

Work preliminary to the preparation of the
Plan Violence and health, in accordance with law
of August 9, 2004 relative to Public Health policy

Summary Report

VIOLENCE AND HEALTH

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INTRODUCTION

I. BACKGROUND AND PROBLEM

A. General context

In 2002, WHO published the “World Report on Violence and Health”[46]. Its authors considered that violence, described as a “global challenge”, had considerable cost in terms of repercussions on the health of the victims and as a burden on health facilities. Consequently, attacking the roots of violence became a priority for health professionals and administrators. Nine recommendations conclude the report and the first one, “*Create, implement and monitor a national action plan for violence prevention*”, has been highly instrumental in the process leading to the present report.

Indeed, in France, the law of August 9, 2004 (n°2004-806) relative to public health policy envisages the development of five strategic public health plans (2004-2008) and among these is a national plan to limit the impact of violence on health. The law defines a strategic plan as “an array of activities and coherent programs” covering several years. This process of strategic planning must “give greater clarity to efforts invested in improving health”.

The subject of the relationship between violence and health is not well documented in France and sources of information are lacking to quantify the overall public health impact of the phenomenon of violence, as defined by WHO. Moreover, the outlines of the problem are not clear and the field is very broad since the subject “violence and health” concerns all ages (from early childhood to old age), takes several forms (physical violence, sexual assault, psychological violence, institutional violence, violence towards oneself...) and affects diverse life spaces (private life, the public domain...). It is clear this issue involves many different actors, both in institutions and in associations, and it must necessarily be approached within an interdepartmental framework (health/social programs, health/justice, health/employment, health/education...).

Faced with these gaps in knowledge and with the need to organize extensive discussions among all actors concerned, the High Committee of Public Health (HCSP) was contacted in February 2003 by the Ministry of Health, which wished to study “*more particularly the conditions necessary for applying the recommendations of the report published by WHO to the French situation*”. The Ministry also wanted the suggestions of the HCSP to “*take into consideration the work in progress for the preparation of the law on public health*”. In its report [19] the HCSP considers that violence is indeed a public health problem, because even though the determinants of violent phenomena are generally of social origin, “the results of violence appear mainly in the area of health”. The Committee makes the following recommendations: 1) develop epidemiological knowledge about violence and its determinants; 2) make it easier to identify violent situations; 3) improve the management and follow-up of cases; 4) organize prevention activities.

The Steering Committee of the Plan “Violence and Health” and the thematic commissions it coordinated worked to deepen understanding of these subjects and to develop proposals for appropriate solutions and actions.

B. The field of study and the work of the commissions

1. The choice of work topics

Since publication of the report by WHO, many countries have prepared action plans, but in the vast majority of cases the plans refer to a limited aspect of the problem of “violence and health” (violence towards women, interethnic violence, domestic/family violence, violence towards children, school violence, suicide, traffic accidents). Only a few countries attempted, like France, to tackle the problem as a whole. During preliminary work on the French plan, it nevertheless appeared necessary to limit the field of reflection by excluding various themes already taken into account in other plans or programs, or which appeared marginal compared to the topic of violence. Suicide, which was recently the subject of great attention (a strategic plan, bulletins...), was not included, but its effects on friends and relatives were addressed within the framework of the topic “psychological trauma”. The same reasoning was applied to addictive behaviours. Traffic accidents were also ruled out of the field of reflection because they were the subject of a strategic plan in late 2002. However, that plan is primarily focused on monitoring, law enforcement, the training of drivers and education. It is not well developed with regard to aspects of health and it is hoped the grant offered by the DHOS¹ and the recommendations made in that plan by the HAS², will direct attention in France to issues too often neglected until now (criteria for the triage and transportation of victims in an emergency, standards for long-term follow-up of trauma victims and information on outcomes, in particular). In addition, accidents of daily living seemed somewhat marginal compared to the topic of violence, although further reflection is needed on the deliberate exposure of private citizens to severe risks by the designers, builders or owners of residential property (risk of lead poisoning, heating or electrical installations not up to norms, etc...), or to risks engendered by private citizens themselves (principally risks imposed on young children by families).

Finally, the analysis of available documents and the deliberations undertaken by the DGS³ made it possible to set up 6 theme-based commissions to address the topics which appeared to have priority in terms of public health. The titles of these 6 commissions are indicated below, with the names and disciplines of their presidents:

Perinatal period, children and adolescents:	François Baudier, MD, Public Health
Gender and violence:	Jacques Lebas, MD, Public Health
The elderly and people with disabilities:	Marie-Eve Joel, Professor of Economics
Violence and mental health:	Anne Lovell, Anthropologist, Senior Researcher, INSERM
Violence, work, employment, health:	Christophe Dejourn, Psychiatrist, Professor of Occupational Psychology
Institutions, organizations and violence:	Omar Brixi, MD, Public Health

The themes of the commissions correspond to a complex division by age, sex, the place where violence occurred, type of work activity of the offenders and/or status of the victims, and by accompanying pathology (these various dimensions being represented separately or simultaneously in each commission). This distribution, which proved to be functional in the end, aimed at encouraging dialogue among experts who shared knowledge on a given set of

¹ Direction de l'Hospitalisation et de l'Organisation des Soins; Directorate of Hospitalization and the Organization of Care

² Haute Autorité de Santé; French National Authority for Health

³ Direction Générale de la Santé; General Directorate of Health

themes. For example, with regard to childhood, the group created around this age category brought together experts on child abuse in families and experts on violence in school settings, rather than developing an approach based on place of residence or place of occurrence; for example, in families or in institutions.

The disciplines of the presidents (anthropology, economy, psychiatry and psychology, public health) are emblematic of the need for approaching the problem “violence and health” in a multi-disciplinary fashion and not solely through the eyes of medicine.

2. The composition and work methods of the commissions

The commissions were organized so as to ensure representation by professionals working in health settings, in research and in institutions or associations.

The commissions operated according to the following principles:

- Delineate the field of study and the list of priorities through discussions with the steering committee and by using jointly defined criteria (in each commission sub-topics were thus examined in detail; these were emerging or poorly documented topics, or, on the contrary, topics known to be priorities because of their frequency but which were poorly dealt with at present...);
- Carry out work according to a work plan common to all the commissions, comprising reflection on the delimitation of the subject, an inventory of present knowledge and existing programs, recommendations for research and intervention and the identification of indicators for evaluation;
- In all cases, deal with issues relating to both the victims and the offenders;
- Establish links with already existing plans and programs and propose bridges to topics excluded from the field and mentioned above;
- Supplement the work of the members by hearing expert testimony;
- Conclude by showing how public health professionals can play a role in reducing the impact of violence on health.

The commissions met 4 to 6 times from September 2004 to February 2005 and they submitted a preliminary report of their work to the inter-ministerial Steering Committee in January 2005. Their work program included extensive reviews of scientific literature and existing data, hearings with commission members as well as public figures, examination of written submissions, and seminars. The work of the commissions and the entire process of reflection were given support at all times by the DGS and the DGAS⁴ (initial reflection, documentation, practical organization of the meetings, and assistance in drafting reports).

Some overlapping between commissions was inevitable (for example, violence and mental health and violence during adolescence, violence in health care institutions and according to age category, etc.). But in the end, redundancies proved a source of richness in the reasoning process, in as much as collaboration among commissions was facilitated through regular meetings of their presidents with the president of the Steering Committee.

3. New approaches

3.1. Towards medicalisation of violence?

The simple fact of thinking about violence in terms of the field of medicine is, in itself, a relatively new approach. But many social problems are increasingly being addressed by the health care system, as noted by the Commission “Institutions, organizations and violence”:

⁴ Direction Générale de l’Action Sociale; General Directorate of Social Action

“in contemporary society, there is a collective delegation of responsibility to actors whose profession is considered a sacred trust, as in the case of physicians. However, health professionals very often have a negative experience with this growing demand, and are overwhelmed by the attribution of a front-line role in the management of violence”. And it is true that the somatic or psychological consequences of violence constitute an increasingly visible reason for the health system and organizations for social and medical protection to assume responsibilities for care. Because of this, health professionals, particularly those working in public health, have the obligation to undertake the prevention and treatment of the effects of violence on health. This presumes the development of a new culture and a new vision for tackling problems which, until recently, were primarily the shared interest of the police and the judiciary. Thus, in many countries at the present time (perhaps less so in France), the expression “road violence” takes into account a changing perception of the avoidable causes and effects of traffic accidents, from one based on an organizational and “mechanical” model (infrastructure, regulations, vehicle characteristics, etc...), towards an increasing interest in the behaviour of road users and the injuries of victims. The study of accidents (accidentology) has been broadened to include the study of victims (victimology).

The development of victimology (which in France dates only from the 1990’s) testifies to this medicalization of violence, in that it is bodily and psychological injuries that become the main focus of study. It is thus symptomatic that the DGS, in its 5 national priority plans annexed to the public health law of August 2004, chose the impact of violence on health as one of the topics. However, a certain scepticism is needed when confronted with the “taking over” of violence by the health sector. Indeed, while it has a legitimate and essential function in the healing of injuries caused by violence, an approach to violence solely through its medical consequences would obscure the causes and mechanisms of violent acts, which of course require a different approach than those of medicine, public health and victimology. This is the reason why the question “violence and health” requires a multi-disciplinary and interdepartmental approach, which is the one chosen by the steering committee and the commissions.

Finally, there is also a tendency to call upon physicians, and primarily psychiatrists, to deal with problems of violence which do not necessarily have anything to do with health, or which relate to moral questions (for example, violence on television). During hearings before the Commission “Violence and mental health” on the theme “violence and the media”, it was seen that, in newspapers, *“psychiatry appears to be the object of some confusion between moral issues, science and/or the clinic, as demonstrated by a certain use of psychiatry in the media to resolve social and moral problems”*.

3. 2. The question of gender

Due to its recognized frequency and the seriousness of its consequences, violence towards women unquestionably dominates the picture of violence according to sex. However, it is important to go beyond this statistical reality and look at the question of “gender”, that is to try and understand why socially established sex roles lead to relationships of domination and power which generate violence. This approach also makes it possible to recognize that similar processes of discrimination are at work in acts of violence towards homosexuals. This way of looking at gender-related violence appears to be the most promising one in terms of understanding both its mechanisms and its prevention, and in dealing with those responsible for this violence.

“Whether it is called violence towards women, domestic violence, or marital violence, it is explicitly understood to be related to “gender relationships”, that is, to the historic division

of roles between men and women, justified on philosophical, political, biological, or social grounds, and which have varied throughout history. The “Gender and Violence” commission thus decided to include the question of “gender” in the study of an issue that is at the crossroads of physical and psychological realities concerning health, and of social realities concerning violence” (“Gender and Violence” commission).

3. 3. Institutional violence

The notion of institutional abuse was recognized belatedly. Stanislas Tomkiewicz, who was one of the first in France to refer to it in the 1980’s [39], was in the habit of saying that all institutions secrete violence. Apart from violence committed by a lone individual (a distinct and isolated case of acting out), violence is also generated by institutions themselves and the two situations have proven to be closely related. It thus appeared very important to look at medical institutions (in particular, those specialized in psychiatry), and social and medico-social institutions (especially those intended for elderly people and the disabled, including children and people with mental disorders) and to analyse how abuse directed towards these vulnerable people may be the result of failures in the complex system which typifies the social and medico-social institution (failures related in particular to staff management and the organization of work). It is indeed likely that violence tends to develop in those institutions where social relationships are marked by the abuse of power and where relationships of dominance tend to overshadow relationships based on individual rights and adherence to standards.

This organizational aspect of the origins of violence in medical institutions has also been analysed in the context of schools, companies, prisons, etc. All the commissions confronted this set of themes, particularly the Commissions “Violence, work, employment, health” and “Institutions, organizations and violence”. The Commission “Violence, work, employment, health” consequently analysed the “conditions favouring violence, as well as those averting violence, in the work environment”.

II. VIOLENCE: A BATTLE OVER DEFINITIONS

The definition of violence suggested by WHO in its 2002 report [46] and used by the working group of the HCSP, was used as a basis for initial discussions by the commissions. According to WHO, violence is:

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”.

This definition posed problems in all the commissions, and it was mainly the word “intentional” which raised many questions.

For the Commission “Institutions, organizations and violence”, it appeared that, because the subject was institutions, it was necessary to be very clear about what is and what is not intentional, clear about what an institution, even in spite of itself, engenders or encourages because of a particular mode of organization or relationship to work, at all levels.

The Commission “Violence and mental health” had to deal with all the ambiguity surrounding the relationships which exist between violence and mental health (*“in public opinion, the connection between violence and mental health is made especially in relation to mental illness, insofar as in the public mind, mental illness has always been associated with violence. In the same way that the unscientific and degrading concept of the ‘madman’ survives, the*

association of mental illness with violence persists in social representations through a “shift in meaning”, so that every violent action which is unusual, either by the way it is done, by its hideousness, or by the absence of an obvious motive, is attributed to a mentally ill person. ‘It’s a crazy act’ quickly becomes ‘It’s the act of a crazy person’ ... (Y. Pélicier, quoted in [12], p. 39)”. This commission felt that WHO’s definition “makes it possible to understand the psychopathological effects of violence, but leaves aside the question of the relationship of violence to mental illnesses, which constitutes one of the underlying questions addressed by the commission. Moreover, the qualifier ‘intentional’ presumes premeditation, which may prove to be absent in a subject with psychotic symptoms at the time of an episode of violence.”

Two commissions considered WHO’s definition especially restrictive when applied to violence towards particularly vulnerable or completely dependent populations: young children, the elderly, persons with disabilities. The Commission “Perinatal period, children and teenagers” did not wish to limit itself to notions of ‘intentional use’ and of ‘physical force’ contained in WHO’s definition and felt the definition should be “*broad, defining ‘violence’ as anything an individual regards as such*”. Indeed, the topic of “violence and health” refers to personal experience and perceived psychological trauma. In the case of the young child, even such a broad definition, depending on a concept of violence as defined by the victim, is inoperative insofar as many chronically abused children do not consider themselves as victims because they have never known other ways of relating emotionally to their family. The word ‘intentional’ does indeed raise issues in the case of child abuse for at least two reasons. The first relates to the concept of intentionality, which is crucial in the case of shaken baby syndrome. In this pathology, there is “abuse” in a literal sense (the child has somatic consequences, often extremely serious, from the treatment inflicted upon him) but the intention to harm is not always obvious. In some cases, cerebral and retinal lesions characteristic of shaking are found along with fractures of bones or visceral injuries, and thus the diagnosis of intentional injury is not in doubt. In other cases, the advanced educational level of a parent who shakes a very young child violently (in particular, one not yet able to hold up its head) leads to the assumption that he or she should not be unaware of the harmful nature of the act. Finally, in other cases, one does not know what to think (shaking through exasperation to calm the child without knowing the possible serious consequences? To arouse it? To revive a child who has a fainting spell? In play?).

The second problem is that of “neglect”, as emphasized by the commission: for the child, “*an intervention is more likely to occur when the danger is physical in nature. However, this is not necessarily the greatest danger experienced by a child living in a family that is not capable of raising it. In general, physical violence is more often taken into account because it is more easily “demonstrable”. Both professionals and families have difficulty recognizing deprivation as a form of violence. However, for very young children, a non-violent attitude consists in meeting their psychological, somatic or cognitive needs. Can one regard as violent those situations where children do not receive what they need? These considerations lead back to various definitions of the child ‘at risk’ or ‘in danger’, of ‘neglect’ and of ‘abuse’*”.

The thinking by the Commission “The elderly and persons with disabilities” is along these same lines. Its members have arrived at the broadest of definitions, with particular emphasis on notions of neglect and omission, by taking into account the concept of “violence by default”: significant and prolonged insufficiency of proper care. Thus, the commission used a classification of types of maltreatment towards vulnerable persons developed by the *American Medical Association* (see for example [2]), employed by the Council of Europe [9] [10], and comprising 7 categories: 1) physical abuse (attacks upon the physical integrity of the

person: criminal behaviour, blows, injuries, brutality, slaps, pushing and shoving, neglected or poorly treated bedsores, physical restraint by attaching to a bed or chair, sexual abuse...); 2) psychological, affective, and moral abuse (denigration, threats, coarse language, insults, familiarity, humiliation, infantilization, emotional blackmail...); 3) financial abuse (living off the vulnerable person, improper cashing of checks, holding back pension payments, depriving the person of any control over resources, depriving the person from benefiting from property, sale of property, premature use of inheritance...); 4) infringement on the rights of persons (the right to life, to an identity, to sexuality, to the right of expression, to a free choice of lifestyle...); 5) abusive treatment with drugs (withholding of necessary drugs or care, non-treatment of pain, or on the contrary the imposing of inappropriate treatment, drug abuse, not following prescriptions); 6) active neglect which consists of intentionally not meeting the person's needs (withholding of food, drink, the necessities of daily living); 7) passive neglect (ignoring or having a lack of interest and consideration for the needs of the person: being absent, forgetting different things such as changing the patient's position, meals, the toilet...).

