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Haringey Council

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24 March 2015

To: All Members of the Overview & Scrutiny Committee

Dear Member,

Overview and Scrutiny Committee – 26 March 2015 – to follow document

I attach a copy of the following report for the above-mentioned meeting which was not available at the time of collation of the agenda:

Agenda Item 14 – Scrutiny Review – Violence Against Women and Girls

To receive the final Environment and Community Safety Scrutiny Panel project report on Violence Against Women and Girls.

Yours sincerely

Natalie Layton
Principal Committee Co-ordinator

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Agenda Item 14

Haringey Council

Report for:	Overview and Scrutiny Committee – 26 March 2015	**Item Number:**	**14**

Title:	Violence Against Women and Girls; Environment and Community Safety Scrutiny Panel Project Report

Report Authorised by:	Cllr Barbara Blake, Chair, Environment and Community Safety Scrutiny Panel

Lead Officer:	Robert Mack Principal Scrutiny Support Officer Rob.mack@haringey.gov.uk 0208 489 2921

Ward(s) affected: All	**Report for Key/Non Key Decisions:** N/A

1. Describe the issue under consideration

1.1.1 Under the agreed terms of reference[1], the Environment and Community Safety Scrutiny Panel can assist the Council and the Cabinet in its budgetary and policy framework through conducting in depth analysis of local policy issues.

1.1.2 In this context, the Panel may:

- Review the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;

- Conduct research, community and other consultation in the analysis of policy issues and possible options;

- Make reports and recommendations on any issue affecting the authority's area, to Full Council, its Committees or Sub-Committees, the Executive, or to other appropriate external bodies.

1.1.3 Cabinet Members, senior officers and other stakeholders were consulted in the development of an outline work programme for the Overview & Scrutiny Committee. Project work undertaken by the Environment and Community Safety Scrutiny Panel on Violence Against Women and Girls was agreed as part of this work programme by the Committee in July 2014.

[1] Overview and Scrutiny Protocol, 2012, Haringey Council

2. Cabinet Member introduction

N/A

3. Recommendations

3.1.1 That the Overview and Scrutiny Committee:

(a) Agree the report; and

(b) Agree the recommendations contained in the final report

4. Alternative options considered

4.1 The options considered during the course of this scrutiny project are outlined in the body of the report.

5. Background information

5.1.1 The Terms of Reference for the project were;

"To consider and make recommendations to the Overview and Scrutiny Committee on how the Council and its partners address early intervention and prevention in domestic violence and abuse and specifically;

- The development of improved links between Violence Against Women and Girls services with NHS services; and
- Any gaps in services, particularly in respect of increasing levels of awareness amongst professionals and the community."

5.1.2 The Panel heard from a range of stakeholders, including NHS England, Barnet, Enfield and Haringey Mental Health NHS Trust, Haringey Clinical Commissioning Group (CCG), Whittington Health, the North Middlesex University Hospital and Public Health

5.1.3 A number of themes emerged from the project, which are outlined in more detail in the main body of the report.

6 Comments of the Chief Finance Officer and Financial Implications

6.1 The Panel has put forward a number of recommendations for consideration. At this stage, the recommendations are fairly high level and further work will be required to fully assess their financial implications. As the Panel will be well aware, Council and other public sector budgets are under pressure and there is little new funding available to support these recommendations and so their implementation may require redirection of existing resources. However proposals to undertake joint work and integrated commissioning may allow improvements in value for money. For these reasons a robust business case must be drawn up and recommendations should only be adopted if this demonstrates and if the necessary resources have been identified.

7 Assistant Director of Corporate Governance Comments

7.1 The recommendations arising from the Project Report are within the terms of reference of the Panel.

7.2 Under Section 9F Local Government Act 2000 ("LGA"), Overview and Scrutiny Committee have the powers to make reports or recommendations to Cabinet on matters which affect the Council's area or the inhabitant of its area. The Constitution provides that the Scrutiny Review Panels must refer their findings/recommendations in the form of a written report to the Overview and Scrutiny Committee for approval. Afterwards, final reports and recommendations will be presented to the next available Cabinet meeting together with an officer report where appropriate. The Overview and Scrutiny committee must by notice in writing require Cabinet to consider the report or recommendations.

7.3 Under Section 9FE of the LGA, there is a duty on Cabinet to respond to the report. That response must indicate what (if any) action Cabinet, proposes to take, within 2 months of receiving the report or recommendations.

8 Equalities and Community Cohesion Comments

8.1.1 Overview and scrutiny has a strong community engagement role and aims to regularly involve local stakeholders, including residents, in its work. It seeks to do this through:

- Helping to articulate the views of members of the local community and their representatives on issues of local concern

- Bringing local concerns to the attention of decision makers and incorporating them into policies and strategies

- Identifying and engaging with hard to reach groups

- Helping to develop consensus by seeking to reconcile differing views and developing a shared view of the way forward

8.1.2 The evidence generated by scrutiny reviews help to identify the kind of services wanted by local people. It also promotes openness and transparency as meetings are held in public and documents are available to local people.

9 Head of Procurement Comments

N/A

10 Policy Implication

10.1.1 Work carried out by the Environment and Community Safety Scrutiny Panel during 2014/15 should contribute and add value to the work of the Council and its partners in meeting locally agreed priorities. In particular, domestic violence is one of the priorities within the Haringey Community Safety Strategy for 2013 - 2017.

11 Reasons for Decision

11.1 The evidence behind the recommendations are outlined in the main body of the report.

12 **Use of Appendices**

12.1 As laid out in the main body of this report.

13 **Local Government (Access to Information) Act 1985**

Haringey Council

Scrutiny Project – Violence Against Women and Girls

A REPORT BY THE ENVIRONMENT AND COMMUNITY SAFETY SCRUTINY PANEL

March 2015

www.haringey.gov.uk

Contents: **page**

Chair's Foreword:

Tackling violence against women and girls is a key priority for Haringey Council. The Council is dedicated to working with partners across the borough to address and eliminate violence against women and girls. Cases of abuse, be it physical or sexual, can be some of the worst crimes and victims can often find it hard to talk about their experiences and are often unsure where to turn to for appropriate support. We want to prevent these crimes happening in the first place. Where violence does occur, we want to ensure victims have the confidence to report cases. In addition, there should be support for victims and their children so that they are able to rebuild their lives and are protected from further harm.

