



# HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual

Recognising and Responding to Victims of Domestic, Sexual and Gender-Based Violence (DSGBV) in Vulnerable or At-Risk Communities



Seirbhís Sláinte  
Níos Fearr  
á Forbairt

Building a  
Better Health  
Service



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# Foreword

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Building capacity of front-line staff to provide a responsive service is a critical element of work in domestic, sexual and gender-based violence (DSGBV). Appropriate training is essential to improving understanding of the dynamics of DSGBV and, consequently, to ensure a consistent, appropriate and culturally competent response to persons presenting to services.

Most often, the victims of domestic violence are women and children, and almost all will come in contact with our services at some point. Domestic violence is often a hidden aspect, and not the presenting problem. Women experiencing domestic or sexual violence access our services via many routes, e.g. family doctor, emergency departments, 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 service at all points of entry. To ensure victim safety, staff need to know the signs, indications and consequences of abuse, to know how to respond in an appropriate way, and to be able to make referrals, as appropriate, to a specialist service, where women will be supported to make changes in their lives at a pace that suits their situation.

There is a considerable and growing body of research documenting the significant health impacts on both adults and children who have experienced abusive relationships. The effects of domestic violence in monetary terms are difficult to measure. However, the cost to the NHS for health care (both physical and mental health) is estimated to be £1.73 (€1.91) billion a year (Walby, 2009). This includes GPs and hospitals. There is also evidence that health-care utilisation is up to 20% higher five years after abuse has ceased (Rivara et al., 2007). In this context, the role of early intervention is clear.

In 2016, the HSE National Social Inclusion Office commissioned a national training programme to support front-line HSE staff to develop the skills to recognise and respond to victims of DSGBV in vulnerable or at-risk communities. The tender was awarded to Sonas, the largest provider of front-line services to women and children experiencing domestic abuse in the greater Dublin region.

This manual was developed by Sonas in partnership with the HSE National Social Inclusion Office. It draws from and builds on the *HSE Practice Guide on Domestic, Sexual and Gender Based Violence: For staff working with children and families* (Health Service Executive, 2012). I extend sincere thanks to Cristina Hurson (Sonas) and Ruth Armstrong (HSE) for their commitment to the development of this resource.

We are very grateful to the practitioners who shared their expertise and material, which, in turn, contributed to the development of this manual. Specifically designed to be an easy-to-use resource and complement the training programme, we hope that this manual will support you in your work to improve responses to DSGBV within the HSE.

Diane Nurse

HSE National Lead: Social Inclusion

# Background

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In 2016, the National Social Inclusion Office in the Health Service Executive (HSE) commissioned a national training programme to support front-line HSE staff to develop the skills to recognise and respond to victims of DSGBV in vulnerable or at-risk communities.

The development of a training programme aligns with the *Second National Strategy on Domestic, Sexual and Gender-based Violence (2016-2021)*, specifically in relation to Action 1.100: Awareness-raising for professionals who work with persons who are at high risk, marginalised or have specific needs, and Action 1.500: Develop and deliver education/training modules, both initial training and developmental training, for continual delivery to specific target groups in the public sector, i.e. the HSE, with a focus on establishing standards, addressing quality improvement, and measuring outcomes. The training also responds to *Ireland's second National Action Plan on Women, Peace and Security (2015-2018)*, specifically under Pillar 3: Protection, relief and recovery.

The *HSE Policy on Domestic, Sexual and Gender Based Violence (2010)* identified the need for specific skills and awareness as core elements of good practice, central to strategic planning and the provision of prevention and intervention initiatives regarding domestic violence and/or sexual violence. The policy also prioritised nine areas that form the basis of the policy, one of which outlined the importance of a trained and skilled workforce: **to ensure that a comprehensive and appropriate health service response is delivered at all points of entry to the Health Service Executive.**

This manual has been developed to accompany and complement the HSE training programme and to act as a further resource to front-line HSE staff.



# Resource Overview

## Training Development

The HSE National Social Inclusion Office worked in partnership with Sonas to develop the training programme, this resource manual, and the delivery of a train-the-trainer programme.

The purpose of the train-the-trainer programme is to:

- » deliver a culturally appropriate, learning programme for HSE staff and partner service-provider organisations;
- » establish standards, address quality improvement and measure outcomes; and
- » identify appropriate interventions and provide practitioner guidance for identifying and responding to survivors of DSGBV in vulnerable or at-risk communities.

The training programme comprises:

- » a training toolkit, to assist trainers in delivering the programme to others;
- » a training programme, including face-to-face skills-based training and case studies; and
- » this resource manual, reflecting the content of the *HSE Practice Guide on Domestic, Sexual and Gender Based Violence: For staff working with children and families* (Health Service Executive, 2012).

## The Training Organisation

### Sonas Domestic Violence Charity

Sonas is the largest provider of domestic-violence support services in the state, with over 1,200 women and children supported in 2016 across the greater Dublin region and Wicklow. Sonas supports victims of domestic abuse through dedicated support teams working across its services. For more information, please see the Sonas website: [domesticabuse.ie](http://domesticabuse.ie).

Sonas's approach is client centred, need led, and outcome focused. Its model of work is informed by a public health analysis of domestic abuse. Its guiding principles include early intervention and prevention, with particular strengths in secondary prevention, working with families and a diverse client base of service users with additional and complex needs.

Sonas provides the most comprehensive range of support services in the country to victims of domestic abuse, including refuge, helpline and community-based services, including visiting support, outreach and court accompaniment, and residential-based services, including safe homes and long-term supported housing for victims with additional and complex needs.

Social inclusion is woven throughout Sonas's response, which includes:

- » specific support-service response to victims of domestic abuse who are in homeless services;

- » specific support-service response to women in Dóchas prison; and
- » specific support-service response to the partners of men being supported by the Move (Men Overcoming Violence) organisation.

Sonas is primarily funded by Tusla, the Child and Family Agency. Sonas has an ongoing commitment to social inclusion, having initially been set up 25 years ago to provide support services, including housing, to victims of domestic abuse who had additional and complex needs.

## Training Partners

### Cairde

Cairde is a community development organisation working to tackle health inequalities among ethnic-minority communities by improving ethnic-minority access to health services, and ethnic-minority participation in health planning and delivery. Cairde works with disadvantaged ethnic-minority communities from Africa, Eastern Europe and the Baltic states.

Cairde's action areas are:

- » improving access (health information and advocacy);
- » improving delivery (participation); and
- » influencing planning (research and policy).

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## Siobán O'Brien Green

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Siobán O'Brien Green MSocSc (Social Policy) has worked in government agencies and the non-profit, research and academic sectors for over 20 years. She has worked on the issue of gender-based violence since 1998, in service provision, communications, teaching, training and research. Her core research and areas of interest include female genital mutilation (FGM), domestic violence (or IPV), sexual and reproductive health, maternal health and gender equality. She is currently undertaking her PhD research in the Trinity Research in Childhood Centre (TRiCC), in Trinity College Dublin, focusing on help and safety seeking by women who have experienced domestic violence during pregnancy.

## Consultation with Stakeholders

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Sonas consulted and collaborated with various organisations at national and local levels in the development of the HSE training programme. The aim of the stakeholder consultation was to design a culturally appropriate, accessible programme relevant to health and social-care professionals.

The consultation with stakeholders took the form of meetings with specialist support organisations and individuals, and a training needs analysis with HSE Primary Care staff to inform the content.

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## Stakeholders

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The following individuals and organisations were consulted about the development of the training programme and this accompanying resource manual:

- » Siobán O'Brien Green
- » Mary O'Neill, HSE Project Manager, Sexual Health
- » Pavee Point Traveller and Roma Centre
- » Cairde
- » HSE Refugee Clinic, Baleskin Refugee Reception Centre
- » HSE Primary Care
- » HSE National Social Inclusion Office
- » HSE Quality Improvement Division
- » HSE Mental Health Services
- » HSE Social Inclusion Services, South East Community Healthcare

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## Continuous Professional Development (CPD) Points

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CPD points have been awarded and are available for the following health- and social-care professions:

- » Nursing and Midwifery Board of Ireland (4 CEUs)
- » Irish Association of Social Workers

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## Guiding Principles for Developing Best-Practice Responses

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The following principles underpin this resource manual:

### Rights based – Human rights, women and children

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Domestic violence is a human rights issue affecting both men and women, however, the vast majority of survivors are women. The rights-based approach taken in the development of this resource manual applies to women's and children's rights, as most of the learning and examples used are taken from Sonas, which provides services to women and to children.

### Safety, welfare and protection

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The primary objective must be securing the safety of people experiencing domestic violence, and ensuring that service providers are not put in a potentially violent and/or unsafe situation.



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## Empowerment

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Supports should help survivors of domestic violence to determine their own needs by involving them in decision-making and choices affecting them, and supporting them to move from crisis to safety, independence and self-help.

## Privacy and confidentiality

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Those consulting and interacting with domestic-violence survivors should be respectful of privacy and confidentiality and cognisant of the real dangers if these are breached. They must also be mindful of any legal requirements, especially with regard to child protection.

## Accountability

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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.

## Partnership and collaboration

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A multi-agency and multidisciplinary approach is required to adequately address the complexity of the issue.

## Skills base and awareness

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Those responding to domestic violence must have appropriate sensitisation training and ongoing education to do so. Public awareness of the issue is another important consideration.

## Respect

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A supportive and compassionate ethos should underpin all service responses, thereby building a culture of empathy, kindness, consideration and trust amongst domestic-violence survivors and those providing intervention.

## Evidence informed

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The examples and resources referenced in this document are based on a variety of sources, which are referenced throughout the resource manual.

## Early intervention and prevention

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It is recognised that early intervention leads to better outcomes for clients and reduces the need for longer or acute services. This resource manual takes the approach of **recognising** and making an intervention **(responding)** as early as possible.

## Cultural competence

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Provision of culturally competent health services that are respectful of, and responsive to, the cultural and ethnic diversity of service users is intrinsic to quality, effective service delivery. The goal of culturally competent health-care services is to provide the highest quality of care to every patient, regardless of ethnicity, cultural background, English proficiency or literacy.

## Disclaimer

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The training resource/handbook focuses on domestic violence, domestic abuse, and intimate-partner violence in relation to violence against women. This is because of:

1. the prevalence figures in relation to the impact of domestic violence on women compared to men – one in seven of those impacted by domestic violence is a woman, compared to one in 17 men, and women are more than twice as likely as men to experience severe physical abuse; and
2. the disproportionate impact of domestic violence on women – women are more at risk of injury and are twice as likely as men to require medical attention, and ten times more likely to be hospitalised as a result of their injuries (Watson and Parsons, 2005).

Services for men are listed in **Section 3 – Refer (Review)** of the manual.

## Language and Terminology

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The terms ‘domestic abuse’ and ‘domestic violence’ are used interchangeably throughout this document. The training and this accompanying resource manual try to use gender-sensitive language, but it is acknowledged that many of the examples used are gender specific – this approach is due to Sonas’s work with women and children.

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A number of sources use the language of domestic violence. These include the national *Report of the Task Force on Violence against Women* (Office of the Tánaiste, 1997) – referenced by the HSE and Tusla – Irish legislation, and An Garda Síochána statistics. On the other hand, the 2005 Irish study by Watson and Parsons uses the term ‘domestic abuse’. Sonas is of the view that the issue is broader than violence in the traditional sense, and that the term ‘domestic abuse’ is more encompassing and reflective of the experience of clients. These terms, including ‘intimate-partner violence’ (IPV) are used interchangeably by services and agencies.

The terms ‘victim’ and ‘survivor’ are used depending on the background of the writer. For example, ‘survivor’ is seen to be more hopeful and emphasises triumph – as described in *Surviving Sexual Violence* (Kelly, 1988) – and ‘perpetrator’ and ‘abuser’ are primarily used in a US/UK context.

### Intimate-partner violence

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The World Health Organization (2012) defines **intimate-partner violence** as ‘any behaviour within an **intimate** relationship that causes physical, psychological or sexual harm to those in the relationship, including acts of physical violence, sexual violence, emotional (psychological) abuse and controlling behaviours’.

For other terms used in this resource, please refer to the glossary in **Section 5.3**.



# SECTION 1

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# RECOGNISE

# 1.1 Definitions, Underpinning Policy and Legislation

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**Domestic abuse** is a pattern of behaviour and involves the threat or use of any or all of the following in close adult relationships: physical, sexual, emotional or psychological abuse. The ultimate goal in domestic abuse is to instil fear in order to control and subdue the other person in the relationship.

Domestic abuse, and other forms of violence against women, stem from gender inequality and a refusal by perpetrators to accept that women and children have rights. Domestic abuse can and does intersect with sexual and other forms of gender-based violence and occurs across cultures, social classes and ethnicities.

**Gender-based violence** against women is violence that is directed against a woman because she is a woman, or that affects women disproportionately. A gendered analysis of violence suggests that violence against women – whether in the home, between friends or in dating relationships – or violence perpetrated by strangers reflects and reinforces the power inequalities experienced by women with respect to men in all societies, including our own.

**Domestic violence** takes many forms and can affect anyone, irrespective of age, educational background, culture, gender, or sexual orientation.

The national *Report of the Task Force on Violence against Women* (Office of the Tánaiste, 1997) named recommendations for the future development of policy in Ireland in relation to domestic and sexual violence therein. The task force's definition is generally accepted as the standard definition in use:

'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. 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 of access to v, personal items, food, transportation and the telephone.'

Domestic abuse is not inevitable. While there will always be those who seek to abuse, recognition and the support of rights, accessible and appropriate services, and perpetrator accountability informed by a criminal-justice sanction will reduce domestic abuse.

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The following is the policy and legislative context for the development of this resource manual:

- » Department of Justice and Equality: *Second National Strategy on Domestic, Sexual and Gender-based Violence (2016-2021)*, 2016
- » Office of the Attorney General: Domestic Violence Act 1996; Domestic Violence (Amendment) Act 2002; and Domestic Violence Act 2018
- » Office of the Attorney General: Criminal Law (Sexual Offences) Act 2017
- » Office of the Attorney General: Criminal Justice (Victims of Crime) Act 2017
- » Office of the Attorney General: Child Care Act 1991
- » Office of the Attorney General: Children First Act 2015
- » Department of Children and Youth Affairs: *Children First National Guidance for the Protection and Welfare of Children*, 2017
- » Office of the Attorney General: National Vetting Bureau (Children and Vulnerable Persons) Act 2012
- » Office of the Attorney General: Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012
- » Department of Foreign Affairs and Trade: *Ireland's second National Action Plan on Women, Peace and Security (2015-2018)*, 2015
- » Department of Justice and Equality: *National Traveller and Roma Inclusion Strategy 2017-2021*, 2017
- » Department of Justice and Equality: *The Migrant Integration Strategy: A Blueprint for the Future*, 2017
- » Department of Justice and Equality: *National Strategy for Women and Girls 2017-2020: creating a better society for all*, 2017
- » Department of Children and Youth Affairs: *Better Outcomes, Brighter Futures: The national policy framework for children & young people 2014-2020*, 2014
- » Department of Health: *National Sexual Health Strategy 2015-2020*, 2015
- » Department of Justice and Equality: *Second National Action Plan to Prevent and Combat Human Trafficking in Ireland*, 2016
- » HSE: *National Intercultural Health Strategy 2007-2012*, 2007
- » HSE: *HSE Policy on Domestic, Sexual and Gender Based Violence*, 2010
- » An Garda Síochána: *Domestic Abuse Intervention Policy*, 2017
- » An Garda Síochána: *Garda Síochána Policy on the Investigation of Sexual Crime, Crimes against Children, Child Welfare*, 2013
- » Council of Europe: *Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention)*, 2011
- » Reception and Integration Agency: *RIA Policy and Practice Document on safeguarding RIA residents against Domestic, Sexual and Gender-based Violence & Harassment*, 2014

Please see **Appendix 1** for a brief outline of relevant policy and legislative documents.

# 1.2 Facts and Myths

The following are some widely held beliefs and myths in relation to domestic abuse.

## **Pregnancy is one of the protective factors against domestic abuse.**

Pregnancy can trigger or exacerbate male violence (Royal College of Midwives, 2006). One in eight women attending the Rotunda Hospital suffered abuse during pregnancy (O'Donnell, Fitzpatrick and McKenna, 2000).

