assaults against women, the woman was injured. About one in three of those injured needed medical attention. Most of these injuries consisted of relatively minor bruising, scratches and welts (Tjaden and Thoennes, 1998). However, more severe injuries, including broken bones or fractures, burns and lacerations, are also recorded, particularly in relation to assaults by partners (Guthrie, 1998; McWilliams and McKiernan, 1993; Williamson, 2000).

Rape and sexual assault may result in women acquiring sexually transmitted infections, including HIV and hepatitis (Winn et al, 2003; WHO, 2000). Pregnancy as a result of rape may cause psychological distress to the woman, including having to make decisions about whether to continue with the pregnancy (Lathrop, 1998; Rape Crisis Centre, 2003). If the woman decides to keep the child, there can also be difficulty for both the woman and the child in the long term (Rape Crisis, 1993). Sexual assault is linked to a range of gynaecological complications, including vaginal infection, bleeding, recurrent urinary tract infections, and chronic pelvic pain (Golding, 1996). These symptoms are reported by female survivors of both child and adult sexual assault, including women abused through prostitution (Farley and Barkan, 1998; Golding, 1996).

In a sample of 892 women in two London hospitals, 2.5% of women reported experiencing domestic violence in their current pregnancy (Mezey et al, 2001). A recent study in the north of England found that 3.4% of the 475 respondents had experienced domestic violence during their current pregnancy. In both of these studies, the lifetime prevalence stood at 13-17% of the women surveyed. An earlier (1993/94) Canadian study showed slightly higher results, with 5.7% of a sample of 728 women reporting domestic violence during their

pregnancy (Muhajarine and D'Arcy, 1999). Violence against women during pregnancy has been associated with miscarriage, premature birth, low birth weight, fetal injury and maternal death (RCOG, 2001, cited in Johnson et al, 2003).

Women survivors of violence also report a range of chronic health conditions, including gastro-intestinal problems (Goodwin et al, 2003), reproductive health problems, respiratory difficulties, migraine (Goodwin et al, 2003), impaired hearing or sight, joint pain, other chronic pain, and disability (Springer et al, 2003; Williamson 2000). Clinical research may focus on discrete populations with clearly defined characteristics, which has implications for the kind of research done in relation to violence against women. For example, there are a number of studies which consider the links between domestic abuse, and/or childhood abuse, and gastrointestinal disorders, but an extensive search of the same databases has failed to identify any comparable, or comparative, research with rape or sexual assault survivors. It may be that gastro-intestinal disorders are not commonly reported by sexual assault survivors. It may also be the case that, in the absence of routine screening, sexual assault survivors who do have gastro-intestinal disorders are less likely to disclose their assault history. A recent study looked at the relationship between women's history of abuse and subsequent (non-acute) surgical interventions. The study found that the number of surgeries undergone by women survivors of childhood abuse or domestic violence was significantly higher than for women with no reported history of abuse – 88.9% of women survivors of childhood abuse and 95% of survivors of domestic violence, compared with 67.3% of the control group (Hastings and Kaufman Kantor, 2003). Twice as many survivors of domestic violence as women with no abuse history had undergone major surgery. The authors acknowledge that the sample size was small (n=53) and possibly difficult to generalise from because it was predominantly made up of white women. However, they argue that the results are significant enough to warrant further investigation, particularly around the need to review perioperative nursing practice with a view to improving the identification and subsequent treatment of women survivors of abuse who are presenting for surgery (Hastings and Kaufman Kantor, 2003).

Women who have experienced violence report significant mental health difficulties (Carlson et al, 2003; Thomson, 1998; Women's Health Team, GGNHSB, 2003; Thompson et al 2002; Williamson, 2000). The mental health impact of child abuse and neglect has been relatively well documented, although research findings are not always consistent. A 1999 study of women attending GP surgeries in north London looked at the correlation between women's reported experiences of physical and sexual abuse at different points in the life cycle, and their mental health status. The study found that childhood experiences of physical abuse were associated with several mental health indicators, including depression, anxiety and self-harm. The study found that women reporting childhood experiences of sexual abuse were five times more likely to suffer from post traumatic stress disorder (Coid et al, 2003). However, it found no association between childhood experiences of sexual abuse and other adverse mental health outcomes. This is at odds with findings in other studies, which have identified a correlation between sexual

abuse in childhood and adult experiences of mental health difficulty, including depression and anxiety (Fleming et al, 1999; Follette et al, 1996; Mullen et al, 1996). Coid et al acknowledge the difference in outcome between their study and others, and suggest it may be due in part to differences in methodology and in part to a different 'starting position', i.e. they made no assumptions about child sexual abuse being "the primary abusive experience associated with the psychopathological symptoms measured in adulthood" (Coid et al, 2003: 336). An invited response to this study strenuously refutes the findings in relation to child sexual abuse and psychiatric morbidity, while acknowledging the value of looking at child sexual abuse in the context of other forms of abuse (Mullen, 2003).

The north London study also reported associations between sexual assault in adulthood and substance misuse, and between rape and anxiety, depression and PTSD. Domestic violence had the strongest links across all of the mental health measures used in the study, with the exception of self injury (Coid et al, 2003).

Rates of PTSD in women survivors of violence are high (Farley and Barkan, 1998; Ullman and Brecklin, 2003). Other recent research has established an association between early onset child sexual abuse and both borderline personality disorder and complex PTSD, with the possibility that some women should be considered under the latter diagnosis rather than the former (McLean and Gallop, 2003). There is also some evidence that repeated experiences of violence or abuse have a cumulative effect, resulting in higher rates of PTSD, and more intense reactions (see Farley and Barkan, 1998, on PTSD in women working in prostitution; Ferguson (publication pending) on Complex PTSD in survivors of domestic abuse and child sexual abuse; Follette et al, 1996; Herman, 1992). Large numbers of women in acute mental health settings have histories of child sexual abuse (Nelson and Phillips, 2001).

The Adverse Childhood Experiences (ACE) Study, carried out in a large primary health care organisation in the U.S. in 1995/96, is a large scale study of the health impact of a range of experiences, including physical and sexual abuse. The study gives a very clear, if depressing, picture of the degree to which adverse childhood experiences - including sexual abuse, physical abuse, and witnessing violence towards mothers – are related to some of the leading causes of death in adults – including alcoholism, drug abuse, depression and suicide attempts, ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease (Felitti et al, 1998).

Much of the chronic ill health reported by survivors of child sexual abuse has traditionally been identified as somatic. Relatively little research has been done to establish how much of what was considered 'somatic' is actually rooted in women's experiences of violence and the impact of this on their bodies. Nelson (2002) explores some of the connections between the nature of the abuse experienced in childhood and the physical health difficulties experienced subsequently. She concludes that an increased awareness of

what actually happens to children who are being abused may shed light on a range of “medically unexplained symptoms” (Nelson, 2002:51).

The consequences of violence against women for women’s health can be severe. However, acknowledging the potential impact on women’s health must be balanced against the danger of pathologising both the causes and the consequences of violence against women.

### **3.1.3 Socioeconomic consequences**

Given the established relationship between poor health and poverty, it might be expected that violence against women will also have socioeconomic consequences.

Women living with ongoing abuse lose work days and earnings as a result of being injured (Browne et al, 1999; Lloyd and Taluc, 1999). Similarly, women may lose time at work, and sometimes be forced to leave jobs, as a result of sexual assault. Poverty can be seen as both a causal factor and a consequence of violence against women; findings from the U.S. National Comorbidity Study suggest that women living below poverty levels appear to be more vulnerable to assault, but also that women living above poverty levels at the time of an assault are twice as likely to lose income as a result (Byrne, Resnick et al, 1999).

That women become homeless as a result of domestic abuse is perhaps self-evident. Recent Scottish research has demonstrated that as a consequence of leaving a violent partner, women may go through a lengthy period of disruption before settling in a new permanent home (Edgar et al, 2003; Fitzpatrick et al, 2003). The difficulties they have been left with as a result of the violence they have experienced may be compounded by the disruption and trauma of living in temporary accommodation, perhaps moving many times before achieving safety.

The relationship between other forms of violence against women and homelessness is less well documented. Burgess and Holmstrom noted as far back as 1974 that 44 of the 92 women who took part in their landmark study on rape trauma syndrome moved house shortly after the assault. However, little has been done since then to examine the effects that relocation might have on women in this situation. Similarly, while support organisations are aware of adult survivors of child sexual abuse who move repeatedly in an effort to stay safe, it appears only peripherally in the research literature.

Farley and Kelly (2000) identified safe housing as a priority for women and girls trying to exit prostitution. For women working in prostitution, there are other compounding factors. Often precipitated into prostitution by poverty and/or abuse, women may then find themselves unable to leave if they incur fines as a result of being arrested for soliciting (Routes Out of Prostitution, 2003).

### **3.2 Consequences of violence against women for children and young people**

Children and young people are affected by violence against women whether they are living with it or not. Young people who are affected by violence in their own lives are most likely to turn to other young people in the first instance for support (Young Women's Centre, 1997). The attitudes of young people are shaped by the society they live in, and many young people grow up believing that at least a degree of violence against women is acceptable (Burton and Kitinger, 1998).

In a recent Minnesota study of women who had experienced violence by a partner, 114 women were interviewed about the extent to which their children were involved in the violence – 21% reported that their children had tried to get help when they were being assaulted, and 23% reported that their children had been physically involved in the events. Factors affecting children's attempts to intervene included the stability of the woman's financial and social situation, the frequency of the abuse, and the impact of the abuse on her life and health. Children were more likely to intervene when their mother's financial/social situation was less stable, when the abuse was frequent and the greater the impact on the woman's life and health. Children were less likely to intervene if the abuser was their biological father (Edleson et al, 2003). The authors suggest that these findings demonstrate a need for more careful assessments by all of the agencies involved in responding to domestic abuse, in order to improve the safety of women and children.

In this country too, there has been a development of work which considers the implications of domestic abuse for child protection (Hester, 2000; Humphreys, 2000; McGee, 2000) and examines the need for child protection services to develop an awareness of domestic abuse. In particular, it is argued, service providers must begin to understand how the abuse of women and children is used by abusive men to maintain control over them. In doing so, it is suggested, they will have to dismantle some of their own prejudices and misconceptions about where the responsibility for domestic abuse resides and place it back where it belongs – with the abusive man (Humphreys, 2000).

Forman (1991) viewed this from the other side of the glass, so to speak. She interviewed women whose children had been sexually abused and found that all of the women had experienced some form of abuse by their partner, and 17 of the women had experienced physical violence. This suggests that in addressing issues of child protection, it may also be necessary to consider whether the mother of an abused child may herself be in need of protection and support.

The effects on children of living with domestic abuse include difficulties with sleeping and eating, disruptive or very withdrawn behaviour, and delayed development (Hague, Kelly et al, 1995). Scottish Women's Aid has produced

a series of reports based on the perspectives of children themselves, and it is clear from these that many children also experience high levels of fear and anxiety. The extent to which abusive men control the behaviour of children as well as women is also evident (Scottish Women's Aid, 1996).

Women's experiences, as indicated already, do not fit neatly into boxes. Nor do the experiences of children. As with research into violence against women, studies looking at childhood experiences of violence focus largely on a single type of violence (Saunders, 2003). Multiple experiences of violence and relationships between different types of violence are less explored, and Saunders advocates that, as with research into adult experiences of violence, a more integrated approach to researching how violence affects children and young people is required and should be developed (Saunders, 2003).

The impact of childhood and adult experiences of violence on women's mental health has already been acknowledged, including the links to substance misuse. Looking at the effect this then has on children provides another way to understand the effect that violence against women has on children. For example, the importance of recognising and addressing the impact on children of living with a parent with substance misuse issues has been acknowledged by the Scottish Executive (Scottish Executive, 2003).

Violence against women can be seen as an underpinning cause of difficulty for children across a broad spectrum of issues currently being addressed by the Scottish Executive.

### **3.3 Consequences of violence against women for society**

Crisp and Stanko (2000) observe that relatively little research had been done into the financial implications of domestic violence, particularly within the U.K., and that within the body of research which had been done, there are wide variations in the methodologies adopted. They raise questions about the lack of accurate baseline data on which to base such research, and argue the need to move beyond awareness raising of the impact of domestic violence, and to develop effective monitoring systems which allow the cost and the benefits of different interventions to be measured. They also suggest that studies carried out in one part of the country can have relevance in another, that extrapolating and contextualising data can help to avoid needless duplication – “a broken arm is a broken arm in the city as well as in the country” (Crisp and Stanko in Taylor-Browne (ed.) 2001: 354)

Subsequently, the Women and Equality Unit commissioned research into the economic costs of domestic violence. The research aims to put a monetary value on the 'cost' of domestic violence. Methodologically, the research draws on the Home Office approach to costing crime, and applies this to data drawn from the 2001 British Crime Survey report on domestic violence.

Although the full report is not yet available,<sup>12</sup> an interim report estimates that the cost of each 'female domestic homicide' is £1.1 million, based on lost economic output, the use of public services, and 'the human and emotional impact' (Walby, 2002).<sup>13</sup>

If there is little on the economic impact of domestic violence, there is even less on sexual violence. An extensive database search yielded only one article specifically on the costs of rape. Post et al, writing in response to a Supreme Court ruling that rape was a "noneconomic violent crime", estimated the financial costs of sexual violence, including 'sex offense homicides' in the state of Michigan for 1996 to be \$6.5 billion. This was based on an estimated 61,581 rapes and sexual assaults for that year, and estimates of \$87,000 as the cost of a single incident of rape/sexual assault, and more than \$3 million as the cost of a single 'sex-offense homicide'. The higher cost of homicide is attributed to the greater costs of health care, loss of productivity and lost quality of life (Post et al, 2002).

The impact of violence against women on society is about more than financial costs. Riger et al (2002) describe the "radiating impact" of domestic violence, based on an ecological approach to the issue. Using the image of a wheel, they identify the 'first order' effects, i.e. the effects on the woman, as the centre of the wheel. Second order effects, the spokes, represent the impact of violence on a woman's relationships with others, including her ability to function socially, educationally and economically. The outer rim of the wheel they identify as the third order effects, and this relates to the impact on other people in a woman's life, including her children and other family members (Riger et al, 2002). All layers in the wheel are connected. The authors use the example of how intimidation of family members (on the rim) is used by abusers to continue to control the woman. If the woman is reliant on family members for childcare to allow her to work, their reactions to intimidation by her abuser may have more than one effect on her, i.e. the fear such intimidation may engender in her, but also the threat to her livelihood (Riger et al, 2002: 196-198).

### **3.4 Consequences of violence against women - conclusions**

- Violence against women has a significant impact on the lives of individual women, their health, their safety, their self-esteem, and their ability to participate in society
- Violence against women impacts on the lives and development of children, either as a result of witnessing violence against their mothers

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<sup>12</sup> Publication was scheduled for Autumn 2003.

<sup>13</sup> Lost economic output costed at £370,000; use of victim's services by the family - £4,700; use of health services - £630; criminal justice costs - £22,000; value for human impact, emotional suffering and grief - £700,000. The interim report does not provide detailed information about how these figures are arrived at.

or other significant women in their lives, or because they themselves experience violence as a result of living in a violent world

- The scale of violence against women implies the need for a response from the whole of society which is only just beginning to be acknowledged, both through the provision of appropriate interventions and the development of strategies to challenge and change the situation.

## **4. Responding to violence against women**

The starting point for this report is the assumption that all forms of violence against women are linked. However, the research literature focuses mainly on discrete aspects of violence against women, with different aspects attracting attention within different fields.

This section of the report reviews research which assesses the effectiveness of interventions to address violence against women, identifies some of the gaps in the literature, and attempts to assess how far what has been learned about one aspect of violence against women can be transferred to another.

### **4.1 Responding to rape and sexual assault**

#### **4.1.1 The criminal justice system response**

The reporting and subsequent investigation and prosecution of rape and sexual assault are the focus of much of the available research literature on the subject, particularly in Britain. As already indicated, the establishment of specialist police units in Scotland to deal with sexual assault dates back to the mid 1980s, and followed highly publicised research which critiqued existing police practice (Chambers and Millar, 1983). The trend towards specialism in this area continued throughout the 1990s, and is now standard across the Scottish police forces. Although the model varies slightly from one force area to another, key components include dedicated interview suites, specialist officers, and a 'victim-centred' approach. In some areas there is also a dedicated forensic suite.

Practitioners acknowledge that there have been significant improvements in the police response to rape and sexual assault complainants over the last 20 years (Christianson and Greenan, 2001), and this is supported by research. A study of 23 women in Sussex who had reported to the police between 1991 and 1993 found that 57% of them felt mostly positive about the response of police officers, while 43% were mostly negative about the response of police officers (Temkin, 1997). None of the women, including those who felt negative about the service overall, felt that they were disbelieved, or that the police were 'heavy-handed' in their approach. In addition, the majority of the women (19 out of 23) valued the manner and attitude of the police officers who dealt with them. For the women who were 'mostly negative' about their experience with the police, poor follow up, difficulty accessing information, disbelieving attitudes and insensitive handling were the main features of their complaints about the service.

Temkin concludes that "the believing, sympathetic, non-judgmental attitude of the police, the unpressured pace and supportive manner in which their

statements were taken, the access which they had to police officers and to information thereafter and the help and backing they received...during the course of the investigation and afterwards” were the main reasons for women feeling positive about the experience of reporting (Temkin, 2001: 524). Follow-up, she maintains, continues to be a problem, particularly in the area of information on the progress of the case.

These findings are similar to those from a survey of 48 women who reported to police in New Zealand between 1990 and 1994, in which 40% of the women expressed some degree of satisfaction with the police response, and 38% were dissatisfied (Jordan, 2001). The author acknowledges some of the difficulties inherent in measuring ‘satisfaction’ with a process which by its nature is bound to be distressing. She notes:

“Because rape is such an intense and sensitive area, when the police act with professional caring and demonstrate their respect for the victim, this is noticeable and greatly appreciated. When such qualities are lacking, however, their absence is also very noticeable.” (Jordan, 2001: 696).

She goes on to explore the balance to be struck between the need (of women) for the process to be manageable, and the need (of police officers) to focus on the end result of that process:

“...at the very time that a raped woman is seeking to be believed and validated, the police will be intent on obtaining proof and verification that she is telling the truth. Her need for validation may clash with the police search for verification, and the techniques used by the police in their quest for evidence may threaten and undermine her sense of confidence and safety in them. While she struggles to regain a sense of autonomy following the rape, the police feel they as professionals must retain control of the proceedings.” (Jordan, 2001: 701).

