Need and acceptability of a health-justice partnership for women with pelvic floor dysfunction

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Abstract

Background/Purpose: The current paper reports three new studies exploring need and feasibility of a Health Justice Partnership (HJP) for women with Pelvic-floor Dysfunction (PFD) focusing on: levels of legal need of women with PFD; whether women with PFD would confide in healthcare professionals about legal issues; and perspectives on HJP referrals by healthcare professionals.

Methods: Study 1 (*n*=37) examined clinicians views; Study 2 (*n*=104) explored views of women with self-reported PFD; and Study 3 (*n*=109) explored views of women with diagnosed PFD referred for women's health physiotherapy. In all studies participants completed online surveys about their legal experiences and need, as well as their views of an HJP.

Result: In Study 1, clinicians suggested over 25% of patients mentioned legal issues, mainly current and historical abuse, and over 80% found the idea of HJP referral acceptable. Study 3 noted over 80% of PFD patients had legal issues, with over 80% reporting acceptability of an HJP. Clinicians and patients believed an HJP would improve patient health. Similar results with respect to the acceptability of an HJP were observed in Study 2 with a self-reported sample, but with lower percentages noting legal problems.

Conclusions: These studies suggest that offering legal support to patients with PFD who it may be beneficial, and that an HJP referral system would be acceptable, and that legal support was felt to offer potential health benefits.

Keywords: health justice partnership; pelvic-floor dysfunction; legal needs; acceptability of HJP referrals; women's health; healthcare professionals

The current series of related consecutively-conducted studies explored the legal needs of women with Pelvic-floor Dysfunction (PFD), and whether they and their healthcare professionals would find the idea of direct referral to Legal Aid solicitors through a Health Justice Partnership (HJP) acceptable. PFD involves abnormal activity or function of the pelvic floor tissue (Grimes & Stratton, 2020), and affects approximately 25% of adult women (Kenne, Wendt, & Brooks-Jackson, 2022; Milsom & Gyhagen, 2019). PFD can result in faecal and/or urinary incontinence, prolapse, a decrease in sexual function, pain or pressure in the abdomen, and vaginal dryness (Frawley et al., 2021; Jundt et al., 2015; Quaghebeur et al., 2021). In addition, there are significant psychological issues associated with PFD (Osborne & Reed, 2025; Scott et al., 2002; Vardeman et al., 2023) that, together with the physical issues, severely reduce quality-of-life (De La Ossa et al., 2023; Mladenović et al., 2011). Anxiety and depression have an exaggerated presence within this population (Vrijens et al., 2017), and pain is common (Peinado-Molina et al., 2023). These issues, coupled with prolapse, impact mobility and intimacy (Hadizadeh-Talasaz et al., 2010), and relationship breakdowns occur at high rates (Goncalves & Karantzas, 2006; Mirskaya et al., 2023) for this population.

In addition to the above issues, physical, sexual, and intimate-partner, abuse are high for women with PFD (Cichowski et al., 2014; Krause et al., 2019), and this population also reports high levels of adverse childhood experiences, which is common for many chronic conditions (Barnes et al., 2020). Postma et al. (2013) noted that individuals receiving treatment for post-traumatic stress disorder (PTSD) due to adult rape were 2.7 times more likely to experience PFD. Rapkin et al. (1990) nearly 40% of women with PFD reporting pain also reported physical abuse in childhood, and Jamieson and Steege (1997) noted women who experienced abuse were more likely to report pelvic pain.

While all these issues are important, and clearly need support in themselves (Demirci et al., 2023; Osborne & Reed, 2025; Vrijens et al., 2017; Xie et al., 2022), they also reduce treatment engagement (Khan et al., 2013; Woodburn et al., 2021). First-line physical treatment for PFD involves women's health physiotherapy, like pelvic floor muscle training (PFMT), and some psychotherapeutic approaches (Osborne & Reed, 20205). Patient non-engagement with PFMT is often due to the presence of psycho-social issues (De La Ossa et al., 2023; Fall et al., 2010), and non-engagement means that many women need surgery later, when their condition has worsened (Woodburn et al., 2021). Surgical treatment is more invasive and riskier than PFMT, as well as being more financially costly to the NHS (Reed et al., 2022). As a result, developing an understanding of processes facilitating effective treatment will involve addressing psycho-social issues.

The association between experience of abuse and PFD suggests a Health Justice Partnership (HJP) could be of benefit to this patient population. HJPs exist to assist patients with legal issues that can contribute to the causes and consequences of ill health (Berg et al., 2001; Tobin-Tyler & Teitelbaum, 2019). A victim of abuse might present to medical services with a stress-related illness caused by the abuse, which could interfere with their PFD treatment (Khan et al., 2013; Woodburn et al., 2021). Healthcare professionals could, with the patient's consent (and only after this has been obtained), use a referral system to refer the patient to a Legal Aid solicitor for this health-impacting legal issue (Beardon et al., 2021; Fuller et al., 2020). Under such a system, patients would not have to navigate legal process, as referral is directly from medical to legal services, and would be spared the need to repeat their story with each referral, preventing triggering of damaging psychological and physical ill health (Beardon et al., 2021). In an RCT , Moffatt et al. (2006) discovered that welfare rights advice for individuals enhanced their quality-of-life, and Zuckerman (2004) noted that an HJP benefitted paediatric patients, and reduced subsequent hospital visits.

It is currently unknown whether a HJP could be expanded to women's health treatment for PFD. A first step in exploring the potential for using such an HJP is to determine its acceptability to both medical staff, who must make referrals, and patients who have to disclose sensitive legal issues to a healthcare professional. Although several studies note levels of abuse for women with PFD are high (Barnes et al., 2020; Cichowski et al., 2014; Krause et al., 2019; Osborne & Reed, 2025), the range of legal problems they face has not been documented. Moreover, many women who have experienced trauma hesitate to report such issues or may feel uncomfortable confiding in an unfamiliar healthcare professional (Dutton & Painter, 1993). As a result, this current series of new studies seek to explore: (1) the level and type of legal issue that are reported by women with PFD; (2) whether women with PFD would be inclined to confide in their doctors about their current situation; and (3) perspectives on legal aid and solicitor referrals provided by healthcare professionals during appointments.

Study 1

The initial study examined perceptions of clinical staff working in Women's Health regarding patient legal needs, and the potential acceptability of a HJP to the clinical staff. It was thought important to examine this issue first, as, if clinical staff did not feel there was a need or they had reservations about using such a system, this would not be a practical innovation. To this end, staff working in Women's Health, Urogynaecology, and Neonatal departments (consultants, nurses, physiotherapists, midwives, and psychologists) were asked to complete a brief survey concerning their experiences of patients' legal needs raised during appointments.