The National Institute for Health and Care Excellence (2014) provides guidelines on domestic-abuse inter-agency working for health- and social-care commissioners, specialist domestic-violence and -abuse staff, and others whose work may bring them into contact with people who experience or perpetrate domestic violence and abuse. The guidance aims to help identify, prevent and reduce domestic violence and abuse as defined here: <http://www.nice.org.uk/guidance/ph50/chapter/glossary#domestic-violence-and-abuse>.

Guidance for those who are routinely involved in the care of pregnant women who may present with complex social factors is also available (National Institute for Health and Care Excellence, 2010). The guideline describes how access to care can be improved, how contact with antenatal carers can be maintained, the additional support and consultations that are required, and the additional information that should be offered to pregnant women with complex social factors.

## **Children are more at risk when there is abuse in the family home**

There is a clear link between domestic abuse and child abuse (Buckley, Holt and Whelan, 2006). Domestic violence impacts on children's emotional and psychological well-being. Exposing children to domestic violence is considered emotional abuse, as described in the revised Children First guidelines (Department of Children and Youth Affairs, 2017). Research has found that there is a correlation between the frequency of children witnessing domestic violence and the prevalence of childhood abuse (Davidson, Devaney and Spratt, 2010).

Children and adolescents living with domestic violence are at increased risk of experiencing emotional, physical and sexual abuse, of developing emotional and behavioural problems, and of increased exposure to the presence of other adversities in their lives (Holt, Buckley and Whelan, 2008). Mertin and Mohr (2002) also describe how witnessing abuse or experiencing abuse has similar effects on children.

## **You are more likely to experience abuse in the workplace or out socialising than at home.**

Statistics consistently report the risks at home: 216 women were murdered in Ireland between 1996 and 2017 by their partners or ex-partners, and 63% of these murders occurred in the family home. Victims are more likely to be sexually assaulted, raped or murdered by men known to them than they are by strangers (Women's Aid, 2017). This report dispels the 'stranger

danger' myth, stating that 88% of women murdered in Ireland were killed by men known to them.

## **Drugs, alcohol and stress are the main causes of domestic violence.**

The connection between drug and alcohol use and domestic violence is complex. There is a link between violence and alcohol consumption, however, many people who drink alcohol and use drugs do not abuse their partners. Most of the research to date in this area has been carried out in relation to alcohol, but there is no doubt that the level of intimate-partner violence identified among people receiving treatment for drug and alcohol misuse is a cause for concern. Please see **Section 4.4** for further information on domestic violence and drug and alcohol use.

## **Women who experience abuse tend to be older and from disadvantaged areas.**

Domestic violence is not confined to any one 'type' of person. It has been described as the 'most democratic of all crimes' (Women's Aid, 2018). It affects people of all ages and sexual orientations, and from all socio-economic, educational, religious and cultural backgrounds.

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## **Women in abusive relationships choose to stay in them. If it were that bad, they would just leave.**

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She may not know that it's domestic abuse. Choosing to leave any relationship is not an easy decision.

Women who wish to leave an abusive relationship can face many barriers: fear, guilt, the children, financial reasons, not knowing options, reliant on a partner's visa, not knowing it is abuse, etc.

Fear is often a factor. It can be very dangerous for a woman to leave a relationship. Statistically, a woman is more at risk of being seriously harmed or murdered in the year after she has left an abusive relationship. One in every two women murdered in Ireland is murdered by a man, most often a partner or ex-partner (Women's Aid, 2017).

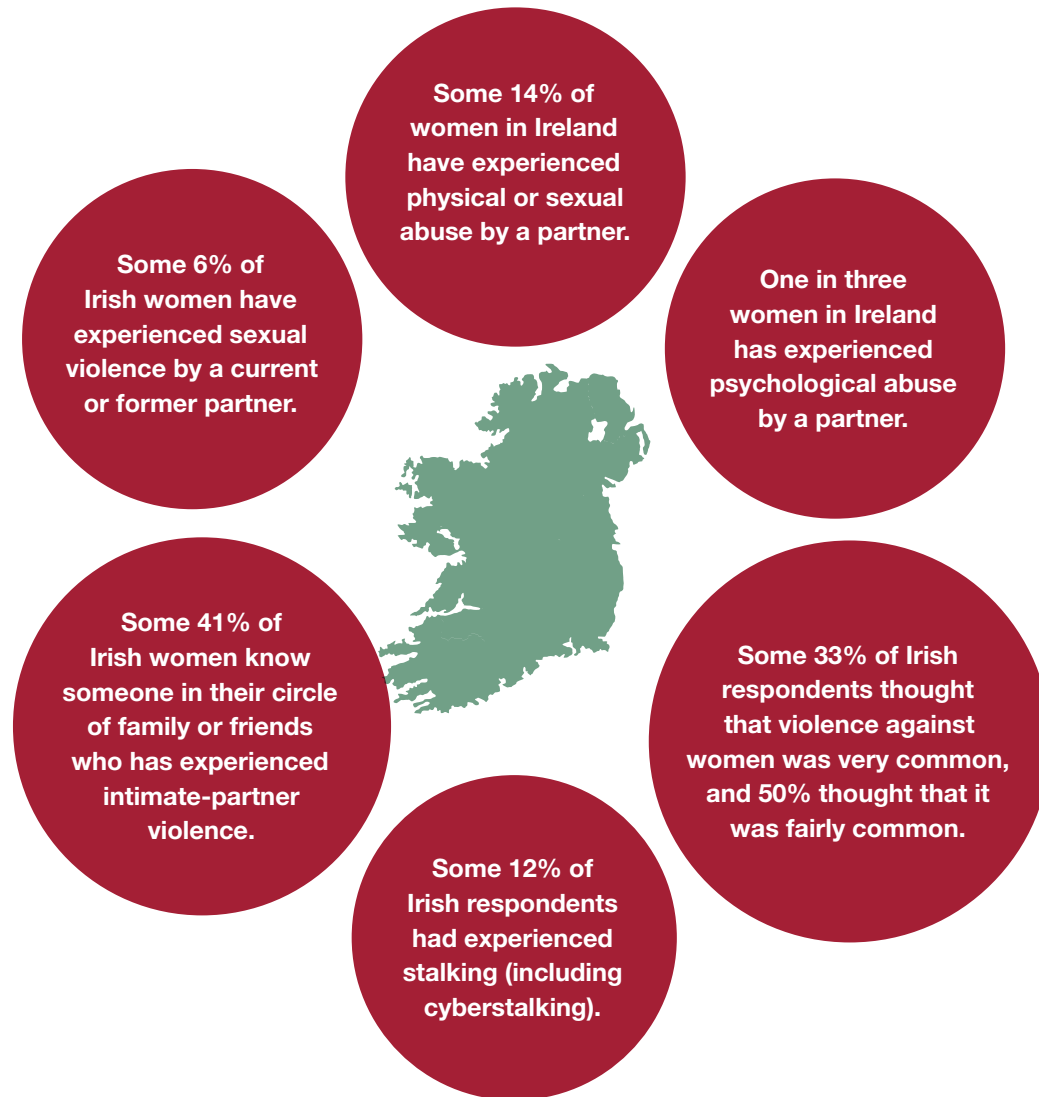


# 1.3 Statistics and Prevalence Figures

As a guiding principle of this resource, having an evidence base formulated from data, research and statistics helps with understanding and then responding to the issue of domestic abuse. There is no single or national data collection mechanism in Ireland specifically devoted to domestic abuse. It is widely understood that domestic abuse is significantly under-reported, and disclosure rates to services and An Garda Síochána do not correspond to prevalence rates. One of the objectives of the *Second National Strategy on Domestic, Sexual and Gender-based Violence (2016-2021)* – Action 3.600 – is to improve data collection.

In 2014, the European Union Agency for Fundamental Rights (FRA) carried out a survey on violence against women in the European Union (EU), called *Violence against women: an EU-wide survey*. This was the first study of its kind to capture the scope and nature of violence against women across the EU.

## Findings from this study in relation to Ireland include:





# 1.4 Recognising Abuse

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Signs that a woman may be experiencing domestic abuse include but are not limited to the following:

**She seems afraid of her partner or is always very anxious to please him.**

**She stops seeing friends or family.**

**She says that her partner continually phones or texts her when she is out of the house and wants to know where she is and whom she is with at all times.**

**She may have unexplained bruises or cuts.**

**She may have little money or access to cash, even when she is working or the family appears to have sufficient funds.**

**She may have changed her behaviour, becoming more withdrawn, anxious or depressed.**



The following are examples of abuse:

Physical/Sexual Abuse	Emotional/Psychological Abuse	Financial/Social Abuse
<ul style="list-style-type: none"> <li>» Pushing, throwing, kicking</li> <li>» Slapping, grabbing, hitting, punching, beating, tripping, battering, bruising, choking, shaking</li> <li>» Pinching, biting</li> <li>» Holding, restraining, confinement</li> <li>» Breaking bones</li> <li>» Assaulting with a weapon, such as a knife or gun</li> <li>» Burning</li> <li>» Imprisoning</li> <li>» Sexually assaulting: ‘assaults that have an explicit sexual content and includes a variety of forms including rape, sexual assault and sexual harassment’ (Department of Justice and Equality, 2010)</li> <li>» Sexually harassing: ridiculing another person to try to limit his/her sexuality or reproductive choices</li> <li>» Sexually exploiting, such as forcing someone to look at pornography or participate in pornographic film-making</li> <li>» Rejecting sex and intimacy – the opposite of the aforementioned – whereby the abuser withholds sex and intimacy as a form of further abusing his/her partner</li> </ul>	<ul style="list-style-type: none"> <li>» Threatening or intimidating to gain compliance</li> <li>» Destroying of the victim’s personal property in his/her presence</li> <li>» Yelling or screaming</li> <li>» Name-calling</li> <li>» Constantly harassing</li> <li>» Embarrassing, making fun of, or mocking the victim, whether alone, within the household, in public, or in front of family or friends</li> <li>» Criticising or diminishing the victim’s accomplishments or goals</li> <li>» Not trusting the victim’s decision-making</li> <li>» Telling the victim that s/he is worthless on his/her own, without the abuser</li> <li>» Excessive possessiveness, isolation from friends and family – telling someone where s/he can and cannot go, making up lies about family/friends</li> <li>» Excessive checking-up on the victim, to make sure that s/he is at home or where s/he said that s/he would be</li> <li>» Blaming the victim for how the abuser acts or feels</li> <li>» Threatening/attempting self-harm or suicide, maybe in front of the victim</li> <li>» Using children – undermining parenting or making threats to harm children</li> </ul>	<ul style="list-style-type: none"> <li>» Withholding economic resources, such as money or credit cards</li> <li>» Stealing from or defrauding a partner of money or assets</li> <li>» Exploiting the intimate partner’s resources for personal gain</li> <li>» Withholding physical resources, such as food, clothes, necessary medications, or shelter</li> <li>» Preventing the spouse or intimate partner from working or choosing an occupation</li> <li>» Limiting access to transport</li> <li>» Limiting access to a car seat or buggy</li> <li>» Monitoring or abusing through social media</li> <li>» Locking doors – stops victim from leaving the home, or from supports gaining access thereto</li> <li>» Social isolation</li> <li>» Name-calling, intimidating family/friends</li> <li>» Highlighting flaws or belittling any supports</li> </ul>

Domestic violence can culminate in murder, femicide or homicide.

# 1.5 Trauma

Trauma results from physical and emotional harm. It impacts on an individual's mental, physical, social, emotional and/or spiritual well-being. How a person responds to trauma often depends on what kinds of internal and external resources s/he has to help him/her cope.

Domestic violence is characterised by complex trauma, which is defined as:

- cumulative;
- emotionally and socially complex;
- chronic;
- being under siege;
- never knowing when events might occur; and
- feeling that the victim cannot escape.

(Source: Courtois and Gold, 2009)

Knowledge about the effect and impact of trauma is important for two reasons. Trauma can impact on a victim's ability to disclose the abuse, for example, a victim can be 'numb' as a result of the abuse, or minimise the abuse, as the behaviour has been normalised. Professionals need to assess and check in terms of the impact of trauma on a victim when screening or making an intervention. Providing support to victims of trauma can also lead to professionals being impacted by the trauma, known as secondary traumatic stress or compassion fatigue.

## Secondary traumatic stress, compassion fatigue, and vicarious trauma

These are conditions related specifically to work with trauma populations. Providing trauma intervention services places these workers at risk for traumatic responses themselves (Newell and MacNeil, 2010).

Having an awareness of how being exposed to trauma can affect professionals providing support to victims is important, as professionals can become accustomed or 'hardened' to disclosures. Vicarious trauma comes closest to identifying the specific experiences of anti-violence workers (Richardson, 2001). This can also lead to professional burnout, however, an organisational culture that is supportive of professionals who deliver care-based services can minimise the effects of these conditions. Please go to **Section 2.10 (Self-Care)** for further information.



# 1.6 The Impact of Domestic Violence on Women and Children

The following list outlines some of the potential impacts and/or manifestations of domestic violence on women. Please note that the effects can overlap, regardless of the type of abuse that can present in health and clinical settings.

## Potential Impacts

- » Walking on eggshells – anxiety/nervousness
- » Apologising all the time – unable to make decisions
- » Low self-esteem
- » Feeling of being trapped/hopelessness
- » Isolation
- » Feeling guilty, inadequate, useless, etc.
- » Developing eating disorders, gastric issues, menstrual irregularities, etc.
- » Depression/PTSD/flashbacks
- » Losing financial independence – turning to crime
- » Turning to drugs or alcohol as a way of coping
- » Developing agoraphobia
- » Self-hate
- » Feeling degraded/humiliated
- » Developing a self-harm/suicidal ideology
- » Increasing tiredness, muscle tension, headaches, or sleep issues
- » Homelessness
- » Death by murder or suicide

## Physical/Sexual:

- » Physical injury – bruises, cuts, broken bones, marks on neck, stab wounds, loss of consciousness, concussion, chronic pain, death
- » Miscarriage/stillbirth
- » Sexually transmitted infections (STIs), fertility issues, chronic pain, unwanted pregnancy

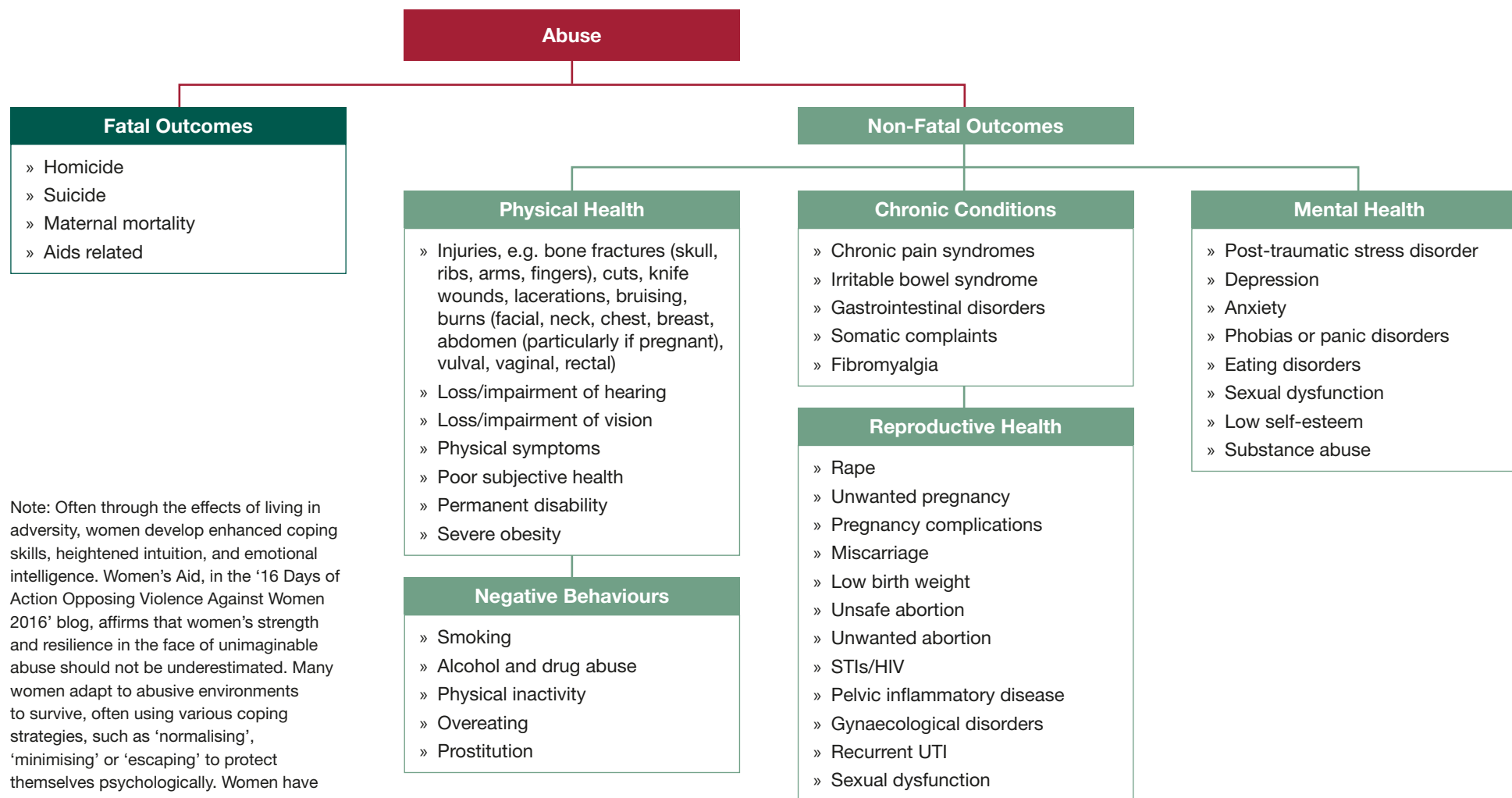
## Emotional/Psychological:

- » Lack of trust in own judgement, low mood, inability to make decisions, low self-esteem, self-harm, suicidality, PTSD, eating disorders, sleep issues, feeling degraded/broken

## Financial/Social:

- » Malnourished, or lacking choice in food, feeling trapped or isolated, no access to suitable clothes for weather

## Health Outcomes of Violence Against Women



Note: Often through the effects of living in adversity, women develop enhanced coping skills, heightened intuition, and emotional intelligence. Women's Aid, in the '16 Days of Action Opposing Violence Against Women 2016' blog, affirms that women's strength and resilience in the face of unimaginable abuse should not be underestimated. Many women adapt to abusive environments to survive, often using various coping strategies, such as 'normalising', 'minimising' or 'escaping' to protect themselves psychologically. Women have reported to Sonas's support staff that they have a heightened ability to read situations, including subtle cues in their environment. This has enabled them to make themselves, and their children, safer.