Jordan asserts that the achievement of a sense of control over the proceedings need not be achieved by one party at the expense of the other. Citing Temkin, she notes the value women place on belief, respect for the complainer, and a non-judgmental approach by the police (Jordan, 2001).

Recorded crime statistics for Scotland show a steady increase in the reporting of rape (Scottish Executive, 2003). This picture is similar in England and Wales (Harris and Grace, 1999; HMIC/HMCPS, 2002) and across Europe (Regan and Kelly, 2003). However, in none of these jurisdictions has the increase in reported rapes been matched by an increase in prosecutions or convictions. In fact, the conviction rate for rape has fallen during the period in which the reporting levels have risen (Harris and Grace, 1999; Regan and Kelly, 2003).

In an attempt to identify some of the reasons for this, the Home Office requested a joint inspection by HM Inspectorate of Constabulary and HM Crown Prosecution Service Inspectorate into the investigation and prosecution

of rape cases. Their report was published in April 2002. The terms of reference were:

“...to carry out an analysis of investigations, decision-making and prosecutions of allegations of rape, from initial report through to case disposal.” (HMCPSI/HMIC, 2002: 2).

The review covered all offences of rape against women, men and children. In relation to the investigation stage, the key findings echo some of the research findings already discussed, included the need for consistent training of police officers and forensic examiners, and improvements in the physical environments in which interviews and examinations take place. In addition, the review identifies partnership working with other agencies (e.g. through dedicated sexual assault referral centres) as key to improving the response to victims. Improved and standardised recording systems, and a review of timescales needed for submission of files to the Crown Prosecution Service are identified as the main administrative improvements required.

Although the report does not consider the role of forensic examiners in detail, it does note the limitations on choice posed by the lack of female forensic examiners, and the implications of forensic examiners learning ‘on the job’ rather than through accredited training programmes. The report considers that quality of forensic evidence is crucial to effective prosecution of rape and sexual assault, increasing the likelihood that prosecution will happen, and that a conviction will result (HMCPSI/HMIC, 2002). In addition, it is suggested, any measures which reduce the trauma of the investigative process for individual women are to be welcomed, improving not only the likelihood of achieving a conviction, but also the woman’s recovery rate following a sexual assault. This view is supported elsewhere in the literature (Campbell et al, 2001; Kelly and Regan, 2003).

In a study commissioned by Rape Crisis Network Europe (RCNE), Kelly and Regan reviewed recent literature on the conduct and outcomes of forensic examinations. They identify some of the key elements of good practice in relation to forensic examinations, emphasising “the rights and dignity of the victim” (Kelly and Regan, 2003: 6). These include “speedy response; avoiding the triage system in hospital A&E departments; a private dedicated space; a well equipped examination room; trained and skilled practitioners; female examiners; a streamlined victim-centred information gathering process; time to move at the speed the victim/survivor is comfortable with; protocols and evidence kits which are applied flexibly, according to the facts of the case; space to discuss the process, debrief and undertake crisis intervention, and provision of, or links to, medical follow up and advocacy/support services.” (Kelly and Regan, 2003: 12)

These conditions, they argue, are crucial, both to the quality of the evidence gathered, and to the comfort and health of the complainers (Kelly and Regan, 2003: 12). In their subsequent review of five different approaches to forensic examination, they note that the use of trained doctors is one of the more common models. They identify a number of difficulties inherent in this

approach, including problems with recruiting women doctors, the need for participating doctors to take on a generic forensic role, thus perhaps limiting their knowledge about sexual assault, and problems with limited availability of doctors at certain times. They also suggest that there may be limited co-ordination and integration across the services, and an absence of advocacy and support.

Some of these issues are addressed by the use of forensic nurses, who have a more extensive role in providing healthcare advice, advocacy and support to complainers, in addition to evidence gathering and providing forensic reports for the courts. This model is widely used in North America and has several advantages, including a higher degree of specialism, cost effectiveness, and a more holistic approach to health intervention following sexual assault (Kelly and Regan, 2003; Ledray, 1999).

A holistic approach is also found in the provision of Sexual Assault Centres, which in Canada are designed to “attend to the medical, emotional, social and medico-legal needs of clients in a prompt, professional, and compassionate manner and to provide leadership in the prevention of sexual assault” (Du Mont and Parnis, 2002, cited in Kelly and Regan, 2003: 15). These are usually hospital based, often attached to accident and emergency facilities, with a dedicated examination room and possibly interviewing facilities. There are several examples of similar centres in England, including The Haven, a referral centre based in a sexual health setting which provides forensic examination and sexual health follow up in southeast London (Kerr et al, 2003), and the St Mary’s Centre in Manchester, which was the first such centre in England. As yet, there are no such facilities in Scotland, although discussions are ongoing in Glasgow about how such a service might be developed (Dutton and Cavanagh, 2003).

Kelly and Regan conclude by identifying the key components required in order to begin developing minimum standards:

- “Privacy through the development of dedicated rooms, or a centre;
- Philosophical principles underpinning practice that emphasises respect, dignity, rights and choice;
- Enhancing forensic practice through capacity building – both the number of trained examiners (often through involving nurses) and their skills base;
- Access to female examiners;
- Ensuring that even if people have to wait for a medical practitioner, that a staff member is available to greet them, take them to the more private rooms, and explain their rights and what may happen next;
- Linking provision of immediate medical care, forensic examinations, crisis and short term counselling, follow up medical care and advocacy;
- Combining service provision with training, awareness raising and system advocacy;
- Leadership within the service, and some form of community accountability;

Ensuring access is as wide as possible, and that outreach efforts are targeted at under-served populations.”

(Kelly and Regan, 2003: 17)

Finally, they note the emerging debate about how far forensic evidence actually influences the outcome of sexual assault trials, citing Canadian research which demonstrates that only documented injury appears to have a predictive influence on convictions (Du Mont and Myhr, 2002; cited in Kelly and Regan, 2003). Given the trauma for women undergoing forensic examination, further research would seem to be indicated in this area.

In another report for Rape Crisis Network Europe, Regan and Kelly address the issue of attrition in reported rape cases, raising serious concerns about the extent to which convictions for rape have fallen across Europe, as shown in their pan-European study (Regan and Kelly, 2003). They maintain that this downward trend in conviction rates is contrary to what might be expected, given the role of the women’s movement in raising awareness and challenging rape stereotypes, the development of rape crisis lines and other women’s counselling projects, the development of training and practice guidelines, increased media awareness and legal reforms. However, they argue that it is symptomatic of a situation in which rape has received little attention compared with domestic violence and trafficking. The study indicates that countries with adversarial legal systems have the highest attrition rate – England and Wales, Scotland and Ireland all have conviction rates below 10%. At 6%, the conviction rate for rape in Scotland is second only to that in Ireland.

The Justice ministries for the countries involved in the study offered a range of technical and procedural ‘barriers to successful prosecution’, including limited or absent evidence, under-reporting or delayed reporting, lack of support services, delays in court proceedings and ‘limited incentives for prosecutors’. The authors contend that, despite a wide range of legal and procedural reforms which have been enacted across Europe since 1980, there is still an absence of good practice in enabling rape complainants to give their best evidence or in supporting and protecting “their dignity and integrity” during the trial process (Regan and Kelly, 2003: 17).

Overall, they argue, rape is very much ‘a forgotten issue’ on political and social policy agendas, attracting neither the debate nor the resources which have gone into highlighting domestic violence as a social policy priority. They make a number of recommendations for change, including the suggestion that research should be undertaken to explore the points of attrition in rape cases and identify possible reasons for the increase in attrition.

A small scale pilot study which addresses these issues has already been undertaken in Scotland. The study retrospectively tracked the progress of 191 complaints involving sexual offences through the criminal justice system, by examining crime reports, interviewing police officers, examining fiscal files and interviewing precognition officers and procurators fiscal. Two police forces were involved, one urban and one rural, and seven fiscal offices. Of a total of 47 cases which began as complaints of rape, 17 did not progress beyond the

police, a further 15 did not progress beyond the fiscal, and of the 15 which went to court, eight resulted in a conviction (Jamieson, 2001).

Although this seems an improvement on the 22% conviction rate reported in an earlier study (Brown, Burman, Jamieson, 1992), Jamieson notes that more than half of the cases which proceeded to court involved child complainers. A further breakdown of the figures shows that of the nine cases involving child complainers, five resulted in a conviction, compared with only two out of the 14 cases involving an adult complainer. Although Jamieson comments on the range of reasons given in police crime reports for not proceeding, including withdrawal of the complaint, false allegation, and no known suspect, she does not identify any one area of police procedure as particularly problematic. In relation to cases marked 'no proceedings' by the procurator fiscal, she suggests that the basis for deciding there is 'insufficient evidence' might bear further exploration. Acknowledging that the fiscals interviewed all maintained that decisions should be made on the basis of sufficiency of evidence, and not on the credibility of the complainer, she nonetheless notes:

"In the case files we examined, we formed the impression that judgements about credibility were most often recorded in cases in which there is equivocation about the sufficiency of the evidence." (Jamieson, 2001: 80).

The HMCPSI/HMIC report also notes concern about the role of the complainer's credibility in cases where there is limited evidence, and in particular "...found that the prosecutor's approach too often tended to be one of only considering any weaknesses, rather than also playing a more proactive role in seeking more information and trying to build or develop the case." (HMCPSI/HMIC, 2002: 9). Amongst a raft of measures outlined in the subsequent Action Plan it is noted that revised guidance on rape has already been made available to prosecutors, and that a revised training package for sexual offences will be commissioned. In addition, it is noted that the CPS agrees with the recommendation that rape cases should be handled by specialist prosecutors, and that consideration is already being given to how to implement this.

There have been some significant changes in the legislative response to rape and sexual assault over the past three years in Scotland. A recent Lord Advocate's reference on the definition of rape clarifies Scots law and makes it clear that rape is based on an absence of consent, and does not require the use or threat of force. The introduction of the Sexual Offences (Procedure and Evidence) (Scotland) Act 2002 prohibits the accused in sexual offence trials from conducting his own defence, and tightens the restrictions regarding use of sexual history/character evidence. The Solicitor General has recently announced a review of the prosecution of rape and sexual offences in Scotland. All of these initiatives might be expected to improve the treatment of rape complainers and hopefully the attrition rate. Regan and Kelly (2003) recommend that governments evaluate recent and new legal and procedural reforms. A precedent has been set in Scotland with the evaluation of the Protection from Abuse (Scotland) Act 2001, and it would seem that this

exercise would bear repeating in relation to the recent sexual offences legislation.

A search of the literature produced little from Canada on rape or sexual assault. As noted earlier in this report, Canada has no specific offence of rape, having made the shift to a broader 'sexual assault' spectrum of offences in the early 1980s. In a recent overview of the Canadian experience, Hague et al note that this creates some difficulty in trying to compare reporting and prosecution of rape in Canada with experiences in the UK, as the figures available from Justice Canada provide the totals for all sexual assaults, across all three of the levels of sexual assault defined in law, and with no distinction made between offences against children and offences against adults (Hague, Kelly and Mullender, 2001).

The legislative reform in Canada also included the removal of the requirement for corroborative evidence in sexual assault cases. In practice, however, it would seem that prosecutors are still reluctant to proceed with cases which do not have some form of corroboration (Du Mont and Myhr, 2000, cited in Krug et al, 2003: 170).

Hague et al note with some surprise a decline in reported sexual assaults over the five years before their report, and with some disappointment the absence of the kind of detailed data that is available on 'family violence' from Statistics Canada (Hague, Kelly and Mullender, 2001). It would seem that in Canada, as in Europe, rape and sexual assault are 'forgotten issues', despite the best efforts of women's advocacy services.

#### **4.1.2 Supporting survivors of rape and sexual assault**

Rape crisis centres have provided support services for rape and sexual assault survivors in Scotland since the 1970s. In common with similar services in other parts of the world, centres were usually based on a feminist political perspective, with support provided 'by women, for women'. The support aimed to be woman-centred, non-judgmental and non-directive. It was free, and it was confidential. The stated goal was to help the woman regain control over her life, and support was delivered in ways designed to enhance this:

"Most women have their initial contact with us through the telephone. Women assaulted by men have had their sense of control over their own lives and bodies destroyed. In using the telephone a woman has the power over her contact with us - by hanging up when she wants, by ringing back if she wants, by making arrangements to meet face-to-face and keeping or breaking them - she chooses the extent of her involvement." (Edinburgh Rape Crisis Centre, 1981: 6).

The mechanics of service delivery varied from one area to another, often dependent on funding. Where possible, centres provided medical and legal

advocacy for women, and accompaniment through the criminal justice process. Until the late 1980s, most centres were run entirely by volunteers.

Believing women and validating their reactions to sexual assault were core to the process. Challenging the social norms of the time, rape crisis centres gave a clear message to individual women and to the rest of society – women were not responsible for rape, men were:

“When a woman has been raped she often encounters disbelief and blame from all corners – family, friends, police, doctors. She suffers from the fear that somehow she contributed to the attack. Our acceptance without judgement of whatever the woman wants to tell us can help begin the process of banishing this guilt. We do not doubt or question what she says.” (Edinburgh Rape Crisis Centre, 1981:6).

Belief and unconditional acceptance continue to be central to the ethos of rape crisis. In a recent handbook on rape and sexual assault, “believe the woman” is still at the top of the list (Rape Crisis Centre, Glasgow, 2003).

The basic philosophy has changed little over the last 20 years. The services, however, have changed and adapted, partly in order to meet the requirements of funding and regulatory bodies. However, change has also been prompted by the demands of women using the services. Services which were established around a ‘crisis line’ as the primary source of support have shifted emphasis, as women making contact with centres have developed more of an expectation of receiving ‘counselling’, reflecting a wider public acceptance of counselling than was the case in the early days of the movement (Christianson and Greenan, 2001). Rape crisis centres today are more likely to offer face-to-face support routinely, using a formal appointment system (Rape Crisis Scotland, 2003). Centres also develop their services in response to the needs of particular women, for example women asylum seekers and women working in prostitution (Rape Crisis Scotland, 2004).

Although some centres carry out in-house evaluations of their service, usually based on feedback questionnaires from service users, there has been little formal or independent evaluation of the rape crisis response to survivors of rape and sexual assault anywhere. One U.S. study which sought the views of rape survivors on the responsiveness of services following an assault found that 75% of women rated their contact with rape crisis centres positively (Campbell et al, 2001). Elsewhere, the same group of authors note that evaluation of rape crisis services in the U.S. has come hand-in-hand with increased dependence on State funding (Riger et al, 2002), and suggest that this link to funding requirements is instrumental in creating tensions between practitioners and programme evaluators. They go on to advocate an evaluation approach which is more holistic, with a focus on best practice, as well as best value; on accountability as well as accounting (Riger et al, 2002).

Consistent with this view, Rape Crisis Network Europe (RCNE) has developed a set of ‘best practice guidelines’ for NGO’s working with women who have experienced sexual violence. Their report, based on information drawn from

their membership, outlines a good practice model based on a political understanding of sexual violence as an abuse of power (RCNE, 2003), and the need, therefore, for a politicised response to it. This underpins all aspects of the work to be undertaken. Client-centred, accessible services, working with each woman to identify what she needs and then helping her to find appropriate support for her situation, are seen as core elements. The involvement of women who are survivors of sexual violence in the delivery of the service is also seen as important, demonstrating to women who are still in crisis that they can survive and be strong again. Evaluation of services is seen as crucial, through information gathered from service users, but also through regular networking and contact with other centres to share elements of good practice (RCNE, 2003).

Linked with the delivery of direct services to women is the perceived need to work for change in the societal values and attitudes which allow sexual violence against women to be perpetuated. The report identifies campaigning for legislative and social policy reform, public education work, research and training as essential components of a strategy to improve service responses to women who have experienced sexual violence (RCNE, 2003).

Some of the elements of the 'best practice' approach identified in the RCNE guidelines are shared by many other services involved in supporting survivors of rape and sexual assault. Outwith the voluntary sector, mental health services are the main source of support, therapy and counselling for survivors. Campbell (2001) reviewed the available literature, primarily from the U.S., on the effectiveness of different interventions used by mental health practitioners. She notes that most of the research has been conducted with white women (and by implication middle class women), because in the U.S., this is the group which accesses mental health services. The findings, therefore, may not reflect the experiences of minority ethnic women or working class women. Citing Wyatt (1992) she notes that African American women are perhaps more likely to use informal support systems, i.e. family and friends, but goes on to suggest that more work is needed to provide a fuller picture of why minoritised groups are less likely to access mental health services (Campbell, 2001).

Campbell's review acknowledges that, in general, there is a need for more research which evaluates interventions. The existing body of research focuses primarily on cognitive behavioural therapy (CBT) and feminist therapy. CBT approaches are primarily used to help women deal with the immediate aftermath of an assault, particularly in response to the high levels of fear or anxiety they may experience. Feminist therapy is utilised more as a response to the longer term difficulties of women who have been raped, particularly in relation to guilt and self-blame. Although noting the value of CBT techniques in reducing anxiety and fear, she questions whether there is any evidence that they are as helpful in reducing self-blame and guilt. Feminist therapy, she suggests, may be a more effective intervention in relation to guilt and self-blame, since it encourages the woman to see her experience in the context of societal inequalities, not as her individual problem. In practice, she acknowledges, mental health workers are likely to

use a combination of these approaches, since they will be seeking to address both short and longer term difficulties (Campbell, 2001).

In an effort to identify what kind of intervention was helpful to women, Campbell et al surveyed 102 women survivors of rape in Chicago, examining the impact of a range of service responses, or lack of response, on their psychological and physical health outcomes (Campbell et al, 2001). The services considered included the legal system, medical/forensic services, mental health services, rape crisis centres and religious groups<sup>14</sup>. Over half of the sample found contact with the legal system 'hurtful' rather than 'helpful', and although 47% of those who sought medical attention found it 'healing', almost a third found it 'hurtful'. In contrast, the majority (over 70%) of survivors experienced interventions by mental health services, rape crisis centres or religious communities as 'healing'.

The study found that ethnic minority women and women who had experienced 'acquaintance rape' had a particularly poor response. Overall, the researchers concluded that "a key focus on violence against women research and interventions must be the prevention of secondary victimisation." (Campbell et al, 2001: 1253). They recommend three approaches to achieve this – an increased involvement of rape crisis services; increased training for all service providers, and the development of coordinated multi-agency responses.

