Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Policy on Domestic, Sexual and Gender Based Violence

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HSE Policy on Domestic, Sexual and Gender based Violence within the context of existing statutory responsibilities. This policy highlights the significance of the domestic context for the occurrence of sexual violence.

The HSE Vision in relation to Domestic Violence and/or Sexual Violence is:

To implement an integrated and co-ordinated health sector response to Domestic Violence and/or Sexual Violence in order to:

- *Prevent Domestic Violence and/or Sexual Violence.*
- *Ensure that all families experiencing or at risk of experiencing Domestic Violence and/or Sexual Violence will receive a continuum of supports from health and community service providers who will understand the issue and who will recognise and respond to the impact this type of violence has on health.*

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Foreword

This HSE policy on Domestic Violence and/or Sexual Violence has been developed by a multidisciplinary HSE Working Group. Its aims and objectives are underpinned by the recommendations of a research report, *Domestic Violence and/or Sexual Violence in Ireland: an overview of national strategic policy and relevant international literature on prevention and intervention initiatives in service provision* (2008), which was completed by the National University of Ireland, Galway.

This policy supports our vision, which is to implement an integrated and co-ordinated health sector response to Domestic Violence and/or Sexual Violence. We aim to support prevention and early intervention, and we will ensure that all families experiencing or at risk of experiencing Domestic Violence and/or Sexual Violence will receive a continuum of supports from health and community service providers, who will understand the issue and who will recognise and respond to the impact such violence has on health.

Domestic Violence and/or Sexual Violence is a global health issue and is a leading cause of death for females aged 10-44 years. It has a devastating and long term impact on families. A health-focused analysis of Domestic Violence and/or Sexual Violence is crucial, not only because the consequences of such violence require a significant amount of healthcare system resources, but most importantly because the health care system is often the route through which victims seek to access supports.

The policy is designed to dovetail into the National Strategy developed by Cosc, the Office for Prevention of Domestic, Sexual and Gender-based Violence. The success of this strategy relies on a multi-agency approach, so that everybody plays their part in helping families create safer lives for themselves. The HSE recognises the crucial role it plays here, and its policy reflects these goals.

The content of the policy has been influenced by feedback from the non-governmental organisations who have tirelessly worked in this sector to secure better services and better lives for victims of domestic abuse.

This work is an important stepping stone towards an effective, multi-agency response to Domestic Violence and/or Sexual Violence that will create safer futures and better health for thousands of families as well as society as a whole.

Phil Garland,
Assistant National Director Children & Family Social Services,
Health Service Executive.
February 2010

1.0: Introduction

The HSE acknowledges that Domestic Violence and/or Sexual Violence (DV) is a serious health, social and human rights issue. It has a devastating impact on victims, perpetrators and their families. The abuse affects people across our society – from all walks of life, from all cultural, social and ethnic backgrounds and across all age groups. The majority of victims are women, but a significant number of men are affected and abuse also occurs in same-sex relationships. The Women's Health Council (2009) outline that international research literature shows that minority ethnic women are at increased risk of Domestic Violence and/or Sexual Violence, and that they face a range of barriers to accessing relevant services. According to the Census 2006, 12 per cent (n.246,441) of the female population in Ireland are members of minority ethnic groups, comprising a diverse range of women who may be asylum seekers, refugees, migrants, travellers, foreign students, members of new and established communities etc.

Violence in the home is particularly disturbing for children and we know from research that service responses to Domestic Violence and/or Sexual Violence and Child Protection can be disconnected from one another. A Practice Document on Domestic Violence and/or Sexual Violence – A Guide to working with children and families has been developed by the HSE Dublin South West Social Work Children and Families Department to better connect Domestic Violence and/or Sexual Violence and Child Protection issues. Child abuse and partner violence are estimated to overlap in 40 – 60% of cases (Garcia-Moreno (2005).

Domestic Violence and/or Sexual Violence has significant negative health effects, both in the short and long term for individuals, families and society. It is regarded as a complex social and health issue involving both a public health and criminal justice approach. The health burden from violence against women aged 15-44 is comparable to diseases such as HIV, tuberculosis, cancer and cardiovascular disease (Heist et al (1999). The health consequences of Domestic Violence and/or Sexual Violence reach far beyond immediate injury and therefore require knowledgeable care (Hagemann-White (2006).

International research data points to the huge cost incurred by the health services in terms of caring for women who have experienced violence. Limited Irish data is available on the health costs in relation to Domestic Violence and/or Sexual Violence, due to inadequate data collection mechanisms and the difficulty in estimating hidden personal and social costs. A US study in 2003 indicated that the largest component of Domestic Violence and/or Sexual Violence related costs was healthcare, which accounted for more than two-thirds of the total costs (NCIPC (2003). There is evidence that healthcare utilisation is up to 20% higher 5 years after the women's abuse has ceased, compared to women who have not experienced violence with an intimate partner (Rivara et al (2007). Irish estimates in relation to sick pay, lost productivity and wages point to a cost of €573million each year (Sherlock (2007).

The healthcare system is usually the first statutory agency where women experiencing Domestic and Sexual Violence seek support, and they often seek this support up to five years before they seek assistance elsewhere (Kelleher and O'Connor (1995). This policy document has not focused on counselling services for people affected by Domestic Violence and/or Sexual Violence, and/or Sexual Violence. It is recognised that a vast menu of counselling services are provided. The policy does focus on perpetrator accountability.

This policy document is relevant to all health workers and our interactions with the diverse range of men and women and settings in which we work. Additionally, we need to take into account the 'Principles for Best Practice for Service Delivery: An Interculturally Competent Approach to Meeting the Needs of Victims/Survivors of Gender-based Violence', The Women's Council (2009).

This Policy will need to be systematically implemented throughout all of our services and in conjunction with connected strategies and actions e.g. 'The HSE National Intercultural Health Strategy 2007-2012', 'Ireland's National Strategy to Address Female Genital Mutilation (2008)' and 'Translating Pain into Action', The Women's Health Council (2009).

The HSE was established in 2005 from 10 Regional Health Boards. This single Health System has provided an opportunity for improved co-ordination and planning for more long term, comprehensive and sustainable responses to address this issue more effectively.

This HSE policy identifies its responsibilities in relation to Domestic Violence and/or Sexual Violence in order to implement an integrated and co-ordinated health sector response to the issue. Clear leadership from within the Health Service is central to success in combination with effective inter-agency collaboration and co-operation.

Historically, Domestic Violence and/or Sexual Violence responses were provided by the Non Governmental Organisation (NGO) sector. These services developed incrementally and in an ad hoc manner as funding came from 8 (and later 10) Regional Health Boards.

A key message from the research commissioned by the HSE is that the approach to addressing Domestic and/or Sexual Violence must be multi agency and cross sectoral. In this regard, the HSE will work in close collaboration with agencies, both statutory and voluntary, and in particular with the Office of Cosc, which is about a whole government approach to addressing Domestic and Sexual Violence.

The policy focuses on a strengths-based approach to addressing Domestic Violence and/or Sexual Violence and is about delivering on 8 Key High-Level Goals and Actions:

1. To ensure that a comprehensive and appropriate Health Service response is delivered at all points of entry to the Health Service Executive.
2. To promote primary prevention of violence and invest in early intervention.
3. To provide best practice in all service provision to victims of Domestic Violence and/or Sexual Violence
4. To support Multi sectoral approaches.
5. To ensure the safeguarding of children in situations of Domestic Violence and/or Sexual Violence.
6. To ensure data collection as a basis for driving high quality and more relevant service development.
7. To monitor and evaluate service provision.
8. To ensure Consumer involvement.

Domestic Violence and/or Sexual Violence is a global health issue and is a leading cause of death for females aged 10-44 years.

García-Moreno et al., 2005

1.1: Purpose:

This HSE policy sets out a vision for the future focus and work of the HSE over the next three years. The Policy outlines goals and actions on preventive measures and on the provision of a co-ordinated and integrated service for victims and their children.