To assist this, a study was conducted by the Environment and Community Safety Panel between September 2014 and March 2015, to examine the level of collaborative work with partners to tackle VAWG across Haringey and ensure we have services which can detect and respond to specific crimes. The work focussed specifically on the response of health services.

The aim was to capture what individual statutory agencies did to provide services for domestic violence and abuse and to recommend ways for a more co-ordinated response. It is clear that there are many initiatives underway. With good practice and a clear referral pathway, we feel a performance framework can be developed so that we can be confident we are making progress in preventing violence against women and girls

Councillor Barbara Blake
Chair of the Review Panel

SCRUTINY PROJECT – VIOLENCE AGAINST WOMEN AND GIRLS

Executive Summary

The aim of this project was to help the identification, prevention and reduction of domestic violence and abuse in Haringey. It is a complex issue that needs sensitive handling by a range of organisations and professionals. The cost in human and economic terms is such that even marginally effective interventions can be cost effective.

There has been an increase in the reported incidents of domestic violence and abuse (DVA), with 4,061 incidents reported to the Police on Haringey in 2013-34. This could be because victims are likely to report instances due to greater confidence in the response and improved detection rates. Whilst this is welcome, many challenges still remain. It is widely acknowledged that there is still considerable under reporting, especially from primary care services in health.

The Panel found the issue of DVA to be a complex area of policy. It involves a large number of different partners contributing to the response as no one single agency can effectively respond to the issues in isolation. However, the recently established Violence Against Women Strategic Group is now making progress in Haringey and tackling a number of important areas that require attention. Amongst these is the need for a clearer referral pathway into services for victims to be developed, which the Panel was pleased to hear is currently being addressed. A single point of access would be particularly welcome.

The Panel noted the lack of publicity for DVA services in Haringey and feels that this should be resolved quickly by partners once the referral pathway has been developed. The Panel also noted that funding for support services lacks stability, with a significant percentage of it coming from a range of grants, each running to different timescales and monitoring arrangements. However, it is not clear how this can be mitigated easily, especially in the current financial environment. The Panel feels that it is important that information is obtained and responded to on the experience of victims in accessing services and welcomes moves to address this.

The work of the Panel focussed on the response of health services to DVA and it noted that there has been some encouraging progress nationally in recent years. Of particular note are the IRIS scheme for GP services and the growing use of hospital based Independent Domestic Violence Advocates (IDVAs). These have both proven to be successful in dramatically increasing the number of referrals from health services where they have been used. Haringey has yet to commission either of these schemes. The Panel noted that the decision to not commission IRIS is to be reconsidered by Haringey CCG and is of the view that health commissioners should give both of these initiatives serious consideration.

An important issue in respect of improving links between NHS acute provider trusts and DVA services is that hospitals treat patients from different boroughs, whilst DVA services are often borough based. This leads to professionals in acute provider trusts having to navigate patients through different referral pathways, depending on where the patient is from. In addition, hospital based DVA services are funded by some boroughs but not others whose residents may also benefit from them. A greater use of joint commissioning might provide an equitable solution to these issues.

Earlier detection and an increase in referrals from health services is very likely to lead to greater pressure on services to support the needs of victims and survivors, which already appear to be struggling to meet demand. Although these services were not looked at in detail as part of this piece of work, the Panel is of the view that if partners are aiming to increase the level of referrals, especially from health colleagues, they will also have to address the capacity of support services to deal with them. The Panel notes the recent launching of the first London-wide service for victims of abuse by the MOPAC and this may have the potential to assist as well as reducing inconsistencies between boroughs. However, it could also further complicate an already complex structure.

Recommendations:

1. That information be shared with the Panel by the Violence Against Women and Girls Strategic Group for their plans on how the views of service users will be obtained and responded to. (*Paragraph 3.15)*

2. That a clear timeframe be set by the Violence Against Women and Girls Strategic Group for the approval of a referral pathway. *(3.17)*

3. That work to develop the referral pathway focus upon simplifying the process and establishing a single point of entry. *(3.17)*

4. That the Strategic Group develop proposals for publicising domestic violence and abuse services and, as part of this, consideration be given to joint commissioning. *(3.20)*

5. That the Strategic Group, working together with the Local Safeguarding Children's Board (LSCB), develop proposals for multi agency training on Female Genital Mutilation (FGM) for health and social care professionals and that Members also be included in relevant training on the issue. *(3.25)*

6. That consideration be given by the Strategic Group to developing multi agency and multi disciplinary training on domestic violence and abuse. *(3.25)*

7. That consideration be given by the Violence Against Women and Girls Strategic Group on how best to secure the regular engagement of local NHS acute trusts and the MHT on a basis that is achievable and sustainable. *(4.2)*

8. That, in view of the strong evidence of the effectiveness of the IRIS scheme in facilitating the detection of domestic violence and abuse, the Haringey CCG reconsider its decision not to commission it. *(4.18)*

9. That CCG explore further the potential of joint commissioning of IRIS with neighbouring boroughs in north central London. *(4.18)*

10. That staff training provision on DVA be reviewed by Whittington Health to ensure that sufficient time is allocated and that it is delivered in an appropriate and interactive format, with the use of e-learning avoided *(4.26)*

11. That the business case currently under development by NMUH for the establishment of a post of hospital based IDVA be supported and recommended for approval by the CCG and that consideration also be given to establishing a similar

post at the Whittington hospital. *(4.39)*

12. That the options of providing hospital based IDVAs by joint commissioning between boroughs whose residents use the same hospitals and/or the re-location of one or more of the boroughs IDVAs to local hospitals be considered by the Community Safety Partnership, in consultation with the CCG. *(4.40)*

13. That the Violence Against Women and Girls Strategic Group work together with partners to ensure that all relevant professionals understand and receive training on completing the referral form for DVA (the CAADA DASH RIC) in order to promote its wider use. *(4.44)*

1 BACKGROUND

1.1 The project was commissioned by the Panel to look at the issue of Violence Against Women and Girls. As this is a wide and complex area of policy and there was limited time available, the Panel decided to focus its attention on a specific area. It looked at the response of NHS health services to domestic violence and abuse (DVA) and, in particular, detection and early intervention, which are both areas that require further development. In addition, the Panel also looked at gaps in services, such as promotion and publicity.

