Sane Responses

Seminar Report: 17 March 2003
Exploring positive ways of working with mental health and domestic violence

June 2003
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Foreword

The Sane Responses Seminar in March 2003 marks the beginning of a process to improve the services available to women who have experienced domestic violence and who also have mental health problems. This initiative, led by the Greater London Domestic Violence Project, reflects the concern of many agencies in both the domestic violence and mental health fields, who have identified the need for cross-sector thinking, networking and action.

1 in 4 women experience domestic violence over their lifetimes and 1 in 9 women experience domestic violence in any one year. The results of the British Crime Survey found that more than half of victims of domestic violence are involved in more than one incident. No other type of crime has a rate of repeat victimisation as high. Over 25% of reported violent crime is made up of domestic violence incidents and in London alone there are approximately 40 murders a year. In addition, 17% of homelessness applications are as a result of domestic violence and over 100,000 women in London seek medical help each year. It has been estimated that the costs of dealing with this issue are at least £278 million per annum within London.

The recent Department of Health consultation document on women and mental health – *Into the Mainstream* – highlights the frequency with which women’s experiences of violence and abuse lead to mental health problems. Women who experience domestic violence report more depressive symptoms, are at greater risk of suicide (domestic violence is a factor in at least 1 in 4 suicide attempts by women) and make greater use of mental health services than women in the general population. In addition women mental health service users are much more likely to have experienced domestic violence than women in the general population. Even when women have managed to leave violent relationships, there are often still long term effects on their mental health. In fact, the impact of domestic violence has been found to have psychological parallels with the impact of torture and the imprisonment of hostages.

These links between domestic violence and mental health are complex and to date there has been relatively little work linking these two areas in the UK. This is perhaps because they are both uncomfortable issues that provoke strong opinions and because of the challenges involved in understanding the ways in which the two are connected.

However, as this report demonstrates, front line workers do already have a great deal of first hand knowledge and understanding of the relationships between domestic violence and mental health, and of how to develop more effective work across the two sectors. This report summarises the presentations and workshop findings from the Sane Responses seminar in order to further the debate about the links between mental health and domestic violence and to suggest ways forward for future action.
Acknowledgements

This report is the product of the time, expertise and thoughts of the speakers and delegates at the Sane Responses seminar. Without their support and contributions the seminar and this report would not have been possible. This report is a product of their collective contributions and gives voice to their different needs and experiences.

Our thanks also go to those speakers and delegates who are involved in our ongoing initiative around mental health and domestic violence, including the forthcoming Round Table Event planned for June 30th 2003.
Executive Summary

1. In Brief

This report summarises the presentations and discussions at the Sane Responses seminar on March 17th 2003. It also highlights the key themes and recommendations that emerged from the day.

Part One introduces the Sane Responses initiative, the working definitions of domestic violence and mental health and some brief contextual information about survivors of domestic violence who also have mental health problems.

Part Two presents case-studies (Woman’s Trust and the Zindaagi Project) of organisations that are developing innovative work in this area and summarises the workshop discussions.

Part Three summarises the workshop responses including definitions of domestic violence and mental health, explorations of how these two issues inter-relate and barriers to effective service provision.

Part Four lists the key recommendations made throughout the day and Part Five briefly describes how the Sane Responses initiative has developed since the March Seminar.

Finally, the Appendices include biographies of all the speakers at the Sane Responses seminar, full transcripts of the speakers’ presentations and a list of delegates who attended the event with contact details.

2. Presentations

Linda Regan, Senior Research Officer, Child & Woman Abuse Studies Unit, London Metropolitan University, chaired the Sane Responses seminar. Presentations given during the day included:

Farah Naz - Counsellor at Newham Asian Women’s Project; Consultant with CVS Consultancy; Psychotherapist & Author of ‘Cultural Cocktail: Asian Women & Alcohol’ provided an overview of the meanings of domestic violence and mental health, explored the links between the two areas, outlined potential barriers to developing this work, challenged popular myths and suggest possible positive ways forward.

Professor Catherine Itzin: Department of Health discussed the links between domestic violence and mental health for survivors of domestic violence and focussed on the National Institute for Mental Health in England (NIMHE) Violence, Abuse and Mental Health project.

A video: “What Women Want” produced by Mental Health Media was also shown. This is a training pack designed to help stimulate debate about services for women. It features stories from female service users and gives an insight into issues such as sexual abuse, self-harm and motherhood. It highlights examples of best practice in mental health services - and the positive results. This gave delegates an opportunity to hear directly from women with mental health needs about what has helped and harmed them.

Kyria Conner: Director of Woman’s Trust spoke about the women-led services provided at the Women’s Trust and discussed the model of counseling and support which they feel to be effective and appropriate for women affected by domestic violence.
Dipty Morjaria: Zindaagi Development Manager at Newham Asian Women’s Project spoke about the importance of providing integrated services and focused upon the interventions provided by the Zindaagi Project.

Susan Austin, Clinical Services Manager: Women’s Therapy Centre spoke about the psychoanalytic approach taken at the Women’s Therapy Centre.

Rose Christie: Project Manager, Insight Into Violence Project, Maya Centre also spoke about the psychoanalytic approach taken at the Maya Centre.

3. Workshops
Delegates attended two workshops during the day. In the morning delegates were broken into small sector-specific groups and asked to think about their definitions of domestic violence and mental health, and to explore their understandings of the ways these two sectors are related. This helped to challenge myths around mental health and domestic violence, develop a picture of the level of understanding and knowledge and identify needs such as resources, training and knowledge gaps. In the afternoon workshops, delegates were asked to explore the barriers to effective service provision and to suggest ways to develop positive work across these two fields.

4. Key Themes
While many issues were discussed during the day two key themes did emerge:

- Currently both the domestic violence and mental health sectors are failing to provide adequate and integrated services for survivors of domestic violence who also have mental health problems.
- It is critical that both sectors work together to address this failure and to overcome existing barriers to joint working in order to provide safe and effective services for women experiencing domestic violence and mental distress.

5. Key Recommendations
The key recommendations that emerged from the presentations and workshops included the following needs for:

- Funding
- Training and awareness raising
- Co-ordinated networking and joint working
- Models of good practice and minimum standards
- Policy and protocols
- Victim-led services
- Specialist services
- Empower clients
- Information dissemination, sharing and research
- Support for workers
- Prevention and early intervention
- Think local
- Services for children
- Communication
- Challenging myths and stigma of domestic violence and mental health
• Evaluation of current and newly developed work
• Understanding domestic violence in its social context
• Cultural awareness
• Positive screening
• Flexible and creative service delivery
1. Introduction

This report summarises the key messages and issues which came out of the Sane Responses Seminar held on March 17th 2003 by the Greater London Domestic Violence Project (GLDVP). GLDVP is a second tier support agency which works to end domestic violence across Greater London by supporting direct service providers and promoting joint working. It is a London Action Trust project (www.lat.org.uk for further details).

1.1 The Sane Responses Initiative

The decision to hold a seminar on the links between domestic violence and mental health was developed after informal consultation with other voluntary agencies, which identified gaps in current service provisions for survivors of domestic violence who also have mental health problems. The hope was that the seminar would launch the beginning of an initiative to identify positive and creative ways to work towards more inclusive and effective service provision across the domestic violence and mental health fields.

It was decided that a seminar should be held in order to bring together service providers and policy makers from both sectors to:

- Explore the links between domestic violence and mental health problems
- Share examples of good practice
- Identify current exclusions and existing practice
- Highlight the knowledge and needs of the two sectors
- Identify possible ways forward
- Establish links between organisations and enable networking and information sharing
- Begin a dialogue between the sectors

GLDVP has decided to continue this work after the Sane Responses seminar in an attempt to ensure that the development of work across the domestic violence and mental health sectors was encouraged and supported in the longer, as well as short, term. A Round Table Expert Event on mental health and domestic violence is planned for 30th June 2003 and it is hoped that suggestions for future interventions will emerge from this.

The aims of Sane Responses are:

- To increase the safe choices for women and children experiencing domestic violence by raising awareness and standards within existing service providers.
- To hold perpetrators accountable for their behaviour by raising awareness and standards within existing service providers.

The objectives of Sane Responses are:

- To develop a picture of the exclusions faced by women experiencing domestic violence, who also have mental health problems, in accessing provision in both the domestic violence and mental health sectors.
- To identify models of good practice in providing services for women with these ‘cross-sectoral’ needs
- To identify a set of minimum standards for working with women who experience domestic violence and also have mental health problems
- To encourage networking and information sharing between the sectors with the aim of improving cross-sector training, collaboration and referrals
- To develop a plan of action designed to address the existing gaps in service provision
1.2 Definitions:

**Sane Responses understands domestic violence to be:** ‘a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person, usually a man, over another, usually a woman’, within the context of an intimate relationship. It can be manifested in a variety of ways, including but not restricted to, physical, sexual, emotional and financial abuse, and the imposition of social isolation and is most commonly a combination of them all.\(^1\)

Domestic violence exists in all socio-economic classifications spanning all ages, classes, ethnicities, religions and cultures. British statistics state that one in four women experience domestic violence at some stage during their lives and that one in nine women will be experiencing such violence at any given time\(^3\).

**Sane Responses understands mental distress to be:** something which can affect anyone, rich or poor, young or old, impacting hugely on the lives of those affected and the lives of the people close to them. One in four of us will experience a mental health problem at some point in our lives. Each year more than 250,000 people are admitted to psychiatric hospitals and over 4,000 people take their own lives. However, mental health is a complex issue and there is much controversy about what it is, what causes it and how people can be helped to recover. Seeing somebody’s problems solely as an illness that requires medical treatment fails to acknowledge the importance of the many different influences on a person’s life, and on their thoughts, feelings or behaviour, which can cause mental distress. It may also prevent us from exploring the various non-medical treatment options that are available. Mental distress can take many forms including depression and anxiety, panic attacks, phobias, depression, manic depression and schizophrenia.

Concepts of mental health are socially constructed, and beliefs about actual and desirable characteristics of men and women are different, also there may be massive differences in experience – e.g. between a working class woman and a professional man. Ideas of what is “mentally healthy” differ for men and women – and healthy women may be expected to be more submissive, dependent, sensitive and emotional.

1.3 Context

1.3.1 Survivors, domestic violence and mental health

The recent Department of Health consultation document on women and mental health – *Into the Mainstream* – highlights the frequency with which women’s experiences of violence and abuse lead to mental health problems. Women who experience domestic violence report more depressive symptoms, are at greater risk of suicide (domestic violence is a factor in at least 1 in 4 suicide attempts by women) and make greater use of mental health services than women in the general population. In addition women mental health service users are much more likely to have experienced domestic violence than women in the general population. Even when women have managed to leave violent relationships, there are often still long term effects on their mental health. In fact, the impact of domestic violence has been found to have psychological parallels with the impact of torture and the imprisonment of hostages.

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\(^1\) Domestic violence is overwhelmingly committed by men towards women. However, it can also occur in same sex relationships and in a minority of cases, by women towards men. Moreover, the violence may also be perpetrated by extended family members. However, for ease of reading, this report reflects the overwhelming majority of domestic violence cases where the abuser is male and the victim / survivor is female.

\(^2\) Definition from the London Domestic Violence Strategy 2001

1.3.2 Current Service Provision

Given the links between domestic violence and mental health problems, it is not surprising that both sectors will often serve the same women. While services that deal specifically with domestic violence or mental health exist, few systems currently are equipped to provide the range of services needed by survivors of domestic violence who also experience mental health problems.

Unfortunately, differing models of work mean these services often conflict with each other. Treatment for mental health has focussed primarily on the medical model, whereas safety and support are the primary focus of domestic violence initiatives. Despite the overlap between the client base for these two sectors current services in the U.K. are limited in the way they deal with domestic violence and mental health as co-existing issues, and are more geared towards single provision.

