Agenda - Equality and Social Justice Committee

Meeting Venue:	For further information contact:
Committee Room 5	**Rhys Morgan**
Meeting date: 22 May 2023	Committee Clerk
Meeting time: 12.00	0300 200 6565
	SeneddEquality@senedd.wales

Pre-meeting registration (11:30-12:00)

1 Introductions, apologies and substitutions

(12:00)

2 The public health approach to preventing gender-based violence: evidence session 1

(12.00-12.45)

Lara Snowdon, Public Health Lead - Violence Prevention Unit, Public Health Wales

Break (12:45 -13:30)

3 The public health approach to preventing gender-based violence: evidence session 2

(13.30-14.30)

Dr Jen Daffin, Community Clinical Psychologist - Psychologists for Social Change

Oliver Townsend, Head of Partnerships and Practice - Platfform

Senedd Cymru
Welsh Parliament

Break (14:30-14:45)

4 The public health approach to preventing gender-based violence: evidence session 3

(14.45-15.45)

Johanna Robinson, National Adviser for Violence Against Women, Gender Based Violence, Domestic Abuse and Sexual Violence

Yasmin Khan, National Adviser for Violence Against Women, Gender Based Violence, Domestic Abuse and Sexual Violence

5 Papers to note

(15:45)

5.1 Correspondence from the Minister for Social Justice and Chief Whip to Stephen Crabb MP regarding the benefits system in Wales

(Pages 1 - 2)

6 Motion under SO17.42 (vi) and (ix) to exclude the public for the remainder of the meeting

(15:45)

7 The public health approach to preventing gender-based violence: consideration of evidence

(15.45 - 16.05)

8 Legislative Consent Memorandum on the Protection from Sex-based Harassment in Public Bill: consideration of draft report

(16:05- 16:20) (Pages 3 - 7)

By virtue of paragraph(s) vii of Standing Order 17.42

Agenda Item 2

Document is Restricted

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

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

PGBV 05

Ymateb gan: Iechyd Cyhoeddus Cymru | Response from: Public Health Wales

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Public Health Wales response to the Equality and Social Justice Committee Inquiry into the public health approach to preventing gender-based violence

Introduction

The Equality and Social Justice Committee is undertaking an inquiry into the public health approach to preventing gender-based violence. The inquiry will explore how effective the implementation of a public health approach to preventing gender-based violence has been, and what more could be done. This paper outlines the Public Health Wales response to the inquiry. This paper will be accompanied by the submission of oral evidence to the Committee on 22nd May 2023.

Background

Gender-based violence is a major public health problem, a criminal justice issue, and a violation of human rights. Violence contributes significantly to the global burden of premature death and injury, as well as having serious, lifelong consequences for health and wellbeing (Krug et al., 2002). Preventing violence before it occurs and developing effective response strategies can improve the health and wellbeing of individuals and communities, and have a wider positive impact for the economy and society (World Health Organization, 2021).

Public Health Wales plays an important and wide-ranging role in the prevention of gender-based violence in Wales. This ranges from programmes and projects which have a direct impact on the prevention of gender-based violence, including resourcing of a permanent team focused on the prevention of violence through a public health approach, including as a founding member of the Wales Violence Prevention Unit (VPU); hosting of the ACE Hub Cymru which seeks to establish Wales as a world leader in preventing, tackling and mitigating the impacts of ACEs and trauma; and the National Safeguarding Team (NST) which works to improve NHS safeguarding response across Wales.

Public Health Wales also delivers programmes which have an indirect impact on preventing gender-based violence, as well as working closely with Welsh Government and other criminal justice, health and voluntary sector partners, such as:

- First Thousand Days Programme
- Wales Healthy Schools Programme
- Whole School Approach to Emotional Health and Wellbeing
- Representation on the national partnership board for the VAWDASV Blueprint and chairing of workstreams
- Representation on the Criminal Justice Board including chairing of the early intervention and prevention workstream

Responding to the terms of reference of the inquiry

The terms of reference for the inquiry are to:

1. Put a spotlight on what works in preventing gender-based violence before it occurs (primary prevention) and intervening earlier to stop violence from escalating (secondary prevention).
2. Consider the effectiveness of a public health approach to preventing gender-based violence and what more needs to be done to address the needs of different groups of women, including LGBT+, ethnic minorities, young and older people at risk of violence at home and in public spaces.
3. The role of the public sector and specialist services (including the police, schools, the NHS, the third sector and other organisations that women and girls turn to for support) in identifying, tackling and preventing violence against women, and their role in supporting victims and survivors.

This paper begins with outlining some of the key concepts used in the inquiry, including the definition of gender-based violence, a public health approach to violence prevention, and risk and protective factors for gender-based violence. This is followed by sections which address each point in turn, concluding with suggestions of opportunities for action.

What is gender-based violence?

Gender-based violence refers to "*any type of harm that is perpetrated against a person or group because of their factual or perceived sex, gender, sexual orientation and/ or gender identify*" (Council of Europe, 2023).

Gender-based violence is based on an imbalance of power and is carried out with the intention to humiliate and make a person or group of people feel inferior and/ or

subordinate. This type of violence is deeply rooted in the social and cultural structures, norms and values that govern society, and is often perpetuated by a culture of denial and silence. It is both a cause and a consequence of gender inequality.

Gender-based violence is disproportionately perpetrated by men, and women and girls are disproportionately victimised. However, men and boys can also be the target of gender-based violence, and this should not be neglected in response and prevention efforts. As such, the term gender-based violence is often used interchangeably with violence against women, and/ or violence against women, domestic abuse and sexual violence (VAWDASV).

What is violence prevention?

Violence can be predicted and prevented like any other public health issue. Public health identifies three tiers of prevention (figure 1). Primary prevention aims to prevent violence before it occurs, secondary prevention focuses on the immediate response to violence (early intervention), and tertiary prevention focuses on long-term care and harm reduction after violence has occurred. We need coordinated interventions at each tier to make sure that violence, at a population level, is not only stopped before it occurs, but that it is responded to in a safe, effective and compassionate way when it does happen, helping to prevent violence in the future.

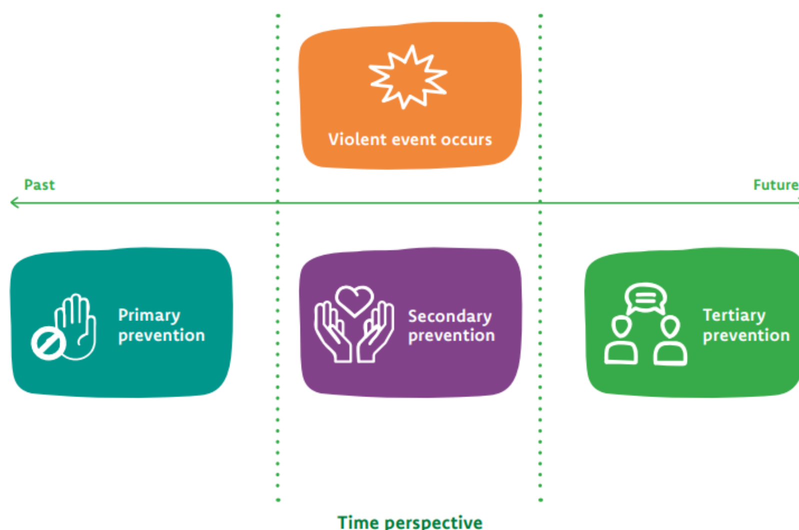

Figure 1: Spectrum of prevention

Primary prevention

Primary prevention means stopping violence from happening in the first place. It means transforming the social conditions, such gender inequity that excuse, justify or even gender-based promote violence. Whilst individual behavioural change may be the intended result of prevention activity, it can't be achieved before, or in isolation from, a broader shift in the underlying drivers of violence across communities, organisations and society as a whole. Primary prevention approaches can work across the whole population (universal) or be targeted at particular groups which may be at an increased risk of experiencing violence (targeted). Examples of these programmes include early years and family support, whole-school approaches to preventing gender-based violence, or active bystander training.

Secondary prevention

Secondary prevention (early intervention) supports people at the earliest opportunity when they have experienced violence. This can prevent violence from recurring and can limit harm through a safe and compassionate response. Secondary prevention includes taking a trauma-informed approach by listening to and believing people who've experienced violence and trauma, recognising their strengths as individuals, and promoting opportunities for their wellbeing, healing and recovery. It is important to recognise that different people will need different types of support depending on their needs and circumstances. Secondary prevention also includes making sure people know where to report any violence they have experienced or witnessed. Examples of secondary prevention include identification and referral in healthcare settings, to specialist service support, therapeutic care, helplines or diversion of those at risk of entering the criminal justice system.

Tertiary prevention

This involves response, treatment and rehabilitation after violence has occurred, as well as prevention of long-term harm, including repeat victimisation or perpetration. Examples of these programmes include long-term support and advocacy for victims, management of offenders, or perpetrator programmes.

When all three types (primary, secondary and tertiary) are used together, they create a comprehensive response to violence.

What is a public health approach to preventing gender-based violence?

A public health approach is a way of working that focuses on the health, safety and wellbeing of an entire population. It draws upon multi-disciplinary evidence to take a systematic approach to promoting health and wellbeing and reducing health inequalities across a population. The tools and skills used to understand public health problems can also be adapted to complement existing approaches used by policing and criminal justice partners to prevent violence.

The World Health Organization's (Krug et al., 2002) public health approach to violence prevention is often used as a frame of reference for developing a systematic and evidence-informed process for violence prevention. The Wales VPU (Snowdon et al., 2023) have worked with partners across Wales to coproduce an adapted version of this model to create a public health approach to violence prevention that works for Wales. The four-step model set out below reflects the views of stakeholders in Wales and developments in knowledge about the practical implementation of violence prevention efforts:

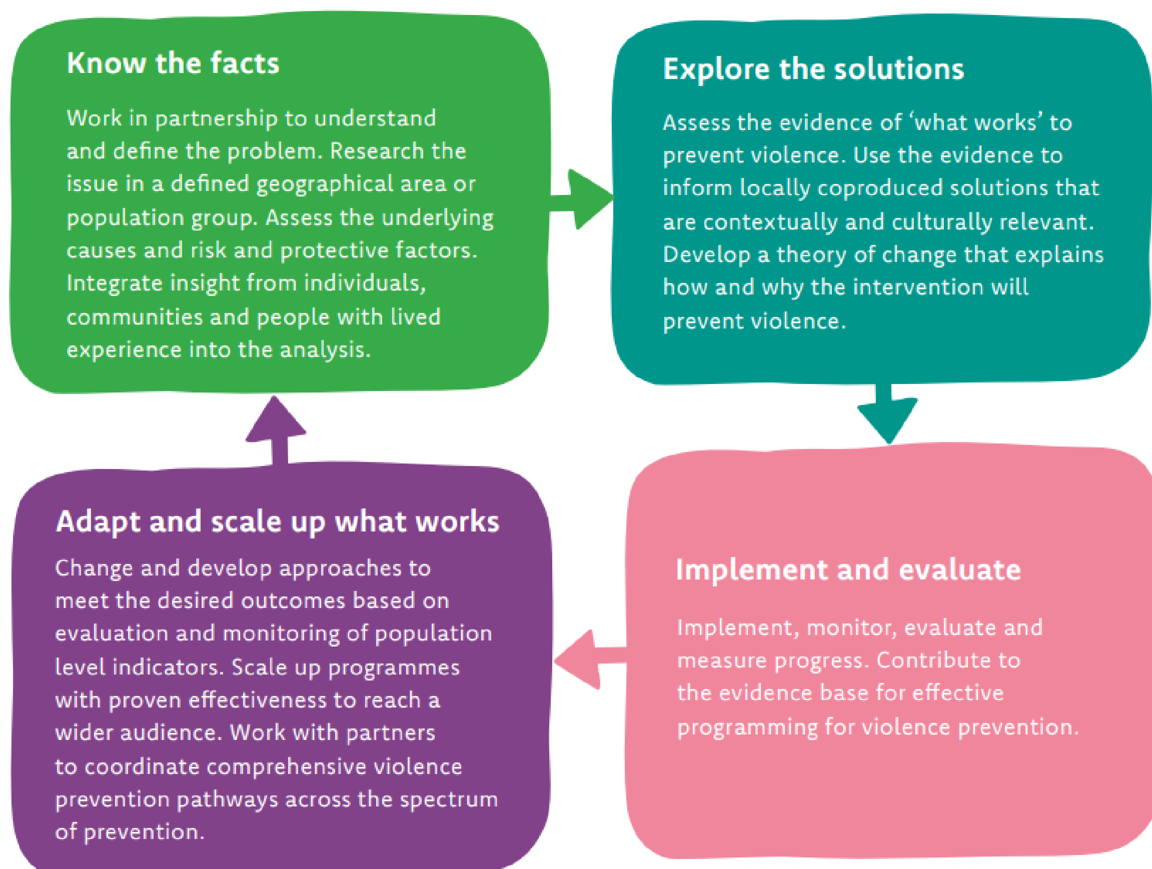

Figure 2: The four stages of a public health approach to violence prevention (Snowdon et al., 2023)

In addition to this approach, the following guiding principles are widely considered to be key features of a public health approach:

- **Population health** – A public health approach takes into account the health of whole populations, rather than individuals. The foundation of this approach is to understand the health needs of an identified population and use population level data to identify trends, patterns, associations, and inequalities in health need. This knowledge can be used to inform prevention programming, resourcing, and strategic action.
- **Evidence-based** – violence prevention programming should be informed by the best available evidence of effective practice. Programmes should be based on a theory of change and should be evaluated with the findings made publicly available to build the collective evidence base of 'what works' to prevent violence. The Wales VPU in partnership with Liverpool John Moore's University

have created a Violence Prevention Evaluation Toolkit which is a user-friendly guide to evaluating violence prevention interventions (Quigg et al., 2020).

