Working Paper on Intervention against Domestic Violence in England and Wales[1]

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Part 1: The Intervention Sequence and the Response to Core Questions

1 Empirical data and case story

This working paper is based on two multi-agency workshops in which the intervention responses to a specific form of violence were explored (see background paper). Each workshop comprised two half-day sessions, and a focus group methodology was used. Participants were given a case story in three sequences to discuss. Six 'core questions' were introduced during the discussions. The stories were agreed across the four countries, but adapted to fit the national context when necessary.

Participants in the workshops were: five police from two cities; two social workers from two cities; three housing workers from two cities; two social workers from two different cities; two health workers; six non-governmental organisations (NGOs) from two different cities (including specialist NGOs); two lawyers from two different cities; one magistrate and one prosecutor.

For the England and Wales workshops on domestic violence the story was as follows.

1ST PHASE OF THE STORY

Anne is 32, with two children. She moved three years ago with her husband to a medium-sized town, some 200 miles from the area where her family lives. There have been loud quarrels, increasing over the last year when Anne was pregnant with her second child. The neighbours in the flat above have called the police twice because of this; the police came, but they decided to take no further action. Another neighbour has noticed several times that Anne has bruises, but does not know her well enough to speak to her about it. The older child, who began school last autumn, has not yet made any friends and shows an unusual degree of aggressive behaviour. Anne has repeatedly asked her family doctor to prescribe her sleeping pills and complains of chronic headaches.

2ND PHASE OF THE STORY

Six months later, the situation has escalated and Anne is now considering seeking help. She doesn't have family or friends close, and is too ashamed to talk with work colleagues.

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Several of the professionals – doctor, health visitor, children's teacher - who have some kind of contact with Anne have begun to wonder about the possibility of domestic violence.

Her husband brings her to the hospital with bruises and a dislocated finger. He tells the nurse that she fell downstairs and she nods in agreement. But while she is alone and being examined, she admits that her husband caused the injuries. The hospital gives her a card with a helpline number she can call for advice and help. She calls without telling them her real name or her address and asks what she can do; she tells them that she is very afraid of her husband but doesn't want to leave him because of the children. They tell her that she has the right to live without violence and advise her that she can contact the police, but they also tell her about a specialist domestic violence service where she can get support.

3RD PHASE OF THE STORY

The violence has continued, and Anne is now taking further steps to end the relationship and is thinking about divorce. She makes contact with an Independent Domestic Violence Advisor (IDVA) and confides that she is frightened of what her husband might do to her if she makes a formal complaint. (He once said her would kill her if she ever left him).

Acting on information from the IDVA about her options, Anne contacts the police and they issue a Domestic Violence Protection Order which obliges her husband to leave and to stay away from the residence for 48 hours, which is extended by the court to 14 days. He is prohibited from making contact with Anne in any way. A few days later Anne tells the IDVA that her husband has threatened to kill her (and their children). When the IDVA calls to check how Anne is just before the order is due to expire Anne tells them, nervously, that everything is alright again. The IDVA takes the case to supervision for possible referral to a Multi Agency Risk Assessment Conference (MARAC).

2 Intervention pathways from the perspective of professionals

Multiple potential entry points of intervention emerged: through police being called out; Social Services notified by other agencies of concerns for children's safety; housing departments receiving reports of disruption/violence occurring at a specific address; health professionals in emergency departments encountering victim-survivors that seek treatment for injuries, or health visitors receiving a referral because of the children. Based on the story used in the workshops, the most likely interventions paths were for health professionals to make referrals to other statutory agencies, and less commonly, to specialised support services.

Any or many of these referrals may result in no further action beyond initial referral or engagement. If cases make it further than initial gatekeepers, which actors become involved depends on subsequent action: women may be advised to seek legal advice and engage a lawyer; if the perpetrator is prosecuted then the Crown Prosecution Service and magistrates/judges are brought in, and if a notification to Social Services is actioned then social workers may undertake an investigation and assessment. The choices and actions of victims can have limited influence on the course of intervention, unless their initial contact is through specialised support services that have remained fairly independent from statutory agencies. For instance, participants identified that:

- health professionals were likely to make referrals to statutory agencies, if children were involved, even without women's consent;
- police and prosecutors may pursue a 'victimless' prosecution within which the victim does not have to give evidence;
- Social Services may initiate child protection/safeguarding investigations and/or proceedings as a means to drive women to take action.

The dominance of risk discourse (see framing of the problem, below) has brought a range of agencies under this umbrella, with each using the same risk assessment tool as a screening filter for which victim-survivors receive support and intervention; entitlement to services is now organised hierarchically according to level of risk. This has created a 'high risk pathway' as the most common entry point into intervention, onto which victim-survivors begin to travel through contact with agencies. For instance, various organisations (police, housing, Social Services, NGOs) may make a referral to a Multi-Agency Risk Assessment Conference (MARAC) for those cases classified as high risk. Engagement with MARACs is twofold for most of the agencies represented in the workshops: to refer victim-survivors in order to secure support and involvement from other organisations, and as core members of the group to pick up referrals. In many areas, the police have a more prominent leadership role in that they host, chair and co-ordinate the MARAC. The centrality of MARAC to domestic violence interventions was immediately apparent in the workshops; MARAC was mentioned by multiple participants in response to the first part of the story, even before it was established that Anne was experiencing domestic violence. While others expressed surprise at reference to MARAC on the basis of what little was known, that some (police, health) invoked it so readily was telling. Any of the agencies at the workshops might make the initial referral to MARAC, based on risk assessment, and from there most of the core agencies reported that they would become involved: police; Social Services; health (visitors); specialised support services.

Specialised women's services offer a slightly different intervention sequence, since unlike statutory agencies, they might work with women without making a referral to any other agency, and they may not so readily make a referral to MARAC. However the channelling of funding towards supporting high risk victim-survivors means that many are also key actors in the high risk pathway. Independent Domestic Violence Advisors (IDVAs) have become a core form of provision in most areas, often replacing caseworkers who provided support to women that did not reach high risk thresholds or community-based services where risk was not part of eligibility assessments. Some specialist NGOs that participated in the workshops were deeply integrated into MARACs, others more ambivalent. Nevertheless, the process of risk assessing victims has become routine.