1.2 The role of overview and scrutiny in respect of crime and community safety is to scrutinise the work of the Crime Reduction Partnership i.e. partnership activities. However, this issue also cuts across other partnership bodies such as the Health and Wellbeing Board, the Safeguarding Adults Board and the Local Safeguarding Children Board.

Terms of Reference/Objectives

1.3 The terms of reference for the project were as follows:

"To consider and make recommendations to the Overview and Scrutiny Committee on how the Council and its partners address early intervention and prevention in domestic violence and abuse and specifically;

- *The development of improved links between Violence Against Women and Girls services with NHS services; and*
- *Any gaps in services, particularly in respect of increasing levels of awareness amongst professionals and the community."*

Sources of Evidence:

1.4 Sources of evidence were as follows:

- Research documentation and relevant local and national guidance;
- Interviews with key stakeholders and local organisations; and
- Practice in other local authority areas.

1.5 A full list of all those who provided evidence is attached as Appendix A.

Membership

1.6 The membership of the Panel was as follows:

- Councillors: Barbara Blake (Chair), Gallagher, Gunes, Hare, Jogee, Newton and Wright
- Co-opted Member: Mr I Sygrave (Haringey Association of Neighbourhood Watches)

2 INTRODUCTION

Definitions

2.1 The term “Violence Against Women and Girls” originates from the United Nations Declaration (1993) on the elimination of violence against women. This defined violence against women and girls as: *“Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”*

2.2 It is now widely used as the term to describe a range of types of crime and abuse that are against women and girls and includes the following types of abuse and crimes:

- Sexual violence, abuse and exploitation
- Sexual harassment and bullying
- Stalking
- Trafficking and forced prostitution
- Domestic violence and abuse (DVA)
- Female genital mutilation
- Forced marriage
- Crime committed in the name of “honour”.

2.3 The government definition of DVA is: 'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality”

2.4 This can encompass, but is not limited to, the following types of abuse:

- Psychological;
- Physical;
- Sexual;
- Financial; and
- Emotional.

2.5 The Government definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

2.6 The government has recently announced the creation of a new offence of coercive and controlling behaviour. The maximum penalty for the new offence will be five year imprisonment and a fine. The new law will help protect victims by outlawing sustained patterns of behaviour that stop short of serious physical violence but amount to extreme psychological and emotional abuse.

2.7 Coercive and controlling behaviour can include the abuser preventing their victim from having friendships or hobbies, refusing them access to money and determining minute aspects of their everyday life, such as when they are allowed to eat, sleep and go to the toilet.

Prevalence

2.8 DVA is probably the most prevalent form of Violence Against Women and Girls. The 2012/13 British Crime Survey (BCS) of England and Wales self-completion module on intimate violence provided a general overview of its scale. The findings included the following:

- 7.1% of women and 4.4% of men reported having experienced any type of DVA in the last year, equivalent to an estimated 1.2 million female victims of domestic abuse and 700,000 male victims;

- Overall, 30.0% of women and 16.3% of men had experienced any domestic abuse since the age of 16, equivalent to an estimated 4.9 million female victims of domestic abuse and 2.7 million male victims;

- Women were more likely than men to have experienced intimate violence across all headline types of abuse asked about;

- In the last year, partner abuse (non-sexual) and stalking were the most common of the separate types of intimate violence: 4.0% of women and 2.8% of men reported having experienced partner abuse (non-sexual); 4.1% of women and 1.9% of men reported having experienced stalking; and

- Two per cent of women and 0.5% of men had experienced some form of sexual assault (including attempts) in the last year.

2.9 It is likely that the BCS data understates the level of violence against women. Amongst other issues, it does not differentiate between acts of primary aggression and self defence and approximately 75% of violence committed by women is done in self defence or retaliatory. It also does not differentiate between cases where there is one incident or those where violence is repeated. Where there have been four or more incidents, approximately 80% of victims are women.

Haringey Statistics

2.10 Recent statistics relating to Haringey show the following:

- There were 4061 incidents of domestic violence reported to the police between October 2013 and September 2014. This represented a 26% increase during the period, which was the 4th highest in London. All London boroughs also recorded an increase during this period. Haringey's rate is the 13th highest rate in London.

- Over half of all DV offences occur at the weekend. It peaks during the summer months, with July to September recording the highest number of offences per month. There is also a peak around Christmas;

- 93% of offenders are male, particularly between the ages of 18 and 34;

- Victims are mostly aged 21-30. Over one-third of domestic violence victims have been the victim of another offence in the previous 12 months;

- Ex-partner (42.1%) and husband (33.2%) is the most likely relationship between victim and perpetrator;

- Domestic violence was a concern in 75% of child protection cases;

- Over two thirds of offenders flagged with DV issues are identified as having mental health issues; and

- Half of offenders are recorded as having a substance misuse issue.

3. ACTION TO ADDRESS DOMESTIC VIOLENCE AND ABUSE

Strategic Approach

3.1 The current strategic approach by the Community Safety Partnership for tackling the issue was included within the Community Safety Strategy 2013-2017. This was based on;

- Haringey's Community Safety Strategic Assessment 2012/13; and

- The 2012 Joint Strategic Needs Assessment chapter on domestic and gender based violence.

3.2 Actions arising from the strategy were as follows:

- To establish a single, strategic commissioning lead for domestic violence;
- To improve data collection and agree a robust and meaningful set of performance indicators;
- To improve awareness raising in the community and in schools;
- To roll out the IRIS (identification and referral) project in GP surgeries;
- To increase the provision of safety planning support for high risk victims;
- To increase the uptake of accredited perpetrator programmes; and
- To develop an understanding of – and measurements for - wider gender-based offences (e.g. female genital mutilation, forced marriage, sexual crimes).

3.3 A delivery plan was developed to take forward these actions. Most of the actions have progressed to plan, with the exception of the IRIS project. This is due to funding not being identified by Haringey CCG and a difference in views about the approach to domestic violence in primary care.

Partnership Audit

3.4 A partnership audit on the coordinated community response to DVA was undertaken by Standing Together Against Domestic Violence in 2012. This identified a number of gaps in services including:

- The need for a clear delivery plan, with particular focus on prevention, early intervention and risk;
- Stronger links between commissioners and operational groups; and
- Improved co-ordination.