(Source: Irish College of General Practitioners, 2014)

## The impact of domestic abuse on children

The *Children First* guidelines (2017) list a number of ways in which domestic violence can impact on children. Exposure to violence in the home is named as a type of emotional-abuse risk. A lack of protection and an exposure to danger are named as types of abuse in relation to neglect. Domestic violence is also named as a specific factor that places children at great risk of abuse. Children and adolescents living with domestic violence are at increased risk of experiencing emotional, physical and sexual abuse, of developing emotional and behavioural problems, and of increased exposure to the presence of other adversities in their lives (Holt, Buckley and Whelan, 2008).

**Children can also be the direct recipients of abuse in domestically violent situations, and the link between child abuse and domestic violence is well established.**

- » Some perpetrators can and do use children in the relationship to further abuse the adult victim therein, e.g. making the child join in the abuse of his/her parent, which, in itself, is abuse of the child.
- » Some perpetrators can and do separately or additionally physically, sexually, emotionally or psychologically abuse the child/children in the relationship.

Effects on children can vary according to age, the level of violence being witnessed, the length of time over which it is happening, the extent of their witnessing it, and support from others. It is also important to note that 'witnessing abuse, or experiencing the abuse has similar effects on children' (Mertin and Mohr, 2002). 'Children may blame themselves for the violence or for being unable to prevent it. They may try to intervene and be injured themselves. They may become confused with torn loyalties (Irish College of General Practitioners, 2014).'

The impact on children and young people depends on their age or stage of development, but it can include the following:

Young people: High incidence of domestic violence and challenging behaviours in young people's relationships, identity issues, separation from parent, peer relations and relationships.

School-age children: Difficulty developing sense of awareness of self; children have more insight into the situation and may try to predict and/or prevent abuse.

Toddlers: Aggressive and possessive behaviours, poor social skills, difficulty developing empathy, poor self-esteem, and act out what they see.

Babies: Attachment issues – in extreme cases, failure to thrive, self-soothing, feeling overwhelmed – affect security and relationships.

Children and young people with physical disabilities or communication difficulties are as susceptible to harm and abuse as a child without additional needs. It is also important to note that research, mostly conducted outside the UK, shows that disabled children are three times more likely to be abused than non-disabled children (NSPCC, 2012).

Protective factors that influence the extent of the impact and can improve a child's response to violence are as follows:

**The non-abusive parent-child relationship is the most important protective resource on which the child can draw for his/her recovery from the exposure to domestic violence.**

**Individual characteristics of the child: resilience, self-esteem and coping strategies**

**Availability of social support**

**Ongoing support from relevant services**

(Source: AVA Project, 2015)

## The link between domestic violence and child abuse

One review of studies in the US indicates that child abuse is 15 times more likely to occur in households with domestic violence than in households without (Mills *et al.*, 2000), while another research piece indicates that child abuse and domestic violence cases overlap in 40% to 60% of cases (Garcia-Moreno, 2002).

Barnish (2004), in reviewing UK and international studies, comments that there is convincing evidence to suggest that 'the presence of domestic violence is a risk marker for, and significant predictor of child abuse, and vice-versa'. This has been echoed by other researchers (Humphreys and Stanley, 2006; Irwin and Waugh, 2007). An Irish study found a strong correlation between frequency, i.e. the amount of times that a child was exposed to domestic violence, and a strong likelihood that s/he would also experience physical and sexual abuse (McGavock and Spratt, 2016).

## Parenting

Parenting in the context of domestic abuse can present almost unimaginable challenges. Sometimes a perpetrator will abuse the mother in front of the child, sometimes not caring if the child witnesses the attack, and other times as a further deliberate means of abuse. Some perpetrators deliberately abuse *children* as a further means of abusing the mother, or to exert control and dominance over children. However, with support – even in the midst of hurt and trauma – children regain their childhoods, women regain their confidence as parents, and families recover to build resilience. Negative effects can lessen and disappear once a child is safe.

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## Liam's Story: 'I wish I was a Superhero ...'

"My name is Liam and I am 10. Before moving to Sonas, I lived with my Mam and my brother. My Mam's boyfriend was really mean to all of us. He locked me in rooms and pushed me down the stairs. He used to call my Mam bad names and hurt her. I remember sounds of crying, screaming and things breaking. I used to wish I was a superhero and have magic powers so I could make him disappear. I hit him once to make him stop choking my Mam. I was scared but I felt I had to protect her.

Since we came to Sonas, I don't have to protect her any more. I see people who talk to me about what happened and how I feel. My Mam, is getting the help she needs and she is getting much happier and we are all getting on better. I am in a new school, I have loads of new friends, playing sports and my coach says he thinks I am brilliant and have loads of talent."



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(Sonas Domestic Violence Charity, 2015)



# 1.7 Barriers to Disclosure and Why Survivors Stay

It takes a lot of courage to disclose abuse. Many women never tell anyone. Being exposed to trauma and abuse can affect a woman's ability to form trust in relationships with service providers and professionals. She may fear being judged/exposed and feel shame and guilt.

There are various reasons why women never disclose the abuse they experience. Examples include:



**Never assume that the woman will tell another person or that someone else will screen for domestic violence. You may be the only person she can tell or will tell.** Guidance on enabling a disclosure is covered in **Section 2 – Respond**.

## Why victims stay

Women stay in abusive relationships for many reasons. Fear is often a significant factor. Leaving can be a very dangerous time for women and children. Some 76% of women who have separated from abusive partners suffer post-separation violence (Humphreys and Thiara, 2002).

Statistically, a woman is more at risk of being seriously harmed or murdered in the year after she leaves an abusive relationship. Women can experience many barriers when trying to access help or leave an abusive relationship. The decision to leave can be a complex decision, based on much more than individual choice alone.

The decision can be influenced by a range of structural factors, including:

**socio-economic position;**

**legal status in the country;**

**knowledge of services;**

**availability of services;**

**response from services to previous attempts at seeking help; or**

**opportunity to leave.**

**Some factors, individual and structural, that can affect a woman leaving are as follows:**

She fears for her safety. Her partner may have threatened to harm her, the children, himself, her family, her property, etc.

She does not identify her experience as abuse, or as being worthy of support and attention. Her partner may have minimised his behaviour and accused her of overreacting.

She believes that it is her fault. Abusers are experts at manipulating/grooming/brainwashing other people to take responsibility for their abusive behaviour.

She is dependent on her partner for resources. He may have denied her access to the family finances.

She has nowhere to go. Abusers often isolate their victims from family, friends and services.

Her residence in Ireland may be legally dependent on her partner. Her visa may be based on family reunification or being the spouse of a European Union (EU) or Irish citizen.

She may be unaware of services that can help her. She may not speak English.

She may know the services, but not meet their eligibility criteria. She may not qualify for social welfare or housing supports due to habitual-residence or immigration status conditions.

She may have additional needs, such as addiction or mental-health problems, which could exclude her from some services. Problem drug and alcohol use could limit her ability to access a women's refuge in a crisis.

She fears stigma – cultural beliefs and expectations – and she may be pressured by family, peers or religious leaders to make her marriage work and keep her family together.

Her self-esteem has been so affected by the abuse that she believes that she cannot manage without her partner. An abuser can intentionally erode a woman's self-confidence so that she will become dependent on him.

She may not want to leave the relationship, but she wants the abuse to stop. Abusers often promise to change, particularly if the woman is thinking of leaving or contacting/involving domestic-abuse, health or social services.

# 1.8 Summary of Best Practice: Recognise

## Recognise

- » Domestic violence is predominantly about the abuse of power and control of one partner over another.
- » Once domestic violence is substantiated, the perpetrator must be held solely accountable for the violence.
- » Domestic violence occurs in all sectors of the community, regardless of age, socio-economic background, gender, sexuality or ethnicity.
- » Domestic violence is often a hidden aspect, and not the presenting problem. It should always be considered as a possibility, from referral through to assessment, intervention and closure, in all cases.
- » Domestic violence is significantly harmful to children – at a minimum, emotionally – and often coincides with the physical and sexual abuse of children.
- » Services should take account of the links between domestic violence and child abuse and respond appropriately, in line with national guidelines and child protection legislation.
- » Violence is complex and requires a comprehensive approach, often across disciplines and agencies.
- » The safety of the victim and the children should be paramount at all times.
- » People in domestically violent situations have the right to autonomy and self-determination. They are usually the best judges of how to manage their complex situations and highly skilled at doing so. Understanding these choices and working together with the victim is paramount to good practice.
- » Inter-agency collaboration is good practice. The children, victim and perpetrator require separate interventions.
- » Careful consideration must be given to how professionals make contact with a victim of domestic violence in a safe manner – one that will not put her and/or her children at potential further risk.

# SECTION 2

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# RESPOND: BRIEF, FOCUSED INTERVENTIONS

This section will focus on interventions that can be used in any health- or social-care setting, without having specialist expertise, such as screening (how to ask patients or clients questions about domestic abuse), basic risk assessment, and safety planning. This section will also give guidance in relation to child welfare and protection issues to be considered when responding to domestic violence and factors that could impact on the intervention, such as readiness to change. Dealing with fears and frustrations are also mentioned, as it is important to recognise these and understand that these challenges can have an impact on professionals.

# 2.1 Domestic-Violence Screening – Why Ask the Question?

Health- and social-care professionals have an important role with regard to contact with victims of domestic violence, and particularly those working in women's health services. Health-care professionals are often the first point of contact by women who have experienced domestic violence. It is vital that health- and social-care professionals screen for (or ask about) domestic violence if they recognise any of the signs of abuse, **if it is safe to do so**, and not assume that someone else might ask the question – it could be the victim's only opportunity to disclose. The World Health Organization states that the role of the health-care provider or 'first-line support is the most important care that you can provide' (World Health Organization, 2014).

There are various reasons why health- and social-care professionals might not screen for domestic abuse, including:

**lack of time, particularly in clinical settings;**

**lack of privacy or adequate space to facilitate a disclosure;**

**lack of confidence in the professional's own knowledge and skills to adequately deal with the disclosure;**

**personal beliefs – assumptions can be made about minority groups, or about victims from disadvantaged backgrounds, and a lack of understanding can lead to professionals accepting domestic abuse as a cultural norm; and**

**denial – not being open to recognising the signs of abuse.**

**It is important not to force a disclosure.**

# 2.2 Good-Practice Responses: Brief, Focused Interventions

## Screening: How to ask the question

**In a clinical setting, or if you don't have an ongoing professional relationship with the victim, the following approaches could help:**

- » Enable the disclosure: create a supportive environment, for example, display domestic-violence posters, information leaflets, helpline phone numbers, etc.
- » Only ask about domestic violence if the victim is on his/her own, to ensure safety.
- » Frame the question: 'As domestic violence is such a widespread issue nowadays, we ask everyone who comes into our service about it.'
- » Be direct: 'Are you afraid of your partner? Is it safe for you at home?'
- » Offer domestic-violence support information: whether or not abuse is disclosed, and if it isn't, keep an open-door policy – 'I am here if you want some more information.'

## **If you have concerns about someone you know, a patient or a client, the following could help:**

- » Your response can make a big difference, and though it may be hard to avoid telling someone what to do, it is best practice to let him/her know that you believe him/her, don't blame him/her, and aren't going to minimise his/her experiences. People experiencing abuse often feel powerless – their voice isn't heard, their opinions aren't respected, and the ability to make choices for themselves is compromised by fear, threats or violence.
- » Find a safe time and place to talk if you are the one approaching the victim about the issue. You might want to start with 'I've noticed,' or 'I saw/heard.'
- » Respect her decision if she does not want to talk, but let her know that you are there for her if she does. Many victims of domestic abuse feel ashamed about their experiences.
- » If and when she does talk, it is important to let her know that you believe her. Many abusers can be charming and use friendships and family relationships to further isolate their victims.
- » Ask how she is coping and how the behaviour has been affecting her, and if she has children.
- » If she has children, you may want to ask how the behaviour is affecting them. Domestic abuse is the emotional abuse of children, whether they are the direct targets of the abuse or not. Many abusers also abuse children directly and/or use them to further abuse their mother.
- » Focus on the safety of the woman and, if there are children in the situation, their safety.
- » Let her know that the abuse/violence is not her fault, and there is help and support that she can access. See **Section 3 – Refer (Review)** for services.

### Avoid:

- » blaming her;
- » minimising her experiences, for example, by blaming the abuser's behaviour on drugs and/or alcohol (many people use drugs and/or alcohol without being abusive to their partners – an abuser has a choice about how to behave);
- » telling her what to do – her confidence has already been eroded, including her capacity to make decisions (she needs to be able to make her own choices and decisions) – this includes suggesting that she apply for a domestic violence order (please see **Appendix 5** regarding information on domestic violence orders);
- » making negative comments about her partner (as difficult as this may be), as she may feel the need to defend him – instead concentrate on his behaviour and how it is impacting her;
- » asking, if she is not alone, or you could be overheard; and
- » directly confronting the partner about the abuse, as this may put everyone including children, if they are in the situation, at an increased risk of danger.

**The woman's safety and the safety of any children in the situation are the paramount consideration.**

Questioning or screening is not a one-off activity, especially for certain high-risk groups and for ongoing patient interaction. It is fine to ask more than once, for example, during pregnancy.



## 2.3 Child Welfare and Protection

Exposure to domestic violence is an indicator of the emotional abuse of children and one of the circumstances that may make a child more vulnerable to harm (Department of Children and Youth Affairs, 2017).

Recent Trinity College Dublin research found a direct correlation between children witnessing abuse and experiencing childhood abuse (McGavock and Spratt, 2016). Witnessing abuse or experiencing abuse has similar effects on children (Mertin and Mohr, 2002).

Child welfare and protection is a priority. If you have concerns about a child, then contact your local duty social work team. The Tusla website has a list of each social-work department in each area. A link to the website can be accessed in **Section 5.1: Further-Learning Resources**, at the end of this manual. If you have immediate concerns about a child and it is outside of office hours, you can contact the Gardaí directly.