- **Preventative** – programmes should be implemented across the spectrum of prevention; to prevent violence before it occurs (primary prevention); respond earlier and more effectively to reduce harm when it does occur (secondary prevention); and to prevent reoffending, re-traumatisation and prevent the intergenerational cycle of violence and abuse (tertiary prevention).
- **Focused on addressing the root causes of violence, vulnerability, and inequality** – violence prevention interventions should take an aetiological approach. This means focusing on understanding and seeking to address the causes of violence, vulnerability, and inequalities in affected communities. Interventions should be based on a theory of change which seeks to tackle these causes and address the negative impact of risk factors which promote violence.
- **Asset-based and empowering** – programmes should be designed to build on the resilience and assets of individuals and communities. Interventions should empower partners, communities and individuals to prevent violence, rather than being based on a punitive approach.
- **Place-based and coproduced** – interventions should be context specific and designed in partnership with the communities in which they take place. This is sometimes described as 'by and for' communities who have the knowledge of their area. This should include the voices of those with lived experience including victims and survivors.
- **Working in partnership and whole system leadership** - violence prevention initiatives should draw upon multi-disciplinary, multi-agency expertise through a partnership approach. The prevention of violence is a societal issue that requires action by the whole system including multiple agencies, it cannot be done in isolation.
- **Policy and legislation that is supportive of violence prevention** – a public health approach involves advocating for policy and legislation that is supportive of a public health approach to violence prevention, such as recognition of the importance of preventative approaches that enhance the health and wellbeing of future generations.

- **Trauma-informed** - There is national and international recognition of the importance of working in a trauma-informed way. Recognising the impact of traumatic experiences allows support services to mitigate any further impacts of the trauma. International research has highlighted strong links between trauma-informed approaches and improved health and wellbeing. The ACE Hub Wales and Traumatic Stress Wales have recently published a National Framework to Respond to Trauma in Wales (2022). This framework establishes a consistent definition and framework for the implementation of trauma-informed approaches in Wales.
- **Life course approach** – a life course approach is one that considers the impact of violence and opportunities for prevention across the life course. Through a public health lens, it is important to understand that interventions (especially those in early childhood) can prevent violence in the long term, and improve educational outcomes, employment prospects and the health and wellbeing of individuals and communities. They also have wider implications for the economy and society. A public health approach is not designed to replace existing approaches, skills and expertise utilised by the police and other criminal justice partners. Instead, a public health approach should be used to complement and add value to the work of existing partnerships to prevent violence.

Risk and protective factors for gender-based violence

The socio-ecological model provides a holistic model for understanding the various factors that can affect an individual's behaviour, thoughts and beliefs. It is a versatile model that has been adapted to understand many human experiences, not just violent behaviour.

The nesting circles (figure 3) place the individual at the centre surrounded by various systems that are all influential over the person. The individual is influenced by personal and biological factors, such as age, educational attainment, and income.

The first circle around the individual encompasses the relationships that the individual may have with family, friends and partners. These relationships can affect the individual's experiences and influence their behaviour, thoughts and beliefs. The next circle looks beyond the immediate relationships and includes the settings or

communities in which social interactions occur, such as schools, workplaces, online, neighbourhoods and religious establishments.

Whilst these systems do not necessarily directly impact the individual, they can exert negative and positive influences that can affect the individual, such as the social networks a person is able to get involved in.

The outer circle highlights the broader societal factors, such as health, educational or economic policies, and social and cultural norms, that an impact on an individual's life.

The diagram below shows some of the key risk and protective factors that are evidenced in the research as important factors in mediating the likelihood of experiencing gender-based violence (Dhanani, 2023).

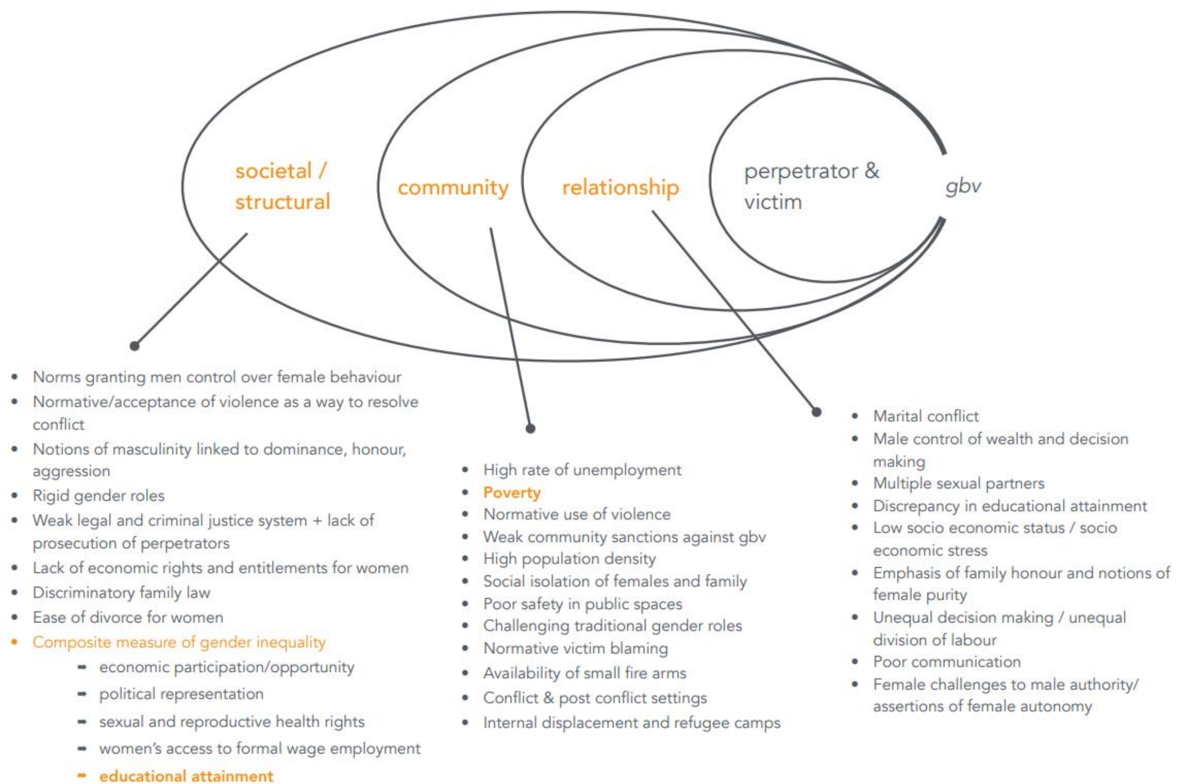

Figure 3: Gender-based violence as a determinant of health (Dhanani, 2023)

What works to prevent gender-based violence?

In 2020, the Welsh Government commissioned the Wales VPU team in Public Health Wales to undertake a systematic review exploring '[what works to prevent violence against women, domestic abuse and sexual violence]?' The report was published in

September 2021 (Addis and Snowdon, 2021) and provides a systematic assessment of the evidence base for the primary and secondary prevention of violence against women, domestic abuse and sexual violence (VAWDASV), and was designed to inform the Welsh Government VAWDASV strategy.

The systematic evidence assessment was undertaken in two stages; a search of databases to identify reviews of interventions designed to prevent VAWDASV published since 2014 and a supplementary search to identify primary studies published since 2018. Reviews (n=35) and primary studies (n=16), focusing on a range of types of VAWDASV, and types of intervention were identified. An additional grey literature search was undertaken to identify evaluations of VAWDASV prevention programmes in Wales undertaken over the last decade.

The socio-ecological model highlights four levels where prevention can occur and acts as a framework for the presentation of findings. At the individual level, effective interventions focus on working with young people to transform harmful gender norms and empowerment approaches. At the relationship level, the focus is on interventions to prevent adolescent violence including promoting healthy relationships and bystander interventions. At the community level a range of interventions, situated in schools, the workplace, and healthcare settings are outlined. Finally, the societal level encompasses interventions such as legislation and alcohol policy. Promising approaches to the prevention of VAWDASV are evident within each level.

The systematic evidence assessment identifies a range of effective practice to prevent VAWDASV that can be considered for implementation as part of the delivery of the national VAWDASV strategy. In the tables below, a summary of interventions with strong (table 1) and promising (table 2) evidence are outlined:

Table 1: Interventions with strong evidence of effectiveness

Changing Gender Norms	**School Based Interventions**	**Adolescent Dating Violence**	**Bystander Interventions**
Interventions that are underpinned by the transformation of harmful gender norms to prevent VAWDASV. The	Interventions delivered in a school setting to prevent VAWDASV, as part of a whole school approach,	Interventions targeting adolescents to prevent dating violence, within the school, college, online and	Interventions focus on equipping people with the confidence and skills to safely intervene when they witness

focus is often on men and boys often within school, college and sports settings.	including healthy relationships, education and bystander skills.	community settings. These include healthy relationships, education and bystander skills.	behaviours that can result in VAWDASV in a range of settings.
• Real Consent • Coaching Boys into Men	• Fourth R • Healthy Relationships Programme • Shifting Boundaries • Safe Dates • Stepping Stones	• Safe Dates • Fourth R • Shifting Boundaries	• Green Dot • Bringing in the Bystander • The Intervention Initiative

Interventions with promising evidence of effectiveness

Web and ICT based Interventions	**Theatre Interventions**	**Empowerment**	**Marketing**
Interventions using web-based or mobile technologies to optimise identification, referral, and prevention programmes.	These were applied, participatory theatre projects delivered in school, college and community settings	Interventions designed to promote empowerment through coaching for young women.	Social norms marketing campaign aimed at male university students.
	• Every 3 days • Safe dates	• My life, My Choice	• Social norms Sexual Violence Prevention Marketing Campaign
Night-time Economy	**Education and Screening**	**Alcohol Policy**	**Legislation**
Bystander interventions, awareness raising campaigns and alcohol legislation	Education and training for healthcare professionals undertaken within a range of	Intervention includes a range of measures including alcohol price, outlet	Legislation designed to invest in VAWDASV prevention and improved funding and response.

for employees in nightlife settings	healthcare settings.	density, bar management.	
• Good Night Out Campaign		• Minimum Unit Alcohol Pricing	• Violence against Women Act (US)

Gaps in the evidence

However, the review also found significant gaps in the evidence base for VAWDASV prevention. These include:

- Exploitation and trafficking
- VAWDASV among older age groups
- So-called honour-based abuse
- Many interventions focus on changes at the individual and relationship level within community settings, there is less evidence for societal level prevention
- The majority of studies were undertaken in the USA, with relatively few studies from the UK and no randomised control trials for primary prevention
- Diverse communities - to understand how prevention programmes intersect with the needs of individual and communities who are LGBTQ+, people from ethnically minoritized groups, people with disabilities, people from older age groups, Traveller Communities, Asylum Seekers, migrants, and refugees.

There were a range of shared characteristics across the effective interventions. These include:

- theoretically informed and evidence-based
- culturally relevant (often peer-led or using 'role models')
- empowering and skills-based
- extensive (a high level of dose -response)
- rooted in transforming harmful social norms.

In summary

In summary, this was a complex and extensive project which sought to explore the range of effective practice for primary prevention and early intervention. It tells us that the prevention of VAWDASV is increasingly feasible and effective. There was

significant value in exploring the literature as part of a public health approach which suggests that to be effective in preventing gender-based violence, there must be an 'eco-system' of interventions which prevent VAWDASV through a whole-system approach.

Effectiveness of a public health approach and what more needs to be done to address the needs of different groups of women, including LGBT+, ethnic minorities, young and older people at risk of violence at home and in public spaces.

The principles of a public health approach provide a useful framework to investigate and understand the causes and consequences of violence and for preventing violence from occurring through primary prevention programmes, policy interventions and advocacy (Krug et al., 2002). Increasingly, countries and international bodies, including Australia (Our Watch, 2021); Scotland (Arnot and Mackie, 2019); the United States (David-Ferdon et al., 2016); England (Bath, 2019) and the World Health Organization (WHO, 2019) (WHO, 2016) have produced system-wide frameworks for the implementation of a public health approach to violence prevention.

For example, the WHO's RESPECT Framework (WHO, 2019) presents a typology of seven strategies for the prevention of violence against women through a whole system approach. These include: (1) relationship skills strengthened; (2) empowerment of women; (3) services ensured; (4) poverty reduced; (5) environments made safe; (6) child and adolescent abuse prevented; (7) transformed attitudes, beliefs, and norms.