3.5 Action has been taken to address the gaps that were identified but some still remain.

Governance

3.6 Governance structures were amended in response to the partnership audit. Co-ordinated action by partners from Haringey's Community Safety Partnership is now led by the Violence Against Women and Girls Strategic Group, which is chaired by Dr Jeanelle de Gruchy, the Council's Director of Public Health. The Strategic Group is responsible for undertaking a wide range of work, including the development of practice. It has a broad membership of over 20 senior officers, which includes the Police, NHS organisations, Probation and Children and Adult Services. The Panel

noted the comment of Dr de Gruchy that one particular challenge was that no one organisation has the lead role.

3.7 There is also a Violence Against Women and Girls Advisory Group that comprises directors and chief officers of specialist violence against women and girl services operating within the borough. In addition, there is a Practice Network that meets twice yearly and has a wide membership.

3.8 The Strategic Lead for Violence Against Women and Girls is based within the Council. The role involves co-ordinating the response across the Community Safety Partnership as well as ensuring that there are effective links with other relevant priorities. A Violence Against Women and Girls Co-ordinator has been temporarily recruited to support the Strategic Lead. There are also three additional posts within the Children and Young People's Service (CYPS) that work specifically on domestic violence and violence against women and girls.

Support Services

3.9 A range of services, both commissioned and non commissioned, are provided within the borough to support victims and survivors;

Service Name	VAWG Type	Risk level	Summary
Multi Agency Risk Assessment Conference – coordinated by Standing Together Against Domestic Violence	DV	High risk	Coordinate the MARAC
Independent Domestic Violence Advocacy Service - Nia	DV - female	High risk	Take referrals from the MARAC
Hearthstone Domestic Violence Advice and Support Centre	DV – all risk levels	All levels	Specialising in housing options and support
Floating Support – Solace Women's Aid	DV - female	Standard and medium	Housing related support to live independently in the community – more longer term
HAGA – Haringey Advisory Group on Alcohol	DV	All levels	Support for DV victims with alcohol dependency
Imece Women's Centre	DV, forced marriage and "honour" based violence	All levels	Specialist support for Turkish, Kurdish, Turkish Cypriot and any other Turkish Speaking women
Victim Support	DV and general crime	Standard	Support and advice
The Water lilly Project	DV	Standard and medium	Service user support group for women in contact with HAGA
Wise Dolls	DV	Standard and medium	Art therapy
LGBT Domestic Abuse	LGBT DV	All levels	Counselling, advice line, advocacy,

Partnership (DAP)			support groups

3.10 Of particular note are the following;

- Multi Agency Risk Assessment Conference (MARAC); This deals with cases that are considered to be high or very high risk of harm and meets on a four weekly basis. It looks at instances where there is a serious risk of injury or homicide and undertakes risk assessment and management.

- Independent Domestic Violence Advisers (IDVA) Haringey has 3 IDVAs who provide independent one-to-one support of victims of domestic violence and support for victims who are assessed as being at high risk of harm. IDVAs also play a key role at the MARAC.

- Hearthstone Domestic Violence Advice and Support Centre; The main focus of the service is on housing support but it can also provide advice and referrals to a range of other services.

- Solace Women's Aid; They are commissioned to provide:
  - Emergency refuge accommodation and floating support for women and girls over the age of 14 who have experienced any form of abuse; and
  - The POW Project, which is a peer education pilot project working with young women aged 16 years plus to raise awareness of violence against women.

- Haringey Advisory Group on Alcohol (HAGA); This provides support for domestic violence victims who have substance abuse issues or who live with someone who does.

3.11 A London-wide service for victims of DVA has recently been launched which is funded by £5 million from the MOPAC. The new service, which was a Mayoral manifesto commitment, will aim to co-ordinate services and give all victims access to specialist support through both Independent Domestic Violence Advocates (IDVAs) and other support workers.

Funding

3.12 Funding for Violence Against Women and Girls comes from a number of sources. Funds are received from the Mayor's Office for Policing and Crime (MOPAC), which the Council matches through its community safety budget. In addition, Public Health also provide funding for work in two distinct areas;
- Prevention work amongst young women; and
- A domestic violence worker to address issues associated with alcohol through Haringey Advisory Group on Alcohol (HAGA).

3.13 The Housing Options and Support Service provide funding for the Hearthstone services associated with housing and the Senior Practitioner in CYPS. Some funding for services also comes from London Councils as part of pan-London initiatives.

3.14 The Panel is concerned about the lack of consistent funding for DVA. A large percentage comes from a number of different grants, all operating to different time

scales. There is also a time consuming administrative burden arising from these. The Panel is of the view that there is a need for greater stability in funding sources so that greater continuity can be established, thus facilitating long term planning. However, it is accepted that this may be difficult to achieve in the current austere climate.

Service User Views

3.15 The Panel noted that the Strategic Group had developed a user voice model and a plan for its implementation. The Panel feels that it is very important that the views of services users are both sought and responded to so that DVA services can ensure that they are meeting the needs of clients effectively. It therefore requests further details of how the views of users will be obtained and responded to by commissioners and providers.

Recommendation:
That information be shared with the Panel by the Violence Against Women and Girls Strategic Group for their plans on how the views of service users will be obtained and responded to.

Referral Pathway

3.16 Developing the referral pathway is a priority for the Strategic Group to address and it is currently in the process of being re-designed. The reason for this is that it is currently felt to lack clarity. The issue needs to be resolved prior to the re-commissioning of the IDVA service. There are, in particular, issues with where clients should go to in the first instance. Until this issue had been resolved, publicity cannot be progressed.

3.17 The Panel feels that this lack of clarity was confirmed in the evidence of those who it heard from, including people directly involved in addressing DVA issues and especially health colleagues. Current pathways appear overly complex and in need of simplification. The Panel would endorse fully the need for a simple and clear pathway to be developed as a priority and requests confirmation of the time line for this. The Panel would also concur with the view of Dr Hughes, the Medical Director for North and East London from NHS England, that the establishment of a single point of entry which could act as a triage for referral to other services would be particularly welcome.

Recommendations:

- ***That a clear timeframe be set by the Violence Against Women and Girls Strategic Group for the approval of a referral pathway***; ***and***

- ***That work to develop the referral pathway focus upon simplifying the process and establishing a single point of entry.***

Publicity

3.18 There is a lack of publicity regarding DVA services but, as previously mentioned, this issue cannot be addressed until such time as the referral pathway is fully developed. In terms of health services, all of the NHS health trusts that the Panel received evidence from identified publicity as a challenge and acknowledged that it needed to be improved. Funding for publicity was also referred to as being as issue.