#### **4.1.3 Developing a multiagency response to rape and sexual assault**

A recent report on the subject of multi-agency responses to sexual violence suggests that the literature in this area is largely descriptive rather than evaluative in focus (Dutton and Cavanagh, 2003). The report, commissioned by the Glasgow Violence Against Women Partnership, provides a comprehensive review of the literature on multi-agency models in Britain and the United States. The authors examine the development of Sexual Assault Response Teams (S.A.R.T.s) in the United States, noting that the model may operate slightly differently in different parts of the country. Generally there will be a degree of consistency in the membership of the teams, which may involve a Sexual Assault Nurse Examiner (S.A.N.E.), a representative from the police or sheriff's office, a detective, a prosecutor, a rape crisis advocate and staff from the emergency department. Following examination by the S.A.N.E., a nurse who has undergone specialist training in gathering forensic evidence, the complainant is interviewed in the presence of, usually, the S.A.N.E., the investigating police officer, and a rape crisis advocate. From there on, the S.A.R.T. will maintain contact throughout the investigation and prosecution process (Dutton and Cavanagh, 2003).

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<sup>14</sup> Religious groups are commonly associated with support services for survivors of violence in the U.S.

The original S.A.R.T. model, developed in California, is built on the assumption of an immediate police involvement. Subsequent adaptations have sometimes moved away from this approach, arguing that women may feel under pressure to report to the police. In addition, if they believe that seeking help with injuries or other health concerns may involve them in having to report to the police, some women will avoid accessing healthcare services, and thus miss out on screening for sexually transmitted infections and pregnancy (Ledray, 1999). However, in all S.A.R.T. derivatives, the principle of providing a coordinated response is unchanged, simply the range of services involved (Dutton and Cavanagh, 2003).

Dutton and Cavanagh raise a justifiable concern about the lack of evidence to support the view that S.A.R.T. and S.A.N.E. initiatives are 'best practice' in responding to survivors of rape and sexual assault. Advantages of S.A.N.E. schemes are said to include – better collaboration with law enforcement, higher reporting rates, shorter examination time, better forensic evidence collection, more complete documentation and improved prosecution rates (Ledray, cited in Dutton and Cavanagh, 2003). However, no substantial empirical study has yet been carried out.

Although rape crisis centres in the U.S. are now routinely involved in S.A.R.T.s, there have been significant periods of tension and debate during the development of these multiagency responses. The campaigning and political lobbying work of rape crisis centres has undoubtedly played a massive role in increasing awareness of sexual violence and challenging the myths and stereotypes which abound about women and rape. In the process, rape crisis centres have raised women's expectations that they should be able to access services if they are raped, leading to a steady increase in the numbers of women approaching services. The pragmatic response to this is to seek the most efficient way to deliver services. The involvement of statutory service providers in developing this response has inevitably meant the loss of much of the political focus of the early work, as the emphasis has shifted from 'stopping violence to managing rape' (Matthews, 1994).

Similar tensions have followed the development of Sexual Assault Referral Centres (S.A.R.C.s) in the U.K. There are currently four S.A.R.C.s in England, with plans for more. Based on a medico-legal response to rape, none of the centres involve rape crisis or other women's groups. Counselling is provided by professional counsellors, and the services are 'gender neutral', i.e. providing services to all adults.

In summary, Dutton and Cavanagh identify some common themes in the development of multi-agency responses to women survivors of sexual violence. They note that services are "primarily instigated by statutory service providers; primarily based on medico-legal service provision; gender-neutral in the provision of services" (Dutton and Cavanagh, 2003: 75). Their over-riding conclusion is that there is "a significant lack of research examining the

effectiveness of these initiatives” (Dutton and Cavanagh, 2003). In the light of this, a forthcoming evaluation of the U.K. S.A.R.C.s is to be welcomed.<sup>15</sup>

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<sup>15</sup> The Home Office has commissioned Prof. Liz Kelly of the Child and Woman Abuse Studies Unit at Metropolitan University to undertake an evaluation of Sexual Assault Referral Centres in England. Publication of the report is expected later in 2004.

## **4.2 Responding to women working in prostitution**

“Some of the questions about prostitution cannot be resolved by research, since they are fundamental questions about the kind of society one wishes to see, how one understands gender equality, and what it means to sell sex.”

(Bindel and Kelly, 2004: 1)

Although there is little dispute that women working in prostitution are at significantly higher risk of being physically or sexually assaulted than women in the general population (Farley and Barkan, 1998; Farley and Kelly, 2000), there are different degrees of understanding or acceptance of prostitution as violence against women. For some there is a distinction to be made between ‘forced prostitution’, including trafficking, and women ‘choosing’ prostitution as an occupation (Butcher, 2003). Others assert that the harm caused to women by prostitution should define it as a form of violence against women (Farley and Kelly, 2000; Miller and Jayasundara, 2001). The nature of policy and practice responses to women in prostitution is determined largely by which of these positions is adopted.

### **4.2.1 The criminal justice system response**

Policy and legislative frameworks play a significant role in determining the focus of responses to women working in prostitution. In Scotland, the focus of the criminal justice system has been largely reactive, working from a ‘crime management’ perspective which defines women in prostitution as offenders, more likely to be arrested than the men who buy sex from them. The imposition of fines adds to the debt many women are working to repay, they may then be jailed for non-payment of fines, and the debt problems are then exacerbated. In the meantime, women who are assaulted while working in prostitution may be reluctant to report assaults to the police because they can then be arrested on outstanding warrants. Thus women’s experiences as victims of male violence remain largely invisible (Women’s Support Project, 2002).

Looking for ways to change this situation, the Routes Out Partnership recently commissioned a review of legal responses to prostitution in four countries. The review assesses current and past approaches to prostitution in Victoria (Australia), Ireland, the Netherlands and Sweden; identifies the rationale for the changes made in each country’s position and assesses the impact of the changes on women involved in prostitution and the men who use them. The countries studied utilise one of three regimes – Victoria and the Netherlands have both moved to legalisation involving state sanctioned brothels, Ireland has adopted a regulatory approach, and Sweden has moved to a position of

criminalising the buying of sex and decriminalising the selling of it (Bindel and Kelly, 2004).

In the state of Victoria, Australia, and in the Netherlands, legalisation of prostitution is primarily focussed on licensed brothels; some aspects of street prostitution are still illegal. The rationale for adopting this approach can be seen, in part, as being about removing the 'nuisance' element of street prostitution by providing a state sanctioned indoor environment. The provision of a 'clean' and safe environment is also seen as an advantage, improving the sexual health of prostitutes (and the men who use them) and breaking the links between prostitution and organised crime (Bindel and Kelly, 2004).

The authors comment that this does not appear to be the case in practice. In both Victoria and the Netherlands, there is still evidence of strong links between organised crime and prostitution, along with a significant increase in the number of licenced and unlicenced brothels. Police and local authorities have inadequate resources to enable effective monitoring of which brothels are operating without licences, and in the Netherlands, it is noted that the expansion of 'legal' prostitution has been matched by a similar expansion in 'illegal' prostitution. Women working in prostitution are still stigmatised, and many continue to work illegally because they do not want to be officially recorded as prostitutes (Bindel and Kelly, 2004).

'Regulation' of prostitution involves a mix of approaches including responding to the 'nuisance' aspect of prostitution and/or adopting an unofficial position of tolerance. The goal is 'management' by maintaining public order, rather than 'prevention'. Implementation of a regulatory approach in Ireland since 1993 has not resulted in any discernable weakening of the links between prostitution and organised crime. It has, however, had a negative impact on women, as the powers given to the police to deal with public soliciting have primarily been used against women, rather than customers and pimps (Bindel and Kelly, 2004).

Sweden passed legislation in 1999 which made it a criminal offence to buy any form of sexual services, in line with an overall policy on gender equality which determined that ending prostitution rather than managing it must be the goal. At the same time, the provision of sexual services by women was decriminalised, and their status shifted from 'offender' to 'victim'. Linked with the legislation is a commitment to increasing the resources of police and prosecutors to deal with it, along with the development of drug rehabilitation programmes and exit strategies for women. Street prostitution in Stockholm has subsequently reduced by two thirds. This is seen by the Swedish government as a long term project, with the goal not only of reducing the numbers involved in prostitution but also of changing public attitudes. In the meantime, the decriminalisation of women working in prostitution, and the consequent freedom from the cycle of arrest/fine/jail, has removed at least one barrier to women's ability to leave (Bindel and Kelly, 2004).

The researchers, while noting that "Virtually no evaluation of overall approaches has been undertaken...", go on to suggest that the evidence that

does exist “does not commend a legalisation approach.” (Bindel and Kelly, 2004: 31). They conclude that the Swedish model is the most coherent “in terms of philosophy and underpinning” and note with interest that it is the only model of those reviewed which does not criminalise those who sell sex (Bindel and Kelly, 2004: 32).

In Scotland, the debate has polarized further, and more publicly, since 2002, when a private member’s bill introduced by Margo McDonald MSP proposed that local authorities should be allowed to establish prostitution ‘tolerance zones’ in designated areas. Although the Bill fell at committee stage, it generated considerable debate. The Scottish Executive established an Expert Group on Prostitution to review the available evidence on effective responses to prostitution. The group met for the first time in August 2003, and has already heard evidence from different parts of Scotland. The group has also commissioned a piece of consultative research to gather the views of women working in prostitution, both indoors and outdoors.

Meanwhile, the Bill has been resubmitted and is currently being reconsidered by the Local Government and Transport Committee. Written evidence submitted to the committee reflects the polarisation of the current debate in Scotland about what constitutes an appropriate response to prostitution. Supporters of the Bill argue that the use of tolerance zones increases the safety of women working in street prostitution by enabling them to work within sight of each other. This view, they argue, is supported by a noted increase in the number of attacks on women working in street prostitution in Leith (Edinburgh) since the ‘unofficial’ tolerance zone was dropped. Prostitutes themselves, it is argued, support the introduction of tolerance zones, and as a matter of human and civil rights, their views should be given consideration (ScotPep, 2003).

Those opposed to the Bill argue that this view makes the assumption that women want to work in prostitution. If this is taken as a given, then obviously women will want any measure which promises a degree of safety. They also dispute the evidence on increases in attacks on women when tolerance zones are removed, citing a report by Base 75, an agency in Glasgow which provides support services for women working in prostitution, which shows no difference in the numbers of attacks reported to them by women before and after the introduction of ‘sensitive policing’ in Glasgow city centre (Routes Out Partnership, December 2003).

The Bill is still in progress. The Expert Group is expected to report on Stage 1 of its remit (on street prostitution) in Autumn 2004.

#### **4.2.2 Supporting women abused in prostitution**

Good practice in responding to women working in prostitution is identified in a guide originally published by the Franki Women’s Support Project in Bolton, and subsequently adapted and published by the Women’s Support Project in

Glasgow. The guide highlights the need for realistic interventions, based on an understanding of the harm caused to women by prostitution, but recognising that for women, making the decision to leave prostitution may not be a simple or straightforward choice (Women's Support Project, 2002). A range of services and interventions may be required at different points in this process.

It has already been noted that prostitution impacts negatively on all aspects of women's health (Farley and Barkan, 1998). The medical literature, however, focuses predominantly on the prevalence and prevention of sexually transmitted infections in women working in prostitution, and pays scant regard to their wider health needs (Baker, Case and Policicchio, 2003). Health interventions, therefore, have tended to focus more on the threat to public health posed by women working in prostitution, rather than on the health needs of the women themselves. Although practice in this area is clearly beginning to change, with an increasing focus on the broader health concerns of women working in prostitution (Routes Out, 2003), there is still little to be found in the research literature which goes beyond "condoms and safer sex negotiation skills" (Farley and Kelly, 2000: 22).

There is a similar lack of research on what works in advocacy and support services for women working in prostitution. The Home Office Crime Reduction Programme funded 11 pilot projects addressing prostitution until March 2002. Three of the pilot projects focussed on young people, three on policing, and six on 'exiting and support'. Of the latter, two of the pilots identified a reduction in the number of people entering or an increase in the number of people exiting prostitution as a primary goal. The remainder primarily focussed on reductions in kerb crawling, soliciting and 'associated nuisance', or a range of other 'harm reduction' indicators (Home Office, 2001). An evaluation of the pilot studies is pending.

### **4.2.3 Developing a multi-agency response to prostitution**

The Routes Out Partnership was established as a thematic social inclusion partnership in Glasgow in 1999, with the aim of improving and coordinating responses to women working in prostitution in the city. Membership of the partnership board reflects the diversity of agencies involved in responding to prostitution and women working therein – the police, the health board, the local drug action team, social work and other council services, and the women's voluntary sector.

Routes Out is based unequivocally on the principle that prostitution in any form is harmful to women, and works towards preventing women, particularly young women, from becoming involved in prostitution, and providing viable alternatives to women who wish to leave prostitution. It is, in effect, a demonstration project, testing an approach which involves crisis intervention and short term initiatives to support women who are still involved in

prostitution, and longer-term interventions to support women who are leaving prostitution (Routes Out, 2003).

The Partnership is supported by a range of agencies, including Base 75, which provides a range of services at evening drop-in clinics, including methadone prescribing, and access to accommodation. Rape Crisis in Glasgow has been funded to develop a specific project 'Supporting Women Abused through Prostitution'. The Routes Out Intervention Team is funded through the Partnership to assist women to achieve some stability, before beginning to identify what they may need to do to be able to leave prostitution (Routes Out, 2003).

## **4.3 Responding to survivors of child sexual abuse**

### **4.3.1 The criminal justice system response**

There has been an increasing focus in the last two years on the prosecution of cases of child sexual abuse involving child witnesses<sup>16</sup>. Changes in the procedures relating to child witnesses in such cases are to be welcomed, and will hopefully improve both the process and the outcome of sexual offences trials involving child witnesses. However, despite a noted rise in the numbers of adults reporting historical cases of child sexual abuse to the police (Scottish Executive, 2003), no research has been identified which examines the investigation and prosecution of historical abuse complaints.

What is known from practitioners, and from survivors, is that the increase in reporting is not matched by an increase in prosecution of historical cases. The chief reason for this is likely to be insufficient evidence. Lack of forensic evidence and the absence of witnesses are common barriers to prosecution across all forms of violence against women. Additional factors in historical abuse cases include the length of time which may have elapsed, and the implications of this for the reliability of the memories of witnesses. The age of the alleged abuser may also be significant, as the procurator fiscal must consider whether it is in 'the public interest' to prosecute if the accused is very elderly, and/or or very frail. Prosecution is most likely to proceed, and to result in conviction, in cases where there are two or more complainers reporting similar incidents involving the same accused. Even then, defence advocates may succeed in demonstrating inconsistencies in their narratives, making it difficult for a jury to convict 'beyond reasonable doubt'.

Broader measures designed to address the needs of all victims of crime obviously have relevance for adult survivors of child sexual abuse. For example, should a complaint survive the investigative process and be referred for trial, it is likely that the complainer will be defined as a 'vulnerable witness',

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<sup>16</sup> Partly as a result of a well publicised case in July 2001, in which complaints of sexual abuse were made against six men from Ayrshire by two children. An 11 year old girl gave evidence for 10 days and was cross examined by all six defence advocates. The trial ended when the second child, a six year old boy, was deemed too distressed to continue.

given the nature of the offence and the levels of fear which they may still have in relation to the abuser. As such, there may be an entitlement to the range of special measures which have recently been introduced to ease the experience of giving evidence in such cases<sup>17</sup>. This, however, will be of limited value until some of the prosecution difficulties are resolved.

#### **4.3.2 Supporting adult survivors of child sexual abuse**

In Scotland, as elsewhere, the earliest responses to adult survivors of child sexual abuse came from within the voluntary sector, and in particular from rape crisis services. From the early 1980s, increasing numbers of women making contact with rape crisis centres were disclosing childhood abuse by family members. Incest survivor groups and campaigns developed out of these early contacts, and by the 1990s, several new voluntary organisations had been established with a specific remit to provide services for survivors of childhood sexual abuse (Christianson and Greenan, 2001). In addition to providing support and counselling services for individual survivors, these organisations have also advocated for the development of a more consistent response from the statutory sector.

Most voluntary organisations provide a service which could broadly be described as client centred and non-directive. Support may be provided face to face and/or by telephone. In some organisations, all support is provided by paid staff; in others, volunteers may provide the support, with supervision from a paid staff member. Support may be open ended, or time limited. Some organisations also run support groups for adult survivors of child sexual abuse.

Evaluation of the service is generally carried out in-house, as part of the routine evaluation and monitoring of the organisation's work. Occasionally, organisations are funded to carry out a more formal evaluation of particular aspects of their work. More often, though, evaluation is seen as a necessary part of the evidence gathering required by funders, both private and public. At times, it may be limited to an assessment of satisfaction with the services provided, rather than a measure of outcomes or change for individual women (Riger et al, 2002).

#### **4.3.3 The health service response**

As might be expected from the documented impact of child sexual abuse on mental health, adult women survivors of child sexual abuse are significant users of mental health services, both as inpatients and outpatients (Mennen, 1990, cited in Thomson, 1998). Survivors also access general primary care services, both as a result of chronic physical health difficulties and emotional distress.

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<sup>17</sup> Vulnerable Witnesses (Scotland) Act 2004.

Despite this, relatively little attention has been paid in recent mental health policy developments to the specific needs of survivors of child sexual abuse (Short Life Working Group on the Care Needs of Survivors of Child Sexual Abuse (SLWG), 2004). The Framework for Mental Health Services in Scotland (1997) acknowledged that physical and sexual abuse are detrimental to mental health, and that responses to survivors of such abuse should therefore be within the scope of extended primary care services. Since then, more explicit attempts have been made to address how mental health services in Scotland might best respond to adult survivors of child sexual abuse.

Two Scottish studies have explored the experiences of women survivors of child sexual abuse who have accessed mental health services and other support services. Thomson (1998) reported on the experiences of women who had disclosed abuse in a range of settings, voluntary and statutory. Nelson and Phillips (2001) focused on the experiences of women survivors of child sexual abuse who had been inpatients at one Edinburgh hospital.

Thomson interviewed 19 women about their experiences of service responses to their disclosures of child sexual abuse. Common themes included the importance of confidentiality, establishing trust, having the time and space to talk, and the need for professionals to have more awareness of the impact of sexual abuse on women's lives. Common difficulties encountered by women included long waiting lists, and consequently long delays between their initial disclosure of sexual abuse and being able to access a service. Negative and/or disbelieving responses from professionals were also a concern for women (Thomson, 1998).