Method

Participants

All clinicians in the Women's Health, Urogynaecology, and Neonatal departments of a large metropolitan hospital were sent a study link that gave information about the survey and contained a link to get further information. Once they had read the information sheet, and consented to participate, they were taken to an electronic survey. In total 37 clinicians consented to participate. This formed a convenience sample for the initial study. As there was no plan to use analytic (hypothesis testing) statistics beyond descriptive analysis, this was not thought to constitute a challenge to statistical power. Of these 37 participants, 4 did not answer more than 25% of the questions, and so were excluded from the study. Of the remaining 33 participants, there were 10 doctors (consultants/registers), 8 nurse specialists, 8 physiotherapists, 5 midwives, and 2 psychologists. These clinicians reported having a mean of 34 (SD±17.38; range=13-75; median=30) appointments with patients per week. Ethical approval for the study was given by the University's Psychology Ethics Committee, and all participants gave their informed consent in accordance with the Helsinki agreement.

Materials

The survey concerning legal issues and HJP asked 10 questions, and was developed after consultation with stakeholders: solicitors involved in legal aid, clinicians involved in healthcare for PFD, and patients with PFD. An initial version of the survey was sent to one solicitor, two clinicians, and two patients, who were asked to comment on whether the questions reflected their experiences of legal issues for this group. Their comments helped to refine the topics asked about, and the wording of the questions included. These questions concerned: (1) the participant's clinical role; (2) the average number of patients seen during the week; (3) the percentage patients seen with issues that could appropriately be dealt through legal means (none, 1-25%, 26-50%, >50%); (4) the percentage of problems falling in each of 9 legal issues (getting benefits, non-benefit financial issues, eviction or foreclosure, immigration issues, child support, divorce or separation, intimate partner abuse (IPA), historical abuse, non-intimate partner abuse); (5) whether the clinician thought clinical outcomes would be better if any legal needs were met (yes, maybe, no, no idea); (6) whether the clinician would consider referring to a solicitor for these issues (yes, maybe, no); (7) if the clinician was aware of any legal referral pathways (yes, yes but not available here, no); (8) whether the clinical had ever referred to NHS Safeguarding or Social Services (yes, no); (9) whether the clinician had found NHS Safeguarding supporting and helpful (yes, no, don't know); and (10) whether the clinician had found Social Services supporting and helpful (yes, no, don't know). A final question asked for any other comments in a free text box, with scope to link the comment to particular questions, which were used to help understand responses to the questions.

Procedure

An e-mail with an invitation to participate in the study was sent by e-mail to all clinical staff in the Women's Health, Urogynaecology, and Neonatal departments of the hospital. The invitation contained a link to an information sheet and consent form, which, if consented to, allowed access to the survey. The survey could be completed on any digital device. The survey took about 10 min to complete and could not be paused and returned to later. There were contact details provided if the clinician had any questions about the survey (these were not used often). The quantitative data were analysed in terms of percentages of clinicians responding in various manners to each of the survey questions. These responses were illuminated by use of comments derived from the open text comments box.

Results and Discussion

In response to the question concerning the percentage of patients having a problem that would be appropriately dealt with through legal means: 5 (15%) of clinicians selected 'none' ("*My patients in this role have not divulged any non-medical problems that I have felt would need a solicitor.*"); 17 (52%) selected between 1-25%; and 11 (33%) indicated 26-50% of patients. Thus, 28/33 (88%) of clinicians reported that their patients had mentioned legal issues during their appointment.

Figure 1 about here

The mean percentage of patients indicating particular types of legal needs to their clinicians is shown in Figure 1. Inspection of these data suggests that abuse of all types (but especially intimate partner violence) was reported to clinicians more often than other forms of legal issue. Also occurring with over 20% of patients seen by clinicians were issues with getting benefits. Although the other legal issues reported less frequently, all were reported with one physiotherapist commenting: "*These include, but are not limited to, parenting concerns, financial deprivation, domestic abuse, drug use, immigration issues, housing issues.*"). These data suggest that abuse is a commonly reported issue for patients seen by this group of clinicians, which has been noted in several previous studies (Cichowski et al., 2014; Krause et al., 2019).

When asked if they felt there could be better outcomes if their patients had legal support, the majority of clinicians (23/70%) said 'yes' this would help ("*Massive impact on lives of parents and children.*"; "*Modern holistic care recognises the interaction between health, mental health and social pressures.*"; "*These aspects are definitely all linked to how doctors care for patients.*"). A few clinicians (4/12%) said that 'maybe' it would help, and pointed to issues for the clinician in dealing with such non-medical issues ("*Clinicians avoid questions that lead to unsolvable problems, or no clear pathway or referral point.*"; "*We are programmed to be helpful and feel diminished when unable- thus avoid issues.*"). Only 1 clinician (3%; a consultant) said no it would not help; and 5 (15%) clinicians said that they had 'no idea if it would help. These responses indicate that around three quarters of the clinicians think that legal help would be of benefit to some of their patients.

In terms of whether the clinician would, themself, consider referring their patients directly to a solicitor: 22 (67%) clinicians said 'yes' they would make such a referral ("*You know that this could actually solve a lot of their problems, and have a positive impact on their wellbeing.*"; "*It can be very disempowering as a professional not to have a full range of options available for the patients.*"); 8 (24%) of the clinicians said 'maybe' they would refer; and 3 (9%; 1 consultant and 2 nurses) said they would not consider this option ("*I focus on medical issues only.*"). These data suggest that most clinicians in this sample would consider having an option of referral as potentially helpful, with only a few being opposed to this idea. Opposition to the idea was not specific to any one group of clinicians. Despite the high proportions of clinicians not ruling out this option, 27 (82%) said they were not aware of any means by which such a referral could be made, but such an option would be positive for the patient and themselves (“*If we had easy access to effective legal or social help we would delve deeper.*”; “*I feel helpless and beyond referral to safeguarding, I often quickly veer back to dealing with clinical problems.*”). The remaining clinicians (6/18%) said they were aware of the means to make such a referral, but that it did not exist for their locality.

In terms of having previously made referrals to other services, 24 (73%) clinicians said that they had referred to either NHS Safeguarding and/or Social Services (“*I frequently copy letters (with permission) to AMs, MPs, children's commissioner, complaints services at housing associations, social services to engage appropriate services.*”). Of those who had made such a referral: 38% said that NHS Safeguarding was helpful (“*We have an excellent safeguarding team and a weekly meeting for specialist staff [including social workers] to discuss issues affecting patients.*”); with 50% not knowing whether it had helped or not; and 3 (13%) saying it was not helpful. For Social Service referrals, 46% of those who had made such a referral reported it had been helpful; 25% said that they had no knowledge of whether it was helpful; and 29% said that the referral to Social Services was not helpful (“*I often referred patients to social services and found it very slow and frustrating. disheartening and felt like they did not want to help the patient.*”).