As can be seen, this very broad definition includes failures in appropriate care and in the "normal" functioning of health services. In this context, the example of bedsores is particularly enlightening: *"bedsores are a serious condition which may bring about the death of an elderly person or even that of a neglected young patient. They are an indicator of care and are preventable using known and effective procedures, when these are in fact employed. Bedsores may be considered one of the symptoms and a sign of chronic maltreatment, of severe neglect (in half the cases of bedsores among elderly patients), of a lack of care, of carelessness or incompetence in managing changes of position, nutrition and patient mobility. Bedsores constitute violence by default in that there is often a lack of knowledge, sometimes of means, and always inadequately organized care"* [13]. This example is a good illustration of the fact that maltreatment and violence are not always equivalent expressions when the word maltreatment is used to indicate the opposite of proper treatment.

The Commission "Violence, work, employment, health" decided on a fairly narrow definition of violence, owing mainly to the fact that concepts of hierarchy and power relationships are inherent to the world of work and it is therefore essential to use precise terminology and avoid any semantic confusion: *"If the subject matter included under the heading of violence needs to be limited, it is because violence should be distinguished from aggressiveness (cf [3]), from power relationships, from domination... But it is also because it appears necessary not to dilute the concept of violence in too vast a field. This would have the disadvantage of minimizing the gravity of the question specifically asked of the commission and of incorrectly underestimating the importance of some behaviours, while, on the contrary, possibly treating certain reprehensible behaviours as though they were premeditated crimes and calling for disproportionate penalties. Harassment is not torture. Being transferred, without right of appeal, to a provincial town must be distinguished from being sent out of the country for political reasons; the threat of dismissal must be distinguished from deportation to a Gulag. What may be tolerated in ordinary rhetoric or comes from everyday language cannot be used to justify a lack of conceptual rigor in scientific deliberation"*.

The boundaries of violence also include its social dimensions, which portray certain acts as socially acceptable behaviours in certain contexts and as unacceptable behaviours in others. Depending on the social acceptability of violent behaviours, the trauma that results can have a range of meanings for the subject. *"Looking at violence as an act subject to rules leads to a distinction between violence inherent in establishing the social order and deviant violence and to an examination of the differences between the two"* (Commission "Violence and mental health"). These considerations of course raise the problem of the use of research

results and intervention programs originating in other countries that are culturally and socially different. Moreover, it is important to remain vigilant and to recognize that, in some cases, one cannot take refuge in “cultural context” in order to justify certain destructive violence, such as female genital mutilation.

The acceptability of violence relates as well to constraints that may be considered as justified; those exerted by a psychiatric institution on patients for example, or those aimed at preventing a very young child from harming itself. The question then becomes one of knowing when justifiable constraint becomes unjustifiable violence, through its excesses or its arbitrary nature.

In the end, each commission chose a “working definition” which enabled it to operationalise reflections and discussions and to arrive at conclusions and recommendations.

For the Commission “Perinatal period, children and teenagers”, violence is: *“the deliberate or unintentional (due to carelessness, neglect, forgetting, lack of knowledge...) use, and/or the threat of the deliberate use, of physical force or of power against oneself, another person, a group or a community. Depending on its intensity and/or its repetitiveness, the form it takes, its timing, the vulnerability of the person, even the absence of a restraining third party or of support (from another person, a group or a community), it is experienced by the person (or the system) as an attack on their dignity and integrity in some or all of their physical, psychological, intellectual, material, social and culture dimensions. The emotional reaction to the use or threat of force, brings about, or strongly risks bringing about, immediately and/or over time, trauma, death, mental anguish, poor or deficient development, even an act of violence...and may thus compromise the well-being and the life of the person or persons involved, regardless of the socio-economic, cultural or political milieu under consideration”*.

The Commission “Gender and violence” worked primarily on studying the question of gender and, using a public health approach, looked at violence especially as it affects people’s health.

The Commission “The elderly and persons with a disability” considered that “the plurality of definitions of maltreatment is a reflection of a multiform reality, which is difficult to grasp”. They thus decided to use “a broad definition of violence such as *“the fact of taking action against someone or of refraining from taking action on behalf of someone, or of making the person act against his or her will by employing force or intimidation, and thus causing or being likely to cause physical or psychological damage. This violence can be apparent through violent gestures or words, threats, neglect, taking advantage of people, restrictions, and arbitrary deprivation of freedom in public as well as in private life. In this broad definition, having the intention to coerce is not required, nor is it necessary for the perpetrator to perceive the violent nature of coercion. Indeed, it is rare that coercion results in incidents or acts that are particularly serious and spectacular. Maltreatment often corresponds to a succession of small acts which, joined together, create the conditions for the isolation and suffering of vulnerable persons”*. The members of the Commission stressed *“the importance of unintentional violence, or violence “by default”, following the terminology of Stanislas Tomkiewicz [39], which manifests itself in an insidious and daily manner which is barely perceptible. The maltreatment often begins with seemingly innocuous acts, which do not constitute penal infringements but are harmful and likely to transform their recipient into a victim”*.

The Commission “Violence and mental health” developed an “*approach to violence based on the assumption that definitions of violence are not fixed, that they vary with time and*

cultural contexts". At the same time, the work of the commission required that *"the study of violence in relation to mental disorders and mental health be delimited. This goal became complicated by the fact that there is often a discrepancy between scientific facts and their representation by the public. Moreover, the study of social representations themselves and their consequences can teach us much about the cognitive bases of stigmatisation and discrimination towards people who suffer from mental disorder. The field of study was then defined as much in terms of violence "caused" by mental disorder as in terms of violence directed towards those who suffer from it. Since the field remained very large, it was necessary to delimit the commission's area of work to violence which leads to psychological suffering and/or disorders, which call for the use of medical and health knowledge. It is thus by looking at its effects on mental health that the study of violence was undertaken, once it was defined as a social object."*

The Commission "Violence, work, employment, health" based its work on a narrow definition according to which: *"violence consists in using force to take action against someone or to make him or her act against their will"* (according to the Robert dictionary of the French language). This being so, it was considered that *"violence in the world of work justifies that one also takes into account two complementary situations where the victim agrees to violence (an exception to "against their will" as it appears in the definition). This is the case in certain suicide attempts and some suicides, in particular when they are carried out in the work place. In order not to limit in advance the etiological explanation of these violent acts to that of 'aggressive behaviour turned against oneself', behaviour which consists of 'acting on one's own body in order to inflict injury or death', will be accepted as a complement to the definition of violence.*

"It also appears necessary to include in the definition actions which consist in deliberately exposing a worker to risks of intoxication, disease or accident, when the latter is not aware of the risk which he or she incurs by carrying out the prescribed task (for example, sending a subcontractor to make repairs in a zone of strong radioactive contamination without informing him of the danger). Violence in this case consists in 'behaving towards someone or making him or her behave so that they unknowingly take risks endangering their own life or that of others'".

Finally, the Commission "Institutions, organizations and violence" proposed *"to use the WHO definition of violence while not relying solely on the concept of 'intentional' and to widen the typology to include organizational and institutional logic having the potential to produce violence"*.

In conclusion, if these definitions show differences between them, this is a function of the nature of the different areas under study and makes it possible to develop definitions that are consistent with the problems analysed by each commission. The summary report will endeavour to bring together the data produced during these weeks of work, with particular emphasis on the relationships between "violence" **and** "health", whether this refers to the impact of violence on health and the health system, or to health states that engender violence. The objective is to make recommendations addressed to the main actors in public health, whether they are in charge of health policies and programs, are health professionals, or belong to the community of researchers contributing to research in public health.

The reports of the six thematic commissions may be consulted on the site of the Ministry of Health and Solidarity, specifically at the following addresses:

http://www.sante.gouv.fr/htm/dossiers/violence_sante/sante_mentale.pdf

http://www.sante.gouv.fr/htm/dossiers/violence_sante/genre_et_violence.pdf

http://www.sante.gouv.fr/htm/dossiers/violence_sante/institutions.pdf

http://www.sante.gouv.fr/htm/dossiers/violence_sante/perinatalite.pdf

http://www.sante.gouv.fr/htm/dossiers/violence_sante/pa_ph.pdf

http://www.sante.gouv.fr/htm/dossiers/violence_sante/travail.pdf

CHAPTER 1: THE STATE OF THE QUESTION ON THE RELATIONSHIP BETWEEN VIOLENCE AND HEALTH

Present knowledge on acts of violence, their risk factors, their perpetrators, the nature of the victims and health consequences is presently insufficient, heterogeneous and of unequal quality. There are indeed numerous data, statistical or not, concerning different populations, the different types of violence, collected using various methods and from multiple sources, but these data are not organized for the most part. Their level of representativeness is highly variable, with only national mortality statistics being exhaustive and covering the entire population of both sexes and all ages. When there are studies carried out on a national level on representative samples of the population, they generally deal with specific populations, as in the ENVEFF study⁵ [22] and often exclude minors, as for example in the studies on victimisation by CESDIP/INSEE⁶ [47,48]. Few data concern violence occurring in institutions, and even less deal with violence of organizational origin and related to institutional functioning. Methods and data collection tools are highly variable, which makes grouping and/or comparing data, even on the same theme, difficult, not to say dangerous. Certain data are routinely collected (data on child abuse gathered by the ASE⁷ and the general councils for example). Other data come from epidemiological, socio-demographical or clinical research, and further data come from telephone hotlines (SNATEM⁸, ALMA⁹...). As far as research tools are concerned, they are also very diverse: questionnaires, face to face interviews, telephone interviews, analysis of cases.... The six commissions attempted to assess what existed, by bringing together knowledge obtained by these multiple approaches and often by making use of foreign scientific literature when French data were nonexistent. Below, we summarize this knowledge with the objective of evaluating the magnitude of the problem of violence and its relationship to health, while highlighting and analyzing problems with data reliability, and we will describe some of the risk factors identified and discussed by the commissions.

I. MORTALITY

Violent death is an entity made up of four categories defined by the coding used for the cause of death (following the International Classification of Diseases by WHO): accidents, suicides, homicides and deaths labelled "Event of undetermined intent". It is usual to consider them together because of possible errors of classification, which themselves may be related to problems of certification (for example, a suicide declared as an accident on the death certificate and coded as such). The analysis of national data furnished by the CépiDc at INSERM (Center for the Epidemiology of medical causes of death) indicates that in 2001, there were 41,066 violent deaths in France, both sexes and all ages combined [21] Most of these deaths (69%) were accidental, 25% were suicides and there were few homicides, 489 or 1.2% of all violent deaths. Excess male mortality is conspicuous, especially as concerns suicides (3 times more frequent among men). Since 1980, violent deaths have markedly

⁵ Enquête Nationale sur les Violences Envers les Femmes en France; National Study on Violence towards Women in France

⁶ Centre de Recherches Sociologiques sur le Droit et les Institutions Pénales/ Institut National de la Statistique et des Études Économiques ; Center for Sociological Research on the Law and Penal Institutions/National Institute for Economic Studies

⁷ Aide Social à l'Enfance ; Social Aid to Children

⁸ Service National d'Accueil Téléphonique pour l'Enfance Maltraitée ; National Telephone Hotline for Abused Children

⁹ ALlo MALtraiteance des personnes âgées; hotline for reporting maltreatment of the elderly

declined (by 33% among men and 39% among women). These figures (few homicides, a decrease in violent deaths by one-third over 20 years) would appear reassuring at first glance and are not in accordance with widespread public opinion that violence continues to increase. However, some phenomena are disturbing. First of all, there is the poor position of France in relation to the rest of Europe, with mortality rates for violent deaths that are double those of the United Kingdom and the Netherlands (the difference concerns suicides as well as accidents). Then there is the unreliability of figures for homicide. Indeed, when figures indicated above are corrected by taking into account deaths “from unknown causes” (which generally correspond to cases of suspicious deaths for which forensic conclusions have not been passed on to the CépiDc), we find that the total number of violent deaths increases from 41,066 to 48,416 (an 18% increase), but especially that the number of homicides increases from 489 to 1170 (a variation of +140%). It thus appears that the reliability of data on national mortality statistics, a necessary tool for evaluating health policy, is severely compromised by the non-communication of essential information by some forensic science laboratories.

Under-registration of homicides is particularly worrying in the case of very young children. For example, in the research project on suspicious deaths of under-one infants carried out by Unit 750 of INSERM [40], the cross-checking of data from the CépiDc with those gathered in the courts in the same Departments (in the regions of Île de France, Brittany and Nord-Pas-de-Calais) for the same period (1996-2000) gives disturbing results. Out of 80 deaths suspected of being violent deaths in the “courts” study, only 23 could be found under the heading of homicide in the official statistics on cause of death; 16 deaths could not be found at all; 7 were found under the heading of deaths from “unknown or unspecified causes”; 17 were under the heading of “natural” medical cause; 1 was classified as SUID; and finally 16 were under the heading of deaths from accidental trauma or from undefined cause. Even if aspects of the circumstances and medical details surrounding these 80 deaths raise fears that these are involuntary or voluntary homicides, it seems wise not to try and decide on their possible classification at this point using these data, but rather to categorize them according to whether the cases did or did not lead to an investigation and hearing. This still leaves 71 cases that led to judicial proceedings, compared to the 23 cases from the CépiDc statistics.

The under-registration of fatal cases of child abuse is a recognized fact in the English language literature [31]. Its origins may be found at several levels: erroneous diagnosis of accidental death or of Sudden Unexpected Infant Death (SUID), inexact certification of the cause of death even after the results of investigations are known, non-transfer of forensic laboratory results. As concerns deaths from “unknown cause”, the hypothesis is that they are a mixture of SUID and homicides, as has been shown in the United States [32], and that homicides are hidden under the category SUID; 29% of suspicious deaths were registered as SUID in national statistics in 1994 according to a British study [34].

II. DATA ON VICTIMS

Data are fairly numerous on acts of violence concerning the general population, or more often specific populations (children, women, persons with disability, persons with mental disorders...) but there is less information on the health consequences of this violence. In all cases, the commissions underlined problems of reliability, linked in particular to the under-declaration and under-registration of acts of violence and/or their consequences.

A. Acts of violence as they are declared by the victims or concerning victims

1. Acts of violence recorded in the general population

1.1 Studies on victimisation (CESDIP/INSEE)

This population-based method of study was conceived to gain knowledge about delinquency, independently of official systems of recording. It thus enables identification of offences that, for one reason or another, have not been brought to the attention of the institutions responsible for preventing them. In this manner, a series of national studies on victimisation were carried out, the first in 1986 by the CESDIP, and the subsequent ones carried out each year since 1995 by INSEE, in a sample of around 6000 households, within the framework of the continuing study on family living conditions. The totality of the aggressive acts recorded in the studies by the CESDIP for the period 1984-2001 covers a wide spectrum, from a menacing attitude or insults to injuries requiring hospitalisation. We can note a global increase in the incidence of all acts of violence, which has tripled from an initial figure of 5% to 15% in the space of 15 years. This increase involves mainly verbal violence and, to a much lesser degree, physical violence. As concerns multiple victimisations, the average number of aggressive acts suffered by each victim over the two years covered by each study has grown, in a statistically significant fashion, from 1.3 attacks to 2 attacks, or more than a 50% increase between 1984 and 2001. But this increase is broken down differently according to the various types of aggression and it is essentially verbal violence that has increased. The question arises as to whether these behaviours have indeed increased, or whether more people have become increasingly sensitive to them.

1.2 The reporting system of the National Department of Education

In some school districts, as after certain events, the National Department of Education has attempted to objectively describe the facts in order to constitute a basis for discussion with the teaching staff. This has given rise to an observatory and to a database on reporting (SIGNA). Unfortunately, this system is limited only to reporting and has no analytical tool for studying the numerous variables that may be associated with violence.

2. Children and adolescents

In 2002, data published by the ODAS¹⁰ indicates that Social Aid to Children services (ASE) reported 18,500 abused children (5600 cases of physical violence, 5900 cases of sexual abuse, 5000 cases of serious neglect, and 2000 cases of psychological violence). While the number of abused children remains stable (18,300 in 2000), the typology of abuse in 2002 confirms a tendency begun in 2000: reports of sexual abuse increased slightly whereas those for physical violence diminished. There are important regional differences in reporting. Thus, in the Nord-Pas-de-Calais region, the proportion of children referred to the ASE is 35% higher than the national average.

In 2000, the 119 hotline (“Hello, Abused Children”) received 22,782 calls for physical, psychological or sexual abuse of minors. This figure is to be compared to the 18,300 cases of the ODAS/ASE for the same year (which has a broader definition of abuse). Duplications doubtless exist but cannot be identified. It should be noted, moreover, that the number of cases transferred by 119 to the appropriate authorities (the Departmental General Council) is low (6030), principally because many callers wish to remain anonymous.

¹⁰ Observatoire de l’Action Sociale Décentralisée ; Observatory of Decentralized Social Action

Data on child abuse pose numerous problems of reliability, in particular their lack of exhaustivity and biases related to under-registration. At the present time in France, in order to estimate the frequency of child abuse, two main types of data are available: those from retrospective studies among subjects of differing ages and circumstances (the general population, groups affected by specific pathologies) and those produced through routine data recording (ASE/ODAS, SNATEM, statistics on medical causes of death...). True population-based epidemiological studies are yet to be carried out.