However, Sane Responses believes that the causal links between experiences of domestic violence and mental health problems make working together a necessity, so that ineffective repeat services are avoided and limited resources are maximised. Overall, studies suggest that outcomes for the survivor are more likely to be positive if approached in an integrated holistic way. Joint working across the domestic violence and mental health sectors is therefore the only practical way forward.
2. Case Studies
A number of examples of good practice emerged during the Sane Responses Seminar. The examples of Woman’s Trust and the Zindaagi Project will be highlighted below.

**Woman’s Trust**

Woman’s Trust is a woman only, woman-led charity based in Kensington & Chelsea providing free counselling and support services to women who have or are experiencing domestic violence. Woman’s Trust also provides training for workers in the public sector who work with women and children who are affected by domestic violence.

**Counselling Service**
18 one to one counselling sessions with a professional counsellor are provided. The service is open to all women who are, or have been affected by domestic violence, targeting in particular, those women who are unable to fund this support themselves. Woman’s Trust can advise and refer women who do not fall into this category to other services. Counselling sessions offer a time to explore feelings and talk through difficulties in a safe, confidential and non-judgemental environment.

**Support Groups**
Support groups run on a weekly basis, specifically for women who have an experience of domestic violence. These groups give the opportunity to share experiences, talk about feelings and create support networks in a friendly and confidential environment. Groups have no more than 8 women run in blocks of 8 on a weekly basis.

**Personal Development Workshops**
Personal development workshops provide women with information and experience about different topics. They are one day or half-day events; each covers different topics which women have told us they would like to learn about. Workshops provide an opportunity to learn in depth about a subject that may help women with the difficulties they face. A maximum of 20 women attend a workshop.

**Training & Information** - Woman’s Trust also provides training and advice services to front-line workers who have contact with women who have or are experiencing domestic violence. Trainings are usually one or two day events, and are aimed at enabling all public sector workers especially agencies with few resources to access good quality affordable training.

**How to contact us.**
Women who want to access the support and counselling service can phone us direct for an appointment. We will accept a referral from someone else on a woman’s behalf as long as she has given her consent. There are no drop-in facilities at our office – always phone first for an appointment. The office is usually staffed from 9.30am to 5.30 pm Mon-Fri, we are a small organisation and are not always able to answer the phone, all messages are returned as promptly as possible.

**Contact Details:**
Woman’s Trust, Top floor Unit 1, Kensington Cloisters, 5 Kensington Church St, London W8 4LD
Tel 020 7795 6444/6999 Fax 020 7795 612345 email wtrust@onetel.net.uk
Zindaagi Project – Newham Asian Women’s Project

Zindaagi, meaning life, is aimed at promoting the positive mental health and well-being of Asian women and is targeted at supporting Asian women who express their pain through self-harm and attempted suicide. The main ethos of Zindaagi is to develop and deliver a holistic approach to healing and expression by integrating mental, physical and emotional health. Based upon the findings of a multi-agency research pioneered by NAWP, Zindaagi was established to promote community education and awareness, mitigating taboos and stigma associated with self-harming behaviour. Zindaagi liaises with mainstream mental health care providers to ensure that genuine access is afforded to Asian women experiencing mental distress and that appropriate interventions are developed to understand and meet their needs.

Zindaagi aims to co-ordinate and develop specialist support services in east London for young Asian women and self-harm in the following ways: development of specialist counselling services, offering support and information for Asian women’s voluntary sector organisations providing support to young Asian women in distress and by providing training and awareness raising workshops to frontline health, social care and educational professionals.

Contact Details:
C/o Newham Asian Women’s Project, 661 Barking Road, Plaistow, London, E13 9EX
Tel: 020 8472 0528 email: zindaagi@nawp.org
3. Workshop Questions and Responses
Two workshops were held during the Sane Responses Seminar. The first asked delegates to define domestic violence and mental health and to explore the links between the domestic violence and mental health sectors. The second asked delegates to list both barriers and opportunities for working across these two fields.

3.1 Workshop One – Definitions and Relationships Between Domestic Violence and Mental Health

3.1.1 Defining Domestic Violence: “The scars you can’t see are the ones you carry for life.”

Delegates from the mental health sector were asked to define domestic violence as a way of establishing what their understandings were and exploring a variety of definitions. Some delegates preferred the term ‘domestic abuse’ as they felt this was more inclusive of non-physical forms of violence.

While there were a great breadth of definitions and understandings, the shared understanding reached at the end of the workshops by most delegates was that domestic violence is a dynamic of power and control by one person over another in an intimate relationship, or after an intimate relationship has ended. Other familial relationships (for example, parents, siblings and uncles) were also included by many delegates.

Such violence occurs across classes and races. It includes physical, psychological, emotional and sexual abuse in a pattern of coercive control. This behaviour is part of a pattern, rather than of isolated incidents, which tends to increase in intensity over time. The importance of retaining a gendered definition contextualised in relation to wider societal inequalities was stressed. However, delegates did recognise that while it is largely women who experience domestic violence, men also do experience such violence. However, due to the social context and inequalities in wider society it was felt that women and men experience domestic violence differently.

Tactics used to perpetuate the dynamic of power and control included intimidation within immediate family or community, lowering self esteem, threats of abuse, codes of silence and secrecy, emotional abuse, blackmail, psychological abuse including putting down, bullying, constant undermining, physical abuse, sexual abuse, threats of murder or suicide, isolation, economic deprivation, enforced dependency, shame and blame. Some delegates saw domestic violence / abuse as a form of torture.

The importance of cultural context was stressed by a number of delegates. It was felt that cultural context impacts on the way people experience violence and the tactics which can be used. In addition, access to services is often mediated by cultural issues – either services are inappropriate, inaccessible or there are additional barriers such as location or language.

3.1.2 Defining Mental Health

As with the section above, delegates from the domestic violence sector were asked to define mental health as a way of establishing what their understandings were and exploring a variety of definitions.

Again there were many variations in delegates’ understanding of mental health. However the following definition encapsulates much of the debate: Mental health is a continuum influenced by internal and external factors. There are many different stages of mental health, various interpretations by different practitioners and cultures and very different levels of intervention. There are mental health

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4 Quote from Sane Responses Seminar delegate.
issues that we all experience on a day-to-day level and others where external intervention through clinicians, diagnosis, medication, mental health care plans may be required. Mental ill-health can affect anybody. It is a social, spiritual, emotional and physical balance or condition. Good mental health was seen to be a state of well-being, including a positive outlook and the ability to control choices.

It was recognised that mental health is a very subjective issue and therefore there was a reluctance to use labels. However, poor mental health was seen to include: denial of the problem, lack of coping mechanisms, inability to function, difficulty in disclosing, depression, lack of control, low self esteem, suspicious, lack of trust, paranoia, self harm and suicide, eating disorders, isolation, multiple personalities, anxiety, fear, feeling detached and misunderstood, loss of confidence and independence, distortion, confusion, memory loss and post traumatic stress disorder (PTSD).

However, it is important to stress that in cases of domestic violence some of these so-called indicators of poor mental health such as suspicion, lack of trust, paranoia, anxiety and fear are likely to be firmly founded in a realistic expectation of violence or death at the hands of an abuser. This is bound up with different constructions of what constitutes a ‘normal’ response to trauma.

In addition it was stressed that different cultures hold different understandings of mental well-being and distress, and that gendered expectations also inform the definition.

3.1.3 The Relationship between domestic violence and mental health

It was generally accepted by delegates that experiences of domestic violence can lead to mental distress. However, this link was understood to express itself in different ways with different individuals. Generally, it was felt that experiences of domestic violence could decrease women’s independence, trust, self-esteem, ability to cope and make decisions, and increase her experience of depression, detachment, isolation, paranoia, guilt, shame, self-blame, self-harm, suicide, murderous thoughts, eating disorders, insomnia, panic attacks, confusion, memory loss, fear, anxiety, distortions, denial and PTSD.

Many delegates also highlighted the ways in which mental distress can be used by perpetrators as another form of power and control. Where a perpetrator is the main carer for a woman with mental health problems threats of withholding medication, sectioning and the loss of children can be used against her. Her mental ill-health will often mean that other professionals, including mental health professionals, social workers and legal professionals collude with the perpetrator rendering her even more powerless. In addition, both the perpetrator and others may use a woman’s mental ill-health as a justification for his violence.

3.2 Workshop Two – current barriers to work

In the second workshop delegates were asked to discuss the barriers and opportunities for working across the domestic violence and mental health fields. The key barriers mentioned will be listed below. The opportunities highlighted by delegates are included in Section Five.

3.2.1 Different Models of Intervention

The different models which the mental health and domestic violence sectors work from were seen to be perhaps the most important barrier to the development of positive cross-sectoral initiatives. Crudely put, the divide is between a predominantly medical model in the mental health field which has a tendency to focus on diagnosis and ‘labelling’ of patients, and a social-feminist model in the domestic violence field which contextualises women’s experiences of mental health within a social and experiential framework. This simplified extraction over-polarises the divide between the sectors; in
reality each sector has a variety of different models and understandings from which they work. Nonetheless the divide exists and much resistance to shifting current understandings was described by delegates.

In addition, delegates felt that a further divide had developed because the majority of mental health services are delivered within the statutory sector which was seen to provide fairly top-down and prescriptive treatment; while most domestic violence services are delivered by the voluntary sector which was seen to provide a more client-led and holistic service. Moreover, involvement by mental health professionals in domestic violence partnerships ranges from patchy to non-existent.

These divisions have led to conflict over the legitimacy and effectiveness of different types of intervention. Both sectors feel they hold valid and useful knowledge and are unwilling to ‘give up’ their approaches. Perhaps the key is to look for creative ways of combining and integrating the best of both models.

3.2.2 Poor relations between sectors
Aside from different models of practice, most delegates perceived the links between agencies both within and across sectors as poor, with joined up thinking almost non-existent. Most agencies hold on to a single-focus approach, failing to address the additional needs of the women they work with. Much fragmentation was described both within and across sectors. This was seen as a key barrier to the development of effective interventions. Delegates cited active fear and lack of trust across sectors, negative attitudes to working together and denial of responsibility as limitations to joint working. In addition, lack of awareness, motivation, communication, shared outcomes and systems for joint working such as protocols, referral structures and directories of services prevent positive service delivery. Stronger conflict over models of intervention, definitions, and competition for funds also contribute.

In particular, the problems of information sharing were discussed at length. Currently there is much resistance to information sharing, partly due to territorial issues and partly due to uncertainty over which information it is safe, ethical or legal to share. It is of course critical that any information sharing is carried out with client-safety as its key aim, however the current failure to share information or establish systems for information sharing is also hampering relations between the sectors.

All of these factors meant that women with experiences of domestic violence and mental distress often fall between the gaps of current patchy and poorly co-ordinated service delivery.

3.2.3 Lack of resources
The lack of financial and other resources was cited as one of the key reasons why work has not been developed across the mental health and domestic violence sectors. Within the mental health sector women's mental health needs in general seem to be relatively poorly resourced, and many of the small voluntary organisations providing services in the domestic violence sector suffer from a hand-to-mouth funding situation. These limitations mean that practical steps which would make services more accessible, such as training and child care provision, are not taken.

3.2.4 Negative attitudes
Both mental health and domestic violence are issues around which much mythology and stigma has developed; both are almost taboo subjects. Victim-blaming myths such as: women who stay with violent partners must enjoy the violence, be sado-masochistic or deserve what they get; women with mental health problems can not be trusted and are incapable of making decisions are still very prevalent. This leads to women being pathologised and feared. Other oversimplifications or misconceptions, such as dealing with a woman’s safety or accommodation issues will meet all her
mental health needs, are very prevalent. Many delegates felt that this confusion and mythology were the root cause of inadequate and inappropriate service provision.

3.2.5 Lack of sensitive and effective screening
The lack of sensitive screening in mental health agencies for domestic violence (and vice versa) means that many women clients are given inappropriate responses that not only waste time and effort for the agency, but prevent or limit recovery for the client. While mental health problems and domestic violence fail to be identified they cannot be effectively addressed.

3.2.6 Secondary victimisation
Secondary victimisation and trauma can be experienced by women who approach services for support but find their cases are dismissed, treated unsympathetically or where they are made to revisit their past experiences time and again with different professionals who are not equipped to provide sympathetic or appropriate responses. Delegates particularly cited women's experiences in some residential mental health settings where levels of verbal and sexual abuse were said to be high.