In the document, commissioned by the HSE in 2007, "Domestic Violence and/or Sexual Violence in Ireland: an overview of national strategic policy and relevant international literature on prevention and intervention initiatives in service provision", the importance of the role of health professionals in recognising and responding to Domestic Violence and/or Sexual Violence was highlighted (Kearns, Coen & Canavan (2007). Along side this, the review of the Sexual Assault Treatment Units (SATU) services commissioned by the National Steering Committee in 2005 emphasised the role of health professionals.

1.2: The HSE Vision in relation to Domestic Violence and/or Sexual Violence is that:

We aim to implement an integrated and co-ordinated health sector response to Domestic Violence and/or Sexual Violence in order to:

- ***Prevent Domestic Violence and/or Sexual Violence and***
- ***Ensure that all families experiencing or at risk of experiencing Domestic Violence and/or Sexual Violence will receive a continuum of supports from health and community service providers who will understand the issue, and who will recognise and respond to the impact this type of violence has on health.***

1.3: Consultation:

In 2005, the HSE set out to establish a cohesive direction for staff and agents of the HSE in its approach to the management of Domestic Violence and/or Sexual Violence.

A HSE working group came together to agree a national approach in which the overriding focus was to advance evidence based service responses. The group commissioned the services of the Children and Family Research Unit in NUIG to develop a document that would inform policy and planning regarding Domestic Violence and/or Sexual Violence. The NUIG document "Domestic Violence and/or Sexual Violence in Ireland: an overview of national strategic policy and relevant international literature on prevention and intervention initiatives in service provision (Kearns et al, 2007)" has greatly assisted in the formation of this policy. This document has been developed through consultation with key stakeholders, including Government Departments and Agencies, Non-Governmental Organisations and Service users.

1.4: Structures, Implementation and proposed linkages:

The National Task Force on Violence Against Women (1997) was a major landmark in the evolution of a response to the issue of violence against women in Ireland. The report consolidated both national and international thinking on violence against women and set out a framework to build a co-ordinated response to violence against women in Ireland.

In December 1997, the government established the National Steering Committee (NSC) to implement the recommendations of the Task Force and to inform government policy. Five Government Departments as well as relevant non-governmental organisations and nominated experts in the area of violence against women

are represented on the committee(See Appendix A for current remit of NSC).
Eight Regional Planning Committees (RPCs) were established by the end of 1998, one in each of the former Health Board areas (See Appendix B for remit of the RPCs).

These committees, which were disbanded in 2008, (some continued to meet) were a useful mechanism for regional interagency communications.

A layer between the NSC and the RPCs was the National Forum which again comprised of representatives from the relevant government departments, the NGO sector and a representative from each of the RPCs. The NSC and RPCs were the main institutional mechanisms in place to advance the recommendations of the National Task Force Report.

Cosc, the National Office for Prevention of Domestic, Sexual and Gender based Violence was set up in June 2007. Part of the remit of the office is to provide enhanced co-ordination and leadership to address the problem of Domestic and/or Sexual Violence.

Their role includes:

- Working with organisations in the sector to ensure the delivery of well co-ordinated services for victims.
- Raising awareness about the level and impact of these crimes and of local services that are available for victims.
- Developing strategies for preventing and dealing with these crimes in line with international practice.

New Structures:

Following a review of the role, remit and structure of the RPCs over the past ten years, the HSE and Cosc have agreed to rename, refocus and re constitute the regional committees. The role of the new Regional Advisory Committees (RAC) on Domestic and Sexual Violence is to

- Promote effective linkages;
- Develop and promote interagency collaboration;
- Foster working partnerships within and between the statutory and non statutory service providers;
- Progress the implementation of the national Cosc Domestic Violence and/or Sexual Violence Strategy.

Multisectoral approaches:

As Domestic Violence and/or Sexual Violence is a complex social issue involving not only a public health approach but a criminal justice approach, the involvement of many sectors and disciplines is required. Ellsberg (2006) notes that health programmes must co-ordinate closely with the other social partners at national and international level. At a planning level, the health sector will actively work with relevant stakeholders to ensure more appropriate responses and positive outcomes. Healthcare providers must also take into consideration the non-medical needs of the injured and connect with the sectors meeting those needs. Programmes for the perpetrators of violence will require close co-operation between Health and Justice Departments. These initiatives will require the creation of formal referral procedures and protocols.

2.0: Defining Domestic Violence and/or Sexual Violence

The National Task Force on Violence against Women in 1997 formulated recommendations on the future direction of Domestic Violence and/or Sexual Violence policy in Ireland. The terms "Domestic Violence" and "Intimate Partner Violence" are both used to describe violence between two adults in an intimate relationship. The comprehensive Task Force definition of Domestic Violence and/or Sexual Violence is generally accepted as the standard definition in use in Ireland today:

Domestic Violence refers to the use of physical or emotional force or threat of physical force, including sexual violence, in close adult relationships. This includes violence perpetrated by a spouse, partner, son, daughter or any other person who has a close or blood relationship with the victim. The term "domestic violence" goes beyond actual physical violence. It can also involve emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone". (Report of the Task Force on Violence Against Women 1997).

The National Task Force definition of Domestic Violence and the existing Irish legislation on Domestic Violence and/or Sexual Violence is gender-neutral. However, the majority of victims are women, but a significant number of men are affected and abuse also occurs in same-sex relationships. Additionally, there are other forms of violence experienced by women, men and children in Ireland today e.g. trafficking, forced prostitution and female genital mutilation.

3.0: The Prevalence of Domestic Violence and/or Sexual Violence in Ireland: A Review of the Statistics

Research has shown that violence against women is endemic in many countries.
International evidence demonstrates that the context, pattern, intent and impact of Domestic Violence and/or Sexual Violence need to be measured to give a true picture of prevalence.
The following data has been sourced from the Cosc National website.

Sexual Violence

- 1 in 5 girls and 1 in 6 boys in Ireland experience contact sexual abuse in childhood
- 42% of women and 28% of men experienced some form of sexual abuse or assault in their lifetime

Source: McGee et al (2002).

Domestic Violence and/or Sexual Violence

- 15% of women and 6% of men have experienced severely abusive behaviour from a partner
- 11% of the Irish population have experienced a pattern of behaviour with an actual or potential severe impact on their lives
- 29% of women and 26% of men suffer domestic abuse when severe abuse and minor incidents are combined
- 29% of women and only 5% of men report severe abusive behaviour to the Garda Síochána

Source: McGee et al (2002)

- The Women's Health Council (2009), in their survey of GPs to determine service provision and barriers for minority ethnic women in Ireland, found that one-third of GPs reported that at least one disclosure of Domestic Violence and/or Sexual Violence had been made to them by a minority ethnic woman at some stage in the past. For 93% of GPs who responded to the study, such disclosures had been made in the previous year. The number of disclosures made to these GPs ranged from one to twenty. The figures indicate a considerable population of minority ethnic women who are victims/survivors of Domestic Violence and/or Sexual Violence

(See Appendix C for more detailed statistical information on the prevalence of Domestic Violence and/or Sexual Violence.)

Current Service Provision:

The HSE fund a range of services under direct Domestic Violence and/or Sexual Violence Funding:

The HSE fund 19 Refuges, 25 Support Services and 16 Rape Crisis Centres as well as Safe Ireland, and the Rape Crisis Network of Ireland (RCNI). The role of these Networks is to:

- Develop, coordinate and implement best practice standards and projects including:
  - National projects such as nationally standardised data collection (with member and non-member services)
  - Models of outcomes evaluation
  - Models of best practice service delivery which include minimum standards
- Support member services to reach those standards and participate in the projects in accordance with nationally agreed best practice standards
- Influence national policy

Total funding allocation from the HSE to the sector is €20.5 million (List of services, Appendix D and E). The HSE fund a number of Sexual Assault Treatment Units (SATUs). In 2007 an additional €1.5 million was allocated to the SATUs to assist towards the implementation of the recommendations of the national review which was commissioned by the Department of Health and Children.

Additionally, the HSE through its primary care and hospital services manage the significant impact of Domestic Violence and/or Sexual Violence on the health and well-being of victims. HSE staff and allied health professionals e.g. Primary Care Teams, Practice Nurses, General Practitioners, Family Support Workers, Social Workers, Community Welfare Officers, Public Health Nurses, Hospital Doctors and Nurses etc. provide a range of services to people who experience Domestic Violence and/or Sexual Violence. It is important to recognise the huge and valuable contribution that all of these services and practitioners make in the area of Domestic Violence and/or Sexual Violence.