Retrospective studies of course pose the problem of recall rates, which decrease with the length of the recall period, and the problem of memory bias. It should be noted, however, as concerns the question of the long-term consequences of abuse, the rare prospective studies carried out (cohort follow-up studies in English-speaking countries) show results similar to those of retrospective studies, in particular concerning the statistical relationship between abuse experience during early childhood and later suicidal tendencies.

As far as routine data collection is concerned, it is very difficult to compare figures from diverse sources because of differences in the geographical zones covered, the age ranges, and the definitions used. Even within the same population, (students in secondary schools), figures differ according to who is involved (physicians, social workers...) and the numerous duplicate cases cannot be identified. If they are not identifiable within the same organization, they are even less so from one organization to another. Changes over time also pose complex problems of interpretation. For example, in the data published by the ODAS, what is the significance of a decrease or an increase of several hundred cases from one year to the next, of a small change in the distribution of the different types of abuse? Variations in the "tendency to report", a potential shifting of interest from one type of violence to another type, and possible changes in reporting procedures, all these factors doubtless play an important role. The ODAS thus underlines the effect on figures of the tendency of the National Education department to refer cases directly to the courts without notifying authorities in the General Council¹¹. Whereas the SNATEM may be considered a "good tool for measuring public mobilization when faced with the drama of abuse", it cannot be a viable epidemiological observatory for a multitude of different reasons (calls not followed up, the meaning of silent calls, slanderous denunciations, anonymous calls, double counting...).

Finally, the bringing together of these data leaves the impression of considerable heterogeneity and real difficulty in evaluating the size of the problem. Only the offices of the National Education Department have a denominator that enables the calculation of frequencies. Thus, during 2000-2001, there were 3 children considered in danger and 0.9 abused children for each 1000 students. Calculations applying figures from ODAS to those for the same age group from the national population (figures from the census by the INSEE in 1999) lead to a prevalence rate of abuse of children of 1.4 per 1000.

It is difficult to evaluate the contribution in measuring the extent of the problem made by the different sectors liable to care for children and able to recognize abuse. In the clinical setting, when confronted with certain particular types of lesions said to be accidental in origin, the tendency to be suspicious is much less developed in France than in other countries. The INSERM study on "suspicious infant deaths" clearly shows several ways under-registration occurs: reticence on the part of paediatricians, in particular out of fear of harming the family, leads them to declare fewer violent or suspicious deaths than they suspect exist; all the

¹¹ Administration at the Departmental level. The Department is a geographical, political and administrative division. There are 100 Departments in France, grouped into 26 Regions.)

investigations necessary for recognizing abuse are not always carried out, in particular, the autopsy. In addition to this under-registration, there is the cumulative effect of under-reporting, which may be related to a certain lack of motivation due to the rarity of feedback when a case is in fact reported. Difficulties in cooperation between hospital departments on the one hand, and maternal and child health services and the General Councils on the other hand, leave the impression there are missing data in the ODAS/ASE figures, the extent of which is unknown (data which are now centralized and analyzed by the National Observatory of Children in Danger [ONED]).

Following this assessment, it appears certain there is an under-estimation of child abuse in France (problems encountered with mortality data are the most telling symptom of this situation). In addition, the problem is not only quantitative and there are probably selection biases at work, the most obvious being social bias, with the favoured classes probably most able to escape identification and reporting. The ODAS links abuse with an increase in severe financial insecurity in France. The problem is that no exhaustive geographically based data exist which can be applied to the general population in the same zone. In the study carried out by the U. 750 of INSERM [40], a comparison of data from the courts with the general population as concerns socio-professional category (data from the INSEE census of 1999 for the same Departments) shows that, in that study, the percentage of white collar mothers accused of causing the death of their child was not significantly different from that which would be expected, taking into account the distribution of socio-professional categories in the general population.

3. “Gender violence”

As noted at the beginning of this report, the issues chosen by the Steering Committee and the commissions go beyond the theme of violence towards women and include more generally the relationship between “gender” and the occurrence of violence, the latter, as we have seen, being related to social roles attributed to each sex and to power relationships between the sexes. However, data presented below concern principally violence towards women, which is consistent with reality, since it is in fact women who pay the heaviest toll for “gender violence”.

3.1. Violence towards women

During the past 15 years, the results of more than 50 studies have been published worldwide on the frequency of violence towards women, called marital or domestic violence. Globally, between 10% and 50% of women who have lived in a couple relationship have known this type of violence, and between 3% and 52% of them report such violence as having occurred in the course of the preceding year [43]. A more recent publication confirms these latter figures [16].

3.1.1. The ENVEFF study

In France, the principal data come from the ENVEFF study [22], the first national study on violence towards women, which was carried out in a representative sample of 6970 women aged 20 to 59 years between March and July, 2000 in metropolitan France, on the initiative of the Secretariat on Women’s Rights. It was coordinated by the Demographic Institute of Paris University 1 (IDUP), and carried out by a multidisciplinary team of researchers from the CNRS, the INED, the INSERM and from universities. Non-institutionalised women living in France were interviewed by telephone on the subject of verbal, psychological, physical or

sexual violence sustained during the past twelve months in public, at work, within the couple, or in relationships with the family or persons close to them. The ENVEFF study made it possible to show the importance of the problem in France, and to label and count violent acts towards women.

During the twelve months preceding the study, 4% of women questioned experienced at least one act of physical aggression (blows, physical brutality, threats with a weapon). In public, whether in the street, public transport or public places, and for all age groups, nearly 19% sustained at least one type of violence: 13.3% of women interviewed said they were verbally aggressed (insults, threats), 5.2% said they were followed about, and nearly 2% experienced physical aggression, in which men were the offenders 80% of the time.

Among the women interviewed, 11% said they had been sexually assaulted at least once during their life. The most frequently reported aggressions were attempted forced sex (5.7%), groping (5.4%), and forced sex (2.7%). While the majority of these women reported a single sexual assault, a quarter of the women reported having experienced several.

ENVEFF provides a good deal of information on intra-familial violence: during the preceding 12 months, 10% of women experienced marital violence. This violence was distributed as follows: insults, 4.3%; emotional blackmail, 1.8%; psychological pressures (of which 7.7% was mental harassment), 24.2%; physical aggression, 2.5%; rape and other forced sexual practices, 0.9%. The frequency of the violence experienced was uniform across socio-professional categories. Immigrant women (with the exception of Italian or Spanish women) have more frequent situations of marital violence.

Marital violence develops in cycles of increasing intensity and frequency over time. During the phase of escalation during which there are psychological aggressions and verbal violence, the woman attempts to maintain an equilibrium and master her fear. This first phase is followed by an explosion of violence set off by some upsetting event during which the man seems to lose all control of himself. The woman is now terrified and tries either to defend herself or to seek shelter of some kind. Then follows a period of remission during which the husband tends to regret what he did or said, tries to minimize his actions and to justify them through external circumstances outside his control. He tries to gain pardon and promises never to do it again. There are several reasons why women don't leave their violent partners. First, they hope to change their partners' behaviour by helping and supporting them. They also hope to maintain family unity and avoid a separation that would distance the father from his children. The lack of economic resources and the obstacles of a separation may seem insurmountable to them. They may also experience threats to themselves, their children or members of their family, and these threats destroy all hope of escaping the situation. Added to these motives is often a lack of knowledge of their rights as well as of places where they may be sheltered.

ENVEFF exposed a massive and poorly understood problem, and also showed the habitual under-declaration of violence experienced by women. The results of this study in fact show that many women spoke about the violence they experienced for the first time on the occasion of the study and that marital violence is the most hidden of the different forms of violence. Thus, more than 2/3 of the women compelled by their spouse into forced sexual practices or relations stayed silent and 39% had concealed instances of physical aggression.

However, this study has certain limits since some women belonging to specific populations (prisoners, the homeless, long-term hospitalised patients, religious orders...) were not included in the investigation. In addition, information on migrant women, who nevertheless experience specific violence, is inadequately considered because their numbers were not sufficient for an analysis by geographic origin. Also, the most disadvantaged migrants are difficult to identify and interview by telephone.

3.1.2. Other sources of data

- In international scientific publications, pregnancy and the postpartum period appear to be an especially vulnerable time, even a true risk factor for violence. A study was carried out in three public maternity hospitals in the Paris Region and the Champagne-Ardennes Region, with the objective of estimating the frequency of marital violence during the year following the birth of a child. The study included 706 women who were interviewed at the time of delivery, then answered a postal questionnaire 5 to 12 months following the birth. An analysis of the data shows that 4.1% of women studied experienced violence by their spouses after the delivery [36].
- The issue of “gender, violence and health” does not benefit from statistics gathered by the Ministry of the Interior and the Ministry of Justice. Each year, they publish statistics on offences recorded by the police and the gendarmerie. Up to now, these statistics give no information on the victims. The “Statistical Annals of the Justice Department” do not deal with the issue of gender and are unaware of the link between recorded violence and health. This state of affairs is not surprising since the Annals are above all an accounting instrument developed by and for an administration that wants to know, from one year to the next, the changes taking place in the volume and the nature of its own activities.
- The National Federation of Solidarity among Women is financially supported by the offices of the General Directorate of Health to process information from its network of 54 associations on their activities in the area of the health of women who are victims of marital violence, and to draw lessons from calls to the hotline “Marital violence – women information service”, in particular as concerns visits to physicians and medical certificates. A summary document is produced each year. As an illustration, out of 109,757 calls received in 2003, 11,382 were about marital violence. This confirms, if there was a need, the typology of violent partners (husband, ex-husband, common-law husband...). Since 1999, there have been over 10,000 calls each year about marital violence. For around half the women, the telephone constitutes the first step; the others tried recourse to physicians or the police, or both.

3.2. *Violence towards homosexual, bisexual or trans-sexual persons.*

The lack of data also greatly concerns violence towards homosexual persons, and very few acts of this type are recorded. Indeed, associations of homosexuals and hotlines are the only places where complaints are lodged. People don't make complaints because they would be obliged to reveal their homosexuality. In addition, the attitude of the police towards them is often one of mockery. As to the identity of the aggressors, the majority of cases are not violence within a couple, but violence by persons seeking to “punish” a behaviour not considered to be in conformity with their own representations of the family and sexuality. As concerns the identity of the victims, there is no information broken down by sex, violence towards women homosexuals being even more concealed than that towards gay men. In

addition, recognition of homophobic crimes is just beginning, with several towns in the provinces having recently been affected.

3.3. Violence towards prostitutes

In France, the study on the living conditions of prostitutes in Paris, carried out in 1995 by Serre and collaborators [37], shows that 41% of prostitutes had suffered aggression during the 5 months preceding the study. Transvestites were the most vulnerable. The client was the main aggressor (58%). The motives of aggression, when they were reported, were theft, rape, hatred of prostitutes and homophobia. Welzer-Lang and Shutz-Samson, in their work on prostitutes around Lyon [44], identified the most common reported motives of violence experienced: homosexuality, prostitution, skin colour, drug dependency and transsexualism.

4. Violence towards vulnerable persons (the elderly and persons with disability)

4.1. Data from the general population

In the absence of a national study such as the one done on violence towards women, or of a system of information on a national level, there are no tools presently available to measure abuse towards the elderly or persons with disability, whether they are cared for in social or medico-social institutions or are living in their homes. It is therefore not possible to give a reliable estimate of the size of the problem at the present time. Available estimates are extrapolated from summaries of foreign studies and vary from 5% for people older than 65 years, or about 600,000 persons for France, to 15% for those older than 75 years, or 680,000 persons. Other studies, in Norway and Sweden, suggest that 2% to 5% of the elderly are badly treated in their homes and by their families. In Canada, 4% of the elderly said they were mistreated by their family or by home care personnel (1992 telephone survey). In the USA, between 4% and 10% of persons over 65 years of age were said to be victims of abuse in studies in 1981 and 1984. Figures are thus variable from one country to another and do not reflect the same realities. They are the result of complaints that are neither verified nor evaluated, which prevents having a clear picture of the situation.

The study entitled “Life events and health” (coordinated by INSEE and carried out in metropolitan France) and which began in late 2005, aims to provide information on incidents of violence and to improve knowledge on the potential relationships between violence and health. The study should therefore compensate for some of the lack of information noted above. Unfortunately, some gaps will remain due to the methodology used. Thus, persons over 75 years of age will not be included and only persons living in an ordinary household will be in the study, to the exclusion of persons cared for in health, social or medico-social facilities.

4.2. Violence in institutions

The circular of April 30, 2002 strengthens procedures for reporting occurrences of abuse in social and medico-social facilities to the central administration. Reports of abuse in these facilities are sent by the decentralized services to the Directorate General for Social Action, which presents a yearly report. In any case, the figures are partial and reflect incompletely the reality in the field. From 2001 to today, the DGAS was informed of over a thousand situations of abuse, more precisely, 1147 incidents (all sectors grouped, households and facilities).

The number of French Departments that report abuse is constantly increasing: from half the Departments in 2001 to 90% in 2004. Forty-one percent of reports relate to facilities caring for minors (principally children with disability), 24% of facilities caring for adults with disability or who are marginalized, 31% of facilities caring for the elderly, and 4% of reports concern facilities whose category was not specified. Facilities caring for adults or minors with disability account for 55% of all reports made. Sixty-three percent of reported sexual violence concerns minors with disability. Sexual violence in facilities caring for children with disabilities accounts for 57.7% of all violence occurring there.

4.3. Data from networks of associations

4.3.1. The Alma hotline network

The number of calls received by the ALMA-France network (hotline to report maltreatment of the elderly) increased from 2118 in 1997 to 7366 in 2002. A total of 12,400 telephone calls were received between 1995 and 2002 at the Departmental branches of ALMA. Among the 1593 calls related to situations of abuse identified by ALMA in 2002, 71% concerned persons living at home. An analysis of the cases of violence in care facilities shows that the abuse described is of various kinds: physical, financial, psychological, and medical abuse, or neglect. Victims are for the most part elderly women (75%) who are widows, living in the family, with property or resources at their disposal, and often dependent on a third party for activities of daily living. The average age of victims is 79 years.

It should be emphasized that the data declared by the networks, essentially ALMA based on user complaints, concern only half the Departments in France.

4.3.2. The francilien (Paris region) association for the proper treatment of the elderly and/or persons with disability (AFBAH)

Following its founding in January 2004, the call Centre, located in the Paul Brousse hospital and provided by the Assistance Publique – Paris Hospitals, received 2086 calls between January 21 and September 30, 2004. These calls corresponded to: 1) reports of abuse; 2) requests for information (simple requests for documentation, helpful addresses, diverse questions...); 3) redirected reports of abuse: these are calls concerning reports coming from outside the Paris region and which are directed to an ALMA branch or a social service when there is no existing Departmental branch; 4) statements (facts related by callers who refuse to have their declaration transferred to Departmental structures, and who for the most part wish to remain anonymous and often give minimal information, which sometimes does not even allow the place where the abuse took place to be identified).

There is a clear predominance of cases described as situations of passive neglect (lack of help, forgetting, indifference) and of psychological abuse. Very often the so-called “main” abuse is associated with other forms of abuse whose relative importance it is the responsibility of the Departmental team to describe. Psychological abuse is present in more than one-third of cases. Associated physical abuse usually corresponds to occasional acting out by the presumed offender.

4.3.3. The SNATEM

Reports prepared by the National Hotline for Abused Children (SNATEM) do not make it possible to identify calls concerning children with disabilities.

As we can see, the above figures don't tell us very much because of their heterogeneity and the fact there are obvious under-declarations and flaws in identifying and recording cases. A qualitative study on the perceptions of the elderly concerning maltreatment was recently done by the DREES¹² at the request of the Secretary of State for the Elderly. It was carried out in two populations: a diffuse population of elderly persons over 65 years of age for whom there was no *a priori* knowledge of abuse, and a population who had reported abuse or made a complaint. The study shows that the elderly persons interviewed did not consider themselves victims of abuse. In addition, in spite of increasing numbers of training programs, professionals are not always sensitive to the question and there is globally a lack of sensitisation, of information or even training, and of evaluation of practices. Aside from the denial that surrounds situations of abuse, denial by both the victims and their carers, fear of reprisals causes witnesses and families to remain silent. This is especially true in a context where access to facilities or services is difficult. In addition, there are difficulties related to sharing confidential medical information, a situation which isolates physicians who cannot confide in social workers, persons to whom they would normally disclose information in cases of abuse towards the elderly or persons with disability. All this results in under-reporting. In addition, in the great majority of cases, the persons concerned, whether in facilities or in families, and whether they are private individuals or professionals, have less need to "report" to an administrative or judicial authority as much as they need to ask for guidance and assistance before filing an official report, considered by most to be the last resort. And this type of guidance is of course not recorded in an information system on abuse.