3.2.7 Focus on crisis work not early intervention
The fact that both the mental health and domestic violence sectors largely focus on crisis intervention work rather than long term prevention or early intervention initiatives was cited as a barrier to the provision of effective services for women. The mental health sector was seen to focus too heavily on acute mental ill-health while much of the domestic violence sector focuses its efforts on women fleeing extreme violence. It was felt that while these crisis services are critically important, long term strategies should focus on preventative work in schools and early intervention, for example at a primary care level.

3.2.8 Lack of awareness of existing services
Many delegates reported that both service providers and survivors of mental distress and domestic violence were unaware of the existence of many support services. This means that opportunities for appropriate interventions are often missed.

3.2.9 Children
Women's fear that they will have their children removed if they declare either domestic violence or mental distress means that they often reach crisis point before approaching services. Whilst child protection is obviously critical, it is often used as a form of control by perpetrators who threaten to inform child protection agencies of a woman's mental health status in order to secure custody for themselves. Professionals may collude with the perpetrator on such issues. In addition, the lack of child care at most mental health service provision means that mothers may have additional access problems.

3.2.10 Lack of services
Delegates identified an acute lack of services, both generic and specific, across both sectors. In particular, the lack of safe, supported housing for women experiencing domestic violence and mental distress, advocacy services, support networks, outreach provision, effective intervention with perpetrators, childcare and counselling were cited. Even where such services are provided a massive lack of capacity and long waiting lists were said to limit access.

3.2.11 Staff problems
Delegates described various problems with staff in both the mental health and domestic violence sectors as a barrier to effective intervention. Difficulties were reported in recruiting and retaining
strong staff members due to low salaries, high workloads and eroding demoralisation. Current staff are often resistant to working with additional issues due to fear, negative personal attitudes, lack of training, knowledge or understanding. Power dynamics between and within sectors were also seen as problematic, with hierarchies of issues pushing both domestic violence and mental health down the agenda. Staff uncertainty as to correct paths of action and concern that incorrect interventions may make problems worse also lead to additional issues being ignored. In addition, self-preservation and fear for the effects of increasingly complex work on the well-being and mental health of staff were mentioned.

3.2.12 Lack of training
Many of the problems with staff mentioned above were seen to be the result of a lack of effective training around mental health and domestic violence as co-existent issues. This means that staff continue to be ill-informed about the issues, safe interventions, possible routes of referral and appropriate responses and to hold onto negative and incorrect stereotypes and prejudices about women experiencing domestic violence or mental distress. Bearing in mind the immense power which staff hold in deciding what interventions and treatment a woman may receive, comprehensive and ongoing training is clearly essential.

3.2.13 Women’s fear
Some women’s fears about approaching agencies for support obviously may limit their chances of receiving safe and appropriate interventions. This fear was thought to be caused by several factors including lack of knowledge of the type, location and response of existing agencies; fear that they will be sectioned or detained; concern that their children will be removed; and that their legitimacy, for example in legal proceedings, will be diminished. Partial disclosure may be another tactic women use in order to receive some treatment but protect themselves against unwanted interventions.

3.2.14 Gender and Race
Many delegates felt that the gender and race politics of the mental health and domestic violence sectors limit the services that women can access. Broadly speaking, the mental health sector was seen to be dominated by white men, particularly at a management level; and the domestic violence sector is predominantly staffed by white women. The consequence of this was seen to be a general failure to meet women’s needs within the mental health sector, and a general failure (with some notable exceptions) across both sectors to meet the needs of women from black and minority ethnic groups. Delegates described the additional cultural barriers of language, different constructions of what mental health means and the predominantly western psychological constructs which dominate the mental health field, among others, as critical barriers to accessing services.

3.2.15 Unsafe practice
Some current practices were described as unsafe by a number of delegates. These increase women’s fears of approaching services and mean that inappropriate interventions are provided to very vulnerable clients. Two key examples were given; the first was the involvement of family, in particular the perpetrator, in care planning. The second was the use of mixed sex services which could include work with partners perpetrating violence or others who perpetuate additional verbal or physical violence.

3.2.16 Perpetrator issues:
As stated above, the power held by the abuser when a woman is experiencing mental distress is immense. Often they are involved in care planning, have the power to section their partners and to administer or withhold medication. Women’s mental health problems also provide a useful justification for a partners violence, de-legitimise her statements (particularly in a legal context) and reduce her chances of securing child custody.
4. Recommendations

One of the key aims of the Sane Responses Seminar was to look for positive and creative ways for the sectors to work together to provide a more effective service for their service users. The suggestions below were made by speakers and delegates during the seminar:

4.1 Funding

Unsurprisingly, the need for additional resources and funding were the most commonly made recommendations at the Sane Responses Seminar. In particular, it was felt that specifically targeted or ring-fenced funds, rather than patchy short-term funds which cannot support sustainable developments, would help to ensure the effective development of services across Greater London.

While additional resources were seen to be essential there were also pragmatic suggestions about how to maximise the funds currently available for domestic violence and mental health work. These included assessing the effectiveness of current interventions and reallocating existing resources to more effective programmes, identifying shared outcomes, working together as agencies and sectors rather than competing for funds and obtaining small-scale funds for collaborative pilot projects which, if successful, could then be replicated elsewhere.

4.2 Training and awareness raising

After the need for additional resources, the urgent need for training was the most commonly cited recommendation to emerge from the Sane Responses Seminar. While it was acknowledged that intensive training was needed in both sectors (mental health training for the domestic violence sector and vice versa) certain professions within the health sector, which were perceived to be male-dominated, were seen to be a particular priority. These included targeted training for psychiatrists, psychologists, GPs, CP Teams and Accident and Emergency workers. Outside of the specific domestic violence and mental health sectors delegates also suggested that social workers, the police and members of domestic violence forums also receive training in order to shift resistant negative attitudes.

It was also suggested that training should be formally integrated into existing training programmes and included as part of basic professional qualifications. Accreditation of such training was seen to be important in order to ensure that any training developed is of a good standard and is given professional recognition.

The importance of consistency and clear core messages for training on mental health and domestic violence was also raised to avoid confusing and damaging myths and stereotypes being perpetuated.

It was proposed that the potentially high costs of providing such training could be reduced by facilitating cross-training where mental health agencies agree to train domestic violence agencies in return for reciprocal training. Multi-agency training was also seen as potentially useful allowing an exploration of the reality of providing services in a multi-agency environment, giving each agency the opportunity to understand the position of others in terms of service delivery.

More broadly, it was felt that public awareness-raising was a critical part of the change process in order to shift the negative prejudice and stereotypes associated with both domestic violence and mental health.
4.3 Co-ordinated networking and joint working: complex issues need complex responses
While delegates acknowledged the numerous challenges of partnership working, this was also seen to be the most critical strategy needed in order to develop effective, holistic and inclusive services for survivors of domestic violence who also have mental health problems. Networks and joint working were seen as a positive strategy at local, London-wide and national levels. Several suggestions were made as possible ways to avoid competition and polarisation across the sectors:
- Inclusive multi-agency fora with a focus on mental health and domestic violence, to include representatives from Primary Care Trusts, GPs, Social Services, Police, Housing, Education etc. to meet regularly to share ideas, best practice and information.
- Set up sub-groups on existing fora e.g. mental health sub-groups on domestic violence fora.
- Informal links between local practitioners.
- Cross-sectoral placements or secondments.
- Sharing office space across the sectors.
- Facilitating multi-agency or cross-sector training.
- Developing shared outcomes.
- Joint funding proposals.
- Regular seminars, workshops and other events to raise awareness and encourage networking at both a local and national level.
- Collaborative pilot projects.
- Identify domestic violence key workers or named contacts within each primary or secondary care unit, and mental health key workers in domestic violence service providers.
- Development of joint protocols and policies e.g. around assessment.
- Create directories and accessible websites of services to ease referral.
- Develop continuity of support services (both within individual boroughs and across Greater London).
- Build sustainable links when there is no imminent crisis.
- Develop shared understanding of terminology.
- Develop inter-borough contacts and referral systems.
- Providing centres or one-stop shops where a variety of professionals with different skills and expertise can work and be accessed including housing, women’s aid, social services, police etc.
- Develop integrated services where mental distress and domestic violence are addressed concurrently and packages of care are developed in partnership.
- Mutual understanding and respect
- Respect the creativity that comes from difference

4.4 Models of good practice and minimum standards
While there was much enthusiasm and energy for change expressed at the seminar, many delegates said that they were both unsure about how to develop safe and effective work across these two sectors and fearful of making potentially life threatening mistakes. It was therefore seen as vital that existing models of good practice are published to prevent endless reinvention of the wheel. In addition, delegates felt that it would be useful to develop a set of minimum standards for working across the mental health and domestic violence sectors, both to guide the development of new work and to ensure that any new developments have the safety of women as their guiding principal. The need for mechanisms such as good practice and minimum standard guidelines and toolkits, workshops, seminars and training sessions at which these models of good practice and minimum standards can be widely disseminated across both sectors was also seen as critical.

4.5 Policy and protocols
As with the need for models of best practice and minimum standards, many delegates also suggested that there needs to be a clear legislative and policy framework to encourage positive change in practice across the mental health and domestic violence sectors. This was seen as essential at several levels.
Firstly, many suggested that individual agencies need to develop internal policies (domestic violence agencies developing mental health policies and vice versa) which provide clear guidance and a plan of action for clients with dual needs. These should include mechanisms for screening, referral and joint caring for clients.

Beyond this, it was suggested that local protocols between agencies in particular geographic locations should be established to ensure clear systems of referral and lines of responsibility. In addition, confidentiality and information sharing protocols would have to be reviewed or developed, and multi agency strategies allowing for longer term planning and joint working created.

At a regional level (Greater London) it was felt that a co-ordinating body which could provide centralised guidance, model policies and training as well as lobbying for change at a national and government level would be useful to ensure consistency of standards and effective regional networking.

Finally, at a national level, delegates felt that there should be significant shifts in legislation and policy which address these two issues in tandem, the political will to push through legislative and institutional change, national standards or targets covering both sectors and a national champion to lead on this cross-sectoral issue and monitor change.

4.6 Victim led services
A key principal, which delegates wanted to see at the heart of any service development, is the involvement of victims / survivors in decision making processes. The strong message which emerged from the Sane Responses Seminar is that it is common sense to involve victims / survivors in the planning and delivery of all services to ensure that their needs are prioritised and that services are relevant and effective. While it was felt that some voluntary sector organisations are already attempting to work in this way, the statutory agencies were felt to be lagging behind in working in this way and needed to prioritise user-consultation on issues of service safety, accessibility and effectiveness.

4.7 Specialist services
While it was recognised that the principles of safe and effective work with women experiencing domestic violence who also have mental health problems need to be integrated into mainstream organisations, it was also felt that a cornerstone of good practice is the development of specialist services, rather than simply expecting women to find safe and relevant support and intervention in mainstream services. Many delegates described women-only, women-focussed and women-led services as the ideal model with specialist staff who are trained across the domestic violence and mental health fields.

In addition, specialist refuges providing a safe haven for women with low, medium and high mental health support needs were seen as critical as were outreach, advocacy and telephone support services. Mentoring or buddyng systems were also suggested as a way of providing targeted support for women who chose to remain in their own homes. Finally, it was felt that the development of a more extensive network of effective perpetrator programmes was needed to ensure that the perpetrators of domestic violence are held accountable for their actions. It is critical that such services are in line with the Respect minimum standards for perpetrator programmes (see http://www.changeweb.org.uk/respect.htm for details).

4.8 Empower clients
In addition to ensuring that services are client-led, many delegates felt that it was important to focus on supporting and empowering clients, highlighting positive role models and women’s achievements, and helping them to access services, challenge poor service delivery and raise issues critical to their
needs as clients. It was felt that individual assessments should focus on individual women’s strengths and seek to support and develop their self esteem in order to empower them to find the support and services best suited to their individual needs.