Nelson and Phillips echo Thomson's findings to some extent, with similar negative experiences of responses to disclosure reported by many of the 22 women interviewed. However, where the Thomson study focuses primarily on the process of disclosure and the reactions women experienced, the more recent report provides a more detailed analysis of what women found helpful in responses from workers and services, and how far these responses assisted their recovery (Nelson and Phillips, 2001). In particular, this report highlights that for many survivors of sexual abuse, the levels of awareness and attitudes of staff, as characterized by their willingness to ask about child sexual abuse, are more important than any particular theoretical perspective (Nelson and Phillips, 2001).

A recent survey of clinical psychologists working in the Greater Glasgow area sought information about their awareness of the prevalence and impact of child sexual abuse and their practice in the detection and management of sexual abuse issues. The survey also addressed the level of training psychologists had undertaken and the degree of confidence they felt in working with clients who had been sexually abused (Biggam and Johnson, 2003).

Awareness of the prevalence and impact of child sexual abuse was high, although the proportion of survivors of child sexual abuse in the collective

caseload was found to be somewhat lower than the national average. In response to questions about the range of therapeutic techniques being utilized, 57% of the respondents (n=74) indicated that they found cognitive behavioural therapy (CBT) helpful when working with this client group. Significantly, 95% of the respondents indicated that they were trained to use this model, compared with only 23% who had been trained in the use of other approaches (Biggam and Johnson, 2003).

The authors also reviewed the literature on psychological interventions with survivors of sexual abuse. Acknowledging the scarcity of studies on either individual or group therapy approaches, they provide a useful overview of some of the main methodological difficulties inherent in designing research in this field. Most of the studies reviewed used pre- and post-intervention testing to identify changes in rates of depression, trauma symptoms, self-esteem or other mental health indicators. Most found significant improvements across these indicators. However, citing Donaldson & Cordes-Green (1994), the authors comment that “inherent weak research designs mean that such changes cannot be definably attributed to the intervention” (Biggam and Johnson, 2003).

Only one of the studies they reviewed on group therapy used a comparison group (Alexander et al, 1989, cited in Biggam and Johnson, 2003) and this absence of a control group is one factor that weakens the other studies. However, they also acknowledge the inherent ethical difficulty of providing a therapeutic intervention to one group of clients and withholding it from another. In addition, they comment that the range of factors which may contribute to the efficacy of group psychotherapy interventions is extensive. This would include personal characteristics of the clients and/or the therapist, the level of competence and experience of the therapist, the clients’ commitment to the process, and whether clients are also engaged in individual therapy.

A lack of reliable research on the effectiveness of individual psychotherapy is also identified, with much of the concern focused on similar weaknesses in research design. However, Biggam and Johnson note that some of the results are of interest, with an indication that “gains were maintained across global and specific measures” in three out of the seven studies of individual psychotherapy interventions they reviewed (Biggam and Johnson, 2003: p 39).

Recent guidance on treatment choice in psychological therapies suggests that cognitive behavioural therapies have the most demonstrable benefit in the treatment of depression, anxiety and post traumatic stress disorder, three of the more common mental health sequelae of child sexual abuse (Department of Health, 2001). However, the guidance is framed purely around a symptomatic approach, with no focus on the causes of mental health difficulty in adults. There is therefore no specific analysis of the efficacy of a CBT approach for survivors of child sexual abuse, beyond short-term symptom alleviation.

## 4.4 Responding to domestic abuse

### 4.4.1 Criminal and civil justice responses

Many aspects of the criminal justice system response to domestic violence have come under scrutiny in Scotland and elsewhere over the last two decades. Throughout the 1970s and 1980s, domestic violence advocacy organisations consistently identified the justice system's inadequate response as the most significant barrier to women achieving safety. Frustration at the perceived indifference of police, prosecutors and judges was gradually matched by the realisation that "the failure of the courts and police to protect women was not simply a matter of an attitude on the part of individual practitioners. It was a lack of legal tools to intervene in a legal system that did not take into account...the complexities of women's experiences in a society in which citizens' access to resources and social privilege is determined by their sexuality, race, gender and class position.". This 'lack of legal tools' contributed to low arrest rates, ineffective prosecution and infrequent conviction (Pence and Shepard, 1999:9).

Attrition in domestic violence cases is still remarkably high. A recent study in England found that of 869 domestic violence incidents reported to the police, only 291 were deemed to have a power of arrest attached. Of 222 actually arrested, 60 individuals were prosecuted for criminal offences. Ultimately, only 31 individuals were convicted, and only four of those received custodial sentences. Three police areas in Northumbria were studied, each with slight variations in the policing approach adopted. The authors note with concern that cases from the area which used a 'positive policing' approach, i.e. most likely to arrest, were most likely to fail at court. The authors suggest the need for a more consistent approach across police areas, but also for this to be reflected in the courts (Hester, Hanmer et al, 2003).

In Scotland, several aspects of the justice system response to domestic abuse have been reviewed since the publication of the *National Strategy to Tackle Domestic Abuse in Scotland*. The short-life working group established by the Scottish Executive to review legislation related to domestic abuse acknowledged the complexity of criminal and civil law in this area, and recommended bringing all of the legal remedies together in a single Act. The working group also recommended that a feasibility study be carried out into the practicalities of establishing a domestic abuse court to provide a more cohesive judicial response. A pilot domestic abuse court was subsequently proposed and is due to be implemented in Glasgow.

Many women experience ongoing harassment and abuse after leaving an abusive partner, and may resort to civil remedies in an effort to protect themselves. The Protection from Abuse (Scotland) Act 2001 (PFA Act) strengthened the existing provision around the use of interdicts by allowing powers of arrest to be attached to an interdict, regardless of the relationship

between the two parties; this provision was previously only available as part of a matrimonial interdict. An early evaluation of the Act suggests that interdicts granted under the PFA Act are gradually replacing common law interdicts. This in turn implies that more people seeking protection by interdict are able to access powers of arrest. However, the authors note with some concern that awareness of the provisions of the PFA Act is variable. Few of the women who responded to postal questionnaires had heard of it, and some professionals were unclear about the detail of the provisions. Training for professionals is recommended, along with awareness raising for the general public. The evaluation commenced immediately after the Act was implemented, and the authors suggest that it should be seen primarily as a 'scoping exercise', with a recommendation that a more comprehensive evaluation should take place (Cavanagh, Connelly and Scoular, 2003).

For women with children, there may be further difficulties if their partner has a right to contact with the children. Research with survivors of domestic abuse in England found that contact with children by a violent ex-partner led to further abuse of the woman and/or the children in 92% of cases. In cases where the partner applied to the court for contact it was rare for this to be denied, and even in cases where there were allegations of physical or sexual abuse of the children, contact orders which allowed direct visiting contact were granted in 75% of the cases. The authors acknowledge that a broader piece of research would be valuable, involving the children, ex-partners and professionals involved in the administration and monitoring of contact orders (Radford, Sayer and AMICA, 1999). There is a lack of any empirical research in Scotland on the use of contact orders in cases where there has been domestic abuse, but the Scottish Executive has recently commissioned research which should address this gap.

The remainder of this section will explore some of the key themes identified in the research literature in relation to the policing and prosecution of domestic violence, and the development of coordinated justice system responses to domestic violence.

### ***Policing domestic violence***

In Scotland, there have been significant changes in the police response to women reporting domestic abuse since the publication, in 1990, of a Scottish Office circular to Chief Constables which provided guidance for Scottish forces on how to respond to domestic abuse. The guidance indicated clearly that allegations of assault by a partner should be investigated as thoroughly as any other assault, and that where sufficient evidence existed, an arrest should be made. The guidance also outlined steps which should be taken to ensure the safety and welfare needs of women and children were addressed as a priority (HMICS, 1997).

The thematic inspection by Her Majesty's Inspectorate of Constabulary in Scotland which resulted in the publication of *Hitting Home* in 1997<sup>18</sup> reviewed

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<sup>18</sup> The inspection took place in 1996.

the progress made since 1990 and made several recommendations for further improvement in the Scottish police forces' response to domestic violence. Some of the recommendations would now be seen as standard in any service review, on almost any issue – for example, awareness training, the development of written guidelines, and participation in local multiagency partnerships. Others referred more specifically to organisational issues within forces. The use of nominated officers was clearly identified as beneficial, to improve the monitoring of individual incidents and the provision of follow-up contact to victims, and also in improving liaison with other agencies. It was noted that, even in forces which had designated domestic violence liaison officers, there was a lack of clarity about who had responsibility for deciding on further investigative action, and it was recommended that this should be addressed. The use of statistics on repeat victimisation as an aid to monitoring the effectiveness of interventions was commended as an example of good practice by one force, and the report recommended that this should be adopted more widely. Concern was expressed about the lack of information sharing in most forces between officers dealing with domestic abuse and those dealing with child abuse cases. This echoed a concern about the lack of formal procedures in some forces for sharing information about possible child protection concerns with relevant agencies, in particular the social work department and the Reporter to the Children's Panel (HMICS, 1997).

On the whole, whilst noting the areas which merited further attention, the HMICS report commended the Scottish police forces for the improvements which had already been made in response to the 1990 circular on domestic violence. A subsequent study of police forces in England and Wales reviewed the impact of organisational structure on police responses to domestic violence, and focused specifically on how Domestic Violence Officers (DVOs) were being deployed. The report concurs broadly with the HMICS report on the main areas requiring improvement, but is couched in more critical terms, and notes in particular that:

“No single structure emerged as either more or less problematic than any of the others. The problems related less to the structure than to the status of domestic violence work within forces, the level of commitment of headquarters and divisional commanders, the clarity with which responsibilities were defined and the effectiveness of management arrangements.” (Plotnikoff and Woolfson, 1998:41).

The authors suggested a range of measures which might be adopted by police forces to overcome this, including the establishment of performance indicators for domestic violence, with associated reporting requirements from divisions to force headquarters; the introduction of a standard format for reports; clarification and documentation of the responsibilities of key staff in relation to domestic violence, and clarification of the role of DVOs.

Both of these studies were designed to identify gaps in existing police response to domestic violence. Based largely on analyses of force policies and procedures, examination of organisational structures and interviews with

serving officers, they provide a broad perspective on the police response to domestic violence at the time. Both studies take the position that responses to domestic violence should be consistent with responses to other offences, in terms of the standard of investigation, recording and monitoring approaches, and identification of the “lines of accountability” (Plotnikoff and Woolfson, 1998: 41). Although acknowledging that assaults by partners are ‘different’, the route to improving the policing of domestic violence in both of these studies is predicated on ensuring that structural and procedural gaps are filled.

A different approach was adopted in Leeds, where a 1997 study set out to evaluate a ‘tiered’ response to domestic violence. This 12 month pilot project took place in the Killingbeck division of West Yorkshire police, and aimed to reduce repeat victimisation by providing a graded response to domestic violence, with the police intervention intensifying in response to repeat callouts to the same woman, or the same perpetrator. The level of response was determined by the number of times the offender had attended in the previous 12 months, either in relation to his current partner, or another woman. A first attendance warranted a Level 1 response; one previous incident triggered Level 2, and two or more previous incidents triggered a Level 3 response. Although no formal risk assessment approach was adopted as part of the project, some men were assigned immediately to level 2 or 3, despite no prior attendance, if the level of violence used warranted a more intensive response (Hanmer, Griffiths and Jerwood, 1999).

The range of interventions with the women included issuing information letters; ‘police watch’ i.e. assigning additional patrols in the neighbourhood following an assault; ‘cocoon watch’ which involved neighbours, family and friends in actively contacting the police to report incidents; target hardening, i.e. improving the physical security of the woman’s home, and issuing panic buttons and mobile phones. Simultaneously, a series of official warnings and information letters would be sent to the offender, and a graded response activated via the Crown Prosecution Service (CPS) and the magistrates’ court (Hanmer, Griffith and Jerwood, 1999).

Responsibility for allocating the interventions rested with a DVO, a sergeant who was appointed specifically to progress this project. The volume of work increased during the pilot study and a second DVO was appointed to cover the last three months. It is worth noting that that this increase in the volume of work for the project did not represent an increase in the number of incidents reported, but rather an increase in the number of incidents which were accurately recorded as domestic violence incidents. Recording was acknowledged to be poor at the beginning of the project, with only 50% of domestic violence incidents being accurately coded; this increased to 80% over the lifespan of the project (Hanmer, Griffiths and Jerwood, 1999).

The twin focus on both women and men created “an interactive crime prevention approach” (Hanmer, Griffiths and Jerwood, 1999: 5) which sought to protect women by “demotivating the offender” (Ibid: 6). The removal of any responsibility from the woman for ‘pursuing charges’ gave a clear message to

both parties that domestic violence was a crime and would be dealt with as such. Women interviewed after receiving an intervention commented favourably on the value of the pro-arrest policy, and gave feedback about the effect it had on their partners. Women who received Level 2 or 3 interventions also noted that a strong verbal warning, including the threat of arrest, could have a significant effect, but that this was lost if not acted upon at a subsequent attendance. Level 2 and 3 women felt that the 'warning letters' sent out by the project were less effective, easily dismissed by the men, although level 1 women felt they provided an authoritative condemnation of their partners' actions.

The police watch component attracted some of the most positive comments from women, who felt that the patrols enhanced their safety. Some women reported favourably on the presence of police patrols in their area, even where the records indicated that this aspect of the response had not been activated in their case. Very few women remembered the 'cocoon watch' component, although those who did generally regarded it as beneficial.

The sought for outcome in this project was a reduction in repeat victimisation, and this was achieved. The project was able to demonstrate that early intervention reduced repeat offences, with only 25% of the Level 1 entrants to the project (i.e. those for whom this was a first offence) requiring a second attendance during the lifespan of the project, and only 9% requiring a third attendance. By comparison, of those who started at Level 2<sup>19</sup>, 46% had a repeat attendance; and of those who started at Level 3<sup>20</sup>, 64% had a repeat attendance. Predictive factors for repeat offences included a history of domestic violence offences predating the project; arrest, with men who were arrested being 51% more likely to re-offend<sup>21</sup>, and the beat area the victim lived in, with women living in high crime areas more likely to be repeat victims. The issue of whether the couple was living together at the time of the offence was not identified as having statistical significance in determining the likelihood of repeat attendances. However, it was noted that offences were likely to be more serious (as evidenced by a much higher rate of criminal charges being made) when the woman was separated from the offender (Hanmer, Griffiths and Jerwood, 1999).

The Killingbeck project represented an important step forward in the development of a consistent evidence based police intervention in response to domestic abuse. Factors which contributed to its success included the focus on both victim and offender; the involvement of all police officers, rather than just specialist DVOs; improved communication and co-ordination between the police and related agencies, and 'low additional resource implications' (Hanmer, Griffiths and Jerwood, 1999: 40). It established reduction in repeat

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<sup>19</sup> i.e. those who had not received a Level 1 intervention either because they had offended prior to the project's start date, or the nature of the assault suggested intervention at Level 2 as more appropriate.

<sup>20</sup> For similar reasons to those indicated above.

<sup>21</sup> The authors suggest that arresting the man does not make it more likely that he will re-offend, rather that those men most likely to be arrested (because of the seriousness of the offence) were also those most likely to re-offend.

victimisation as a performance indicator for tackling domestic abuse which was both achievable and measurable, and demonstrated that proactive policing could enhance women's safety. Crucially, however, the project also demonstrated that arrest played a less significant role in reducing repeat victimisation than early and repeated police interventions (Hanmer and Griffiths, 2001).

In the U.K., pro-arrest policies have been adopted increasingly by police forces since the Home Office and Scottish Office circulars of 1990. Such policies were in adopted in North America from the early 1980s onwards, and were seen as integral to a response which placed responsibility for challenging abusive men with communities rather than with individual women. The earliest proponents of pro-arrest policies were agencies advocating for women abused by their partners, acting on the rationale that domestic violence should be treated no differently from any other crime – where there was a sufficiency of evidence, arrest should follow.

The police department in London, Ontario became the first in Canada to adopt a pro-arrest policy in 1981, implementing a recommendation by the London Co-ordinating Committee on Family Violence (F/P/T Ministers Responsible for Justice, 2003). Subsequently, a series of six studies in the U.S., known as the Spouse Assault Replication Program (S.A.R.P.), produced some conflicting results. The first study, which took place in Minneapolis, was widely cited as providing evidence that arrest was an effective deterrent which reduced repeat offending. However, analysis of the data from some of the subsequent S.A.R.P. studies suggested that there was no, or minimal deterrent effect, with some even suggesting that there might be an increase in violence following arrest (Miller, 2003).

Research in Ontario following the adoption of the pro-arrest policy found that charging men who had assaulted their partners did reduce the violence (London Family Court Clinic Inc, 1991, cited in F/P/T Ministers Responsible for Justice, 2003). More recent analysis of the S.A.R.P studies suggests that the impact of arrest may be different for different perpetrators. It is more likely, for example, to act as a deterrent to future offending if the perpetrator is employed or has some status in the community than if the perpetrator has nothing to lose. Individual offender characteristics, such as age or previous criminal record, may also be more significant than arrest as predictors of repeat offending (Maxwell et al., 2001, cited in Miller, 2003).

Pro-arrest policies are not without critics. Some women's advocacy organisations are concerned about the removal of all control from the woman, although others have argued that pro-arrest policies bring police response to domestic violence into line with responses to other crimes. Women themselves may have ambivalent feelings about the efficacy or the desirability of arrest. Some women fear retaliation, or that the arrest will have no effect on their abuser; a belief which may be strengthened if he is arrested then released with no further action. Arrest may be seen as unhelpful by women who want the violence to stop, but not the relationship. For others, it is the case that the violence does indeed increase following an arrest (Hoyle and

Sanders, 2000). Black and minority ethnic women, and others from “over-criminalised communities”, may be reluctant to involve the police if they fear racism against themselves or their partner (F/P/T Ministers Responsible for Justice, 2003: 18).

Other women welcome the removal of any suggestion of responsibility for making the decision on whether their partner should be charged. In a 1996 study in the Yukon, 85% of women whose partners had assaulted them believed the pro-charge policy was positive, and 68% indicated increased confidence in reporting future incidents (Department of Justice Canada, 1996, cited in F/P/T Ministers Responsible for Justice, 2003). A recent review of Canadian policies and legislation on domestic abuse has reaffirmed a commitment to the pro-charging policies currently in place in Canadian provinces, in all cases where there are reasonable grounds to believe that an offence has been committed (F/P/T Ministers Responsible for Justice, 2003).