The current data, albeit on a limited sample, suggest that many clinicians have been exposed to patients reporting legal issues that the clinicians feel would be appropriately helped by referral to a solicitor. The majority of the clinicians sampled would be willing to make such a referral, if they knew of a method that would allow such a referral to be made. Of course, this was not a universally held view, with a small percentage of clinicians suggesting they would not make such a referral. However, these results suggest that an HJP involving referral to a solicitor would be acceptable to most clinical staff, who also thought it may benefit their patients as well as their own professional practice and confidence. The possibility of such a service depending on legal aid was highlighted by the fact that many of the legal problems involved partner abuse, which would be covered under such a scheme.

Study 2

As there appeared to be broad support from clinical staff for an HJP, the second study turned to examine views of potential service users. To this end, women involved in support groups for pelvic-floor problems, often around postnatal issues, were approached to see whether they would participate in a survey of legal issues. It was hoped to examine whether the clinicians' views of the legal problems they thought their patients were discussing, correspond with issues noted by women who self-report such health issues. In addition, a measure of their pelvic-floor function was included to determine whether there was any relationship between the severity of the self-reported pelvic symptoms and legal issues.

Method

Participants

Participants were recruited through the social media platforms (Instagram, Facebook), as well as online group chats to sample a varied demographic of potential participants. The inclusion criteria were being over the age of 18, providing informed consent, being assigned as female at birth, and being fluent in English. Other than having to adhere to the above inclusion criteria, there were no additional exclusion criteria. G-Power analysis indicated that for a medium effect size, with a rejection criterion of $p<.05$, that for 80% power, 102 participants would be requited for a t-test, and that 88 participants would be needed for a X^2 test. In total, 112 participants consented, but 8 provided incomplete data (more than 25% missing data), and were excluded, leaving 104 participants. The age range of the participants was 18 to 84. Of the participants, 97% identified as White British, and the remaining 3% consisted of African/Caribbean/Black British (1%), Asian/Asian British (1%), and other (1%). The participants were offered no compensation or reward for participating in the survey. The study was conducted under the University Psychology Ethics Committee, and all participants gave their informed consent in accordance with the Helsinki agreement.

Materials

Legal Needs and Perception Questionnaire: This survey was based on that presented to the clinicians in Study 1. Prior to its use, it was shared with three PFD patients who made comments on its usability and validity from their perspective. Their comments were used to develop the questionnaire for a patient sample. The survey on the HJP comprised 9 questions: (1) whether they had experienced any of 9 legal issues (getting benefits, non-benefit financial issues, eviction or foreclosure, immigration issues, child support, divorce or separation, intimate partner abuse (IPA), historical abuse, non-intimate partner abuse), which could be summed to give a total number of legal problems experienced; (2) whether they believe their health would improve if they could see a legal advisor (yes, maybe, no, no idea); (3) whether they have ever considered consulting legal advice? (yes/no); (4) whether they have ever sought legal advice? (yes/no); (5) whether there were any barriers to seeking legal advice (yes/no); (6) whether they would ever disclose legal problems to a medical practitioner (yes/no/don't know); (7) whether they would feel comfortable with a healthcare provider referring for legal advice (yes/no); (8) whether they feel they would have the freedom to make their own decisions about the legal referrals provided by a medical practitioner (yes/no); (9) whether they would feel coerced into making a decision about the legal referrals provided by a medical practitioner (yes/no).

Australian Pelvic Floor Questionnaire (APFQ; Baessler et al., 2008) comprises 20 questions, organised into three categories, Pelvic Organ Prolapse (6 items), Colorectal-Anal Distress (8 items), and Urinary Distress (6 items). The section on sexual issues was removed on request of the ethics committee. Each question is answered on a 5-point Likert scale (0 = Not present, 1 = Not at all, 2 = Somewhat, 3 = Moderately, 4 = Quite a bit). The internal reliability (Cronbach α) of the overall scale for the current sample was .929; POP scale = .851; colorectal scale = .907; urinary scale = .843.

Procedure

The survey was presented through an electronic platform, and all responses were made via the participants' computer or mobile device. A post containing information about the study, and a link to gain more information, was initially placed on a variety of social media and online platforms. Clicking the link took the participants to an information sheet, where the purpose of the study was described, and the questions regarding potentially sensitive topics was highlighted. A contact number if the participants wished to ask any questions about the study was provided. If the participants consented, they were taken to the survey. The survey took about 15 min to complete, and participants could pause if they needed to. A contact number was available if they needed to ask any questions.

Results and Discussion

Figure 2 about here

Figure 2 shows the percentage of participants who indicated that they have experienced particular types of legal issue. Inspection of these data immediately reveals that this group of women with self-declared PFD reported fewer legal issues than might have been expected based on the clinician's reports in Study 1. Only 27/104 (26%) of the sample reported that they had experienced a legal issue (that is, answered 'yes' to at least one of the legal issues listed). The mean number of legal issues experienced by the sample (the mean total number of legal issues that each participant said 'yes' to) was .49 (+.98; range=0-6). The most common ones reported were divorce and historical abuse, both reported by about 10% of the sample; with employment and child support each being reported by around 7% of the sample.

Table 1 about here

Table 1 displays the percentages of patients with no experience of a legal problem (*n*=77) and those with a legal problem (*n*=27; i.e. those having indicated at least one legal issue) who agreed with each of statements about an HJP referral system. In terms of whether the participants believed their condition would improve if they could get legal help, only 6/104 (6%) thought it would improve. However, this percentage was much lower for those who had not experienced a legal problem than for those who had experienced a legal issue (2% versus 10%). A chi-square test revealed this to be a medium effect-sized significant difference, $X^2(1)=10.904$,

$p<.001$, $w=.323$. Of the overall sample, 25/104 (24%) had sought legal advice for a problem. Not surprisingly, this figure was lower for those who had not, than for those who had, experienced a legal problem, $X^2(1)=15.450$, $p<.001$, $w=.385$. For the overall sample, 10/104 (10%) reported the presence of barriers in obtaining legal help, which was lower for those who had not experienced a legal problem compared to those with a legal problem, $X^2(1)=6.669$, $p<.01$ $w=.253$ (a small-sized effect). These data suggest that those who had experience of a legal problem felt it more likely that getting help with this legal problem would aid treatment for their clinical condition. They also tended to more often feel that there were barriers to obtaining this legal help.

