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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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.

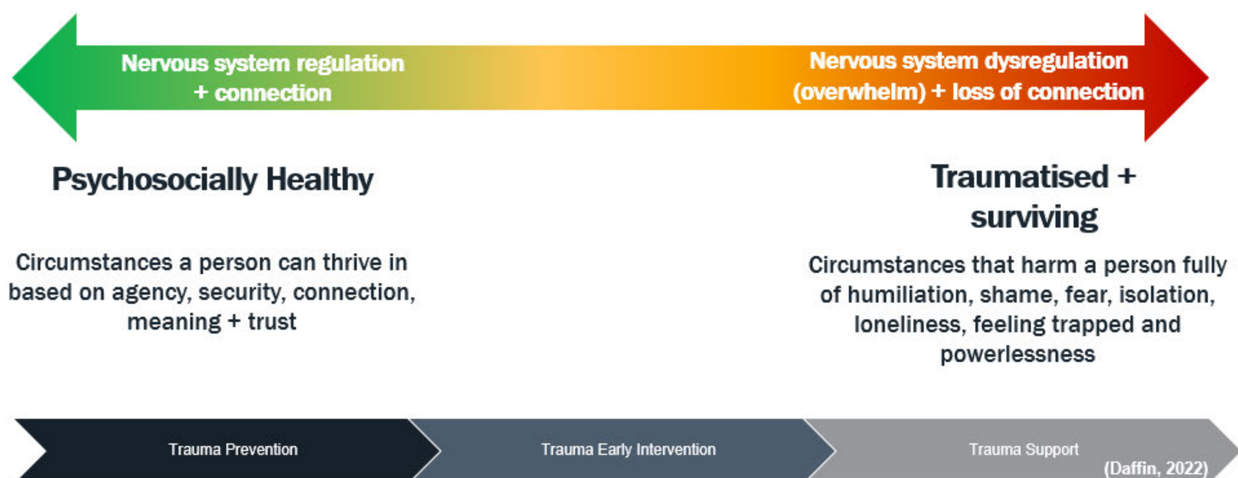

Figure 1. Continuum of Relational Health

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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