4.0 National and International Policy Context:

This HSE Policy has been developed, based on an analysis of evidence-based best practice in Domestic Violence and/or Sexual Violence Service provision, carried out by Kearns et al (2007): "Domestic Violence in Ireland: an overview of national strategic policy and relevant international literature on prevention and intervention initiatives in service provision" (see Appendix F for outline).

4.1: Core Principles of Good Practice:

Central to strategic planning and provision of prevention and intervention initiatives regarding Domestic Violence and/or Sexual Violence are the principles which underlie such an approach. The following are a series of core principles extracted from several relevant documents pertaining to Domestic Violence and/or Sexual Violence, which will be core to all work in the HSE.

PRINCIPLES	DESCRIPTION
Human rights	Domestic Violence and/or Sexual Violence is a human rights issue affecting both men and women; however, the vast majority of victims are women.
Safety	The primary objective must be securing the safety of people experiencing Domestic Violence and/or Sexual Violence, and ensuring service providers are not put in a potentially violent situation.
Empowerment	Supports should help victims of Domestic Violence and/or Sexual Violence to determine their own needs by involving them centrally in decision-making and choices affecting them, and supporting them with their choices to move from crisis to safety, independence and self-help.
Privacy and Confidentiality	Consultation and interaction with Domestic Violence and/or Sexual Violence victims should be respectful of privacy and confidentiality and cognisant of the real dangers if these are breached.
Responsibility	An act of violence committed against any person is an offence punishable by law and must be treated as such. Perpetrators must be held accountable for their actions and bear the consequences.
Multisectoral and Multi-dimensional collaboration	Approaches involving a myriad of agencies and disciplines are required to adequately address the collaboration and complexity of the problem.
Skills base and awareness	Those responding to Domestic Violence and/or Sexual Violence must have appropriate training and on-going education to do so. Public awareness of the issue is another important consideration.
Respect	A supportive and understanding ethos should underpin all service responses thereby building a culture of empathy and trust amongst Domestic Violence and/or Sexual Violence victims and those providing interventions.
Diversity	Service responses should be mindful of the culturally diverse nature of the population and should adopt interculturally competent approaches to meeting the needs of those who have experienced DV (see: The Women's Health Council (2009): Principles of Best Practice for Service Delivery: An Interculturally Competent Approach to Meeting the Needs of Victims/Survivors of Gender-based Violence).

Finally, in order to achieve the highest quality service standards, a culture of continuous monitoring and evaluation needs to be embedded in all organisations delivering Domestic Violence and/or Sexual Violence services. Monitoring and evaluation processes require that all Domestic Violence and/or Sexual Violence services should have an outcome or impact focus against which effectiveness of all interventions can be measured.

Violence in the home is particularly disturbing for children....

5.0: High Level Goals and Actions

Based on the literature review of national and international best practice, the service information and practice experience, the HSE have prioritised the following nine headings which form the basis of HSE policy:

1. **To ensure that a comprehensive and appropriate Health Service response is delivered at all points of entry to the Health Service Executive.**

   Context:

   People experiencing domestic or sexual violence access the services via many routes, e.g. family doctor, Accident and Emergency, reproductive health, mental health, family planning, sexual health, addiction services, paediatric services etc. Therefore a comprehensive and appropriate health sector response is required from the health services at all points of entry. To ensure victim safety, staff need to know the signs, indications and consequences of abuse, know how to respond in an appropriate way and be able to make referrals, as appropriate, to a specialist service, where people will be supported to make changes in their lives at a pace that suits their situation.

   A significant barrier in preventing and intervening in Domestic Violence and/or Sexual Violence is the lack of appropriate education and training for frontline health care professionals. It is of the highest importance that all relevant professionals receive basic knowledge about the nature of the problem during their initial education/training. Training will focus on increasing awareness regarding victim safety, the nature and consequences of abuse and the need for adopting strengths-based, effective approaches. Specific training and forensic skills are required to deal with sexual violence. Training will also aim to highlight the need to include Domestic Violence and/or Sexual Violence firmly on the agenda of all front line health professionals and to equip them with basic skills and tools to enable them to recognise, respond and refer (the 3Rs).

Recognise: Recognise the signs, indications, nature and consequences of abuse
Respond: Know how to respond appropriately and effectively to ensure victim safety
Refer: Know how to make a referral to an appropriate service/agency

Additionally, continuing education is needed both for those whose initial training did not address this topic, and for all practitioners at different stages of their professional lives. This should include more in-depth education, specifically on methods of prevention and intervention (Hagemann-White (2006)).

2. To Promote primary prevention and invest in early intervention

Context:

Primary Prevention refers to preventing Domestic Violence and/or Sexual Violence before it occurs. Promoting Primary Prevention involves supporting the development and evaluation of evidence based programmes specifically designed to prevent Domestic Violence and/or Sexual Violence. Successful primary prevention programmes will compliment responses from all sectors aimed at discouraging Domestic Violence and/or Sexual Violence while promoting gender and social equality. Specific measures which the HSE will engage with inter-sectorally include:

- Investing in early interventions (Home visitation/school based awareness and skills development/public education).
- Increasing adult involvement in the activities of children and young people.
- Training and educating health professionals to raise awareness of Domestic Violence and/or Sexual Violence and appropriate responses.
- Working with Cosc to support multisectoral responses aimed at strengthening local communities.
- Working with Cosc to support multisectoral responses aimed at changing cultural norms.
- Working with relevant Government Departments and Agencies, as well as relevant NGOs to support multisectoral responses aimed at reducing income inequality.
- Working with Cosc to support improved criminal justice and social welfare responses.

Furthermore violence prevention programmes targeted at children or those who influence them during early development show greater promise than those which target adults. Such early intervention has the potential to shape the attitudes, knowledge, and behaviour of children while they are more open to positive influences. This in turn can affect lifelong behaviours (Kearns et al (2008).

3. To provide best practice in all service provision to victims of Domestic Violence.

Context:

The majority of women/men who are experiencing Domestic Violence and/or Sexual Violence wish to remain at home with adequate protection. The HSE policy is to enable people to remain safely in their own homes if this is their wish and appropriate to their needs. This is in the context of a co-ordinated strategy that places people and their children at the centre and in the context of comprehensive assessment of risk. When remaining in their own home is no longer an option, a primary requirement of safety is ensuring immediate access to temporary accommodation on a 24/7 basis in agreed local accommodation provision. Gathering the views and respecting the wishes of victims of Domestic Violence and/or Sexual Violence is of critical importance to ensuring that crisis accommodation continues to meet the needs of service users. The function of transitional housing in the continuum of care requires further analysis.

4. To support multisectoral working.

Context:

As Domestic Violence and/or Sexual Violence is a complex social issue involving not only a public health approach but a criminal justice approach, the involvement of many sectors and disciplines is required. Ellsberg (2006) notes that health programs must co-ordinate closely with other social care professionals at national and international level. At a planning level, the health sector will actively work with relevant stakeholders to ensure more appropriate responses and positive outcomes. Healthcare providers must also take into consideration the non medical needs of the injured and connect with the sectors meeting those needs. Programmes for the perpetrators of violence will require close co-operation between Health and Justice Departments. These initiatives will require the creation of formal referral procedures and protocols.

5. To ensure the safeguarding of children in situations of Domestic Violence and/or Sexual Violence.

Context:

International research has indicated a strong correlation between Domestic Violence and/or Sexual Violence and child abuse, therefore it is important to consider the impact of Domestic Violence and/or Sexual Violence on children and the implication this has for both Domestic Violence and/or Sexual Violence and Child Protection services in the future. The HSE will be working to deliver on its key actions in this regard outlined in this Policy document and the actions within the Ryan Report Implementation Plan (2009).

6. To ensure data collection as a basis for driving high quality and more relevant service development.

Context:

The collection, management and sharing of data are central to the development of effective strategies for tackling Domestic and Sexual Violence. This process will enable the Health Sector and others to plan more targeted and effective responses based on sound evidence. Data gathered by the Health Service must complement data gathered by other Departments so that the achievement towards nationally set outcomes may be monitored effectively.