3.19 There are various examples available of how services could be publicised discreetly that are in use in other areas. One example that was mentioned was the bar code stickers used by Standing Together Against Domestic Violence as part of their maternity domestic violence project in west London.

3.20 The Panel is of the view that a plan for publicising services needs to be developed by partners on the Violence Against Women and Girls Strategic Group. It also feels that consideration should be given to jointly commissioning this as a means of obtaining economies of scale and avoiding duplication. The services to which people are referred or signposted to by partners are the same and it therefore makes less sense to have separate arrangements for publicity.

Recommendation:
That the Strategic Group develop proposals for publicising domestic violence and abuse services and, as part of this, consideration be given to joint commissioning.

Female Genital Mutilation

3.21 The Panel heard evidence from Dr de Gruchy, the Chair of the Strategic Group, that there was an issue with female genital mutilation (FGM) and, in particular, it is a big issue for both the Whittington and NMUH hospitals. There are alerts within the trusts for instances and it is now mandatory for clinicians to report FGM. The Panel noted that in 2012/13, there had been 96 cases reported by the Whittington and approximately 2% of women who attended ante natal had been found to have suffered FGM.

3.22 The Panel also noted that around 30 cases per month present at NMUH per month who have suffered FGM. The women in question are mostly of child bearing age and tend to come from the gynaecology department as this is where FGM is most likely to be identified. A report has to be submitted every month on the number of cases.

3.23 A business plan has been presented to Enfield and Haringey CCGs for a multi-disciplinary service for FGM at NMUH consisting of:

- Obstetric & Gynaecology consultant
- A midwife (with support from safeguarding midwife)
- A psychologist
- Input from urology service
- Input from a named doctor

3.24 There is a need for training for a wide range of professionals on the issue of FGM. Partners currently make their own arrangements for this. The Panel noted the

evidence of Dr Hughes who was of the view that multi disciplinary/multi agency training might have considerable benefits. She felt that it could promote better awareness and understanding of the roles of different agencies as well as helping to develop a joint approach to the issue.

3.25 The Panel notes that Members can be alerted to instances of FGM within their surgeries. The Panel would recommend they also be included in training on the issue to increase their awareness of the issue and how to respond to it.

Recommendations:

- ***That the Strategic Group, working together with the Local Safeguarding Children's Board (LSCB), develop proposals for multi agency training on Female Genital Mutilation (FGM) for health and social care professionals and that Members also be included in relevant training on the issue; and***

- ***That consideration be given by the Strategic Group to developing multi agency and multi disciplinary training on domestic violence and abuse.***

4. HEALTH SERVICES

Introduction

4.1 The Panel looked in depth at how local NHS health services respond to DVA and received evidence from NHS England, Haringey CCG, Whittington Health, North Middlesex University Hospital (NMUH) and Barnet, Enfield and Haringey Mental Health Trust (BEH MHT). All of these trusts are involved to varying degrees in partnership activity related to DVA, including membership of the Violence Against Women and Girls Strategic Group. In addition, they also have important roles in detection and referral.

4.2 The previously mentioned partnership audit commented very favourably on the commitment of local NHS organisations to DVA issues. They are represented within the governance structure but, although the Strategic Group has representation from Haringey CCG. The Panel noted that it nevertheless had still not secured regular involvement from all local acute trusts and the MHT. However, the Chair of the Strategic Group commented that senior people in the NHS were very busy and a means of securing their regular engagement needed to be developed. In particular, the acute trusts all served more than one borough, placing additional strain on their resources.

Recommendation:
That consideration be given by the Violence Against Women and Girls Strategic Group on how best to secure the regular engagement of local NHS acute trusts and the MHT on a basis that is achievable and sustainable.

4.3 Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in local areas. CCGs are overseen by NHS England, which retains responsibility for commissioning primary care services, such as GP and dental practices, as well as some specialised services. All GP practices belong to a CCG but they also include other health professionals, such as dentists, pharmacists and optometrists.

4.3 There was an acknowledgement amongst the health service organisations that the Panel received evidence from that they need to improve their response to DVA. In particular, the level of referrals from health services have been low despite the significant number of women and girls attending GPs and hospitals for treatment for ailments or injuries linked to DVA.

4.4 The cost of DVA to the NHS was estimated to be £1.7 billion per year in 2009 with the major costs being to GPs and hospitals. This does not include mental health costs, which is estimated at an additional £176 million. Recent figures compiled by the charity Safe Lives show that almost a quarter of “high risk” victims have been to A&E with injuries sustained during violent abuse and some went as many as 15 times before the problem was addressed.

4.5 In respect of GP practices, there is evidence that the incidence of DVA in practice populations is greater than in the general population. A study in Newham showed that 80% of women in violent relationships sought help from health at least once

and 41% of women surveyed in a GP waiting room had experienced violence in a relationship. However, only 15% had a reference to violence in their GP notes.

4.6 The Panel received evidence from Dr Henrietta Hughes, the Medical Director for North and East London at NHS England. She stated that victims and perpetrators are both likely to be patients. DVA was a risk factor for both immediate and long term conditions. There was an increase risk during pregnancy and the newborn period.

4.7 The Panel heard that a number of initiatives have been introduced to address the situation and, in particular, the IRIS scheme and the provision of hospital based IDVAs were both discussed in the course of the Panel's work. Guidelines for health services, social care and the organisations they work on how they can respond effectively to DVA were published by the National Institute for Clinical Excellence (NICE) in February 2014. These contain 17 recommendations which cover detection, support and treatment.

GP Services

4.8 GPs are very well placed to detect domestic violence at an early stage. They are also, like DVA services, borough based and therefore should be able to provide easy access to services. When domestic violence is suspected, GPs assess immediate levels of risk and whether there are any safeguarding issues. In Haringey, the options available to them are to refer to Hearthstone or, where the risk is deemed sufficient, the MARAC. There is a well known overlap between safeguarding and domestic violence and anyone who is a victim of domestic violence and has children is immediately flagged up as a safeguarding risk.

4.9 GPs also provide people with information and signposting to services but these are not necessarily followed up. Patients do not need to agree be referred to the MARAC but consent is needed for referral to Hearthstone. However, Dr Masters from Haringey CCG stated that the issue was complex. Whilst there are grey areas in respect of the need for consent, there are nevertheless limits to how strongly victims can be encouraged to seek assistance.