4.9 Information dissemination, sharing and research
Several critical issues were raised regarding information. Firstly it was felt that the current lack of clear and widely disseminated information detailing the available services in both the domestic violence and mental health sectors limits accessibility for many women who might wish to make use of such services. Awareness raising campaigns, information cards and directories of services were recommended as services to this problem.

Secondly, delegates felt that information sharing was a key issue in developing services across the two sectors. As mentioned in Section 5.5, the development of information sharing protocols to ensure that staff in both the mental health and domestic violence sectors are clear about which information it is ethical to share and why they are doing it, was seen to be critical. Confidentiality was seen as a cornerstone of such policies, particularly when deciding which information it is safe and appropriate to share. Referral to another agency does not necessarily mean that all details have to be disclosed, but shared assessments and care-planning could be of great benefit to women service users.

Finally, the need for further information collection and research was highlighted. It was felt that the limited research across the mental health and domestic violence sectors means that the links are often overlooked or denied. A comprehensive body of conclusive evidence exploring the links between experiences of domestic violence and their impacts on mental health would help make the case to policy and decision makers, as well as funders, that services do need to be developed and improved.

4.10 Support for workers
While services clearly need to be developed and improved, this will inevitably demand much of front-line workers. It is therefore essential that workers are provided with comprehensive training around the overlaps between domestic violence and mental health, as well as ongoing support and supervision. Particularly because of the emotionally demanding nature of the work of both of these sectors, staff care plans need to be put in place to ensure that they have the time and space to debrief as well as the support they need to continue to provide effective services. It was suggested that supervision for workers should come from both internal managers and another member of staff from an agency in the other sector (so mental health workers would receive peer supervision from a domestic violence worker and vice versa). It was also felt that most agencies would require additional staff to make sure that existing workers have manageable case loads and working hours.

4.11 Prevention and early intervention
A theme which ran throughout the Sane Responses Seminar was the need for a greater focus on preventative and early intervention work. In particular, it was felt that discussions of mental health should focus on general well-being and not just coping with crisis. Almost by definition much of the existing work in the mental health and domestic violence fields is crisis-oriented due to cultures of acceptance and denial, and the frequency of inappropriate or ineffective interventions at earlier stages. An example of this cited on the day is the frequency with which GPs prescribe anti-depressants, rather than asking patients about the cause of their distress and referring them to appropriate services. Suggestions to improve preventative and early intervention work included improved training for both sectors to improve screening and identification of issues, public awareness raising campaigns and work in schools to educate both teachers and children around mental health and domestic violence.

4.12 Think local
While national or regional interventions were seen to be useful, the most effective strategies were seen to be small-scale and locally focussed because services are so often delivered locally.
Suggestions for how to develop work locally included the creation of borough or regional strategies developed and owned by local agencies, mapping of existing local services, local referral directories, seminars, community champions, community based projects and services

4.13 Services for children
While the Sane Responses Seminar predominantly focussed on the safety and needs of women, children’s services were also felt to be essential both because women’s choices are affected by what is available for their children, and because of the effects of witnessing domestic violence or living with a parent with mental health problems on children’s own well-being. In particular the provision of good quality, affordable and accessible child care attached to all women’s services was seen as essential. In addition, specialist support services providing counselling and other interventions to improve children’s mental well-being were also seen as critical.

Many women’s fear that disclosure of experiences of either domestic violence or mental health problems will lead to the removal of their children by Social Services was also highlighted by many delegates. Effective, integrated children’s services attached to both mainstream and specialist women’s services could help to reduce this concern.

4.14 Communicate
The mythology and mystery surrounding both mental health and domestic violence services was seen as a core barrier to women’s access to services. Many delegates at the seminar felt that clinical jargon needed to be replaced by straightforward explanations which both women service users and workers from other sectors could understand in order to demystify the services being provided. It was also felt that shared understandings of terminology needed to be developed across sectors to ensure that women service users were receiving unambiguous messages about the intervention and treatment options open to them.

4.15 Challenging myths and stigma of domestic violence and mental health
The stigma attached to experiences of domestic violence or mental health problems still remains strong. Many delegates identified this stigma as a central barrier to women’s access to safe and effective services. It was therefore suggested that firm challenges to the myths which feed this stigma have to be built into all work across these two sectors through awareness raising, training and research which disprove myths.

4.16 Evaluation of current and newly developed work
Evaluation of existing or developing pilot projects which work across the mental health and domestic violence fields was seen as essential by many delegates. It is only by gathering data and demonstrating the links between experiences of domestic violence and mental health problems, and the success of particular models of intervention that positive models for change will be accepted by mainstream organisations.

4.17 Understand domestic violence in its social context
As described in Section 4.2, the mental health and domestic violence sectors largely work from different understandings of the links between domestic violence and mental distress. Delegates at the Seminar stressed the importance of working from a gendered understanding of the social context within which the power and control dynamics of domestic violence occur because this more accurately reflects the reality of women’s experiences. This was seen as a critical cornerstone of safe and effective working.

4.18 Cultural awareness
The need for culturally specific services, as well as cultural awareness training for all services in both sectors was highlighted throughout the seminar. This was seen as critical in order to ensure that all women, including those from black and minority ethnic groups, were provided with accessible and...
relevant services. Planning for the provision of translated service information and trained interpreters was also seen as a critical part of equitable and accessible service delivery.

4.19 Positive screening
Many delegates felt that positive screening should be introduced in both sectors, for mental health problems in domestic violence agencies and vice versa. However, they stressed that it was critical that such screening should not be implemented before all staff had received comprehensive training in the issues, appropriate responses and possible points of referral.

4.20 Flexible and creative service delivery
A key recommendation to emerge from the seminar was the need for greater creativity and flexibility in the way in which services are delivered. Many felt that there was a huge need for more community-based services with opening hours which suited the needs of working women or mothers. In addition, an increase in the number of outreach, advocacy and telephone support services were seen as essential. These services need to be able to respond quickly to women’s needs and acknowledge that recovery and healing is not a process which can be rushed. Interventions must be moulded to the needs of individual women, rather than prescribing a time-limited course of counselling or other action, provision must be made for ongoing support for as long as the individual needs it.

The final, and essential, message which emerged from the seminar was that it is not acceptable to continue to use a lack of time and money as an excuse for not developing relevant and accessible services across the mental health and domestic violence fields.

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5 I.e. routinely asking clients about their experiences of domestic violence or mental distress in order to provide effective interventions (i.e. the aim of positive screening is to provide more effective services rather than to exclude clients from services)
5. The way forward

Since the Sane Responses Seminar in mid-March 2003, work has continued to try to ensure that the process of service development across the mental health and domestic violence fields continues. This seminar report is part of that process.

In addition a Round Table on mental health and domestic violence is planned for June 30th 2003 to bring together professional from both sectors to discuss the issues raised in this report and possible ways forward. It is hoped that an ongoing Working Group will be established at this event to guide future developments and ensure that these twin issues remain and rise on service provider’s agendas.

We are also seeking funds to employ a full-time worker who could support the development of networks, research, training and a toolkit focussing on the links between mental health and domestic violence and models of good practice for interventions.

We would also like to secure funds to pull together the data from the Sane Responses Seminar and the Round Table event into a more comprehensive report backed up by a literature review and some additional research material.
APPENDIX ONE: Biographies

Linda Regan: Senior Research Officer, Child & Woman Abuse Studies Unit, London Metropolitan University

Linda Regan has been working with Professor Liz Kelly CBE and others for over ten years at the Child and Woman Abuse Studies Unit, University of North London, which has a national and international reputation for its research, training and consultancy work. The Unit exists to develop feminist research methodologies, theory and practice, especially in relation to connections between forms of sexualised violence. Their work involves a creative combination of large and small-scale research projects, training, policy development and networking, which requires bridging the worlds of academia, policy, practice and activism. The Unit has completed over 30 research projects, many of which have directly addressed child sexual abuse, sexual exploitation of children and domestic violence including work with perpetrators. Recently completed projects include: a project delivering a training for trainers programme in counter trafficking in countries in the Balkans funded by the Department for International Development; an evaluation of a programme for violent men; a review of the literature and experience of sex offender registration and community notification; with colleagues from three UK universities, a study investigating children’s understandings and experiences of domestic violence funded by the ESRC; a self training manual on violence against women funded by the Council of Europe Police and Human Rights Programme; for the Home Office, the first contemporary investigation of trafficking of women into the UK for the purposes of sexual exploitation; a European Commission funded project on the sexual exploitation of children in the context of children’s rights and child protection in Europe and a study of attrition in rape cases in Europe.

The unit are special domestic violenceisors to the British Council on violence against women and are the seminar directors for their international seminars on violence against women. The Unit is currently undertaking: two projects on attrition and best practice in Sexual Assault Centres with respect to reported rape under the Home Office Crime Reduction Programme; a project looking at the workings of section 41 of the Youth Justice and Criminal Evidence Act for the Home Office; a training for trainers project to enhance good practice in counter-trafficking in destination countries funded by the EU STOP programme; a study of self-defence courses for women and girls across Europe funded by the EU Daphne programme and a review of health based models of response to sexual assault globally, funded by the World Health Organisation. In addition the Unit delivers training and consultancy to a number of organisations overseas.
Farah Naz: Counsellor at Newham Asian Women’s Project; Consultant with CVS Consultancy; Psychotherapist & Author of ‘Cultural Cocktail: Asian Women & Alcohol’.

Farah Naz is a consultant for the Civis Trust, leading in mental health, BME women, user consultation and disability and work with marginalised communities. Farah Naz has undertaken interim management for EACH an alcohol support organisation and is currently undertaking interim management for ASRA Housing Association as Head of Care. Additionally, Farah is a competent trainer and has delivered training in a range of areas.

She is also a trained and practising psychotherapist working at Newham Asian Women’s Project as well as managing her own private practice. She has set up and managed a counselling service in Greenwich. She is the author of ‘A Cultural Cocktail: Asian women and alcohol’.

Farah Naz also recently wrote a publication commissioned by the Department of Heath on early intervention in mental health. Currently, she is developing two handbooks on refugees and mental health – one targeted to refugee community organisations and the other to primary care workers.

Professor Catherine Itzin: Department of Health

Catherine is Research Professor and Co-Director of the International Centre for the Study of Violence and Abuse at the University of Sunderland. She has been appointed from January 2003, as a fellow of the National Institute for Mental Health in England. In this capacity she is leading a project on Violence, Abuse, and Mental Health focussing initially on the mental health implications of child sexual abuse and domestic violence. She is editor of Home Truths About Child Sexual Abuse: Developing Policy and Practice, and (jointly with Jalna Hammer) Home Truths About Domestic Violence: Feminist Influences on Policy and Practice published by Routledge in 2000.

She has published in particular on pornography and child sexual abuse, using survivor experiences to develop policy, sex offender treatment and the overlap between incest, paedophilia, pornography and prostitution.

Kyria Conner: Director of Woman’s Trust

Kyria is trained as an integrative arts psychotherapist. She has been working with women affected by domestic violence for over ten years and has been at Woman’s Trust since 1999.

Dipti Morjaria: Zindaagi Development Manager at Newham Asian Women’s Project

Dipti Morjaria is Zindaagi Development Officer at Newham Asian Women’s Project (NAWP); a project that offers support to Asian Women who are vulnerable to self harm and/or have attempted suicide. She has an extensive youth work background and recently was the Youth Work Co-ordinator for TEENS @ NAWP project for Young Asian Women. Dipti has been with NAWP for two years. Her experience includes specialist work with young lesbians and gay men, young people with learning disabilities and young black people. Dipti has been training in anti-discriminatory practice, homophobia and heterosexism awareness and sexual health for 9 years.

Susan Austin: Clinical Services Manager: Women’s Therapy Centre

Susan Austin is a psychoanalytic psychotherapist. She is Clinical Services Manager at the Women’s Therapy Centre in Islington, which provides subsidised individual and group analytic psychotherapy. She also works in private practice.