In terms of their perceptions of a potential HJP referral system there was little difference in the views of those who had and had not experienced a legal problem, with the majority being well disposed to the possibility of such a system. Of the overall sample, 50/104 (48%) said they would disclose their legal problem to the clinician, with no difference between the two groups, $X^2(1)=.193$, $p>.30$, $w=.043$. Around 80% (83/104) of the sample reported that they would feel comfortable disclosing a legal problem to a clinician; which was similar for those who had not, and had, experienced a legal problem, $X^2(1)=.743$, $p>.30$, $w=.085$. Of the sample, 94/104 (91%) would feel they had freedom to accept or reject the referral; 69/77 for those who had not experienced a legal problem, and 25/27 for those with a legal problem, $X^2(1)=.205$, $p>.30$, $w=.044$. Only 14/104 (14%) of the sample would feel coerced into accepting the referral; 9/77 for those without, and 5/27 for those with, a legal problem, $X^2(1)=.801$, $p>.30$, $w=.088$.

The sample mean pelvic-floor score as indicated by the APFQ was 88.52 (+52.92; range=0-260). The sample mean scores for the particular symptoms were: Prolapse = 24.16 (+19.68; range=0-100); colorectal symptoms = 26.41 (+19.62; range=0-97); and urinary distress

= 35.95; range=0-100). There was a significant moderate correlation between the number of legal issues experienced and overall pelvic-floor symptoms, *r*=.317, *p*<.001. When the sample was divided into those who had and had not experienced legal issues, independent t-tests revealed more severe symptoms for those with legal issues than those without for each of the APFQ subscales. The mean POP score was 19.91 (±1.93) versus 36.26 (±22.10) for those without and with legal issues, which produced a large effect-sized significant difference, *t*(102)=3.97, *p*<.001, *d*=.888[.431:1.341]. Colorectal scores were 22.56 (±16.89) for those without, and 37.38 (±22.99) for those with, legal problems; a difference which was significant with a large-effect size, *t*(102)=3.56, *p*<.001, *d*=.797[.343:1.247]. Urinary distress was higher for those with (mean = 45.06±20.45) compared to without (32.77±20.90) legal issues, a significant difference with a large effect-size, *t*(102)=2.65, *p*=.005, *d*=.592[.145:1.036].

Table 2 about here

Table 2 displays the percentage of participants with lower and higher pelvic-floor symptoms (split at the sample mean for the APFQ) who agreed with the various suggestions regarding the HJP referral system. Inspection of these data shows little difference between the two groups, with the exceptions that the higher PFD symptom group were more likely to think that legal help would help their condition, and were more likely to disclose their legal problem to the clinician.

These data suggest that a sample of women with self-reported pelvic-floor problems would feel comfortable with an HJP system, and expressed few concerns about such a system.

The potential benefits of such a system were better recognised by those who had experienced a legal problem, and also by those who had higher levels of pelvic-floor symptoms.

Study 3

The third study developed the findings from Study 2 by focusing on a sample of women who had been referred to hospital for PFD (as opposed to the PFD being self-reported). As this group is the key population for whom the HJP would operate, then this population appeared to be important to study. Based on the indications from Study 2 in a sample of self-reported PFD, those with higher reported symptoms may be expected to demonstrate a greater level of legal need, and a greater willingness about the idea of an HJP. A further aim of Study 3 was to explore whether the clinicians' perceptions of legal need, which were higher than that of the self-reported PFD sample in Study 2, would be reflected by a clinical group of patients.

Method

Participants

Women who were consecutively referred to the Women's Health Department of a large metropolitan hospital (the same as used in Study 1) were asked if they would be willing to participate in the study. The inclusion criteria were being over the age of 18, providing informed consent, being assigned as female at birth, being fluent in English, and being referred by a medical practitioner (independent from the study) for treatment for PFD. Other than having to adhere to the above inclusion criteria, there were no additional exclusion criteria. G-Power analysis indicated that for a medium effect size, with a rejection criterion of $p<.05$, that for 80%

power, 62 participants would be needed for a Pearson corelation. They were provided with a brief explanation, initially, and if they expressed interest, were given a full information sheet and a consent form. If they wished to participate, they could sign the consent form at any point they wished, and return it. In total, 135 participants were approached, and 121 agreed to participate. Of these, 12 provided incomplete data (more than 25% missing data), and were excluded, leaving 109 participants. The age range of the participants was 21 to 79. Of the participants, 90% identified as White British, 3% as African/Caribbean/Black British, and 7% as Asian/Asian British. The participants were offered no compensation or reward for participating in the survey. The study received ethical approval from NHS Trust, and all participants gave their informed consent in accordance with the Helsinki agreement.

Materials and Procedure

The materials were as described in Study 2, and comprised the Legal Needs and Perception Questionnaire, and the APFQ (Baessler et al., 2008). The internal reliability (Cronbach α) of the APFQ for the current sample was .902; POP scale = .883; colorectal scale = .892; urinary scale = .875. The procedure was as described in Study 2.

Results and Discussion

Figure 3 about here

Figure 3 shows the percentage of patients indicating that they had experienced various legal issues. These data reveal the PFD patients reported more legal issues than the self-reported sample in Study 2, and reported legal issues in numbers similar to those estimated by the clinicians in Study 1: 91/109 (84%) of the sample reported they had experienced a legal issue. The mean number of legal issues experienced by the sample was 1.83 (±1.36; range=0-5). The most common issues reported were IPA (about 30%), along with abuse, employment and getting benefits (each about 20%). These data are similar to, but somewhat higher than, the levels suggested by clinicians about their patients in Study 1.

Table 3 about here

Table 3 shows the numbers (percentages) of patients agreeing with the statements concerning the HJP referrals, along with the point biserial correlations with numbers of legal issues (the sum of legal issues each participant has indicated that they had experienced), and the PFD symptoms scores (total APFQ score). In terms of whether the patients believed their condition would improve if they could get legal help, 33/109 (30%) thought it would improve. This was positively related to numbers of legal issues experienced, as well as urinary and overall PFD symptoms. Of the sample, 37/109 (34%) had sought legal advice for a problem, and this correlated, not surprisingly, positively with the number of legal issues experience, but also with POP and overall PFD symptoms. For the overall sample, 20/109 (18%) reported the presence of barriers in obtaining legal help, but this did not correlate with legal problems of PFD symptoms. Reflecting Study 2, these data suggest those with more experience of legal problems, and higher PFD symptoms, felt it more likely that getting legal help would aid their treatment.

In terms of patient perceptions of a potential HJP referral system, 75/109 (69%) said they would disclose their legal problem to the clinician, with this being positively related to the numbers of legal problems experienced, and to most PFD symptoms. Around 75% (82/109) reported they would feel comfortable disclosing a legal problem to a clinician, which was mildly positively related to PFD symptoms. Of the sample, 98/109 (90%) felt they would had freedom to accept or reject the referral, and only 10/109 (9%) would feel coerced into accepting the referral. These latter two perceptions were not correlated with legal problems or PFD symptoms.

