Combating Gender-Based Violence: a Nottingham Approach

Human Rights Law Centre
Aoife Nolan, Ms Jane Lewis, Dr Julie McGarry and Dr Lyndsey Harris

On 6th December 2016, the Human Rights Law Centre at the University of Nottingham hosted a panel discussion in support of 16 Days of Activism against Gender-Based Violence and Nottingham-based charity Equation. This discussion aimed to raise awareness of gender-based violence ('GBV') and to discuss policies affecting victims.

Professor Aoife Nolan, Co-Director of the Rights and Justice Research Priority Area and Professor of International Human Rights Law, opened the discussion with an introduction to the 16 Days of Activism campaign and introduced the panel which consisted of three experts in the field of GBV namely, Ms Jane Lewis, Dr Julie McGarry and Dr Lyndsey Harris.

Ms Jane Lewis

First to present her findings was Ms Jane Lewis who is Community Safety Strategy Manager (Domestic & Sexual Violence Strategic Lead) for the Nottingham Crime and Drugs Partnership. Ms Lewis began her presentation by submitting that statistically there are many cases of sexual abuse and violence both internationally and in the UK. Many grow up experiencing it as a child and experience it in relationships. Ms Lewis further emphasised the importance of such violence being labelled 'gender based' since this plays a significant role in abuse. Yet she also stressed the importance of providing abuse services for men since they are also victims and survivors of GBV.

It took until 2013 for the Government to form one definition of abuse whereas prior to this, organisations and individuals had to navigate many different definitions of abuse. The definition now refers to 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.' Ms Lewis submitted that there are two significant parts to this definition; firstly, that the Government is beginning to move away from acts of violence and recognise the significance of controlling or coercive behaviour. Secondly, Ms Lewis also emphasised the impact of multiple perpetrators and gave the example of sexual abuse conducted by gangs. She also noted that the Government is finally recognising issues raised by honour-based violence, forced marriage and FGM.

Ms Lewis reiterated the importance of the inclusion of controlling and coercive behaviour, which is defined under s. 76 of the Serious Crime Act 2015. Prior to the inclusion of this particular behaviour, domestic violence was tied to crimes of physical violence such as actual bodily crime and grievous bodily harm. Additionally, Ms Lewis submitted that in order for coercive and controlling behaviour to be established under s. 76, the behaviour must be engaged in 'repeatedly' or 'continuously'. The idea that the behaviour must be continuous

may save some difficulties that Ms Lewis has experienced with the police in the past. Survivors would often report individual incidents of abuse to the police and over time these police officials become cynical jaded and are therefore less likely to arrest perpetrators. Nonetheless, Ms Lewis predicts that the requirement of 'continuous' behaviour will be difficult to prove.

Following on from this, Ms Lewis discussed the concept 'space for action' which is the opposite of coercive control as established by Liz Kelly in 2003. The idea behind such is that survivors feel safe to walk down any street and go about their daily lives without feeling fear to do so and this is a particular challenge that survivors face.

In terms of GBV locally in Nottingham, reporting data shows that only 40% of survivors report and there are approximately 14,000 perpetrators in Nottingham. Ms Lewis followed this by mentioning services that operate locally in Nottingham such as Equation (which offers services for men and also perpetrators) and Rape Crisis (which offers therapeutic and practical support for female and male survivors of sexual abuse).

Ms Lewis concluded her presentation with her working strategy, which includes stopping cuts to DVSA (Domestic Violence and Sexual abuse) services, embedding specialists in teams, focusing on patterns of abuse and not incidents, establishing knowledge on identifying multiple perpetrators and managing them. Finally, Ms Lewis submits the importance of distinguishing self-identified survivors and those identified by agencies; it is self-identified survivors who normally will seek and accept help.

<u>Dr Julie McGarry</u>

Dr McGarry was next to present her work, which focuses on examining responses to domestic violence and abuse by professionals in health care settings. Dr McGarry is a nurse by background and an Associate Professor for the Faculty of Medicine & Health Sciences at the University of Nottingham and Chair of the Domestic Violence and Abuse Integrated Research Group.

Dr McGarry began her presentation by discussing GBV from a health perspective. She noted that, in working terms, recognition of the health issues that arise as a result of GBV took some time. These health concerns include short-term physical injury, long-term mental health injury and even death. In 2014, NICE (National Institute for Health and Care Excellence) introduced the standards for domestic violence and abuse, which set the tone in terms of health care obligations. In order for health care professionals to meet these standards, they have obligations to undergo training that will allow them to identify, manage and refer when faced with GBV.