2.1 Participants' Responses to Core Questions

This section sets out participants' responses to core questions following each phase of the above narrative. The extracts in italics represent quotes from participants.

(1) As a professional, what might lead you to try and discover whether this might be a case of domestic violence or, on the other hand, what might keep you from getting involved?

In one workshop, participants struggled to respond to this and leapt immediately to making referrals on the assumption that Anne was experiencing domestic violence. When taken back to the need to establish this, there was broad agreement that a health visitor –as a universal service available for all children under five – or a family doctor (GP) would be ideally placed to co-ordinate information gathering. Risk of harm to the children was the spur for action. A worker from an NGO did question this on the basis that *'a lot of assumptions are being made – maybe she's just having a hard time… we need to tread carefully to respect her rights and just find out if she's having a hard time and needs to talk about it and where she wants to go next with it'.*

In the other workshop, this question led into a discussion about information gathering in order to identify any further evidence of domestic violence. Health professionals – family doctors – were again named as well placed to 'ask questions'. This was neatly summarised in one workshop as *'processes are in place to find out what is happening in the household'* (Police officer). It was also clear that information gathering was blurred with information sharing, since what background checks and medical/school records revealed was only deemed useful if all relevant agencies were party to it.

The only barriers to being involved were those of the intervention sequence; for example, lawyers were clear that they would need to be instructed by a victim – *'she needs to have identified there's something wrong happening for her to get to me to be able to advise her'* (Lawyer).

(2) How might it come about that your institution or profession is the place to which a parent or child turns to for advice, intervention or support? Or how else might it happen that someone in your position would become involved?

Referrals from health – emergency departments where Anne presented with injuries – were the most common route for other agencies to become involved based on the storyline. This could be either a referral to community-based health service (e.g. health visitors) or to MARAC, which would then alert police and Social Services.

Here there was a notable silence around the possibility of Anne herself seeking advice, intervention or support, but there was a widely shared assumption that agencies were obliged to act, and could, even should do so, irrespective of her consent.

(3) Would you consider asking Anne directly about suspected abuse, or what reasons might there be not to do so? How important do you think this is?

The possibility of asking Anne directly if she was experiencing violence was strikingly absent. Yet participants thought that the practice of 'ask and act' should be mandatory in all health settings (currently it is recommended as good practice in some), and were in agreement that a conversation with Anne should take place.

How to ask was a central theme of group discussion. In one workshop, this focussed on enabling women to speak, and the importance, yet in practice inconsistency, of routine enquiry, flowed from the above warning by one participant of making assumptions. Here the focus was on finding creative ways to invite Anne to tell, such as the stickers in (female) hospital toilets which women can attach to the bottle of urine bottles or maternity notes to alert medics to the fact that they need to talk about violence. For asking women, there was a consensus that *'the act of asking should be routine, but the questions shouldn't be. The questions are very artificial, that's why they're not well used'* (Health visitor). Offering opportunities for women to speak, in ways that did not make it appear that they had sought help but could be disguised in case the perpetrator became aware, was perceived as critical.

> DV Co-ordinator: *When I was a support worker, a midwife invited me to an appointment, and if the partner came home from work I was just going to say that the midwife's assistant, but give the women the opportunity to speak to me, and then I went out and I was able to do individual visits with her, and without that, she wouldn't be able to engage with services. I think sometimes there's an assumption that women don't consent, and I know they don't in some cases, but it's about being proactive and finding creative ways in order for people to be able to open up.*

However in the other workshop, information gathering/sharing was privileged over asking Anne, on the grounds that she would not be able to identify what was happening as violence.

> *Specialist NGO: Women may not have an understanding.*
>
> Police: *And sometimes they don't have an understanding, but with training health professionals and social workers it's completely different, because they will turn it round and say 'yes but it's not in my guidance, I don't have to' [with respect to asking women].*
>
> …

Prosecutor: *I think (specialist NGO) is right, lots of these people that we deal with, do not understand that what they have been subjected to is domestic abuse for years if not decades. So a lot of the time those questions are asked, the answers they will give may not be what we would perceive as the correct ones because they do not understand. They've been subjugated for years, treated poorly for years and perhaps we don't as professionals deal with it the correct way. I don't think we should be relying on the engagement of survivors. I know it's easier with engagement but if you don't have it you don't have it. It's a bonus if you do have it, but we should be looking at what other information is there available to us as professionals to intervene, to protect not just her but the children.*

This exchange exemplifies how domestic violence has become professionalized in the UK, and the lack of critical reflection on information gathering/sharing by agencies.

Speaking to the perpetrator was not regarded as a viable option because of the possibility of compromising Anne's safety. For some agencies this was so far outside of their everyday practice that it had not occurred to them (e.g. specialised women's NGOs) but it was difficult to keep them exploring the subject of engaging with the perpetrator as the discussion quickly moved away. Overall there was very little knowledge of interventions with perpetrators, with participants in both workshops speaking uncertainly about routes onto specialist perpetrator programmes, and emphasising that this aspect of intervention into domestic violence was not part of their role.

(4) When might you pass on information to relevant authorities or institutions without the consent of the victim? Or, on the other hand, what might keep you from doing so?

Practitioners reported that systems, processes and procedures enabled them to share information without women's consent. Those from the statutory sector were firmly invested in this approach, perceiving that these procedures had been developed to protect children and carried obligations to act. In one workshop, there was almost universal agreement that information sharing was essential, and as evident below, that taking action was also necessary even where women had not agreed.