7. To Monitor and evaluate service provision.

Context:

In order to achieve the highest quality of service standards a culture of continuous monitoring and evaluation needs to be embedded in the HSE and funded services. A consistent theme in the literature is the evaluative work on the effects and effectiveness of various Domestic Violence and/or Sexual Violence interventions. Service development should be built from a strong evidence base around what works best in Domestic Violence and/or Sexual Violence practice.

8. To ensure Consumer involvement.

Context:

Involving people who experience Domestic Violence and/or Sexual Violence in service planning, design, delivery and evaluation will guide the development of initiatives with service users. In this way the HSE will be working from a client centred perspective and will be ensuring that the experiences of people who seek help and support from Health Professionals is positive. Clients involvement at every step of service development will diminish the risk of experiencing the institutional barriers that people too often report.

6.0: High level Goals, Objectives, Actions, Outcomes, Performance Indicators / Targets / Timeframes and Who is responsible?

Abbreviations

Please note for the purpose of this document Domestic Violence and/or Sexual Violence refers to both Domestic Violence and/or Sexual Violence.

Health Service Executive	HSE
Network of Refuges/Support Services, Rape Crisis Network Ireland	Networks
Health Information & Quality Authority	HIQA
Recognise, Respond, Refer	3Rs
Ambulance and Emergency Service	A/E
Local Health Office	LHO
Department of Justice, Equality and Law Reform	DJELR

HIGH LEVEL GOAL 1:
AIM: To ensure that a comprehensive and appropriate health service response is delivered at all points of entry to the Health Service Executive (HSE).

Objective 1:
To ensure that all HSE frontline staff are aware of their obligations to recognise and respond to Domestic Violence and/or Sexual Violence.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To disseminate the National HSE Policy on Domestic and Sexual Violence and enclosed National Template (to facilitate staff to Recognise, Respond and Refer to Domestic Violence and/or Sexual Violence issues) to all staff in the HSE, with the support of Senior Management (see Appendix E).	A dissemination plan is agreed and implemented.	2010-2011	Number of staff who received the Policy and Template in each LHO area.	National Network of Trainers, Children & Family Services, HSE, Network & Child Care Managers on behalf of Local Health Managers	All HSE staff receive policy and Template Recognise Respond, Refer.	1

Objective 2:
To deliver training in Domestic Violence and/or Sexual Violence to all HSE frontline staff.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
• To agree and deliver a suite of National training packs for all front line staff in different healthcare settings, from agreed existing materials. • To Implement the recommendations on standardization of Sexual Assault Services as set out in the National Review of SATUS.	All staff trained in the 3Rs to recognise, respond and refer underpinned by user- friendly information on local area services available and local action groups.	2010-2011	Number of staff trained by LHO.	National Network of Trainers, Children & Family Services, HSE, Cosc	Flexible modules delivered to 2000 front-line staff by the end of 2010	1

Objective 3:
To promote community and organisational awareness regarding Domestic Violence and/or Sexual Violence.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To agree in Partnership with the Networks & Cosc a national awareness training pack for all community groups and organisations that receive funding from the HSE. This pack will include the 3Rs.	Agreed national training pack. Training delivered.	2010	Number of groups who attended the training by LHO area.	HSE Designated Officers, Cosc, Networks HIQA	50 groups trained.	1

HIGH LEVEL GOAL 2:
AIM: To promote primary prevention of Domestic Violence and/or Sexual Violence and invest in early intervention.

Objective 1:
To ensure screening for Domestic Violence and/or Sexual Violence in different healthcare contexts/environments and with specific target groups.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To agree an assessment form with DV questions for routine use by all staff in different community and hospital contexts / environments and with specific target groups: • Child Protection & Welfare. • Pregnant women. • Addiction services. • A/E services. • Mental Health services. • Community Welfare Services. • Primary Care Services • Maternity Services. • Social Inclusion Services etc.	All staff will use the assessment form at first contact in different contexts/ environments and with specific target groups.	2010-2011	Number of staff who received the assessment form at the training in each Operational Region. No. of screening forms completed.	National Network of Trainers, Children & Family Services, HSE and Designated Officers, Networks.	2000 trained in use of screening tool.	1

HIGH LEVEL GOAL 3:

AIM: To provide best practice in all services to victims of Domestic Violence and/or Sexual Violence

Objective 1:

To develop standardisation within Specialist Domestic Violence and/or Sexual Violence and Sexual Violence Services.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To work in partnership with the National Networks to develop standardisation within specialist Domestic Violence and/or Sexual Violence services. To incorporate the standards into Service Level Agreements both for national organisations and local organizations.	Standardisation agreed and developed in key target areas.	2010-2011	Number of standards in place in all HSE funded services. Standards incorporated into SLAs.	HSE, HIQA, Networks, Cosc Agreed regional person to oversee implementation of national standards.	Standards developed in specialist DV services.	2

Objective 2:

To develop a local co-ordinated strategy to ensure that women/men and children who have experienced Domestic Violence and/or Sexual Violence can choose to remain safely in their own homes if that is their wish and if it is safe for them to do so. This objective is in the context of co-ordinated community services in which the safety of the victim and their children in paramount.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
In partnership with those who have experienced Domestic Violence and/or Sexual Violence, agree a comprehensive risk assessment tool and safety tool which will assess women / men and children's support and safety needs to remain safely in their own homes. This is in the context that the safety and welfare of children is paramount. To continue to provide a range of support and accomodation options, particularly bearing in mind the needs of minority ethnic women living in direct provision accommodation. To work in partnership with Department of Justice Equality and Law Reform. To remove perpetrators from the home and not the victim, when this is considered the viable course of action. DJELR provide Perpetrator programmes in line with best practice and required enforcement.	A comprehensive risk assessment tool will be agreed from existing materials and piloted in 2 areas of the country. A safety tool will be agreed from agreed existing materials and piloted in 2 areas of the country. Inter-agency Partnership agreements will be established in 2 pilot sites with key stakeholders to keep women / men and children safely at home and/or to provide a range of support and accommodation options, in conjunction with the NGO sector. Perpetrator programmes developed and delivered in co-operation with the Dept. JELR and in line with existing best practice.	2010-2012	Number of women/ men and children who safely stay in their homes by pilot area. No. of risk assessments completed in each pilot area. No. of safety assessments completed in each pilot area. No. of women / men remaining in their own homes. No of women / men attending perpetrator programs in each LHO and outcomes of same.	HSE, Dept. JELR, Networks, Cosc	No. of Risk Assessments Carried out. No. of assessments completed Activity in perpetrator programmes.	2

HIGH LEVEL GOAL 4:

AIM: To support multisectoral approaches to Domestic Violence and/or Sexual Violence.

Objective 1:

To ensure that Service Level Agreements/or Grant Aid Agreements are in place with all services funded by the HSE in line with the HSE policy position and Cosc strategy.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To ensure that Service Level Agreements/or Grant Aid Agreements are in place with all services funded by the HSE.	SLAs & GAA will reflect best practice against standards and will include the needs of minority ethnic communities. Designated Officers to take a lead role in SLA/GAAs.	2010-2011	Number of organisations with SLA/GAA in place per HSE Operational Region.	HSE, HIQA, Networks, Cosc.	No. of SLAs in place as a % of the required number by HSE Operational Region	1

Objective 1:
At a planning level, the health sector will actively work with relevant stakeholders to ensure more appropriate responses and positive outcomes.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
Members of the Regional Advisory Committees (RACs) under the umbrella of the NCS and Cosc will work together to create formal referral procedures and protocols which will facilitate cross sectoral co-operation	Each member of staff is mandated by their head of discipline to work with other agencies in an integrated way in the interest of client outcomes.	2010-2012	Procedures and protocols will be developed and a formal structure put in place by the end of 2010 to facilitate multi agency co-operation around service delivery.	HSE, Cosc. Networks, Other Agencies.	Procedures & Protocols in place	1
To progress the implementation of the national actions with all member organisations of the RAC as per the Cosc National Strategy	National actions implemented in the area of Domestic Violence and/or Sexual Violence.	2010-2013	Number of national actions delivered by the HSE funded services.	HSE, Cosc. Networks, Other Agencies.	% of national actions implemented per Operational Region.	2

HIGH LEVEL GOAL 5:

AIM: To ensure the protection and welfare of all children in situations of Domestic Violence and/or Sexual Violence.