In June 2003, the DGAS set up an information system called "Prevention of risks, inspections, reporting of abuse in social and medico-social facilities" (PRISME)¹³. It should be noted, however, that data is furnished to the PRISME information system by the decentralized facilities of the Ministry of Health (DDASS)¹⁴ and concerns only clients cared for in social and medico-social facilities, with clients from health facilities or those for the elderly or persons with disability being excluded. In addition, in order to supply information to the database, the DDASS depend on information furnished by the facilities, and the methods for transmitting this information by the facilities are not clear and are based on administrative directives.

Furthermore, there is no organized and coherent system of epidemiological data collection concerning household violence, outside the data collection done by the ALMA France network in the Paris region. There is therefore no centralized and uniform procedure, in terms of methodology of data collection, relative to violence or abuse towards the elderly or persons with disability.

5. Mental health, violence and victims

5.1. Violence towards persons with mental disorders

First, in stark contrast to the abundance of literature devoted to violence caused by persons suffering from severe psychiatric disorders, little research has been done on problems of violence undergone by patients or former patients. Moreover, to our knowledge, there have

¹² Direction de la recherche, des études, de l'évaluation et des statistiques (Directorate of research, studies, evaluation and statistics)

¹³ Prévention des risques, inspections, signalements de la maltraitance en établissements sociaux et médico-sociaux.

¹⁴ Direction départementale des affaires sanitaires et sociales (Departmental Directorate of social and health affairs.)

been no studies done in France equivalent to international studies on this question. Without claiming exhaustivity, we can however draw attention to some knowledge about the subject.

A cross-sectional study of homeless persons with mental disorders showed that 44% of subjects had experienced violence in the two months preceding the interview. This could include theft, physical attack, sexual aggression, or else burglary or threats with a weapon [23]. Similarly, another study shows that, among patients suffering from schizophrenia and living in therapeutic housing, 34% had been victims of theft or aggression during the preceding year [25]. A British study was done on violent victimisation of patients with psychosis living outside the hospital setting. There were 691 subjects followed by community mental health teams. Sixteen percent said they had been beaten, molested, attacked or been victims of another violent crime during the preceding year [42]. The prevalence rate during one year is twice that reported by the general population in Great Britain.

Numerous other studies are detailed in the report by the Commission “Violence and Mental Health”. These studies are on persons with mental disorders living outside care facilities. Violent acts towards patients in the context of the hospital or others services are of a different kind than those committed in ordinary life spaces. Institutional violence is part of socially established relationships, which are at the same time, power relationships. This is “legitimate” violence in the sociological sense of the term, to the extent that the psychiatrist (or the caretaker under his direction) has received a mandate from society to cure or care for persons suffering from mental disorder using methods often perceived as violent. On this subject, data are practically nonexistent, at least in France.

5.2. Violence and psychological trauma

Psychiatric and psychological consequences of violence have been fairly well documented for the past 20 years. It is even a recurrent theme in constant progression in the international literature beginning in the early 1980s, since there were more than 1500 publications referenced on the subject in 2004, against only 22 in 1980. With an increase 70 times higher than in the reference year of 1980, the growth rate for these articles clearly exceeds that for articles in other psychiatric categories. For example, the rate of articles on schizophrenia only doubled during the same 20-year interval (going, it is true, from 1130 in 1980 to 2426 in 2000), and yet at the same time, scientific interest in schizophrenia was profoundly renewed. This remarkable growth arises from two factors. First, there is unquestionably an increasing awareness on the part of the scientific community, which henceforth takes into consideration the impact of violence (from ordinary violence to human and natural catastrophes) on public health as well as on mental health. Secondly, it is also proof of greater visibility in the social arena of the psychological consequences of violence and trauma, which is accompanied by the strong desire of professionals, health authorities, the media, and of course the victims themselves to destigmatize psychological disorders that follow violent events.

A very detailed discussion of the notions of “psychological trauma”, of “psychological suffering” and of “Post Traumatic Stress Disorder” (PTSD) is to be found in the report by the Commission “Violence and Mental Health”, but it is not accompanied by figures on prevalence, precisely because it is quite difficult to measure the frequency of a phenomenon whose contours are not yet clear. PTSD, for which there are American statistical data and whose definition is clearer than in the case of psychological trauma and psychological suffering, is described next in Part B on the health consequences of violence.

B. The health consequences of violence

Existing data relate to both the pathological consequences observed among victims, whether they are somatic or psychological, as well as the impact on the use of the health system.

1. The health impact of violence towards women

According to WHO, women victims of violence lose between 1 and 4 years of life in good health and marital violence is responsible for a doubling in total yearly health expenses among women.

The impact of violence on women's health, especially marital violence, has recently been well documented in France, in particular in the context of reports by the working group presided over by Professor Henrion, and by the High Committee for Public Health. This violence leads to three main types of medical disorders: traumatic, gynaecological (vaginal infections or haemorrhages, chronic pelvic pain, loss of libido, STD/HIV and unwanted pregnancies due to the refusal to use prophylactics, or to certain imposed sexual practices) and psychological disorders. These negative effects on the health of women victims bring about not only short-term but also long-term consequences, even long after the violence has ceased. Being subjected to chronic violence causes feelings of fear, anxiety, of shame and guilt, which tend to isolate the victim.

These women consult the health system for traumatic lesions, particularly in the context of pregnancy monitoring, or in the emergency department. General practitioners, emergency medicine personnel, and all gynaecologists and/or obstetricians often find themselves on the front line. But in the majority of cases, while the diagnosis of deliberate violence is made, it is not the physician who notices the violence, but the woman herself who first mentions the problem. And often, whether because of lack of training or because of prejudice, the physician remains indifferent to this medical disorder. The most frequent response of the medical profession to reports of problems felt by women is the prescription of psychotropic medicine. While women talk little about the violence with which they are confronted, physicians question them about it even less often.

The impact of physical or sexual violence on the mental health of women was measured in the context of the ENVEFF study. It is significant, since 17% of women who have experienced one violent episode, and 25% of those who have experienced several violent episodes, have high levels of post-traumatic stress. This is characterized by nightmares, anxiety disorders and panic attacks. The rate among women who have not experienced this type of event is 5%. Suicide rates also appear to be closely linked to the experience of violence. From 0.2% among women not having declared violence, the rate increases to 3% for women having declared one violent episode and to 5% for women declaring several episodes.

The level of utilization of medicine is also different. Women who are victims of violence use psychotropic medicines more often and more regularly: 30% when they report several violent episodes, 20% when they report one and 10% when they don't report violence. Finally, the probability of having been hospitalised is significantly greater when women have been assaulted.

The hotline "Marital violence – women information service" gathers information on the consequences of violence, expressed in terms of physical and psychological health. The most

frequently cited items are: trembling or permanent tenseness (61%), fear (65%), depression, a loss of self-esteem or “psychological damage” (70%). Other effects reported include voluntary contamination by HIV (6 cases in 2002, 3 cases in 2003) or miscarriages (37 cases in 2002, 42 in 2003), or even disabilities (67 cases in 2002, 70 cases in 2003).

Finally, it should be noted that marital violence affects children as well. Children of assaulted mothers have a 6 to 15 times greater risk of being abused themselves.

2. Female genital mutilation

WHO [45] defines female genital mutilation as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.” and distinguishes four principal types:

Type I - excision of the prepuce, with or without excision of part or all of the clitoris;

Type II - excision of the clitoris with partial or total excision of the labia minora;

Type III - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);

Type IV - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue.

In France, it is estimated there are about 60,000 women or young girls mutilated or threatened with mutilation. The populations affected by this violence are concentrated in several regions or Departments: the Paris region (Île de France), Upper Normandy, the Rhone, the Bouches du Rhône and the Nord.

The health consequences are more or less severe depending on the procedures used (the type of mutilation). These mutilations can cause intense pain, haemorrhages which may be fatal, urinary retention or local infections. Over the long term, they may cause injury to adjacent organs or cheloid scarring, vulvar abscesses, and local or general infections, which may bring about women’s sterility. Infibulations, resulting in retention of menstrual blood, cause pain and infections. From the perspective of sexual sensitivity, some African women are now openly describing the consequences of these mutilations. These practices also cause obstetrical complications, in the case of infibulation as in that of excision (more and larger perineal tears). There are certainly mental repercussions but these are poorly understood.

3. Homophobia and suicide

Vulnerability to suicide is related to lowered self-esteem. A report submitted to the DGS has a chapter on homophobia. It is based on assessment made by people working in the field and interviewed at random on violence carried out against homosexuals or populations considered to be homosexual. Homophobia appears linked to health problems such as anorexia, auto-mutilations, and drug dependency. As concerns suicide, studying an exclusively adult homosexual population limits the subject. Indeed, 25% of boys treated for suicide attempts evoke their homosexuality for the first time following the attempt. In addition, the summary of several recent studies shows that, while those considered homo, bi or trans-sexual represent 3% of the general population of 12 to 25 year olds, they make up 50% of all boys dying by suicide in that age category [1,11,14,38,41].

4. Psychological trauma

The development of a specific psychiatric disorder is not a systematic response to a traumatic situation, nor even the most frequent, since PTSD is not observed to develop in two thirds of cases. This clearly indicates that the normal response to violence is not necessarily the development of a psychiatric disorder.

PTSD is of course not the only possible disorder following unusual events, where violence occupies a central place. Other manifestations are frequent, such as anxiety, depression, somatisation disorders, decompensation of a former pathology, alcoholism or 'partial PTSD' (a new term for a series of symptoms similar to PTSD, but of insufficient intensity or number to allow the diagnosis of frank PTSD, and whose evolution is also chronic [15,30]).

But there are some individuals who are vulnerable to PTSD. A certain number of risk factors have been found among subjects liable to develop PTSD [8,18]:

- A past history of multiple traumas (especially during early childhood) is the most significant risk factor, along with the precariousness of social relationships (low social capital) [5,17].
- Gender is the second most important factor since the prevalence of PTSD is twice as high among women, although there is presently no satisfactory explanation for this [6].
- Low educational attainment and limited intellectual capacity are also risk factors [27].
- Belonging to an ethnic minority is also a risk factor, but which is in fact linked to the preceding ones (essentially a past history of multiple trauma and low educational attainment) since it generally affects poor ethnic minorities and does not appear to be related to any cultural particularities [7].
- A "genetic" factor has also been suggested to explain family transmission of the risk [18].
- Finally, serious psychiatric antecedents have also been incriminated. In this respect, studies find a significantly higher rate of PTSD among mental patients than in the general population when they are exposed to similar or even less severe acts of violence [28,29].

These different risk factors show that characteristics of individuals most vulnerable to PTSD replicate very closely characteristics of people living in situations of insecurity.

People vulnerable to other non-specific pathologies are those persons already suffering from psychiatric disorders or from chronic and severe somatic disorders, or who have a past history of traumas, and who are either going to decompensate, or who will see their pathology worsen following a traumatic event. The risk of co-morbidity with PTSD is significant since the characteristics of these two populations overlap so much [33].

III. DATA ON THOSE RESPONSIBLE FOR VIOLENCE

A brief look at figures from the Direction of Public Safety on arrests in France shows an increase in the number of persons considered at a given time as potentially responsible for offences (violent or not). This figure has been almost constantly increasing for the past 30 years, going from 200,000 to over 400,000. The 300,000 mark was passed in 1983, and then the rate of increase slowed down, and it took 15 years to reach 400,000. But since 1996, there

has been a period of very rapid increase, which brought the curve to 450,000 in 1998. A decrease, just as rapid, which continued until 2001, has now been reversed, since there were 472,000 people held for questioning in France in 2004.

During the period that arrests increased by a factor of 2 (2.37 to be exact), extension of detentions increased by a factor of 4, and since 1984, when the 50,000 mark was passed, the curve has never fallen below that point. The sudden increase seen in the curve as a whole since 2001 may be seen here as well, and recent modifications in legislation, which have increased the number of measures leading to prolonged detention, make it doubtful there will be a reduction in this trend. In the face of the massive increase in the number of arrests, it is therefore difficult to say what is due to an increase in offences, and what is due to more strict enforcement of guidelines relating to these offences.

The commissions were not able to bring together well-organized data on perpetrators of violence, but three fairly well-documented aspects are presented here: psychiatric patients as perpetrators of violence; perpetrators of violence within institutions; certain characteristics of perpetrators of violence, whether in the public or the private sphere.

A. Factors related to violence among psychiatric patients who carry out violent acts

People at risk for committing offences are more probably those who suffer from a combination of psychopathological disorders (personality, mood, psychotic disorders, addictive behaviours and psychological trauma, etc.) and from complex social difficulties. Among the latter are family problems (violent and/or neglectful families, abusive, incestuous and dysfunctional families), school difficulties and failure, occupational problems (unemployment), relationship and affective problems (relationships broken off, isolation), and any situation exposing the person to marginalization or exclusion. The similarity of factors predictive of “criminal” violence and those predictive of psychiatric disorders (which may manifest themselves by violent acts), leads to confusion between criminal and psychiatric violence [4].

Among strictly psychiatric risk factors, we find primarily:

- The psychiatric disorders themselves;
- Psychotic states with hallucinations, delusions of persecution, mystical states;
- Mood disorders;
- Alcoholism and drug abuse;
- Personality disorders of various generally mixed types, including antisocial, paranoid, borderline, passive-aggressive, schizoid, and dependent types, and avoidance behaviours.
- Exposure to psychologically traumatic events and their effects, in terms of anxiety and depressive disorders, addictive behaviours, etc.

At the present time, it is impossible to predict violent behaviour by a specific individual. Factors relating to the environment, particular events, to chance and to confounding factors are both too numerous and too diverse, and their associations too variable and singular, to be able to give a stable value and reliability to predictions about the occurrence of a violent act.

The importance of maintaining continuity of care in order to prevent a recurrence among psychiatric patients already having committed a violent crime is illustrated by a recent study,

the only longitudinal study of its type carried out in France. It was carried out on 97 patients committed to a Unit for Difficult Patients (UMD, Unité pour Malades difficiles) and presenting “a major immediate or potential danger, incompatible with keeping them in an ordinary hospitalisation unit” [26]. The study analysed the clinical and social evolution of 80 men and 17 women four years after admission to the UMD. Following hospitalisation, the state of most of the patients was considered to be “improved”, and no cases were identified which had deteriorated. During a period of 4 years, the condition of only 8 men and 1 woman necessitated rehospitalisation in a UMD, but 30% of all subjects in the study are described as presently dangerous, although not needing hospitalisation in a UMD. This study suggests that the therapeutic time spent in a UMD and good psychiatric follow-up were beneficial for patients considered as dangerous. Studies of this kind, with psychiatric populations considered at risk for dangerous or violent acts, should be repeated, using larger samples and with better epidemiological and clinical tools, and longer follow-up.

B. Perpetrators of violence in social and medico-social institutions

Data from the DGAS, based on the analysis of reports of abuse occurring in social and medico-social establishments, indicate that:

- The person implicated varies according to the type of establishment: in facilities for minors with disabilities, 6 times out of 10 (61%), the person implicated is a resident of the facility, the staff is implicated in 20% of cases, and the family in 13% of cases. In facilities for adults with disabilities: residents are implicated in 40% of reports, the staff in 47% and the family in 13% of reported abuse. In facilities for the elderly, the staff is implicated 75% of the time, co-residents 13% and the family 9% of the time.
- For all violence taken together, staff is implicated in 40% of reported abuse, residents in 35%, the family in 9%, and third parties (anonymous persons from outside the facility) in 17% of cases.
- Residents are implicated in 53% of reported cases of sexual violence.

C. Some characteristics of perpetrators of violence

Whether it is violence against women or child abuse, the first characteristic is *proximity*; the offender is a close relative, friend or associate.

One of the main lessons from the ENVEFF study is that women are more often at risk in their homes than in a public place. Indeed, it is in the intimacy of the family that most violence of all kinds is perpetrated, and the most frequent gender-related violence is marital violence. In a retrospective study carried out at the Forensic institute of Paris for the period 1990 to 1996 and which found 441 homicides of women, the perpetrator of the homicide was the husband in 31% of cases, and a partner in 20%. In only 15% of cases was the assailant unknown to the woman [24].

The *age* of perpetrators of certain kinds of violence is decreasing. Thus, according to the National Observatory on Delinquency (OND), as concerns sexual violence, one out of four offenders is a minor, and this figure is on the increase. Between 1996 and 2003, the number of minors implicated in rape of under 18-year olds increased by 67%, which represents an increase of around 500 individuals. The phenomenon is even more evident for sexual harassment and other sexual aggressions towards minors: in 7 years, the number of minors implicated went from 900 to 2000, which corresponds to an increase of 117%.

Perpetrators of violence have often been victims themselves as several studies have emphasized. For example, in a British study, it was shown that 12% of former victims of abuse became perpetrators of acts of paedophilia or sexual abuse [35].

IV. RISK FACTORS FOR VIOLENCE

A. In social and medico-social facilities

When perpetrators of violence are care workers, particularly in the case of the elderly, it has been shown that solitude and distress when faced with care responsibilities play an important role. Physical abuse is usually related to acting out on the part of the presumed perpetrator, in situations of long term mental distress and physical and psychological exhaustion.