Health visitor*: It is about sharing information between agencies. For example, the woman having been in hospital, we wouldn't normally share the health information with police outside of the MARAC process, unless it was very relevant obviously, but within a MARAC process it may be deemed important to do that. It gives us permission to do that because all the core agencies are signed up to that information sharing agreement.*

…

Police*: There are no tensions about sharing information in the MARAC process.*

Health visitor: *You only share the information that it's necessary to share. So in terms of health, we wouldn't give her whole health history, but if she had been in the emergency unit and there'd been some injuries consistent with domestic abuse, we might share that, but we wouldn't necessarily share if she was diabetic, if it wasn't deemed to be relevant they we wouldn't share that information.*

However, some, including police, recognised that this was a 'debatable' dilemma which could breach trust.

(5) When could it be right/appropriate to initiate measures of protection from further violence, even against Anne's wishes? What concerns might prevent you from doing this or cause you to hesitate?

Child protection/safeguarding procedures were invoked in both workshops as obliging agencies to act even where they perceived that this might jeopardise the trust with Anne. This involved a referral to Social Services, who while nominally obliged to investigate possible harm to children, are actually not that likely to do so, and referrals to MARAC. Reporting to the police was identified as Anne's

prerogative, and an action which would significantly increase risk if done without her consent, as it would make explicit her disclosure to the emergency nurse. Referrals to Social Services, where there were concerns about (or simply the presence of) children were described as 'no choice' and 'having to act'.

Some sought to reconcile the possibility of increasing risk to her– as any action would alert the perpetrator to her disclosure - against child protection procedures and duties. Again the need to 'safeguard trust' as well as children was raised as a concern that would cause practitioners to hesitate, but there was consensus that because agencies were aware that children were being 'exposed' to domestic violence, they would have to act.

> Housing*: she's shared that [DV] with that one person, obviously you'd make the referrals around that, but that would be quite a big thing for her. That needs to be nurtured, it's not about breaking confidences she won't then approach someone if it happens or continues, so you have to safeguard that as well [other voices agreeing].*

One suggestion to protect the relationship with Anne that would still meet professional obligations would be to inform her that a referral was going to be made and combine this with information about specialist support services. There was, however, no universal endorsement that Anne needed to be informed that a referral to Social Services was going to be made. Most of all, the measures of protection that were discussed were about the children, rather than Anne.

(6) If Anne was from a minority community, would your strategies of intervention differ in any way from what you have described in the first part of our workshop?

Strategies of intervention for minority women were initially reported not to differ, but on reflection most practitioners identified that while the '*process might be the same'; 'the process is the process'*, the approach might not be. Engaging a woman from a minority background was reported as having extra layers: *'the only thing different is that they may have additional barriers'* (Specialist NGO). These included: building trust, particularly around confidentiality; enabling women to access support where options are more limited because of immigration status; recognising the complexities of family and community connections where these are associated with honour and shame. One emergency nurse said '*culture is not a barrier for me but for women it might be a barrier*'.

> Lawyer: *So as a family law solicitor, my advice on legal remedies is exactly the same regardless of where they're from. I'd ask different questions - being alive to the specific issues that those women face, not so much because that will affect the legal remedies, but more so that I can understand her case and to be able to present it to the judge properly, to be able to advocate for her properly - if they're from an ethnic minority background, try to understand their case, but the actual legal remedies would be exactly the same. My difficulty is that they can't access me.*

One solution, suggested by specialist BME organisations but widely endorsed by other participants, was to ask women additional questions about what their community norms were, in order that practitioners could understand if barriers could, where possible, be dismantled.

> NGO: *I can't see what the issue is with right and wrong, isn't it just that people need information about to make choices that might be informed by whatever cultural issues/baggage they've got going on… it's making adjustments that you make for anyone that's not able to access the service. It's about finding ways to enable them to access the service for their benefit. It's seeing where the barriers are in place, whether that be language or cultural issues, and removing those barriers.*

Specialist services for minority women were briefly acknowledged to be essential, especially in multi-agency fora such as MARACs where members could not reasonably be expected to be experts on *'subtle differences'* between communities in diverse cities.

However, how culture was framed (differently in each workshop) influenced what these barriers were perceived to be.

Part 2: Framing of domestic violence and interventions

In this section, extracts in italics are taken from an internal document, a legal context paper, prepared by researchers.

3.1 Key frames in legal and institutional documents

(1) Domestic violence: an incidentalist[2] approach to 'risk'

There remains a gap between the policy framing of domestic violence and the way it is recognised and lived by victim-survivors and those who support them. Until April 2013, domestic violence was defined in government policy as 'any incident' of psychological, physical, sexual, financial or emotional abuse, between intimate partners or family members, regardless of gender or sexuality. The 2013 amendment added in 'coercive control', however

> *Despite the addition of 'a pattern' of coercive control, it remains an incident-based definition since even controlling behaviour is framed as 'a pattern of incidents'. This means that how domestic violence is lived is not even part of a policy based definition. It is also worth noting that this is a studiedly gender neutral definition.*

The new definition remains gender-neutral and includes family members, when a common-sense understanding is violence perpetrated by an intimate partner, which may, particularly although not exclusively in certain communities, also involve family members. Furthermore, the retention of 'between' implies a shared responsibility for violence, obscuring the actions and intent of the perpetrator.

Domestic violence is also framed prominently in current policy in terms of a risk discourse. As noted, high risk designation is a common threshold for whether or not intervention is necessary, or resourced. Some have noted that this means women are only eligible for support if perpetrators are viewed as sufficiently dangerous. It also reinforces a limited understanding of domestic violence as comprising physical violence with risk of injury and death; risk assessment tools privilege physical and sexual violence over course of conduct, psychological and emotional harm, even with their capacity to record women's levels of fear. In this sense the risk discourse supports an incident-based framing of domestic violence.

(2) Multi-agency co-operation and information sharing

Multi-agency working has become an orthodoxy in domestic violence intervention, in recognition of victim's multiple needs and the responsibility of various state agencies to enable women – and children - to live free from violence.