Objective 1:

To ensure best practice in child protection and welfare of all children in situations of Domestic Violence and/or Sexual Violence: The Welfare of Children is of paramount importance.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To ensure that the Children First Guidelines and Procedures are being adhered to by all specialist Domestic Violence and/or Sexual Violence Services. Children's welfare and protection issues in Domestic Violence and/or Sexual Violence services take precedence and should be referred to the Child Protection Social Work Services in the HSE. The safety and welfare of children is paramount.	Children First Guidelines and Procedures are adhered to by all specialist Domestic Violence and/or Sexual Violence Services. Best Practice Guidance agreed and outlined, taking into account existing examples of best practice.	2010-2011	Child Protection policies in place in all HSE funded services, based on requirements of Children First and Duty to Care. Best Practice Guidance outlined and disseminated and factored into SLAs.	HSE & the Networks	HSE personnel and all organisations funded by the HSE are clear about their responsibilities in relation to Children First Guidelines.	1

HIGH LEVEL GOAL 5: continued

AIM: To ensure the protection and welfare of all children in situations of Domestic Violence and/or Sexual Violence.

Objective 1:

To ensure best practice in child protection and welfare of all children in situations of Domestic Violence and/or Sexual Violence: The Welfare of Children is of paramount importance.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To ensure that the assessment form for children at risk will contain key questions regarding Domestic Violence and Sexual Violence. To develop and disseminate guidelines on working with children in Domestic Violence and/or Sexual Violence situations. (from existing materials)	The assessment form for children at risk will contain key questions regarding Domestic Violence and Sexual Violence.	2010-2011	No. of children identified at risk regarding Domestic Violence and Sexual Violence are followed up.	HSE & the Networks	Assessment form for children at risk will contain key questions regarding Domestic Violence and Sexual Violence.	1
To ensure that the assessment form for children at risk regarding Domestic Violence and Sexual Violence contains questions regarding children's welfare.	All Domestic Violence and/or Sexual Violence screening and assessment tools will contain questions regarding children's welfare.	2010-2011	No. of children identified at risk regarding Domestic Violence and Sexual Violence are followed up.	HSE & the Netowrks	All Domestic Violence and/or Sexual Violence screening and assessment tools will contain questions regarding children's welfare.	1

HIGH LEVEL GOAL 6:
AIM: To ensure data collection is fully developed as a basis for driving high quality and more targeted and evidence based service provision.
Objective 1:
To put in place a systematic data collection system for Domestic Violence and/or Sexual Violence.

Action	Outcome	Timeframe	Performance Indicator	Responsible	Target	Priority
To develop, agree, and implement with Cosc, HIQA, and the Networks a systematic data collection for use in HSE and funded services. To agree a mechanism for dissemination of results of analysis to influence service planning for Domestic Violence and/or Sexual Violence Services.	Core data set agreed and collected, with ethnic identifier. Responsible persons assigned in each LHO area to collect data with national collation. Yearly analysis of data with a view to reconfiguration of service provision to meet identified need, based on evidence-based best practice.	2010-2011	Standardised data collected and analysed. Mechanism for dissemination of results of analysis to influence service planning agreed.	HSE, HIQA, Cosc, Networks.	Comprehensive data collection and analysis. Mechanism agreed for Service planning based on analysis of current situation and identified needs.	1
To use data effectively to evaluate the outcomes of service delivery.	Outcomes and performance indicators agreed and analysed and incorporated into SLAs.	2010-2011	Agreed outcomes established. Baseline set with indicator data. Evaluation nitiated.	HSE, HIQA, Cosc, Networks.	Performance Indicators illustrate progress against outcomes.	1

Objective 1:
To make explicit, available and accessible information on local service provision.

Action	Outcome	Timeframe	Performance Indicators	Responsible	Target	Priority
To make information on service provision accessible in user-friendly formats.	Use of Cosc website, and local directories and HSE website.	2010	Availability of local directories and Cosc website.	HSE, Cosc, HIQA, Networks, Citizens Information Centre.	User-friendly information on Domestic Violence and Sexual Violence service provision available in each LHO.	1

HIGH LEVEL GOAL 7:

AIM: To monitor and evaluate service provision

Objective 1:

To ensure accountability at national, regional and local level for assessment, planning, implementation and evaluation of service provision in Domestic Violence and/or Sexual Violence.

Action	Outcome	Timeframe	Performance Indicators	Responsible	Target	Priority
The HSE in partnership with the Networks and service providers will establish clear roles, reporting relationships, and levels of accountability (see High Level Goal 4).	A nominated HSE person in each Operational Region will be responsible for all Domestic Violence and Sexual Violence service level agreements and for local co-ordination of service responses.	2010-2013	Nominated person in each Operational Region responsible for negotiating and monitoring all Domestic Violence and Sexual Violence service level agreements and service co-ordination.	HSE	Nominated person per Operational Region identified. 100% of SLAs monitored.	1

Objective 2:

To monitor the implementation of the HSE Policy document.

Action	Outcome	Timeframe	Performance Indicators	Responsible	Target	Priority
To work in partnership with Consumer Affairs, HIQA, Cosc, the Networks to deliver the actions and to set up a HSE Working Group to monitor the implementation of the HSE Policy.	The strategy and actions agreed will be delivered Monitoring Group established.	2010-2013	No. of actions implemented	HSE, HIQA, Cosc, Networks.	% of actions implemented.	2

HIGH LEVEL GOAL 8:

AIM: To ensure consumer involvement in Domestic Violence and/or Sexual Violence service provision in line with the new HSE Strategy on Service User Involvement (2008).

Objective 1:

To actively promote participative consumer involvement at all levels of service design, development, delivery, and evaluation.

Action	Outcome	Timeframe	Performance Indicators	Responsible	Target	Priority
The HSE and the Networks will ensure that consumers are actively involved in the design, delivery and evaluation of services. Particular attention should be given to ensuring the participation of minority ethnic communities	Consumers are actively engaged in design, delivery and evaluation of the services.	2010-2013	Consumers involved in each LHO Region, the RACs and at policy level. SLAs reflect active consumer input and involvement.	HSE Designated Officers/Co-Ordinators for Domestic Violence and/or Sexual Violence services, LHMs, Networks. Representatives of diverse communities.	Best Practice examples shared.	1
To ensure that the principles of best practice for service delivery: An interculturally competent approach to meeting the needs of Victims/Survivors of Gender Based Violence (The Women's Council (2009) are implemented in practice.	Staff competent in inter-cultural practices.	2010-2013	Principles disseminated to front-line staff and incorporated into training packages.		Principles disseminated to front-line staff and incorporated into training packages.	1

In Ireland, the most recent survey on domestic violence found that 15% of women (or about 1 in 7) and 6% of men (or 1 in 16) have experienced severely abusive behaviour from an intimate partner at some time in their lives.

(Watson and Parsons, 2005)

APPENDICES:

Appendix A: Remit of National Steering Committee: Domestic Violence and/or Sexual Violence

The remit of the Committee is to:

- advise on the development and implementation of policies and guidelines for action on domestic and sexual violence against women including those concerning services and supports, perpetrators, and State intervention;
- advise on research to be undertaken and needs assessments nationally;
- assist Cosc in the promotion of interagency co-operation and sharing of information;
- assist and advise Cosc in the development of codes of practice for collecting statistics and monitoring responses;
- assist and advise Cosc in promoting public awareness about the issues involved in violence against women;
- assist and advise Cosc in identification of legal issues affecting the prevention of, and action responding to, violence against women;
- share information on international developments in relation to the issue of violence against women.

Appendix B: remit of Regional Planning Committees (RPCs)

The remit of the RPCs included:

- Assessing needs in the region;
- Developing plans to meet those needs;
- Developing an implementation plan and service targets.