Studies in the 1990s examined the impact of coordinated approaches to domestic violence, and found that arrest was more likely to reduce repeat offending in those areas which had adopted more integrated criminal justice approaches (Steinman, 1990, cited in Shepard et al, 2002). This might include proactive prosecution, consistent advocacy and support for women through the whole criminal justice process, and access to mandatory treatment programmes for offenders (Tolman and Weisz, 1995, cited in Shepard et al, 2002).

### ***Prosecuting domestic violence***

In Scotland, the decision to prosecute is made by the procurator fiscal, and is based on two key factors – whether there is a sufficiency of evidence, and whether it is in the public interest to proceed to trial. Two independent sources of corroborative evidence are required – in cases of assault, the statement of the complainer is one source of evidence. Other sources might include forensic evidence, medical reports, photographs of the injuries sustained or the scene of crime, or the testimony of other witnesses who saw or heard the assault. Taken together, the evidence must demonstrate beyond reasonable doubt that an offence was committed, and that the accused person was the perpetrator of that offence.

In cases of assault by a partner, as in other cases of violence against women, the presumption has been that the woman herself is the main witness in the Crown case. The nature of the crime means that eye witnesses are rare, or reluctant to come forward. Children and young people are often the main witnesses to assaults on their mothers, but it may not be considered appropriate to call them as witnesses in court. Corroboration may therefore be difficult to find. Even where women have welcomed the arrest and charging of their abuser, they may be unwilling or unable to co-operate with the prosecution. The time delay between arrest and trial can mean that they have reconciled with their partner in the hope that things will now change; or they may be pressured to ‘withdraw the charges’ by the accused or his family.

Whatever the reason, the procurator fiscal must then decide whether to proceed to trial with a 'hostile' chief witness (Barry, 2000).

In other jurisdictions, prosecution may proceed without the woman's co-operation. In Canada, a 'pro-prosecution' policy has applied in all provinces since 1986, i.e. cases will be prosecuted where there is sufficient evidence, regardless of the wishes of the individual complainant. In practice, this means that the Crown must consider whether to lead the case without the woman's testimony, taking into account the strength of any other available evidence. It is not generally considered appropriate to compel her to testify, or to charge her with contempt if she doesn't (F/P/T Ministers Responsible for Justice, 2003).

By reducing the number of withdrawals of charges, the pro-prosecution policy aimed to reduce the attrition rate. Early studies suggested that it was successful. 38.4% of charges were dismissed or withdrawn prior to the introduction, in 1981, of the pro-prosecution policy in London, Ontario. By 1990, this rate had decreased to 10.9% (F/P/T Ministers Responsible for Justice, 2003).

The policy also aimed to improve the co-operation of women survivors with the criminal justice process. The non-co-operation of survivors of domestic violence continues to be a source of frustration for prosecutors (Brown, 2000, cited in F/P/T Ministers Responsible for Justice, 2003) but there are ongoing developments to improve this position. A recent study identified the availability of witness support and the use of video taped evidence as the two most influential elements in determining the co-operation of women (Dawson and Dinovitzer, 2001, cited in F/P/T Ministers Responsible for Justice, 2003).

In the U.S.A. the use of 'no-drop' policies has a similar history, with different jurisdictions adopting variations on this theme since the 1980s. The most rigidly applied policies include the option of arresting and jailing women who do not co-operate with the prosecution of their abusive partner. More flexible approaches are similar to the Canadian model, intent on prosecution where there is sufficient evidence, but acknowledging the difficulties some complainants may have in testifying (Ford, 2003).

As with mandatory arrest policies, pro-prosecution or 'no-drop' policies can be contentious. Although predicated on the assumption that prosecution protects women, Ford (2003) suggests that there is a lack of empirical evidence to support this. Where there is evidence, as in a 2001 study which found that 'no-drop' policies did increase convictions, he notes that further analysis identified a significant degree of 'screening out' of cases which were unlikely to gain convictions (Smith et al, 2001, cited in Ford, 2003). Overall, he argues, 'coerced victim participation' in domestic violence prosecutions has no demonstrable impact on the safety of women in the wider community, and may actively jeopardise the safety of the individual woman it seeks to protect (Ford, 2003).

### ***Work with domestic violence offenders***

It is not within the scope of this report to review the substantial body of literature on offenders. However, in the context of domestic abuse, it is important to acknowledge that 'making men visible'<sup>22</sup> is central to the effectiveness of the multi-agency initiatives which are recognized as examples of best practice. How far domestic violence offender programmes actually improve the safety of women and children continues to be the subject of debate. Research suggests that a significant number of men attending probation programmes refrain from violence in the short term but that this impact diminishes over time (Burton, Regan and Kelly, 1998; Dobash et al, 1996). Attrition is high (Burton, Regan and Kelly, 1998) and sanctions for breaching probation orders are not always implemented, although where they are, the completion rate improves and recidivism appears to reduce ((Mullender and Burton, 2000).

The content and ethos of domestic abuse offender programmes may vary considerably. Some programmes take a therapeutic focus, others an educational focus. Most involve a combination of individual work and groupwork. In the U.K., most programmes are psycho-educational, and make use of cognitive behavioural techniques combined with an analysis of the gendered nature of domestic abuse (Mullender and Burton, 2000). Minimum standards of practice have been adopted by RESPECT, the National Association for Domestic Violence Perpetrator Programmes and Associated Support Services. Key principles for RESPECT would include work with the partners of abusive men as an essential part of any programme, and the need for programmes to be linked to the overall community response to domestic abuse (RESPECT, 2000).

Men's programmes in the U.K. are almost exclusively court-mandated probation programmes. An exception is 'Working with Men', a project based in north Edinburgh and initially funded by DAPHNE<sup>23</sup> to carry out a feasibility study into the development of a voluntary intervention for men who have assaulted their partners, or are at risk of doing so. A model of good practice was developed as part of the initial study. This involved practitioner training programmes on how to recognise and respond to abusive men, the adaptation of an existing men's programme, and the design of a suggested referral pathway for a men's service. An overarching theme was the integration of any voluntary men's programme into a multi agency response to domestic abuse. The project is now funded by DASDF<sup>24</sup> to develop the model further (City of Edinburgh Council, 2002).

### ***Coordinated criminal justice responses to domestic abuse***

Probably the best-known example of a coordinated criminal justice response to domestic abuse was developed in Duluth, Minnesota from 1980. The

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<sup>22</sup> From the title of a report by Moira Andrew and Rory Macrae of the Domestic Violence Probation Project, Edinburgh.

<sup>23</sup> A European funding source for partnership initiatives to tackle violence against women.

<sup>24</sup> Domestic Abuse Service Development Fund, set up by Scottish Executive.

Duluth model, as it has become known, is sometimes assumed to apply only to the development of education groups for abusive men, or even to the 'Power and Control wheel' diagram which is used to explain the dynamics of domestic abuse. In fact, it is a pragmatic and methodical approach to developing an interagency response to domestic abuse, involving both individual advocacy and institutional advocacy. The rationale for engaging in both of these approaches is encapsulated in this definition given by an advocacy worker from Duluth:

“When I advocate for an individual woman, I am trying to help her overcome the many obstacles on her path to effectively using the courts and police to protect her. When I do systems advocacy, I am trying to build a new path. I come to understand what I need to do in systems advocacy by my work with individual women.” (Pence, 2001, in Renzetti et al, 2001: 329).

Based on eight key components (see table, below), the Duluth model has been successfully replicated, with some adaptation, in several countries, including New Zealand, Australia, and the U.K. (Balzer, 1999; Holder, 1999).

#### **Eight Key Components of Community Intervention Projects**

- |   |
|---|
| <ol style="list-style-type: none"><li>1. Creating a coherent philosophical approach centralizing victim safety</li><li>2. Developing “best practice” policies and protocols for intervention agencies that are part of an integrated response</li><li>3. Enhancing networks among service providers</li><li>4. Building monitoring and tracking into the system</li><li>5. Ensuring a supportive community infrastructure for battered women</li><li>6. Providing sanctions and rehabilitation opportunities for abusers</li><li>7. Undoing the harm violence to women does to children</li><li>8. Evaluating the coordinated community response from the standpoint of victim safety</li></ol> |
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(Shepard and Pence, 1999: 16)

The effectiveness of the Duluth model, in its original form, can be attributed largely to the coordinating and facilitating role played by the Domestic Abuse Intervention Project. This independent non-profit agency which was set up in 1980 with the specific goal of providing that coordinating role (Pence, 1999). The size of the city was also significant – with a population of just 85,500, this was a relatively small area, with a correspondingly small network of criminal justice workers and agencies. Finally, some of the key players in that network were supportive of the initiative – in particular, the police chief and the city attorney (Shepard and Pence, 1999). In the United States, these positions function with considerably more autonomy than would be the case in this country, and that too, undoubtedly facilitated the adoption of new policies and procedures to support the development of a coordinated response.

Elsewhere, use of the Duluth model has involved a degree of adaptation to account for cultural as well as structural differences. In New Zealand, the model informed the development of the Hamilton Abuse Intervention Project, with some changes to address the needs of Maori women and men – in particular a commitment to service provision by Maori staff, using materials which reflect the culture and history of Maori people (Balzer, 1999).

In the Australia Capital Territory (ACT), the Interagency Family Violence Intervention Programme, based on the Duluth model, was initially established as a 12 month pilot, and has subsequently achieved impressive results, including substantial increases in reporting, arrests and guilty pleas<sup>25</sup>. More importantly perhaps, 75% of 'victims of family violence' who were contacted 12 months after proceedings were finalized reported that they felt safe/fairly safe. Only one person had been further physically assaulted in that period (Humphreys and Holder, 2002).

The Australian project has involved significant levels of institutional change, and its success is attributed largely to effective change management processes. The Duluth model is acknowledged as a significant influence, although a note of caution is sounded about the need to avoid a 'one size fits all' assumption (Holder, 1999).

In the U.K., the Domestic Violence Intervention Project in Hammersmith took on elements of the Duluth approach in the development of twin services focused on 'supporting women and challenging men'. The project evaluation is positive about the benefits of both the Women's Support Service and the Violence Prevention Project which provided education groups for abusive men. However, project staff in the Women's Support Service acknowledged that they had had less of an impact in the area of 'institutional advocacy' (Burton, Regan and Kelly, 1998).

The Women's Safety Unit (WSU) in Cardiff is central to a recent development in the U.K. of a criminal justice intervention which aims, like the Duluth model, to address all facets of the criminal justice system. The goals of the WSU include increasing the number of women seeking help; increasing the numbers of arrests, charges and convictions; the extension of appropriate services to women and children, and a reduction in repeat victimisation. The Unit provides advocacy and support for individual women, and works closely with the police and the CPS as part of an interagency approach designed to improve the safety of women and children. 1150 women with 1482 children were referred to the project over the first 14 months. An evaluation of the project included interviews with 222 women who had attended during that period (Robinson, 2003).

South Wales Police have adopted a pro-arrest policy, along with a Police Watch initiative based on the Killingbeck three tier intervention in West Yorkshire. The combination of the pro-arrest policy, Police Watch and liaison with the Women's Safety Unit are credited with a 36% reduction in repeat victimisation. Multi-Agency Risk Assessment Conferences (MARACs) have also been initiated, and these are seen as further enhancing the potential for co-operation between agencies and reductions in repeat victimisation of women (Robinson, 2003). An evaluation of the MARACs has been commissioned, and publication is imminent.

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<sup>25</sup> A 40% increase in reports to the police over a 30 month period; an increase from 16% to 27% in arrest rates, and an increase from 24% to 61% in guilty pleas (Humphreys and Holder, 2002).

Initially, the CPS in Cardiff agreed to designate a specialist domestic violence prosecutor. This subsequently proved to be unworkable (due to the workload) and it is now agreed that all prosecutors must be able to effectively prosecute domestic violence cases, and that they will work closely with WSU staff. Domestic violence cases are heard at Pre-Trial Review court on Mondays, and a WSU staff member is always in court at this time. The presence of a worker from WSU (usually the seconded police officer) is seen as providing a valuable source of supplementary information which can inform the decision making of prosecutors about how to proceed with a case (Robinson, 2003).

Court procedures have also been reviewed. The court process for domestic violence cases dealt with by the magistrates' court has been reduced from 14 weeks to seven weeks as a result of the streamlining which has taken place. Cases which go to the Crown Court are also now dealt with on Mondays, and since January 2003, there has been agreement that only experienced full time judges will hear domestic violence cases (Robinson, 2003).

Overall, there has been a steady decrease in the number of cases discontinued, or in which the woman retracts. It is surprising, then, to note that cases in which the WSU is involved are more likely to involve retractions or be discontinued, despite the assumption often made that increased support for women will increase the likelihood that they will stay with the criminal justice process. The evaluation report speculates that this outcome may be due in part to the severity of the cases being referred to the WSU, but it is also noted that it is not clear whether the WSU was contacted before or after women retracted – i.e. prosecutors may be referring women to the WSU because they (the women) have decided not to proceed. It may also be that contact with the WSU means that women feel supported in a decision not to proceed with prosecution, for a variety of reasons, not least of which might be that prosecution may not be in the best interests of the women concerned (Robinson, 2003).

Justice system responses to domestic abuse continue to evolve in response to changing perceptions of what is required to protect the women who experience it and to challenge the men who perpetrate it. There has been a general trend towards greater understanding of the effects and dynamics of abuse, and the implications of this for women's ability to seek protection from the justice system. The research reviewed suggests that pro-arrest and pro-prosecution policies give a clear message that domestic abuse is a criminal act, and have some impact on reducing recidivism. However, the overall tenor of the research literature is that these shifts in policy are most effective when located in the context of a coordinated justice system response to domestic abuse.

#### **4.4.2 Support and advocacy services**

In Scotland, as elsewhere in the U.K., Women's Aid is acknowledged as the lead organisation providing support for women experiencing domestic abuse, and several studies have affirmed the value women place on the services offered by Women's Aid (Hague and Malos, 1996; Sissons, 1999). The best known aspect of the service offered by Women's Aid is undoubtedly refuge provision. Recent research commissioned by the refuge provision working group<sup>26</sup> notes that women who had accessed refuge were particularly positive about the practical support provided and the non-judgmental, empowering approach taken by Women's Aid workers. The researchers also note, however, that some women indicated that they would value a more proactive approach by refuge staff – "You say if we need support, just ask. But not all women are strong enough to ask, so you should ask more often." (Fitzpatrick et al, 2003: 49).

Women's Aid in Scotland has tended to define the service provided to women as either 'practical' or 'emotional' support. Elsewhere, particularly in North America, 'advocacy' is more routinely referred to. It has been noted by some researchers that there is a degree of confusion about the distinction between 'support' and 'advocacy' for women experiencing domestic abuse. Some service providers use the terms interchangeably; others draw a clear line between the provision of a direct support service and the use of advocacy to ensure that an individual woman receives the service she needs and to which she is entitled (Sullivan and Keefe, 1999). This might involve providing women with information about entitlement to services, and liaising between women and the services they require (Kelly and Humphries, 2001). A further distinction is made between individual advocacy, which aims to facilitate access to services for one woman, and systems or institutional advocacy, which works at a more strategic level to address the failure of institutions to respond appropriately to survivors of domestic abuse as a group (Kelly and Humphries, 2001; Pence, 2001; Riger et al, 2002)). Systems advocacy may be framed around an issue of broad concern to survivors, or it may be a strategy adopted as the result of examining the situation of an individual woman in some detail – "chasing an individual story down" (Burton, Regan and Kelly, 1998:5).

This latter approach may be of particular value in achieving change at a local level (Burton, Regan and Kelly, 1998), but can also be used to achieve broader policy shifts. The campaigns run by Southall Black Sisters and Justice for Women in support of Kiranjit Ahluwalia, Sara Thornton and Amelia Rossiter, women who had been convicted of killing their abusive partners, played a significant role both in raising awareness of the long term effects of living with domestic abuse, and in facilitating the acceptance of the defence of 'provocation' (Gupta, 2003). Southall Black Sisters have also

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<sup>26</sup> Established by the National Group to Address Violence Against Women to review the 1991 CoSLA recommendation of 1 refuge space per 7,500 of the population, this short life working group initiated an audit of current refuge provision which involved a qualitative review of Women's Aid refuge provision, as well as a statistical analysis of the demand for refuge space.

advocated consistently since the late 1980s for changes in immigration rules. In particular, they campaigned for changes to the 'one year rule'<sup>27</sup> to ensure that women coming to the U.K. to marry are not forced to remain with a partner who is violent (Joshi, 2003).

Advocacy, by its nature, presents a challenge to the status quo. It is no surprise therefore, that the voluntary sector has largely led the way in developing advocacy responses to women experiencing domestic violence. Indeed the earliest services for women experiencing domestic abuse were those provided by support and advocacy organisations in the voluntary sector, often acting to 'fill the gap' in existing service provision. As an extension to this 'gap filling' role, women's support and advocacy organisations also took on the task of challenging the practice of statutory agencies, demanding services and legal protection for survivors of domestic violence (Pence, 2001). Kelly and Humphries note that although individual social workers, healthcare staff and even police officers take on the role of 'advocate' for women, their ability to challenge may be compromised by their role within a statutory agency (Kelly and Humphries, 2001).

There has been relatively little research of either support or advocacy interventions which examines outcomes or efficacy (Kelly and Humphries, 2001; Sullivan and Bybee, 1999). A review of outreach and advocacy approaches to women experiencing domestic violence identified only three evaluated outreach or advocacy projects in the U.K. (Kelly and Humphries, 2001). The picture is similar in the U.S. (Abel, 2000; Sullivan and Bybee, 1999). Abel suggests that this should not be surprising given the nature of the work, which is largely based on crisis intervention and often focused on women in refuge. She acknowledges that services must inevitably be fairly open ended to meet the needs of women in this situation, but notes that this creates difficulty in designing outcome evaluations (Abel, 2000). This is echoed in a recent evaluation of the Scottish Domestic Abuse Helpline, which acknowledges that the short-term transient nature of the contact with women callers, as well as the focus on crisis intervention, makes it difficult for helpline volunteers to ask women questions to support an evaluation of outcomes. The evaluation therefore focuses primarily on the processes involved in running the helpline, and a statistical analysis of calls received (Brown, 2004).