> *Since the early 1990s, successive governments have promoted an inter-ministerial approach to policy development at national level, and multi-agency coordination and service provision at a local level.*

Westminster policies have thus obliged local government to implement multi-agency approaches through fora and more recently the MARAC system. The intention is to standardise responses to

[2] Here we are drawing on Jeff Hearn's concept of 'incidentalism' – drawn from interviews with perpetrators, where abuse is reduced to specific incidents of physical violence.

victims, including the 'plurality of discourses'[3] where domestic violence is viewed variously by police as crime, by health within the medical model and by Social Services in a family welfare framework.

Multi-agency approaches have also become synonymous with information-sharing, particularly through the MARAC forum. There is some concern that information sharing has become viewed as an intervention in itself.

> *In some instances, information-sharing is legally required, that is, it is mandatory as in cases involving child protection. In other instances, it is 'permitted' but must follow the basic ground rule that it should be necessary for the prevention and detection of crime or protection from serious harm.*

(3) Criminal justice focussed

> *That responses to domestic violence, and later all forms of violence against women and girls (VAWG) emerged through the Home Office has meant that approaches to policymaking and co-ordination have been criminal justice focused.*[4]

The integration of MARAC into national and local responses to domestic violence has deepened the role of criminal justice agencies, since these fora are often chaired by police, and in some areas IDVAs (central to MARACs) are co-located in police stations. Interventions with perpetrators are often linked to prosecution; while community-based perpetrator programmes run by the voluntary sector have multiple routes in, the probation service runs an ostensibly national programme for men who are convicted. New legislation to criminalise coercive control – described as 'non-violent' domestic violence - is currently under consultation.

(4) The gendering of leaving home

A consequence of minimal engagement with perpetrator interventions at policy level is a focus on women as victims to leave relationships, and particularly to leave shared homes. Limited enforcement of available civil remedies - occupation orders for example give women the right to stay in the family home and prevents perpetrators from doing so – has exacerbated this.

> *In practice magistrates tended to take a restrictive view while many judges were reluctant to grant ouster orders as disproportionate.*[5]

The expectation is that women leave, not perpetrators. This has been conceptualised as 'forced migration' from research that explored women's journeys when escaping from domestic violence. [6]

Approaches have evolved at local levels, such as 'sanctuary schemes' which aim to keep women safe in their homes, by providing additional locks, panic alarms and in some cases entire 'panic rooms'. Yet the possibility of further measures to require perpetrators to leave shared homes has only recently been introduced in the form of Domestic Violence Protection Orders (DVPOs).

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[3] Harne, L. & Radford, J. (2008) *Tackling Domestic Violence: Theories, Policies and Practice* Buckingham: OU Press p179.

[4] See Coy, M., Lovett, J, Kelly, L. (2008) *Realising Rights, Fulfilling Obligations: A Template Integrated Strategy on Violence Against Women for the UK* London: End Violence Against Women Coalition

[5] Edwards, S. (2000) Domestic Violence and Harassment: as assessment on the civil remedies and new directions in prosecution. In Browne, T. (ed.) *What works in reducing domestic violence?* London: Whiting and Birch

[6] This is a concept developed by a CWASU PhD student, Janet Bowstead.

The Crime and Security Act 2010 introduced a new civil provision mirroring the European 'removal order', comprising an initial temporary notice (Domestic Violence Protection Notice, DVPN), authorised by a senior police officer and issued to the perpetrator by the police, followed by a Domestic Violence Protection Orders (DVPO), imposed at the magistrates' court. These orders aim to give victim-survivors time, space and support to consider their options by placing conditions on perpetrators, including restricting/removing perpetrators from households, and preventing contact with, or molestation of, victim-survivors.

Despite planned national rollout following a pilot period, these provisions are not yet operating in all areas and in some there are no imminent plans for their introduction because of the potential policing costs.

(5) Austerity (cuts)

Since a change of government in 2010, cuts in central funding to local governments and services have become more and more intense, with a dual impact: specialist NGOs have seen the amount of funding they receive reduced, and budgets for statutory services have been squeezed ever tighter.

Austerity measures have produced savage cuts to funding and exacerbated competitive tendering processes with local commissioners increasingly offering contracts to more generic (cheaper) services. Services for black and minority ethnic (BME) women, in particular, have been affected by disproportionate cuts to funding.

The cumulative impact is to diminish both direct support options for women experiencing domestic violence, and universal services such as police, Social Services and health who can also provide measures to enhance their safety.

3.2 Key frames from the perspective of professionals

The dominant frames in the workshop discussion were those of child protection/safeguarding, risk, and multi-agency information-sharing.

(1) Child protection/safeguarding

The most frequently – and quickly - mentioned intervention was to make a referral to child protection/safeguarding services ('safeguarding' has fairly recently become a preferred or interchangeable term with child protection, and participants used both). Making a referral to child protection services (Social Services) on the basis that children were being 'exposed' to domestic violence was the first response to the first part of the story in one workshop, and dominated the rest of the discussion. Statutory agencies in particular were adamant that even based on the information in the first part of the story, the threshold for a referral to Social Services had been met because of '*risk of harm to the children'*.

Emergency nurse*: From a nursing point of view, in an emergency department, what would lead me to try and find out if it's domestic violence due to the children involved, so it's a safeguarding issue. As a nurse my hands are pretty much tied with regards to the woman, but for the children I could go down that avenue…*

One police officer raised the principle of protecting children through protecting women: 'e*veryone's said the same thing, safeguarding the children is paramount, here, but the best way to safeguard the children is to be engaging with the mother, because she's the best person to be protecting the children'.* This did not reappear in discussions in either workshop.

In the other workshop, child protection was not mentioned so quickly, and did not dominate – there was much more discussion of women's needs – but it was nevertheless taken for granted that child

protection procedures enabled agencies to act. There was more distinction here between those that actively endorsed speedy child protection responses (typically participants from statutory agencies) and those that accepted that these were part of the system, but critiqued them for being used coercively against women.

> Lawyer: *There needs to be a different way of approaching it other than to blame the woman and say you've failed to protect the children. Women on the phone to me feel like they're being abused not just by the perpetrator, but by Children's Services as well.*

(2) Risk

Risk discourse was a significant normative motif, to the point where it was rarely the subject of discussion between participants, but peppered their sentences and musings on courses of action. The following statements from participants indicate how pervasive notions of risk are to intervention.