Rose Christie: Project Manager, Insight Into Violence Project, Maya Centre

Rose Christie is a Senior Counsellor and Project Manager of the Insight into Violence Project at the Maya Centre. She is a Psychoanalytic Psychotherapist member of UKCP and supervisor at WPF counselling and Psychotherapy.
APPENDIX TWO: Presentation by Farah Naz

Slide 1: Working together for the same end?

A major goal for us here today is to help bridge the philosophical and service delivery gaps between the domestic violence and mental health communities.

Both the mental health and domestic violence sectors are working together for the same end when we are working with women and children affected by domestic violence; but both sectors have perhaps different routes to get to that end. Its not necessary for us to have identical approaches to achieve the best for our client groups but it would help if we were to improve our collaborative work. I will be talking a little about the need for collaborative work and how we can move forward. I will look at the following areas.

Slide 2:

- How are mental health and domestic violence linked?
- Why do we need to build models for collaborative working?
- Key barriers to collaborative working
- The future for domestic violence and mental health

To begin with let’s look at some factors, which clearly show how mental health and domestic violence are linked.

Slides 3, 4, and 5

Some facts regarding mental health and domestic violence:

- Domestic violence is a factor of at least 1 in 4 suicide attempts by women
- The psychological facts of domestic violence can include low esteem, suicidal thoughts, dependence upon the perpetrator, feelings of hopelessness about the violence ending, a tendency to minimize or deny the violence.
- The impact of domestic violence has been found to have parallels with the impact of torture and the imprisonment of hostages.
- Abused women are more likely to suffer from depression, anxiety, psychosomatic symptoms, eating problems and sexual dysfunction.
- Women who have mental health issues are particularly vulnerable to domestic violence.
- At least 750 000 children witness domestic violence and it is thought that the majority of these children are at risk of developing mental health problems.
- Studies show that 50% or more of women in touch with mental health services have experienced violence and/or abuse.
- 20% of women in England have some form of mental illness.
- 1 in 4 women will experience severe depression at some point in their lives.
- Depressed women are at risk of suicide.

As you can see I am not presenting a long list of hard-hitting statistics, that is because we don’t have them. The obvious dearth of statistics results in the lack of strategic alliances, which would tackle identifiable need.
I would like to emphasise that in no way am I implying that a woman affected by domestic violence is synonymous with a person that has mental health issues. I am supporting the argument for democratic services in that women affected by domestic violence should experience equity by being targeted as people who may need to use mental health services. This means that pathways to care for such women must be created and domestic violence agencies have a central role to play here as agencies that engage well with women affected by domestic violence and so are well placed to act as referral agencies.

**The link between mental ill health and domestic violence**

So 20% of women have some form of mental illness - that’s 1 in 5. Most of us have some mental health issues whether we have trouble sleeping, get nervous before we do a presentation, have trouble making friends, find certain types of people difficult and then there are mental health issues which can have an impact on our lives such that we are not able to see things clearly or not able to carry out necessary tasks effectively. The more serious mental health issues are often diagnosed although today there are a few clinicians who are moving away from diagnosis.

There are a number of approaches taken to challenge mental health issues in the field itself. There are a range of professionals working toward this including psychiatrists, psychologists, psychotherapists, community mental health workers, occupational therapy workers, counsellors and more. Today, we will be hearing about the different approaches which mental health workers take. And you will note there is some dissension around which approaches or combination of approaches are most appropriate for different presenting issues which provides choice to women.

For women affected by domestic violence, for example, it is suggested by some that trauma oriented therapy along with peer support groups is perhaps the most appropriate psychological intervention. This is certainly something that has been largely agreed in the states through collaborative models, which have been set by the domestic violence and mental health sector.

Still, most mental health workers would agree what is considered to be the causes of mental ill health. They would be as follows,

**Slide 6: Factors explaining the acquisition of psychological disturbance that are commonly accepted by most mental health clinicians are as follows:**

- genetic predisposition
- physical disease
- developmental traumas leading to specific traumas (i.e. loss of a parent may be associated with depression in later life).
- personal experiences leading to the poor development of adequate coping mechanisms (e.g. parents who provide poor models of how to cope with rejection)
- counter productive cognitive patterns, unrealistic goals, unreasonable values and assumptions learned from significant others

There is also broad agreement on factors, which are considered to precipitate mental illness, they are:

**Slide 7: Factors, which could precipitate mental ill health, include:**

- physical disease
- severe external distress (e.g. loss of employment, loss of a partner, trauma)
- chronic insidious external stress (constant criticism or abuse from a significant other)
specific external stress (that which acts on a psychological vulnerability)

As you can see it is acknowledged that domestic violence may have some significant impact on the mental well being of victims and survivors of domestic violence.

So, its clear that in order to deliver the most responsive and appropriate services we will need to build models which enhance service delivery. Perhaps to build models for collaborative working.

Slide 8: Why do we need to build models for collaborative working?

Domestic violence can have serious psychological consequences and can also imply existing mental health issues

It has long been recognized that domestic violence has serious psychological consequences. However, collaborative models for addressing these issues have been slow to develop. This is due in part to the different perspectives of domestic violence and mental health service providers, and to the lack of an integrated framework that addresses both the social and psychological needs of affected women and their children.

Slide 9: Joint working between domestic violence workers and mental health providers is important on different levels.

**Collaboration is important for the women and children affected by domestic violence**

For women who may seek help in either system, having a provider who helps them assess their needs and who provides access to a full range of resources can only enhance the quality of care they receive. As some women will feel safer and more connected with a mental health provider, others will feel more comfortable in a domestic violence environment. If clinicians and domestic violence workers are able to develop the trust and understanding necessary for good working relationships, they will better be able to help women affected by domestic violence to traverse those boundaries and to be safe, to heal, and to move forward in their lives.

**Collaboration is important for providers as well.**

Mental health clinicians are less likely to feel overwhelmed by women’s need for safety or their need for legal support if they are working in partnership with domestic violence advocacy programs. At the same time, having clinicians who can assess the mental health needs of a domestic violence survivor and/or her children, provide treatment, or help negotiate the mental health system will only enhance the capacity of domestic violence projects to address the needs of the women they serve.

**Collaboration is necessary for the development of effective models**

It is essential to create and make available collaborative treatment and service delivery models that reflect the social needs as well as the psychological concerns of women and their children who are affected by domestic violence - models that address the trauma of both past and current abuse. There are a number of good practice models, which are not widely publicized as good effective models. Moreover, most that do exist have not performed evaluations to test for efficacy, due in part to resource constraints and because their aim is to deliver a project and not research based.

**Key barriers to collaborative working**

As expected there are barriers to collaborative working for mental health and domestic violence especially as the history and formation of each sector is so different; that is one has emerged from a grassroots movement and the other from clinicians.
Four key barriers emerge immediately when considering the development of collaborative models for mental health and domestic violence.

Slide 10: Key Barriers

i. **The needs of women using domestic violence services are increasingly complex.**
As legal protections for women affected by domestic violence improve, women with greater resources are less likely to utilize domestic violence shelters. Increasingly, shelters are seeing women with the fewest resources - i.e., low-income women, refugee women, women who are forced into adapting societal roles by their cultural and familial norms, women who have been multiply-victimized as children and as adults. These are women who have experienced greater adversity throughout their lives, and who may be more vulnerable to the mental health consequences of abuse. Many refuges and agencies are already struggling with limited resources, and so feel unprepared to respond to the emerging complex needs of presenting women. There is also a growing awareness among domestic violence advocates of the need to address the traumatic effects of domestic violence on children and to provide longer-term services to support women in the community once they move out of refuges.

So as needs become more complex it becomes more difficult to consider building collaborative relationships which agencies do you build these with? Schools, child support centres and so on.

Both sectors improving their ability to respond to our multi needs and multi cultural society resolve this.

ii. **Empowerment models versus clinical models?**
Second, for some workers in the domestic violence and mental health fields there is an obvious difference in approach and sometimes these can be felt to clash. For example, some domestic violence groups are concerned about replacing an advocacy-based empowerment model with clinically-based approaches and interventions and for mental health workers they may have a similar concern.

While many domestic violence organizations do recruit mental health trained workers, more often than not, these staff members function as advocates rather than as clinicians. More often than not it will be these clinically trained staff members who are more likely to recognize mental health needs and make referrals to mental health providers.

Yet, routine mental health assessment of women entering domestic violence services remains a controversial topic. While many agencies screen for mental health problems, formal mental health assessment is not the norm, since women generally seek services to address safety rather than mental health issues.

Moreover, mental illness is still highly stigmatized and is frequently used against women in child custody cases by abusers as well as by the legal and child welfare systems. Conducting mental health assessments for domestic violence workers may pose a threat to the nature of their advocacy empowerment model as well as possibly alienating and endangering vulnerable women.

Similarly, mental health workers may feel experience tensions and criticism in that their work may be seen by domestic violence workers as stating that there is something wrong with the woman and that the mental health worker is ignoring what really needs to be fixed i.e. a society that tolerates domestic violence. This can lead to not addressing real mental health issues. The crisis-orientated work undertaken by many domestic violence workers is surely necessary as immediate safety, housing, economic and legal needs are of prime importance. This can prevent any longer term recovery and support issues sometimes assuming that all other issues will disappear once the issue of domestic
violence is resolved. This is a dangerous assumption and can lead to prolonged mental ill health. Mental health needs should be picked up early in full assessments.

An important bridge is provided by trauma work emphasizing what has happened to a person rather than what is wrong with a person.

iii. **A recognition of limitations**
Thirdly, there is apprehension perhaps from both the domestic violence and the mental health sectors toward working together.

Some domestic violence workers may feel that mental health providers have not recognized the limitations of their own training in preparing them to understand and respond to domestic violence. Domestic violence workers also express concern that mental health approaches to domestic violence (e.g., diagnosis, medication, couples counseling) can be pathologising, create special risks for women and their children, and fail to capture and respond to the social underpinnings of abuse.

Similarly, mental health practitioners and clinicians may feel that a lack of mental health assessments and expertise in the domestic violence sector can put their service users at serious risk. And mental health experts may also feel that the lack of psychological understanding of domestic violence constitutes a serious misunderstanding of it, which will not result in the eradication of domestic violence.

So, the occasional mutual minimizing of the importance of both domestic violence and mental health work is a major barrier to the delivery of an effective service for our service users. This is remedied by each sector delivering training to one another.

iv. **Resources for collaborative work**
Lastly, for the domestic violence and mental health sector to form joint working there is an urgent need for resources that will help them address these issues and for some time, both sectors have been operating under resourced. Practitioners and workers need to receive reports, recommendations, training materials, and model protocols.

There are a number of questions, which we need to answer through dialogue and research like how to improve their responses to domestic violence survivors who have experienced multiple forms of abuse across their lives.

The DOH has promised that this will be addressed through a number of new initiatives.

**The future of mental health and domestic violence**
All of us here recognize the need for working collaboratively. We all know that domestic violence more often than not results in disempowerment and disconnection from others. And so it makes sense that recovery would be based on the empowerment of the survivor and the creation of new connections. Traumatized women need their strengths recognized and encouraged and for this the mental health worker must have an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of injustice. Similarly, domestic violence workers must recognize the need for mental health assessment and the need for specialized intervention where identified by mental health workers. Domestic violence workers would benefit from training to assist them to understand the traumatic impact of both current and past abuse and in recognizing when women have mental health needs that would benefit from clinical intervention.

DOH strategy papers, too, have acknowledged the need for developing services targeting women including women only community centres; the need for more talking therapies and the need for
therapeutic interventions to be based on empowerment models. The NIMHE also plans to provide mental health provision for specific groups of women including women affected by domestic violence. We will hear more about this later.

We need interdisciplinary working groups or committees that are examining the intersection of domestic violence, substance abuse, and mental health from the perspectives of various human service delivery systems.

**Slide 11: We would hope for:**

- The formation of stakeholder networks and public education initiatives to address multi needs and our multi cultural society;
- The development of trauma-based treatment options and services;
- Education and cross-training (meaning domestic violence workers training in mental health and vice versa) of service providers;
- The creation of policies supporting appropriate trauma-sensitive service provision;
- Efforts to consult with domestic violence workers and mental health workers and to learn from one another’s expertise.