B. Work-related violence

1. Occupational settings conducive to violence

Violence among colleagues is seen in occupational settings that are strongly influenced by references to manliness. This is the case in the building and construction industries and, more generally, in situations where the job exposes workers to significant physical risks. Violence is also practiced against young workers or employees during their apprenticeship period. In these cases, more senior employees generally practice violence on the newer ones. Practices of violent hazing are similar to this phenomenon. They persist in some professional settings, in particular in the Army, but also in certain engineering and technical schools. The Army however is not a “regular work place” and is one of the milieus in which violence is sometimes used as an instrument of power by the upper ranks.

The deliberate exposure of certain employees to major health risks is a form of violence that is often found among sub-contractors, especially in the case of serial sub-contracting where, at the end of the line, one finds undeclared workers. Sub-contracting can be a way of providing workers for dangerous jobs which expose them to accidents or to poisoning and occupational illnesses. Thus, even in companies operating within the law, job insecurity is a condition that can be used to force employees to expose themselves to dangerous situations. The most frequent reported cases concern immigrant workers with insecure work status who are exposed, without their knowledge, to jobs whose procedures disregard work safety and laws. We find here the justification, in the chapter on the definition of violence, for the addition of the complementary formulation of the main definition of violence: “violence is also deliberately behaving towards someone or making him or her behave so that they unknowingly take risks endangering their own life or that of others”. When it is a question of exposure to toxic substances or to radiation, it may happen that, once their job is completed, victims are unaware they may have contracted a progressive illness which may prove to be lethal.

2. Unemployment and violence among youths

The harmful effects of unemployment on health fall not only upon the dismissed workers themselves. The condition into which they are put, the psychopathological downward spiral in which they are often caught, has heavy consequences on the psychological development of their children. The social disapproval, of which the parents are victims, destroys the meaning of all the effort made by the parents to have a job, to earn a living and to meet the needs of the

family. Thus, violence in secondary schools originates among children whose parents are chronically out of work. But it disrupts the whole school which, by trying to adapt to new objectives based on the prevention of violence (organized activities more than teaching) ends up polarizing students around questions of discipline, order, authority and external forms of savoir-vivre and showing respect. Violence by youths belonging to social strata severely affected by chronic unemployment is not directed just at adults, and this is an important point. Violence is directed as well at other students, those who, by following the rules laid down by the schools, unknowingly cast doubt on the coherence of the collective strategies of defence used by the former.

3. The organisation of work as a source of violence

Changes in work relationships, especially in the past few years, contribute to a growing risk of violence. An analysis suggests that conditions favouring violence are related to choices and decisions concerning the organization of work. Thus, factors such as reductions in the work force, reorganization, flexibility, the evaluation of results and overall quality, and clandestine employment have major effects on the occurrence of violence at work. They all operate through the same mechanism: by breaking down solidarity, by disorganizing cooperation, and by undermining the foundations necessary for living together, which are the principal means for preventing violence in the work place. This is a problem which goes far beyond the scope of this public health report, but which is obviously conceptually important for those whose job it is to formulate recommendations for the Plan “Violence and Health”. The issue is treated in detail in Part 3 of the report by the Commission “Violence, work, employment, health”.

C. Risk factors identified in the general population

Echoing the preceding reflections on employment and unemployment, many writings deal with the socio-economic situation in which violence develops. The simplistic association between poverty and violence is soon replaced by a more complex analysis that includes the effects of cultural and affective factors.

Thus, the ENVEFF study recognizes the negative role of unemployment in marital violence (male job instability having an important impact on this type of violence, which is frequently found among those lacking unemployment benefits [16%]), but the study also notes that marital violence is to be found in all social classes in practically the same proportions. The question then arises as to the meaning of the association between the loss of a job for a man and violent assaults on his wife, and on the relative importance of the loss of financial means as opposed to the loss of an image of virility and authority linked to employment and to power conferred by a salary (a phenomenon which can affect all social classes). To these factors can be added the role of religious beliefs found in the ENVEFF study results, and which condition certain representations of the family, in particular the importance of male authority. (It is in this context that one can understand the fact that, among Muslim women, situations of repeated violence are multiplied by a factor of 3. However, this result does not take into consideration the educational level nor the socio-economic status of the woman or her aggressor, but globally, in the study as a whole, these two variables are not linked to the frequency of violence). Women, in calls to the hotline «Marital violence – women information service», also mention the authoritarian nature of the partner, as well as jealousy.

Research carried out in France on the occurrence of violence following pregnancy [36] showed that age, education, the fact of having worked during the pregnancy, and parity were not associated with the frequency of marital violence. On the other hand, women living in an unstable couple relationship were more numerous in declaring violence than women in a couple relationship before and after the birth.

In data from studies on victimisation carried out by the CESDIP and the INSEE, one is struck by the important part represented by middle and upper social classes among persons who mention verbal violence, especially in the last years of the study.

As concerns alcoholism, it is found in all areas and by all studies as a major risk factor for violence. Accordingly, in the ENVEFF study, the spouse's alcoholism, mentioned by 2% of women interviewed, multiplied overall situations of violence by a factor of five and severe violence by a factor of ten. Of course, the reasons why men drink are central to explaining the mechanisms behind violence and need to be explored, as do the prevalence of alcoholism and the link alcohol-violence as a function of social class.

In the area of violence and children, whether it is child abuse or violent acts committed by children or adolescents, one finds the same debate concerning socio-economic factors and affective factors. As seen in paragraph II. A. 2. above, white collar mothers are implicated, as are those from other social classes, in extreme violence (leading to death) towards very young children. French studies have noted the link between poverty and child abuse, but there are numerous confounding factors, including problems in prenatal care, prematurity and low birth weight. Prematurity, which may lead to both neonatal hospitalisations and to modifying the image of the expected child, is one of the known risk factors for a lack of early attachment between the mother and infant. Numerous English-language studies have identified risk factors for disorders in parent-child relationships. Many of them are affective in nature:

- violence towards the mother
- single mothers
- unwanted pregnancies
- pregnancies carried to term because of missed opportunities for voluntary termination of pregnancy (leading to resentment towards the child)
- first-time parenthood
- postpartum depression
- prematurity
- early hospitalisations of the child
- social isolation, and especially exclusion brought on by housing difficulties
- psychiatric illness of one of the parents
- addictive behaviours.

Other work has identified fairly precisely certain perinatal variables that affect the occurrence of violence towards the child:

- mothers under 20 years of age
- dropping out of school (or the low educational level of parents)
- the consumption of alcohol during pregnancy
- postpartum depression
- violence towards the mother

- behavioural and parenting problems
- the announcement of foetal anomalies during pregnancy
- coercive behaviour of the mother towards the child under 5 months of age.

Added to these affective factors are most certainly educational factors and lack of knowledge (see the role of new parent), reinforced by social isolation (single mothers without a supportive family), and the demands of a baby. It is thus probable that, rather than poverty, social and emotional isolation, as well as affective immaturity are involved.

Isolation obviously plays a first line role in triggering violence towards vulnerable and often difficult persons, by the people caring for them (mothers or maternal aids; care workers for the elderly in institutions or at home).

V. IN SUMMARY: WHAT DO WE KNOW ABOUT VIOLENCE IN RELATION TO HEALTH? WHAT KNOWLEDGE IS AVAILABLE?

Reliable scientific data are lacking in this area. Those that are available are scattered, heterogeneous, from multiple sources often difficult to access, and collected using various methods. On some subjects, in particular for everything relating to the theme “violence and mental health”, **the paucity of French data leads to the analysis of the international scientific literature, which is primarily in English. Thus, when looking at a social phenomenon such as violence, this fact can lead to risky extrapolations concerning both an understanding of causes and the political and cultural context, and the kinds of public health solutions that can be envisaged.**

Large areas of the problem of “violence and health” remain poorly studied (such as the problem of violence towards people with mental disorders or the health impact of violence in the work place), **or not even investigated** (the total absence of economic studies on the cost of abuse). In addition, **available data have undisputed problems of reliability**, mainly of two kinds: problems of exhaustivity in sampling and biases of various kinds making interpretation of figures difficult and their representativeness doubtful.

Exhaustivity of data collection on acts of violence is clearly not achieved by any of the present registers:

- ***At the present time, it is not possible to know the actual number of homicides from statistics on mortality*** because forensic data are frequently not sent to the CépiDc.
- ***Underdeclaration by the victims themselves*** is doubtless an important problem: self censoring by women victims of marital violence or by victims of homophobic acts, denial by elderly persons who don’t consider themselves to be victims....To this must be added under-declaration by witnesses who fear reprisals.
- ***Failure to recognize problems***, in particular the health consequences of abuse, is a widespread phenomenon, especially in the medical sector (lack of recognition of the problem by general practitioners, gynaecologists, obstetricians, paediatricians, emergency personnel...; near total absence of any contribution by hospitals to statistics on abuse) but also in the school and work settings.... In addition, the identification of problems will always be incomplete when it depends on a system whose coverage is insufficient (the example of the ALMA hotline which covers only half the Departments).

- Even if acts of violence are suspected, *the under-investigation of suspect cases is not rare* (see for example the frequency of the concluding diagnosis of SUID [Sudden unexplained infant death] in the presence of a suspicious infant death when no autopsy necessary for establishing this diagnosis has been performed).
- *The under-reporting of identified cases* is frequent in spite of the legal obligation (for example, in the case of child abuse, it is stipulated in article 2. III, line 6 of the Child Protection Law of July 10, 1989, that one must “arrange for the collection of information relative to abused minors”). This under-reporting is found among numerous professionals, especially physicians, and particularly, general practitioners who are isolated and confronted with the problem of medical confidentiality (not applicable, however, in the case of child abuse). This is also the case with the teaching profession, and the subjectivity found in reporting of abuse by schools reflects individual and collective differences in thresholds of leniency.

From a quantitative perspective, to this deficiency in exhaustivity must be added the problem of **double counting** (within the same organization: separate reporting by school physicians and social workers, without verification of overlapping within the same school; within the same system: multiple reporting of abuse for the same case originating in anonymous calls to assistance hotlines; between institutions: duplications of data provided by the National Education Department and that provided by the ASE, for example).

Finally, **understanding all the health consequences of violence will remain impossible as long as the tools for data collection, categorization and classification used by the Justice Department persist in not taking into account the characteristics of the victims**, the perpetrators being the only ones identifiable by the computer programs used by the courts.

The biases are of at least three kinds:

- *Related to the institutions*, which gather data according to their own logic and for evaluating their own activities.
- *Related to possible changes in the focus of interest*: thus, in the case of children, statistics, which claim that sexual violence has become more frequent than physical violence, may only reflect a growing interest for the former, which, because of this, becomes the object of better screening and reporting.
- *Related to presuppositions concerning the socio-economic living conditions of perpetrators and victims*. Most of the systems responsible for recording data on abuse (the ASE for example) have little access to the more favoured social classes.

This underlines the importance of population-based studies (like the ENVEFF or the studies on victimisation by the CESDIP and the INSEE, which showed that violence affected all social classes) and the necessity now for carrying out large population-based epidemiological studies.

In spite of all the problems of reliability that have been presented above, the analysis and the comparison of existing data enable us to identify a certain number of results which appear scientifically solid.

The magnitude of the problem appears important, if we can judge by some of the figures reported above:

- The correction of official figures for homicides leads to estimating their number at around 1200 per year, and the study by Unit 750 of INSERM on suspicious deaths of

infants leads to the assumption that official figures on homicides for that age group could be multiplied by a factor of 10.

- According to data from the ODAS and the National Education Department, each year, 1 school-age child out of 1000 is considered to be abused.
- The ENVEFF study showed that during the 12 months prior to the study, 4% of women interviewed had experienced at least one act of physical aggression, 10% had experienced marital violence and 11% said they had experienced at least one sexual assault during their lifetime.

Is violence increasing in France at the present time? This is not a certainty, if we believe data on mortality and physical violence from the CESDIP/INSEE studies. On the other hand, the same study shows that verbal violence is increasing (or tolerance for this violence is decreasing?). What is certain is that the visibility of violence is becoming greater and greater, because: identification and reporting is improving (thus, the number of Departments which report abuse in social and medico-social facilities to the DGAS is constantly increasing, from half the Departments in 2001 to 90% in 2004); psychological trauma is being taken into consideration more and more often (sometimes doubtless in error); police and judicial procedures are becoming more and more strict and are accompanied by an increase in recorded violence (note the changes in arrest rates); finally, the media play an important role in this visibility.

The place where violence occurs is very often in private: children abused by their parents, marital violence, elderly persons abused in their home in 71% of cases dealt with by ALMA.

The health consequences are enormous. As an example:

- In the ENVEFF study, 17% of women having experienced a violent episode and 25% of these who experienced several violent episodes have *an elevated level of posttraumatic stress*. The rate of *suicide*, which is 0.2% among women who have not reported violence, increases to 3% for women who have reported one episode of violence and to 5% for women who have reported several episodes.
- These women have *a high level of use of health resources*: they are hospitalised more often and use psychotropic drugs more often and more regularly: 30% when they report several episodes of violence, 20% when they report one of them, and 10% when they don't report any.
- *Homophobia is associated with higher suicide rates*: whereas 3% of the 12-25 year old general male population are homo, bi or trans-sexual persons, they make up 50% of all youths dying from suicide in the same age category.
- *Female genital mutilations* are responsible for veritable anatomical impairments and serious consequences in terms of fertility.

The perpetrators:

- These are *often close relatives*: husband or common-law husband of the assaulted women; carers of the elderly in institutions.
- *They have often been victims of violence themselves* during their lifetime.
- *More and more minors are involved*, in particular as perpetrators of sexual assault.
- Dangerous psychiatric patients see their *dangerousness decrease when they have proper follow-up of care*.

Risk factors:

- *Alcoholism and unemployment* are unanimously recognized risk factors.

- The analysis of results becomes more complicated concerning *socio-economic level*, and *affective factors* doubtless play a dominant role. Biases mentioned above would be considerably reduced by prospective studies using cohorts.
- **Organizational factors**, in particular the organization of work, can create conditions for violence.
- **Social isolation** is one of the principal explanatory keys of violence.

All these results should be accompanied by reliable quantitative data obtained within the framework of good quality information systems, and confirmed by in-depth studies dealing with certain aspects, in particular everything relating to the causes and the mechanisms of violence.

CHAPTER 2: VIOLENCE AND HEALTH: PRESENT MEASURES

I. LEGISLATIVE AND REGULATORY MEASURES

Legislative and regulatory texts on preserving the well-being of persons, on the prevention of or the response to violence, have their origins in founding texts of the Rights of Man, among which the most important is the Declaration of the rights of man and the citizen, of August 26, 1789: “*Men are born and remain free and equal in rights.*” The Universal Declaration of the Rights of Man adopted by the General Assembly of the United Nations in resolution 217 A (III) of December 10, 1948 states in articles 3, 4, and 5 that “*Everyone has the right to life, liberty and security of person*”, that “*No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms*”, and that “*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment*”. The preamble of the French Constitution of 1958 adopted the main principles described in earlier texts.

In France, these founding principles are detailed within various codes: the civil code, the penal code, the work code, the code of the family and of social action, and the public health code, to cite the principal ones. These measures are both numerous and diffuse.

Legislative and regulatory measures taken in response to violent situations cover primarily the question of interpersonal violence. Debate has rarely broadened to include problems of violence towards self or to institutional, legislative or “state” violence. In fact, the French system primarily takes into consideration person to person violence and abuse and is just beginning to consider institutional abuse that may be the result of a weakening of organizations, or even the failure of a complex service delivery system.

It is beyond the scope of this report to present an exhaustive and detailed description of the legislative and regulatory texts on the prevention of and the response to violence, but rather to indicate the principal measures in 5 areas:

- child protection;
- gender violence;
- violence towards the elderly and disabled;
- professional confidentiality, the duty to report violence and give assistance;
- the rights of those using the health system.

A. Measures relative to child protection

Child protection policy, for the abused child in particular, has been considerably strengthened, as has inter-ministerial coordination, by the law of July 10, 1989, unanimously voted by Parliament, and the object of modifications presently under discussion in Parliament (January, 2007).

Within the context of decentralization, this law appreciably changes conditions surrounding the activity of prevention by shifting new and important responsibilities to the presidents of the General Councils (at the level of the Departments) and to those services under their authority, in liaison with State representatives in the Departments.

To those responsibilities already assigned to the Departmental services for assistance to children, described in the code of the family and social assistance, the 1989 law adds two more which directly and explicitly concern “abuse” of children: carry out prevention activities regarding abuse of minors; organize the collection of information relative to the abuse of minors and participate in their protection.

A free telephone hotline, the SNATEM¹⁵, was created at the national level by the State, the Departments and public and private institutions, which together constitute a group in the public interest to address the question of child abuse.