Confidentiality limits should be explained from the outset, explaining duty of care and safety. It is useful to have a list of the limits of confidentiality, such as:



It is important to familiarise yourself with your organisation's policy on limits to confidentiality, and have examples to hand to discuss with a patient or service user. Discussing these at the outset provides transparency on duty-of-care obligations and will reduce the potential for unintentional upset to the patient or service user. It is best to keep checking for understanding with your patient or service user, to see if s/he is happy to proceed with the disclosure, and explain that you might have to tell someone about what has been said, or report the details.

Best-practice responses in relation to disclosures of abuse from children or young people include the 'Receive, Reassure and Respond' approach:

### Receive

- » Listen. Don't look shocked, don't be judgmental, and do take the child seriously.

### Reassure

- » Stay calm. Tell him/her that s/he has done the right thing in telling you.

### Respond

- » Don't interrogate. Let him/her tell you as far as possible, make notes of any injuries that you have seen or been shown, record what you did next and with whom, and explain what will happen next. Check if the child is safe to talk to you. How has s/he told you that s/he is safe? Do you need to make some adjustments?

### Factors that affect or impact on children and their responses

Protective factors: not all children living in domestic violence experience negative impacts in the long term. With the help of supports, the long-term negative effects of domestic violence on children and young people can be reduced.

#### Factors that can reduce negative impact include:

- » resilience;
- » the non-abusive parent;
- » support networks; and
- » professional support.

#### Other considerations include:

- » the frequency and severity of the domestic violence heard/observed;
- » the length of time exposed thereto; and
- » issues related to race, culture, age, gender, disability, sexual orientation and socio-economic status (norms). **Section 4.1: Intercultural Health** touches on cultural issues like the importance of extended family for certain minority groups, such as Travellers and Roma. For victims of domestic abuse, leaving the abusive relationship can mean having to remove their immediate family from the extended family and supports. Migrant women may feel pressure from their extended family in their country of origin to remain in the relationship.



# 2.4 Assessing Risk

There is no standardised risk assessment framework in Ireland. Assessing different levels of risk allows workers to develop appropriately targeted interventions. The *Children First* guidelines (2017) state that ‘a proper balance must be struck between protecting children and respecting the rights and needs of parents/carers or families. Where there is conflict, a child’s welfare must come first.’

There are many indicators that highlight risk in relation to domestic violence. It is important to note that during pregnancy, and in the post-natal period, the risk of violence can escalate.

### Five key questions, which are helpful to assessing immediate risk:

1. Does the abuser have access to weapons, or has s/he threatened to use weapons?
2. Has the victim ever been hospitalised or injured by the abuser?
3. Have there been previous or are there current threats to kill (e.g. the victim, self, child, pet)?
4. Has there been extreme physical abuse, e.g. choking?
5. Has there been previous or is there current stalking behaviour, e.g. possessiveness/control?

### Key Messages in Relation to Domestic-Violence Risk

#### Change in Risk:

- » Any escalation in the frequency or severity of violence (this requires immediate action by a health- or social-care professional)

#### Power and Control:

- » Extreme possessiveness, jealousy or obsession with partner

#### History of Violence:

- » Profile of abuser, criminality, threat of suicide, previous relationship abuse

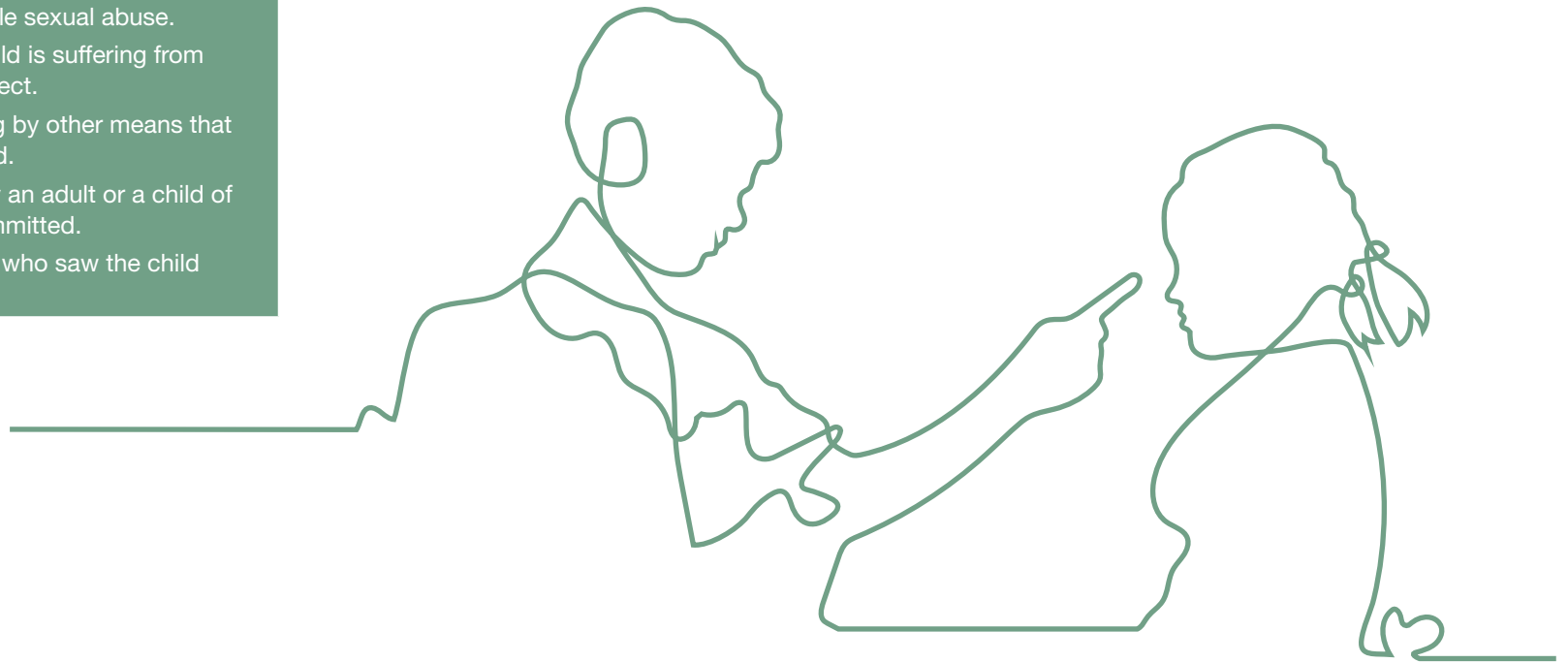
#### Context

- » Pregnancy, new baby or recent separation

## 2.5 Indicators for a Referral to Social-Worker Services (Tusla)

**Children First: National Guidance for the Protection and Welfare of Children (2017) gives the following indicators for making a referral to Tusla:**

- » Evidence of an injury or behavior that is consistent with child abuse, which is unlikely to have been caused in any other way.
- » Any concern about possible sexual abuse.
- » Consistent signs that a child is suffering from emotional or physical neglect.
- » A child saying or indicating by other means that he or she has been abused.
- » Admission or indication by an adult or a child of an alleged abuse they committed.
- » An account from a person who saw the child being abused.



# 2.6 Safety Planning

The safety of women and children in abusive situations is a priority, and any interventions, in which the supportive person or health-/social-care professional has considered the risks posed, enhance the safety of a woman and her children.

**It is important to recognise that although a safety plan can reduce the risks of violence, it cannot completely guarantee safety. Risk is changeable, particularly increasing if a woman is considering leaving, and therefore safety planning needs to be done on an ongoing basis, where possible.**

## What is a safety plan?

Safety planning is an intervention that assists women and children in exploring ways to help them to be safe.

Women and children cannot control perpetrators' abusive behaviour, but they may be able to take steps to help protect themselves and increase their safety.

A safety plan is a semi-structured way to think about steps that can be taken to reduce risk before, during and after an incident of abuse.

Note: Refer to **Appendix 4** for safety plan worksheets.

## How to develop a safety plan

Risk assessments can inform safety plans – the level and type of risk.

Women will already have coping strategies and skills that they find effective in managing their safety. It is important to acknowledge and explore these and use them to guide safety plans.

Safety plans can be developed for a woman and child in whatever situation, e.g. choosing to leave the relationship, choosing to stay, having already left the relationship, at access visits, school collection, etc.

It is important to think about safety **FROM** violence, abuse, threats, etc., as well as safety **TO** engage with services, work, friends, education, etc.

Safety planning with children must be carried out in an age-appropriate, child-friendly manner.

## Sample questions that can help in drawing up a safety plan:

- » What do you currently do to keep you and the children safe? What works best?
- » Who can you trust to tell about the abuse?
- » If you left, where could you go?
- » Do you ever suspect that your partner is going to be violent, for example, when he gets paid, after family/friends visit, when he is drinking, etc.?
- » Can you keep a bag of spare clothes and important documents (birth certificate or passport) at a family member's or friend's house?
- » What is the most dangerous part of the house to be in when he is violent?
- » Can you teach your children a code word to alert them of danger and how to make an emergency call?

(Source: Stella Project, 2007)

## Safety planning with children

Everyone has the right to feel safe from harm. It is important that children and young people have steps to take action to stay safe during an incident.

### Safety planning for children typically encompasses four areas:

- » telling someone they trust about the abuse;
- » having a code word that signals the need for help;
- » agreeing a safe place to go during an incident; and
- » knowing how to ring the Gardaí.

### Sample safety plan (for emergency):

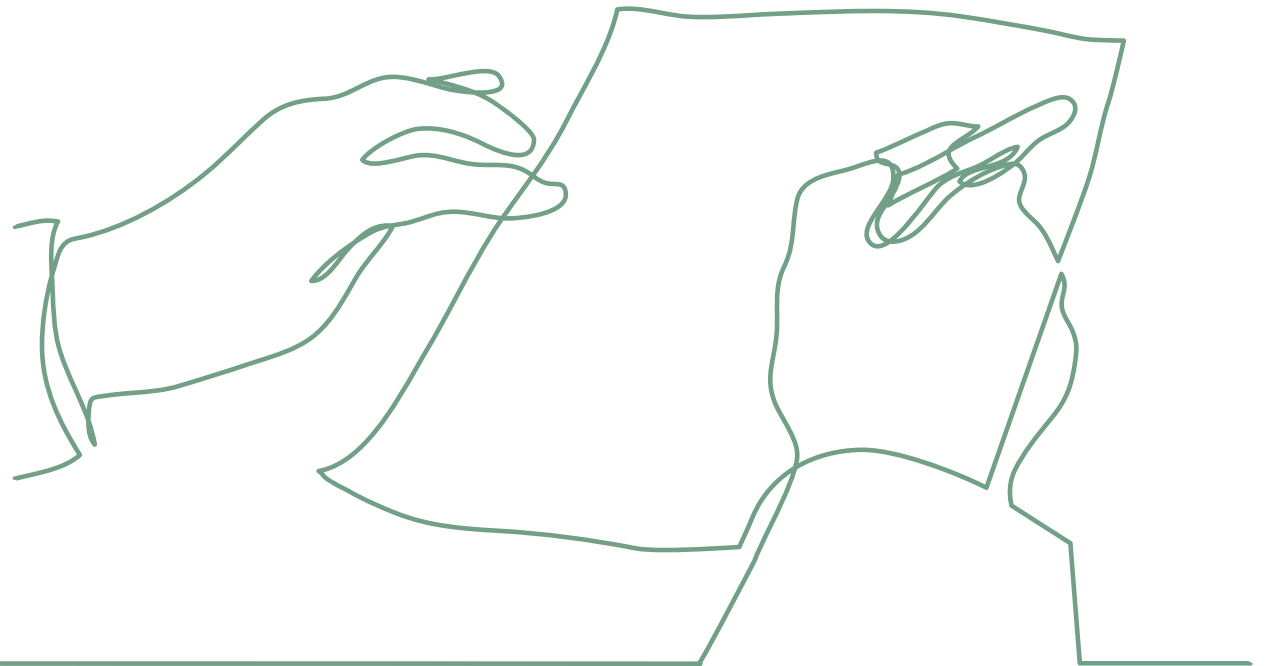
- » When my mammy and I are not safe, I will not try to stop the fighting. I will go to my room or to my next-door neighbour's home.
- » If I call the Gardaí for help, I will dial 112 or 999 and tell them:
  - » My name is \_\_\_\_\_.
  - » I need help.
  - » Tell the Gardaí, 'Someone is hurting my mammy. My address is \_\_\_\_\_.'
  - » I will remember not to hang up until the Gardaí get there.
  - » A code word for help or 'I'm scared' is \_\_\_\_\_.
- » I will practise this with my mammy.



## 2.7 Recording

**Recording or keeping notes on disclosure or discussion of domestic violence can be challenging. The following guidelines might be of use:**

- » Tell the victim what you would like to write down and why. Ask her if this is OK with her. Follow her wishes. If there is anything she does not want written down, do not record it.
- » Keep detailed, accurate records about a victim's injuries and what is disclosed to you.
- » Try to avoid using descriptive language, and keep to facts stated to you or observed by you. Use the exact language/words used by the woman in the description of what happened.
- » Avoid words such as 'alleges' or 'claims', as this implies disbelief. Quote the discussion directly instead.
- » Ensure that records are safe from interception/sighting by a third party, for example, in a case in which entire families are included in the record.
- » Remember that your (clinical) notes may be the only record of evidence in subsequent legal proceedings.
- » Keep a record of the content of the discussion, as statements made may be admissible as evidence in legal proceedings.
- » Any evidence that can be documented after a disclosure is useful, such as photographs, using body maps to document injuries.
- » Even if there wasn't a direct disclosure, records such as attendance at a clinic can be useful.
- » Keep a record of what was discussed.

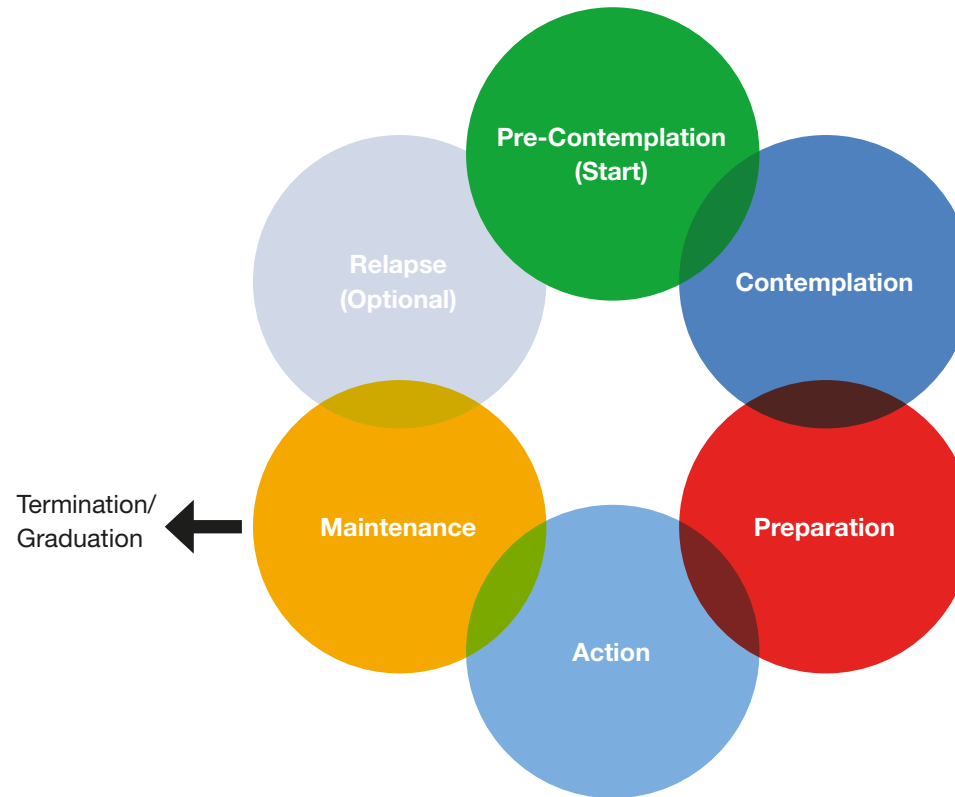


## 2.8 Readiness to Change

Making changes in any aspect of our lives can be a challenge. This is particularly true for women living in abusive situations. Change is often a process, and not an overnight, one-off event. Many women make several attempts at leaving abusive relationships. Effective interventions should empower a woman to feel in control of her own life, and to be able to make changes that enhance her safety and improve her well-being. By talking to her about her experience and situation, you can assess her readiness to change, at what stage of change she may be, and what supports and interventions she may want and need during this process.