> Prosecutor: *obviously for the police initial concern would be immediate risk, that's where the police would probably become involved, Social Services, at a very early stage. They would be looking to make sure that actually there is no ongoing risk, and clearly there is indication here that there is (the first section of the story).*
>
> *…*
>
> Police: *It's more important than someone is talking to Anne than her gets arrested, or a referral goes to Social Services, or anything else [lots of yeses from around table]. It's the most important thing. But it has to be risk assessed and risk managed.*
>
> …
>
> Specialist NGO: I *work with children and young people and if they disclose something to me that I know is a risk of harm, regardless of whether or not a parent says I can do that, I'm going to put a child protection referral in. It doesn't mean I'm happy to do that because I've built up a relationship with that parent, and I could be causing emotional harm to that parent by doing so, but ultimately if there is a risk that someone is going to be harmed in any way, a child or a young person or a woman, or a man, whatever, that overrides my personal viewpoint on how I feel about it.*

Risk thus becomes a compass which guides all other routes of action. Risk discourse is translated into process through risk assessment, which has been standardised through a tool developed by an organisation named Co-ordinated Action Against Domestic Abuse (CAADA), referred to as the Domestic Abuse, Stalking and Honour risk assessment (DASH). This was also axiomatic in both workshops, as references to completing the DASH and making referrals to MARAC were threaded throughout discussions as a universally accepted process.

In the workshops, it was clear that plurality of discourse noted by Hague and Radford (2008)[7] influenced what actions were open to practitioners and what they prioritised: for police and prosecutors, the possibility of successful prosecution and necessity of 'public protection'; for health professionals, safeguarding children; for specialised women's services, ensuring women are able to make decisions about their safety and wellbeing; for Social Services, promoting the best interests of the child. However, the consensus around risk and the MARAC forum to bring agencies together provided a pivot around which these differing priorities coalesced; an overarching discourse replacing the previous plurality. Risk to women, and protection of her and the children is used as the

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[7] Harne, L. & Radford, J. (2008) *Tackling Domestic Violence: Theories, Policies and Practice* Buckingham: OU Press p179.

legitimation for professional intervention. This eclipses and overrides empowerment as a framing. That women are perceived to have no power, as controlled by perpetrators, justifies state responsibility to rescue/protect.

(3) Multi-agency information sharing

MARAC has, according to participants, become the multi-agency response required by national and policy policies. Multi-agency work was accepted as essential; this frame shapes course of action by an obligation to co-ordinate with other agencies: *'…if you want to protect, you must work together… everyone has their role to play in sorting out the mess'* (Police). Information sharing was reported as central to this co-ordination. Multi-agency safeguarding hubs (MASH)[8], which bring together agencies with a remit to safeguard children and adults, were described as a forum to share 'softer' information (by police). In both cases the term multi-agency has become a byword for information sharing.

> Health visitor: *MARAC is about multi-agency discussion round the table so you get a fuller picture [other voices – safety measures]. It's more co-ordinated…*
>
> DV Co-ordinator: *More professionals become aware of the situation, you're all taking responsibility, safety measures to be put in place, to work with the family.*

(4) Less prominent frames

Some frames featured less than those above in the discussions.

Austerity (cuts)

While cuts in funding for statutory and voluntary sector support services (because of government austerity measures) were mentioned as explicitly limiting women's options, this was not a significant subject of discussion in the workshops. However, several repercussions were alluded to: severely limited access to Legal Aid because of significant cuts to the national budget; squeezes on local funding which reduced the number of refuge beds and support hours. It is notable that the language of policymakers (austerity) was not used at all by participants, who preferred the term 'cuts' since this reflected their reality on the ground. A brief but important contribution was made by one participant who noted that cuts to Legal Aid and rationing of resources have combined with discussion at MARAC being included as evidence of victimhood, so some support agencies might make this referral to enable women to access public funding for legal advice. However this '*removed choice and consent from the victim'* since it kick-started a domino effect of police hearing about offences, logging these as crimes, contacting women for statements, and possibly pursuing victimless prosecutions. This is an acute illustration of how systems designed to reduce risk and promote safety can be in profound tension with women's self-determination. However, as only two police officers seemed aware of it, no further discussion was generated.

[8] A Multi-Agency Safeguarding Hub (MASH) 'aim[s] to improve the safeguarding response for children and vulnerable adults through better information sharing and high quality and timely safeguarding responses'. See Home Office (2014) *Multi Agency Working and Information Sharing Project Final Report*. London: Home Office p4.

The gendering of leaving home[9]

This was mentioned briefly in both workshops as an injustice in the sense that women had to leave: '*the woman is victimised by the perpetrator then victimised by every agency by having to leave her home'* (Health visitor). In one workshop, there was some awareness of Domestic Violence Protection Orders (DVPOs), but in the other it emerged that there are no plans for them to be implemented because of the policing costs.

Subordinate frame(s)

Criminal justice approaches did feature strongly in one workshop, with domestic violence frequently described as a crime/offence, but there was an over-representation of police and prosecutors here (three police officers and one prosecutor in a group of 11). In the other workshop (two police officers, no prosecutor and a magistrate) it was a less prominent theme. The close involvement of police in MARACs, and centrality of the latter, meant that criminal justice was integrated into the dominant frame of multi-agency information sharing.

4 Framing culture and difference

Culture was framed in the workshops as women 'not knowing'. At one level practitioners invoked this to mean lack of knowledge over legal rights, and to a lesser extent of support options. A deeper level referred to 'not knowing' about rights to live free from violence.