Certainly, the future looks quite exciting and can provide much hope for women affected by domestic violence; this all begins with the work that much of you are all providing and some of the pioneering projects we will be hearing about today.

Thank you.
APPENDIX THREE: Presentation by Professor Catherine Itzin: Department of Health

GREATER LONDON DOMESTIC VIOLENCE PROJECT CONFERENCE ON

Department of Health Women’s Mental Health Strategy and National Institute for Mental Health
Violence Abuse and Mental Health Project

Presentation by Professor Catherine Itzin
NIMENTAL HEALTHE Violence Abuse and Mental Health Fellow

Introduction
In October 2002, the Department of Health published its Women’s Mental Health Strategy: Women’s Mental Health: Into the Mainstream – Strategic Development of Mental Health Care for Women. This was the subject of extensive consultation over a three-month period. Currently an implementation strategy is being developed and is scheduled for publication shortly.

In January 2003 the National Institute for Mental Health in England appointed a number of Fellows. One of these was a Fellow for Violence Abuse and Mental Health. Its initial focus is on the mental health implications of child sexual abuse and domestic violence for services and professionals responding to child, adolescent and adult victims/survivors and abusers. Its first step is a scoping exercise with key individuals in the diverse sectors and fields associated with issues of violence and abuse. This presentation will discuss the opportunity provided by both of these initiatives to improve services for these groups and individuals.

Overhead on Child Sexual Abuse
Need to acknowledge the high level of prevalence and substantial under-estimate/under reporting, Girls are at greater risk than boys, intra-familial abuse more common in girls, whether the abuser is from within or outside the immediate family, majority of abuse takes place in the home.

Abuse is endemic within our society, with a high level of societal denial regarding the context and prevalence of violence and abuse, and a reluctance to use a gendered language obscures the reality, for example, it is minimised or denied that most male abusive behaviour begins in adolescence, and the close correlation between the risks of boy victims of abuse becoming abusers themselves. This is vital for early intervention, recognising and treating perpetrators who are also likely to be victims, whilst not exonerating them.

The biggest challenge is stopping abusers abusing. Currently the majority of attention and energy is on supporting and healing survivors. The tendency to focus on serial paedophiles and their demonisation (particularly in the media), and emphasis on strangers, can deflect attention from where most abuse takes place, which is, whether it is child sexual abuse, domestic violence or rape, perpetrated by known men and primarily within the home.

Overhead on Domestic Violence
Currently there is a high level of cross-Government commitment to addressing domestic violence, greater user of the criminal justice system for perpetrators and tangible support for women and children. However there is also a danger that domestic violence is addressed in a vacuum, treated in isolation of the whole spectrum of violence and abuse, whereas domestic violence is one aspect in the continuum of abuse. There is also an issue of hidden abuse and violence within minority ethnic communities, traditional cultural norms make it very difficult for women to speak out.
Understanding the continuum of abuse and violence is a critical factor in tackling the root causes of mental illness in these areas. At the same time it is important to acknowledge the impact of the abuse and extent of recovery for girls and boys, men and women. This is dependent upon many factors: nature of abuse, the length, severity, relationship of abuser to the victim, extent of impaired attachments, having experience of a safe, validating environment subsequent to the abuse. The Women’s Mental Health Strategy identifies a whole range of risk and protective factors. However, there is also a need to confront some uncomfortable realities using a gendered language.

Where men are concerned, whilst no-one would suggest that all abused boys become abusers, the aetiology of sex offenders indicates that experience of childhood sexual abuse - particularly with added factors of physical abuse and witnessing domestic violence - creates a significant predisposition. They are more likely to externalise their rage, pain and sense of injustice, deal with their damage and distress very differently to women; and can find it hard to disclose their own abuse. Similarly whether sex offenders abuse children within or outside the family, there is also a greater likelihood that they are also abusing adult women, one study found that 20% of sex offenders were also rapists.

Indicators are that men committing domestic violence may also be directly abusing their children as well as abusing their children by the witnessing of domestic violence:

- Research by Hester worked with all children accepted by NSPCC over 2.5 year period, 75% involved child sexual abuse, of those over half also involved domestic violence.
- DoH study (Farmer and Owen), children on child protection register, domestic violence featured in 40% of CSA cases and 60% of physical and emotional abuse/neglect.
- 45%-70% of children whose mothers were abused suffered direct abuse.

Women tend to internalise their pain (evident from mental ill health implications) and very rarely become abusers themselves. Again it is important to acknowledge that not all survivors of child sexual abuse re-experience abuse in adulthood or enter into abusive relationships. Women who experience domestic violence may not have been abused as children.

But there is also a need to recognise and be able to respond to the real potential for revictimisation within the continuum of abuse and violence, and also not to forget the link with pornography and prostitution (severe form of abuse and exploitation of girls, young women and boys). It is important to acknowledge the nature and extent of revictimisation but in a context that recognises the strength, courage and resilience to survive of women with these experiences, and, given the right therapeutic environment, their capacity for recovery.

Whether women are revictimised may be dependent on the severity and sustained nature of the abuse, family context, other deprivation factors such as not being provided with a safe, validating environment to learn to trust, gain a sense of identify, build their self-esteem and the space and support to heal. Many women have experienced abuse as ‘looked after’ children subsequent to abuse in the home. This can all result in self-blame, self-punishing and self-destructive behaviours such as substance misuse and self-harm.

What is needed is to prevent further abuse and maintain women’s and men’s mental health through:

- early therapeutic intervention of proven effectiveness for victimised children
- effective support and treatment for adolescent and adult survivors including abusers
Overhead: Impacting on their physical and mental health (CSA)
In terms of women internalising their pain: impact on their mental and physical health, tend to have longer hospital admissions, higher rates of prescribing, more severe symptoms. With domestic violence, depression/anxiety/PTSS, mortality from their injuries and suicide - studies indicate high prevalence of abusive experiences in women who overdose, for example of a sample of 257 women admitted with overdoses over a 12 month period, 72% had experienced some form of sexual abuse, 51% attempted/actual penetration.

All studies indicate that it is not unusual for 50% or more of women in the mental health care system to have endured childhood sexual abuse and up to 70-80% when inclusion of violence and abuse in adulthood

Overhead: 'Hidden' re-enactment of abuse
They enter a mental healthcare system which largely fails to recognise the nature and extent of these experiences and underlying causes of their distress. In this context coping mechanisms are misinterpreted, the context of abuse ignored and therefore women cannot recover or deteriorate further.

Overhead: Retraumatisation
Particularly women who are detained under the Mental Health Act (very few voluntary patients now) can feel a tremendous sense of powerlessness, lack of control, not being listened to, experiences remain unvalidated. This can retraumatise women, having things done to you which you may not want, having no say over what happens to you.

Overhead: Issue of safety
The issue of safety is a fundamental right of everyone in the mental healthcare system, but women in particular are vulnerable to coercion, intimidation, abuse and even rape. Issue for all women, many of whom would prefer women-only settings, but particularly for survivors of abuse alongside older women, lesbian women and women from different cultural backgrounds. The re-introduction of mixed wards in the '60s was to 'normalise' the inpatient environment but one can't replicate the outside world. As one woman service user said "when you are at your most vulnerable, what is normal about sitting down to breakfast with a group of men who are strangers in varying states of undress'.

Overhead: What women are saying
Overhead: Women's quotes
There is a high level of government commitment to tackle these issues with regard to women's mental health and to address inequalities in the mental healthcare system, of discrimination and disadvantage. Increasingly there is a stronger women service user voice plus champions in the field, women and some men, that women's issues should be properly addressed. These include:

- Safety, empowerment, choice, overwhelming sense of not being listened to, women want less medication, more talking therapies, thoughts/views/experiences validated, recognition that their vulnerability is not rooted in their biology, but in the social and family context of their lives, choice gender of key worker, value strengths and abilities, etc

Generally women feel that too much attention is focussed on their problems rather than their resilience in surviving painful experiences, their capacity/ability to recover.

Approach Adopted in the Women's Mental Health Strategy:
The underlying message of Women's Mental Health: Into the Mainstream is that women have specific needs that have been poorly met and the need to provide equity of service to all. Gender differences in women and men need to be recognised and addressed and become integral to every aspect of mental health care. This is the first time the notion of 'gender' has been introduced to national mental
health policy, and the gendering of policy and practice is necessary in order to meet the needs of women and men service users.

**Overhead: Gender Sensitive Framework**

*Into the Mainstream* provides strong evidence to demonstrate the need for a gender sensitive approach to mental healthcare services which gives due regard to known and potential gender differences in relation to the following:

**Economic and social context**

Gender inequalities in income and wealth, women are much more likely to live in poverty (two thirds of adults living in poorest households are women), twice as many women economically inactive, twice as many men in full time employment, women employed part time, half in low paid sectors. Women experience tension and stress caused by having competing and often unsupported multiple roles and responsibilities: mothers, carers, partners, and breadwinner. Low societal status and value placed on women’s role in family, potential negative impact on women’s self-worth, can contribute to mental ill health.

**Childhood/life experiences**

Women are more vulnerable to social isolation, higher levels of poverty, lone parenthood, lack of mobility (fear, out in community), longer life expectancy. Major life experience: impact of violence and abuse.

**Consequent vulnerability**

High level of prevalence, with differences in presentation and occurrence, roots of mental distress, different pathways into and out of services.

**Delivery of appropriate care, treatment and support**

Different presentation, different pathways, different treatments required.

**Overhead: Gender Specific Services**

**Overhead: Priorities from consultation period of three months**

**Overhead: Priorities for WMental Healths Implementation Guidance**

**Overhead: Addressing Violence and Abuse**

**Focusing on Violence and Abuse in the Women’s Mental Health Strategy Implementation**

The Women’s Mental Health strategy provides the evidence base for violence and abuse as areas of serious neglect, and the need for this to become a core mental health issue, and it outlines ways forward for mental healthcare services in this regard. The immediate priority is to ensure that all essential elements are put in place so that violence and abuse can be addressed on a routine basis in assessment and care planning processes.

In terms of *inter-agency working*, with domestic violence, involvement in domestic violence forums, Area Child Protection Agencies, Sure-Start schemes etc; voluntary sector services that work with survivors of child sexual abuse, housing regarding the need for safe accommodation. There is also great importance in early intervention in primary care services.

Staff need *training* particularly in ways of asking about abuse, making women feel safe and to trust enough to disclose, and be constantly vigilant to the possibility of disclosures at any time during the care planning process, not just at the assessment stage.

Staff also need to establish an understanding that *violence and abuse can be a contributory factor* to many if not all presentations. Mental healthcare tends to look at different presentations separately, eg self-harm, eating disorders, peri-natal mental ill health, substance misuse. Need to appreciate the
complexity of distress, that there is more that links these symptoms than divides them, that they can all be secondary symptoms of primary distress located in women's experiences, notably childhood sexual abuse and domestic violence.

In developing appropriate therapeutic interventions, services should value the expertise of the voluntary sector; consider the involvement, learning from these therapists and counsellors who have been working with survivors, often for many years.

Staff support is important as staff may themselves be survivors, in one service 30% of nursing staff had some experience of abuse, which they may not have fully addressed.

Addressing Violence and Abuse through the NIMHE Violence Abuse and Mental Health Project
The aim of this project is to focus in policy and practice on tackling the root causes of mental illness in child sexual abuse, domestic violence and sexual violence. This will involve bringing together and building on existing work which has been developed largely in the voluntary sector by women's organisations and children's charities. This in turn will inform policy development, improve practice and support service development. In particular, the focus will be on ‘getting it right in practice’ and what is known to work for women and children victims of domestic violence, sexually victimised children and adult survivors of child sexual abuse, and abusers.

Catherine Itzin and Liz Mayne
National Institute for Mental Health in England
May 2003
APPENDIX FOUR: Presentation by Kyria Conner: Director of Woman’s Trust

I’d like to begin by saying how pleased and excited I am that this conference is happening and that we have this opportunity to discuss together the mental health needs of women who are affected by domestic violence. This has been an important gap in service provision for some time which an event like this can only help to further highlight.