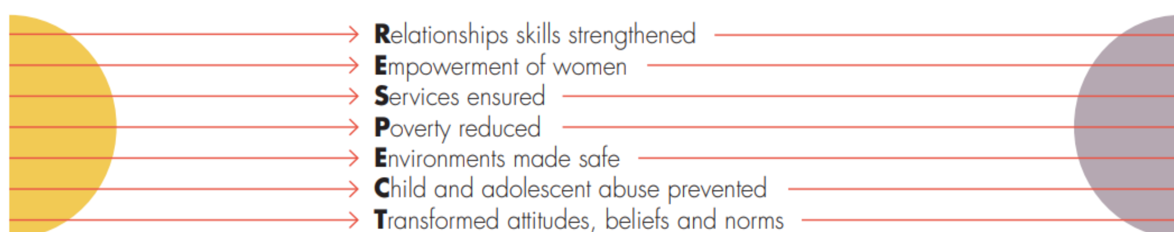

Figure 4:RESPECT 7 strategies to prevent violence against women (WHO, 2019)

In Wales, efforts have been made to develop this approach through the establishment of the Wales VPU. The mission of the Wales VPU is to establish a public health

approach to violence prevention for Wales. Early evaluations of the success of the unit to date have been positive:

- Evaluation of the Wales Violence Prevention Unit: Year 1 Findings
- Wales Violence Prevention Unit: Whole Systems Evaluation Report – 2020/21
- Evaluation of the Wales Violence Surveillance and Analysis System

Gender based violence as an intersectional issue

Gender-based violence is an intersectional issue. The following statistics provide examples of how multiple and intersecting identities/ social categories can impact on the risk, nature and impact of experiencing gender-based violence (Dhanani, 2023):

- Women who had a long-term illness or disability were more than twice as likely to have experienced some form of partner abuse (12.4%) in the last 12 months than women who did not (5.1%)
- Bisexual women were nearly twice as likely to have experienced partner abuse in the last 12 months than heterosexual women
- Women who identified with mixed/multiple ethnicities were more likely to have experienced partner abuse in the last 12 months (10.1%) than any other ethnic group
- Women living in households with an income of less than £10,000 were more than four times as likely to have experienced partner abuse in the last 12 months than women living in households with an income of £50,000 or more
- Women living in social housing were nearly three times as likely to have experienced partner abuse in the last 12 months than women who were owner occupiers
- There has also been recent work conducted in Wales on the experience of older male victims of domestic abuse. Figures indicate that around a quarter of people who experience abuse are male and that male victims tend to be older, with the highest proportion of those affected aged 75 or over (Older People's Commissioner for Wales, 2022).

Recognising inequalities in experience of violence, and utilising an intersectional lens, is a critical part of a public health approach. For example, data on the prevalence of violence against women demonstrates that the probability of experiencing violence (or particular forms of violence) is higher for some groups of women. This is not because

some women are inherently 'vulnerable'. Rather, it is the intersections between the social, political and economic processes of gender inequality and other forms of systemic and structural inequality that explain this.

In turn, experiencing violence, can exacerbate these societal inequities, and violence and structures of power and oppression are reproduced. As such, both analytical and strategic work for the prevention of violence must address these multiple and intersecting systems of oppression and discrimination, power and privilege that shape the social context in which gender-based violence occurs.

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

To take a whole-system approach, it is important to understand that effective violence prevention efforts engage people across the many different environments where they live, work, learn, socialise and play – often called 'settings'. These are the places where social and cultural values are produced and reproduced, and prevention efforts should aim to involve the people, professionals and communities in the settings that are most relevant in their lives.

Figure 5: Wales Without Violence: violence prevention settings (Snowdon et al., 2023)

Preventing gender-based violence requires collective and coordinated action from the public sector, private sector, voluntary sector, communities, and individuals. Everyone has a role to play. The Wales VPU's Wales Without Violence Framework (Snowdon et al., 2023) is a whole system approach to the prevention of violence among children and young people in Wales (inclusive of gender-based violence), which sets out what this approach should look like in practice.

The diagram below shows nine inter-related strategies which provide a comprehensive approach to preventing violence focusing on primary prevention and early intervention. The nine strategies span from birth and early years, through to childhood, adolescence and adulthood, mapped against the socio-ecological model to effect whole system change. In the framework itself there is a description of each strategy, with examples of the types of interventions from Wales.

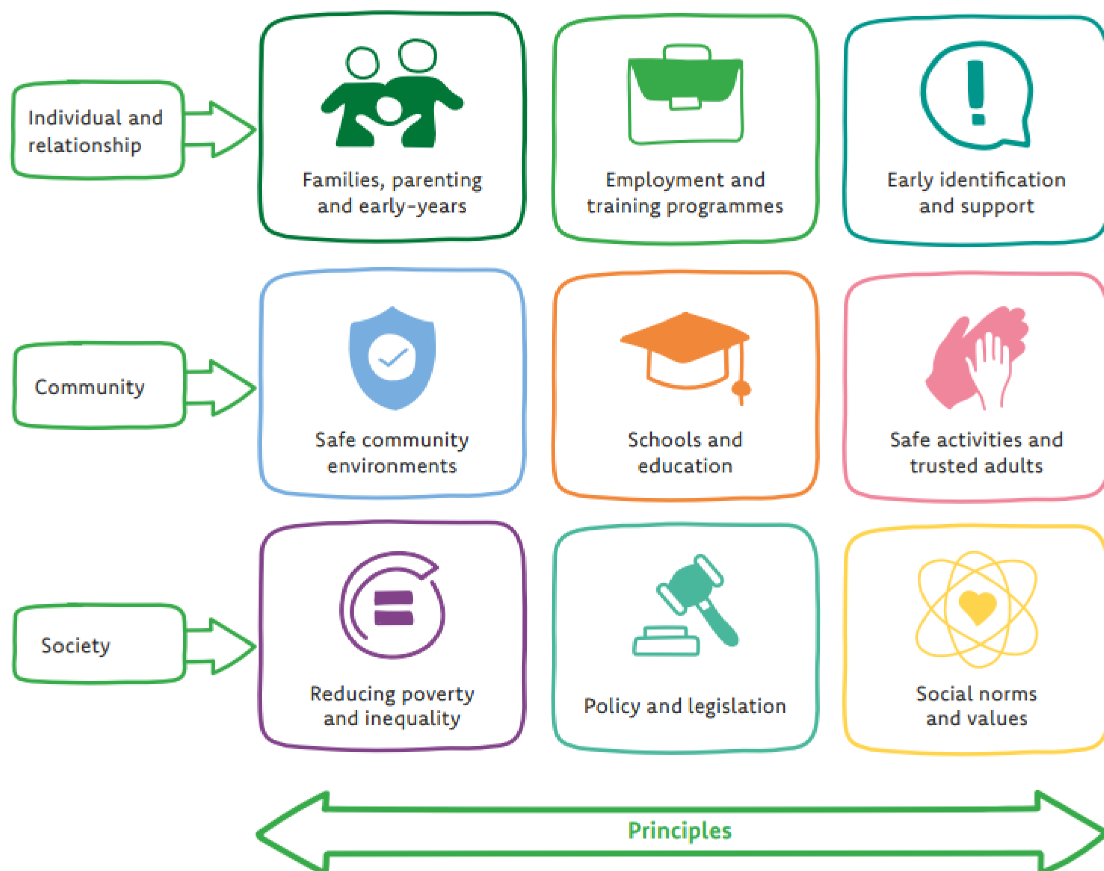

Figure 6: Wales Without Violence: 9 strategies to prevent violence among children and young people (Snowdon et al., 2023)

Opportunities for action

In Wales, whilst there are some examples of promising prevention programming and coordinated action for violence prevention, overall, this approach is in its infancy. Recognition of the importance of a public health approach to violence prevention in the new VAWDASV strategy is a welcome addition to the policy landscape, as is the coordinated action that will be taken under the VAWDASV blueprint, and the Welsh Government procurement of a national active bystander intervention.

However, there is still further and farther to go in terms of systematically embedding evidence-based prevention across the VAWDASV blueprint and other system-wide work on violence prevention, such as:

- prioritising violence prevention within the NHS and education sector, including alignment of violence prevention efforts within the new curriculum for Wales, and Relationships and Sex Education
- ensuring cross-governmental working is joined up in regard to areas which may impact on gender-based violence prevention (such as poverty reduction, equalities, planning, communities, education and early years)
- prioritising funding for investment in prevention and building the evidence base for violence prevention programming in Wales, including how violence prevention programmes intersect with the needs of diverse and marginalised groups
- embedding trauma-informed practice in services across Wales
- embedding evaluation in gender-based violence programming to understand outcomes and impact
- developing multi-agency data on gender-based and other forms of violence to measure prevalence, trends, monitor inequalities, and track progress in prevention.

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

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

PGBV 20
Ymateb gan: Seicolegwyr dros Newid Cymdeithasol Cymru | Response from: Psychologists for Social Change Cymru

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Psychologists for Social Change **Cymru**

Dros Newid Cymdeithasol **Cymru**

What does a public health approach to preventing gender-based violence look like?

Psychologists for Social Change Cymru are part of a network of groups across the UK. The network is made up of applied psychologists, academics, therapists, psychology graduates and others who are interested in applying psychology to policy and political action. We believe that people's social, political, and material contexts are central to their experiences as individuals. We aim to encourage more psychologists to draw on our shared experience and knowledge to engage in public and policy debates.

We strongly support tackling violence in our communities. We believe that such action is an essential part of improving the mental and relational health of the nation and future generations. To do this we believe that a public health approach to violence is essential and that that approach must be trauma-informed, relationally focused and take a whole system view. This is vital if we are to succeed in breaking the vicious cycle of persistent violence, poverty, and poor mental and physical health.

Summary of Key Points

- Taking a trauma informed and relational health approach to understanding violence and aggression is key to breaking the cycle of violence and abuse.
- Our current approach to understanding gender-based violence points the fire hydrant at the fire alarm and misses the fire. If we are to seriously root out violence from our communities and create a safer, happier, and healthier Wales we must point the fire hydrant at the fire.
- To do this we must take a public health view and understand how toxic stress, trauma and not having our material or relational needs met contribute to gender based violence.

To discuss anything in our response further please get in touch with:

Breaking the Cycle: A Trauma informed and Relational Health understanding to preventing Gender Based Violence

The Welsh Government's national Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) strategy 2022-26 states "VAWDASV does not happen in a vacuum, it has roots in cultures and attitudes that run across society. Perpetrators are emboldened and abuse is normalised by the environments in which they live". It also states "it is more than 'behaviours' that enable VAWDASV, it is societal norms, attitudes and beliefs that must be challenged as these are what perpetuate, excuse and legitimise VAWDASV".

It is important we take this statement further. It is more than 'behaviours' that enable VAWDASV it is the conditions within our society and communities that create cultural and social norms that disrupt and erode our social fabric, sense of cohesion, and connection to each other that must be challenged and changed. It is these that perpetuate, excuse, and legitimise violence and dehumanisation as a response.

When we see violence and aggression through a trauma informed and relational health lens, we must question what we mean by 'perpetrator' and 'victim'. In a toxic world that drives the conditions for disconnection, dysregulation and aggression who really are the 'perpetrators' and the 'victims'? We will address in detail this dynamic throughout our response.

Our current approach to understanding gender-based violence points the fire hydrant at the fire alarm and misses the fire. If we are to seriously root out violence from our communities and create a safer, happier, and healthier Wales we must point the fire hydrant at the fire. What we need to do that is to create healthy communities in which everyone has the chance to thrive. We must do this alongside services that have as their core principles social justice, human rights and are least restrictive and compassion focused in their approach.

From the therapy room to the political chambers, it's clear the appetite to look beyond traditional gender norms is growing. Science has shown us clearly the dangers of teaching boys to supress their emotions to maintain an image of being strong and independent. Men tend to take more risks than women, pay less attention to their health, commit suicide more often, and die earlier (Sagar-Ouriaghli, 2019, King, et al, 2020, Raleigh, 2022). The modern acceptance of toxic and restrictive masculinity within our culture props up the patriarchal system and creates problems for society, including an epidemic of mental health problems, mass violence, and violence towards women (Williams, 2019). This is both an individual and a societal problem.

If we are going to get it right for women, we must start with getting it right for everyone. This means understanding what is going on for boys and men too. We need to ask ourselves some uncomfortable questions. What is the link between shame and male violence? Why do we find it hard to value kindness and compassion in men? What role do parents play in defining what is expected from boys (Gabbay, 2021)? It is important to consider the role of schools as

social support networks as children enter adolescence and their reliance on family becomes shared with peer support and influence. Schools also provide a significant, population level opportunity to both prevent and provide early intervention for dating violence and a number of evidence informed, evaluated interventions (e.g. Lights4Violence.eu, Perez-Martinez, Sanz-Barbero, Ferrer-Cascales, Bowes, Ayala et al. 2020).

How does gender based violence show up in mental health services?