The sample mean pelvic-floor score was 156.21 ($\pm$49.34; range=39-277). The sample mean scores for particular symptoms were: POP = 53.82 ($\pm$21.15; range=8-100); colorectal symptoms = 43.34 ($\pm$20.72; range=2-100); and urinary distress = 59.06 ($\pm$23.15; range=4-100). There was a significant moderate correlation between the number of legal issues experienced and overall pelvic-floor symptoms, r=.457, p<.001. Legal issues experienced also correlated with POP symptoms, r=.276, p=.004; colorectal issues, r=.361, p<.001; and urinary distress, r=.399, p<.001. PFD symptoms had a positive point biserial correlation with the view that referral would improve the condition, r_{pb}=.244, p=.011, and with the likelihood of disclosing an issue to clinician, r_{pb}=.238, p=.013, but with nothing else.

These data suggest that a sample of women referred to hospital for PFD would feel comfortable with an HJP, and expressed few concerns about such a referral system. The level of legal issues identified by the current sample exceeds that noted for those with self-reported PFD observed in Study 2. It was more consistent with (if not higher than) the levels of legal issues that clinicians reported their patients had informed them about during appointments (see Study 1). This suggests that not all legal issues are brought up in appointments, perhaps either due to the patients not perceiving them as relevant in that context, or due to a reticence to mention such issues to a healthcare professional. The current very high percentage of women with PFD who noted a legal issue, addressing which would benefit their health, and noting the acceptability of an HJP, suggests such a system would be welcomed.

General Discussion

The current series of three studies explored whether an HJP would be acceptable to both medical staff and women with PFD. It examined the level of legal need for those with PFD, whether women with PFD would confide in healthcare professionals about any legal issues, and clinician and patient perspectives on legal aid and solicitor referrals during appointments. Clinicians in Study 1 suggested over 25% of their patients mentioned legal issues, mainly connected with current and historical abuse. Over 80% of the clinicians reported the concept of an HJP to be acceptable. A similar pattern was noted in Study 3 with women diagnosed with PFD, which found over 80% of patients had legal issues (abuse as well as benefit and financially related), with over 80% reporting acceptability of an HJP. Both clinicians and patients believed an HJP would improve patient health. Similar results were recorded for a sample of women with self-reported PFD, although they noted fewer legal problems. These studies suggest a need for legal support, that an HJP referral system would be acceptable, and that legal support was felt to offer potential health benefits.

The current results provide broad support for the introduction of an HJP for women with PFD, and corroborate the potential benefits noted in other medically-related areas (Beardon et al., 2021; Fuller et al., 2020). The current studies noted a range of legal problems were faced by women with PFD, which included benefit, housing, financial issues, as well as separation and divorce. However, of importance for a legal-aid HJP, the current investigations noted high levels of abuse (IPA and historical) were reported by women with PFD (Study 2 and 3), and were revealed during appointments by clinicians (Study 1). This is in line with previous examinations of abuse experienced by women with PFD (Barnes et al., 2020; Cichowski et al., 2014; Krause et al., 2019; Osborne & Reed, 2025),

Milsom and Gyhagen (2019) suggest a yearly incidence rate for PFD of 1-2% of the population. Assuming the 20-30% of patients with PFD reporting IPA in these studies is representative, which is in line with estimates of intimate partner violence from a large meta-analysis (White et al., 2024), and given an estimated adult female population in the UK of 25 million (UK Census, 2021), this would represent over 50,000 new patients with PFD in the UK who may seek new legal assistance for such abuse (1% PFD incidence, 20% IPA prevalence). It may be that many women who have experienced such trauma would hesitate to report these issues to a healthcare professional (Dutton & Painter, 1993), and the discrepancy in legal issues disclosed by the patients (Study 3), and those disclosed to clinicians (Study 1), does suggest that this is the case. It is unclear whether patients would feel uncomfortable confiding in an unfamiliar healthcare professional, as Study 2 and 3 indicated this was not a strongly held view. However, it may be that some women with PFD simply do not feel these legal issues are relevant, and may under-report them in a healthcare context.

It should be noted that, given the range of legal problems reported by the samples in the current studies, some women will struggle to afford legal services, and many will not be eligible for legal aid. In the UK, legal support is available to clients either free, or at a subsidised rate, depending on their financial circumstances, and the nature of the legal problem that they face. While this theoretically makes the legal system more affordable and accessible, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) took many subject areas out of the scope of legal aid. These removed areas included many areas of family law, although domestic abuse remains within scope of legal aid, so those who have been subjected to IPA would not be affected. To qualify for legal aid, those subjected to IPA need to show that they are, or are at risk of, being a victim of domestic abuse or violence from the other party; in the case arising from a family relationship between them and the other party, they also have to satisfy financial and merits tests. Those who are eligible will either have free public funding, or will have to provide come level of financial contribution to their legal aid. A further problem is that the means test for legal aid has not been uprated in line with inflation since 2009 – since then, prices have risen by 40%. This means that fewer people are eligible for legal aid each year. Research commissioned by the Law Society has found that people on incomes already 10% to 30% below the minimum income standard were being excluded from legal aid (The Law Society, 2024).

The previous UK government (2016-2021) did raise the means-test thresholds for legal aid, but it was found that the Legal Aid Agency's (LAA) antiquated IT system has caused implementation problems , delaying implementation until 2026. A further complication is that recently the LAA have been subjected to a cyber-attack causing a major data breach that has thrown everything into some confusion, and may further delay the uprating of means test thresholds (The Law Society, 2025).

Leaving aside these other aspects of legal problems, not all which would qualify for legal aid, these numbers alone suggest a numerical need exists for an HJP for women with PFD. Such a system would be financially free to run, once the online referral system is set up, and would only require some small amount of time input from clinicians to make a referral. Considering that the psychological sequalae of abuse, such as PTSD, anxiety, and depression, are not only important in their own right, but also impact negatively on PFD outcomes (Khan et al., 2013), this does support the introduction of an HJP. The level of legal need, and explorations based on the current data, is one pillar of support for the introduction of an HJP, but the additional majority positive views of the potential benefits of such a system, expressed by both clinicians and patients, as well as their indication that such a referral system would be acceptable, is another important strand in the evidence (see also Beardon et al., 2021; Fuller et al., 2020; Moffatt et al., 2006; Zuckerman, 2004).