While this resource focuses on the stages-of-change model, another model widely used among domestic-violence service providers is the 2005 model developed by Professor Liz Kelly, 'Working from where the woman is at: Crisis Intervention Model.' This model is used in the *HSE Practice Guide on Domestic, Sexual and Gender Based Violence: For staff working with children and families* (Health Service Executive, 2012) and included in **Appendix 3**.

### The Stages of Change



## Overview of sample beliefs and ‘nudging’ strategies for each stage of change:

1 Pre-Contemplation:	2 Contemplation or ambivalence:	3 Preparation:	4 Action:	5 Maintenance:	6 Relapse:
<ul style="list-style-type: none"> <li>» <b>Belief</b> – ‘My relationship is not a problem.’</li> <li>» <b>Strategy</b> – Learn about the relationship. For example, ask open-ended questions: ‘Tell me how you and your partner handle conflict in your relationship.’</li> </ul>	<ul style="list-style-type: none"> <li>» <b>Belief</b> – ‘I know the violence is a problem, but I need to stay in the relationship.’</li> <li>» <b>Strategy</b> – Discuss the ambivalence, for example, ‘What are the good things about your relationship? What are the not-so-good things? How would you change things if you could?’</li> </ul>	<ul style="list-style-type: none"> <li>» <b>Belief</b> – ‘The violence is a problem, and I’m planning some changes.’</li> <li>» <b>Strategy</b> – Offer support and encouragement. Clarify plans. Prioritise safety planning. List community resources. Provide anticipatory guidance.</li> </ul>	<ul style="list-style-type: none"> <li>» <b>Belief</b> – ‘I am making changes.’</li> <li>» <b>Strategy</b> – Offer support and encouragement. Prioritise safety planning and support systems. List community resources. Review coping strategies.</li> </ul>	<ul style="list-style-type: none"> <li>» <b>Belief</b> – ‘I have adapted to the changes.’</li> <li>» <b>Strategies</b> – Offer support. Review the need for community resources. Discuss coping strategies.</li> </ul>	<ul style="list-style-type: none"> <li>» <b>Belief</b> – ‘I cannot maintain this change. I am resuming the relationship.’</li> <li>» <b>Strategy</b> – Remain positive and encouraging. Discuss lessons learnt from the effort. Review safety plan. Remain open for future discussions and support.</li> </ul>

Adapted from ‘Stages of Change’ for women affected by domestic violence (Prochaska and Di Clemente, 1982)

# 2.9 Dealing with Your Fears and Frustrations

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It is important to recognise that the support process can be slow, as is any change, and note your expectations as a professional throughout the process. Some points to consider include:

The victim might never leave the relationship.

Leaving is a process and can take a long time.

You do not have to be alone during the process. You should avail of support from colleagues and specialised services.

Get to know the local support services and specialised services, so you can provide information to your clients, service users, or patients.

You do not have to know everything there is to know about domestic violence. Listening to the victim and having information on support services is an important support for him/her.

Be aware of your safety and the impact that supporting a victim of domestic violence can have on you. Refer to **Section 2.10 (Self-Care)**.





## 2.10 Self-Care

Disclosures of violence affect everybody differently. Working with the effects of violence professionally can impact on well-being (please see **Section 1.5: Trauma**). Self-care is the act of taking care of our physical, mental and emotional well-being, and recognising the body and mind's healing capacity, which is enhanced through self-care practices. Self-care is an ongoing process.

How do we self-care? Most professionals do it already. Firstly, it is about:

### Increasing self-awareness:

- » Early warning signs of need to self-care – unique to everyone, although there are lots of common signs (headache, feeling overwhelmed, energy levels, emotional eating, or no hunger)
- » Noticing triggers – similar things that challenge our well-being
- » Identify self-care strengths

### Self-care strengths – identifying things that support self-care:

- » These could include supports – colleagues, line manager, or supervision; daily practices – practical things that can be implemented into the working day; or weekly practices – positive outlets that promote well-being.

Maintaining physical, mental and emotional health is vital for everyone, but it can be particularly important for those working in the health- and social-care professions. Practising self-care can be an antidote to burnout, which is a combination of mental, emotional and physical exhaustion.



# 2.11 Summary of Best Practice: Respond

The World Health Organization has developed a useful guide in best-practice responses in relation to sexual and domestic violence (World Health Organization, 2014). The WHO 'LIVES' resource is a valuable tool to summarise the 'Respond' section. Health- and social-care professionals can use this summary on a daily basis to remind themselves about how to implement the interventions described in this section, such as dealing with disclosures, asking the question, risk-assessing and safety planning. Please see **Appendix 2** for further details.

## LIVES

<b>Listen</b>	Listen to the woman closely, with empathy, and without judging.
<b>Inquire about needs and concerns</b>	Assess and respond to her various needs and concerns – emotional, physical, social and practical (for example, childcare).
<b>Validate</b>	Show her that you understand and believe her. Assure her that she is not to blame.
<b>Enhance safety</b>	Discuss a plan to protect herself from further harm if violence occurs again.
<b>Support</b>	Support her by helping her connect to information, services and social support.

# SECTION 3

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# REFER (REVIEW)

# 3.1 Refer

Suggesting a referral provides a victim with information about the supports available to him/her. Knowing how to make an appropriate suggestion for a referral is the starting point. This section will outline how to make the appropriate referral required.

Domestic violence affects various aspects of women's and children's lives. No one service or individual has all the answers, or all the resources. A multi-agency, collaborative approach works well to ensure that all the needs of the woman and/or her family are addressed.

The referral will depend on that with which the woman has identified as needing help.

### Sample agencies for crisis support include:

- » An Garda Síochána;
- » Legal Aid;
- » Sexual Assault Treatment Units (SATUs);
- » hospitals;
- » GPs or medical centres;
- » helplines – domestic abuse, sexual abuse; and
- » emergency refuge/accommodation.

### Sample agencies for follow-on support include:

- » supported housing;
- » domestic-violence specialist service;
- » social-welfare office;
- » helpline;
- » local addiction service; and
- » counselling service.

Once you have agreed with the victim that a referral to a specialist service will be made, the following may be of use:

Identify her priority needs. Ask, 'What is your main concern?' The referral should address her most important, pressing needs.

Referrals need to be consensual in order to avoid a situation whereby risk to the woman and children is increased. If possible, check for understanding of consent. To what is she consenting?

Be familiar with the specialist services in your area. Refer to **3.2 Services** for national contacts, which can lead you to local services. You could visit services, or invite them to your team meeting to talk about what they offer.

If possible, have the relevant forms and information leaflets, and knowledge of the support process in the specialist service. For example, is it accompaniment only, or will there be follow-on support? If the woman decides to take information away with her in written format, ask her if it will be safe to keep it. Can it be seen by the perpetrator?

It is advisable to encourage the woman to make contact with a service/agency herself, however, it is OK to make the call for her, if she wishes – 'We can call them together.'

Listen and reassure her – 'You are not alone.' The approach should empower the woman to undertake action with which she is comfortable, and at a time when she feels ready and able to do it – 'This agency specialises in domestic abuse and is there to help.'

If possible, assist her to ask someone to accompany her to an appointment, and explore practicalities, such as public-transport options, childcare needs, if the service is free of charge or has a related cost, etc.

## 3.2 Services

The following is a list of possible agencies for referral, depending on the support needs identified. It is important to know the services available in your area. **5.1 Further-Learning Resources** lists further resources available to review.

### DOMESTIC-VIOLENCE SUPPORTS

- » Sonas: Advice line (087 952 5217), 24-hour refuge (01 866 2015) and [www.domesticabuse.ie](http://www.domesticabuse.ie); provides online resources, including information on domestic violence orders.
- » Women's Aid: 24-hour helpline (1 800 341 900) and [www.womensaid.ie](http://www.womensaid.ie); the Women's Aid National Freephone Helpline can offer support to women in over 170 languages through the Telephone Interpretation Service.
- » Safe Ireland: Advice line (090 647 9078) and [www.safeireland.ie](http://www.safeireland.ie); provides details of domestic-violence services nationwide.
- » Cosc: [www.whatwouldyoudo.ie](http://www.whatwouldyoudo.ie) lists support services, including domestic-violence services.
- » Nasc: [www.nascireland.org/know-your-rights/domestic-violence/](http://www.nascireland.org/know-your-rights/domestic-violence/); provides supports specifically for migrants and ethnic minorities.
- » Move (Men Overcoming Violence): The head office is in County Clare (065 684 8689) and it is also based in Cork, Tipperary, Limerick, Dublin and Galway. See [www.moveireland.ie](http://www.moveireland.ie), a national organisation that provides intervention programmes for perpetrators of domestic violence.
- » AMEN: Advice line (046 902 3718) open from 9am to 5pm Monday to Friday ([www.amen.ie](http://www.amen.ie)); a dedicated support service for male victims of domestic violence in Ireland.
- » Elder abuse: Information line (1850 241 850, Monday to Saturday, 8am-8pm) and [www.hse.ie/go/elderabuse](http://www.hse.ie/go/elderabuse); this is an HSE-dedicated elder-abuse service, with senior case workers in elder abuse now working in most local health-office areas.

### CHILDREN AND YOUNG PEOPLE

- » Tusla ([www.tusla.ie](http://www.tusla.ie)), the Child and Family Agency, with statutory responsibility for child welfare and protection, universal children's services, including family support, education and welfare, also provides for sexual, domestic and gender-based services.
- » Barnardos ([www.barnardos.ie](http://www.barnardos.ie)) provides services for vulnerable children and families.
- » Jigsaw ([www.jigsaw.ie](http://www.jigsaw.ie)) provides mental-health services to young people aged 12-25 years.
- » Irish Society for the Prevention of Cruelty to Children – ISPCC ([www.ispcc.ie](http://www.ispcc.ie)) provides services to children, including the national helpline, Childline (1 800 666 666).

### LEGAL

- » Gardaí (emergency: 999/112) – Local Garda station details: [www.garda.ie](http://www.garda.ie)
- » Legal Aid Board – The main office is in Co. Kerry (066 947 1000), but local-area offices can be found on <https://www.legalaidboard.ie/en/contact-us/find-a-law-centre/>.
- » Free Legal Advice Centres (FLAC) – Lo-call 1890 350 250 plus local-area centres: <https://www.flac.ie/help/centres/>
- » Courts – Family and district law: <http://www.courts.ie/Courts.ie/Library3.nsf/0/86900F-85DDB12EB780257FB00056C676?opendocument&l=en>

## HEALTH

- » Sexual Assault Treatment Units – Cork, Dublin Donegal, Galway, Mullingar and Waterford: <http://www.hse.ie/eng/services/list/5/sexhealth/satu/>
- » Local GP and medical centres, Well Woman Centres, hospitals
- » Local mental-health services, Samaritans' 24/7 service on 116 123, counselling services, addiction services
- » Drugs/HIV helpline (1800 459 459) or [helpline@hse.ie](mailto:helpline@hse.ie)
- » For information on drugs and alcohol, see [www.drugs.ie](http://www.drugs.ie) and [www.askaboutalcohol.ie](http://www.askaboutalcohol.ie).

## HOUSING

- » To apply for local-authority housing, download an application form from your local authority's website or contact its housing department directly. Find more information about eligibility criteria here: [http://www.citizensinformation.ie/en/housing/local\\_authority\\_and\\_social\\_housing/applying\\_for\\_local\\_authority\\_housing.html](http://www.citizensinformation.ie/en/housing/local_authority_and_social_housing/applying_for_local_authority_housing.html).



# 3.3 Review

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It is important to understand that it might take several visits before a disclosure of domestic abuse is made, and, where possible, an open-door approach should be taken.

Where a disclosure of domestic violence is made, continuing understanding and support are vital, as it may take a woman demoralised by years of violence and abuse a long time to find the confidence and courage to choose a different life. It is important to communicate your open-door policy in terms of coming to you for help (Irish College of General Practitioners, 2014).



# 3.4 Summary of Best Practice: Refer and Review

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## REFER and REVIEW

- » Follow 3R guidelines: Recognise, Respond and Refer.
- » Use the LIVES (WHO) model.
- » Be aware of different terms and phrases used by women, for example, local language.
- » Be sensitive to pregnant women in relation to the background of their pregnancy, and recognise that this is a time of increased risk for them.
- » Know how to access translation and interpretation services. Please see **Section 5.1: Further-Learning Resources**.
- » Know your local sexual- and domestic-violence services.
- » Make your setting sexual- and domestic-violence disclosure friendly. Please refer to the points in **Section 2.2: Good-Practice Responses: Brief, Focused Interventions**.



# SECTION 4

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# THEMES

# 4.1 Intercultural Health

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Provision of culturally competent health services that are respectful of, and responsive to, the cultural and ethnic diversity of service users is intrinsic to quality, effective service delivery. The goal of culturally competent health-care services is to provide the highest quality of care to every patient, regardless of ethnicity, cultural background, English proficiency or literacy. Patients are at higher risk of negative health outcomes, receiving poor-quality care or being unhappy with their care if providers, organisations and systems are not collaboratively working to provide culturally competent care. The HSE report *Learning, Training and Development Needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities* (2005) confirmed the desire and willingness of staff in the health services to be supported in providing a culturally competent service.

An extensive review (Bainbridge *et al.*, 2015) was carried out in Australia to examine available evidence on cultural competence in health-care settings, to identify key approaches and strategies.

The review noted that ‘developing and embedding cultural competence in health services requires a sustained focus on knowledge, awareness, behaviour, skills and attitudes at all levels of service, including at operational or administrative service level, health practitioner level, practitioner-patient level and student-training level’.

Organisational commitment to all elements of intercultural health is required to support staff members who have gained the necessary knowledge and skills through training. This organisational support extends to: supporting staff to access training, implementation of intercultural health policies and practices, organisational support for sufficient training time, management support for training, continued professional development, and support for staff affected by the issues.

A train-the-trainer programme called ‘Intercultural Awareness and Practice in Health and Social Care’ was developed by the HSE Social Inclusion Service in South-East Community Healthcare, providing a useful model for an ongoing national roll-out. The model was developed in partnership with Quality Matters (a not-for-profit organisation working to improve social-service provision in Ireland) and Nasc (the Irish Immigrant Support Centre). The accompanying *Intercultural Awareness and Practice in Health and Social Care* participant’s guidebook (Health Service Executive, 2016) was also developed, relevant extracts from which have been included here.

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## Experiences of minorities in health care

The right to a recognised standard of health is an internationally recognised human right, however, there is substantial evidence of inequality in the state of health and accessibility and the quality of health-care services experienced by minority and vulnerable groups across the globe. In an Irish context, the HSE's *National Intercultural Health Strategy 2007-2012* states, 'It is acknowledged that people from minority ethnic groups are at increased risk of poverty and social exclusion.' The HSE has highlighted that responding to the needs of *all* communities in an equitable, accessible, person-centred way is of principal importance, however, some individuals from ethnic or vulnerable groups have had an inadequate health experience in Ireland.

Research shows that migrants and ethnic minorities have experienced difficulties in accessing health and social services for a variety of reasons relating to their cultural, ethnic or religious backgrounds and their exclusion from mainstream Irish society. For migrants, access to health-care services is closely linked to and dependent on their working and living conditions and legal status. Low pay, poor accommodation and working conditions, social isolation, legal and status issues affecting their eligibility for social-welfare entitlements, and racism and discrimination can lead to health inequalities and impinge on migrants' and minorities' access to health services.

Migration itself can produce health-related issues, of which health-care providers may not have cognisance. Traumatic migratory experiences (such as torture, sexual violence, or trafficking) can influence the mental health and well-being of migrants. In some situations, post-migration conditions and experiences, such as being housed in direct provision for several years, can also contribute to or exacerbate poor mental health.

The issues that migrants and ethnic minorities experience in accessing health and social services can include:

- » communication issues (e.g. language barriers, lack of interpreters, literacy issues);
- » knowledge and informational deficits;
- » immigration-related poverty (e.g. the impact of legal status on eligibility/entitlements);
- » a lack of cultural competency from health-care providers;
- » a lack of trust; and
- » discrimination.

These and other issues can make migrants and ethnic minorities particularly vulnerable. Those such as refugees and asylum seekers, victims of trafficking, unaccompanied children, undocumented migrants, or members of the Roma and Traveller communities are hesitant to seek out much-needed health services. Worryingly, research has shown that, following negative experiences in the health-care system, individuals may subsequently make adverse choices, such as delaying treatment or self-medicating, which could have serious consequences for their health.