I am also very pleased and a bit apprehensive to have the chance to speak to you today about the person centred / humanistic services that have been developed at Woman’s Trust because these services have been very successful and are helping women to make important changes in their lives. From our experience and monitoring so far we believe that the development of the service based upon these models and the effects we are seeing for women in these circumstances are highly significant. We very much welcome the opportunity to open up a discussion about what works, what doesn’t and share experiences. Woman’s Trust has developed this model through a careful process of listening to what women tell us they need, together with the fairly vast amount of information and research that is available on this subject, and the knowledge and expertise of workers with many years experience of this area. Of course there are many approaches but from the point of view of the client, which has to be our focus, this approach has had some very encouraging and effective results, more of which I will tell you about later in my talk.

I only hope I can do the subject justice, when I sat down to write about it I began to realise the enormity of trying to explain something in 15 minutes that has developed at Woman’s Trust over an 8 year period and by the founders of these models no doubt over many years – so it has not been an easy to write presentation but I will try to do my best to provide you with what will be a brief overview of this work and approach.

I’d like to preclude my talk by saying that when I refer to women I will be referring to women affected by domestic violence – this is to prevent me having to repeat the phrase endlessly during my presentation and also because I might repeat it so much it could be all you remember afterwards.

Anyhow, I would like to start by giving you an introduction to Woman’s Trust’s services and a bit of history of our development, as the fact that we are client-led and person centred / humanistic is no accident. I will then look at some of the key issues that have affected service development at Woman’s Trust and finish by showing where the person-centred humanistic approach links in. I’ll finish by reading some testimonials from women who have used Woman’s Trust’s services which will illustrate much better than I ever could what Woman’s Trust do for the women who use them.

Woman’s Trust was founded in 1995 by a group of local women including counsellors and therapists in response to requests from women affected by domestic violence for accessible, appropriate and supportive counselling and support services. Woman’s Trust is a woman-only woman-led specialist service provider and our aim is to empower women to make healthy choices in their lives and to live free from violence and abuse. All Woman’s Trust services have been set up in response to what women have told us they need and what works for them.

Woman’s Trust provides person-centre / humanistic services, including one to one counselling, weekly support groups, self-development workshops and referral to a wide range of service providers for women in London. We also provide childcare and a hardship fund to help with travel costs, WT services are free or low cost depending on circumstances and are primarily for women in the London area although we receive enquiries from women all over the UK and are able to provide some information on services for women UK-wide. Woman’s Trust also provides domestic violence training to professional workers in the public and private sector both in-house and an extensive programme of individual training days. My own training has been as a counsellor and Humanistic Integrative Arts
Psychotherapist and I have worked with the issue of domestic violence and other issues affecting women since 1990, the last 4 years being at Woman’s Trust.

So to start with why do women need a person centred humanistic service like Woman’s Trust? Woman’s Trust came into being because women described a gap in service provision and that was their difficulty in finding good, accessible and supportive counselling services. So it was obvious from the beginning that there was an area of need which for the following reasons was not being met elsewhere, and I may add that women still do experience all of the following difficulties.

Domestic violence is not an easy subject, it is not something that is comfortable to talk about and its something that we can prefer to keep at arms length, but it is we know from the statistics very common. It can and does happen to any woman no matter her background or status, it also involves a great deal of violence, and this is often not actual physical violence and fear and comes not from a stranger but from a person who is close and intimate. There is still a great deal of stigma attached to the subject, for many years our response has been to hide domestic violence, or to believe it happens only to a certain kind of person or that it is somehow provoked – none of which we now know, thanks to the research and work of agencies such as Woman’s Aid, to be true. In addition recent research shows that if women are supported, believed and given a positive response they are more likely to access services that can help them and their children escape violence and abuse.

So we can conclude from this that the response of others to women’s experience of domestic violence is a very important factor in considering the kind of service that can meet her needs.

What do women tell us the response is when they look for help? One of the most common questions asked both to women and to those who work in this sector is ‘why does she stay?’ or ‘why don’t you leave – you must be mad, stupid etc. to put up with a situation like that?’ Because awareness of this issue can be low for the reasons I have just touched upon and training is sparse, when disclosing their experience of domestic violence women are often made to feel responsible and somehow to blame for the situation.

A belief that is in many, many cases reinforced by the partner who is committing the abuse. A very high percentage of women using Woman’s Trust services report that they have been told by their partner that they have provoked the abusive behaviour and many women tell us that they do feel to blame for their situation. An important part of our work is to help women explore these damaging messages in an environment where they will not be reinforced.

Far and away the most common and disempowering aspect of an experience of domestic violence for women is that of feelings of self-blame and the judgement of others including those to whom she may turn for help. This was an important consideration in Woman’s Trust development of services.

Besides being believed and supported there are some other important aspects of this particular issue.

Women often find themselves caught between their family and friends and the abusive partner – their family and/or friends who want her to leave because they fear for her safety and cannot bear to witness the abuse and her partner who threatens to kill, maim or otherwise damage her if she does. What is she supposed to do and who can she turn to for support bearing in mind the very real risk to her personal safety?

At Woman’s Trust the role of the counsellor is seen as key to how successful she will be in accessing the help that she needs because the counsellor and her counselling sessions may be providing the only opportunity that she has to look at her options without being judged or pushed in one direction or another. The counsellor may be the only person who is actually listening to her and if you consider the reality she faces it is obvious that what she needs is once again empathic and positive support.
In addition to this it is vital to look at the reality for clients in this area because the reality is that women can loose their lives, can end up disabled, maimed or damaged. In a domestic violence relationship personal boundaries are eroded on a daily basis and although a lot of excellent therapeutic work can be accomplished in sessions counsellors need to have awareness of the dangers, be able to provide practical safety planning and reinforce boundaries where she feels that the situation is unsafe for her client. This is part of the counsellor’s role at Woman’s Trust and we see this as congruent to a person-centred humanistic approach. Safety planning is addressed in the first assessment stage or even at the point of contact, for instance on the phone if we become aware that the client is in danger.

There are a number of myths associated with domestic violence but one that is worth attending to in the context of counselling services is the powerful myth which can affect attitudes from many professionals to women seeking help. This is that women affected by domestic violence attract partners or are attracted to partners who will abuse them.

Research has shown the contrary and women who have had an experience of abuse or witnessed abuse as a child are no more likely to have an abusive relationship as an adult. Many of the women who use Woman’s Trust services tell us that they have never had a previous experience of an abusive partner or another related experiences.

**Which leads us to look further at the dynamics involved in domestic violence which are as many of you will know power and control** – women affected by domestic violence experience a partner who is abusive and controlling, who uses their power in the relationship to disempower and subjugate them. Women describe many different ways in which they may experience this, physical, psychological, emotional, sexual etc but the underlying dynamic is that of control.

Women often go to many lengths in order to adapt to suit their abusive partner – for instance changing the way she dresses, the friends she has, the places she goes to, her job, her studies etc the list could be endless but all of this behaviour is part of the belief that if she could somehow do it right she could prevent another violent and / or abusive incident.

To offer opportunities for women to come to terms with and heal from their experiences they need to have experiences where they are in control, where they receive a positive response which is not conditional and does not require them to adapt their behaviour in order to receive it. So this was another key aspect in the thinking when Woman’s Trust was developing services for women.

**So, this leads me to my next point which is this – there are other counselling services – do women need specialist services?**

Woman’s Trust works with women from every walk of life, some living in abusive and violent situations, some living in refuges, some who have resettled having escaped a violent relationship. Women tell us that another difficulty they face is the fact that should they have managed to leave and resettle their family, friends and often professionals involved find it difficult to understand why they may continue to experience emotional and psychological problems – after all the problem is now behind her – isn’t it? But it is actually at this time when women resettle or start new relationships that issues and experiences that have been shelved often resurface.

Whilst women are escaping violence they are coping with many crises, pressures and changes which do not allow the space or stability to explore what will be for many very disturbing and distressing memories and experiences. Women report, at the point when they have resettled or embarking on a new relationship, feelings of severe depression, anxiety, abandonment and grieving with very few places where they could safely explore and come to terms with their experiences. In some cases women are suffering from post traumatic stress disorder and some also can develop more enduring mental health problems should they not be able to access support.
Many free and low cost counselling services that women attempted to access have very long waiting lists, counsellors are often not familiar with the issue of domestic violence and how this affects women. Domestic violence is usually not included as part of psychotherapy and counsellor trainings and women tell us at Woman's Trust that this has had a significant effect on their experiences of counselling.

Other free counselling services such as those provided through the NHS were not always able to provide the support that women need. At GP surgeries counsellors can only offer a limited number of sessions, they may also be male. Women tell us that they have found counsellors unfamiliar with the issue of domestic violence and that they did not feel safe enough therefore to explore their experience. Some women have completed an entire programme of counselling sessions without having ever discussed their experience of domestic violence at all. There are other issues which also prevent women using these services, as clients have told counsellors:

"Several of my clients were too ashamed or worried about confidentiality to go to their GP for a referral, since this was often the same GP who would see the rest of their family and their neighbours. Some of my clients had fled to refuges some distance from home and had thus been cut off from their usual support networks. A few of my clients had attempted to get counselling from other sources but were waitlisted, disappointed in the service, or unable to continue for financial reasons." – WT Volunteer Counsellor.

The Woman’s Trust Model
The model that Woman’s Trust has adopted is based on a person centred / humanistic approach. As most of you will know the person centred model was developed by Carl Rogers and in this model the core conditions are the counsellor's unconditional positive regard toward the client, empathy and congruence. The counsellor comes from the stand point of belief in the clients own ability to explore her experiences, to interpret them, gain insights and solve problems, the client is the expert and within her lie the answers that she seeks. The humanistic approach is an amalgam of various psychotherapeutic approaches with the fundamental belief in the clients instinctive and natural urge towards good health and that which is life enhancing and beneficial. In both of these approaches it is the role of the counsellor to provide an authentic, warm and genuine relationship with the client to enable the safe exploration of her experiences. The therapeutic and healing opportunities are provided in the clients and counsellor’s journey and work together, which is seen as a joint undertaking.

What women tell Woman’s Trust they need
Women are often made to feel responsible for the situation and experience very high levels of self-blame and criticism. An important part of our work is to prevent reinforcement of these damaging feelings and the person-centred / humanistic approach enables us to do this by empowering the client and building up her confidence in her own abilities and insights.

Domestic violence damages self-confidence and self-esteem, women’s experiences are often over extended periods of time i.e. ten years plus. During this time the ongoing abuse and violence can cause women to lose belief in their own abilities to be self-determining and autonomous. The person centred / humanistic approach makes it clear to the client through the use of unconditional positive regard that the counsellor has faith in her ability to find the solutions that are right for her. This in turn offers the client an experience in which they are empowered and builds up confidence and self-esteem.

Women have also told us how important it is to them that the counsellor responds in an authentic way, that the counsellor believes her and supports her choices even if these are not those with which she agrees. This is congruent with the person centred / humanistic approach.
Women tell us they need a real relationship with the counsellor and that the counselling needs to provide an experience of a different, warm, creative and supportive relationship. Women described experiences where they said that the counsellor ‘didn’t talk to me’ which they felt did not help them to explore their experiences. This could also link to the very high levels of judgement that women experience from others.

I would like not to conclude with what clients say Woman’s Trust services are doing for them which is key to our belief in this work in this particular area, a belief that we were very pleased to have acknowledged when Woman’s Trust won the Community Care Award in the Mental Health category in 2002, and this I think illustrates why:

“I had been involved in a destructive relationship with a man that beat me up, tortured me physically and mentally … I was so frightened and terrified I couldn’t see another way out than suicide, eventually in total despair I managed to run away – he kept threatening me, I was convinced he was going to kill me … I sunk into the worst depression, a state of mind that separated me from the real world as a prison would do but with no way out. This went on for almost one year, the depression and the panic attacks … were getting worse, so I realised that I couldn’t make it on my own, that I needed help to move on from there, to overcome that experience, only then I had the courage to phone Woman’s Trust.