There are some limitations to the study that should be acknowledged, so that they could be addressed in future work. The survey about legal issues and previous experiences of the patients is based on their self-report, and while there is no reason to doubt their reports (indeed these would form the basis of initial referrals), use of actual data on upheld claims would be useful. These reports are also based on retrospective analysis of problems experienced, and hence on recall, which is notably true for clinicians (not so much for patients). This may have impacted the findings. There are, of course, a wide range of legal issues that could affect PFD symptoms, such as pain, and it is not clear whether all issues impact these symptoms to the same or different extents. The current manuscript did not explore this issue, due to limitations in sample size, but that would be an important issue to explore in future work. It should also be acknowledged that the current Studies 1 and 3 are based on a single site, which, although probably representative of many urban populations, will not generalise to all populations. Although Study 2 was not so limited in recruitment scope, it would be important to explore potential differences in this regard; for example, what are the effects of variations in socio-economic status, ethnic backgrounds, and rural versus urban areas?

The integration of legal and medical services could represent a major step forward for many of the poorest, most deprived, and vulnerable patients, and help tackle some social determinants of PFD. By addressing such issues, the underlying cause of their stress is removed, and better health outcomes are achieved, relieving pressure on the NHS.

Final Statements

Conflict of interest – There are no conflicts of interest for any author.

Ethical approval – Ethical approval for the study was given by the University's Psychology Ethics Committee, and all participants gave their informed consent in accordance with the Helsinki agreement.

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References

Baessler, K., O'Neill, S.M., Maher, C.F., & Battistutta, D. (2009). Australian pelvic floor questionnaire: a validated interviewer-administered pelvic floor questionnaire for routine clinic and research. *International Urogynecology Journal*, *20*, 149-158.

Barnes, A.J., Anthony, B.J., Karatekin, C., Lingras, K.A., Mercado, R., & Thompson, L.A. (2020). Identifying adverse childhood experiences in pediatrics to prevent chronic health conditions. *Pediatric Research*, *87*(2), 362-370.

Beardon, S., Woodhead, C., Cooper, S., Ingram, E., Genn, H., & Raine, R. (2021). International evidence on the impact of health-justice partnerships: a systematic scoping review. *Public Health Reviews*, *42*, 1603976.

Beardon, S. (2022). Implementation of Health-Justice Partnerships: Integrating welfare rights advice services with patient care (Doctoral dissertation, UCL (University College London).

Berg, J.W., Appelbaum, P.S., Lidz, C.W., & Parker, L.S. (2001). *Informed consent: legal theory and clinical practice*. Oxford: Oxford University Press

Cichowski, S.B., Dunivan, G.C., Komesu, Y.M., & Rogers, R.G. (2013). Sexual abuse history and pelvic floor disorders in women. *Southern Medical Journal*, *106(12)*, 675.

De La Ossa, A.M.P., Catai, C.C., Lopes, S., Pena, C.C., De Paula, N.A., Fernandes, A.C.N.L., & Jorge, C.H. (2023). Do patients undergoing physical therapy in a rehabilitation center have a high prevalence of pelvic floor dysfunction and psychological disorders? A cross sectional study. *Brazilian Journal of Physical Therapy, 27*(4), 100536.

Demirci, A., Hızlı, F., Hamurcu, H. D., & Başar, H. (2023). Which type of female urinary incontinence has more impact on pelvic floor and sexual function in addition to anxiety and depression symptoms: A questionnaire-based study. *Neurourology and Urodynamics*, *42*(4), 814-821.

Dutton, D.G., & Painter, S. (1993). Emotional attachments in abusive relationships

Fall, M., Baranowski, A.P., Elneil, S., Engeler, D., Hughes, J., Messelink, E. J., ... & Williams, A.C.D.C. (2010). EAU guidelines on chronic pelvic pain. *European Urology*, *57*(1), 35-48.

Frawley, H., Shelly, B., Morin, M., Bernard, S., Bø, K., Digesu, G. A., ... & Voelkl Guevara, J. (2021). An International Continence Society (ICS) report on the terminology for pelvic floor muscle assessment. *Neurourology and Urodynamics*, *40*(5), 1217-1260.

Fuller, S M., Steward, W.T., Martinez, O., & Arnold, E.A. (2020). Medical–legal partnerships to support continuity of care for immigrants impacted by HIV: lessons learned from California. *Journal of Immigrant and Minority Health*, *22(1)*, 212-215.

Goncalves, C.V., & Karantzas, G.C. (2006). Exploring differences in attachment, intimacy and coping across the formation and dissolution of romantic relationships. In *Proceedings of the APS psychology of relationships interest group 6th annual conference*, 63–70.

Hagen, S., Stark, D., & Dougall, I. (2016). A survey of prolapse practice in UK women's health physiotherapists: what has changed in the last decade? *International Urogynecology Journal*, *27*, 579-585.

Hadizadeh-Talasaz, Z., Khadivzadeh, T., Khadem ghaebi, N., & Ebrahimipour, H. (2022). Exploration of sexual experience among women with pelvic organ prolapse: a qualitative study. *Sexual and Relationship Therapy*, *37(2)*, 238-252 42.

Jamieson, D.J., & Steege, J.F. (1997). The association of sexual abuse with pelvic pain complaints in a primary care population. *American Journal of Obstetrics and*

Gynecology, *177(6)*, 1408-1412.

Jundt, K., Peschers, U., & Kentenich, H. (2015). The investigation and treatment of female pelvic floor dysfunction. *Deutsches Ärzteblatt International*, *112(33-34)*, 564.

Kenne, K.A., Wendt, L., & Brooks Jackson, J. (2022). Prevalence of pelvic floor disorders in adult women being seen in a primary care setting and associated risk factors. *Scientific Reports*, *12*(1), 9878.

Khan, Z.A., Whittal, C., Mansol, S., Osborne, L.A., Reed, P., & Emery, S. (2013). Effect of depression and anxiety on the success of pelvic floor muscle training for pelvic floor dysfunction. *Journal of Obstetrics and Gynaecology, 33*(7), 710–714.

Krause, H., Ng, S. K., Singasi, I., Kabugho, E., Natukunda, H., & Goh, J. (2019). Incidence of intimate partner violence among Ugandan women with pelvic floor dysfunction. *International Journal of Gynecology & Obstetrics, 144*(3), 309–313.

Milsom, I., & Gyhagen, M. (2019). The prevalence of urinary incontinence. *Climacteric*, *22*(3), 217-222.

Mirskaya, M., Isaksson, A., Lindgren, E.C., & Carlsson, M. (2023). Bearing the burden of spill over effects: Living with a woman affected by symptomatic pelvic organ prolapse after vaginal birth–from a partner's perspective. *Sexual & Reproductive Healthcare, 37*, 100894.

Mladenović-Segedi, L., Parezanović-Ilić, K., Ćurčić, A., & Višnjevac, N. (2011). Quality of life in women with pelvic floor dysfunction. *Vojnosanitetski Pregled*, *68*(11), 940-947.