The law provides for the submission of a case before the judicial authorities without delay: *“when a minor is the victim of abuse or when abuse is suspected, and when it is impossible to evaluate the situation or when the family obviously refuses to accept the intervention of the child protective services, the president of the General Council immediately notifies the judicial authorities and, if need be, provides information on actions already carried out with the minor and the family involved”*.

The reform presently under consideration proposes to:

- strengthen prevention activities (from pregnancy on);
- organize reporting procedures, by clarifying the relationship between social protection and legal protection;
- diversify modes of care.

The International Convention on the rights of the Child, adopted by the United Nations November 20, 1989, came in to force in France on September 6, 1990.

In addition, several laws, decrees and intra and inter ministerial circulars give rulings on:

- sexual offences perpetrated against children;
- the prostitution of minors;
- the prevention and suppression of sectarian movements;
- the role of the school in the prevention, detection and reporting of abuse;
- the lifting of rules of professional confidentiality for physicians, in suspected cases of child abuse.

¹⁵ Service National d'Accueil Téléphonique pour l'Enfance Maltraitée ; National Telephone Hotline for Abused Children

Finally, the law of March 6, 2000 creates the post of defender of children. This defender is a State authority, whose role is to defend and promote the rights of children. The person is named for a period of six years by ministerial decree. The defender may be petitioned by the minor child involved, his or her legal representative or by associations recognized as working in the public interest.

B. Violence and gender

Legislative texts concern primarily sexual assault, equal rights between men and women, and homophobia.

As concerns equal rights between men and women, it should be noted that a circular from the department on the Rights of Women, dated October 12, 1989, in which the public authorities affirm their resolve to tackle marital violence, launched the first national information campaign and the creation of action committees against violence towards women, at the level of the Departments.

Rape between spouses was recognized in September 1990.

The law of November 2, 1992 defined sexually-related abuse of authority in the work place.

The law on social modernization of January 17, 2002 undertakes the fight against mental harassment in work relationships.

Instructions relative to setting up the global plan for combating violence towards women, “Ten measures for the autonomy of women”, 2005-2007, were presented to the council of ministers November 24, 2004.

As concerns homophobia, law n°2003-239 of March 18, 2003, article 47 and law n° 2004-204 of March 9, 2004 provide for the following:

“In cases envisaged by the law, penalties incurred for a crime or misdemeanour are increased when the offence is committed because of the sexual orientation of the victim.”

C. Violence towards the elderly and disabled

Acts of maltreatment of elderly or disabled persons are considered within the context of the particular vulnerability mentioned in the penal code, which specifies that this vulnerability is “due to age, an illness or a physical or mental deficiency”. As concerns attacks on individuals, penal law has included vulnerable individuals – and more generally the victim – in the description of the facts of the case, by making age, economic status, and physical or mental status of the latter an aggravating circumstance, or a distinctive aspect of the offence.

Considering the principle of legal responsibility of institutions, the health or social facility which cares for vulnerable individuals may become responsible for acts perpetrated within the facility, as can its legal representative if he or she knew of acts perpetrated within the facility without taking appropriate measures.

D. Professional confidentiality, the duty to report violence and give assistance

The penal code states that the article, which penalizes the divulgation of professional confidentiality, is not applicable in cases where the law imposes or authorizes the revealing of confidential information. In addition, it is not applicable:

- To those persons informing judicial, medical or administrative authorities of “privations or physical abuse, including when this concerns sexual assault” of which they have knowledge and which were inflicted on a minor 15 years old or younger or on a person unable to protect themselves because of their age, their physical or mental state.
- To the physician, who, with the consent of the victim (or without consent if the victim is a minor), informs the public prosecutor of physical abuse observed during the carrying out of his or her professional duties and which leads to the presumption that acts of violence of diverse nature had been committed.

Physical abuse inflicted on a minor 15 years old or younger can henceforth be revealed not only to medical and administrative authorities, but also directly to judicial authorities. The judicial authorities may therefore be informed during a trial by an individual under obligation of professional confidentiality and appearing as a witness.

The penal code firmly sanctions the simple fact of knowing the existence of acts of maltreatment and of hiding them, of not revealing them or even of abstaining from giving aid to the victim prior to as well as following the commission of such acts. For example, knowing about the neglect of persons within an institution is liable to make the witness of this neglect legally responsible.

E. The rights of those using the health system

French law makes provisions for the protection of patients and the representation of clients, by decision-making bodies (the Departmental Committee for psychiatric hospitalizations, [CHDP], in particular). The law of June 27, 1990 affirmed the rights of patients, hospitalised because of their mental disorders.

The law of March 4, 2002 concerning the rights of patients and the quality of the health system, and the law of August 9, 2004 concerning public health policy, encourage the active participation of consumer representatives and reinforce the official framework for their activities.

II. ACTIVITIES, MEASURES, FACILITIES AND PROGRAMS

It is important here to distinguish between general programs, which may include a dimension for “prevention or management of violence” (for example, occupational medicine and the CHSCTs¹⁶) and specific measures and programs devoted to the problem of violence and its relationship to health. It is the latter that we will examine here.

The work of the commissions has revealed a profusion of experiments at various levels and on different scales and it was not possible for them to make an exhaustive inventory of them all.

¹⁶ Comité d'hygiène, de sécurité et des conditions de travail (Committee for Health, Safety and Working Conditions, committees composed of management and staff, in institutions with more than 50 employees)

Therefore, no assessment will be attempted which might give preference to known experiments to the detriment of others, perhaps just as interesting, which the commissions are unaware of due to their composition and the information available to their members. The global assessment, highly complex, is still to be done.

Important and detailed information on the various experiments may be found in the reports of the six commissions and in their annexes. Here, we will describe the measures and programmes specifically concerning violence, at the national level. Our emphasis will be on a description of recent measures by bringing attention to possible gaps and difficulties in implementation.

A. National prevention programmes

1. The national committee against violence towards women

This Committee was created by decree December 21, 2001 and is an expression, at a national level, of the partnership developed locally by Departmental committees for action against violence towards women. Presided over by the Minister of Parity and Equality in Work, this authority brings together representatives from eleven ministries. The main missions of this authority are to organise cooperation of State services with concerned partners for the prevention of violence towards women and for the care and follow-up of women who are victims of violence, of prostitution and sexual exploitation.

November 25, 2004, the global action plan of 2005-2007 for combating violence towards women was announced: “10 measures for women’s autonomy”. This plan followed the acknowledgement that, in spite of efforts already made, France is still behind in finding answers for combating violence towards women.

The Minister of Parity and Equality in Work presented a Charter on Equality to the Prime Minister March 8, 2004. One of its six themes concerns respecting the dignity of individuals and includes a chapter relative to combating violence towards women. Another concerns sexual exploitation and prostitution and another concerns immigrant women. In this way, several actions are advocated for combating marital violence, genital mutilations and exploitation through prostitution and commerce of human beings and for better assisting victims.

2. Work of the national committee for vigilance against maltreatment of the elderly

This committee is placed under the presidency of the Secretary of State for the Elderly, and has developed an action programme (published in March, 2003 and available on line at the ministry’s Internet site¹⁷) that suggests several strategies for preventing violence towards the elderly. Study on the question is continuing and three areas are given preference:

- Training of carers, whether professional care workers or not (medical and paramedical personnel, managers, lay carers). The field targeted is vast: continuing education, initial training, validation of acquired experience.
- Risk management of violence and maltreatment in social and medico-social facilities. Beyond approaches by sector, primarily interested in those risks subject to regulations (fire safety, food safety...), or approaches which favour face to face encounters between perpetrator and victim, the approach here is about promoting an integrated strategy for managing risks which takes into account the totality and the complexity of

¹⁷ <http://www.sante.gouv.fr/>

“accompanied care and housing” activities for vulnerable persons. The approach is especially interested in organisational factors that may lead to violence. It is necessary to prepare operational tools for putting in place a method for managing risks, with emphasis on detecting risks, the upward flow of information and follow-up of incidents.

- Financial violence regarding the elderly. In light of the fact that financial violence regarding the elderly is regularly denounced, it is essential: to have a better understanding of the phenomenon by studying the situation concerning this type of violence in France and the steps already taken, in particular through the project reforming measures for the legal protection of adults; to increase awareness among public and private actors concerning this problem; to suggest tools for increasing awareness and mobilising actors in social institutions (especially: tutelary organisations, banks, insurance companies, capital managers, professional bodies...).

B. Present measures for management and care of victims of violence

1. Medico-Psychological Emergency Units (MPEU)¹⁸

1.1. How they function

Medico-psychological emergencies are dealt with through Medico-Psychological Emergency Units (MPEU), which are structures integrated into the SAMU¹⁹ and set up throughout the country for victims of catastrophes or accidents affecting many people at once. In the field, their immediate task is to give care as soon as possible to people who have gone through a potentially traumatic event and to help them come to terms with this often-tragic experience. In addition, they also have a larger role beside rescue workers and decision-makers in the “psychological management” of the crisis caused by the event. Following this, they care for victims individually, within the framework of more structured consultations enabling intensive care, and may care for groups of professionals such as the rescue teams, who have intervened in especially unusual and traumatic events.

The Medico-Psychological Emergency Units are notified by the physician regulator of the SAMU, but it is the coordinating psychiatrist who decides on the necessity to intervene. The practical details, the guidelines for notification, the procedure for calling volunteer, etc. have been previously worked out according to instructions given at the national level, but adapted in each Department by the psychiatrist in charge. Each action necessitates a specific procedure with operational details adapted to the situation (number of personnel, type of care, duration of the operation). Those cared for can be the direct victims, families and relatives but also those involved in managing a particularly trying operation. The MPEUs may be mobilised in the case of collective catastrophes or accidents with a large number of victims (Red Plan), but also during events involving only a single person but which have a strong collective psychological impact (armed robbery with hostage-taking, violence in the work place, suicide or accidental death in an institution...).

Therapeutic care is done in three ways: immediate care in the field; care immediately following the event or post-immediate care; medium term care.

During the first five years, the number of interventions by MPEU teams continuously increased, and has finally become stable. Working groups from the National Committee have now been able to reflect on the limits and indications for intervening and to better define the

¹⁸ Cellules d’urgence médico-psychologiques (CUMP)

¹⁹ Services d’Aide Médicale Urgente (Emergency medical services)

field of operation for the MPEUs. The government has consequently decided to strengthen the system and (since May, 2003) has made plans for setting up a permanent unit in each region and in each Department of more than one million inhabitants. Thirty cities are thus affected. Public officials also hope to encourage the development of networks of emergency medico-psychological teams and the improvement of their working conditions.

It thus appears important to remember that work by professionals in medico-psychological emergencies is work in psychological treatment, by professionals in psychological trauma care, among persons with psychological injuries, that is, victims who have been confronted with a traumatic event. These emergency interventions are followed up by specialised consultations in psychological trauma available in some public hospitals. Psychosocial support and accompaniment of victims is another complimentary aspect of care, but should not be confused with care provided at present by the MPEUs. This type of care is usually ensured immediately by teams of first-aid workers (the Red Cross, civil disaster units...) whose activities may stretch over several days or even weeks depending on the type of event.

Finally, victim associations, most of which are federated within the National Institute for Aid to Victims and for Mediation (INAVEM), participate in the care of affected persons during the period following the catastrophe.

1.2. Boundaries of the theoretical framework and obstacles to proper functioning

The question of boundaries arises because indications for intervention are difficult to define, depend upon a psychiatric approach, necessitate a certain “culture” on the part of the SAMU and cannot follow a model in the strict sense because there is no objective set of criteria to adhere to. The parameter for starting the process that appears to be the most pertinent, although difficult to grasp, is doubtless the emotional impact of the event on the teams of first aid workers and their colleagues, which indicates that the event in question is out of the ordinary. This criterion appears henceforth more important than the collective nature of the event.

Whereas, strictly speaking, the situations in which the MPEUs intervene are those events where there are numerous victims in one place and at one time, in reality there are certain situations that bring about excessive demands on the MPEUs, outside the bounds of a catastrophe. The medico-psychological emergency is sometimes used as a means to heal social, institutional and financial distress.

There is a high degree of inequality in care of victims. For example, there are not enough consulting facilities for children and adolescents, and some patients cannot always be cared for in psychological trauma consultations. In this case, there remains the possibility of care in the private sector, which requires financial resources that are often nonexistent, and thus the question of social inequality in care is raised.

Finally, the functioning of the MPEUs is limited by problems of resources. Budgets intended for compensating volunteers have still not been allocated. Similarly, since the position of psychologist within the SAMU currently does not exist, an important part of their work is not being paid for (especially overtime, which is often necessary).

1.3. The necessity of evaluation

In the case of care immediately following an event, psychological “debriefing” or PIPI (Post-Immediate Psychotherapeutic Intervention) often targets the helpers (fire brigades, emergency

medical personnel, institutional care staff...) and is indicated for members of groups (bank personnel, adolescents from the same class...). This entails using a specific technique, which is difficult to carry out, which should be reserved for trained specialists and which is currently the object of some controversy. Debriefing essentially aims to reduce mental stress experienced during the critical event, the idea being to prevent negative psychological consequences. It has gradually become a genuine care technique routinely proposed to subjects exposed to a traumatic event, even on an individual basis. Reviews of the literature, especially the most recent, tend to show the highly controversial nature of psychological debriefing, done in a single session after exposure to a potentially traumatic event. In addition, it should be noted that in most of the studies, the term “debriefing” groups several very different practices under the same heading, going from immediate intervention in the field to delayed interventions, several days after the traumatic event.

2. Clinical Forensic Medicine Units

In a certain number of public health facilities, Clinical Forensic Medicine Units (Unités Médico-Judicaire, or UMJ²⁰) have been set up. These instruments are at the disposition of the courts, and were created by a circular from the Direction of Hospitals (DH) dated February 27, 1998. There are approximately 150 of these units throughout France (Overseas Departments included).

These units, whose financing comes from the Ministry of Justice, carry out forensic medical acts necessary in judicial enquiries, on orders from a judge or a judicial police officer. The purpose of these units is therefore to receive, examine and take needed forensic medicine samples on all victims sent on orders from judicial authorities, in order to certify assault and battery and to decide on the extent of total incapacity to work (TIW).

They also carry out clinical forensic medicine examinations of persons under arrest.

Their mission consists solely in fulfilling the needs of the justice system and is not a health care mission, as defined by the code of public health in article 6111-2. At present, forensic medical acts carried out under orders from judicial authorities are paid for by the Ministry of Justice on the basis of rates fixed by the penal code and the cost of running these units cannot be paid for by public health insurance.

3. Referral centres in hospitals for receiving victims of sexual violence

These were created by the DGS/DH circular dated May 27, 1997 concerning regional facilities for receiving and caring for victims of sexual violence. The DGS/DH circular dated July 13, 2000 extends the coverage of the first-mentioned circular to include minors who are victims of any form of abuse.

These circulars coordinate emergency care for these victims in hospitals, whether this is given through emergency services, in gynaecology/obstetrics services, or in paediatric services. They define the objectives of emergency reception of victims of sexual assault, as well as modes of care and follow-up.

In addition, they specify the need to identify regional reference centres which can fulfil the same missions as any hospital centre and which can also be responsible for building

²⁰ Unités Médico-Judicaire (UMJ)

relationships with and counselling the health professionals who make use of them and for ensuring the training and education of private health professionals and institutions involved in caring for victims.

In 26 regions (metropolitan France and the Overseas Departments), nearly 50 regional centres have been identified. These are located in several different departments, in particular forensic medicine, obstetrics/gynaecology, and paediatrics. At present, no functional evaluation of these centres has been done concerning care of adult victims. Only one study has been carried out, in April 2004, on the reception of minors who were victims of sexual assault. Nineteen reference centres responded and the evaluation noted 358 cases of physical violence, 36 cases of mental cruelty, 942 cases of sexual abuse and 266 cases of serious neglect.

Therefore, it is important to know, on the one hand, whether these facilities are operational in all the regions, and on the other hand, to see if they are in harmony with facilities provided by the General Councils at the Departmental level.

Aside from these specialty services, it is important not to forget that every physician, from the GP to those working in emergency medicine, and including the obstetrician or the paediatrician in a day care nursery, may, in the course of daily work, see victims of violence. This fact underlines the importance of tools for assisting, sensitising, and informing health professionals, such as the Internet site SIVIC on marital violence (<http://www.violences.fr/>), the report “Women victims of marital violence: the role of health professionals” [20], or the guide “The practitioner confronted with sexual violence: the role of health professionals” on the Internet site of the Ministry of Health.

4. Telephone hotline services

The National Telephone Service for Abused Children (SNATEM, also known as “Hello, Abused Children” or, since 1997, “119”) was founded by the Law of July 10, 1989 relative to child protection and the prevention of maltreatment to minors. The SNATEM is now associated with the ONED (National observatory for children in danger).

The national network ALMA²¹ is a non-profit organisation created in 1994 whose objective is to receive complaints, but it has also developed training and awareness activities.