4.10 A key recommendation of the NICE guidelines is recommendation 16, which states that GP practices and other agencies should include training on, and a referral pathway for, DVA. It can be a challenge for GPs to attend training courses due to the heavy demands on their time. GPs receive two hours per year safeguarding training, which includes reference to domestic violence and abuse. Levels of attendance are around 90%. Dr Masters commented that this is higher than hospital doctors, despite the fact that GPs have similar contracts. Most GPs will have attended such training in the last two to three years. There is an expectation that primary care practitioners will have competencies in respect of domestic violence and abuse. Haringey is also one of the few boroughs that involves GPs in the MARAC.

4.11 The Panel received evidence on the IRIS project, which is a system that has been developed to address domestic violence in primary care settings, such as GP practices. It has been used in a number of areas of the country including several London boroughs. It involves the following:

- Two practice-based training sessions for clinicians and one shorter information session for the reception and administration team;
- A prompt within electronic medical records to ask about DVA;
- A referral pathway to a named domestic violence advocate educator (normally the individual who delivered the training); and
- Advocacy and signposting provided for patients who are referred

4.12 The aims of IRIS are as follows:
- To increase identification of victims of DVA in primary care:
- To facilitate earlier intervention; and
- To provide primary care practitioners with the skills and tools to identify, respond, refer on and record disclosures of DVA from their patients.

4.13 The cost of implementing IRIS over a three year period is around £160,000. However, it is estimated from successful trials that it has the capacity to deliver cost savings of;
- £37 per year per woman registered at participating practices to society as a whole; and
- £1 per year per woman registered at participating practices to the NHS.

4.14 IRIS was trialled in 48 GP practices in Bristol and Hackney between 2007-10. 12 practices in each site were allocated to the intervention part of the trial and 12 in each site were in the control part. Women attending intervention GP practices were 22 times more likely than those attending control practices to have a discussion with their GP about a referral to DVA services. This resulted in them being six times more likely to be referred.

4.15 Hackney, Enfield and Camden CCGs have commissioned IRIS, whilst Haringey has so far not.
- Between April and October 2014, Hackney GP practices referred 72 cases to domestic violence services. During the same period, Haringey GPs referred 10 cases;
- Enfield have reported 80 referrals to DV services since they introduced IRIS in July 2012;
- There were 96 referrals from Camden GPs in the first year of the operation of the scheme there.

4.16 The Panel received evidence from Haringey CCG on their position in respect of the commissioning of IRIS. Whilst they acknowledged that there was evidence that the scheme improves the detection of DVA, the view of the CCG had been that it did not necessarily improve outcomes. They had decided not to commission the scheme due to financial issues and as they had not been convinced of its merit. The CCG nevertheless noted that IRIS had now been commissioned by a number of other boroughs, with the result that Haringey was in danger of becoming an outlier. The clear differences between referral figures in Haringey and some boroughs that were using IRIS were also noted by them. The CCG therefore stated that they were considering re-visiting the issue.

4.17 The commissioning of IRIS has been financed by a range of arrangements in different boroughs. In some places, it had been funded solely by the CCG whilst in other areas, Public Health, the Police and the Council also contributed. Dr Masters

reported that the CCG had approached NHS England regarding the issue as they were interested in exploring the possibility of IRIS being commissioned across the five north central London boroughs (Barnet, Camden, Enfield, Haringey and Islington).

4.18 The Panel is of the view that there is overwhelming evidence of the effectiveness of IRIS in facilitating the earlier detection of DVA and increasing the number of referrals. Whilst it may be open to debate whether IRIS improves outcomes, it is first and foremost a DVA training, support and referral programme rather than a means of treatment. At the very least, detection provides an opportunity for successful interventions to be made. The IT package associated with IRIS would also enable suspected cases to be better followed up and monitored. The Panel is also of the view that there would be merit in collaboration with neighbouring boroughs in the commissioning of IRIS as this may lead to economies of scale. It would also reduce the "post code lottery" that currently exists in relation to DV services.

Recommendations:

- ***That, in view of the strong evidence of the effectiveness of the IRIS scheme in facilitating the detection of domestic violence and abuse, the Haringey CCG reconsider its decision not to commission it.***

- ***That CCG explore further the potential of joint commissioning of IRIS with neighbouring boroughs in north central London.***

Local Hospitals

4.19 Local hospitals can also play an important role in detecting DVA and referring people to services. The areas within hospitals that are most likely to come into contact with victims are A&E and maternity.

4.20 The Panel received evidence from Dorothy Ryan, Domestic Violence and Abuse Lead, from Whittington Health. Her post is funded by the Safer Islington Partnership for two years. This was the third time that the post has been grant funded. It has previously been the case that the postholder undertook the majority of work within the Trust relating to domestic violence but this tended to fall away when he/she was not around. The role was now to facilitate change rather than be the Trust's expert, with the aim of integrating the response to DVA into the work of clinicians. The expectation was now that it would become embedded in clinical practice and progress would therefore be sustained. There was, however, a high level of staff turnover at the Trust, including significant numbers of agency staff.

4.21 Ms Ryan stated that an important part of her work was encouraging staff to look at people who had presented a number of times with the same complaint which might be part of a pattern. Raising the issue of domestic violence and abuse could be viewed as potentially opening a can of worms and it could be easier for staff not raise the issue with individuals. However, survivors were normally desperate to be asked.

4.22 A CQUIN (Commissioning for Quality and Innovation) scheme had been established within the Trust and this provided financial rewards to Trusts based on the achievement of local quality improvement goals. Domestic violence and abuse was included within the Trust's scheme.

4.23 Key areas that were being addressed as part of Ms Ryan's work were as follows:
- Developing robust data collection, which proving to be challenging;
- Revising Trust policies and procedures;
- Devising and delivering training packages;
- Producing referral pathways; and
- Demonstrating outcomes, such as increases in referrals.

4.24 The Trust's policy and strategy had been revised and a programme of training agreed, some of which had already been delivered. She had recently started attending the monthly MARAC meetings in both Islington and Haringey. There had been a particular focus on the A&E Department and Maternity. It had been challenging to facilitate an improved response in A&E but better progress had been made with Maternity. It could be difficult to get staff released for training, although doctors had protected training time.