Moffatt, S., Mackintosh, J., White, M., Howel, D., & Sandell, A. (2006). The acceptability and impact of a randomised controlled trial of welfare rights advice accessed via primary health care: qualitative study. *BMC Public Health*, *6*, 1-9. 45

National Institutes of Health. (2008). Roughly one quarter of US women affected by pelvic floor disorders. Accessed August, 9

Osborne, L.A., & Reed, P. (2025). Women's pelvic-floor muscle dysfunction. In *The Palgrave Encyclopedia of Disability* (pp. 1-16). Palgrave Macmillan, Cham.

Peinado-Molina, R.A., Hernández-Martínez, A., Martínez-Vázquez, S., Rodríguez-Almagro, J., & Martínez-Galiano, J.M. (2023). Pelvic floor dysfunction: prevalence and associated factors. *BMC Public Health*, *23(1)*, 2005.

Postma, R., Bicanic, I., van der Vaart, H., & Laan, E. (2013). Pelvic floor muscle problems mediate sexual problems in young adult rape victims. *The Journal of Sexual Medicine*, *10(8)*, 1978-1987.

Quaghebeur, J., Petros, P., Wyndaele, J.J., & De Wachter, S. (2021). Pelvic-floor function, dysfunction, and treatment. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *265*, 143-149.

Rapkin, A.J., Kames, L.D., Darke, L.L., Stampler, F.M., & Naliboff, B.D. (1990). History of physical and sexual abuse in women with chronic pelvic pain. *Obstetrics & Gynecology*, *76(1)*, 92-96.

Reed, P., Osborne, L.A., Whittall, C.M., Emery, S., & Truzoli, R. (2022). Patient and economic benefits of psychological support for noncompliant patients. *Frontiers in Psychology*, *13*, 829880.

Rodríguez-Almagro, J., Hernández Martínez, A., Martínez-Vázquez, S., Peinado Molina, R.A., Bermejo-Cantarero, A., & Martínez-Galiano, J. M. (2024). A qualitative exploration of the perceptions of women living with Pelvic Floor Disorders and factors related to quality of life. *Journal of Clinical Medicine*, *13(7)*, 1896.

Scott, A., Digwood, K., Teslow, R., & Bloom, A. (2022). Addressing pelvic floor dysfunctions in older women. *The Open Journal of Occupational Therapy*, *10(2)*, 1-10.

The Law Society (2024). Legal aid means test changes delayed until 2026. 14 March 2024: https://www.lawsociety.org.uk/contact-or-visit-us/press-office/press-releases/legal-aid means-test-changes-delayed-until-2026#:~:text=%E2%80%9CThey%20have%20already%20acknowledged%20there,neglect%20of%20our%20justice%20system.&text=%E2%80%9CYet%20the%20government%20continues%20to,help%20when%20they%20need%20it.%E2%80%9D. Accessed 30th July, 2025.

The Law Society (2025). Legal Aid Agency data breach', 24 Jun 2025. https://www.lawsociety.org.uk/topics/legal-aid/legal-aid-agency-data-breach. Accessed 30th July, 2025.

Tobin-Tyler, E., & Teitelbaum, J.B. (2019). Medical-legal partnership: a powerful tool for public health and health justice. Public Health Reports, 134(2), 201-205.

Vardeman, J., Spiers, A., & Yamasaki, J. (2023). “Things are happening that I don’t understand”:

Vrijens, D., Berghmans, B., Nieman, F., van Os, J., van Koeveringe, G., & Leue, C. (2017). Prevalence of anxiety and depressive symptoms and their association with pelvic floor Dysfunctions – A cross sectional cohort study at a Pelvic Care Centre. *Neurourology and Urodynamics, 36*(7), 1816–1823.

White, S.J., Sin, J., Sweeney, A., Salisbury, T., Wahlich, C., Montesinos Guevara, C.M., ... & Mantovani, N. (2024). Global prevalence and mental health outcomes of intimate partner violence among women: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, *25*(1), 494-511.

Woodburn, K.L., Tran, M.C., Casas-Puig, V., Ninivaggio, C.S., & Ferrando, C.A. (2021). Compliance with pelvic floor physical therapy in patients diagnosed with high-tone pelvic floor disorders. *Female Pelvic Medicine & Reconstructive Surgery, 27*(2), 94–97.

Xie, M., Huang, X., Zhao, S., Chen, Y., & Zeng, X. (2022). Effect of psychological intervention on pelvic floor function and psychological outcomes after hysterectomy. *Frontiers in Medicine, 9*, 878815.

Zuckerman, B., Sandel, M., Smith, L., & Lawton, E. (2004). Why pediatricians need lawyers to keep children healthy. *Pediatrics*, *114(1)*, 224-228.

Table 1: Results from Study 2. Percentage (numbers) of participants who had not, and who had, experienced a legal problem expressing agreement with each of the HJP statements. The chi-square values (X^2), effect sizes (*w*), and significance levels (*p*), are also shown.

	Without Legal Issue (*n*=77)	**With Legal issue (*n*=27)**	**X^2(1)**	***w***	***p***
Improve condition	1% (1)	19% (5)	10.904	0.323	0.001
Sought advice	14% (11)	52% (14)	15.450	0.385	0.001
Barriers to help	5% (4)	22% (6)	6.669	0.253	0.010
Disclose to clinician	48% (38)	49% (12)	0.193	0.043	0.734
Comfortable disclosing	82% (63)	74% (20)	0.753	0.085	0.473
Freedom to choose	89% (68)	93% (25)	0.205	0.044	0.638
Coerced by clinician	11% (8)	19% (5)	0.801	0.088	0.335

Table 2: Results from Study 2. Percentage (numbers) of participants in the lower and higher pelvic-floor symptom groups expressing agreement with each of the HJP statements. The chi-square values (X^2), effect sized (^{w}), and significance levels (*p*), are also shown.

	Lower PFD (*n*=53)	**Higher PFD (*n*=51)**	**X^2(1)**	***w***	***p***
Improve condition	2% (1)	10% (5)	3.107	0.173	0.043
Sought advice	19% (10)	29% (15)	1.582	0.123	0.208
Barriers to help	9% (5)	9% (5)	0.004	0.006	0.949
Disclose to clinician	40% (21)	57% (29)	3.295	0.188	0.043
Comfortable disclosing	85% (45)	75% (38)	1.743	0.130	0.187
Freedom to choose	89% (47)	92% (47)	0.362	0.059	0.548
Coerced by clinician	15% (8)	12% (6)	0.247	0.049	0.619

Table 3: Results from Study 3. Number (N) and percentage (%) patients agreeing with the statements concerning the HJP referrals, along with the point biserial correlations with numbers of legal issues, and the PFD symptoms scores.