The National Institute for Aid to Victims and for Mediation (INAVEM) is a privileged partner of the Justice ministry and a member of the National Council for Aid to Victims (CNAV). Since 1986 in France, it has regrouped the various services assisting victims. Its principal objectives are, on the one hand, to define and evaluate activities providing assistance to victims, and on the other hand, to coordinate and support associations within the network. In 2003, more than 150 associations assisting victims were members of the INAVEM. These associations are present throughout the country and their services are free. They work with all authorities receiving victims (courts, lawyers, hospitals, police, specialised organisations...). The objectives of the associations in the INAVEM network are to receive victims and inform them and their relatives of their rights, to accompany them in the steps to be taken and to give them psychological support during all stages of penal procedures.

²¹ ALlo MAitraitance des personnes âgées; hotline for reporting maltreatment of the elderly

5. *Insufficiently developed practices*

5.1. *The evaluation of victims*

As noted by the Commission “Violence and Mental health”, the identification of specific psychiatric disorders such as PTSD has allowed victims of violence the right to seek redress, even in the absence of physical sequelae, the imputability of the former to violence having now been demonstrated by psychiatry. But it should be noted that solutions to issues linked to evaluation of victims and modalities of redress (financial, symbolic and, today, psychological) are far from constituting a consensus.

As concerns victims, evaluation remains poorly structured. The evaluation of credibility, which is based on an often-superficial psychiatric examination, is highly criticized by different professionals. Judges rarely find solid facts that reassure them as to the veracity of the plaintiffs’ statements. As for psychiatrists, they denounce, practically as a group, the impossibility of the task and wonder about the relevance of their knowledge for answering such questions.

The evaluation of damages is already more advanced, since it is based on years of experience in the field of insurance. But despite this, the question remains of knowing whether the extent of compensation should be enlarged beyond that of just PTSD, to include non specific disorders and the decompensation of prior pathologies, and whether this should be given a regulatory framework within a new set of rights for victims of violence. If this is the case, there must be a redefinition of the field of post-traumatic disorders based on specific research results, which are currently lacking.

5.2. *Long-term follow-up of care strategies used for victims*

This issue is particularly important in the case of children reported as being abused and registered with Child Protective Services. The long-term outcome is rarely known, which prevents any critical analysis of initial decisions made (placement; maintenance in the family, according to what conditions...). This absence of long-term evaluation is all the more detrimental because in France, the decision generally is made more on the basis of the dogma that “the family is naturally good”, than on criteria which have been scientifically evaluated.

C. *Managing violent offenders*

The law of June 17, 1998, relative to the prevention and suppression of sexual offences as well as the protection of minors, took effect in March 2001. It established novel socio-judicial follow-up that includes the possibility of a treatment order being given. The principal behind the latter arises from the hypothesis that the origin of the offence is to be found within a specific psychopathological context, which may be treated by specialised care in order to avoid a recurrence. This may appear straightforward; however, applying this law is difficult because of the need to coordinate professionals from distinctly different fields – health, justice, social work – and by the clinical complexity of cases.

Indeed, on a clinical level, similar aggressive acts may be the consequence of different disorders. In addition, an order to treat may not be given when the offender does not consent to it. Finally, it must be accepted that results may be modest.

The law provides for the intervention of three types of health professionals: the expert psychiatrist, the treating physician (member of a multidisciplinary psychiatric team) and the

coordinating physician (the intermediary between medicine and the courts). These three physicians face a recent clinical issue that is not well understood by professional psychiatrists, both because of a lack of knowledge about it and because of its extent. Namely, psychiatrists are unevenly distributed throughout the country and their numbers are diminishing over time, which has consequences for the management of convicted persons and for the implementation of the law.

Starting in the 1990s, the Ministry of Health thus decided to develop a health policy based on the development of clinical knowledge and the training of professionals, as well as on a consideration of what is being provided by health services. Thus, a review of clinical and therapeutic methods in the Western world was carried out in 1995. Research was undertaken at the national and international levels. A policy for training and informing health professionals was put in place, in particular following the first consensus development conference on clinical practice in the management of sex offenders, organised by the French Federation of Psychiatrists in 2001.

Difficulties in implementing the law also come from the difference in cultures between the health and justice settings, which is an obstacle in coordinating professionals and which can be used by sex offenders to their advantage. The ministries involved have therefore set up a series of working sessions, in particular on the themes of legal expertise and court-ordered treatments, minor offenders, prevention issues, and professional guidelines and training.

D. The European Setting

The DAPHNE initiative, launched in 1997, is one of the activities started by the European Commission in light of the growing concern caused by violence in Europe towards children, adolescents and women. Given its success, in 2000, the European Commission approved and launched a quadrennial DAPHNE programme (2000-2003), which is being followed by the DAPHNE II programme, henceforth a five-year programme (2004-2008) with a budget of 50 million Euros for the period.

Its specific objectives are:

- Prevent violence towards children, adolescents and women; protect and support those who are victims; treat and rehabilitate the offenders;
- Promote close cooperation between NGOs and other organisations active in combating violence and contribute to sensitising public opinion about violence, at the European level.

After seven years of existence, the DAPHNE programme encourages setting up specific projects (multidisciplinary networks, improving knowledge, the promotion of “zero tolerance”, the prevention of violence) and also encourages concerned organisations to take into account and make use of existing results.

CHAPTER 3: RECOMMENDATIONS AND CONCLUSIONS

The detailed recommendations of the six commissions may be found on the Internet site of the Ministry of Health (in French). They cover the following topics: research, implementation of legislative and regulatory measures, actions to be taken and the diffusion of knowledge. There

are approximately 150 recommendations and in what follows, we will present only summaries by area: research, legislation and regulatory issues, actions, information and training. Priority has been given to general problems and the types of strategies to be used, rather than following the specific themes of each commission. The recommendations benefited from contributions made by participants in the National Seminar organised by the DGS, April 13, 2005, where discussions encouraged input by professionals who are working in the field, in the different regions. The recommendations chapter of the summary report aimed especially at giving the Director General of Health as many concrete elements as possible that might be of assistance in preparing the Plan. To this end, a very detailed and highly organised list of these recommendations was prepared. Finally, following the recommendations chapter, the general conclusions attempt to identify the main lines and major strategic directions for the system and for health professionals.

I. IMPROVING KNOWLEDGE AND RESEARCH ON VIOLENCE AND ITS IMPACT ON HEALTH

As we have seen, the size and the characteristics of the impact of violence on health are poorly understood in France, and it appears that the means dedicated to research on this subject are notoriously insufficient. The development of research in this area is all the more justified that, *“in the absence of scientific knowledge, the only answer to violence is increased security and repression”* (Report of the Commission “Violence, work, employment, health”).

It is in recognition of this fact that the six commissions insisted on the necessity of developing research. There are numerous preliminary questions to be answered: What data are lacking? To be gathered using what methods? By what teams, using what means? Should the development of existing resources be envisaged? Research on a subject such as violence and its health consequences is, by nature, multidisciplinary and should associate the allied approaches of clinical medical research (in psychiatry, occupational medicine, paediatrics, geriatrics...), epidemiology, psychology, sociology, economics.... Indeed, a quantitative approach to the phenomenon should be followed up by an analysis, using qualitative methods, of the circumstances surrounding the occurrence of violence, “risk factors” or “situations of risk” and the characteristics of the groups most vulnerable to violence as well as of those perpetrating violent acts. Finally, it is important to remember that, prior to research seeking to produce new knowledge, it is imperative to make an assessment of what already exists, and this review of scientific knowledge about the impact of violence on health should be done on a national as well as an international level. The recommendations of the 6 commissions relative to research are summarised in the following box.

RESEARCH: WHAT ARE THE MAIN DIRECTIONS?

Faced with the present lack of reliable data on the size and nature of the health consequences of violence, and, more generally, on the relationships existing between violence and health, improving epidemiological knowledge of the phenomenon is essential (as recommended in the report to the HCSP). In addition, it is necessary to go beyond an interest just in figures (their exhaustivity, their representativeness, their reliability) and use qualitative methods, found both in the humanities and the social sciences as well as in the clinic setting, to tackle the mechanisms behind the occurrence of violence at both individual and group levels (with an interest in particular for organisational problems which are sources of violence within institutions).

Only solid scientific knowledge about the problem can support actions and programmes, furnish a pertinent basis for training the professionals who will be involved, and provide information for the public. Indeed, good quantitative and qualitative data are indispensable for enabling: the definition of priorities for action (in terms of the kinds of violence targeted, the populations affected or at risk, situations of risk, the types of health problems responsible for or generated by violence); the choice of appropriate strategies for action; the development of indicators for evaluation; the creation of specific competencies.

Two avenues should be pursued, following a rigorous chronology: research, and the development of an information and observation system. A first stage is that of the review of existing data, a second is the development of the research, and a third is the setting up of “routine” information systems. The latter should not be developed without a minimum of consensus on definitions, categories to observe, sources to explore, data gathering tools to construct, and on guidelines ensuring consistency. For accomplishing this, the research results are the best guide.

The review of existing research can be carried out according to methods similar to collective expertise. However, it should not be forgotten that, as soon as one becomes interested in social phenomena such as violence, studies carried out in other countries may of course be enlightening, but are located in other socio-political and cultural contexts, and thus prudence is necessary when attempting extrapolation of results. Assessing what exists should also include a critical analysis of the reliability of the data and of the comparability of sources (each institution creates a body of data according to its own logic and which is intimately connected to its own activities), as well as the identification of methods used for correcting data.

Selection of priority themes for collective expertise can be put forward, in collaboration with appropriate researchers and institutions (principally INSERM). The relationship between violence and the media is certainly one of these themes, considering the near absence of data on the subject in France, and the lack of agreement surrounding results produced at the international level. However, such an expertise should be done mainly on the methodological aspects that would enable research to be carried out on this theme in France (early thinking on the subject is briefly described in the report by the Commission “Violence and mental health”).

What kind of research is pertinent to the problem “Violence and health”?

- **This research is by nature multidisciplinary.** It is thus necessary to: strengthen, or develop through training, the necessary skills; constitute teams bringing together all the pertinent disciplines for each project; manage the research projects using multidisciplinary scientific steering committees.

- **Results combining quantitative data with data from interviews have a particularly high credibility** and may constitute a solid basis from which to develop policies that take into account the various points of view.

- **Some methods should be developed and given preference: the creation of cohorts, and especially birth cohorts** (the only way of linking problems of violence to risk factors without the usual biases found in retrospective studies); **the association of studies in institutions with population-based studies, using complementary methods; the complementary use of large existing studies or the repeating of studies on the theme of**

violence, or the introduction of this theme into new studies (studies on the perinatal period, health studies by INSEE, “life events and health” by DREES, CSF/INSERM, ENVEFF); **field research using techniques of observation** (enabling the detection of unreported violence).

- **Priority themes must be identified: 1) when knowledge is practically non-existent or the problem is poorly defined** (psychological suffering, in particular that of the offenders); violence towards people suffering from mental disorders; the long-term consequences of violence; its cost; the relative role of affective and socio-economic factors in certain types of violence, especially towards children, the elderly, and people with disabilities; the financial maltreatment of the elderly; the demands on performance in the work place, pushed to the extreme...); **2) when the social cost is significant, with violence creating veritable social disintegration over the long term** (child abuse; violence linked to unemployment); **3) when nearly the entire population under consideration** (for example, pregnant women, school children) **can be reached by public health measures which may result from the research.**

- **For a given theme, all sources with a potential for making a contribution should be explored and certain major sources, presently producing few data, should become an object of research. This is the case with the health system, which is necessarily used by numerous victims of violence, and which contributes little to an understanding of the problem.**

- **Organisational factors leading to violence are to be examined (how does institutional functioning lead to violence, or protect against it?).**

The French research community is presently not really prepared to deal with these kinds of developments and questions. **Decisive policies are needed in order to carry out a research programme on the theme “Violence and Health” which is truly equal to the challenge in terms of health and social functioning that this problem represents. They need to:**

- **Develop the research setting through: training; the creation of multidisciplinary functional units, which include clinical research; the development of disciplines such as psychiatric epidemiology (in INSERM in particular).**

- **Develop research grants, within a framework of cooperation between the Ministry of Health and the National Research Agency, and in cooperation with European initiatives.**

- **Set up a scientific steering committee (with representatives from the major Public Scientific and Technical Institutions (EPST) and to which the members of the 6 commissions that prepared the plan can contribute.**

II. IMPLEMENTATION OF EXISTING LEGISLATIVE AND REGULATORY MEASURES

It was clear from the commissions’ work that the legislative framework for combating violence and its health implications exists in France and that, on the whole, it is satisfactory and sufficient as concerns the upholding of the fundamental rights of persons confronted with violence. This includes certain vulnerable populations as well as victims of violence. For the time being, the implementation of existing legislative and regulatory texts is preferable, *a priori*, to the preparation of new laws. The interventions proposed in the box below concern knowledge about the legislative and regulatory framework, information for those professionals involved, methods for monitoring and the conditions necessary for enforcing the law. The recommendations proposed by the commissions cover this entire large field.

**IMPLEMENTING EXISTING LEGISLATIVE AND REGULATORY MEASURES:
WHAT ARE THE CHIEF OBJECTIVES?**

Not enforcing the law is violence done towards the weakest. And yet the legislative and regulatory framework, which enables combating violence towards persons deemed vulnerable, exists in France, and it is satisfactory. What's more, introducing specific legislation relative to the protection of vulnerable persons runs the not inconsiderable risk of stigmatising persons who are already viewed negatively.

In fact, the law is there and, quite often, it is not enforced because the texts are disregarded due to the discouraging nature of their numbers on the one hand, their complexity on the other hand, and finally because of their technical and often laborious style. They must therefore be disseminated but in a manner in which they can be understood. Simple recommendations (simple in spirit, but doubtless more complicated in their application) can thus be suggested:

- **Bring together all the legislative and regulatory texts** concerning the upholding of the fundamental rights of people faced with violence, and the rights of certain vulnerable persons and victims (regardless of the status of these persons and the places where violence may occur).
- **Find out about similar texts at the European level; do a comparative study of them.**
- **Create a series of non-technical tools for explaining these texts**, tools which are adapted to each context, type of population, institution....
- **Disseminate the texts along with these tools**, for example, through the organisation of training seminars for the personnel concerned.
- **Monitor the extent to which the rights of persons are protected in health, social and medico-social facilities, businesses, educational institutions... (all the kinds of institutions potentially involved)**, and this in addition to monitoring the adherence to norms (safety, working conditions).

These recommendations presuppose **the setting up of a working group bringing together jurists and community and health professionals.**

There should be reflection on support to be given to witnesses of violence and to those close to victims, particularly when they are minors.

Finally, it is important to **clarify anything having to do with regulations for reporting violence and professional confidentiality and to begin a discussion on the ethics of reporting violence and respecting the law, without always having to follow the most complicated procedures.**

III. INITIATIVES TO BE TAKEN: PREVENT AND DETECT VIOLENCE, IDENTIFY AND MANAGE ITS CONSEQUENCES

There are many recommendations in terms of initiatives to be taken proposed by the six commissions and they are difficult to categorise. Grouping together initiatives aimed at causes and others concerning the consequences of violence, they belong to different registers (from the field of social issues and the field of health), and they follow different logical approaches. The first logic is an approach by type of intervention, such as prevention and management. In fact, in many cases the proposed strategy takes into account all possible dimensions in terms of action, from prevention of the occurrence of violence to the management of its consequences, and including its detection, screening for its health consequences and secondary prevention of repeat offences. An approach in relation to the actors working in prevention and treatment and their modes of functioning is also to be found in the proposed recommendations. There is also a strategy of approach in terms of the population: the general population, “specific” populations with particular vulnerability (pregnant women, sex workers, those seeking work...), and populations defined according to the place where violence occurs (businesses, prisons, health facilities, schools). It should be noted that schools have a particular status since, for the age range under consideration, the school population is included within the general population. The distinction between treatment of causes and treatment of consequences does not appear very helpful, to the extent that the conditions of perpetrator and that of victim are not clear-cut, with the perpetrators often in need of and even asking for care. All the commissions underlined this fact. An approach by sector, clearly separating the care of victims and the management of perpetrators, runs the risk of *“reproducing the point of view of institutions and thus missing its objective. For example, it is taken for granted to consider a victim of violence as a person with care needs, whereas the perpetrator of violence will not be considered from the same angle, even if he has the same needs”*. (“Violence and Mental Health” Commission). These perspectives have an essentially social and institutional basis which can prove to be counterproductive to the global approach undertaken here and that is why it has appeared particularly appropriate to follow the Commission “Violence and Mental Health” in its search for a *“common frame of reference, a central feature of which is the taking into account of individuals and recognising them as persons with needs”*, with need being considered as *“a principle cutting across different treatment recommendations”*.

Finally, it is not possible to suggest recommendations for action without bearing in mind that violence is largely dependent on the social and political environment. Thus, in the arena of work and employment, *“the prevention of violence cannot depend exclusively on health personnel nor be obscured by the presence of an [unemployment] insurance coverage. The prevention of social violence depends first of all on employment policy. The prevention of violence in the workplace and of social violence depend on work policy in the strict sense of the term, and by continued attention to the organisation of work.... A health policy concerning the prevention of violence and its pathogenic effects cannot ignore work and employment policies”* (Commission “Violence, Work, Employment”). Recommendations presented within the framework of a report destined to be the introduction to a “health” plan should not tackle this topic in a detailed manner, but it seemed important to underline the organisational aspects of violence prevention and the role that health professionals can play in the institutional environment.