4.25 Training was currently not always well attended and this could be exacerbated by staff sickness and people leaving. Staff at the Trust were working under a lot of pressure though, particularly those in A&E who were required to meet the four hour targets for seeing patients. The first training sessions had only been for one hour. Staff required ongoing support and it was not possible to cover all of the issues within one hour. The Trust intranet was being used extensively for training and it was hoped that all packages could eventually be delivered this way.

4.26 The Interim Strategic Violence Against Women and Girls Lead commented that the use of e-learning to train violence against women and girls had been widely discredited. One particular flaw is that it did not allow for discussion of the issues raised. Recommendation 15 of the NICE guidelines states that specific training should be provided for health and social care professionals on how to respond to DVA. In particular, level 2 staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. The Panel is of the view that one hour of training is insufficient to cover this. In addition, the use of e-learning is unlikely to be effective in developing questioning skills on this issue as it requires interaction with other people.

Recommendation:
That staff training provision on DVA be reviewed by Whittington Health to ensure that sufficient time is allocated and that it is delivered in an appropriate and interactive format, with the use of e-learning avoided.

4.27 Ms Ryan was working with IT and clinical leads in A&E on how enquiries regarding possible domestic violence and abuse could best be recorded. This could include whether the individual had been asked whether they had been subject to it. These could be flagged up by the use of a discreet code. She stated that Islington currently used a system called MODUS for referrals which worked very well. It was

not cheap but was cost effective. Haringey did not have this system and were instead still using a paper based system.

4.28 The Panel also received evidence from Chantal Palmer, Named Midwife for Safeguarding Children and Vulnerable Women, North Middlesex University Hospital (NMUH). The Trust uses both universal and selective screening for DVA. It is not feasible to ask everyone detailed questions and there needed to be specific indications. There is a trust wide policy on the issue and relevant data is collected.

4.29 Safeguarding training includes domestic violence and abuse and is provided for staff at all levels within the organisation. Where appropriate, referrals can be made to safeguarding services, when children are involved, or to the MARAC. She is invited to attend the MARAC when there were specific cases that required her input. There is partnership working between NMUH and the MARAC, SOLACE and Hearthstone. Staff at NMUH can phone SOLACE Women's Aid if they required specific advice regarding an issue affecting an Enfield resident.

4.30 More progress in improving the response to domestic violence had been made so far in maternity than in A&E. Universal screening is in place in maternity and referrals can be made to specialist services. Information is available on services and staff training undertaken. There is a system in place for flagging up cases where it was thought that domestic violence and abuse might be an issue, which is part of the serious case review process.

4.31 In respect of A&E, more training is required for staff and a specific plan is being put together to address this. Ms Palmer was of the view that training needed to be made relevant to the needs of practitioners. Role plays could assist by presenting scenarios that they might be familiar with. Patients affected by domestic violence could often present with something apparently unrelated and there was a need for staff to dig beneath the surface to find out what was actually happening but professionals did not always find this easy.

4.32 She was of the view that most acute trusts were in a similar position to NMUH in terms of their response to DVA. In particular, progress was needed in A&E departments. It was easier to address issues in maternity than in A&E as there was a longer term relationship with the patient.

Hospital based IDVAs

4.33 A number of boroughs now have or are considering basing IDVAs within hospitals as a means of improving the early detection and referral of DVA. Hospital based IDVAs typically provide training and awareness raising sessions within hospitals for medical staff, assist with the identification of DVA by encouraging staff to routinely ask questions to patients and enable staff to know where to refer onto specialist support for those patients who positively identified as experiencing DVA.

4.34 Co-ordinated Action Against Domestic Abuse published a research paper in June 2013 regarding the commissioning of hospital based IDVAs. Their conclusions were as follows:

- The data shows that hospital-based IDVAs reached different groups of victims than IDVAs based in other settings;

- Hospital based IDVAs reach a more a vulnerable group, with younger victims experiencing higher severity abuse and with more complex needs, e.g. substance misuse, mental health issues
- Hospital IDVAs may reach victims earlier. More victims were still living or in an intimate relationship with the perpetrator. Fewer victims had previously attempted to leave the perpetrator. There was also a shorter length of abusive relationship before accessing the IDVA service.
- Hospital IDVAs reached victims who were hidden from other agencies. Victims had high usage of A&E departments and made fewer reports to the police.

4.35 IDVAs have been based at both the Royal Free and UCLH hospitals since October 2013. Prior to the introduction of the IDVAs, there were 4 referrals from the two hospitals to DVA services between June 2012 and September 2013. In the period between the introduction of the scheme in October 2013 and July 2014, the number of referrals to DVA services was 95. Of these, 19% were referred to MARACs as high risk. The scheme was initially funded by Camden CCG but is now funded by the MOPAC.

4.36 The cost of the hospital based IDVAs at the Royal Free and UCLH was £78,000 per year. However, this cost can potentially be offset against the reduced impact on health and other services of successful earlier intervention. In particular, visits to A&E are expensive with each one costing an average of £114 according to the most recent Department of Health figures. The North Middlesex University Hospital (NMUH) is currently developing a business case for Haringey CCG to commission an IDVA based at the hospital.

4.37 The Panel noted that it had been challenging for both the Whittington and NMUH to achieve progress with the response of A&E services to DVA. It heard that that there had previously been an adviser from Solace Womens Aid based in A&E at NMUH and this been found to be very useful. Ms Palmer was of the view that having an IDVA on site could make a big difference as it would mean that access to services was available there and then. It could also enable the issue of domestic violence to become part of the culture as well as helping to develop a dialogue on the issue. In addition, it would help to free up clinical staff who might otherwise be engaged in dealing with the issue.

4.38 The Panel notes that local acute trusts all cover more than one borough. Domestic violence services are borough based though and differ from each other. The Panel is of the view that it is unrealistic to expect clinicians based in hospitals to remember all of the different pathways and services that individual boroughs have. Having an IDVA based at the hospital could provide a quick and accessible solution and this was why some trusts are considering this option. There is also strong evidence from CAADA that hospital based IDVAs can be effective in detecting DVA at an early stage. The evidence also suggests that referrals from hospital based IDVAs may be more likely to include people at a comparatively high level of risk.

4.39 The Panel would therefore support the commissioning of such a service by the CCG at the NMUH and recommends that consideration be given to commissioning a similar service at the Whittington.