Appendix C: Prevalence of Domestic Violence and/or Sexual Violence in Ireland: A Review of the Statistics

In Ireland, the most recent survey on Domestic Violence and/or Sexual Violence abuse found that 15% of women (or about 1 in 7) have experienced severely abusive behaviour of a physical, sexual or emotional nature from a partner at some stage in their lives (Watson and Parsons, 2005). One woman in 11 had experienced physical abuse in relationships, one in 12 sexual abuse and one in 13 severe emotional abuse. Women's Aid reported that in 2007, 22,545 calls were made to its helpline and support workers responded to 11,733 calls (Women's Aid, 2007). Garda statistics show that in 2003 there were 8,452 call outs were recorded on Domestic Violence and/or Sexual Violence. A fulltime general practitioner sees at least one recently abused woman each week, although the woman may not be presenting with obvious signs or symptoms (Hegarty (1999)).
According to the Sexual Abuse and Violence in Ireland (SAVI) research "adult sexual assault" is perpetrated against approximately 1 in 4 Irish women. The perpetrator was a partner or ex-partner for about (23.6%) of those women. Using 2006 CSO figures for females ages 15 and up in Ireland, that translates to partners or ex-partners perpetrating sexual violence against about 106,000 women. For those female survivors utilising face-to-face Rape Crisis Centre services in 2007, (23.9%) of the perpetrators of sexual violence against adult women were partners or ex-partners (Rape Crisis Network National Statistics 2007). The Dublin Rape Crisis Centre reports that, of the instances in which they have information in 2007, 11% of the perpetrators of sexual violence against adults using their face-to-face counselling services were husbands, boyfriends or partners. Women's Aid reports that approximately 5% of the callers to their helpline in 2007 disclosed incidents of sexual violence. That figure does not include the fact that, for women whose partners perpetrate violence against them, free and equal negotiation of sexual contact is extremely difficult if not impossible.

Around the world, as many as 1 woman in 4 is physically or sexually abused during pregnancy, usually by a partner (Heise et al., 1999). Violence before and during pregnancy has been found to have serious health consequences for both mother and child. Violence leads to high-risk pregnancies and pregnancy related

problems, including miscarriage, pre-term labour and low birth weight. Research amongst pregnant women attending the Rotunda Hospital in 1995 revealed that 1 in 8 women had personal experience of abuse during pregnancy (O'Donnell et al., 2000). 74% affected women reported mental abuse and 69% had suffered physical abuse. Women who have experienced physical or sexual violence or both by an intimate partner have significantly higher levels of emotional distress and are more likely to have thoughts of suicide or to have attempted suicide than women who have never experienced partner violence (Garcia-Moreno et al, 2005), The Women's Health Council (2005).

The greater prevalence of depression and anxiety in women worldwide as well as in Ireland points directly to the extent of violence being experienced by women (Women's Health Council, 2005). For instance, in a study of Irish general practices, it was found that among women who were depressed, 67% had experienced Domestic Violence and/or Sexual Violence as compared to 33% who had not (Bradley, 2002).
For the vast majority of victims, Domestic Violence and/or Sexual Violence is endured as a chronic long-term condition that escalates over time. By the time a woman's injuries are visible, violence may be a long-established pattern. For some women, escalation is fatal; the ultimate preventable outcome is homicide. 138 women have been murdered in Ireland since data collection commenced at the end of 1995. This figure translates to approximately one woman per month; of these, 63% have been killed in their own homes. Of the resolved cases, 48% were killed by a partner, husband or ex partner (Women's Aid (2009).

International Data

The World Health Organisation (WHO) Multi-country Study on Women's Health and Domestic Violence and/or Sexual Violence against Women (2005) highlights the following:

In every country where reliable, large-scale studies have been conducted, results indicate that between 10% and 69% of women report they have been physically abused by an intimate partner in their lifetime.

Population-based studies report that between 12% and 25% of women have experienced attempted or completed forced sex by an intimate partner or ex-partner at some time in their lives.

Abused women are more likely than others to suffer from depression, anxiety, psychosomatic symptoms, eating problems, sexual dysfunction and many reproductive problems including, miscarriage and still birth, premature delivery, HIV and sexually transmitted infections unwanted pregnancies and unsafe abortions.

Forced prostitution, trafficking for sex and sex tourism appear to be growing. Existing data and statistical sources on trafficking of women and children estimated 500,000 women entering the European Union in 1995 (WHO 2005).

National Data

The National Crime Council 2005
15% Women and 6% Men have experienced severely abusive behaviour from a partner
(Watson D & Parsons – 2005)

District Court Services Annual Report 2008
Barring Orders applied for 3096 - granted 1251
Safety Orders applied for 3328 - granted 1502

Appendix D - List of Services

RCC	REFUGE	SUPPORT SERVICES	
Athlone Midlands RCC	Adapt Services, Limerick	Support Services Ascend Women's Support Services, Roscrea, Co Tipperary	
Carlow and South Leinster RCC	Adapt Kerry Women's Refuge & Support Service	Carlow Women's Aid	
Sexual Violence Centre, Cork	Aoibhneas Women's Refuge, Coolock, Dublin	OSS Cork, Cork City	
Donegal RCC	Esker House Women's Refuge, Athlone	Family Life Centre Boyle, Co Roscommon	
Dublin RCC	Bray Women's Refuge	Inishowen Women's Outreach, Co Donegal	
Rape Crisis Centre North East Dundalk	Clare Haven Services, Ennis, Co Clare	Longford Women's Link	
Galway RCC	Cuan Saor Women's Refuge and Support Service, Clonmel, Co Tipperary	Offaly Domestic Violence and/or Sexual Violence Support Service, Tullamore	
Kerry RCC	Cuanlee Refuge, Cork City	Sonas Housing Association, Dublin	
Kilkenny Rape Crisis and Counselling Centre	Donegal Women's Domestic Violence and/or Sexual Violence Service	Teach Tearmainn D V Support Services, Newbridge, Co Kildare	
Rape Crisis Midwest Limerick	Drogheda Women & Children's Refuge	Tearmann Domestic Violence and/or Sexual Violence Services, Newbridge, Co Kildare	
Mayo RCC	Amber Women's Refuge, Kilkenny	West Cork Women Against Violence Project	
Sligo RCC	Mayo Women's Support Services	Dublin Women's Aid	
Tipperary RCC	Meath Women's Refuge & Support Service	Southill Domestic Abuse Project, Co Limerick	
Tullamore Sexual Abuse and Rape Crisis Counselling Centre	Oasis House Women's Refuge, Waterford City	Dublin 12 Domestic Violence and/or Sexual Violence Service	

RCC	REFUGE	SUPPORT SERVICES	
Waterford RCC	Cope Waterside House Women's Refuge, Galway City	Domestic Violence and/or Sexual Violence Advocacy Service (DVAS), Sligo	
Wexford Rape and Sexual Abuse Support Service	Wexford Women's Refuge	Inchicore Outreach Violence Against Women Centre	
	Womens Aid Dundalk, Co Louth	YANA, North Cork DV Project	
	Saoirse Women's Refuge,Tallaght Co Dublin	Letterkenny Women's Centre Co Donegal	
	Blanchardstown Women's Refuge Yet to be opened	Domestic Violence and/or Sexual Violence Response (DVR), Connemara, Co Galway	
	Rathmines Women's Refuge (associate member of Safe Ireland)	Laois Support Service against Domestic Abuse	
		Ruhama Dublin (not SI Member)	
		Tralee Women's Resource (not SI Member)	
		Vita Roscommon (not SI Member)	
		Westmeath (not SI member)	
		Open Door Tralee (not SI member)	
		Good Shepherd, Cork, DV is part of range of services. (not SI member)	
16	19	26	

Appendix E
Sexual Assault Treatment Units in Ireland

SATU Dublin Rotunda Hospital

SATU Waterford Regional Hospital

SATU Cork, South Infirmary Victoria University Hospital

SATU Mullingar, Midlands Regional Hospital, Mullingar

SATU Galway, Hazelwood House, Parkmore Road, Galway

SATU Donegal, Letterkenny General Hospital

Appendix F: Strategic Policy Context:

This section of the Policy document sets out a brief overview of the current strategic policy context pertaining to Domestic Violence and/or Sexual Violence. For more detailed analysis, see Kearns et al (2007): "Domestic Violence and/or Sexual Violence in Ireland: an overview of national strategic policy and relevant international literature on prevention and intervention initiatives in service provision".