In both workshops, but to a much greater extent in one, culture was equated with 'not knowing' that domestic violence is 'wrong', that it is perceived by women from minority communities as 'normal'. These separate understandings – one can know violence is wrong, even unjust, while believing it to be normal – indicate that some practitioners conflated habituation with acceptance when notions of culture were in play. This appeared to be because culture was viewed as a framework that normalised violence to the point where women were unable to identify it as wrong. Discussion was laced with a terminology of othering: 'they, 'them' and 'their'. This sat in tension with earlier discussions about the generic case, where women not naming abuse was invoked to legitimise acting without their consent.

> Housing: *You have to be careful with how you do it because their norms, their values, their community, we might not necessarily agree with them, but they might, and for someone to go in and say actually, what you've been brought up with and what you believe is right is wrong, and you're doing it wrong, and you're making the wrong decisions, you're isolating yourself further away from them. So to have someone go in who already has that relationship and understand that point of view would be much better than for someone like me to go in and say 'actually I think you should engage with me'…*
>
> Specialist NGO: *You have to take into account what they think is normal. That plays a big part as well, because you can't really challenge their beliefs or what they've been brought up in. We're all entitled to our own opinion, so we can be able to share what we think, but we can't force them to take it on board and say yes 'what's been happening all my life is domestic abuse', because they're not going to do that, so it's about educating but in a way that isn't patronising.*

[9] This has been conceptualised as 'women's forced migration'. Bowstead, J. (2013) *The Extent and Implications of Women's Forced Migration Journeys to Escape Domestic Violence* London Metropolitan University, Unpublished PhD thesis.

In this process, domestic violence becomes 'culturalised' and othered when experienced by women from minority communities. Some practitioners in one of our workshops assumed that women do not understand domestic violence to be socially 'wrong', because they [practitioners] culturalised their experiences. In part this also reflects an absence of a gender analysis, leaving many reaching for alternative explanatory frameworks. There was some dissent to this culturalisation from a police officer who said '*Many issues we interpret as cultural are actually particular to that relationship so some issues are not really cultural'.*

However in the other workshop, 'not knowing' was more nuanced, linked to the discussion noted earlier that women from all backgrounds subject to domestic violence do not 'understand' that this is 'wrong'. That women did not perceive domestic violence to be 'wrong' in their own lives was attributed to absorption of what perpetrators tell them: that is their fault, they provoke/deserve it. Recognition of abusive behaviours was therefore not culturalised in the same way.

Framings of culture were in play differently here, focused on extra layers of material constraints which inhibit women's ability to escape violence, and the responsibility of agencies to address these. This included having no recourse to public funds because of insecure immigration status, including limited access to legal remedies and the paucity of refuges offering culturally specific cooking spaces and language support. Practitioners from a specialist NGO for BME women also raised dynamics that were specific to some minority communities, such as notions of shame and honour, strongly linked to family and community norms.

Culture was framed not here not so much as not knowing, but as not being enabled. For intervention this meant acknowledging that minority women's options were more materially limited.

> Lawyer: *The huge difficulty here for minority women is that the government expects women who can't get access to legal aid, can't afford legal aid, to take action themselves, so do all the divorce themselves, do the children issues themselves, and that is all the more difficult if English is not your first language.*

Minority women were also reported to perceive different options rooted in the realities of social and institutional racism; for Muslim women, Islamophobia meant reluctance to report to the police in case perpetrators were judged to be terrorists, and for women from African-Caribbean communities, not wanting to compound the overpolicing and criminalisation of young black men. To understand this, workers needed to be willing to learn about women's community backgrounds and the meanings, and potential consequences, of courses of action.

> Specialist NGO: *We would ask specific questions in order to look at what we needed to put in place, and what they need to be safe.*

In contrast, the implications of culture for intervention in the other workshop were much more about equipping women to recognise the complicity of their cultural beliefs in acceptance of violence, rather than addressing the material/practical constraints associated with minoritisation, poverty and isolation, albeit with some dissent.

> Health visitor: *It's a difficult balance because if you're not careful you can end up colluding as well with things that are not good… [children's rights to education impacted upon by cultural beliefs]… but there is a fine line, you can't collude with something that don't believe is right, and which is illegal within the country they're living in, so the balance is you want to try and take account, and sort of work with them, work within their culture…*
>
> …
>
> NGO: *I can't see what the issue is with right and wrong, isn't it just that people need information about to make choices that might be informed by whatever cultural issues/baggage they've got going on… it's making adjustments that you make for anyone that's not able to access the service. It's about finding ways to enable them to access the*

service for their benefit. It's seeing where the barriers are in place, whether that be language or cultural issues, and removing those barriers.

DV Co-ordinator: *Perhaps there's a difference between educating people on what the law is within a country, and about human rights, and the more subtle cultural beliefs, perhaps we shouldn't be seeking to change those, but I suppose just giving them as much information as possible to make their own decisions.*

Immigration status was discussed in relation to women's options for seeking civil legal remedies, because of limitations on publicly funded Legal Aid for those without British citizenship, and access to refuges where women are ineligible for more general public funds. This reduced the availability of specific safety options.

Part 3: ETHICAL ISSUES AND DILEMMAS from the perspective of practitioners

5. Ethical issues in the workshops

Participants were encouraged to reflect on any tensions arising from interventions. These are divided here into professional/practical dilemmas and ethical dilemmas, although inevitably there is overlap.

5.1 Practical and professional dilemmas

5.1.1. Acting without women's consent

While systems and procedures were invoked to justify acting without women's consent, or against their wishes, especially with respect to safeguarding children, a minority of participants reflected on the balancing act of predicting intervention outcomes against impact. This juxtaposed 'keeping women safe' with awareness that criminal justice interventions might be only temporary, and at the time of initiation the outcome is unknown, which might ultimately 'make her situation worse'. This was a practical or professional dilemma, most explicitly articulated by those in the criminal justice system.