Much has been written and documented about the inequity between how men and women are treated in our society. The book Invisible Women by Caroline Criado Perez exposes in depth the data bias that exists making our world one predominantly designed for men.

There are specific ways in which this bias shows up in mental health services which perpetuate inequity and violence against women. In the UK, being a woman means you're three times more likely than a man to have a mental health problem. This topic was covered recently by Dr Sanah Ahsan, Clinical Psychologist in a Guardian article entitled "Are women really more mentally ill than men?" Here Dr Ahsan points out the additional burden women carry. That it is therefore not a 'chemical imbalance' but a 'power imbalance' that is at play. Women are more likely to live in poverty, experience sexual abuse, intermate partner violence, be thought of as lesser, and lack of adequate support and social welfare for childcare or caring responsibilities. Current work culture too is a source of additional stress and pressure (YouGov, 2022).

Women are more likely to be diagnosed with anxiety and/or depressed and 75% more likely to be given a diagnosis of 'personality disorder'. A controversial diagnosis that Clinical Psychologist's Dr Jen Daffin and Dr Carly Jackson wrote about in an IWA article earlier this year called "How the Mental Health System Discriminates Against Girls and Women". Older women are also twice as likely to be treated with electro-convulsive therapy or ECT, another controversial treatment. Rates of self-harm among young women have more than tripled since the 1990s and experience of PSTD in women after giving birth are at levels high enough to be a public health concern (Etran, et al., 2021). Yet there are no clinical sound pathological or medical reason for these variations.

What these figures suggest is that discrimination against women not only leads to poorer mental health but poorer intervention from mental health services. The way society treats women, including institutional and political injustice means women are more likely to be subjects to stress and toxic overwhelm and not have their emotional and relational needs met. But once they reach out for help this same prejudice presents itself in how they will be treated by mental health professionals. Their needs are downplayed, ignored, overshadowed or treated more harshly. They are likely to have their trauma experience overlooked and overshadowed with other mental health diagnosis, such as with the diagnosis of personality disorder. When misogyny masquerades as clinical practice it compromises patient safety and dignity alongside professional integrity too.

Creating Trauma and Relationally Informed and Responsive Communities to Address Gender Based Violence

Whilst we need services that are trauma and relationally informed, addressing this problem is much broader. Reducing the demand for mental health services will require us to address this problem before people arrive at needing a mental health intervention. Today nearly 4 in 10 Welsh households cannot currently afford anything beyond essential everyday items and many families struggled these past winters with heating their homes and feeding their children (Bevan, 2022). As people's struggles have worsened anti-depressant prescription rates have significantly increased as well. A steady increase that's been happening in Wales over the past 20 years (BBC Wales, 2021). Behind these devastating figures lie decades of socioeconomic deprivation following the closure of the coal, steel, and iron industries. Leaving a legacy of long-term unemployment, high rates of poverty, and an entrenched loss of hope and apathy in many once flourishing communities across Wales.

Adverse Community Experiences

We know that the stresses of living with inadequate access to economic and educational opportunities, or a lack of opportunity itself, contribute to experiences of community level adversity and violence (Pinderhughes, Davis, & Williams, 2015). This means trauma and violence are equally created by political, social and cultural processes when, for example, people and communities aren't able to have their basic emotional and physical needs met and are unable to live in safety or without threat (WHO, 2014; Compton et al., 2020).

The specific way in which adverse community experiences impact our mental health can be summarised as prolonged exposure to humiliation, shame, fear, distrust, instability, insecurity, isolation, loneliness and being trapped and powerless (Psychologists for Social Change, 2015). A lack of opportunity, and poor infrastructure alongside disconnected and socially fragmented communities create the conditions for community level adversity and violence (Pinderhughes, Davis, & Williams, 2015).

Adverse Experiences, Victimisation and Crime

Adverse community experiences, such as concentrated poverty, segregation from opportunity, and community violence, contribute to community trauma, which can exacerbate adverse childhood experiences (ACEs). ACEs influence adult behaviour and

responses including a propensity towards violence. The link between childhood adversity, victimisation and criminality in adulthood is well established. The Scottish Government Justice Analytics Service makes a strong case for preventing crime by targeting those most at risk of experiencing adverse childhoods and supporting people in the justice system whose lives have been affected by adverse childhood experiences (ACEs) to reduce reoffending and prevent intergenerational crime and victimisation. It argues that this will require a coordinated and collaborative effort across all of government (Scottish Government, 2018).

Prolonged exposure to stress in childhood disrupts healthy brain development. This can manifest as what often gets labelled as social, emotional, and behavioural problems. It is more helpful to think of these issues as responses to trauma and distress, of not having our relational health needs met. Children who experience toxic stress are more likely to become adults who risk-take and engage in criminal activity (Levenson et al, 2016). ACEs have been linked to many factors that increase risk of offending including substance and alcohol use, deprivation, poor educational attainment, and mental health problems (Centres for Disease Control and Prevention, 2015).

People who experience multiple ACEs are more likely to be a victim of violence in adulthood than people who have no ACEs. Research shows that people who are abused as children are more likely to be abused as an adult. As exposure to toxic stress increases, so too does adult sexual victimisation (Ports, et. al., 2016). People who experience child abuse or witness domestic violence in childhood are more likely to be abused by a partner in adulthood than those who did not experience abuse or witness violence. This is particularly true for women (CSEW, 2017). These studies point to the importance of understanding the role of childhood maltreatment in preventing and addressing victimisation in adulthood.

But this is only half of the story.

The Social Determinants of Health and Violence

In public health, recognition of the importance of the social determinants of health has led to significant shifts in practice and research. It is now widely acknowledged that our mental health is too largely determined by the conditions in which we are born, grow, work, live, and age (WHO, 2014, Shim & Compton, 2018). Addressing the social determinants of mental health involves shifting our focus from medication, therapy, and neurobiological innovation and towards understanding how policy and circumstances cause mental ill health. It means moving our focus from asking 'what is wrong with you' to asking, 'what has happened to you, or didn't happen for you that should, and what did you do to survive'?

Mental Health is complex but at its simplest, mental health problems and diagnosis are the result of nervous system overwhelm (automatic fight, flight, freeze, fawn responses to threat) and loss of connection with the self, others and the world. Poverty is known to heighten isolation, disconnection and nervous system overwhelm (Compton & Shim, 2020; Porges, 2011).

The relationship between poverty and mental health is now well established in the literature, with The World Health Organisation stating that:

"There is good evidence, for example, that common mental disorders (depression and anxiety) are distributed according to a gradient of economic disadvantage across society and that the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences."

(WHO, 2014).

A 2022 major review by Nuffield Foundation and the University of Huddersfield of children's social care in England and Scotland found that family poverty and inequality are key drivers of harm to children. Demonstrating a link between poverty and child abuse and neglect. (Bywaters & Skinner, 2022). Deep poverty, growing rapidly in the UK in recent years, and persistent poverty are more damaging for children's safety and development than a low income or temporary difficulties. Insecurity and unpredictability of income, often the result of benefits administration practises, housing and employment, compound the problems of parenting with an inadequate income. Recent research about neighbourhood factors has focused more on social relations and indicates support for the role of adverse community experiences alongside economic status as an explanation for how poverty, poor relational health and violence interact in their complexity.

A growing evidence base since 2014 suggests this link is now demonstratable across the mental health diagnosis spectrum, beyond experiences of anxiety and depression. Traumatic experiences in childhood are frequently reported by people with a diagnosis of mental illness; 85% of people with a diagnosis of schizophrenia; 82% of people with a diagnosis of personality disorder, 77% of people with a diagnosis of affective disorders including major depressive disorder + bipolar disorder and 70% of people with a diagnosis of PTSD report experiences of childhood abuse and/or neglect (Rokita, et al, 2018).

It is not only a lack of economic security that causes these issues. The impact of the 'price of privilege' is well documented too. A lack of money is not the only mean by which toxic stress is created and manifests. Materialism, pressure to achieve, emotionally absent parental figures and perfectionism also erode our relational health (Levine, 2008).

What all this means is that when our circumstances lack the conditions for relational health, we are more likely not to have access to safe secure nurturing relationships. We are then more likely to be in a state of nervous system overwhelm, a state of threat and not have the opportunities to learn how to self sooth, feel safe within our own bodies and relate to others in a healthy way. Whilst we may witness violence as a culturally normal response and have relational patterns of violence passed down to us through our parental figures own experiences of adversity and distress, we will also be ourselves primed by our own 'fight or flight' hypervigilant dysregulated threat state to respond with defence and violence. For boys and men who are socialised to value masculinity as strength and a defending of honour there is little genuine choice other than violence. For those using substances as a means of

managing or escaping overwhelm the ability to stay out of violence as a response is a weighted challenge as the alternative here would be shame. Johan Hari's TEDx talk Everything you think you know about addiction is wrong articulates our misunderstanding of drug addiction and the need move towards understanding addiction as connection seeking.

Shame is the fear of disconnection, of not living up to what is expected and then being rejected. Of not belonging. We are physically, emotionally, and cognitively hard-wired for connection, love, and belonging. Shame is a deeply social response, and it is traumatic. It is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love, belonging, and connection (Brown, 2022). Our emotional pain runs on almost the identical pathways as physical pain (Robert, 2020). Shame is highly correlated with addiction, depression, violence, bullying, and eating disorders. It is why the oxytocin/Prudue Pharma scandal in the US became an addiction epidemic (Keefe, 2021).

Moving from shame to guilt is a key child development stage in our early years. We are learning about these emotions when we are about 1-5 years old (Erikson, 1956). If we receive safe secure nurturing relationships, we learn to move from "I am bad" to "I did something bad". Shame and guilt are learned within our social environment through observation, modelling, and verbal transmission (Eisenberg, 2000). If we are not given appropriate opportunity to learn these key emotions, there is a cost to our relational and mental health longer term including our ability to regulate and manage our emotions, stay out of 'fight' as a response and how we feel about ourselves alongside how we respond within our relationships with others.

There is substantial evidence to support the experiences of post-traumatic stress for people who have experience intimate partner violence (Jones, Hughes & Unterstaller, 2001). What we speak less about is the trauma of those who we often label as 'perpetrators'. We say, what's wrong with you? Why are you so bad? Why are men bad? Whereas when we understand the impact of trauma, childhood development and our relational needs it makes much more sense to ask 'what happened to you? What did you not get that you needed? Some of the symptoms of trauma include feeling tense, on edge, feeling irritable and having angry or aggressive outbursts, self-destructive or reckless behaviour as well as re-enactment of trauma (for example, violence and abuse; WHO, 2019). When we ignore the impact of trauma we miss the bigger picture. That bigger picture is the missing piece to addressing and healing violence in our communities and towards women.

Psychological formulations provide hypotheses, explanation of a person's journey towards using violence or surviving violence. Trauma is often part of both journeys and this represents a significant assessment and treatment need for people. For those who have used violence there is also an additional treatment need to address that violence including psychological treatment needs – including violent thinking which has repeatedly and cross culturally been shown to account for around a third of the variance of male violence (Walker & Bowes, 2013)

> "When you study prison populations you see a common preponderance of childhood trauma and mental illness. The two go together. So, what we have in prison are the most traumatised people in our society."
>
> Dr Gabor Mate

Our Relational Health Needs

Relational health refers to the capacity to develop and sustain safe, stable and nurturing relationships (SSNR's), which in turn prevent the extreme or prolonged activation of the body's stress response systems (Garner, 2021). Not only do SSNRs buffer adversity and turn potentially toxic stress responses into tolerable or positive responses, but they are also the primary vehicle for building the foundational resilience circumstances that allow children to cope with future adversity in an adaptive, healthy manner.

Relational health is about having safe and supportive relationships with our families, our friends, our communities, and ourselves. It's about having our core needs of agency, security, connection, love, belonging, meaning, and trust met (PSC, 2015).

We also need predictability, consistency, acceptance, empathic responses, and opportunity for repair when there are ruptures or breakdowns in our relationships.

We are not born with the ability to meet these needs ourselves. We first learn how to make sense of our emotions through our primary attachment figure tending to our needs. Through them tending to our cries and voicing back to us or 'organising our feelings' we learn to make sense of our emotional world and develop a sense of trust in others, ourselves and the world. What we are also learning here is how to feel safe and secure. A core need for happy healthy children and parents too. We call this developing a 'secure base' and it is how we learn to regulate our emotions as well as how we learn to do relationships. It gives us the blueprint for how we will respond in relationships with other people, as well as how we relate to ourselves, throughout the rest of our life. This is called our relational patterns.

Emotional regulation is a term generally used to describe a person's ability to effectively manage and respond to an emotional experience. We unconsciously use emotion regulation strategies to cope with stressful situations many times over throughout our day. But we are not islands and we can only ever be as regulated as the people around us (Porges, 2011). This is why our circumstances are so important but also deterministic of our mental health.