Dr McGarry proceeded by giving an example of a study she has done and this entailed talking to survivors who had accessed the emergency department in hospitals. One survivor ('Sheila') had gone in with an injury and did not disclose that this injury was as a result of the actions of the perpetrator. Instead, she told

staff she had fallen off a stepladder. This injury had perplexed staff but they failed to take their suspicions any further and ask 'Sheila' if there was anything she would like to discuss. Dr McGarry gave a further example of 'Jane' who had been injured by the perpetrator but this perpetrator threatened to tell the department she was 'mental' if 'Jane' disclosed any information. This was particularly threatening given the survivor's mental health history. Dr McGarry reiterated that these are two examples of how working with survivors can be very complex.

Dr McGarry moved on to discuss three studies that she has most recently been involved in; all of which have one overarching theme. One is a study with her colleague Kim Watts known as 'Stride' project. Another study focuses on the role of a domestic abuse nurse specialist in the emergency department. The third and final study is related to the latter and looks at the role of acute care services.

With regard to the emergency department, Dr McGarry submitted that domestic violence often goes unreported and staff should be educated to identify the risk, ask questions, assess the need for intervention and initiate any measures that need to be taken. However, this is made difficult by the high intensity environment of the emergency department and as well as the four-hour targets staff have to address all types of injuries. She emphasised that whilst these staff are compassionate and caring they often have many different people and issues to address at once.

Dr McGarry continued her presentation by explaining that in the aforementioned studies, they looked at locating specialists in these environments and questioned whether this would make a positive difference. The role of the specialists would involve education, training and support. The aims and objectives of Dr McGarry's research were to explore particular situations (all of which were very different in each study), examine effectiveness (looking at quantitative measures, understand experiences and examine thoughts) and consider sustainability.

Dr McGarry concluded her presentation with a summary of findings from her studies. Firstly, she established that for a lot of health care professionals this was the first time they had training dedicated to DVSA. In addition, vulnerable individuals' health care needs (beyond their presenting injury) are not being effectively addressed. Dissemination of expertise is still in working progress and education at pre-qualifying level is crucial. Lastly, Dr McGarry submits that there is still work to be done to develop the infrastructure that supports identification and management of GBV.

<u>Dr Lindsey Harris</u>

Dr Lindsey Harris was the last panellist to present her research based on survivors of domestic and sexual violence with complex needs. Dr Harris is an Assistant Professor in Criminology for the Faculty of Social Sciences at the University of Nottingham. She is also an expert on survivors of abuse with complex needs.
Dr Harris began by distinguishing two parts to her presentation, firstly an evaluation of findings in relation to survivors of GBV with complex needs and

secondly her current works on an autoethnography of providing support to survivors of domestic abuse.

Dr Harris explained her work focuses on the power relationship, which underlies the aforementioned 'coercive' legislation and the barriers to survivors in terms of accessing justice. There are many ways in which DVSA can be interrelated, such as the use of coercion and threats, the use of intimidation, emotional abuse, isolating and blaming and using the children to form abuse. Dr Harris submitted that her work predominantly focuses on the survivor's experience and particularly those with 'complex needs'. This includes individuals with a history of mental ill health and/or substance abuse, primarily drugs and alcohol. In reference to Ms Lewis' presentation, Dr Harris explained that a survivor's mental health can be used against them as a form of power of control, providing the example of a perpetrator buying a substance for the victim that they will ultimately abuse.

Dr Harris proceeded to link these issues with academic studies on the barriers and difficulties that survivors face. One is the concept of victim blaming (Walklate 2007) which studies the attitudes that reinforce the idea that women are culpable for their own victimisation and are subsequently left feeling abandoned. Dr Harris linked this to the Ched Evans case and explained that many victims are marginalised, especially when they have complex needs because of the stigma attached to such needs. This ties in with Christie's study (1986), which looked at the 'ideal victim'. The Westmarland study (2015) looked at attrition rates in terms of the number of cases that are reported to the police and how many result in prosecution. Dr Harris expressed particular interest on how this study might relate to victims with complex needs. Issues on intersectionality were also raised and examples included the extent that disability impacts survival (Thiara et al 2012) and difficulties behind having English as a second language (McCulloch and Pickering 2012).