In order to provide a comprehensive contextual account of the problem of Domestic Violence and/or Sexual Violence, this review has examined Domestic Violence and/or Sexual Violence from a macro perspective, focusing on national and international strategic policy, legislation and practice. Significant strategic policy development and practical service guidance at international level with regards to the issue of Domestic Violence and/or Sexual Violence are outlined in this report, in particular, drawing on work of key bodies such as the World Health Organisation (WHO) and the Council of Europe. This high-level strategic thinking and evidence-based research forms a sound basis for the development of related policy and strategy in Ireland.

It is important to understand that Domestic Violence and/or Sexual Violence is situated in a medico-legal context, based on both public health and criminal justice approaches. Moreover, Domestic Violence and/or Sexual Violence is a complex, multi-dimensional problem that requires addressing in a multisectoral and multi-disciplinary manner. Notwithstanding this, the overarching responsibility for Domestic Violence and/or Sexual Violence needs to be led by one statutory body. A significant policy development in Ireland has been the recent establishment of the Office for the Prevention of Domestic Violence and/or Sexual Violence – Cosc – under the aegis of the Department of Justice in July 2007. The multisectoral nature of Cosc membership, which includes representatives of the HSE and the Department of Health and Children, provides an important opportunity to adopt a public health and multi-disciplinary approach to the problem.

Frameworks for Tackling the Problem of Domestic Violence and/or Sexual Violence

International and domestic research indicates that the health care system is usually the first route through which Domestic Violence and/or Sexual Violence victims seek support. In recognition of this, the HSE has reviewed various models to support staff to recognise, respond and refer appropriately regarding Domestic Violence and/or Sexual Violence. From the HSE perspective, the Ecological Model (See Fig. 1 and Appendix C) is very useful in helping us to understand the context in which Domestic Violence and/or Sexual Violence occurs and thus prevent victim blaming. The HSE considers the Public Health (See Figure 2 and Appendix C) and the Hardikar Models very useful for responding appropriately to Domestic Violence and/or Sexual Violence. These models are concerned with:

- Addressing the underlying risk factors for both victims and perpetrators;
- Taking action to prevent the problem;
- Improving the safety of individuals;
- Providing services tailored to the needs of victims of Domestic Violence and/or Sexual Violence.

Both models therefore provide a useful framework for developing comprehensive health responses while acknowledging the need for multi-agency and multisectoral collaboration.
The Hardikar Model recognises different levels of need and assumes that most people's needs can be met within universal services. For higher levels of risk or need, additional services and more complex multi agency responses are required. The Hardikar model may provide a practical base for the development of local Domestic Violence and/or Sexual Violence policies facilitating improved recognition, responding and referring. This model advocates using strengths-based approaches and allows us to understand more clearly the role and purpose of different forms of support services.

Significantly, Rutherford et al. (2007) have identified important indicators to guide policy development:

- Interventions delivered during infancy and in childhood and those sustained over time are more likely to be effective than short-term programmes;
- Proven and promising interventions with adolescents and young adults include providing at-risk disadvantaged secondary school students with incentives to complete their education and
- Comprehensive, scientifically based programmes are more likely to be successful.

The Wolfe and Jaffe (1999) Public Health Model for Domestic Violence and/or Sexual Violence Prevention is also a useful guide for developing HSE local policies to address Domestic Violence and/or Sexual Violence in terms of prevention, early intervention and targeted interventions where Domestic Violence and/or Sexual Violence is evident.

A Public Health Model for Domestic Violence and/or Sexual Violence Prevention
(Wolfe and Jaffe, 1999)

Life Stage	Primary (Targeted to Populations Before DV Occurs)	Secondary (Targeted to Individuals Following Early Signs of DV)	Tertiary (Targeted to Victims and Perpetrators After DV is Evident)
Infants and preschoolers (0-5 years)	**Home visitation.** Public health nurses and trained paraprofessionals assisting new parents.	**Home visitation with high-risk families.** Support and services for family members identified as being at high risk of perpetrating or becoming victims of DV.	**Home visitation with abused victims and their children.** Specialised services for those identified by DV specialists as having been harmed by DV.
School-age children (6-12 years)	**School-based awareness and skill development.** Collaborative efforts by schools and communities to teach violence awareness and alternative conflict-resolution skills.	**Community-based early intervention.** Children exposed to violence are offered crisis support, individual counselling, and educational groups.	**Disorder-based treatment services.** Children who show emotional and behavioural problems are offered specific mental health services that address the underlying trauma.
Adolescents and high-school-age youths (13-18 years)	**School-based awareness and skill development.** Same as school-age above, with emphasis on issues related to dating violence and forming healthy intimate relationships.	**Community-based early intervention.** Same as above, tailored for adolescents exposed to violence and emphasising dating relationships.	**Disorder-based treatment services.** Same as above, with the possible involvement of juvenile justice system as an identification and access point for treatment.
Adults (18+ years)	**Public education.** Media campaigns promoting awareness of Domestic Violence and/or Sexual Violence and providing information about local resources and how to respond to Domestic Violence and/or Sexual Violence situations.	**Community-based early intervention.** Individuals exposed to violence are identified at the earliest possible opportunity and provided with appropriate, co-ordinated services.	**Community-based intervention for chronic DV.** Intensive police, court, and community collaboration to address situations of chronic and dangerous DV.

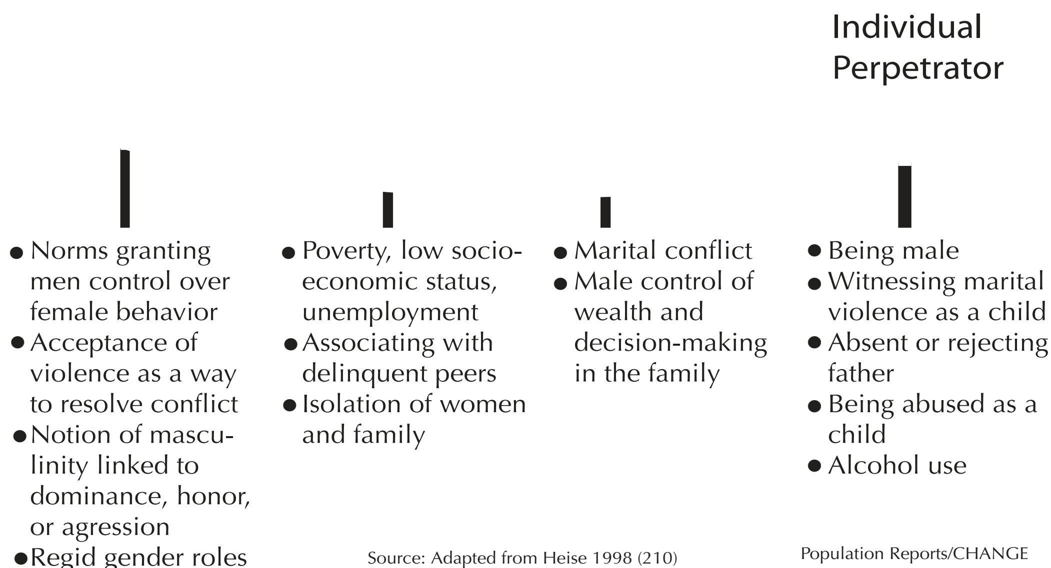
<table>
<tr><th colspan="2">Model of need and intervention: adapted from Hardikar, Exton and Barker 1991</th></tr>
<tr><td>Tier 4: Acute (Tertiary Prevention)
People at risk of death or serious harm from an abusive partner</td><td>Gardaí, court and legal protection, child protection services (where children are involved), alternative housing (where people are unable or do not want to stay in their own homes), Multi agency risk management.</td></tr>
<tr><td>Tier 3: Complex (Tertiary Prevention)