	N (%)	Legal	POP	Colorectal	Urinary	PFD
Improve condition	33 (30%)	.257**	.103	.139	.302***	.244**
Sought advice	37 (34%)	.330***	.198*	.119	.109	.214*
Barriers to help	20 (18%)	-.030	.086	.205	.098	.169
Disclose to clinician	75 (69%)	.239**	.062	.270**	.209*	.238*
Comfortable disclosing	82 (75%)	.102	.010	-.001	-.163	-.072
Freedom to choose	98 (90%)	.049	.071	-.141	-.043	-.049
Coerced by clinician	10 (9%)	-.149	.-055	.192	.024	.069

Figure 1: Results from Study 1. Mean percentage (standard error) of patients reporting various types of legal issues to their clinician.

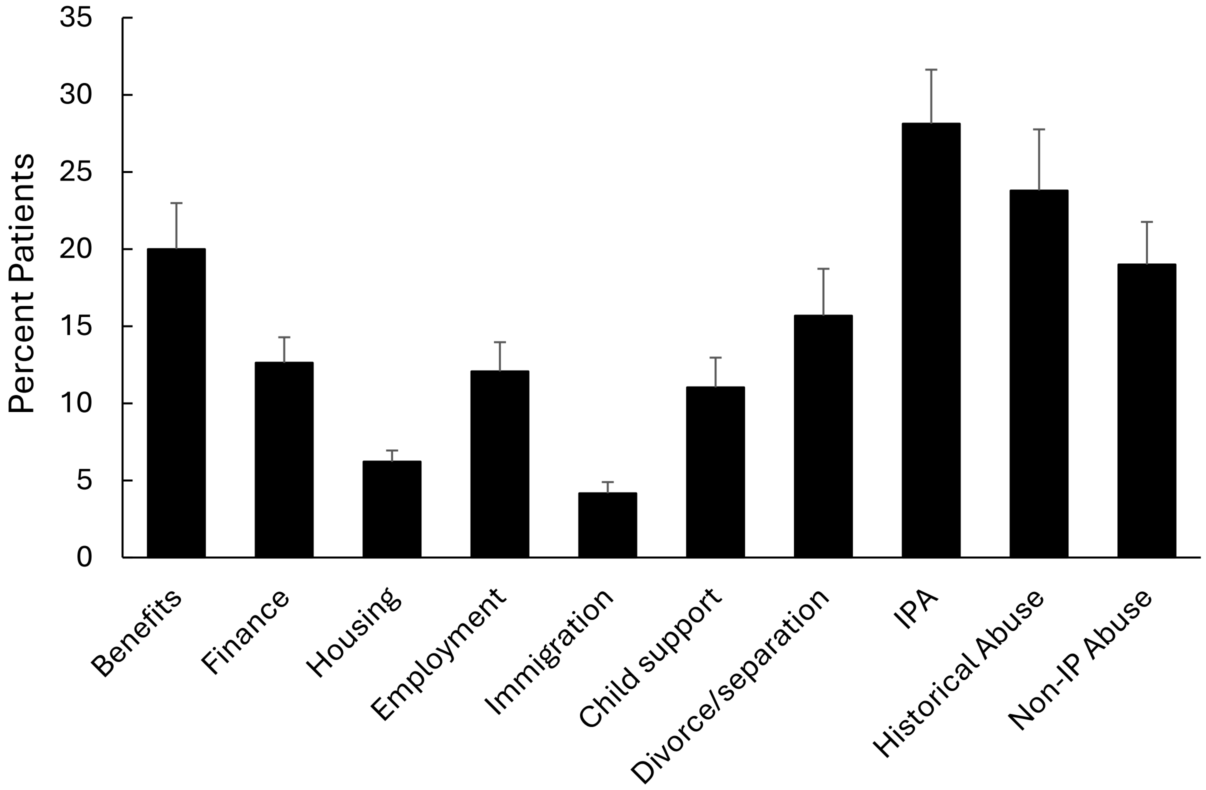

Figure 2: Results from Study 2. Mean percentage of patients reporting various types of legal issues.

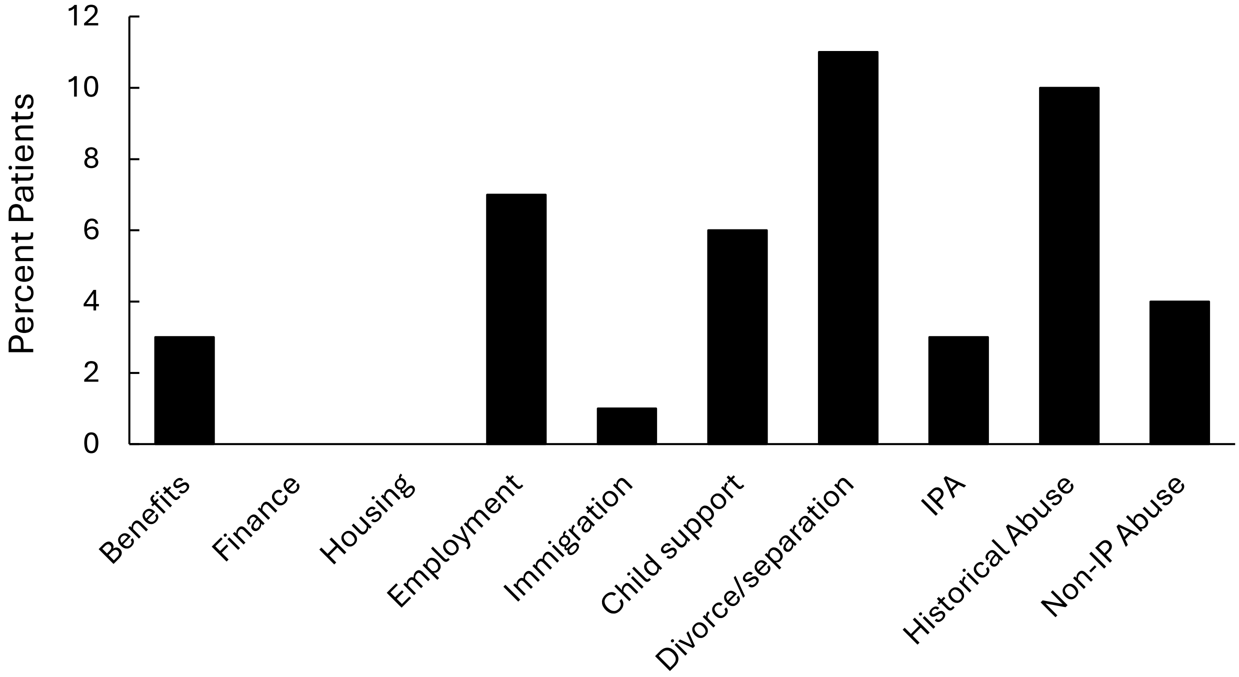

Figure 3: Results from Study 3. Mean percentage of patients reporting various types of legal issues.