It is normal for all of us to feel overwhelmed and dysregulated throughout the day and periods of our lives. This does not make us broken or weak. But when we are persistently overwhelmed there are costs to our physical and mental health. You may know this as toxic stress or adverse childhood experiences. Too much stress in our daily lives, particularly our

early years compromises our health and can lead to diabetes, heart disease, mental health issues including addiction as well as autoimmune issues, cancer and arthritis. It can also disrupt our cognitive development too. We also know that the first two months of our lives have a disproportionate impact on our later life mental health outcomes than any other period in our development (Perry & Oprah, 2021). We know that we are more likely to experience emotional overwhelm if we're living in poverty, faced with injustice, forced to rely on fear and shame-based systems, and don't feel connected to our communities, ourselves, or the people around us.

We must also understand how a lack of relational health resources can lead to people experiencing a lack of power over themselves, their futures, others and their environments. This leaves them with a sense that they lack inner safety and might seek to address that from seeking safety from others, making demands on others because they cannot meet those demands themselves. This often negatively impacts on relationships, as people try to control others or their environments as a means of increasing their own safety.

Community and Childhood Adversity, Relational Health and Gender Based Violence

Intimate partner violence (IPA) is inherently relational and the result of an interaction between individual, relational, community and societal factors (Garcia-Moreno et al., 2005; Velotti, et al, 2018). Whilst stress in our circumstances can lead us to respond from a position of 'fight' which would be alleviated once a stressor is removed, for many people being in a threat state is all they have ever known. They have not been provided the opportunity to learn relational health; to have the skills to make sense of their emotions or regulate their responses.

> "I'm a traumatised child raised by a traumatised child. My mother was traumatised."
>
> Male Prison Inmate from the Compassionate Prisons Project

Step Inside the Circle, a short documentary by the Compassionate Prisons Project, is a call to action to spread the word about Adverse Childhood Experiences (ACEs). It is a call to recognize the physical, emotional and social impact ACEs have wrought upon society and to stress the importance of care (not punishment) going forward in the prison system.

Unresolved trauma has been well documented to impact a person's reflective functioning and affective mentalization (Luyten et al., 2020). In other words, their ability to pause and think

before reacting alongside holding in mind the other person's position and to hold empathy towards others and ourselves.

Boys and Men's Relational Health

For men and women there are additional respective gender constructs, stories about how men and women should be, that add complication to this already very complex picture. Whilst girls are encouraged to care for others and be emotionally in tune (and discouraged from very many other things) boys are discouraged. The girl's toys and boy's toys BBC experiment shows us how engrained this is into our automatic responses. In an experiment where boy and girl babies were given the 'opposite gender' clothing a research team asked adults to interact with the babies, providing them a range of toys to do so. On the whole participants gave the 'girl's' girl toys and the 'boy's' boy toys. Not based on their actual sex but on assumptions they made about their gender based on their clothing. These assumptions run deep within our culture. The Netflix documentary Beyond Men and Masculinity shows how as a society we are failing to equip boys with the appropriate skills and experiences to understand and regulate their emotions healthily. Boys in their primary and early attachment relationships, which is reenforced then by society, are discouraged from learning to connect with and organise their feelings in a way that will provide relational safety and security. Instead, they are shown to supress their emotions compromising their ability to have access to relational health and respond in relationally heathy ways. There is now a robust evidence base demonstrating the link between emotional regulation skills and ability, reflective capacity and aggression (Garofalo, Gillespie, Velotti & 2021). To break the cycle of intermate partner, family violence and violence towards women more generally we need to be equipping boys and men with emotional (nervous system) regulation and relational health skills (Orozco-Vargas, et al., 2021).

This is another part of the story that we must pay addition to and address if we are to create opportunities for responses other than abuse, oppression and violence.

Diversity, Inclusion, and Intersectionality

Whilst the mental health sector perpetuates discrimination against women there has been criticism that current dominant interventions are not designed with men's needs in mind either. This point can be taken further, and it could be argued that the reductive approach to mental health care provision in the NHS is not person centred enough full stop and a lack of appropriate provision for men is part of a wider issue that needs addressing. There are many good examples to draw on, for example, men's shed, MAC-UK, and it takes balls to talk.

This same issue is extended to offering intervention and service that are culturally competence, anti-racist, LGBTQ+, and disability inclusive. These intersecting issues will require a public health approach to violence that understands trauma and relational health

through a social justice lens. It will require us to understand power, its impact on our experience of what is threat and how individuals and/or communities will make sense of that drawing on their own social positions and experiences (Johnston & Boyle, 2018).

The role of the public sector and specialist services

Public services must delivery their support and design their services with a trauma informed, relational health and social justice approach at the core. They must be literate in these theoretical concepts and adept at applying this theory into practice. They must understand how a lack of relational health can lead to the need to have power over others and external validation. Poor relational health leaves us with a lack of inner sense of safety. As a response to needing to feel safe people can seek this by trying to control others and their environments. In jobs that have a high exposure to trauma distress create the conditions for a workforce that is at greater risk of becoming trapped in abusive, controlling, and violent responses. If we are going to better support the people who use our public services, we must first understand our own cultures and context and their contribution to the problem.

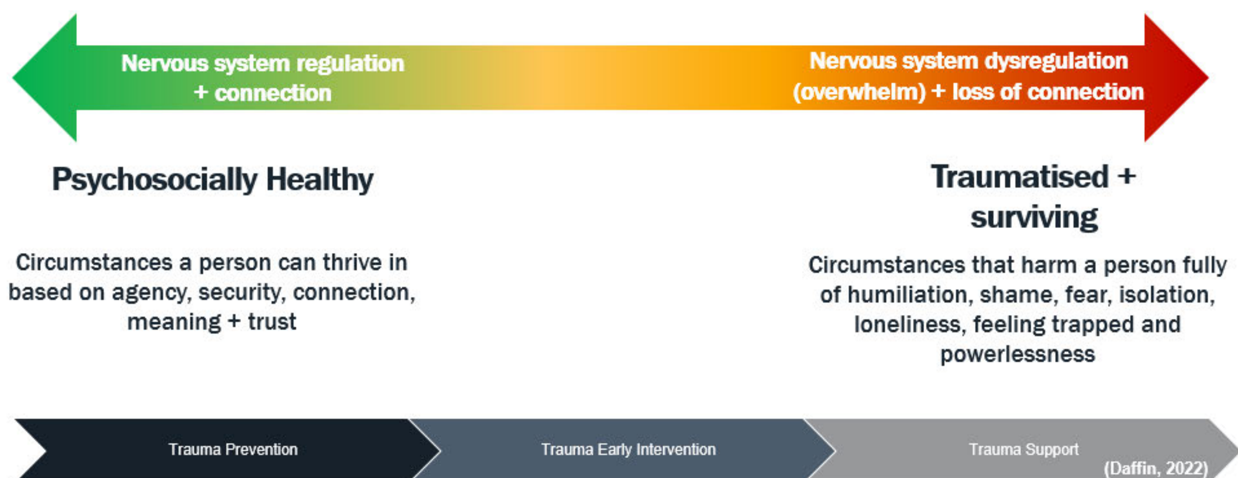

Figure 1. Continuum of Relational Health

Our public services are in the process of moving away from approach that are underpinned by humiliation, shame isolation and fear and towards relationally healthy ways of responding. But this is a huge cultural shift and a task to ensure our policy, practice and intervention is based on agency, security, connection, meaning and trust and humiliation, shame, fear and powerlessness. For example, high schools use the restrictive practice of seclusion, which is an undocumented and regulated approach to 'behaviour' management not grounded in relational theory or practice. The benefits system sanctions and punishes people, and

although much work has been done within the police forces in Wales to become ACE aware recent report suggest there is still distance to travel in making that social justice informed. South Wales Police have the highest number of officers and staff involved in allegations of violence against women and girls – accounting for 63% of all complaints against Welsh police forces.

Our public sector services would benefit from support to dedicate time and resource to assessing their current approaches against the relational health model conditions for relational health depicted in figure 1 to ensure their practice, policies and interventions or actions are not contributing to relational harm. This equally applies to the workforce who should not be forgotten as key to breaking the cycle of violence too.

Early intervention programmes in high school would be appropriate here. By year 8, children are already being exposed to dating violence (perpetrating and surviving) and so intervention programmes are also required by the time children reach high school (Vives-Caces et al. 2021). Teachers need to be equipped with evidence informed, evaluated approaches to address dating violence (e.g. Lights4Violence which was trialled in Wales and five other European countries). Lights4Violence.eu provides free resources, manuals and guides to teachers in six European languages to support teachers with this task.

What does a whole society approach to the concept of healthy relationships look like?

A whole society approach to healthy relationships starts with developing a public health approach to relational health. A new public health approach to relational health needs to be integrated into primary, secondary, and tertiary preventions as well as across public service sectors beyond health care (AAP, 2021). This would include an understanding of how trauma, poverty and other social determinants contribute to our mental health.

We must ensure this includes a public information campaign that tackles outdated or untrue information, such as the 'chemical imbalance' theory of depression, equipping the population with an accurate understanding of what influences our mental health to increase the opportunity for informed patient consent. Additionally, we need to provide relational health knowledge to the public sector workforce and support them to apply it to themselves and their practice.

We must equally make relational health knowledge part of the education curriculum and allow teaching staff the space and time to provide safe security nurturing relationships across all stages of education, not just in primary school but high school and college. An example of this is the Cardiff University primary AGENDA programme but this programme would benefit from including theory about relational health, attachment theory and an understanding of he importance of secure base. There should be an impact assessment and evaluation to

understand what teaching staffs needs are to implement a relationally informed approach as part of a move towards whole school approaches.

Using a relational health understanding we must create public policies that address the problems outlined in this paper by continuing to redress the unfair and unjust distribution of resources as well as the social norms that perpetuate them and create healthy communities to reduce exposure to toxic adversity. We must continue to focus on creating the right circumstances in which everyone has a chance to thrive across government, public services and as a society. This would include reducing restrictive and other shame inducing practices from our public policy and services, including in mental health services, education, social care, and prison settings. Appropriate accountability mechanisms should be created to ensure this can be evaluated and monitored.

Finally, protections should be strengthened to ensure social media is not impacting upon children's relational health, wellbeing and increasing their exposure to abuse and violence.

Thank you for your time and consideration of our response. We look forward to seeing how this work develops. If you'd like to discuss any of the points we raise further please do get in touch.

Yours sincerely,

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

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

PGBV 21

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28th April 2023

Equality and Social Justice Committee: The public health approach to preventing gender-based violence

Summary of Response:

Platfform has decades of expertise in responding to distress held by people, and communities. This distress, caused by poverty, inequality, and trauma, can lead to perpetuating cycles of intergenerational violence. In our response below, we set out our perspective on the social determinants of mental health, and the links between those determinants, and how it can play out in individuals and across communities.

To tackle gender-based violence, we need to build connected and relational communities that can understand and articulate their shared experiences. We need to tackle poverty and entrenched inequality – it is very difficult to have the space for healing and connection when you are trapped in the toxic stress of poverty. We need to listen to and hear the distress and pain of people who have been harmed – whilst also understanding the trauma shared by over 80% of people who cause harm. This is the space we believe that public health across Wales must occupy, so responses can be developed in partnership with communities, survivors, people who harm – and the range of organisations across Wales – to deliver real change.

About Platfform

Platfform was born in 2019 from Gofal, a mental health charity established in Wales in the late 1980s. Through decades of working across housing and mental health, we gained real insight into the reality of mental health in society, the impact of trauma, and the causes of distress. That work led us to change our focus and become Platfform, the charity for mental health and social change.

Today we work with over 9,000 people a year. We support people of all ages, across urban and rural communities, in people's homes and alongside other services. Our work spans inpatient settings, crisis services, community wellbeing, supported housing and homelessness, businesses, employment, counselling, schools and youth centres.

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A brief note on language:

We explore in the response below, that reinforcing a categorical view of domestic abuse is not helpful in navigating the complexity of people's needs and that it is important to avoid perpetuating feelings of shame and intergenerational harm. For these reasons, except when quoted as part of research, we have chosen the phrase "people who harm others", to reflect the link between relational health, past trauma, but also the need to recognise the very serious harm often done to people because of intimate partner violence (IPV).

We have used the term intimate partner violence (IPV), in our response to allow for the nuance of relationship types and statuses, whilst recognising that the vast majority of IPV happens to women.

Wales and Violence Against Women, Domestic Abuse and Sexual Violence

Wales has a long history of addressing, with cross-party consensus, the structural and individual factors that make gender-based violence such an entrenched public health issue. At Platfform, we acknowledge the decades of work in which activists led the way in campaigning for changes and delivering services often in the context of societal judgement, denial, and dismissiveness. Many of the women who led the movement for recognition and early support, have also driven forward the work that culminated in the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act. It is on their shoulders that we stand.

We also acknowledge that this journey is not over. Historical abuse and entrenched inequality continue to leave a legacy with significant impacts on people across Wales. We also recognise that the impacts of austerity have made it harder for organisations across Wales, and beyond, to operate within VAWDASV policy. Ambitious pan-Wales legislation that introduced duties such as the 'Ask and Act' duty, will have struggled to have widespread impact due to the multiple demands on public service delivery. Furthermore, the interrelation between Wales' responsibilities as a devolved nation, and the power still held by the UK Government, has inevitably made it difficult to set out a pan-Wales approach that captures

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the similarly radical spirit of legislation such as the Wellbeing of Future Generations (Wales) Act.