(Source: Health Service Executive, 2016)

## Equality or diversity?

Promoting equality and diversity has become a hallmark of good practice in the provision of health- and social-care services. Although the terms 'equality' and 'diversity' are often used interchangeably, they mean different things.

Equality means treating everyone equally, regardless of their colour, age, gender, ethnicity, sexual orientation or disability (that is, adhering to Ireland's equality legislation), however, diversity extends beyond equality. It is about recognising individual as well as group differences, and changing how you behave in order to accommodate the unique and distinct needs of different groups. The Department of Children and Youth Affairs notes that equality and diversity are not about treating everyone the same – they are about treating people in such a way that the *outcome* for each person can be the same.

Every professional and organisation will, at a minimum, endeavour to promote equality, and some will go further than others to promote diversity.

(Source: Health Service Executive, 2016)

## Cultural health norms and local resources

Culture can be considered at a number of levels: the technical level is policy, law and strategy, and the deeper level of culture is comprised of people's beliefs, values and attitudes, i.e. cultural norms. The iceberg-theory-of-culture image, used to illustrate this understanding, is very useful.



Like an iceberg, culture is not static – it changes over time. An iceberg rarely floats in the ocean on its own – it is often surrounded by other icebergs of different sizes and shapes, which bump into each other or float away from each other, depending on ocean currents. This is important, as an understanding of culture as fixed and unchanging can lead to cultural misunderstandings, and even stereotyping, wherein we develop an oversimplified idea about a person or group of people.

In a diverse society, there are many cultural beliefs, values and attitudes floating around, however – and this is how culture differs from icebergs – all of these cultural norms operate within one overarching technical level: the policies and laws of one particular place. Many people working in front-line health- and social-care settings desire a working knowledge of some of these cultural norms to be able to provide a sensitive and culturally appropriate service.

The HSE's *Health Services Intercultural Guide* (2009) is an excellent resource for health-care workers to reference when coming across a situation in which an unknown cultural or religious issue has emerged. The purpose of the guide is to 'provide information to health care staff so they can deliver a sensitive, appropriate and quality service across cultural lines'. The guide profiles 21 religious groups, three ethnic/cultural groups, and people without religious beliefs.

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Information about each of the 25 groups is organised under the following headings, or essential practice points:

- » Profile of the group
- » Care of the ill
- » Care of the dying
- » Religious icons and symbols
- » Additional notes on maternity and paediatric care
- » Developing a local contact

It is important to remember, however, that understanding diverse cultural norms is not just about having a familiarity with the basics of different cultural practices. A significant amount of research suggests that there is often more variation within cultures than between cultures, and other influences, such as class, family of origin, and education, can significantly impact on cultural norms. Understanding diverse cultural norms means understanding that not every individual will make the same choices or have the same needs, even though everyone is living in the same country and accessing the same services.

While the guide is an excellent starting point for gathering information about the basic practices of different religions and cultures, it is extremely important that this information not fully dictate how you deliver health-care services to an individual.

We all know what cultural norms are, and our individual behaviours can be wildly different, depending on the context. You cannot assume that just because a person is Muslim, that his/her individual needs closely align to Islamic religious norms. 'Many complex and interrelated factors determine a person's relationship to any particular cultural or religious norm (Health Service Executive, 2009).' This is particularly true of migrants and their children, who are adapting to a way of life in a new country. This is particularly poignant in a health-care setting, where cultural misunderstandings can impact on people's health and well-being.

Equal access to health care does not mean treating everyone the same. It means offering everyone the same opportunity to achieve comparable health outcomes, which, in turn, requires an understanding of interculturalism or cultural competence.

According to the HSE's *Health Services Intercultural Guide* (2009), 'interculturalism' means the willingness of an organisation to ensure that cultural differences are acknowledged, respected and provided for in a planned and systematic way in all systems processes and practices. This involves developing individual and organisational cultural competence.

The *HSE's National Intercultural Health Strategy*, (2007), states:

'Cultural competence is more than an awareness and knowledge of different cultures and ethnicities; Lister describes a culturally competent staff member as one who provides or facilitates care which respects the values, beliefs and practices of the client, and which addresses disadvantages arising from the client's position in relation to networks of power.'

(Source: Health Service Executive, 2016)

## 4.2 The Needs of At-Risk or Marginalised Groups

This section will specifically refer to migrants, Travellers and Roma, but there is commonality between the needs of these minority groups and other marginalised groups. While domestic abuse can occur to any person, a range of factors place ethnic-minority women at a higher risk than the rest of the population.

They include the twofold discrimination of gender and ethnic origin, migrant status, increased isolation, and social norms that are defined by patriarchal values (Pavee Point Traveller and Roma Centre, n.d.).

Some people may be victims of trafficking for sexual exploitation, while victims of FGM experience significant health care needs. LGBTI+ persons can experience particularly high levels of stress due to the stigma and discrimination they may face as a result of their cultural backgrounds. This in turn creates barriers to accessing services. It also increases their risk of social isolation.

It is also important to highlight/note that another group at risk is that of victims who are homeless, either because of domestic abuse or violence experienced while homeless. The research evidence presented in *Women's Homelessness in Europe* (Mayock and Bretherton, 2017a) draws strong attention to the role of domestic and other forms of gender-based violence in women's homelessness. Intimate-/male-partner domestic abuse or violence is the reason why many women are forced to leave their homes. The relationship between domestic violence and women's homelessness has other complex dimensions and may result in (some) women remaining in abusive home situations because they do not have the economic

resources to leave. These women essentially find themselves choosing between domestic violence and homelessness.

A study by Mayock, Parker and Sheridan (2015) found that women who were problematic drug and/or alcohol users and/or who experienced mental-health issues and who become homeless as a result of domestic violence often did not consider accessing a domestic-violence service because they believed that they did not 'fit the criteria', presenting instead to homeless services and or alcohol/drug treatment support services. The study also found that women reported being reluctant to access domestic-violence services because of the shame and stigma associated with domestic abuse and/or marital breakdown, linked to a fear of rejection by family members and others. Women frequently avoid homeless services because of fear and because they feel threatened, unsafe and insecure (Mayock and Bretherton, 2017b).

When working with women experiencing domestic abuse, it is useful to identify if they are at risk of homelessness and if they are potentially remaining in an abusive relationship because of having 'nowhere else to go'. Working in partnership with other service providers will better support women to access appropriate accommodation and meet their particular needs.

The situation for Traveller and migrant women can be quite different, due to language and residency status, but some issues are common for ethnic-minority women. Traveller women in Ireland generally have residency status, as they are an indigenous Irish group, whereas migrant and Roma women usually have a different civil status, as they have to prove that they are habitually resident in order to be considered eligible for services (including income support, housing, emergency housing, etc.). There is further information in **Appendix 6: The Impact of the Habitual Residence Condition (HRC) on Travellers and Roma**.

Note: The Council of Europe advises us not to categorise Roma as migrants, as they are EU citizens and should be acknowledged as such.

It is also important to note that violence is NOT inherent in ethnic-minority cultures.

#### Common issues include:

- » fear and mistrust of police and statutory services as a result of racism, discrimination and negative treatment in the past and today;
- » limited knowledge of the legal system;
- » limited or inaccurate information on entitlements;
- » immigration-related poverty, for example, the impact of legal status on eligibility/entitlements;
- » the importance of extended family (leaving the abusive relationship can mean having to remove herself from her extended family and supports; migrant women may feel pressure from extended family in their countries of origin to remain in the relationship);
- » communication issues, for example, language barriers, lack of interpreters, literacy issues;
- » lack of cultural competency by health-care or other provider; and
- » discrimination.

(Source: Pavee Point Traveller and Roma Centre, n.d.; Health Service Executive, 2016)

## Issues and barriers for refugees and asylum seekers

For refugees and asylum seekers coming to Ireland, there are specific issues, such as:

**adapting to a new country, language, etc.;**

**re-traumatisation through having to give detailed accounts of rape and associated events at interview;**

**delays in accessing medical help or counselling;**

**ongoing medical or gynaecological complications, including chronic pain, operations, the trauma of HIV testing;**

**lack of information about services and resources; and**

**the ordeal of having to deal with professionals while not fully understanding what is being said, and having to tell his/her story through an interpreter. In the absence of an interpreter, sometimes a child or family member is the interpreter, placing an unreasonable responsibility on the family member (Irish Family Planning Association, 2010).**

Please refer to **Section 5.1: Further-Learning Resources** for further information on translation and interpretation.

## Issues and barriers for Traveller and Roma women

There is a myth that domestic violence is part of the Traveller and Roma 'cultures'. Domestic violence actually impacts all social and ethnic groups.

Traveller and Roma women face further barriers to exiting violent relationships/households due to the effects of discrimination and social exclusion in:

- » **education** - low levels of awareness, information, literacy and language skills;
- » **employment** - unemployment, poverty and lack of means to provide for basic needs if she leaves;
- » **housing** - discrimination and expulsions by local authorities and private landlords, poor accommodation conditions and overcrowding, not enough Traveller-specific accommodation provision, etc.;
- » **health** - discrimination and negative treatment or lack of trust, and lack of access to medical cards and GPs among many Roma to deal with the effects of violence;
- » **social protection (the right to reside and habitual-residence condition)** - Roma and Traveller women who do not qualify for social-protection payments and benefits have very limited support options;
- » **isolation** - leaving a violent relationship may mean leaving her community; and



- » **the shame and stigma associated with violence**  
- a barrier to talking and reporting violence.

(Pavee Point, n.d.)

There are also cultural factors at play. In some Roma communities (usually the very traditional ones), it is not socially acceptable for a woman to leave her husband/partner, and it would not be supported by her community if she did so. In addition, violence against women is socially acceptable in some Roma communities, and so it is not an issue therein. Please see the Council of Europe's website ([www.coe.int](http://www.coe.int)) for further details in relation to violence against Roma women in Europe in the *Thematic Action Plan for the Inclusion of Roma and Travellers (2016-2019)*.

(Health Service Executive, 2016)

Fear and mistrust in services are a result of racism, discrimination and negative treatment in the past and today, particularly a fear of social workers and An Garda Síochána, due to negative treatment and fear of children being taken into care. This fear is based on past practices of disproportionate numbers of Roma and Traveller children being removed into state care. Events in 2013 that saw two Roma children removed from families heightened fear among Traveller and Roma women in Ireland (Department of Justice and Equality, 2014). Pavee Point Traveller and Roma Centre's report, *Roma Communities in Ireland and Child Protection Considerations (2012)*, highlights grossly overrepresented Roma children in state care institutions. In Hungary and Romania, two thirds of all children in care are Romany. The reference for the full

European Roma Rights Centre report, *Life Sentence: Romani Children in Institutional Care (2011)*, is listed in **Section 5.1: Further-Learning Resources.**

(Pavee Point, n.d.)

### Points on Good Practice Guidelines

- » Recognise and understand the impact of multiple/intersectional forms of discrimination on Traveller and Roma women and how this creates further barriers for women who experience domestic violence.
- » Recognise that exiting violence is difficult unless one can access accommodation, social protection, employment, training, English-language classes, counselling, etc., and unless one has the support of one's community (particularly Roma).
- » Be aware of stereotypes/myths. Avoid ethnic/racial profiling and/or inaction.
- » Be aware of fear and low levels of trust in services among Traveller and Roma women, and build a relationship based on trust and confidentiality (even more important with Traveller and Roma women, who have additional fears of, or lack of trust in, services).
- » Emphasise confidentiality and its limits – communicate this clearly.
- » Check clients' understanding and ensure that the language is suitable.
- » Seek an interpreter when there are language difficulties and adhere to HSE policies on using interpretation services. Please refer to **Section 5.1: Further-Learning Resources** for further information on translation and interpretation.
- » Create an inclusive space, so diverse clients feel welcomed and have a sense of their identity being valued. Display posters and leaflets with translated information on different services/organisations.
- » Individuation: focus on the unique traits of the individual, rather than on traits ascribed to his/her group.
- » When working with women experiencing domestic abuse, it is useful to identify if they are at risk of homelessness and if they are potentially remaining in an abusive relationship because of having 'nowhere else to go'.
- » Access resources and further information, such as the HSE's Values in Action: Patient and Service User Dimension, which gives guidelines on best practice between the service user and the health-care professional (see **Section 5.1: Further-Learning Resources** for link).

(Source: Pavee Point Traveller and Roma Centre, 2011; Health Service Executive, 2016)



## 4.3 Sexual Violence in Intimate Relationships

### Definition

‘Sexual violence refers to assaults that have an explicit sexual content and includes a variety of forms including rape, sexual assault and sexual harassment. These forms of sexual violence can be perpetrated by family members, current and former sexual partners, other relatives and friends, acquaintances (including colleagues and clients), those in a variety of authority positions, and strangers. The many possible combinations of location and relationships mean that sexual violence can be in private or public locations, and in terms of rape, for example, can include many forms – marital rape, familial/incestuous rape, acquaintance/date rape, stranger rape, gang rape, custodial rape, and rape as a war crime.’

(Source: Department of Justice and Equality, 2010)

The Rape Crisis Network Ireland (2015) defines sexual violence as ‘Any actions, words or threats of a sexual nature by one person against a non-consenting person who is harmed by same. This could include: Rape, Aggravated sexual assault, Sexual assault, Sexual harassment, Ritual abuse, Trafficking, Reckless endangerment, Observing/voyeurism, Grooming.’

The Criminal Law (Sexual Offences) Act 2017, enacted in March 2017, has new measures to protect children, criminalises the purchase of sexual services, and introduces a statutory definition of ‘consent’ to a sexual act. The introduction of this statutory definition of consent to a sexual act brings Ireland into line with other common-law jurisdictions, but, moreover, provides a clear statement of the circumstances in

which consent would not be given. This is a welcome statement of the existing legal position, and one that provides much-needed clarity, according to the then Minister for Justice and Equality, Frances Fitzgerald, at the launch of the act (Department of Justice and Equality, 2017b).

As stated in **Section 1.3: Statistics and Prevalence Figures**, the European Union Agency for Fundamental Rights (2014) provides the following statistics:

**An estimated 3.7 million women in the EU had experienced sexual violence in the 12 months before the survey interviews.**

**One in three women (33%) has experienced physical and/or sexual violence since she was 15 years old.**

**Some 11% have experienced sexual violence (rape and/or assault) by a partner or a non-partner since the age of 15.**

**Some 5% have been raped since the age of 15.**

**Some 8% of women had experienced physical and/or sexual violence in the 12 months before the survey interviews.**

**Some 8% had experienced sexual violence by a partner or a non-partner since the age of 15.**

**Some 2% had experienced sexual violence by a partner or a non-partner in the 12 months prior to the interviews.**

**Some 9% had experienced sexual violence before the age of 15 by an adult perpetrator.**

The *HSE Practice Guide on Domestic, Sexual and Gender Based Violence: For staff working with children and families* (Health Service Executive, 2012) includes the following table on myths in relation to rape, which was adapted from that of the World Health Organization:

MYTH	FACT
Sex is the primary motivation for rape	Power, anger, dominance and control are the main motivating factors for rape.
Only certain types of women are raped	Rape is pervasive in all countries and in all levels of society.
Women falsely report rape	Only a very small percentage of reported rapes are thought to be false reports.
Rape is perpetrated by a stranger	The vast majority of rapes are perpetrated by a known assailant.
Rape involves a great deal of physical violence and the use of a weapon	Most rapes do not involve a great deal of physical force. The majority of survivors report that they were afraid of receiving serious injuries or of being killed and so offered little resistance to the attack. This may also explain why little force or weapons are needed to subdue survivors.
Rape leaves obvious signs of injury	Because most rapes do not involve a significant amount of force there may be no physical injuries.
When women say “no” to sex, they actually mean “yes”	“No” means no; a woman’s wishes in this regard should be respected at all times.
A man cannot rape his wife	Marital rape is a crime in Ireland.
Rape is reported immediately	The majority of rapes are never reported to the police. Survivors do not report at all or delay reporting because they think nothing will be done, the perpetrator may have made threats against them or their families, they are afraid of family or community responses or they are ashamed.

For further research on sexual violence, please go to the **Sexual and Domestic Violence** subsection of **Section 5.1: Further-Learning Resources**.

## Services and referral information

There are six Sexual Assault Treatment Units (SATUs) in Ireland. They provide specialist care for women and men aged 14 years and over who have recently been sexually assaulted or raped. SATUs are located in Dublin, Cork, Waterford, Mullingar, Galway and Letterkenny. In addition to these six SATUs, there is an out-of-hours service at the Mid-Western Regional Hospital in Limerick. There is no charge for any of the SATU services or follow-up appointments.