The Michigan-based Community Advocacy Project sought to reduce women's risk of violence from male partners through the use of a structured intervention programme delivered by trained volunteer advocates. 278 women participated in the study; all had been resident in the local refuge for at least one night. Women were interviewed six times over a two year period. The study was evaluated using a control group approach – at the first interview, women were given a sealed envelope which randomly assigned them either into the group which would receive the intervention, or into the control group.

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<sup>27</sup> So called because people coming to the U.K. to marry a U.K. based partner are ineligible to apply for permanent leave to remain until they have been married for 12 months. They are therefore dependent on their U.K. based spouse, with no access to welfare benefits or any other form of State assistance. For women abused by their partners, there was therefore no recourse to the usual avenues of escape (Joshi, 2003).

Women assigned to the control group were not contacted again until the second interview, 10 weeks after this initial contact. Women who received the intervention (n=143) were supported by a volunteer advocate for 10 weeks; on average this involved two meetings per week, an average of 6.4 hours per week. During that time, they identified what was needed to achieve positive change, including safety planning and accessing appropriate protection from the criminal justice system, but also unmet health, social and economic needs (Sullivan and Bybee, 1999).

All of the women, including the control group, were interviewed again at 10 weeks, and then at 6-, 12-, 18- and 24 months. A range of formal test measures were used, assessing the levels of physical or psychological abuse women experienced, their quality of life, depression, degree of social support available, effectiveness in obtaining resources/accessing services, and women's perceptions of their difficulty in obtaining resources. Overall, the results were perhaps not surprising – women who received the intervention experienced less physical violence, and reported improvement in their quality of life, levels of social support and feelings of depression. 25% of the women who received the intervention experienced no further violence over the two years of the study, compared with only 10% of the women in the control group; both groups of women, however, experienced significant incidences of further violence – 79% of the intervention group and 89% of the control group (Sullivan and Bybee, 1999).

Although the Michigan project undoubtedly demonstrates that the provision of advocacy increases women's safety, the research design raises some questions about the ethics of using a control group approach to evaluate interventions to reduce violence against women. The random nature of the control group selection implies that no risk assessment was undertaken, thus excluding women in high risk situations from a potentially life saving intervention.

Domestic Violence Matters (DVM) adopted a different approach to evaluation. This pilot project ran in Islington and Holloway (police divisions) in London from early 1993 for 32 months. The project aimed to provide crisis intervention to women, enhance the criminal justice system response, and promote interagency links and co-ordination. Five civilian workers – four support workers and a co-ordinator - provided crisis intervention between 10am and 2am every day, including holidays. They were located within a police station, and aimed to follow up all domestic violence incidents within 24 hours of the incident being reported to the police. They achieved this in 90% of the 1542 incidents they responded to (Kelly, 1999).

DVM adopted a proactive approach to intervention, maintaining contact with women following the initial referral, rather than waiting for women to make contact themselves. Although most (70%) of the referrals came via the police, women also referred themselves. Over two thirds of the referrals came outwith normal office hours, confirming the need for out of hours services. As well as general support, legal advice was provided in 86% of cases, housing

advice in 60%. Crisis planning was provided in 30% of cases, and accompaniment to safe accommodation in 15%. (Kelly, 1999).

DVM defined 'crisis' as "any point at which routine coping mechanisms break down and the need or potential for change is present" (Kelly, 1999: 15). Kelly suggests that effective crisis intervention is about enabling change, and explains,

"...change was not conceptualised by DVM solely in terms of leaving or taking legal action...Rather it was much more fluid and variable; the basic requirement being *only* that it shift the dynamics of power and control which underpin domestic violence in the woman's favour; ensuring that she had more resources after intervention than before it. This could be strengthened resolve, accurate information, access to other agencies, or a firmer alliance with the criminal justice system; often it was a combination." (Kelly, 1999: 16).

Thus the potential 'performance indicators' for DVM were broad, qualitative and largely assessed by means of feedback from service users. Questionnaires were sent out to 789 people; 221 women responded, and two men<sup>28</sup>. These initial questionnaires were completed either within a week of first contact with DVM (32%), within a month (30%) or more than a month later (38%). A further 23 women participated in a follow up interview – 14 of these were interviewed 12 months after first contact with DVM, and nine were interviewed six months after first contact.

In the initial questionnaire, women identified the immediacy of the response as one of the most positive aspects of the service. 151 of the women gave specific examples of how this had helped them, including comments that it gave them space to explore options, information and support with the practicalities of leaving, and affirmation that their partner's behaviour was unacceptable. The immediacy of the support was credited by some women as having been crucial to their ability to talk about the abuse – "If more time had lapsed I probably wouldn't have talked to anyone about it", or to safeguard themselves – "If the response had not been immediate I would probably have taken him back." (Kelly, 1999: 29). The majority of the women (62%) indicated that what they wanted most from DVM was someone to talk to about what had been happening. Few women, by comparison, wanted to discuss the implications of arrest (13%) or prosecution (17%). Only 15% of the women were still living with the abusive partner at the point of completing the questionnaire, although 50% had been living with him at the time of the incident. Of the 23 women who took part in the follow up interviews, only five were still living with their partner, and there had been no further violence or threats of violence against these five women since their contact with DVM (Kelly, 1999).

The DVM approach was characterized by proactive crisis intervention, with staff taking responsibility for making and maintaining contact with women,

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<sup>28</sup> The evaluation report is unclear about whether feedback from the men was included in the overall analysis of the questionnaire responses.

rather than waiting for women to initiate contact. Summarising women's views on this approach, Kelly notes that:

“The importance of home visits and follow ups illustrate very clearly that pro-active responses are neither resented by women nor ineffectual; rather they appear to accelerate a process of change in a manner which both at the time and retrospectively are valued positively.” (Kelly, 1999: 34)

The evaluation of Domestic Violence Matters has at the heart of it women's perceptions of the service they received, how it helped them to change their situation, and what could have made it better. Service user evaluation can go some way towards informing the future development of individual services. Wider consultation with women survivors of domestic abuse is rare, and where it exists, there may be sharp distinctions between service providers' perceptions of the degree to which they consult with women, and women's perceptions of the extent to which their views actually influence policy or service development (Hague, Mullender and Aris, 2003). It is worth noting that at present, only five of the local multiagency partnerships on violence against women in Scotland indicate that they have or are planning to establish some form of consultation with women survivors<sup>29</sup>.

#### **4.4.3 The health service response**

The involvement of women service users in the design of services was one of the key recommendations of the Scottish Needs Assessment Programme (SNAP) report on domestic violence published in 1997. Identifying domestic violence as “a significant public health issue” (SNAP, 1997: i), the report noted that “between 260,000 and 700,000 women may be experiencing domestic violence” (SNAP, 1997:i). The report made several recommendations, covering the main policy and practice developments which the authors identified as necessary in order to improve the health service response to domestic violence. These included staff training, the development of a monitoring and recording framework, and the development of guidelines specific to each health service setting.

The recent publication by NHS Scotland of guidance for healthcare staff on responding to domestic abuse incorporates some of the recommendations of the SNAP report. The guidance highlights the need for awareness training for staff as a central component in developing a more effective health service response to domestic abuse. Recognising signs and indicators of abuse, supporting disclosure by women, risk assessment and safety planning, and the need for accurate record keeping are also addressed (Scottish Executive, 2003).

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<sup>29</sup> From Multi-agency Partnership reports to the Scottish Executive Violence Against Women Unit, 2003. The five partnerships which indicate some degree of user involvement, focus group activity or other consultation with women survivors are Doorway (South Lanarkshire), East Ayrshire, Glasgow, Renfrewshire and West Lothian.

The NHS Scotland guidance acknowledges the difficulty women may experience in voluntarily disclosing that they are experiencing domestic abuse. It also acknowledges the value of early intervention. The question of how proactive healthcare professionals should be in asking women whether they are being abused by their partner is perhaps less clear in the guidance, and this may be a reflection of the ambivalence within the healthcare community as a whole about the issue of 'screening' or 'routine enquiry' for domestic abuse.

In the United States, screening has been recommended by the American Medical Association and other professional bodies since 1992, although professional groups may differ in the particular approach they advocate (Family Violence Prevention Fund, 1999). Despite the general support for screening expressed in professional guidelines, resistance to implementing screening protocols in the U.S. is still widespread. A survey of 2,400 doctors from a range of medical settings found that only 6% of the 1103 respondents screened all their female patients (Elliott et al, 2002). Barriers to screening included a perceived lack of appropriate interventions (45%), concerns about offending patients (33%), and simply forgetting to ask (41%). Lack of time was cited by only 21% of the respondents (Elliott et al, 2002).

The inconsistent application of a screening approach in an emergency room setting is reported in a study from Ohio, and a range of reasons for this were identified by the researchers. Some members of staff felt it was not their responsibility, others said they were not aware that they were supposed to be screening. Some were clearly uncomfortable about 'asking the question', while others asserted that they "didn't not know where the forms were kept". In addition, the researchers note that no data was collected during night shifts. The researchers report that they had gone to some lengths to ensure that staff were aware of the study and the reasons for it, and that they had spent some time preparing staff for the study through the provision of films and written material. They suggest that continuing education and training may assist with a more consistent approach in the future (Heinzer and Krimm, 2002).

The findings of these studies are consistent with experiences in Scotland and the rest of the U.K. Where attempts are made to implement screening protocols, no matter how selective, there is still a significant degree of resistance from practitioners. Studies in Scotland of GP responses to women concur with much of the North American literature, with GPs identifying lack of time, lack of appropriate services and concerns about offending women with intrusive questions as significant barriers to asking about domestic abuse (Cosgrove, 1998; McKie, 2002; Munro, 2001).

Similar concerns were raised by some of the participants in a London study of midwives' perceptions of routine enquiry in relation to domestic violence. A three hour training session was provided to 145 midwives. They were given information about the prevalence and consequences of domestic abuse, how to administer a screening tool, and how to refer women to local agencies. Although participants were enthusiastic about the study, and saw it as relevant to their work, they acknowledged practical difficulties with

implementing it. Time constraints and competing priorities, both for the women (e.g. financial or social difficulties) and for the midwives (e.g. the numbers of women to be seen in a clinic, and the quantity of other information which had to be shared with women during appointments) were all identified as barriers to applying a consistent approach to screening. Midwives expressed concern about possibly placing women at greater risk as a result of attempting to exclude a partner from a consultation. They also raised concerns about their own safety (Mezey et al, 2003).

Many practical problems associated with implementing screening for domestic violence were identified. The authors note that screening is time consuming, and that there are logistical problems associated with creating an appropriate and safe environment in which to 'ask the question'. They also note that many of the participants disclosed personal experiences of domestic abuse, and comment on the impact this had on the way they engaged with the study. For some it created an additional barrier to implementing the screening tool; for others, their personal experience appeared to enhance their ability to identify signs of domestic abuse and respond appropriately. Much appeared to rest on how far workers had resolved their feelings about what had happened in their own lives (Mezey et al, 2003).

The training provided before the study gave a clear message that midwives were not expected to take on a counselling role. They were asked only to identify and assess the needs of women experiencing domestic abuse before referring on to other agencies. In practice, boundaries are harder to maintain than this. The process of disclosure often involves more of a personal commitment from workers than is implied in simply following a protocol, and the reality is that 'asking the question' may often involve more work than can be anticipated. The authors of this study raise a question as to "the practicality of domestic violence screening by NHS staff within a busy clinical service", observing that as soon as this study was ended, most of the midwives stopped asking women questions about domestic violence (Mezey et al, 2003:751).

A great deal of the research on health interventions has focused on the use of screening tools for domestic violence, and in particular, barriers to implementation by healthcare staff. More recently, two systematic reviews have considered whether there is sufficient evidence that screening leads either to appropriate intervention, or to improved outcomes for women (Ramsay et al, 2002; Wathen and MacMillan, 2003).

The first review, conducted by a U.K. based team of researchers, sought to "assess the evidence for the acceptability and effectiveness of screening women for domestic violence in healthcare settings" (Ramsay et al, 2002: 314) and to this end reviewed three groups of research studies. The first group explored the attitudes of women and health professionals towards screening for domestic abuse in healthcare settings. The second group compared identification rates for domestic abuse between health settings which used screening and those which did not. The third group measured the outcome of interventions with women who had experienced abuse. Studies

included in the third group were limited to those which provided a comparison with a group of women who had received no intervention. The inclusion criteria were strictly applied, and a total of 20 papers were eventually reviewed, from a starting sample of 2520 papers identified from a search of three databases (Ramsay et al, 2002).

In relation to the acceptability of screening, across the five studies reviewed in this category, 43-85% of all women surveyed thought screening for domestic abuse was acceptable (with women who had experienced abuse at the higher end of that scale). Much lower percentages of health professionals favoured screening, giving many of the reasons already discussed above. On the whole, the nine studies which assessed 'numbers of women identified' found that more women experiencing domestic violence were identified as the result of screening. However, the increase tended not to be substantial, and there was some evidence that improved identification was not sustained beyond the period of the study (Ramsay et al, 2002).

The six studies which examined interventions with women who had experienced domestic abuse were the most contentious. The review is critical of the design of studies, highlighting weaknesses in the methodology of most, and in particular the absence of randomized control trials, or any focus on qualitative outcome measures such as 'quality of life' or improved mental health. Overall, the reviewers found little evidence that any of the interventions they considered were effective, and the main conclusion of the review is that there is insufficient evidence to support the use of screening at this time. They suggest that more research is required to identify effective healthcare interventions with abused women (Ramsay et al, 2002).

A more recent review by two Canadian researchers looked more specifically at primary health care interventions designed to prevent further abuse of women. The review identifies two main options open to primary care professionals – identification of women, and referral to appropriate agencies. In relation to the former, the reviewers reach the same conclusion as Ramsay et al, i.e. that no studies to date have demonstrated that screening improves the outcome for women. The authors also note that no research has been conducted to assess potential harm to women as a result of screening (Wathen and MacMillan, 2003).

Overall, Wathen and MacMillan conclude that there is a dearth of evidence based interventions in response to domestic abuse either within a primary care setting or beyond. They concur with Ramsay et al that there is a need for further research, in particular to determine whether a combination of screening by healthcare workers and effective intervention would reduce physical and emotional abuse of women (Wathen and MacMillan, 2003).

Neither of these reviews suggest that clinicians should never ask women about domestic violence – the Canadian review in particular stresses the importance of asking questions to elicit information about domestic abuse when there are indicators of it during routine history taking (Wathen and MacMillan, 2003). Both reviews acknowledge the importance of training for

health professionals in raising awareness of the impact of domestic abuse, and supporting the development of effective interventions (Ramsay et al, 2002; Wathen and MacMillan, 2003).

Despite the acknowledged impact of domestic abuse on women's health, the response of health services beyond the treatment of immediate injuries is still largely confined to identification and referral on to other agencies. Furthermore, there is little quantitative research to indicate whether either of these approaches are effective responses to women. However, it is worth noting that, despite the lack of a clinical evidence base for screening, and despite the reticence of healthcare staff in implementing screening protocols, the majority of women want health professionals to ask about domestic violence. In particular, women who have experienced domestic violence want health professionals to 'ask the question' (Ramsay et al, 2002; Taket et al, 2003).

#### **4.4.4 Multiagency responses to domestic abuse**

The development of a multiagency response to domestic abuse is now widely acknowledged as the most effective way both to support and protect women and children who have experienced domestic abuse, and to challenge male perpetrators (Hague and Malos, 1996; Hague, 2001; Pence and McDonnell, 1999; Scottish Executive, 2002). Some of the features of multiagency criminal justice responses to domestic abuse are addressed elsewhere in this report. However, multiagency responses to domestic abuse may encompass a much more diverse range of agencies, including social work, housing, health, education and the voluntary sector, in particular Women's Aid (CoSLA, 1998; Scottish Executive 2002).

Individual practitioners from different agencies may work very successfully together at an individual case level without any formal interagency agreement. However, the development of a consistent coordinated response is more likely to be achieved when agencies engage in more formal strategic partnerships (Moelwyn-Hughes, 1999). It is crucial that multiagency partnerships on domestic abuse move beyond simply defining the problem and identifying the gaps in services. The development and implementation of shared policies and procedures, the provision of information and training for staff, and the establishment of effective monitoring systems are all essential steps in the process of ensuring that multiagency strategies to tackle domestic abuse move from being statements of intent to supporting the development of good practice (Gamache and Asmus, 1999; Hague and Malos, 1996; Hague, 2001).

Although there appears to be a degree of agreement about the key principles which underpin effective multiagency work, the specifics will vary from one area to another. The geography and demographics of an area, the number and range of services involved, and the gaps in local service provision will all play a role in shaping the development and delivery of a multiagency response to domestic abuse (Hague and Malos, 1996). The commitment of key personnel within the partner agencies will also be significant. Senior

managers may not attend partnership meetings, but their support is crucial to ensuring that proposed policy and practice changes are adopted and implemented (Hague, 2001). The involvement of women's activist organisations, including Women's Aid, in multiagency partnerships on domestic abuse ensures that the safety of women and children remains central to the process, and the impetus for change is not diluted (Kelly, 1999).

Good practice examples of multiagency work to tackle domestic abuse can be found in many areas, both in the UK and internationally. The 'Duluth model' is widely acknowledged to have provided a benchmark against which to measure coordinated criminal justice responses. A central component in the success of the Duluth initiative was the establishment of an independent non-profit organization, the Domestic Abuse Intervention Project (DAIP), to take on the role of coordinating and monitoring the criminal justice response to domestic abuse. The case tracking approach adopted by DAIP to support this work is undoubtedly very effective in identifying problems within the criminal justice system.

The Duluth Model is resource intensive, and this has been identified as a barrier to the adoption of the model in other areas, particularly those with larger populations (Hague, Kelly and Mullender, 2001). The London Coordinating Committee to End Woman Abuse (LCCEWA), for example, has been at the forefront of developing interagency responses to domestic abuse, but has not gone down the case tracking route. Instead, LCCEWA has developed an action research approach, with a focus on short life projects with achievable goals (Hague, Kelly and Mullender, 2001). Membership of LCCEWA is diverse, and women's advocacy organisations have played a central role in the development and leadership of the Committee. Research interviews with women who had sought assistance from services in London suggests that the model is working – the majority were satisfied with the response they got when making the initial approach to services, regardless of which service they approached first. They also reported that appropriate referrals were made to other agencies. The researchers note that with one or two exceptions, there appeared to be a high level of awareness among service providers about the range of relevant services which might provide additional support to women and children (Grasely et al, 1999).