Prosecutor: *There are ethical duties, professional obligations to keep confidential. That's the problem. The question you posed earlier, should we be getting involved where a victim doesn't want this, particularly as we recognise that from the intervention the outcome is probably going to be fairly negative. At what stage do we act?*

…

Magistrate: *if there's enough support, real and effective, if we felt there were appropriate interventions being made with perpetrators, victims were being adequately supported, that their particular needs especially if they're from a BME community, with a whole separate range of issues, if all of those things were being attended to, then there might not even before non-consensual because the likelihood of consent would be greater… And if not there may be certain circumstances under which it would be appropriate to proceed without consent… in some instances it may be true that intervention has made that woman's life worse, and that's too high a price to pay.*

Victimless prosecutions – where there is sufficient evidence to proceed on a charge without a statement of complaint from the victim - were one response discussed as an intervention which did not require women's consent. These were described as a 'huge step forward' (by a health visitor) because it reduced risk to women, who did not have to be seen to be co-operating. Police said they

would '*always look to see if there's the possibility of a victimless prosecution*' because '*it will be always be in the public interest to prosecute'*, and acknowledged that they were 'unburdened' by questions of potential impact because these were picked up by support agencies. Only the prosecutor reflected that victimless prosecutions might have unintended and unknowable consequences for women.

MARAC was one route to a victimless prosecution, as police who hear of crimes at MARAC are apparently required to log these on a crime report, which might then lead to prosecution without women's statements. That this 'removed choice' from women who had earlier decided not to report to the police was noted. There was a tension here between the risk frame and respecting women's choice, particularly with reference to MARACs as the concrete response to risk. Some from specialised NGOs were more ambivalent about their own role in acting without consent, there was an expectation (or acceptance) that statutory agencies would do so, acting on their 'guidance': '*surely if you're a worker and you're governed by these procedures, you would follow them. It seems these three agencies are letting her down by not doing it, by not making a referral'* (Specialist NGO).

While multi-agency information sharing was a prominent subject of discussion, practitioners had to be prompted to consider associated ethical issues of doing so without women's consent. Sharing information enabled practitioners to gather sufficient background to take action, and when asked about privacy concerns, many participants appeared baffled. Practitioners located in statutory services appeared less troubled by the issue of consent, because their professional governance/procedures acted as a justificatory framework.

> Emergency nurse: *She does have to consent to share information, but it will go through regardless of whether she consents*
>
> Social worker: *If issues come to Social Services where the threshold has been reached where there is a need for child protection, we don't need consent. We proceed through Section 47 – the enquiries - which is Safeguarding/Child Protection. From then on we don't need consent from anyone, we do our investigation… If I want information from the health visitor or whatever, I don't need consent because it's the threshold where there is a need for child protection.*
>
> *…*
>
> DV Co-ordinator: *women have the right to make bad decisions I suppose but it's about risk of harm overriding personal confidentiality. What is always taught on any kind of MARAC training is that ideally you would always get a person's consent and you would always inform them unless that was even further going to increase the risk.*

Practitioners from a specialist NGO contrasted the approach of routinely sharing information without women's knowledge or consent with rape crisis services, which have more scrupulous processes about preserving confidentiality (even where perpetrators might be abusive intimate partners). Another participant (police) noted that women who had had contact with some agencies (she identified health, Social Services and housing) would not know they had been referred to MARAC, and when asked suggested the ethical issue here was 'people are discussing her business and she does not know'. She also raised concerns about communication, specifically emails sent about cases, containing personal information, that were copied in many people.

There was in both workshops, a brief but disputed recognition that acting without women's consent was a means to protect agencies, that a 'threat to life' meant 'public safety outweighed confidentiality'.

5.1.2. Interpreters and access to knowledge

Interpreters were discussed as key to enabling access to knowledge and information that would in turn enable women to make the 'right choice'. However, the risks associated with using interpreters, and the complexities of ensuring that women both felt safe and received the intended information were prominent areas of discussion. There were practical dilemmas, then, associated with the use of interpreters, with lengthy discussions about how 'inappropriate' interpreters could be and how difficult it could be for practitioners to be sure that intended words and meanings were being translated accurately.

> NGO: *There's a whole range of concerns around it, it's not just translating the words, is it? We use particular interpretation services because we trust that their staff are trained to understand the issues around what they're interpreting. There may be, for example, the person who is interpreting has a particular judgment, viewpoint, on what is being discussed, so won't give you all the information as you want it and need it because they're thinking well, she should just put with it, or she's talking against my religion that I believe in. There are judgements the interpreter is holding that I think we need to be aware of.*
>
> …
>
> Police: *Or interpreters actually saying to women 'have you really thought about the impact this is going to have on the children, on the community, what will your mother at home think.*
>
> Specialist BME NGO: *We've had one say 'you should go back'.*

An additional complication was when it was assumed that if women had a little English, they could 'get by' without an interpreter, but women might not actually understand what was being said.

Some practitioners could rarely, because of the ways they encountered victims, use interpreters: nurses in emergency units, and police reported that officers attending initial call outs to suspected violence would sometimes use children to translate even though this contravenes official guidelines. There was acknowledgment of the implications here for enabling women to speak, and the quality of information gathered. For instance, in immigration cases where women gave statements without interpreters, there was concern that this would affect how well she was able to present her case.

5.2 Ethical dilemmas

5.2.1. Enabling women to make the 'right choice'

One overarching tension and difficulty expressed by practitioners was enabling women to make the 'right choice' e.g. to seek support and leave abusive partners. This was strongly shaped by the child protection/safeguarding frame, and a tension between the guiding principles of respecting women's 'choice' (framed this way rather than autonomy/self-determination) and protecting children. More than once practitioners said that women had the right to make 'bad decisions' and be in 'abusive relationships', but they did not have the right to 'expose' children to violence, as one emergency nurse articulated: '*she has the right to be in whichever relationship she chooses to be, but my concern is the protection of the children…when it's adults alone, we don't do anything, which is frustrating really*'.