Across the variety of Welsh legislation in both the previous two Senedd terms, and the current Senedd, Wales set an ambitious preventative approach. Whilst not always fully realised, often due to budgetary, legislative, or constitutional constraints, they certainly set the direction of travel which has guided developments by stakeholders ever since. The next stage of Wales' journey to eliminate gender-based violence must be built on that same preventative approach, to avoid the repetition of crisis response after crisis responses.

We believe that a public health approach to gender-based violence is to look at our whole society, breaking down systemic oppression, poverty, trauma and shame and create an approach that works for everyone.

Platfform's focus for this consultation response

Platfform does not provide domestic abuse services. However, we do operate in spaces where we see the distress people who have experienced abuse experience, in its many and varied forms. We also work with people who may have caused harm to themselves as well as others in their lives. We also work within schools and alongside young people who may experience similar harm within their family contexts. In this response, we want to articulate how our experience and expertise in working with trauma and distress can inform, and add an extra dimension to this policy area, with the aim of exploring how a public health and/or preventative approach can be developed even further across Wales.

Our expertise is not in the delivery of IPV services. Our response will speak to the knowledge we have around trauma and its impact, and the need for an evolution in our understanding of mental health – and the opportunities that offers to take a public health approach to prevent future harm and minimise / address current harm.

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Social determinants of mental health

Platfform's Manifesto for Social Change sets out the evidence base for an evolution in our understanding of mental health[1]. Our mental health is largely determined by the conditions in which we are born, grow, work, live and age along with the wider set of forces shaping the conditions of our daily lives.

Deprivation and injustice are causes of mental illness. When we do not have what we need it puts immense strain on us, our families, and communities. This leads to experiences of injustice, adversity, trauma and despair. This, in turn, leads to neglect, abuse, poor health and lives being cut short.

Stress, trauma, poverty, and violence experienced during the first 1,000 days of a baby's life can have lifelong adverse effects on health and wellbeing. This is because the first 1,000 days are when a child's brain undergoes accelerated growth and development, and when the foundations for their lifelong health are built. How well or how poorly mothers and children are nourished and cared for during this time has a profound impact on a child's ability to grow, learn and thrive. Nearly 4 in 10 Welsh households cannot afford anything beyond essential everyday items. Wales has the highest levels of child poverty in the UK. As people's situations have worsened, anti-depressant prescription rates have increased. It's a steady climb that has been happening in Wales over the past 20 years and includes a 30% rise in anti-depressant use with children.

While the impact on poorer communities is greater, we all suffer from the consequences of disconnection and overwhelm. We've less time and energy to take care of ourselves or be there for the people we love, storing up problems for our future generations. The foundations for us to thrive as human beings are safety, purpose, and connection. These aren't just nice words. They mean that as human beings we all need practical things like a sustainable income, decent housing, good nutrition, a healthy environment, thriving culture, equality, local amenities, and transport to make it easier to participate in society and connect with each other. We also need good relationships, and to feel we belong.

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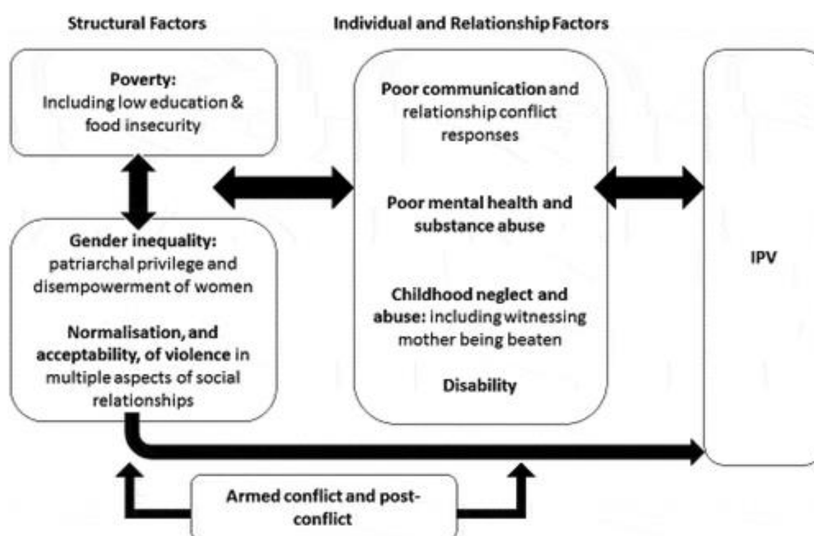
This growing understanding of mental health is the foundation of our approach to prevention, and to our perspective on a public health response to gender-based violence. In addition, understanding that the experiences of abuse, violence or not having our needs met, play a significant role in the underlying causes of trauma and distress. This makes it a complex area to consider, where poverty, inequality and trauma creates the conditions for poor mental health, alongside conditions for emotional and relational dysregulation – but also that understanding that same link, can help us understand how we can start preventing intimate partner violence.

Three key areas of change:

At Platfform, we use, amongst other ideas, ecological systems theory (Bronfenbrenner, 1977[2]), to understand the interrelating factors that contribute to our mental health. A similar approach has been taken to understand the drivers behind IPV and its causes (Heise 1998 and 2011, Fulu and Heise, 2014, cited in Gibbs et al, 2020[3]).

Gibbs et al provide an updated framework for understanding the drivers of IPV. This framework is a helpful place to begin understanding how a public health approach might begin to work, as it draws together a range of drivers behind IPV.



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From Platfform's perspective, we need three key areas of change:

- Intergenerational abuse
- Societal change
- Community response

This widespread, societal intervention is exactly what we believe would be categorised as a public health approach.

1: Intergenerational abuse

It is clear from the evidence base and the recent *Connecting the Dots*[4] report that poverty, inequality and trauma are significant social determinants of our mental health. It is also widely established that trauma plays a key role in the cycle of intergenerational abuse (Smith and Stover, 2015)[5] with exposure to trauma consistently linked to experiencing IPV, as well as children learning to use aggression to solve problems when exposed to IPV. Smith and Stover summarise a wide range of evidence that although not *causal,* there is a clear link between trauma and IPV. To break the cycle of intimate partner violence, this means that we must consider how to ameliorate and address the many problems caused by intimate partner violence – and the societal structures that provide the ideal conditions for that endemic violence.

Trauma amongst survivors and its impact

There is a clear need to respond to the immediate and harmful effects of trauma on people who have or are experiencing IPV. In that space, Platfform would argue for a widespread adoption of the Trauma Informed Framework for Wales[6], and to ensure that VAWDASV commissioners and service providers are fully trained in the framework and understand how services such as refuges fit in within the approach. We would argue that refuges, for example, are situated somewhere along the spectrum between "specialist interventions" and "trauma-enhanced". A clear commitment from Welsh Government that the Trauma Informed Framework training implementation will be linked to the VAWDASV strategy would be welcome. We also believe that specialist providers will

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be able to share their expertise when working with trauma, which needs to be integrated into the implementation and wider engagement planning for the Framework.

We also need to ensure that our mental health system understands, much better, how trauma intersects with a mental health diagnosis. In this, Platfform produced a briefing on the link between Borderline Personality Disorder (now re-categorised as Emotionally Unstable Personality Disorder in the ICD[1]), and the trauma experienced by survivors[7]. Not only have 81% of those diagnosed with a personality disorder experienced trauma, but they are **7 times more likely** to be female. Once a diagnosis is given, often for the best of reasons (to help people access support, for example), it can lead other systems to stigmatise and reinforce existing coercive dynamics.

For example, EUPD (and other mental health diagnoses) is a "key factor" in mothers being made subject to care proceedings (Morris and Broadhurst, 2022[8]), but also evidence shows that mental health is then significantly worsened by that same process. This is made worse when considering that many women have shared, they do not feel they understand or relate to the diagnoses given. In Morris and Broadhurst, the following exchange is cited:

> **Laura:** You just feel labelled mental… And they don't tell you nothing about it. You just get a piece of paper with she's got borderline personality disorder and she needs therapy for 12 months and she can't look after her kid. That's all I got.
> **Interviewer:** So, you don't know what that means, those words?
> **Laura:** No. You don't, no. You have to look it up yourself. I went and Googled it.

In these formal settings, a diagnosis can be hugely detrimental, leading people to second-guess their own emotions. In the above work parents describe how emotional reactions, **or a lack of emotional response**, were criticised by both practitioners and the sitting judge. It creates a sense that they cannot succeed whilst also being true to their feelings and experiences. In this aspect, a mental health diagnosis, intended as a

[1] International Classification of Diseases and Related Health Problems (WHO)

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positive help, clearly and adversely impacts survivors carrying trauma and continues their experiences of abuse and violence.

Whilst there has been progress between the victim advocacy movement and officials in spaces such as the family court (Johnston and Ver Steegh, 2013[9]), the mental health system has not had the same level of engagement with the advocacy movement, and this is an area that Wales could lead in a distinctive, trauma-informed, and survivor-focused way.

Trauma among people causing harm and its impacts

Evidence (Machisa, Christofides and Jewkes, 2016[10]) shows that men who cause harm through IPV, have experienced high levels of trauma. 88% of men causing harm had experienced physical abuse, 63% emotionally abused, 55% neglected and 20% sexually abused. Although discussions around trauma focus on survivors, there is growing understanding of the need to approach people who cause harm differently. Scott and Jenney (2022)[11] state a "potential to improve our work with men who perpetrate violence in interpersonal relationships", but also that adopting an approach of working with people through a trauma lens, can lead to risks being captured much earlier.

Experiences of trauma can contribute to difficulty forming, maintaining – and ending – relationships. One study for example looks at the impact of "betrayal trauma"[12] on trust, and there are numerous other examples of evidence that outline a link between abuse and trauma, and emotional dysregulation. In this context, the public health response must consider how to reduce emotional dysregulation and ensure that the risks of that perpetuating across generations, and further embedding violence into the system, are reduced – and perhaps in time, eradicated.

2: Societal change

To shift to a truly preventative approach to gender-based violence, we need to challenge the structures that enable and/or exacerbate abuse. In some areas, this is described as challenging 'patriarchy', or 'toxic masculinity'. At Platfform we recognise that gender-based violence predominantly impacts women and children, and that recognising the

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gendered nature of abuse is important given the decades of activism to reach that understanding. However, we also believe that the at-times reductive nature of language can lead to a binary understanding of gender-based violence that excludes marginalised voices.

In terms of LGBTQ+ relationships for example, this binary is often unhelpful. Gay men, for example, can exhibit conformity to a 'traditional' masculinity including aggression and inability to show emotional vulnerability (Donovan and Barnes, 2020).[13] Ristock (2002, in Donovan and Barnes, 2020) critiques binaries such as "perpetrator/victim" and "male/female", as often irrelevant for her participants. Ristock argues that individual relationship experiences should not be expected to fit a pattern.

Often, shame can prevent positive engagement with people causing harm (Iwi and Newman, 2015[14]), leading to defence responses based on traditional masculine stereotypes. These defence responses can make it much harder for people causing harm to admit to themselves, and others, that they are making dangerous choices for the people they have a relationship with. At Platfform, we believe we should aim to reduce shame, and normalise conversations and discussions that avoid the use of shame. For example, the MARS programme in the United States (cited in Herman, 2023[15]) avoids in its entirety, the phrase 'toxic masculinity', and instead reframes as 'restrictive masculinity'. This is a helpful example of a shift in language, that still acknowledges the negative impacts of socially constructed gender roles, and the often very real danger and harm it causes, whilst seeking to shift to a shame-free way for men to engage with the subject and to be challenged in their behaviour.

Addressing this shame, to enable earlier conversations with people who harm others, is a shift we would want to see adopted more widely across Wales. At the same time, understanding the very real risk of harm is critical. We draw on Professor Jane Monckton-Smith's work on the Homicide Timeline to inform this element of risk, particularly around prevention. The focus of Monckton-Smith (2021[16]) is, rightly for that context, entirely on the victims of homicide, and the stories she shares are a powerful testament to how far the system must go to protect women. Seeing the ranges of IPV responses as a continuum rather than a spectrum, is highly significant. There is still a mistaken understanding that controlling behaviours, for example, happen in isolation. Monckton-

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Smith's work makes it clear that whilst not all controlling responses will lead to homicide, many homicides will begin with them. This is a vital part of the prevention debate – and we would add from Platfform's perspective, that we need to work relationally, as early as we can, within that timeline, to avoid harm.

By avoiding shame and working to understand the emotional dysregulation of people who harm others, the system can better prevent that harm. This lack of relational health, sometimes significantly so (physical or sexual abuse from an early age, abandonment, etc), can leave people without the ability to regulate or understand relationships. It is also critically important to understand the wishes of survivors in this debate. Herman (2023) who has worked with domestic abuse survivors in the United States for decades, makes the point that whilst some survivors she interviewed sought retribution, the vast majority sought acknowledgement of harm by wider society, an apology if genuinely held and meant, but critically, *redress* offered by society. That redress was held to be more important for survivors than any other element of justice. This in some cases was as "simple" as a public acknowledgement by a court that the abuse happened, communicated to a survivors' parents who has disbelieved her. In others it was funding for re-training in a new role having lost confidence due to abuse – in others it was funding for private counselling to help address the trauma caused by the abuse. Many of these ideas are echoed and expanded on further in the Survivors' Agenda (2020)[17].