A review of multiagency initiatives to tackle domestic abuse which was carried out in the mid 1990s found that multiagency fora and partnerships had some difficulty in identifying ways to evaluate the effectiveness of the work they were doing. In part this may be due to a lack of clarity about what, exactly, is being evaluated. It may also be difficult to identify appropriate baseline data against which to measure progress. Although there appears to be a general consensus that the goal of any multiagency response to domestic abuse should be improved safety for women and children, in practice it seems that it is difficult to demonstrate whether this has been achieved (Hague, 2001).

Since then there has been considerable development in the understanding of what is required to overcome some of the barriers to effective multiagency work. In Scotland, the commitment to working collectively and collaboratively

to tackle domestic abuse was reaffirmed with the publication of the National Strategy on domestic abuse in 2001. Significantly increased resourcing of local domestic abuse partnerships through the Domestic Abuse Service Development Fund (DASDF) has accelerated the development of local strategies and action plans. These have been supported to a large extent by the increased resourcing across Scotland of services for women and children affected by domestic abuse. A recent evaluation of the impact of the DASDF involved a postal survey of local partnerships. Several respondents identified problems within their multiagency groups, including lack of a shared agenda or a shared understanding of the problem; differences in the capacity of partner agencies, and therefore in their ability to contribute at times to the work; and power differentials between the partners, particularly between statutory and voluntary sector members (Reid-Howie Associates, 2003). It was not within the remit of the DASDF evaluation to carry out evaluation of the individual projects funded. It would seem, however, that some research on the effectiveness of the current multiagency response to domestic abuse in Scotland would be worth considering.

## **4.5 Responding to violence against women – conclusions**

There is a substantial body of literature on how services respond to violence against women. However, there is a significant quantitative difference between research which focuses on domestic abuse and that which considers other aspects of violence against women. In part, it must be acknowledged that this is reflective of the much greater numbers of women reporting domestic abuse, compared with other crimes of violence against women. It may also reflect the greater impact which domestic abuse has on service provision, since a wider group of service providers have a statutory responsibility to respond to domestic abuse than, for example, to rape or sexual assault. This is not to say that the needs of survivors of rape or sexual assault, or survivors of child sexual abuse, are necessarily seen as less valid than survivors of domestic abuse.

In theory, it should be possible to adapt responses to women who have experienced domestic abuse to meet the needs of survivors of other forms of male violence. However, the possibility of adapting and replicating interventions is rarely addressed in the literature, and only one research study was identified which attempted to evaluate the use of the same intervention with survivors of different types of violence.

In summary:

- The research literature repeatedly acknowledges the role of women's NGOs in the development of services which are responsive to women's needs.

- Research focuses on discrete issues, although it is recognised that women may experience more than one form of abuse at more than one point in their lives.
- There is a lack of evaluative research in most areas. More evaluation of responses to domestic abuse has been carried out than of responses to other forms of violence against women.
- This is perhaps reflective of the general picture of services, which can be described as “patchy and inconsistent”, with substantially more service development worldwide in response to domestic abuse than there is to other forms of violence against women.
- Different aspects of violence against women are addressed in different areas of the literature.
- Research on interventions with rape survivors is primarily focussed on medico-legal responses, with some literature on therapeutic interventions, but little on interventions by primary care workers. Although there have been recent improvements in the treatment of rape and sexual assault complainants there are still areas of concern, particularly in relation to conviction rates. Rape crisis provision is still poor across Scotland, and there is a lack of independent evaluation of the approach. There is a similar lack of evaluation of sexual assault referral centres (SARCs), although a forthcoming report from the Home Office should address this.
- There are different degrees of understanding or acceptance of prostitution as ‘violence against women’. Some would make a distinction between ‘forced prostitution’, including trafficking, and prostitution as an active choice by women. Others assert that the harm caused to women by prostitution should define it as a form of violence against women. Much of the literature on women working in prostitution is taken up with questions of definition and agency, and in this, it reflects early debates about how far women ‘choose’ to stay with violent partners. There is also a significant body of literature which considers crime management interventions. There is little on interventions which support women abused in prostitution, or assist them in leaving.
- Research on interventions with adult survivors of childhood sexual abuse is primarily found in the mental health literature. Cognitive behavioural therapy (CBT) appears to achieve the most consistent outcomes. However, this may be partly due to the relative ease with which a CBT approach can be measured, compared with other therapies. Research with survivors of childhood sexual abuse suggests that what they value above all is the warmth and empathy displayed by practitioners, and that they are less concerned with the particular therapeutic approach being used. Survivors of childhood sexual abuse also praised the service provided by voluntary sector

support organisations. It is acknowledged that this type of service provision is poorly distributed across Scotland, and that there is a lack of evaluative research.

- Although some work has been carried out which explores the links between childhood sexual abuse and chronic physical health problems, no research was identified which addressed how healthcare staff should acknowledge this or respond to it. No research into the criminal justice response to adult survivors of childhood sexual abuse was identified.
- By comparison, research on interventions with domestic abuse survivors cuts across several sectors, including criminal justice, acute and primary care health services, social work services and outreach and advocacy services.
- Research on the justice system response to domestic abuse suggests that pro-arrest and pro-prosecution policies give a clear message that domestic abuse is a criminal act, and this has some impact on reducing recidivism. However, the overall tenor of the literature is that these shifts in policy are most effective when located in the context of a coordinated justice system response to domestic abuse.
- Evaluation of support and advocacy services for domestic abuse survivors is limited, but the research which has been done shows that such services are much valued by women, and that they may have a significant role in improving women's safety.
- Despite the acknowledged impact of domestic abuse on women's physical and mental health, research into healthcare responses to domestic abuse has not gone much beyond issues of identification and assessment. The literature on screening or routine enquiry for domestic abuse is contentious. There is an emerging consensus among health researchers in the U.K. and Canada that there is limited evidence as yet to support a routine enquiry approach; this is at odds with the position in the U.S., where screening is well established and supported by all the major professional bodies.
- The scarcity of research on interventions for black and minority ethnic women, women with disabilities, lesbian women, and older women affected by male violence against women is perhaps a reflection of the dearth of services for these groups.
- Across all of the literature, across all aspects of violence against women, there is a noticeable absence of attempts to engage women survivors of violence in the development, design or evaluation of services or policy initiatives.

## 5. Making the links

*blame the woman*  
*blame the drink*  
*blame the weather*

(Zero Tolerance, 1995)

This slogan, taken from the Zero Tolerance 'Excuses' campaign, encapsulates some of the most common assumptions made about what causes violence against women. Alcohol and/or drug use, poverty, unemployment, mental illness, stress, poor anger management skills, sexual deviance and personality disorders are all commonly identified either as causes of, or triggers for, male violence against women. It is perhaps to be expected that most people, if asked to consider violence against women, will focus initially on the circumstances surrounding an individual act, rather than violence against women as a wider phenomenon. At an individual level, all of these factors may play a role. There is, however, a need to look at the wider picture. Violence against women is experienced by women of all ages and social classes, all races, religions and nationalities, all over the world. It is overwhelmingly perpetrated by men. Individual characteristics and circumstances alone cannot explain why this should be the case.

Violence may be experienced as a single discrete event in a woman's life. However, when the opportunity is provided, many women describe a continuum of abusive experiences at different points in their lives, and at the hands of different abusers. Domestic abuse, sexual violence, stalking and harassment, child sexual abuse, pornography, prostitution and all of the combinations of these, are linked in many ways. Sometimes several of them happen to the same women. Sometimes several of them are perpetrated by the same men. The context of what happens may differ – perpetrated by known men or strangers, at home or at work, in relationships or out of them – but the impact on individual women and the consequences both for them and the rest of society are too similar to ignore.

The consequences of violence against women for women's health, sense of self worth, economic position and continued safety are consistent across all forms of violence against women. The rates of depression, anxiety and post traumatic reactions are similar whether a woman was abused by her partner or raped by a stranger. Feelings of guilt, shame and self blame are commonly experienced by women survivors of domestic abuse, rape and sexual assault, childhood sexual abuse, and abuse through pornography and prostitution. The role that male violence plays in limiting women's social and economic potential is acknowledged throughout the literature. At a policy level, there is perhaps a clearer understanding of the links between male violence and the poverty of women in the 'developing' countries of the world; certainly it is acknowledged in international initiatives to address violence against women (Spindel, Levy and Connor, 2000).

Common themes also emerge from women's descriptions of the violence they have experienced, regardless of where, when and by whom they were abused. Whether they are talking about physical or sexual assault by a partner, by someone else known to them or by a stranger, they describe the abuse of power and control, being degraded and humiliated, feeling hated and worthless:

"...my father would call me all sorts of names and would storm around saying 'You're no goddam good. You're a whore. You're a nothing.'...It's hard to know which was worse abuse, I think that the 'you're no good, you're a whore, you're nothing' – that constant theme was almost or as bad as the sexual abuse because it was constant."

(Incest survivor, quoted in Stanko, 1985: 30)

"I could not leave the house. I was imprisoned for several days at a time, was unable to cook without the food being thrown at me, or to wash without my head being held under water until I lost consciousness. I was unable to go to the lavatory during the night; he would kick in the toilet door because I had taken too long. When I fought back he would rape me sometimes anally and sometimes over and over again..."

(Domestic abuse survivor, quoted in Bossy and Coleman, 2000)

Liz Kelly has been one of the most vociferous proponents of the need to make the links between different types of violence against women. Talking about the life of Emma Humphries<sup>30</sup>, she gives the clearest possible example of the links between child abuse and neglect, homelessness, prostitution, rape, domestic abuse, prison and addiction:

"Emma's life makes clear the connections between a range of forms of gender violence. Whilst we may separate them in law, in the categories we use in research, and in how we organise institutional responses - in the state and NGO sectors - they were not separate in her experience. It is impossible to understand her life, still less imagine how it might have been different, if we fail to see that it involved repeat victimisation by the same and *different* men, that her attempts to cope with/escape one form of abuse made her vulnerable to others"

(Kelly, 2000).

She goes on to describe the myriad ways in which different forms of violence against women, and children, are linked. These include their relationship to the perpetrators of violence, most often men known to women, regardless of the nature of the assault; tactics of power and control as a feature of men's violence against women; the consequences of violence for women's health and self esteem; high attrition rates across all forms of violence against women and a consequent sense that men may violate women with impunity;

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<sup>30</sup> Emma Humphries was convicted of killing her abusive partner at the age of 17 and served 10 years before being released following a landmark judgement on 'provocation'. She died in 1998 of an overdose of the drugs she became dependent on in prison.

and inadequate or ineffective institutional responses, including failure to encourage or document disclosure (Kelly, 2000).

The World Health Organisation (WHO) has proposed the use of an ecological model to provide a conceptual framework for understanding the nature and causes of violence, including violence against women. Ecological models consider that behaviour does not take place in a vacuum, and address the relationship of the individual to their environment, including interpersonal relationships, community and societal influences. The WHO report uses this model to explore risk factors for different types of violence, including violence by intimate partners and sexual violence (Krug et al, 2002).

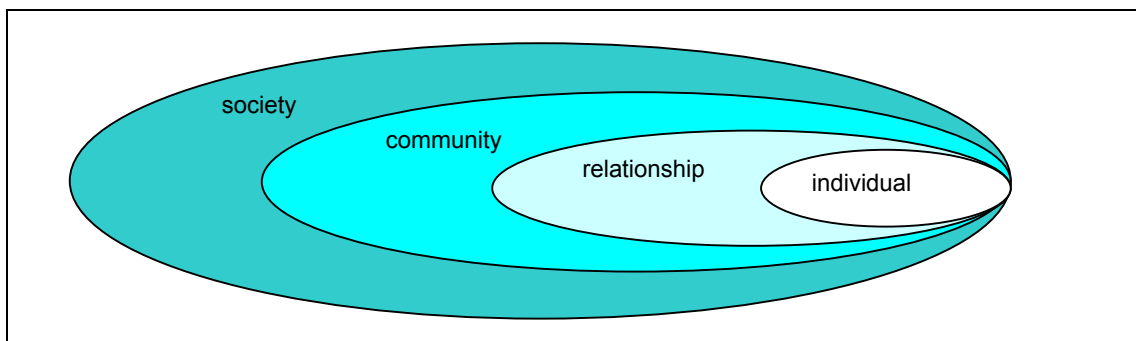


Table 1: Ecological model for understanding violence, WHO, 2002

At the core of the model is the individual, and the personal characteristics which make them more or less at risk of violence. Around the individual are their close relationships, with partners, family members or others, and how far these relationships might increase or decrease the risk of violence. The community in which the individual lives may contribute to their risk factors – which might include the physical environment in which they live, but also issues of social inclusion or exclusion. The outer layer of the model represents the society in which an individual lives, and the pervasive influences of that society, including cultural norms and values, and the legislative and policy framework which supports them (Krug et al, 2002).

This model attempts to integrate several different perspectives on violence against women, suggesting that there may not be one single ‘cause’ but rather a whole range of variables which can increase or reduce a woman’s risk factors for experiencing violence. This is undoubtedly true, but it must be acknowledged that risk factors are not the same as causes. Specific acts of violence against women may have their roots in a combination of factors including the personal history and circumstances of women who are victims of violence and the men who perpetrate it, and the nature of the relationship between women and the men who are their partners, family members, neighbours and colleagues. However, violence against women must be seen in the context of the structural inequality of the wider society within which it takes place, as exemplified in the attitudes, cultural norms and institutions of that society.

If, as has been suggested, violence against women is both the result of gender inequality and the means by which it is perpetuated, (see, for example, Brownmiller, 1976; Dobash and Dobash, 1979; Radford et al, 2000), then initiatives to challenge and prevent violence against women must be located within broader initiatives to address gender inequality. In 1998, a Canadian government report noted that although “significant progress toward the elimination of violence against women” had been made over the previous 20 years, there was still a need for “the development of policies that address the general issue of women’s inequality” (Status of Women Canada, 1998: 21). The publication in the following year of a strategic framework on violence against women reaffirms this commitment to tackling gender inequality as a central component in preventing violence against women. The principles of the framework are simple and clear, the message is unequivocal – “Living free of violence is a right, not a privilege. Violence against women is a violation of human rights.” (F/P/T Status of Women Ministers, 1999).

Canadian policy on violence against women has been held up as a model of good practice, beginning with the establishment of the Canadian Panel on Violence Against Women in 1991, and the subsequent publication of *Changing the Landscape – ending violence, achieving equality* in 1993. This report, which incorporated the views of survivors, activists and policy makers, provided clear evidence of the links between different forms of violence, and between violence against women and other aspects of gender inequality. Together with the groundbreaking prevalence survey on violence against women which was also published in 1993, *Changing the Landscape* set an enviable baseline against which to measure all subsequent policy and practice developments (Hague, Kelly and Mullender, 2001).

Alongside the increased focus on policy development, five research centres were established<sup>31</sup>, with a remit to “promote, coordinate and communicate the results of Canadian research about violence”, specifically violence against women (Health Canada, 1999: 6). Adopting a ‘participatory action research model’, what the Canadian research centres have excelled at is developing partnerships with policy makers and community organisations. This approach has helped to ensure that research is conducted which supports the development of practice, which in turn supports the goal of preventing violence against women. Working as an alliance, the centres have avoided duplicating work, and have been able to share good practice. For academic partners, membership of a research centre has allowed them to maintain a focus on the realities of frontline work, and to see the application of research results. The opportunity to build relationships with practitioners and policy makers has been seen as positive, as has the opportunity to engage in interdisciplinary projects. Frontline workers are able to influence the research agenda, learn something about the process of designing research, and “leave the crisis and talk about ideas”, an opportunity which should not be undervalued (Health Canada, 1999: 15).

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<sup>31</sup> FREDA, in British Columbia/Yukon; RESOLVE in Manitoba/Saskatchewan/Alberta; Centre for Research on Violence Against Women and Children in Ontario; Le Centre de Recherche Interdisciplinaire sur la Violence Familiale et la Violence Faite aux Femmes in Quebec; and the Muriel McQueen Fergusson Family Violence Research Centre in New Brunswick.

It would be reasonable to assume that these parallel developments in policy and research would ensure that the broad agenda on violence against women would be maintained, but this does not appear to be the case. Most of the research listed on the Health Canada website focuses primarily on domestic violence, with little on other forms of violence against women (Denham and Gillespie, 1998; Hague, Kelly and Mullender, 2001). How far this is a reflection of what is happening in practice is debatable (Hague, Kelly and Mullender, 2001).

In England and Wales, an attempt to adopt a more inclusive approach to policy on violence against women have been made by the Home Office, with the publication of *Living without fear – an integrated approach to tackling violence against women*. The document acknowledges that much work has already been developed in response to domestic abuse, and recommends building on existing partnerships in order to develop responses to other aspects of violence against women (Home Office, 1999).

Although the report calls for an integrated approach to violence against women, the format of the report maintains distinctions between domestic abuse, sexual violence and sexual harassment, and predictably, perhaps, focuses mostly on domestic violence. The strongest focus on sexual violence is to be found in the chapter on justice, although even then, it is primarily in the area of statistics that there appears to be more information available on sexual offences than on domestic violence. This may be a reflection of the difficulties of extracting domestic violence related data from Home Office statistics at the time.

It would seem that, even where there is willingness and a degree of political and professional commitment, it is hard for policy makers and researchers alike to maintain a broad perspective on violence against women. This is also reflected in the provision of services to women, with few services, either voluntary or statutory, working from a broad perspective. It would be easy to attribute this to the greater prevalence of domestic abuse, and consequently a greater demand for a response from the public sector. Commenting on the “narrowing agenda” in Canadian public policy, Hague et al note that there has been a distinct move away from talking about and working to prevent ‘woman abuse’ and towards a focus on ‘family violence’. They question whether this is in some way perceived as a ‘safer’ position, and in relation to the research agenda “one in which more marginal experiences and forms of violence against women are seldom prioritized” (Hague, Mullender and Kelly, 2001: 32).

Reviewing some of the Canadian initiatives confirms that making the links between different forms of violence against women makes sense, but requires considerable commitment. Strategies which address violence against women in all its forms must be monitored to ensure that they stay focused on the ‘bigger picture’. More than that, there would appear to be a need to ‘monitor the monitors’, to ensure that the agenda is not inadvertently narrowed.

The 'lens' through which the problem of violence against women is viewed plays a part in how it is addressed. In Canada, the health department leads on violence against women. The Westminster initiative is located within the Home Office Crime Reduction Programme. The recent relocation of the Violence Against Women Unit into the Equalities Unit ensures that the work of challenging violence against women will be incorporated within a broader framework for tackling gender inequality. Making the links between different forms of violence against women will hopefully remain a priority.