The information sharing frame also influenced how practitioners perceived that it was possible to steer women to the 'right choice'. Giving women information (that the behaviours of their partners were abusive, that support was available) was widely described as the way to influence women's decision-making. When asked how practitioners could know that women were making an 'informed' choice (used synonymously with 'right' in the discussion) choice, one participant said: 'you measure by the amount of information, but they can still have that information and make a bad choice' (DV Co-ordinator). This mirrored the assumption implicit in discussions of multi-agency information-

sharing – that having as much information is possible is in itself a form of action, and facilitates action regardless of material context. Whilst for advocates supporting women this process was thought of as empowerment, few practitioners also identified resources as constraints on women's ability to act. Some acknowledged that women may have a different perspective on what choice was 'right' for them in their circumstances, albeit that this was often linked to 'not understanding' that they were subject to DV.

> Police: *But that's her choice and what she's saying to us is 'I want this to continue, I want to stay here, because if you take him away my and children and I have nothing'.*
>
> Lawyer: *That can be the case even where they do understand, they still don't to leave because he says he won't do it again, or you'll be homeless, you'll have no money and that's time and time again why women choose to stay, even if they know they're being abused.*

A common lever to ensure that women made the 'right choice' was to invoke intervention with the children. This was borne of the dominance of a child protection/safeguarding frame, where children's welfare was privileged over women's, and thus failing to leave abusive partners was equated with collusion in harm to children (a clause which is explicitly present in child protection law and policy). For some practitioners, threatening to remove children was reported as a powerful lever to coerce women into taking the action that agencies required, which was typically to leave.

> Lawyer: *The appropriate measures would still be to proceed with care proceedings. If she chooses to go back into that volatile situation that's her choice, but she should not put the children back in that situation. So she either chooses between the partner, who is aggressive and has made these threats and who has breached the order not to have contact with her in any event, against safeguarding the rights of these children to be in a safe and caring environment.*

Here women are expected to walk a tightrope, weighing up when it is possible to leave – not too early and not too late. Some NGOs seemed regretful that they did not have sufficient statutory powers to coerce women into making the 'right choice', and again making a referral to child protection services was included, considered even by women's organisations as not only a legitimate but necessary action. Two participants talked of 'not being able to force women' and more that unless women agreed to take action themselves their 'hands were tied'. By this they meant that they were obliged – legally and ethnically – to make a referral to child protection.

In each workshop, one participant provided a counterpoint to this narrative, questioning whether anyone but the woman could really know what was 'best' and dangers of '*deferring to the experts'* and '*ignoring the woman's wishes*'. A minority were also more reflective about the tensions in reproducing abusive dynamics – 'carrying on controlling behaviour' by insisting that women move or leave. Social Services, and threats to remove children were identified as the primary protagonists in this, with one health visitor noting that *'often part of the abuse, or the way the abuse is perpetrated, is threatening her with loss of the children, and actually as organisations what we do is play into that*'. The contradiction here – that this group explicitly and unwaveringly advocated making a referral to Children's Services and clearly viewed child protection/safeguarding as the dominant frame – was not recognised by participants.

5.2.2. Interventions with perpetrators

While the possibility of intervening with perpetrators did not generate detailed or lengthy discussions, there was a notable difficulty here in weighing up risks that women's safety would be further jeopardised. Social workers appeared to be the most likely organisation to directly engage with perpetrators about violence, since they were tasked, at least nominally, to work with the whole family. However, in one workshop, specialised women's NGOs had to quite trenchantly make the case with a social worker that making a police report, after Anne had told a nurse in the emergency

department that he had caused her injuries, would alert him to her disclosure and thus place her in further danger. This revealed that the social worker did not appreciate how alerting the perpetrator that Anne had spoken out might endanger her. He equated hearing 'quarrels' with emotional abuse of children.

Towards the end of the workshops, perhaps when participants were more reflective, they identified that there is '*more pressure on victims to make the changes, rather than the perpetrators to make the changes'* (Specialist NGO). The focus quickly shifted to the complexities of empowering women to make the right choice rather than on the perpetrator. One worker from a specialist NGO raised it as a challenge: 'It's an interesting concept, why don't we talk to perpetrators?'.Another participant made a fleeting reference to '*survivors complain[ing] that plan[s] of protection around children are always about the mother'* [instead of addressing the perpetrators' actions]. This can be framed as a practical dilemma, but is also an ethical issue, that unless there is criminal justice intervention, perpetrators are not being held to account.

6 Summary

Information sharing, from information gathering through searching institutional data to discussing all knowledge about a case at multi-agency meetings, was routine and participants were relatively untroubled by concerns about confidentiality and privacy. This reflects two core foundations. First, an assumption that systems work to address domestic violence and where they do not, this is because women do not make 'the right choice' (leave an abusive partner) despite information and support to do so. In this way, women become responsibilised. Second, that women's self-determination is subordinated to the responsibility of agencies, with the notion of empowerment barely engaged with, and only then briefly by specialist NGOs. Partly this was attributed to how being controlled and abused rendered women incapable of making choices. This in turn was drawn on to explain why it was not always possible or necessary to gain women's consent before making an intervention. Women's consent, most of the time, meant without women's knowledge. Ethical issues of privacy and confidentiality were only mentioned if moderators prompted, and dismissed against the need to take action where there was risk, especially to children. There was some recognition that procedures protect organisations.

The overall dominant frame in both workshops was child protection/safeguarding, with children's welfare invoked as superseding women's rights. There was an unacknowledged contradiction in the first workshop that although threats to remove children by agencies reflect the abusive dynamics used by some perpetrators, they nevertheless endorsed referrals to Children's Services and even using such threats as a lever to enable women to make 'the right choice'. Notions of privacy were overshadowed by the presence of children and obligations to protect them. 'Rights' were only discussed in relation to a 'right' to choose 'bad relationships'; only one participant made a fleeting reference to a woman's right to live from violence.

Culture emerged as a slippery concept, invoked in different ways, with little or no reference to majority cultures. In one workshop, culture was equated with women 'not knowing' that domestic violence was wrong, although the same argument was used earlier in the generic case to justify acting without women's consent. In the other workshop, culture was equated with not being enabled, because material options were much more limited for women from minority communities. In both workshops, practitioners expressed that interventions would not be different, but the approach of practitioners would need to be in order to address additional barriers.