3: Community response

A developing area in research, policy and practice, is the concept of adverse *community* experiences. The stresses of living with inadequate access to economic and educational opportunities can contribute to experiences of community level adversity and violence (Pinderhughes, Davis, & Williams, 2016[18]), where people and communities aren't able to have their basic emotional and physical needs met and live in a state of threat – combined with poor infrastructure, socially fragmented communities, it can create conditions for community level adversity and violence.

Work across the world has established the need to adopt trauma-informed community development approaches, to work with communities on the

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ground, to combat embedded and entrenched community adversity. The Prevention Institute has created a range of resources underpinned by evidence, that aim to guide trauma-informed community development.

In a recent (2021[19]) report, the Prevention Institute produced a *Public Health Pathways to Preventing Violence*, which pulls together the wide range of organisations and individuals – and conditions – needed to generate public safety. Whilst linked to wider community safety, there are significant parallels that we can draw on in considering a public health response to IPV. Their pathway builds three categories: up front, in the thick, and in the aftermath. In each 'phase', different community stakeholders are involved, and at the outset, there is a clear space for policymakers in creating the wider societal conditions to enable community responses to violence.

The work of the Prevention Institute more widely is well worth exploring for a Welsh context, not least its 2016 report, *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma*. One of the key messages in their framework, is the finding that many communities have an "uneven level of capacity to conceptualise and address community trauma". This is critical. One of the issues that is frequently raised within IPV work, is the need to listen to people's experiences and to bring accountability and redress – indeed as explored above, the idea of being believed, seen and offered justice was one of Berman's (2023) key findings in her interviews with survivors. In a related way, the lack of voice given to survivors, can be echoed in the lack of voice given to communities that have been traumatised over decades of neglect.

Working with communities to find and establish that voice, and to build a conceptualisation of that trauma is an area in which Wales has begun to develop its response. ACE Hub Wales conducted a comparative study (2023[20]) into trauma-informed communities across the country. Amongst the three comparators is a project by Save the Children and Platfform, the Bettws Early Learning Community (ELC), which aims to work alongside families to listen to their experiences and develop new ways of working that meet their needs.

> "The Bettws ELC approach builds on developing practice in Wales, particularly in a number of Families First programmes in the same area which integrate applied psychologists into their practice models. In Bettws ELC, this approach is taken a step further by creating space that draws together not only Families First and mental health colleagues but other crucial players such as the local

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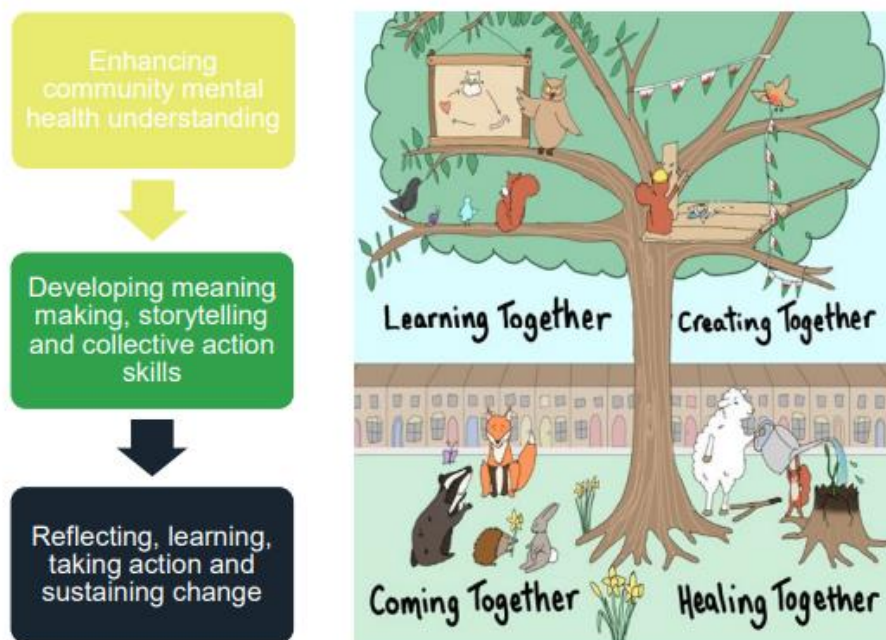
> schools, housing associations, local policing, health visitors, Flying Start workers, and other relevant stakeholders who have influence over the conditions in which children, families and local residents live."

The Embrace model adopted as part of the ELC works to give voice and control back to communities – in this context, to parents and families. Small groups of parents meet monthly over the course of a year, to explore their stories and experiences in a psychologically safe environment. They are supported by an experienced facilitator, who can help them make sense of those experiences. One person, quoted in the ACE Hub report, said:

> "Embrace for me helps me see things in a different way, it allows me to open up and share my trauma in a safe and completely understanding environment, it shows me how mental health works and how I can then use it to accommodate to my life."

This is summarised in a three-part Embrace model:



(Daffin et al., 2022)

Building trauma-informed communities is not easy, or quick, and it takes concerted investment and focus – but it is one way of reconnecting those communities, and working with them as they make sense of, and heal, from sometimes generations of shared collective trauma.

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In relation to IPV, Platfform is clear that a public health approach to violence must consider the importance of building trauma-informed communities.

Practical steps

Our focus in responding was to provide an overview of the links between mental health, trauma and IPV, and to consider how a community-level response could be better understood. However, there are some specific and key aspects we wanted to draw attention to, either as policy recommendations or a specific area for discussion and debate:

- At a society level, a shift in language from shame to relational health – for example, "toxic" masculinity to "restrictive" masculinity;
- At an early years level and in education, a commitment to exploring emotional health and regulation, alongside existing work on sex and relationships;
- At a public service level, the "Ask and Act" training to be extended, and to explore raising healthy challenge to people who harm, and to incorporate elements of the Trauma Informed Framework for Wales;
- At a Welsh Government level, to ensure that use of diagnoses such as EUPD are considered in terms of potential negative impact on survivors, so that harm is not perpetuated by our system;
- At a Welsh Government level, to see further devolution of elements of criminal justice, to incorporate a Survivors' Court, or similar conception, allowing for *redress* to be considered rather than simple punishment;
- At a Welsh Government level, to work to tackle poverty at a community level, giving agency and power back, and to avoid replicating top-down old-power based approaches.
- At a Senedd / Welsh Parliament level, to explore through a Committee enquiry, what trauma informed community development currently looks like / could look like, across Wales.

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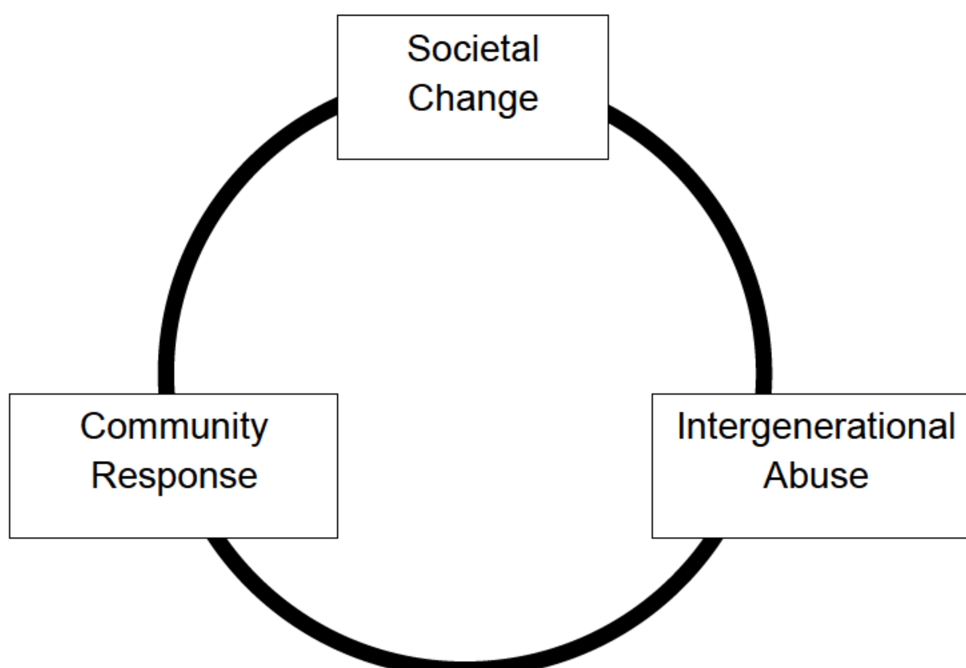
Conclusion

To adopt an impactful public health approach to IPV, there needs to be clarity regarding the drivers behind IPV, and the ability of our public services to address them. We see the impacts of IPV on people every day, in our work at Platfform, and we can see the cycle of intergenerational violence playing out again and again. We also see the very real risk to mental health – and life – in leaving the same patterns to repeat for generations to come.

It is a complex, if not chaotic, area of policy. We know more and more about how to keep survivors safe, but we have not yet managed to break the cycle of abuse and trauma. We are clear that experiences of trauma do not have a causal link to causing harm – but they are part of the mix driving IPV. That powerful mix of trauma, poverty, structural inequality and discrimination, and other factors, can feel overwhelming.

It is why we have articulated the need to work on three key areas – whilst recognising that each of them interacts with the other. A public health intervention in Wales needs to create the conditions necessary for people to heal and connect, as individuals, communities, and a wider society.



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We have broadly set the scene from a mental health perspective, some of the challenges faced by individuals, communities and society around IPV. This must be the start of a nation-wide conversation, to ensure community experiences, as well as factors such as poverty and inequality, are placed front and centre in debates and policies around prevention of IPV.

IPV is a deep-rooted, systemic challenge facing society, communities and individuals across Wales. We will only tackle it, if we continue to challenge our assumptions, to put the voices of survivors at the heart of our work and listen to and address the intergenerational cycle that continues to drive harmful behaviour.

Submitted by

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

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

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Ymateb gan: Cynghorwyr Cenedlaethol ar gyfer Trais yn erbyn Menywod, Trais arall ar Sail Rhywedd, Camdrin Domestig a Thrais Rhywiol | Response from: National Advisers for Violence against Women, other forms of Gender-Based Violence, Domestic Abuse and Sexual Violence

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National Advisers for Violence against Women, Domestic Abuse and Sexual Violence response to the Equality and Social Justice Committee Inquiry into the public health approach to preventing gender-based violence.

Introduction

Gender based violence is preventable. Our collective goal must be to stop violence before it starts. To do this, we need to understand the drivers of gendered violence and what we can do, as a society, to prevent it. An effective approach to understanding and addressing the drivers is a public health approach. The focus of public health is on the health, safety, and well-being of entire populations. A unique aspect of the approach is that it strives to provide the maximum benefit for the largest number of people. At the same time, it does provide targeted approaches for groups of people and particularly utilises an intersectional approach recognising that while we may all experience an issue, we do not experience it equally and in the same way. Therefore, a person centred approach is needed. This will include multi-disciplinary interventions for multi-faceted, complex issues which meet the need of diverse communities.

Public health draws on a science base that is multi-disciplinary. It relies on knowledge from a broad range of disciplines including medicine, epidemiology, sociology, psychology, criminology, education, and economics. This broad knowledge base has allowed the field of public health to respond successfully to a range of health conditions across the globe. A Public Health Approach incorporates whole population programmes and cultural change. We need to recognise the critical context for gender -based violence which is gender inequality and cultural norms of the men as power holders, decision makers and leaders at societal level, in the work- place and in families. The impact of which can lead to intergenerational trauma and an inherited perception of acceptable behaviour.

Gender inequality provides the underlying conditions for violence against women/gender- based violence. It exists at many levels in our society – from how we view and value men and women, to economic factors like the pay gap between men and women, to family and relationship roles and expectations. There is a strong and consistent association between gender inequality and violence against women, the connection However, is it complex and requires consideration from a wide range of perspectives. to creating a greater understanding. It also creates a strong need for a cross-government, cross-policy response.

Many other forms of structural and systemic discrimination and inequality influence the prevalence and dynamics of violence against women. These include racism, ableism, ageism, heteronormativity, cissexism, and class discrimination. In this way gender-based violence affects woman at a much higher rate but also the same ‘drivers’ result in increased abuse of LGBTQ+ people and higher proportions of abuse among black

and minoritized women, disable women and blinds us to the experiences of older women and men.

The public health approach also emphasises input from diverse sectors including health, education, social services, justice, policy, and the private sector. Collective action on the part of these key collaborators can help in addressing problems like violence and abuse.

We know the facts of how gender- based violence harms; there is significant evidence of the cost to the economy- £66 billion in England and Wales (UK Gov, 2017), 2 women a week are killed, and children experiencing domestic abuse or sexual abuse within the home will experience the after effects across their lives in terms of physical and mental health, increased likelihood to use substances and to become victims of further harms. In Wales there is legislative duty to prevent gender- based violence through the VAWDASV (Wales) Act 2015. While there are some programmes that do provide preventative interventions, there is much work to be done to enable this government's ambition for "Wales to be the safest place for a woman in Europe".