The National Sexual Violence Helpline is operated by the Dublin Rape Crisis Centre. It is a free and confidential listening and support service for women and men who have been raped, sexually assaulted, sexually harassed or sexually abused at any time in their lives. It is open 24 hours a day, 365 days of the year, and free to call on 1 800 77 88 88.

A list of all sexual-violence services across the country is available on the Cosc website: [www.cosc.ie](http://www.cosc.ie).

# 4.4 Domestic Violence and Drug and Alcohol Use

The connection between drug and alcohol use and domestic violence is complex. There is a link between violence and alcohol consumption. Many people who drink alcohol and use drugs do not abuse their partners. Most of the research to date in this area has been carried out in relation to alcohol, but there is no doubt that the level of intimate-partner violence identified among people receiving treatment for drug and alcohol misuse is a cause for concern.

- » A study by Gilchrist *et al.* (2017) found that participants considered alcohol to have a direct effect on their behaviour and did sometimes present alcohol as an excusable factor. However, alcohol's role in conflict was not restricted to times of intoxication, but extended across issues such as male entitlement to drink, control, prevention of his partner's drinking, and/or his spending from the family budget to buy alcohol.
- » A review of existing research on the matter, by Humphreys, Thiara and Regan (2005), concludes that 'there is no evidence to support a causal relationship between drug use and domestic violence'.
- » There is evidence that alcohol use by the perpetrator, victim, or both makes the extent and consequences of violence more severe (Graham *et al.*, 2011; Connor *et al.*, 2011), and these events are influenced by a drinking context (Zhan *et al.*, 2011).
- » Alcohol can be used in systemic way to excuse aggression or provide mitigation in legal proceedings (Graham *et al.*, 2011).

- » Individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking and the use of alcohol as an excuse for violent behaviour (Field, Caetano and Nelson, 2004).
- » Research into popular perceptions of domestic abuse indicates that increased blame is attributed to victims of abuse who have been drinking over those who have not. On the other hand, perpetrators who have been drinking receive less blame (Harrison and Willis, 2000).
- » A small-scale study in the UK showed that all of the women interviewed about the role of alcohol in their partner's abuse had also experienced violence and abuse from their partner when he had not been drinking (Jacobs, 1998).
- » Experiencing violence within a relationship can lead to alcohol consumption as a method of coping or self-medication (Wingood, DiClemente and Raj, 2000). The Yale trauma study showed that abused women are 15 times more likely to use alcohol and nine times more likely to use drugs than non-abused women (Barron, 2004).
- » Drug and alcohol use is often present in violent relationships. This can manifest itself in multiple ways. For example, the perpetrator may:
  - act as supplier and use access to drugs as a form of control;
  - force a partner to use drugs;
  - threaten to disclose a partner's use of drugs to the authorities, particularly where there are

children in the family, whom the mother fears will be taken away;

- limit access to information or treatment;
  - use a partner's earnings to buy drugs;
  - take out frustrations and aggression on a partner during a detoxification phase; or
  - sabotage a partner's attempts to stop using drugs or to enter into treatment.
- » Addressing a perpetrator's drug/alcohol use alone will not reduce his/her abusive behaviour. If treatment is able to reduce the severity of the violence, it does not address the complex dynamics of power and control that underpin domestic violence. Therefore, work that specifically addresses such dynamics should accompany a treatment plan.
  - » There is a need for further research into effective services for drug-using perpetrators and the development of training for front-line addiction services staff (Radcliffe and Gilchrist, 2016). A recent capability framework specified the knowledge, values and skills that substance misuse staff need to work effectively and safely in the substance-misuse treatment setting with men who perpetrate intimate-partner violence (Hughes *et al.*, 2015).
  - » Many survivors choose to stay with their violent partners if they know that they are on a drug or alcohol programme because they believe that it will increase their safety. However, the stress of withdrawal and/or relapse of the violent partner may increase his/her violence (Stella Project, 2007).

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- » Women who use alcohol or drugs are not responsible for the abuse that they experience, although their substance use is often blamed. The perpetrator's substance use is often (falsely) blamed, and the abused woman may accept that belief (Stella Project, 2007).
  - » There is considerable stigma against women experiencing domestic abuse, and it is compounded if she is also using drugs or alcohol. It is seen as socially unacceptable (Stella Project, 2007).
  - » Children who witness violence or threats of violence between parents are more likely to display harmful drinking patterns later in life (Trocki and Caetano, 2003).
  - » Children's accounts of intimate-partner violence show that they have a remarkable resilience and ability to heal from previous/bad experiences if they can verbalise safely.
  - » Children in studies of intimate-partner violence stressed wanting parents to talk to them more, to help in decision-making about, for example, what they are going to do (Stella Project, 2007).



## 4.5 Domestic Violence and Mental Health

Workers and health- and social-care professionals should consider that intimate-partner violence (IPV) can impact on a client's mental health and the need to be aware of symptoms masquerading as the problem when domestic violence (DV) has not been disclosed.

Ongoing abuse and violence can induce feelings of shock, confusion, disbelief, terror, isolation and despair, undermining a person's sense of self. These, in turn, can manifest as clinical symptoms (for example, reliving the traumatic event, hyperarousal, depression, anxiety, and sleep disruption). Some trauma survivors experience one or more of these symptoms for a brief period of time, while others develop chronic post-traumatic stress disorder (PTSD) – a common response to overwhelming trauma that can persist for years (Warshaw, Sullivan and Rivera, 2013).

Survivors are also at risk for developing depression, which has been found to significantly relate to the development of PTSD (Cascardi, O'Leary and Schlee, 1999; Stein and Kennedy, 2001). For those who have also experienced abuse in childhood and/or other types of trauma (i.e. cumulative trauma), the risk for developing PTSD is elevated. Experiencing childhood trauma and/or severe long-standing abuse as an adult can also disrupt one's ability to manage painful internal states (affecting regulation), leaving many survivors with coping mechanisms that incur further harm (for example, suicide attempts and substance use). Trusting others, particularly those in caregiving roles, may be especially difficult (Warshaw, Sullivan and Rivera, 2013).

People who experience intimate-partner violence are at an increased risk of the development of physical, medical, psychological and/or mental-health difficulties (Williamson, 2000). The destructive influence of domination on a person's well-being may lead to devastating, although normal, responses to an abnormal situation. These responses may fade away spontaneously at the removal of the stressor, but not if the traumatic experience persists. While keeping in mind that victimisation can lead to mental-health issues, it is also important to remember that women who are currently experiencing IPV can present with what may look like psychiatric symptomatology (for example, an 'exaggerated' startled response on hearing a door slam), but this may, in fact, be an appropriate response to ongoing danger. Although wariness, lack of trust, or seemingly paranoid reactions *may* be manifestations of previous abuse, this 'heightened sensitivity' may also be a rational response that could protect a woman from further harm. Similarly, a survivor's seemingly passive response to abuse can be misinterpreted. While passivity *may* be a response to previous experiences of trauma, for survivors of IPV, it may be an intentional strategy used to avoid or minimise abuse that is beyond their control (Goodkind, Sullivan and Bybee, 2004; Stark, 2007; Warshaw, Sullivan and Rivera, 2013).

Women who experience intimate-partner violence have higher rates of mental illness and are more likely to develop post-traumatic stress and depression. Up to 64% of hospitalised female mental-health patients have histories of being physically abused as adults (Warshaw, 1993). A more recent study noted that intimate-partner violence is very common, but goes

largely undetected in female mental-health patients (Morgan and Zolese, 2010). The study acknowledged that violence in the home is a heavy burden to the survivor, and noted that 60% of women surveyed, who were under the care of an urban community mental-health team, had experienced physical violence from their partners. Some 40% had suffered injuries, and 27% had experienced violence during pregnancy. It also noted that 82% of women regarded routine questions on intimate-partner violence as acceptable, but the study concluded that, despite guidelines from the Royal College of Psychiatrists, there is still reluctance among clinicians to question their patients about the possibility of domestic abuse, and suggested that these women should expect help with intimate-partner violence as part of their routine care.

An individual with a pre-existing mental-health condition who is in an abusive relationship may experience his/her illness exacerbated by the continued stress of feared and anticipated violence. Any subsequent failure to respond may therefore be used by the perpetrator as additional justification to abuse and ridicule his/her partner, thus beginning a vicious cycle. Applying a diagnosis of mental illness to a patient without acknowledging domestic violence in the formulation may have far-reaching consequences for the survivor, as it plays into the hands of the perpetrator by giving him/her another 'stick with which to beat their partner'. The perpetrator can now officially criticise his/her partner with comments such as, 'Take your tablets – you're crazy,' or 'Who else would put up with the likes of you?' and, most frightening of all, if the survivor is a parent, 'What judge would allow the children to remain with someone as crazy as you?' This

fear only serves to place the survivor in an enhanced state of paralysis, as s/he experiences further abuse as a result of the very service from which s/he sought help.

Adult mental-health service professionals, in particular, need to be mindful at the time of assessment and formulation to screen in, or screen out, the possibility of intimate-partner violence in their patients' relationships. They should also recognise – for patients who do experience intimate-partner violence – the possible devastating consequences on their psychological, spiritual and physical well-being. Not to do so – addressing only the signs and symptoms that were screened and observed – may inadvertently contribute to furthering the abuse for these service users.

It is also important to consider the long-term intergenerational effects of intimate-partner violence. When children grow up in families in which they witnesses, or are the additional victims of, violence, this has implications for their mental health and well-being over time (McCloskey, Figueredo and Koss, 1995; Levendosky, Bogat and Martinez-Torteya, 2013; Osofsky, 2003).

The consequences of intimate-partner violence are numerous and may include the following:

#### Physical/Medical Symptoms

- » Physical injuries, both temporary and permanent
- » Fractured bones
- » Bruising
- » Chronic pain
- » Dehydration
- » Poor compliance with treatment for medical conditions, e.g. diabetes, seizure control
- » Psychosomatic disorders
- » Autoimmune disorders
- » Rape, miscarriage, or premature delivery
- » Sexual dysfunction
- » Traumatic brain injury
- » Death by homicide

#### Psychological-/Mental-Health Signs and Symptoms

- » Helplessness, hopelessness, or a frozen/collapsed state
- » Avoidance and emotional numbing
- » Anxiety, panic attacks, agitation, fear
- » Hyper-vigilance
- » Insomnia
- » Sadness
- » Anger
- » Guilt
- » Denial
- » Loss of self-belief, self-esteem and self-confidence
- » Decrease in energy, memory and concentration
- » Decrease in self-care
- » Eating distress
- » Alcohol and/or drug misuse
- » Flashbacks
- » Dissociative states
- » Negative effects of psychopharmacology

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**These symptoms may contribute to the development of a/an:**

- » mood disorder;
- » panic disorder;
- » sleep disorder;
- » paranoid disorder;
- » psychotic disorder;
- » suicidal thoughts;
- » act of deliberate self-harm;
- » post-traumatic stress disorder;
- » complex post-traumatic disorder; or
- » death.

These effects can impact on the woman's coping abilities and may make it more difficult for her to access and maintain support and protection (Women's Aid, 2007).

## SECTION 5

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# FURTHER-LEARNING RESOURCES, GLOSSARY OF TERMS, AND REFERENCES



# 5.1 Further-Learning Resources

## Translation Resources

<b>Women's Aid</b>	<p>» The Women's Aid National Freephone Helpline can offer support to women in over 170 languages through the Telephone Interpretation Service:  <a href="https://www.womensaid.ie/services/helpline/telephoneinterp.html">https://www.womensaid.ie/services/helpline/telephoneinterp.html</a>            The helpline number is 1800 341 900 (8am to 8pm, 7 days a week).</p>
<b>HSE</b>	<p>» Arrangements are made locally, in primary-care centres or hospitals, for translation services.            » <i>On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services</i> (2009):  <a href="https://www.hse.ie/eng/services/publications/socialinclusion/emaspeaking.pdf">https://www.hse.ie/eng/services/publications/socialinclusion/emaspeaking.pdf</a>            This is also available as an app (a piece of software that can be used on a mobile phone, a tablet, or sometimes a computer). The app is available free of charge from Google Play.</p>
<b>Irish Translators' and Interpreters' Association</b>	<p>» Interpreters and translators can register with the Irish Translators' and Interpreters' Association:  <a href="http://translatorsassociation.ie/content/view/7/17/">http://translatorsassociation.ie/content/view/7/17/</a>            It has a database of professional members practising in Ireland. Please make sure that you are satisfied with the qualifications of the professional before you hire him/her.</p>
<b>HSE National Social Inclusion Office</b>	<p>» The National Social Inclusion Office supports various areas of translation and interpretation. For further information, please see the following links.  <b>The National Social Inclusion Office:</b>  <a href="http://www.hsesocialinclusion.ie">www.hsesocialinclusion.ie</a>  <b>Common Health Concerns Translated:</b>  <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/common-health-concerns-translated/">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/common-health-concerns-translated/</a>  <b>Translation and Interpreting Companies:</b>  <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/translation-interpreting-companies/">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/translation-interpreting-companies/</a>  <b>Multilingual Resources and Translated Information:</b>  <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/multilingual-resources-and-translated-material/">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/multilingual-resources-and-translated-material/</a>  <b>Mobile Health Apps:</b>  <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/mobile-health-apps/">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/mobile-health-apps/</a>  <b>Translation Hub:</b>  <a href="http://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/">http://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/</a></p>
<b>Dublin Rape Crisis Centre (DRCC)</b>	<p>» <i>Interpreting in Situations of Sexual Violence and other Trauma: A handbook for community interpreters</i> (2004):  <a href="http://www.drcc.ie/wp-content/uploads/2011/03/RCC_Interpreting.pdf">http://www.drcc.ie/wp-content/uploads/2011/03/RCC_Interpreting.pdf</a></p>

## Multiculturalism and Minority Groups

<p><b>Pavee Point</b></p>	<ul style="list-style-type: none"> <li>» <i>Good Practice Guidelines: for services working with Traveller women experiencing domestic abuse</i> (2011):  <a href="http://www.paveepoint.ie/wp-content/uploads/2013/11/VAW-Best-Practice-Guidelines-for-Service-Providers.pdf">http://www.paveepoint.ie/wp-content/uploads/2013/11/VAW-Best-Practice-Guidelines-for-Service-Providers.pdf</a></li> <li>» <i>Challenging the Misconceptions of Violence against Minority Ethnic Women, including Travellers, in Ireland: An Information brochure for service providers</i> (2005):  <a href="http://www.paveepoint.ie/wp-content/uploads/2013/11/MinorityEthnicWomen05.pdf">http://www.paveepoint.ie/wp-content/uploads/2013/11/MinorityEthnicWomen05.pdf</a></li> <li>» The following link provides further information on working with Traveller and Roma women in relation to violence against women:  <a href="http://www.paveepoint.ie/document/violence-against-roma-women-9-principles-to-human-rights-based-and-gender-responsive-approach-to-protection/">http://www.paveepoint.ie/document/violence-against-roma-women-9-principles-to-human-rights-based-and-gender-responsive-approach-to-protection/</a></li> </ul>
<p><b>European Roma Rights Centre</b></p>	<ul style="list-style-type: none"> <li>» <i>Life Sentence: Romani Children in Institutional Care</i> (2011):  <a href="http://www.errc.org/reports-and-submissions/life-sentence-romani-children-in-institutional-care">http://www.errc.org/reports-and-submissions/life-sentence-romani-children-in-institutional-care</a></li> <li>» Council of Europe in relation to violence against women regarding Roma:  <a href="https://www.coe.int/en/web/portal/roma-women/">https://www.coe.int/en/web/portal/roma-women/</a></li> </ul>
<p><b>HSE</b></p>	<ul style="list-style-type: none"> <li>» <i>Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings</i> (2009):  <a href="http://www.hse.ie/eng/services/publications/socialinclusion/interculturalguide/">http://www.hse.ie/eng/services/publications/socialinclusion/interculturalguide/</a>            This is a resource to help health-care professionals to care for patients from diverse ethnic, religious and cultural groups. It is also available as an app – <b>Understand Me</b> – free of charge from Google.</li> <li>» Learning from development and implementation in <i>Intercultural Awareness and Practice in Health and Social Care on a Train the Trainer Basis Model of Training</i> (2016):  <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/intercultural-awareness-and-practice-in-health-and-social-care.pdf">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/intercultural-awareness-and-practice-in-health-and-social-care.pdf</a></li> <li>» HSE's Values in Action: Patient and Service User Dimension, which gives guidelines on best practice between the service user and the health-care professional. It is not specific to minorities, but it is useful in checking for understanding:  <a href="https://www.hse.ie/eng/about/our-health-service/values-in-action/behaviours/patient.html">https://www.hse.ie/eng/about/our-health-service/values-in-action/behaviours/patient.html</a></li> </ul>
<p><b>Nasc</b></p>	<ul style="list-style-type: none"> <li>» Nasc is a migrant support organisation, and the following link provides information on domestic violence:  <a href="http://www.nascireland.org/know-your-rights/domestic-violence/">http://www.nascireland.org/know-your-rights/domestic-violence/</a></li> </ul>