Recommendations:

That the business case currently under development by NMUH for the establishment of a post of hospital based IDVA be supported and recommended for approval by the CCG and that consideration also be give to establishing a similar post at the Whittington hospital;

4.40 The Panel is also of the view that there would be considerable merit in hospital based IDVAs being commissioned jointly by neighbouring boroughs and would recommend that the CCG give particular consideration to this issue. In addition, it notes that Camden has received funding for hospital based IDVAs from the MOPAC and this may provide an alternative option for funding. One additional option might be to re-locate one or more of Haringey's IDVAs to local hospitals and the Panel would recommend that this option be considered.

Recommendation:
That the options of providing hospital based IDVAs by joint commissioning between boroughs whose residents use the same hospitals and/or the re-location of one or more of the boroughs IDVAs to local hospitals be considered by the Community Safety Partnership, in consultation with the CCG.

Mental Health

4.41 The Panel received evidence from Dr Katrin Edelman, Clinical Director for Haringey, Barnet, Enfield and Haringey Mental Health Trust. She reported that the Trust referred a small number of people to the MARAC but DVA was nevertheless currently under detected in mental health settings. It is likely that a large proportion of mental health patients were suffering from it. The current detection rate is currently estimated to be between 10% and 30%. People who had experienced domestic violence were more likely to have mental health issues. One third of female patients were estimated to be victims whilst 58% of people presenting at domestic violence and abuse services were estimated to have mental health issues.

4.42 There is mandatory training for staff in the Mental Health Trust on domestic violence and abuse. The Trust holds monthly safeguarding surgeries for staff to raise awareness of domestic violence, the services that are available for victims and the MARAC referral process. The Trust's Safeguarding Adults' Lead attends monthly MARAC meetings in Haringey whilst representatives from the Trust attended quarterly MARAC steering group meetings.

4.43 Dr Edelman reported that, whilst the NICE guidelines on domestic violence and abuse are relevant to all health and social care organisations, three are of particular relevance to the Mental Health Trust;

- Creating a disclosing environment; Domestic violence services are generally local and borough based but the Trust's leaflets currently refer to national services. Generic information is of less use and the Trust was therefore reviewing what was available.

- Ensuring that trained staff ask about domestic violence and abuse; There could be misguided hopefulness on both sides that incidents would not be repeated. Although there is a form used to determine the seriousness of the case (the Coordinated Action Against Domestic Abuse (CAADA) Domestic Abuse Stalking and Honour based violence (DASH) Risk Identification Checklist (RIC) or CAADA DASH RIC), she suspected that this was not being widely used and the referrals were made on the basis of individual judgement. The Interim Strategic Violence Against Women and Girls Lead commented that some professionals had found the referral form to be overly complex and that the Police, amongst others, had raised the issue. However, there were also concerns regarding the implications of reducing the amount of detail on the form as this could possibly increase levels of risk. Consideration was nevertheless being given to reviewing and refreshing the form.

- Providing people who experience domestic violence and abuse and have a mental health condition with evidence based treatment for that condition; Cognitive behavioural therapy had been found to be effective in assisting people.

4.44 The Panel is concerned that professionals may not be using the referral form when required. . It is that the necessary level of detail is provided so that referrals can be followed up effectively and feels that partners should ensure that relevant professionals understand and receive training on completing the form.

Recommendation:
That the Violence Against Women and Girls Strategic Group work together with partners to ensure that all relevant professionals understand and receive training on completing the referral form for DVA (the CAADA DASH RIC) in order to promote its wider use.

4.45 Dr Edelman reported that a pilot study had been undertaken by Kings College in London for a future larger study of a domestic violence advocacy treatment in comm***u***nity mental health services. This was entitled the LARA (Linking Abuse and Recovery through Advocacy) pilot study. The scheme involved the following:

- Domestic violence training for all community mental health treatment (CMHT) teams;
- LARA advisors being trained by mental health professionals and the domestic violence sector;
- Clear referral pathways to LARA advisors; and
- LARA advisors integrated within teams.

4.46 Additional funding would be required to develop the pilot project further but it was not likely to be hugely expensive. It was important to identify what worked effectively.

4.47 Dr Edelman stated that research had shown that there were a number of actions that had been found to be effective;

- Improved health professional response to disclosures;
- Documentation of abuse;
- Securing safety; and
- Integrated support.

4.48 In contrast, the following had been found not to be effective;

- A focus on separation from partner; and
- Limited discussion of domestic violence by health professionals.

4.49 Dr Edelman felt that the issue should not be medicalised and that domestic violence and abuse was more of a public health and societal issue. Victims could feel humiliated and this could discourage disclosure as people did not wish to be perceived in this way. Better perinatal services would help to address the issue, which often started in pregnancy.

Appendix A

Participants in the Review:

Dr Henrietta Hughes, Medical Director, North and East London, NHS England

Dorothy Ryan, Domestic Violence and Abuse Lead, Whittington Health;

Dr David Masters, lead GP in respect of Domestic Violence and Abuse, Haringey CCG;

Karen Baggaley, Assistant Director for Safeguarding and Designated Nurse for Child Protection, Haringey CCG

Dr Jeanelle de Gruchy, Director of Public Health, Haringey Council and Chair of the Violence Against Women and Girls Strategy Group.

Chantal Palmer, Named Midwife for Safeguarding Children and Vulnerable Women, North Middlesex University Hospital

Dr Katrin Edelman, Clinical Director for Haringey, Barnet, Enfield and Haringey Mental Health Trust.

Victoria Hill, Interim Strategic Violence Against Women and Girls Lead

Appendix B;

Documents referred to

National Institute for Clinical Excellence (NICE); Domestic Violence and Abuse: How Health Services, Social Care and the organisations they work with can respond effectively (issued February 2014)

Haringey Stat; Domestic and Gender Based Violence (July 2013) (Haringey Council)

Haringey Community Safety Strategy 2013 – 2017 (Haringey Community Safety Partnership)

Domestic and Gender Based Violence in Haringey – Needs Assessment (June 2012) (Haringey Council)

The Coordinated Community Response (CCR) to Domestic Violence; Partnership Audit of Haringey (Sept. 2012) (Standing Together Against Domestic Violence)

IRIS National Report 2014; Annie Howell, Medina Johnson and Sean Harrison (October 2014)

IRIS Commissioning Guidance (Bristol University 2011)

Themis Research Briefing #1; June 2013 – Why Invest in Hospital Based IDVAs (CAADA)