The summary presented below is therefore the product of a compromise aimed essentially at ensuring readability for actors in the field of health and social issues.

THE INITIATIVES TO BE TAKEN: WHAT ARE THE MAIN OBJECTIVES?

The proposed initiatives simultaneously concern prevention, detection, reporting and care. They are directed towards victims, perpetrators and witnesses of violence and involve many professionals from different disciplines.

A review needs to be done of actions already carried out in France and those which have been evaluated and found valid should be encouraged (as, for example, the “Réseau Gaspar” for assistance to teachers faced with violence).

The detection and reporting (of the risk of abuse and of abuse itself) should be improved by:

- **The drafting of good practice guidelines, especially through consensus development conferences.**
- **The clarification of the rules concerning professional confidentiality, regardless of the type of violence involved.**
- **The expansion and increasing professionalism of telephone hotlines as well as the improvement of follow-up to calls.**
- **The obligatory reporting of “marker pathologies” highly indicative of violence (subdural haematomas in children for example).**

The care of victims should mobilise the entire health system, from the hospital to the general practitioner, and make the best use of specific facilities. Thus, it is necessary to:

- **Ensure post-immediate care in clinical forensic medicine units, and inform victims about resources for psychological and social support and legal counselling.**
- **Coordinate rules determining the length of incapacity to work following experienced violence (Incapacité totale de travail or ITT).**
- **Improve reception services and telephone assistance.**
- **Allow the Medico-Psychological Emergency Units (MPEU) to function according to the recommendations of the “Psychiatry and Mental Health” Plan.**
- **Critically evaluate the concept of psychological trauma and the practice of systematic psychological debriefing.**

As concerns the perpetrators of violence, it is necessary to:

- **Recognise their care needs and take into account the perpetrator-victim relationship.**
- **Make wider use of protective measures before judgement of cases, in particular, the physical distancing of the perpetrator of violence.**
- **Maintain the primary function of the MPEU to be a facility of last resort.**

Witnesses of violent acts should be protected and supported (the creation of “local ethics committees”, access to telephone hotline services).

The role of existing measures and structures should be reactivated and strengthened (for prevention and for care) and be supplemented by needed innovations:

- **Strengthen the role of CHSCTs (Committees for Health, Safety and Working Conditions), of health education committees, of the Clinical Forensic Medicine Units, of the abuse referral centres in hospitals, of the CLIC (Local Centres for Information and Coordination, especially for the retired and elderly)....**

- Create and develop resources (in facilities and personnel) when needed: develop **day and residential facilities for pregnant women in difficult situations**; increase the number of **psychologists in maternity wards**; strengthen teams in perinatal networks in terms of psychologists and psychiatrists; create mobile hospital teams so that hospitals are an intermediary and coordinating centre for the care of victims.

The institutional and organisational aspects of violence prevention merit particular attention. These include **the promotion of strategies for the management and organisation of work within institutions that are able to protect against the occurrence of violence** (informal meeting places, the introduction into social and medico-social facilities of the management of “violence risk”, the dissemination to personnel of legislative texts describing and outlining institutional practices, the development of tools for self-evaluation...).

Certain kinds of **interventions should be given priority, especially those which break down the isolation of professionals and vulnerable individuals and/or which bring them closer together**:

- **Develop working in partnerships and in networks**: inter-ministerial and inter-institutional partnerships bringing health professionals closer to those from other sectors (justice, social work, education, police); multidisciplinary hospital and field teams; networks (local and hospital networks involving general practitioners, perinatal networks, networks created around the theme of violence in 2 or 3 pilot regions...).

- **Create and manage these partnerships and networks according to certain clear-cut requirements**: 1) the enlistment of specialized skills and the clear definition of roles; 2) the choice of these skills for the corresponding level of responsibility, according to each situation; 3) sharing with patients; 4) the involvement of associations; 5) the involvement of local government; 6) the sharing and permanence of financing.

- **Develop outreach strategies, beyond medical, social and medico-social institutions**: home visits that allow prevention through education and early detection, and include follow-up protocols for field workers; community discussion centres; telephone hotlines.

- **Carry out discussions on “the right to intervene”**, which assumes the existence of strategies for intervening in institutions, in closed societies such as sports clubs, and in the private sphere (in families and homes).

The initiatives to be undertaken relate to both large segments of the general population considered as being vulnerable and who can be easily reached by public health measures (pregnant women or newborn children, for example), and to **particular populations with specific risks, who are not numerous but who are subjected to unacceptable violence** (victims of genital mutilation or sex workers, for example).

The most productive initiatives will doubtless be those which bring together a set of coherent measures, such as those concerning the perinatal period.

A certain number of principles should direct the preparation of these initiatives:

- Preventive activities should be carried out as **early** as possible.
- There should be a willingness to reduce disparities in preventive and curative care found in some regions and Departments.
- **Involve first-line professionals**, including general practitioners.

- The development of **bridges to other plans** (see the example of the “Perinatal” Plan, and the contribution of the “Violence and Health” Plan to the preparation of the content about violence, to be used for the prenatal visit during the 4th month of pregnancy). It is important to ensure coherency among these different programmes.

Finally, **there should be systematic evaluations of initiatives begun in the context of the Plan**, and these should be conceived during the development of the initiative itself, and carried out using standardised tools.

From its inception, it is imperative to evaluate each measure carried out within the framework of the Plan “Violence and Health”, by putting in place, for each one of its initiatives, sets of indicators of the process, the impact and the results, and to reserve a budget for this activity in the national and regional plans.

IV. INFORMATION AND TRAINING

None of the activities proposed by the commissions can be designed and begun unless their objectives and methods are based on relevant knowledge: data from research, comparative international data, data produced by surveillance and information systems. It is thus necessary to both compile and validate present research data, but also to ensure the creation of a body of knowledge based on new research (which implies a willingness on the part of institutions to collaborate), to centralise data and to identify a service provider to carry out the tasks to completion. The scientific data should be compiled including sources from an international level, with the particular objective of creating documentary databases.

It is only following the training of competent researchers, and after establishment of the research programmes, that the production of routine data can be envisaged, and the creation of information systems and epidemiological surveillance on the problem of “Violence and Health” can be planned.

The dissemination of information raises a number of questions: what should be disseminated to the general public, and how should this be done? What role should be given to the media? What should be disseminated to professionals, and how should this be done? What training activities should be developed among health professionals; among those in other sectors? What type of training should be given to general practitioners, to specialists, and within what framework?

INFORMATION AND TRAINING: WHAT ARE THE MAIN OBJECTIVES?

Strategies for gathering and disseminating information must be defined, taking into account the objective of its use for activities and training. A solid body of scientific knowledge must be constituted.

Research data should therefore be evaluated and French and international scientific knowledge on the problem of “Violence and Health” should be centralised:

- By the **creation of international documentary databases**, bringing together scientific literature and unpublished reports, perhaps in collaboration with WHO.

- By the **development of temporary “Resource Centres”** concerning the specific themes and **associating documentation and networks of experts** (national and international).

Consideration must be given to the development of information and epidemiological surveillance systems:

- With the objective of **producing routine data enabling: the measurement of the magnitude of the problem** of the relationship between violence and health; **the determination of priority areas** for action; **follow-up over time** (with the evaluation of interventions, in particular); **international comparisons; the possibility of alert systems.**

- Following certain criteria: **1) research on methodology will produce the categories to be taken into consideration, the indicators to be used, ways of ensuring coherency of sources, the tools and methods for data collection; 2) priority topics should be targeted** rather than proposing a general approach; **3) all potentially useful sources should be explored and participate** (including those which are currently contributing very little, such as the health services, and emergency services in particular); **4) data collection within institutions should be supplemented by ad hoc population-based studies; 5) a careful prior examination of costs for such a system must be carried out, the basic idea being that these information systems cannot function if they are not managed and run by a sufficient number of highly qualified persons** (qualified principally in statistics, computers, epidemiology, documentation, sociology).

- By reflecting on **the future service provider, the InVS²² for example.**

A phase to **evaluate feasibility must therefore be envisaged.**

Among routine data, **the importance of mortality data** should be emphasized, and the best possible quality ensured, by the **systematic communication to INSERM of the results of forensic medical autopsies in situations of legal obstacles to burial and of court action.**

The dissemination of information should include professionals, the general public, and the media:

- The general public, like first-line professionals, should have access to **information on: factors of susceptibility and risk situations** (families with elderly members or persons with handicaps whose clinical status is worrying, young parents poorly informed about the unpredictable nature of parenthood...); **on the places and possibilities for reporting abuse and for care and management** (of victims, witnesses, perpetrators).

- Strategies for disseminating information should **associate national campaigns and local initiatives and use validated tools** (booklets, brochures such as “Being a parent, not so easy”, for example).

- All actors who intervene in the local context and bring aid to victims of violence are concerned: **health professionals, social services, police services, justice, associations....**

- **The media can be of benefit primarily for getting beyond the anecdotal and “sensationalist” connotations of violence, as well as for putting an end to some misconceptions** (such as those concerning the relationship between violence and mental illness) **and to the stigmatisation of persons suffering from mental disorders.**

- Finally, **an actual campaign to change opinion should be launched**, with France taking the initiative to organise international non-technical conferences aimed at both professionals and the general public.

²² InVS, Institut national de Veille Sanitaire ; French Institute for Public Health Surveillance

Training on the “health aspects” of violence and on best practice in terms of prevention, detection, reporting and care concern several professions:

- All health professionals are concerned, **medical, paramedical and hospital personnel, general practitioners and public health specialists, and at all levels of training (from basic education to continuing education, both general and specialist training).**

- **Key specialities in the legal and health management of violence** are presently insufficiently developed and **training content should be improved, including the possible creation of new diplomas.** This is particularly the case with **psychiatric expertise and paediatric forensic medicine.**

- Outside the health sector, many other professions are concerned: **justice, police, social services, and educational institutions** (systematic training should be given in all the IUFM²³ on the topics of the detection of abuse, the management of violence in educational institutions and the development of psychosocial competencies in students).

- Personnel at all levels can benefit from training on the way violence develops, especially **directors of health, social and medico-social facilities, and managerial staff in businesses.**

- Some **poorly understood topics** should be the subject of training among various professionals (female genital mutilation, homophobia, financial abuse...).

- Finally, **some aspects should be considered as having priority: 1) training in specific or even highly specialised skills** of those professionals who will be involved in activities included in the Plan “Violence and health”; **2) group training of members of multidisciplinary teams; 3) joint training sessions bringing together professionals from different sectors; 4) the use of participative methods** such as “training by doing”; **5) the training of home visitors,** with consideration given for their qualifications and evaluation; **6) follow-up of these various training programmes through supervision and evaluation of acquired skills** (which raises a basic question that is difficult to answer scientifically: what is the relative part of affect versus skills in the appropriate care of vulnerable individuals?).

V. IN CONCLUSION

Beginning with the definition of the impact of violence on health proposed by WHO, the recommendations of the HCSP²⁴ and the request from the Ministry of Health to participate in the preparation of a five-year Plan “Violence and Health”, the six thematic commissions, whose work makes up the content of this summary report, accomplished an important assignment of reflection and conceptualisation to produce concrete proposals. Each commission created its own conceptual field and engaged in multidisciplinary deliberations. Health professionals found themselves confronted with a culture new to them, where the problem of the impact of violence on health could not be viewed simply from the point of view of medicine, but necessitated creating partnerships with professionals from other fields. It is from this perspective that relatively new questions for France were explored, such as the relationship of violence and gender, or that of institutional violence originating in the mode of organisational structure.

The subject area was vast and, as some exclusion was necessary, links with existing programmes or Plans were identified. Nevertheless, it should be emphasized that very few

²³ IUFM, Instituts Universitaires de Formation des Maîtres (Teacher Training Institutes in Universities)

²⁴ HCSP, Haute Comité de Santé Publique (High Committee on Public Health)

countries have carried out such wide-ranging deliberations on this problem since the publication of the WHO “World Report on Violence and Health” [46].

It was not possible to identify a common definition of violence, with the main discussions being about the boundaries of the “social legitimacy” of violence and on whether it was deliberate or not. The differences between the commissions concern essentially whether or not they took into consideration non-deliberate violence (violence “by omission”, neglect, “violence by default” linked to lack of needed care and to lapses in the “normal” functioning of health services). These differences were related to the logical structure of each domain and permitted each commission to develop coherent and, ultimately, operational definitions of the problems under study. The summary report has attempted to bring together data produced during these weeks of work by looking particularly at relationships existing between “violence” **and** “health”, whether this refers to the impact of violence on health and the health system, or to states of health that lead to violence. The goal was to identify ways that public health professionals can best intervene when confronted with the health aspects of violence.

Several key issues emerge from the analysis of the situation and the development of recommendations carried out by each commission:

1) There is presently insufficient scientific knowledge about the problem of “Violence and health”. Nevertheless, and in spite of numerous problems of reliability, the analysis and comparison of existing data allow us to state that *the size of the problem appears significant and that the medical consequences of violence are enormous in terms of health status and the use of medical services*. However, knowledge about risk factors is limited.

2) From these considerations, *it emerges that, in a way, we are presently between ignorance and urgency. We do not have the scientifically sound knowledge necessary for developing and evaluating relevant interventions nor for training the professionals involved. It is thus necessary to develop research on the one hand, and information systems on the other. At the same time, the size of the problem and the gravity of its consequences in health terms encourage implementing an action plan as soon as possible*. Faced with this dilemma, the commissions were unanimous in proposing the improvement of knowledge, and at the same time, relying on the numerous existing measures and facilities by making them more operational and by improving their reliability, and to subsequently, and over the longer term, continue the development of research, the setting up of information systems and the preparation of new programmes and training based on reliable and valid knowledge.

In order to improve knowledge about the relationships between violence and health, two avenues should be pursued, following a rigorous chronology: *research, and the development of an information and observation system*. A first stage is that of the review of existing data, a second is the development of the research, and a third is the setting up of “routine” information systems. The latter should not be developed without a minimum of consensus on definitions, categories to observe, sources to explore, data gathering tools to construct, and on guidelines ensuring consistency. For this, the research results are the best guide.

3) The development of research plays a fundamental role in understanding difficult problems, often perceived by non-professionals as outside the field of science. Thus, it was the ENVEFF study that literally “exploded” the topic of marital violence in France and removed it from the sensationalist news column by transforming it into a social and health phenomenon.

It should be noted, however, that the French research community is presently not really prepared to deal with these kinds of developments and questions. Decisive policies are therefore needed in order to carry out a research programme on the theme “Violence and Health” which is truly equal to the challenge in terms of health and social functioning that this problem represents.

4) *Consideration needs to be given to the development of information systems and epidemiological surveillance, with the objective of producing routine data* which would allow: measurement of the magnitude of the relationship between violence and health; determination of priority areas for action; follow-up over time (with an evaluation component of interventions in particular); international comparisons; and possibilities for creating alert systems.

5) As concerns initiatives, presently existing structures should be drawn upon: the existing legislative and regulatory framework, existing measures for prevention and care.

6) The place and role of health professionals should be stressed, in a plan to combat violence and its health consequences. Aside from their “de facto” role of receiving victims, often in emergencies, health care professionals (and especially general practitioners, emergency medicine specialists, psychiatrists...) can have several important roles in the plan for combating the health impact of violence. These can include *roles in the production of clinical and epidemiological data, in the training of other professionals, and participation in networks, in particular. Getting them involved also assumes helping them break out of their isolation and giving them support* (by providing clear information on the rules for reporting and dispensation from professional confidentiality; by developing strategies for giving assistance in sometimes difficult situations, particularly by way of private practitioner-hospital networks; by giving good basic and continuing education). The involvement of “first-line” professionals is an essential element in combating violence.

7) New initiatives cannot be envisaged without establishing bridges to other programmes (in particular the Plan “Perinatal Period” and the Plan “Psychiatry and Mental Health”). It is thus important to ensure coherency among these different programmes.

8) The public must be informed and use made of the media. It is necessary to create momentum and raise the awareness of the public, professionals and politicians as to the size and gravity of the health aspects of violence. It will then become possible to obtain the acceptance of more *long-term messages encouraging very early prevention through the education of young children, and this reflects back on the importance of all the measures concerning the perinatal period and support for parenthood.*

Such awareness should necessarily be accompanied by a change of attitude among the professionals who will be preparing and implementing the Plan, then evaluating each measure, at all geographical levels. Consideration should be given to problems of invasion of privacy and to evaluating the work of “lay carers” (including its affective characteristics). *Stereotypes should be re-examined (the seemingly obligatory association between poverty and violence, the confusion between violence and madness), and dogmas questioned, one of the most tenacious and counterproductive doubtless being the “naturally good” nature of the family.*

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