## **6. Recommendations**

Women make connections between the different forms of violence they have experienced. They also make connections between the violence they experience and the way they are treated in other areas of their life. Most of the policy, research and practice reviewed takes a more compartmentalised approach, dealing with discrete aspects of violence against women. Promotion of an integrated response to violence against women should be considered as a priority.

Working on this review has provided a timely reminder that, although there is much still to be done, a lot has changed in the last 30 years. It has also been telling to note that, although there is a lot of good work happening in Scotland, it is largely undocumented. Some of this is undoubtedly tied to under-resourcing, some of it to the undeniable need to focus on the provision of the service. Building the capacity of frontline organisations to document the work being done would not only be useful for literature reviewers. Sharing examples of good practice would also save some duplication of effort – how many local partnerships have spent time working out the best way to produce and disseminate information resources for women?

The lack of evaluative research has been a theme throughout this review. There are many interventions, but not many assessments of how effective they are. Although no-one disputes the need for service developments to be evaluated, in practice evaluation tends to be done in-house, with a focus on process rather than outcome. Few services have the resources to commission independent evaluation.

Increasing collaboration between researchers, practitioners and policy makers might go some way to ensuring that services remain effective and responsive, and that research on violence against women is beneficial to service users and service providers. The 'Alliance of Five Research Centres on Violence' has provided a valuable focus for the development of research on violence against women in Canada, and this model would bear exploration to see how it could be developed in a Scottish context. The Centre for Research on Families and Relationships has gone some way down this route, and the proposed Scottish Centre for Criminal Justice Research will make use of a 'virtual department' model to improve the co-ordination and development of research on justice issues in Scotland. Both of these initiatives promote closer working links between academic researchers, policy makers and practitioners/service providers.

Supporting any research programme or service development programme, there is a need to address the collection and collation of data in relation to all forms of violence against women. In order to assess the effectiveness of any work we undertake to improve the situation of a particular group in the population, it is necessary that we are first of all able to 'see' that group in official statistics. Some of the issues which seem specific to violence against women are in fact cross cutting. Gender disaggregation would help to provide

the baseline statistics which are crucial to evaluating the work being undertaken to challenge violence against women, but would also support more general work undertaken to reduce inequality. Concerns about data sharing and data protection are common across all areas of work which involve an interagency response, including homelessness, child protection and substance misuse. Sharing best practice in data collection across sectors might have other benefits, given the links between violence against women and, for example, homelessness.

In relation to service provision, the development of the National Strategy to Address Domestic Abuse, backed by the establishment of the Domestic Abuse Service Development Fund (DASDF), has ensured that the “patchy and inconsistent” services identified in the Henderson report of 1997 are beginning to be more consistent and a little less piecemeal. The role of the DASDF in supporting the work of local domestic abuse partnerships should not be underestimated. Alongside this, there has been an unprecedented development of refuge provision, and the national helpline has increased its hours year on year since its inception. Awareness of the prevalence and effects of domestic abuse is increasing in all public sector agencies, and most local partnerships have already begun to develop local training strategies. Work is also underway to improve criminal and civil justice system responses to domestic abuse, and to increase legal protection for women and children.

Across the other aspects of violence against women, the picture is still somewhat “patchy and inconsistent”. The recent allocations of funding by the Scottish Executive will go some way towards improving service provision, particularly in relation to rape and sexual assault. However, there is a need to develop more stable and consistent approaches to funding services which respond to all forms of violence against women, nationally and locally.

The development of a funding strategy should be located within a broader strategic framework on violence against women. The National Strategy to Address Domestic Abuse in Scotland is due for review. The basic principles of the current strategy are applicable across all forms of violence against women. It would seem an appropriate opportunity to expand the terms of reference of the strategy and incorporate broader aspects of violence against women. Specific work would seem to be indicated in relation to sexual violence.

Broadening the strategic framework on violence against women might include consideration of the types of services on offer to women, and how to ensure that they reflect what women are looking for from services. Research has indicated, for example, that women value a more proactive approach to follow-up support and advocacy. A review of the mechanics of multiagency partnerships might also be worth some consideration. Some of the themes identified by Dutton and Cavanagh in relation to multiagency responses to sexual violence would bear further exploration, as more partnerships begin to develop in response to sexual violence.

Many women disclose in the first instance to people they know – family, friends, workmates – and so more attention should be paid to the development of information and support for the general public. Providing information and support through workplace campaigns, awareness raising programmes in schools and general public education campaigns could greatly enhance the level and quality of informal support available to women from those closest to them.

There are significant gaps in the research literature. Research which addresses the experiences and needs of black and minority ethnic women experiencing violence is scarce, perhaps reflecting the dearth of services for this group of women. There is a similar lack of understanding of the needs of women with disabilities and of lesbian women. There is little assessment of effective interventions for children and young people who have experienced violence themselves, or who have witnessed violence against women. Dedicated literature reviews may be required in each of these areas.

Finally, but most importantly, the views of women themselves should be sought. There is an absence of consultative mechanisms which enable women to input directly to the development of services which might meet their needs. This is a gap which should be filled as a priority before very much more work is developed.

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## Appendix 1

### Tackling Violence against Women in Scotland 1973-2003

1973	<ul style="list-style-type: none"> <li>Edinburgh and Glasgow Women's Aid groups open the first refuges for 'battered women' in Scotland</li> </ul>
1975	<ul style="list-style-type: none"> <li>Parliamentary Select Committee on Violence in the Family agrees refuge provision target of 1 space per 10000 population</li> </ul>
1976	<ul style="list-style-type: none"> <li>Glasgow Rape Crisis Centre (GRCC) opens</li> <li>Scottish Women's Aid (SWA) opens national office</li> </ul>
1978	<ul style="list-style-type: none"> <li>Edinburgh Rape Crisis Centre (ERCC) opens</li> </ul>
1981	<ul style="list-style-type: none"> <li>Matrimonial Homes (Family Protection) (Scotland) Act 1981 – allows women to have abusive partner excluded from the matrimonial home.</li> <li>Scottish rape crisis centres submit joint response to Scottish Law Commission Memorandum on laws of Evidence, calling for an end to sexual history questioning.</li> </ul>
1982	<ul style="list-style-type: none"> <li>Hemat Gryffe Women's Aid – first refuge in Scotland for Asian women</li> <li>Incest survivors' groups start in Edinburgh and Glasgow</li> <li>Sexual Abuse of Girls conference in Glasgow</li> <li>Incest Fact and Myth – Sarah Nelson</li> <li>First paid worker employed by Glasgow Rape Crisis Centre</li> <li>Duffy v HMA - Lord McCluskey allows prosecution of a man for raping his estranged wife.</li> <li>Scottish rape crisis centres attempt to pursue a Private Member's Bill to restrict sexual history evidence questioning – unsuccessfully.</li> </ul>
1983	<ul style="list-style-type: none"> <li>Chambers and Millar – Investigating Sexual Assault</li> <li>Women's Support Project set up in east end of Glasgow by Strathclyde (formerly Glasgow) RCC</li> <li>ERCC first involvement in local police training</li> <li>First joint meeting of Scottish Rape Crisis Centres</li> </ul>
1984	<ul style="list-style-type: none"> <li>Strathclyde Action Against Incest and Child Sexual Abuse set up</li> </ul>
1985	<ul style="list-style-type: none"> <li>Chambers and Millar – Prosecuting Sexual Assault</li> <li>Scottish Office Guidelines to Chief Constables on the treatment of rape victims</li> <li>Law Reform Misc Prov (Scotland) Act 1985 – section 36 restricts use of sexual history evidence in sexual offences trials</li> <li>Scottish Action Against Incest conference in Stirling</li> <li>Edinburgh Action Against Incest sets up helpline run 'by survivors for survivors'.</li> </ul>
1987	<ul style="list-style-type: none"> <li>Scottish Women's Liberation Conference, Working Against Violence Against Women, in Glasgow 12/13 September. 300 women attended, and 150 children</li> </ul>
1988	<ul style="list-style-type: none"> <li>Scottish Office commissions research on use of sexual history evidence</li> <li>Shakti Women's Aid opens refuge for black and minority ethnic women (Edinburgh)</li> </ul>
1989	<ul style="list-style-type: none"> <li>Stallard v HMA sets precedent – rape in marriage confirmed as a crime in Scotland</li> </ul>
1990	<ul style="list-style-type: none"> <li>Women's Support Project/<i>Evening Times</i> survey on Violence Against Women, Glasgow. 1503 women responded.</li> </ul>
1991	<ul style="list-style-type: none"> <li>'Dawn raids' by social workers and police in Orkney; ritual abuse hits the headlines in Scotland</li> </ul>

	<ul style="list-style-type: none"> <li>• WSP report - links between child sexual abuse and domestic violence</li> <li>• CoSLA Working Group on Women and Violence agrees refuge provision target of 1 space per 7,500 population</li> </ul>
1992	<ul style="list-style-type: none"> <li>• 'Sexual history evidence in Scottish sexual offence trials' – research published (Brown, Burman and Jamieson)</li> <li>• Report of the Orkney Inquiry</li> <li>• First paid worker employed by Edinburgh RCC</li> <li>• Zero Tolerance campaign launched by Edinburgh District Council Women's Unit</li> </ul>
1993	<ul style="list-style-type: none"> <li>• WSP registers as independent charity.</li> <li>• 'Judy' – Conservative Party activist and survivor of sexual assault addresses Scottish Conservative Party conference – the impact of the personal on the political</li> </ul>
1994	<ul style="list-style-type: none"> <li>• 'Talking Sense – a guide to women's safety' – Scottish Office</li> <li>• April – Dundee RCC employs first paid worker to set up a young women's project</li> <li>• Rape crisis centres in Scotland formally constitute as the Scottish Rape Crisis Network (SRCN)</li> <li>• SRCN training pack produced</li> </ul>
1995	<ul style="list-style-type: none"> <li>• Hit or Miss report on domestic violence (Tayside)</li> <li>• Rape Crisis and Women's Aid deliver training on domestic violence to all social workers in Tayside.</li> <li>• Central Region funds a 6 month worker to set up a rape crisis centre</li> <li>• Beijing Platform for Action</li> <li>• 'Excuses', the second Zero Tolerance campaign, launched in Edinburgh.</li> </ul>
1996	<ul style="list-style-type: none"> <li>• Ritual abuse resource pack produced by Dundee/Edinburgh Rape Crisis Centres</li> <li>• SRCN runs TV ad over Christmas/New Year – phone records demonstrate that only 10% of calls to RCCs get through.</li> </ul>
1997	<ul style="list-style-type: none"> <li>• Young Women's Project - consultation with 1000 young people in Dundee</li> <li>• SRCN conference, Dundee</li> <li>• 'Hitting Home – a report on the police response to domestic violence'</li> <li>• 'SNAP report on domestic violence'</li> <li>• 'Hidden Figures: the Edinburgh women's safety survey'</li> <li>• 'Service provision to women experiencing domestic violence in Scotland' – Scottish Office</li> <li>• Protection from Harassment Act 1997</li> <li>• Rape and sexual assault leaflet - Scottish Office (date?)</li> </ul>
1998	<ul style="list-style-type: none"> <li>• CoSLA 'Guidance on developing multiagency partnerships to tackle violence against women'</li> <li>• 'wee vip project' – abuse prevention for pre-school children piloted in Edinburgh and Dundee</li> <li>• 'Preventing Violence Against Women' – consultation, Scottish Office</li> <li>• Evaluation of Castlemilk Demonstration Project.</li> <li>• November – first meeting of Scottish Partnership on Domestic Abuse</li> </ul>
1999	<ul style="list-style-type: none"> <li>• EVA Project established in North Lanarkshire – first multi-disciplinary project to be set up in NHS in Scotland to address violence against women.</li> <li>• Routes Out Of Prostitution established in Glasgow as a thematic Social Inclusion Partnership.</li> <li>• Cross Party Group on Men's Violence Against Women and Children established</li> <li>• Scottish Parliament debates domestic abuse for the first time – Domestic Abuse Service Development Fund announced</li> </ul>
2000	<ul style="list-style-type: none"> <li>• Publication of National Strategy to Address Domestic Abuse in Scotland</li> </ul>

	<ul style="list-style-type: none"> <li>• Scottish Executive convenes National Group on Domestic Abuse</li> <li>• Cross Party Group on Survivors of Sexual Abuse established</li> </ul>
2001	<ul style="list-style-type: none"> <li>• Rape Crisis, Glasgow, funded by GGHB to set up SWAP - Supporting Women Abused in Prostitution.</li> <li>• Lord Advocate's reference on the definition of rape leads to clarification of Scots law that rape is based on an absence of consent, and does not require the use or threat of force.</li> <li>• Protection from Abuse (Scotland) Act 2001</li> <li>• First parliamentary debate on child sexual abuse</li> </ul>
2002	<ul style="list-style-type: none"> <li>• Rape Crisis, Glasgow, seeks judicial review of Home Secretary's decision to allow Mike Tyson, a convicted rapist, to enter Scotland to take part in a boxing match.</li> <li>• A young woman kills herself after giving evidence in a rape trial. Her parents condemn the ordeal she was put through in court.</li> <li>• Sexual Offences (Procedure and Evidence) (Scotland) Act 2002 prohibits the accused in sexual offence trials from conducting his own defence, and tightens the restrictions re use of sexual history/character evidence</li> <li>• Scottish Rape Crisis Network funded by Scottish Executive to set up national office, Rape Crisis Scotland.</li> </ul>
2003	<ul style="list-style-type: none"> <li>• Margo McDonald MSP introduces Prostitution Tolerance Zones (Scotland) Bill</li> <li>• Expert Group on Prostitution set up by Scottish Executive.</li> <li>• Aberdeen Rape Crisis Centre employs first paid worker.</li> <li>• Rape Crisis Network Europe report shows that conviction rate for rape in Scotland is 6% - one of the worst in Europe.</li> <li>• Rape Crisis are involved in the training of judges for the first time</li> <li>• Short Life Working Group on survivors of sexual abuse</li> <li>• Scottish Executive research report on Refuge Provision</li> <li>• SWA research report on Sustaining Tenancies</li> <li>• Refuge Online launched by SWA – enabling local WA groups to access information on available refuge accommodation across Scotland</li> <li>• Evaluation of Protection from Abuse (Scotland) Act</li> <li>• NHS Scotland Guidance on responding to domestic abuse</li> </ul>
2004 (to March)	<ul style="list-style-type: none"> <li>• Violence Against Women Service Development Fund established</li> <li>• Scottish Executive announces £1.76million to develop rape crisis services</li> <li>• Scottish Executive publishes Domestic Abuse Training Strategy</li> </ul>

## Appendix 2

### Useful websites

[www.captivedaughters.org](http://www.captivedaughters.org)

The website of the Commercial Sexual Exploitation Resource Institute, provides news about campaigns, resources and research on commercial sexual exploitation of girls and young women.

[www.crvawc.ca](http://www.crvawc.ca)

Centre for Research on Violence Against Women and Children. Collaboration between University of Western Ontario, London Coordinating Committee to End Woman Abuse and Fanshawe College. Research and publications, with a focus on prevention.

[www.cwasu.org.uk](http://www.cwasu.org.uk)

Child and Woman Abuse Studies Unit, Metropolitan University. Research and publications.

[www.cwgl.rutgers.edu](http://www.cwgl.rutgers.edu)

Centre for Women's Global Leadership, U.S.A. Information and resources on....

[www.duluth-model.org](http://www.duluth-model.org)

Domestic Abuse Intervention Project, Duluth, Minnesota, USA. Information about the Duluth model, a coordinated community response to domestic violence. Background papers and resources.

<http://endabuse.org>

Family Violence Prevention Fund, California based organisation working to end domestic violence. Resources, research news, campaign news.

[www.hc-sc.gc.ca/hppb/familyviolence](http://www.hc-sc.gc.ca/hppb/familyviolence)

National Clearinghouse on Family Violence, resource centre run by Health Canada. Information on all aspects of 'family violence', including domestic violence, child abuse, elder abuse.

[www.hotpeachpages.net](http://www.hotpeachpages.net)

International directory of hotlines, shelters and resources on domestic violence.

[www.ojp.usdoj.gov/vawo](http://www.ojp.usdoj.gov/vawo)

Violence Against Women Office of the U.S. Department of Justice. Useful access point for U.S. policy and research resources on violence against women.

[www.owjn.org](http://www.owjn.org)

Ontario Women's Justice Network, Ontario, Canada. Information about legal issues related to violence against women. Not currently active due to lack of funding, but has some useful information up to early 2003.

[www.prostitutionresearch.com](http://www.prostitutionresearch.com)

Prostitution Research and Education, run by Melissa Farley in San Francisco. Research, factsheets, publications on prostitution as violence against women.

[www.rapecrisisscotland.org](http://www.rapecrisisscotland.org)

Rape Crisis Scotland, providing information about rape and sexual assault, contact details for Scottish Rape Crisis Centres, news about legal issues and campaigns.

[www.rcne.com](http://www.rcne.com)

Rape Crisis Network Europe. Information about rape and sexual assault initiatives across Europe, reports and research papers commissioned as part of the "Strengthening the Linkages" project.

[www.scottishwomensaid.org](http://www.scottishwomensaid.org)

Scottish Women's Aid, national office for the Women's Aid network in Scotland. Information about domestic abuse, including contact details for local Women's Aid groups, housing and legal information

[www.statistics.gov.uk](http://www.statistics.gov.uk)

Links to all statistical data collected and published by U.K. Government and Scottish Executive.

[www.un.org/womanwatch](http://www.un.org/womanwatch)

Information on UN initiatives to end discrimination against women and girls, including those addressing violence against women.

[www.vaw.umn.edu](http://www.vaw.umn.edu)

Violence Against Women Online Resources, University of Minnesota. Resources and research articles on all aspects of violence against women.

[www.vawprevention.org](http://www.vawprevention.org)

National Violence Against Women  
Prevention Research Center, U.S.A.  
Resources and research summaries on  
violence against women.

[www.zerotolerance.org.uk](http://www.zerotolerance.org.uk)

Zero Tolerance Charitable Trust,  
Edinburgh. Information about the Trust  
campaigns and public education materials.

[www.womenlobby.org](http://www.womenlobby.org)

European Women's Lobby. News on  
violence against women initiatives across  
the European Union.

[www.womensupportproject.org.uk](http://www.womensupportproject.org.uk)

information and resources, links to other  
useful sites



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