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

In order to prevent gender- based violence before it starts, primary prevention, we must understand the drivers. This is consistent with a public health approach and the 4 step model developed by the World Health Organisation and further adapted by the Violence Prevention Unit.

1. Know the facts
2. Explore the solutions
3. Implement and evaluate
4. Adapt and scale up what works.

Therefore, understanding the drivers, the conditions that facilitate gender- based violence are an essential starting place. These drivers are gendered and they are observed at a whole society level. There is an acceptance and condoning of violence against women. This includes the minimising of street and work -based harassment as "just words" or "banter" through to the excusing of men who have murdered their partners in cases such as the murder of Emma Pattison. The Daily Mail article (10 February 2023) headlined "Did living in the shadow of his high achieving wife lead to unthinkable tragedy?" The idea that a man who does not have the power and control in his relationship in career terms might understandably seek to do the worst harm.

A second driver is that male dominance in decision making in private and public life. The best example of the consequences of this are the high number of cases of abuse now becoming known from male dominated hierarchical organisations including

policing and fire and rescue services. When we have limited inclusion of women in governments, at senior levels in society, and without presence as positive role models at all levels, this supports women as being less valuable and worthy of respect. Woven into this, is gender stereotyping, which reinforces men as dominant, powerful and hypersexual and women as weak, both physically and psychologically, with a focus on their role as care givers.

Primary prevention working with whole populations will address and aim to reverse these drivers. This includes communication and education about the unacceptability of violence, promoting women as leaders and role models across the board from representation in government, to male dominated spheres of work and sport and challenging gender stereotypes of both men and women. Addressing whole society inequality is an essential element of addressing gender -based violence.

There are and have been programmes that have addressed this but many have not done so with the intention of specifically addressing VAWDASV. More links could and should be made. The Welsh Government previously set targets for balanced gender representation in government, there has been great promotion of women in sport in both football and rugby in Wales and the new RSE curriculum has great opportunities for global citizenship and specifically healthy relationships work.

However, intentional programmes to address gender- based violence are more limited and many are resourced through additional funding and non-government funding sources. A collective long-term, sustainable, multi-sectoral programme to support victims and survivors alongside the cost benefit analysis to support investment in prevention must be realised.

The Welsh Government Live Fear Free campaigns, aim to raise awareness of stalking, harassment, abuse and violence against women in all aspects of life including the street and other public places. The 'Call out only' campaign ran between 15 Dec- 8 May 2022, calling on the public (males particularly) to call out challenge assumptions about harassment against women - The campaign aimed to help people identify behaviours associated with street harassment and acknowledges that the experiences of women and girls are serious and prevalent and can cause fear, alarm and distress.

The Call out Only campaign generated over 6.8 million impressions, and over 20,000 views of the campaign website. During the campaign period contacts to the Live Fear Fee helpline increased by 15%. T LFF helpline saw an increase of 1,267% (from 12-164) perpetrators contacts and Respect saw an increase of 69% to their Change that Lasts website (main signposting option of the campaign)

The Welsh Women's Aid Change that Lasts programme provides opportunities at a primary level but mostly secondary interventions to support community responses to violence and abuse through the training of community champions, improving the skills of professionals and includes survivors as experts.

The Violence Prevention Unit are in the second phase of a campaign Safe to Say - https://safetosay.wales/ , a campaign focused on sexual harassment. It has delivered some good results and perhaps, more importantly, through the evaluation of this work we have some improved understanding of what works to create behavioural change in this area. As the public health model requires, it is vital to test our theory and understanding and see what works. This learning helps to improve future campaigns. Through this campaign we have good evidence that most 'personas' (types of people to be reached in the campaign) believed that the environment (e.g. gig venue versus night clubs) altered the level of acceptability of sexual harassment and therefore impacted their willingness to intervene.

In 2020, the Welsh Government commissioned the Wales VPU team in Public Health Wales to undertake a systematic review exploring 'what works to prevent violence against women, domestic abuse and sexual violence ' and this evidence base can now be included in the delivery of the VAWDASV strategy. This has not happened so far but should be informing the new Bystander Campaign that has recently been commissioned by Welsh Government. Further to this, the evidence can inform some partnership work so we can have a broad and effective reach. This should include sports bodies such as the Football Association for Wales and Welsh Rugby Union. Welsh Government as a financial supporter of both bodies should be requiring this activity in its funding.

An international example of primary prevention includes - Our Watch Australia Our Watch home | Preventing violence against women and their children - Our Watch which utilises a public health approach to evidence based prevention through an effective national approach. It seeks to address the social conditions that excuse, justify and promote gender -based violence. It is highly relevant to the Welsh approach and includes evidence based approaches to work place harassment, addressing intersecting inequalities and addressing policies to influence societal change.

Secondary prevention, responding to risks of VAWDASV, is provided in Wales. The most significant and prevalent of these being Ask and Act, the intervention developed by Welsh Government that provides targeted and open enquiry where the context and other indicators are considered to ask a person if they have experienced or are experiencing any form of abuse. This has been most effective in health settings and particularly ante-natal and maternal health. One challenge in the implementation of Ask and Act has been the confidence of professionals in having referral pathways for support when they do have disclosures of abuse. It is important that there is a prompt response and it can be hugely damaging to a victim if they have to wait for services after being encouraged to disclose.

Many bystander campaigns that are cited as primary prevention are actually secondary as they involve a response and intervention into presenting attitudes and behaviours. These can be very effective in preventing an escalation into actual harm. It would be beneficial to increase the provision of this kind of intervention.

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

A public health approach is the most effective way to prevent gender- based violence so long as based on evidence and fully considerate of the drivers, context and system issues. As outlined above these drivers are also drivers for other inequalities. It is also important than an intersectional approach is taken to ensure that interventions are effective and the whole population benefits from the approach. We must consider how intersecting inequalities and the imbalance of power changes the way abuse is experienced and exacerbates it. It is also important that we recognise that the intersecting factors that increase discrimination and disadvantage also drive increased violence. This then leads to disproportionate experiences of violence and abuse by people who experience multiple inequalities.

1. A survey from Welsh Women's Aid's #NoGreyArea campaign found that 97% of LGBTQ+ women in Wales have experienced workplace sexual harassment, compared to 77% of heterosexual women.
2. Data from Crime Survey for England and Wales shows that, in the year ending March 2020, disabled people were more likely to have been victims of domestic abuse in the last year than other people; this is true for both men (7.5% compared with 3.2%) and women (14.7% compared with 6.0%).
3. Black and minoritised women face multiple and intersecting inequalities which contribute to a higher risk of experiencing VAWG. Black women are disproportionately "victimised" with women who identified with mixed/multiple ethnicities are statistically more likely to have experienced abuse within the last 12 months (2020 Imkaan UK report).

Recognising inequalities in experience of violence, and utilising an intersectional lens, is a critical part of a public health approach. For BME women, gender inequalities intersect with and are compounded by racial inequalities resulting in this group particularly vulnerable to cuts to benefits, tax credits and public services, creating

unequal services. Understanding and responding to the intersections between the social, political and economic processes of gender inequality and other forms of systemic and structural inequality will benefit all.

Furthermore, it can be seen that, rather than as some often-express concerns about, addressing misogyny and gender inequality does not minimise that of the experiences of LGBTQ+ people, it addresses the behaviour towards them also. Just as harmful constructs of 'gender' and what are considered to be socially acceptable expressions of gender, play a role in male heterogendered violence against women, so too they play a role in violence perpetrated against people from LGBTI communities. Heterosexism generates and sustains homophobia, biphobia, transphobia, and intersex discrimination, and at the individual level, it reproduces attitudes and behaviours that discriminate against people who are not heterosexual and cisgender.

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

To prevent VAWDASV many stakeholders must play a role in a shared whole system approach. This includes government, as it is government that has the primary role in ensuring the health, safety and well being of the population including women. It is government in its role to set and respond to legislation, policy and protector of human rights that must lead on the response to VAWDASV. Government also has international human rights obligations through its commitment to the Convention on the Elimination of Violence against Women, the United Nations Convention of the Rights of the Child and other international human rights conventions to prevent violence against women and children and protect and support those that experience it. As previously touched upon, the Welsh Government does enable activity that can impact on this area, through the Gender Equality Plan, Poverty Strategy and Anti-Racism Plan to address the intersecting inequalities and structural reforms. It is recommended that there is further activity to strengthen cross government linkages strengthening policy, governance and coordination mechanisms across portfolios. A prompt for this improved thinking could include a VAWDASV assessment for any new government policy or strategy. The Gender equality plan states 'Introduction of a new Impact Assessment Framework and policy makers have a better understanding of gender equality, and how to make policy from an intersectional gender perspective. This should include the consideration of VAWDASV. However, as seen in The Quality Statement for women and girls' health [HTML] | GOV.WALES activity dedicated to

women does not necessarily lead to improvements for VAWDASV. Therefore, there must be a cross government requirement to do so. The revised national indicators for VAWDASV also need to reflect this.

The VAWDASV Act (Wales) 2015 places a duty on public services to prevent gender-based violence and protect and support victims and survivors. There is a duty on Local Authorities and Health Boards to understand the needs in their areas and to develop local strategies that respond to them. They can and should do this with the cooperation of the criminal justice agencies in Wales, the third sector and others who can help to deliver the strategy. These duties are not delivered on in a way that was intended or that they should be. There is limited understanding of the needs in the regions of Wales and limited responses to it. Public services are under-resourced and under pressure and have many demands placed upon them. However, we now that victims and survivors are present and engaging with services. The woman under 40 in the stroke clinic is likely to be there due to non- fatal strangulation linked to sexual violence and/or domestic abuse. We will see similar links to eating disorders, mental health issues and brain injury. More needs to be done to understand the presentations of victims and survivors in our public services and respond to them.

The role of the public sector and specialist services in identifying, tackling and preventing violence against women and girls is critical. From prevention, to handling disclosures at an earlier stage of a victim's journey through to the aftercare support for the recovery there is a role for public, specialist and statutory intervention. One of the biggest challenges is ensuring those at risk can receive a comprehensive approach that includes education, awareness raising and targeted interventions. No single agency can do this. Thus, there is a need for a coordinated response to those at risk of harm and for those experiencing it.

Overall, the public sector and specialist services play a crucial role in identifying, tackling and preventing violence against women, as well as providing vital support services to victims and survivors. This ultimately will reduce demand. Of course, we also need the enhanced preventative response to have the most significant impact and end the harms experienced by women, men and children in Wales every day. Collaborative efforts between these agencies can lead to effective responses and ultimately contribute to a safer, stronger Wales.

Jane Hutt AS/MS
Gweinidog Cyfiawnder Cymdeithasol a'r Prif Chwip
Minister for Social Justice and Chief Whip

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref **PO/JH/128/2023**

Stephen Crabb MP
Chair of Welsh Affairs Committee
House of Commons
London
SW1 0AA

17 May 2023

Dear Stephen,

I am writing to you as Chair of the Welsh Affairs Committee regarding your report on 'The Benefits System in Wales', which was published in March last year.

I was pleased to provide evidence for the inquiry and welcomed all the recommendations which I believe would increase the take-up of social security benefits, both devolved and non-devolved, by people in Wales. I note with interest the recently published report from Policy in Practice which estimates that the total amount of unclaimed income-related benefits and social tariffs is now £18.7 billion a year. This serves as timely reminder that there is more action required by the UK Government to ensure that household incomes are maximised by encouraging individuals to claim their entitlements.

I was disappointed at the response issued by the UK Government to the report which lacked any detail apart from their rejection of the Committee's recommendations. This reflects my own experience of the lack of interaction that I have had with the DWP at a Ministerial level despite my efforts to communicate regularly.

Whilst the good working relationships between my officials and officials from DWP continue to facilitate joint working, like your Committee, I consider that establishing a UK and Welsh Government Inter-Ministerial Advisory Board on Social Security would provide an effective forum through which I could work more collaboratively with the DWP Secretary of State and their Ministerial team.

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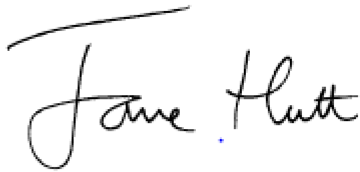
Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Given the impact of the cost-of-living crisis, which has unfolded since your report was published, I think it would be timely to have a renewed focus on this area and for the UK Government to reconsider its response to your recommendations. I would urge you to raise this as a committee.

I would also welcome the opportunity to meet with you as Chair of the Committee to explain how we are simplifying access to devolved benefits, including the development of a Charter for the delivery of benefits provided by the Welsh Government which we hope to publish by the end of this year, and consider how we could maximise our efforts with more co-operation from the UK Government.

Yours sincerely,



Jane Hutt AS/MS
Gweinidog Cyfiawnder Cymdeithasol a'r Prif Chwip
Minister for Social Justice and Chief Whip

Agenda Item 8

By virtue of paragraph(s) vii of Standing Order 17.42

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