Dr Harris continued by reiterating the question: to what extent do survivors with complex needs get wound up with the idea that these individuals are a mere social problem? The way in which the perpetrator controls the survivor is not the only consideration; but how society and institutions contribute to keeping survivors locked in to a situation, is also relevant. Social services contribute to this issue in that they are always looking for a mother's failure to protect. Whereas, with a lot of survivors it is clear they are trying to protect since they are just trying to get through the day alive.

Equally, Dr Harris submitted that a trauma-informed approach is necessary in her opinion. This is based on the evidence that she has reviewed, which demonstrates that DVSA is a highly traumatic incidence and this trauma can influence how a victim responds. Dr Harris provided the example of a survivor who has to present in court whilst the perpetrator is also present, and often the victim will not conform to 'ideal victim' and may appear controlled in their demeanour. Substances are often used by the victim in order to manage the trauma, therefore it is important that professionals do not just treat substance misuse but also provide support for individuals.

Dr Harris concluded her presentation by reiterating the barriers to these survivors; as mentioned previously, the power model demonstrates coercive control but it is also important to consider the disempowerment survivors can feel through the judicial process. Some survivors have experienced difficulties in the courts as needs are often not met, such as lack of screens to shield victims from perpetrators and a lack of sufficient time for a partially sighted survivor to assess her statement. Finally, Dr Harris submits that despite the great developments in the legislation, the way in which it is interpreted by different constabularies across the UK is worth considering.

Q&A

Following Ms Lewis, Dr McGarry and Dr Harris's presentations, Professor Nolan opened up the floor to questions. The following questions were put forward by members of the audience:

1. In Nigeria, there is not a lot of focus on empowering women by NGOs; there should be focus on psychological support and court remedies. Why don't NGOs look at these issues?
2. In some cultures, activities such as GBV are wrong from a human rights perspective but their culture legitimises these acts. How should women handle this?
3. How does the concept of masculinity impact the system?

These questions were met with a range of answers from all three panellists. Ms Lewis began by explaining that Parliament is predominantly made up of men which impacts the nature of the laws implemented to tackle GBV. Although Parliament may not be deliberately failing to consider the impact on women, they will focus on what they know. Things they consider important might not fall in line with that of women. The UK is working on a risk-based approach to domestic abuse, which entails a checklist of criteria as opposed to an assessment of needs.

Dr McGarry followed this with a reference to her personal experience and she has found that there are key issues arising from financial inequality between men and women, particularly older women. Finally, Dr Harris presented a case study in response to the above questions whereby a survivor who came from Iraq was without English language skills and often the perpetrator acted as her interpreter. This further disadvantaged the survivor and whilst she tried to solve the issue in Iraq, the culture meant that being granted a divorce would force her to give up her child. This demonstrated how culture can have a real impact on access to justice.

Further questions were posed to the panel, which included:

1. Gender-based violence is not something that just happens, there is a lot of attention to promoting healthy relationships, should there be more attention on addressing perpetrators?
2. Is there anything that can be done on a local level rather than being signposted to people with important titles? Particularly when addressing language barriers and age etc.

3. There is a constant move towards gender-neutral policy and practice but often women are impacted by GBV in different ways to men. How can we ensure we do not gender neutralise everything?
4. In Nottingham what work has been done to raise awareness for perpetrators in helping them to be better men?
5. What approach has Nottingham taken towards children and young people with regard to GBV?

Dr McGarry began by explaining that her work with the Stride project looks at having the professional confidence to engage with perpetrators and work with them. Dr Harris followed this with her submission that GBV programmes should not be gender neutralised; it is important that there are separate programmes for men and women. Equation is approaching this issue at a local level and Nottingham is leading the way in perpetrator programmes. Dr Harris's approach is that both survivors and perpetrators should be engaged with.

Finally, Ms Lewis closed the discussion with emphasis on the fact that domestic abuse is a choice and where there are male child survivors, it does not mean these children will grow up to be male adult perpetrators. Police get wound up in this assumption, however Nottingham is looking at promoting healthy relationships with children. Additionally, Nottingham is the first city in the UK to recognise misogyny as a hate crime as well as implement a zero tolerance of FGM. Lastly, the white ribbon campaign is a male pledge not to commit violence against women and this international campaign is extremely influential.

Report by Molly Cullen, LLM