I have been in counselling for a few months now and I feel already a different person to the one I was when I started. My counsellor helped me so much, I was in need to talk about what happened, to free myself from that monster that was still growing inside myself like a tumour. She helped me and supported me in those very difficult times in which I had to go back to those horrible memories. I could not have done this without her, I was trapped in those painful memories as in a cage … I can now see why that happened to me and overcome my guilt, and I can also stop worrying about ending up again in a destructive relationships because I know now where that self-destructiveness was coming from. I can see everything much more clearly now and I stopped feeling guilty for what happened. I am positively dealing with my difficulties in relationships. I started making plans from my future, setting priorities and working in order to achieve what I believe are the best things for myself. I have now much more self-esteem than I ever had, I am learning how to look after myself, to recognise my needs and my desires and to value them, I wouldn’t have been able to get to this stage of my life on my own. In all my life this is the best thing I have ever done, I feel like I am renewed. It has been very difficult at some points and of course there are still many things that I will need to work on … but I am definitely on my way up! And it feels like I am in charge of my life, for the very first time.”

“My boyfriend had become physically and verbally abusive towards me. I was not able to out or see any friends as it would make him angry. I felt very isolated. I also had a miscarriage and felt that I could talk to no one. I thought everyone would think I was stupid for staying with him, but I thought it would stop soon. I felt quite desperate.

I went to counselling. I felt responsible for what happened because he was blaming me, I needed to know it wasn’t my fault. I needed to talk to someone who wouldn’t tell me I needed to sort my life out. It helps to know other people are in the same situation and that you’re not a freak.

I realised that bad things happen to people no matter who you are, I think I can give more support to friends who need it as I feel stronger than I ever did. I don’t feel like everything is pent up inside and I feel less angry towards other people. For the future I know most people can come through bad times and end up more positive so even if something similar or worse happened I can get through it.”
APPENDIX FIVE: Susan Austin: Clinical Services Manager: Women’s Therapy Centre

I am not going to give a case study as such, but would like to spend a few minutes talking about the contribution the psychoanalytic approach can make to thinking about domestic violence. I come from the Women’s Therapy Centre in Islington, a voluntary organisation which sets out to meet the individual and group psychotherapy needs of women who might not otherwise be able to obtain this kind of help. It is a self-referral service, with no catchment area restrictions.

I must stress that psychoanalytic therapy is not an alternative to other kinds of interventions and approaches to the complex problem of domestic violence, but it can be seen as an additional tool which may be of help.

In addition to the clinical work that goes on in the consulting room, this kind of thinking can be applied to work in other settings. For example, at the Women’s Therapy Centre, in addition to offering group and individual psychotherapy, we also consult with other agencies, such as a women’s refuge, for whom a psychodynamic perspective can support their more “hands on” work.

Psychoanalytic psychotherapists tend to focus on the internal world, as opposed to the external world.

This is not to dismiss external realities which it would be mad not to acknowledge: that domestic violence goes on and this requires interventions from a variety of disciplines. The psychoanalytic approach offers a particular way of taking seriously and developing with an individual a detailed understanding of their internal world, while acknowledging that external realities are at play. I should add that the Women’s Therapy Centre does not have an approach which is specifically designed to address issues of domestic violence, but rather we feel we have a conceptual and clinical framework which can help to contain and make sense of the experience of female clients who find themselves entangled in abusive relationships.

Perhaps I should describe what I mean by internal world. Put most simply, it is the world inside each of us. It is too easy to equate the external world with objectivity and the internal world with subjectivity, as after all we all experience and make sense of the world around us by reference to what we have inside ourselves.

It is crucial to bear in mind that what we carry inside us is unconscious as well as to some extent conscious. So what we make, for example, of being on the receiving end of violence in an intimate relationship, will depend on the internal world, with its particular history, climate, and ways of relating to oneself and others, which evolve from the very earliest in life of which we are not necessarily aware. A depressingly high proportion of the women we see have been subjected to emotional, sexual or physical abuse in childhood and no one will be surprised to hear that this will often emerge as a profound influence on their adult relationships.

So when is psychotherapy indicated? When history seems to have a way of repeating itself, for powerful but unclear “internal” reasons. People sometimes arrive in therapy with an idea of this. They may have noticed patterns over a long period, and for example have begun to wonder whether they somehow play a part in getting into situations which are contrary to what they know to be best for themselves. Or sometimes people present because they feel stuck with an irreconcilable conflict: for example whether to stay or leave a relationship.

Put in the barest terms, this kind of psychotherapy is about having help with one’s thinking, with the emphasis firmly on holding out for developing an individual’s own resources, rather than the therapist imparting advice or pearls of wisdom.
In this kind of work, the therapy relationship is the primary resource. It’s certainly a relationship which differs from others, unfolding as it does within an unusual setting and boundaries, which permit close observation and commentary in the consulting room of the ways in which an individual is relating or functioning.

For example, in a case which I am supervising, a woman came recently for assessment with a very violent relationship with her husband as the presenting problem. She expressed an anxiety at the outset that a therapist would tell her she should leave her husband. So rather than simply reassure her that this would not be the case, as therapists are not in the business of giving advice, my colleague was able to comment on the way this very troubled individual finds it hard to know her own mind at the moment, and tries to keep the peace internally by lodging a bit of her own thinking, namely the idea that she should leave, in someone else.

This exploration of the fine grain of what emerges in a session, whether as a general trend or from moment to moment, provides the first hand evidence for therapist and patient alike, which can form the basis of new thinking about other relationships, past and present.

The emphasis in psychotherapy is on thinking, putting things into words and developing insight, as opposed to things finding expression through actions or behaviour. The presenting problem will not necessarily turn out to be the main focus of the work, once underlying factors become clear. For example, in the case of the client who came with the anxiety that the therapist would tell her to leave her husband, it soon emerged that the difficulty was not one of the two-person relationship of the couple, but of a three-person relationship, with her mother in the picture as well. The focus soon shifted to profound difficulties around separation between mother and daughter, in which the client was completely entangled with really no awareness. So in a sense things began to be put back where they belonged, and in this case there were even some signs of relations becoming less volatile within her marriage.

While it’s true that arriving in psychotherapy can be a relief, as acute anxiety can get contained early on, it is not a quick fix. The standard contract at the WTC is 2 years once a week, with the occasional possibility of offering 5 years or twice weekly sessions. This is a balancing act between meeting clinical need and meting out limited resources.

If we are holding out for lasting psychological change and development beyond the duration of the psychotherapy, there needs to be an ongoing and substantial emotional experience of a different kind of thinking, relating and working through within the therapy relationship over a period of time. After all our clients tend to be up against a lot internally (as well as externally), and the ways they have of relating to themselves and others, including their particular repertoire of anxieties and defences which come into play in relating to themselves and others, will have taken their particular shape over a lifetime for very good reasons.
APPENDIX SIX: Rose Christie: Maya Centre

Who are we?
- The Maya Centre was founded 18 years ago as Islington women's Counselling Centre.
- We offer a free counselling service to women who meet our criteria which targets women who have very few external resources:
  - They must live locally, on a very low income, (most are living on benefits), have no experience of longer term counselling and not have a degree level education.
- We provide a free crèche facility, as many of our clients are mothers with few contacts in the community.
- We can offer up to 12 months individual counselling and we have an extensive range of group work available.
- We can offer women some choice in the ethnic origin of their counsellor. At present we have counsellors from Turkish, Somali, Irish, Afro-Caribbean, Bengali, Jewish and White British backgrounds.
- We work within a psychodynamic/psychoanalytic framework.
- We are a women only organisation.

Who do we serve?
The Maya Centre was set up with the aim of providing a professional therapeutic service to the deprived women of the local community and this we still do.

Why use a psychodynamic model?
The Psychodynamic model acknowledges that each of us is, in part, a product of our own individual history. How we relate to others as adults is profoundly influenced by our earliest experiences with those who cared for us and the environment, social and cultural setting, in which we lived. We live both in our external and internal worlds. The idea of the unconscious is central, as it is powerfully influential in determining how we perceive ourselves and others and the world around us. The way in which we relate to others is a product of our early relationship patterns and experiences and the echoes of these are present and active in our adult relationships. Psychodynamic counselling offers the possibility of exploring and understanding these patterns and their origins in the context of a secure and safe setting.

Most of the women who are referred to our project are at the very limit of their capacity to cope and continue with their lives. Many have been exposed to violence and abuse from their first months of life. The majority also have some history of inappropriate or abusive sexual experiences in childhood. Of the women seen within the Insight into Violence Project about 15 % have been forced to work as prostitutes, many are referred following attempted suicide and a third are long term users of the mental health system. Common presenting issues at the time of referral are recent suicide attempts, self-harming behaviours, self-neglect, substance abuse, and experience of emotional difficulties in relationships with others, including the mothering of their children. All the women within the project have suffered violence as a major aspect of their relationships. They come seeking emotional support and often with a great need to understand why they have, as adults, chosen relationships within which they have been abused.

At the Maya Centre we believe that psychoanalytic theory with its long established and constantly evolving depth of thinking about the origins and impact of deeply traumatic experience on individuals provides the most helpful ways of thinking about working with the women we see.

When working with this level of trauma it is important to make an initial careful assessment of each woman's needs and ask the question, ‘what can we expect to achieve within the constraints of what we can offer’. Our experience is that a surprising amount is possible if the woman is at a point where
she is able to engage with the process. I would see this process as having 3 phases, each of which has its own intrinsic value.

The first of these is to seek to engage and make a connection with the woman in a way within which they feel respected and valued.

The second, to begin to identify and highlight each woman's strengths, often these have become taken for granted or dismissed as not being important or real capabilities. One of the most common scenarios in the counselling room is one in which something good can be identified by the counsellor and described as such to the client who then denies, attacks and actually attempts to destroy its reality. I would think of this as stemming from long established experiences of having been seen by others in a negative way and this view then becoming that of the woman herself. It is often the whole of my work to enable a woman to allow herself to feel good about one perhaps quite small aspect of herself.

But for some women a third level of exploration is possible. This is one within which a woman can begin to become aware of her own aggressive impulses and explore how she relates to this part of herself. If she can begin to allow herself, first to acknowledge that this is part of how she can feel and accept this, then she can begin to free herself to feel her anger as a positive force related to her ability to defend herself and her children rather than a destructive, negative force with which to hurt and control others.

Here I have omitted a piece of clinical work with a client for reasons of confidentiality which was given as part of the verbal presentation.

**How do we reach women in violent relationships?**
The Maya Centre has a strong, long established network of links with other services within the community. These include GPs, and the whole range of mental health service providers. Approximately 75% of the total number of women referred to our service fit into the remit of the work of the violence project and a large proportion of these are victims of domestic violence.

In addition to our regular referrers we have a special active and ongoing relationship with the Woman’s Aid services in the Borough of Islington. Key workers know that they can readily refer to the project and are able to talk to women about the work that we do in an informed way. We have recently completed a set of 12 sessions of group work for the women in the refuge which was funded by Women’s Aid. It has been decided to continue this as the pilot was so successful. In Islington we also have a refuge for Latin American Women who also regularly refer women to the project. I also offer weekly supervision to the staff of this service. We have developing links with Domestic Violence Matters who are a first point of contact for women based in the local Police Station, and occasionally with the Police themselves who are eager to learn about of our work.
## APPENDIX SEVEN: Delegate List

<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
<th>Organisation</th>
<th>Telephone</th>
<th>Email</th>
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<tbody>
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<td>Austin</td>
<td>The Women's Therapy Centre</td>
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<td>Rachel</td>
<td>Carter</td>
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<td><a href="mailto:northgatewss@supanet.com">northgatewss@supanet.com</a></td>
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<tr>
<td>Nargis Yousuf</td>
<td>Yousuf</td>
<td>Enfield Saheli</td>
<td>020 8373 6219</td>
<td><a href="mailto:enfield_saheli@lineone.net">enfield_saheli@lineone.net</a></td>
</tr>
<tr>
<td>Suhraiya</td>
<td></td>
<td>The Safra Project</td>
<td>07941 659 320</td>
<td><a href="mailto:info@safraproject.org">info@safraproject.org</a></td>
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