People whose lives are severely disrupted by domestic abuse</td><td>Community based supports, advocacy and childcare services (where there are children). Court and legal services. Accommodation options and social and welfare services and supervised contact for children. Multi agency responses.</td></tr>
<tr><td>Tier 2: Vulnerable (Secondary Prevention) People who are vulnerable as a result of domestic abuse (Higher risk groups include those in dating relationships/ Pregnant women/ Older women/ Women in prostitution/ Women accessing substance abuse services/ Women from low income backgrounds/ Ethnic-racial minority groups/ Children living in families where there is Domestic Violence and/or Sexual Violence)</td><td>Information about Domestic Violence and/or Sexual Violence services, access to community outreach and advocacy service. Public Health Nurses (PHN) and community welfare services. Identification within universal services.</td></tr>
<tr><td colspan="2">Tier 1: All People: Universal Services (Primary Prevention)
Home visitation to assist parents of children under 5 years
Universal DV screening (Antenatal clinics/ /GP services/ A and E units/Mental Health clinics/ Substance misuse services
Information and publicity campaigns
Healthy relationship education and prevention programmes
Schools based information initiatives</td></tr>
</table>

The Public Health and Hardikar models clearly outline the opportunities for health care staff to recognise, respond and refer more appropriately to Domestic Violence and/or Sexual Violence. Much of this work can be done by building on existing good practice. Staff will be supported in this work through education and the developments of practical resource materials. The main messages from these models will be translated into realistic goals and action plans in a later section of this document. The HSE realises that improving service responses is a long term process that will involve working collaboratively with key stakeholders and will require a number of phased incremental and integrated stages. Therefore we have set out an initial 3 year timeframe for commencing this process.

In summary, Domestic Violence and/or Sexual Violence has a severe and persistent effect on physical and mental health. When health professionals know about the dynamics of Domestic Violence and Sexual Violence, they are in a unique position to respond better to the needs of victims and provide information on specialist services and how to contact them. Knowing the prevalence of the problem and health impact on victims and children, routinely asking about abuse should be seen as an important form of primary and secondary prevention for a wide range of health problems. Asking about Domestic Violence and/or Sexual Violence can increase public awareness and help to reduce isolation for victims. This should be seen as a routine part of history taking, just as health professionals regularly ask patients about other factors affecting their health.

Figure 1: The Ecological Model explains the occurrence of violence against women and identifies potential prevention strategies.



Heise, Lori. L (1998) Violence Against Women: An Integrated, Ecological Framework, Violence Against Women, Vol. 4, No. 3, 262-290

Figure 2: The Steps of the Public Health Approach

WHO (2007) http://www.who.int/violenceprevention/en/ accessed 18/01/08

Appendix G: Recognise, Respond, Refer:

Domestic Violence

QUALITY IN PRACTICE COMMITTEE

A Quick Reference Guide for Primary Care Staff

What is Domestic Violence?

"….the use of physical or emotional force or the threat of physical force, including sexual violence in close adult relationships.
It can also involve emotional abuse; the destruction of property, isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone."

What can you do?

'3 Rs'		
	Recognise:	know the signs, indications and sequence of abuse
	Respond:	know how to deal with the issue of abuse
	Refer:	make a good, appropriate referral

How do you ask the question?

Broaching the subject can be difficult. Below are some sample questions you might use:

Broad

- How are things at home?
- How are you and your partner relating?
- Is there anything else happening that might be affecting your health?

Specifically linked to clinical observations

- You seem very anxious. Is everything alright at home?
- When I see injuries like this I wonder if someone could have hurt you?
- Is there anything else that we haven't talked about that might be contributing to this condition?

More direct questions

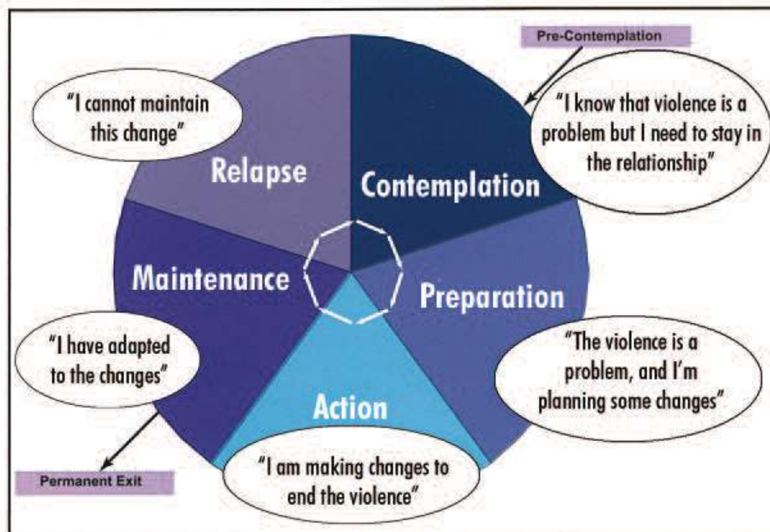
- Are there ever times when you are frightened of your partner?
- Are you concerned about the safety of your children?
- Does the way your partner treat you make you feel unhappy or depressed?
- I think that there's a link between your (insert illness or injury) and the way your partner treats you. What do you think?

Never ask a person about violence unless that person is alone and you cannot be overheard

Readiness to Change

People experiencing violence do not always want to leave but do want the violence to end. Assess their readiness to change their situation through conversation and discussion.

A woman will endure, on average, 35 violent attacks before reporting it to the police.



Abused women are more likely to report to their GP (29%) than to the police (20%).

If there is evidence of abuse make sure to document it in the patient's file and if necessary, use a Body Map to sketch the injuries.

Even if the person is not ready to leave the relationship you will need to have a discussion about a safety plan and possibly an escape plan.

> The most dangerous time for a victim of violence is when she is on the verge of leaving, and for six months afterwards.
>
> Urging her to leave may precipitate a catastrophic event.

Dealing with your Frustrations

People victimised by domestic violence very often stay in abusive relationships.

They may seem to ignore your advice and any intervention may seem like a waste of time. This can be exhausting, frustrating and difficult to understand.

Though you may feel frustration, you may be the first and only point of contact and the following is worth bearing in mind:

- Realise that they may never leave the abuser.
- Recognise that leaving is a process, not an event; the timeline from the beginning of abuse to the point of leaving may take decades.
- Get to know as much as you can about how DV is being responded to at a local level. At a bare minimum you should know the DV support agencies in your area so that you can provide accurate information for your patients.
- Look after yourself

Useful contacts

Women's Aid	Freephone 1800 341 900 (10am – 10pm, 7 days)	www.womensaid.ie
Dublin Rape Crisis Centre	Freephone 1800 778 888 (24 hrs, 7 days)	www.drcc.ie
Legal Aid Board	Lowcall 1890 615 200 (Office hours)	www.legalaidboard.ie
Rape Crisis Network Ireland	Telephone (091) 563676 (Office hours)	www.rcni.ie
Safe Ireland	Telephone (090) 647 9078 (Office hours)	www.safeireland.ie
Samaritans	Freephone 1850 309 090 (24 hrs, 7 days)	www.samaritans.org
For services local to your region:		www.hse.ie (enter 'domestic violence' in the search box)
Cosc		www.cosc.ie
AMEN	Helpline 046 9023718	www.amen.ie

This desksheet is designed to accompany the document Domestic Violence – A Guide for General Practice. It is available to ICGP members on the ICGP members on the ICGP website: www.icgp.ie. It is also on the National Council for the Professional Development of Nursing and Midwifery at: www.ncnm.ie/ipna.

Appendix G: Recognise, Respond, Refer:
Acknowledgements:

- **Membership of Domestic Violence and/or Sexual Violence Policy Development Group:**

  Chair: Dr Aisling Gillen, Specialist, National Planning Children's Services
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  Mary Troy, Women's Health Development Officer, HSE Dublin North East
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  Kate Walshe, Health Promotion, HSE West
  Brid O'Sullivan, Principal Community Worker, HSE South
  Jacqui Deevy, Childcare Manager, HSE Mid West
  Catherine Devaney, Social Inclusion Officer, HSE North West. (RIP April 2009)
  Rosemary P O Callaghan, Women's Health Development Officer, HSE Dublin North-East
  Claire O'Kelly, Specialist, National Planning Children's Services, HSE

- **Consultations took place with**

  Cosc
  Rape Crisis Network Ireland
  Women's Aid
  Safe Ireland
  Dublin Rape Crisis Centre

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