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## Immigration

<b>Irish Naturalisation and Immigration Service (INIS)</b>	» Immigration guidelines for victims of domestic violence: <a href="http://www.inis.gov.ie/en/inis/victims%20of%20domestic%20violence%20-%20note%20for%20web.pdf/files/victims%20of%20domestic%20violence%20-%20note%20for%20web.pdf">http://www.inis.gov.ie/en/inis/victims%20of%20domestic%20violence%20-%20note%20for%20web.pdf/files/victims%20of%20domestic%20violence%20-%20note%20for%20web.pdf</a>
<b>Reception and Integration Agency (RIA)</b>	» <i>RIA Policy and Practice Document on safeguarding RIA residents against Domestic, Sexual and Gender-based Violence &amp; Harassment (2014):</i> <a href="http://www.ria.gov.ie/en/ria/ria%20policy%20document%20on%20domestic%20&amp;%20gender%20based%20violence%20&amp;%20agreed%20report.pdf/files/ria%20policy%20document%20on%20domestic%20&amp;%20gender%20based%20violence%20&amp;%20agreed%20report.pdf">http://www.ria.gov.ie/en/ria/ria%20policy%20document%20on%20domestic%20&amp;%20gender%20based%20violence%20&amp;%20agreed%20report.pdf/files/ria%20policy%20document%20on%20domestic%20&amp;%20gender%20based%20violence%20&amp;%20agreed%20report.pdf</a>
<b>Irish Family Planning Association (IFPA)</b>	» <i>Sexual Health &amp; Asylum: Handbook for People Working with Women Seeking Asylum in Ireland (2010):</i> <a href="https://www.ifpa.ie/sites/default/files/documents/media/publications/sexual_health_and_asylum_handbook.pdf">https://www.ifpa.ie/sites/default/files/documents/media/publications/sexual_health_and_asylum_handbook.pdf</a>

## Child Welfare and Protection

<b>Tusla</b>	» <i>Children First: National Guidance for the Protection and Welfare of Children (2017):</i> <a href="https://www.tusla.ie/uploads/content/Children_First_National_Guidance_2017.pdf">https://www.tusla.ie/uploads/content/Children_First_National_Guidance_2017.pdf</a> » <i>Child Safeguarding: A Guide for Policy, Procedure and Practice (n.d.)</i> – a best-practice document for developing guiding principles and safeguarding procedures: <a href="http://www.tusla.ie/uploads/content/tusla_-_child_safeguarding_-_a_guide_for_policy,_procedure_and_practice.pdf">http://www.tusla.ie/uploads/content/tusla_-_child_safeguarding_-_a_guide_for_policy,_procedure_and_practice.pdf</a> <b>Reporting Child Welfare Concerns:</b> <a href="http://www.tusla.ie/services/child-protection-welfare/concerns/">http://www.tusla.ie/services/child-protection-welfare/concerns/</a>
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## Drugs and Alcohol

<b>Health Research Board (HRB)</b>	» HRB National Drugs Library: <a href="http://www.drugsandalcohol.ie/">http://www.drugsandalcohol.ie/</a>
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<b>HSE</b>	<ul style="list-style-type: none"> <li>» Drug and Alcohol Information and Support: <a href="http://www.drugs.ie/">http://www.drugs.ie/</a></li> <li>» HSE Drugs and Alcohol Helpline: <a href="https://www.hse.ie/eng/services/list/5/addiction/drugshivhelpline/">https://www.hse.ie/eng/services/list/5/addiction/drugshivhelpline/</a> This confidential service has both a Freephone helpline (1800 459 459) and an email support service (helpline@hse.ie).</li> <li>» National Screening and Brief Intervention Project for Alcohol and Substance Use (SAOR): <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/alcohol-and-substance-use-saor/">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/alcohol-and-substance-use-saor/</a> SAOR offers a step-by-step guide for practice, to guide workers in using a person-centred approach throughout their conversations, encounters or engagements with service users.</li> <li>» Information on Addiction Treatment and Rehabilitation: <a href="https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/addiction-treatment-and-rehabilitation/">https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/addiction-treatment-and-rehabilitation/</a></li> <li>» Alcohol Information and Resources: <a href="http://www.askaboutalcohol.ie">www.askaboutalcohol.ie</a></li> </ul>
<b>AVA Project</b>	<ul style="list-style-type: none"> <li>» <i>Domestic Violence, Drugs and Alcohol: Good Practice Guidelines</i> (second edition, n.d.): <a href="https://avaproject.org.uk/wp/wp-content/uploads/2016/08/Stella-Project-Toolkit-2007.pdf">https://avaproject.org.uk/wp/wp-content/uploads/2016/08/Stella-Project-Toolkit-2007.pdf</a></li> </ul>

## Sexual and Domestic Violence

<b>Rape Crisis Network Ireland (RCNI)</b>	<ul style="list-style-type: none"> <li>» <i>Court and Garda Accompaniment Services for those affected by sexual violence</i> (n.d.): <a href="http://www.rcni.ie/wp-content/uploads/RCNI-CAGA.pdf">http://www.rcni.ie/wp-content/uploads/RCNI-CAGA.pdf</a></li> </ul>
<b>Dublin Rape Crisis Centre (DRCC)</b>	<ul style="list-style-type: none"> <li>» <i>Interpreting in Situations of Sexual Violence and other Trauma: A handbook for community interpreters</i> (2004): <a href="http://www.drcc.ie/wp-content/uploads/2011/03/RCC_Interpreting.pdf">http://www.drcc.ie/wp-content/uploads/2011/03/RCC_Interpreting.pdf</a></li> <li>» <i>The SAVI Report</i> (2002), a national study of Irish experiences, beliefs and attitudes concerning sexual violence: <a href="http://www.drcc.ie/about/savi.pdf">http://www.drcc.ie/about/savi.pdf</a></li> </ul>
<b>HSE/SATU/ Department of Justice and Law Reform</b>	<ul style="list-style-type: none"> <li>» <i>Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland</i> (third edition, 2014): <a href="https://www.hse.ie/eng/services/list/5/sexhealth/satu/satuguidelines/satuguidelines3rded.pdf">https://www.hse.ie/eng/services/list/5/sexhealth/satu/satuguidelines/satuguidelines3rded.pdf</a></li> </ul>
<b>HSE</b>	<ul style="list-style-type: none"> <li>» <i>HSE Practice Guide on Domestic, Sexual and Gender Based Violence: For staff working with children and families</i> (2012): <a href="http://www.tusla.ie/uploads/content/Domestic_Practice_Guide_on_DSG_bassed_violence.pdf">http://www.tusla.ie/uploads/content/Domestic_Practice_Guide_on_DSG_bassed_violence.pdf</a></li> </ul>

<b>Humphreys, C.</b>	» <i>Domestic Violence and Protecting Children: New Thinking and Approaches</i> (2015)
<b>World Health Organization (WHO)</b>	» <i>Sexual violence: prevalence, dynamics and consequences</i> (n.d.): <a href="http://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap2.pdf">http://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap2.pdf</a>
<b>European Union Agency for Fundamental Rights (FRA)</b>	» <i>Violence against women: an EU-wide survey</i> (2014): <a href="http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report/">http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report/</a>
<b>National Institute for Health and Care Excellence (NICE)</b>	» <i>Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors</i> (2010): <a href="https://www.nice.org.uk/guidance/cg110">https://www.nice.org.uk/guidance/cg110</a> » <i>Domestic violence and abuse: multi-agency working</i> (2014): <a href="https://www.nice.org.uk/guidance/ph50/">https://www.nice.org.uk/guidance/ph50/</a>

## Reproductive Health

<b>World Health Organization (WHO)</b>	» <i>Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook</i> (2014): <a href="http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/">http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/</a> This is a first-line support for intimate-partner violence and sexual violence.
<b>Irish College of General Practitioners (ICGP)</b>	» Domestic Violence: Tutor Teaching Pack for GPs: <a href="https://www.icgp.ie/go/courses/women_s_health/publications">https://www.icgp.ie/go/courses/women_s_health/publications</a> » <i>Domestic Violence: A Guide for General Practice</i> (2014): <a href="https://www.icgp.ie/go/library/icgp_publications/quick_reference_guides/E5A83CE9-0790-3FA8-7AC524CB228D38E3.html">https://www.icgp.ie/go/library/icgp_publications/quick_reference_guides/E5A83CE9-0790-3FA8-7AC524CB228D38E3.html</a> The document gives guidance to GPs on how to recognise this serious problem and how to respond once the problem has been identified.
<b>Irish Family Planning Association (IFPA)</b>	» <i>Sexual Health &amp; Asylum: Handbook for People Working with Women Seeking Asylum in Ireland</i> (2010): <a href="https://www.ifpa.ie/sites/default/files/documents/media/publications/sexual_health_and_asylum_handbook.pdf">https://www.ifpa.ie/sites/default/files/documents/media/publications/sexual_health_and_asylum_handbook.pdf</a> The handbook concentrates on five common areas of sexual-health service delivery in Ireland: family planning, or contraception; cervical cancer screening; sexually transmitted infections, including HIV; crisis pregnancy counselling; and post-abortion care.

## Children and Young People

<b>Barnardos</b>	» <i>Parenting Positively: Helping teenagers to cope with Domestic Abuse</i> (2009) – parenting in the context of domestic abuse: <a href="https://www.barnardos.ie/assets/files/publications/free/Parenting_positively_DA.pdf">https://www.barnardos.ie/assets/files/publications/free/Parenting_positively_DA.pdf</a>
<b>McGavock, L. and Spratt, T.</b>	» <i>Children Exposed to Domestic Violence: Using Adverse Childhood Experience Scores to Inform Service Response</i> (2016): <a href="https://academic.oup.com/bjsw/article/47/4/1128/2622331/">https://academic.oup.com/bjsw/article/47/4/1128/2622331/</a>
<b>Women's Aid Northern Ireland</b>	» Helping Hands programme and worksheets – to increase children's understanding of safety and promote behaviours that contribute to safety: <a href="https://www.womensaidni.org/about-us/our-work/preventative-education/working-with-children-in-primary-schools/">https://www.womensaidni.org/about-us/our-work/preventative-education/working-with-children-in-primary-schools/</a>
<b>Whitehouse, E.</b>	» <i>A Volcano in my Tummy: Helping Children to Handle Anger</i> (1998)
<b>Humphreys, C. et al.</b>	» <i>Talking to My Mum: A Picture Workbook for Workers, Mothers and Children Affected by Domestic Abuse</i> (2006)
<b>Hester, M., Pearson, C. and Harwin, N.</b>	» <i>Making an Impact: Children and Domestic Violence</i> (second edition, 2007)

## Homelessness

<b>Simon Communities of Ireland</b>	» <i>Women and Homelessness: Resource Guide</i> (n.d.): <a href="https://www.galwaysimon.ie/download/simon-community-women-homelessness-resource-guide/">https://www.galwaysimon.ie/download/simon-community-women-homelessness-resource-guide/</a> » <i>Women, Homelessness and Service Provision</i> (2015) – a detailed analysis of women's experiences of homelessness in Ireland: <a href="http://womenshomelessness.org/wp-content/uploads/2018/01/Women-Homelessness-and-Service-Provision.pdf">http://womenshomelessness.org/wp-content/uploads/2018/01/Women-Homelessness-and-Service-Provision.pdf</a>
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## Training

<b>Project RESPONSE</b>	» <i>Training Manual for Reporting of Gender-Based Violence in Women's Health Services</i> (2015): <a href="http://gbv-response.eu/wp-content/uploads/2017/03/00_manual_response-english_web.pdf">http://gbv-response.eu/wp-content/uploads/2017/03/00_manual_response-english_web.pdf</a>
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## Female Genital Mutilation

<b>RCSI, HSE, AkiDwA</b>	» <i>Female Genital Mutilation: Information for Health-Care Professionals Working in Ireland</i> (2013): <a href="https://www.ifpa.ie/sites/default/files/documents/resources/2nd_edition_fgm_handbook_for_healthcare_professionals_in_ireland_2013.pdf">https://www.ifpa.ie/sites/default/files/documents/resources/2nd_edition_fgm_handbook_for_healthcare_professionals_in_ireland_2013.pdf</a>
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**Irish Family  
Planning  
Association  
(IFPA)**

» Irish Family Planning Association FGM Treatment Service:

<https://www.ifpa.ie/Sexual-Health-Services/FGM-Treatment-Service>

The Irish Family Planning Association provides free specialised medical care and counselling to women and girls in Ireland who have experienced FGM.

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## 5.3 Glossary of Terms

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**Empowerment:** Helping women to feel in control of their lives and able to take decisions about their future. Empowerment is a key feature of domestic-abuse support services.

**Intimate partner:\*** A husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend or ex-lover.

**Intimate-partner violence:\*** Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to this include domestic violence, wife or spouse abuse, wife/spouse battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting.

**Sexual violence:** Sexual violence refers to assaults that have an explicit sexual content and includes a variety of forms, including rape, sexual assault and sexual harassment (Department of Justice and Equality, 2010).

**Sexual assault:\*** A subcategory of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, although the legal definition of rape may vary and, in some cases, may also include oral penetration.

**Screening (universal screening):\*** Large-scale assessment of whole population groups, whereby no selection of population groups is made.

**Support:\*** For the purposes of these guidelines, support includes any or a combination of the following: the provision of legal, housing and financial advice; facilitation of access to and use of community resources, such as refuges or shelters; emergency housing; and psychological interventions and provision of safety-planning advice.

**Vicarious trauma:\*** Defined as the transformation of the health-care provider's inner experiences as a result of empathetic and/or repeated engagement with (sexual) violence survivors and their trauma material (see <http://www.svri.org/research-methods/researcher-trauma-and-safety>).

**Violence against women:\*** A broad/umbrella term, defined by the United Nations as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.' It includes many different forms of violence against women and girls, such as intimate-partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

\*Taken from World Health Organization (2013) *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, Geneva: World Health Organization.



## 5.4 Appendices

### Appendix 1: Brief Outline of Relevant Policy and Legislative Documents

<p><b>Second National Strategy on Domestic, Sexual and Gender-based Violence (2016-2021) (Department of Justice and Equality, 2016b)</b></p>	<p>The overall aims of this strategy are to:</p> <ul style="list-style-type: none"><li>» change societal attitudes to support a reduction in domestic and sexual violence;</li><li>» improve supports available to victims and survivors; and</li><li>» hold perpetrators to account in order to create a safer Ireland.</li></ul> <p>Action relevant to the development of this resource manual: Action 1.500 – Develop a shared approach between Tusla and the HSE, in collaboration with service provider organisations, towards commissioning the training of front-line professionals in each agency that assures a consistent, appropriate and culturally competent response to persons presenting to services. Training should also include a focus on establishing standards, addressing quality improvement and measuring outcomes.</p>
<p><b>Domestic Violence Act 1996, Domestic Violence (Amendment) Act 2002 and Domestic Violence Act 2018 (Office of the Attorney General)</b></p>	<p>The Domestic Violence Act 2018 updates and consolidates the existing law in relation to domestic violence by integrating the changes to the Domestic Violence Act 1996, resulting from subsequent legislation. These include the changes made in the Domestic Violence (Amendment) Act 2002, the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010, the Civil Law (Miscellaneous Provisions) Act 2011, the Courts and Civil Law (Miscellaneous Provisions) Act 2013 and the Children and Family Relationships Act 2015.</p> <p>Consolidating the legislation on domestic violence will enable the general public to be aware of the increased protections that are available in legislation, amending the 1996 act to make the legislation easier to use. The act also incorporates new legislative provisions, which are necessary to enable Ireland to ratify the Istanbul Convention (aka the <i>Council of Europe Convention on preventing and combating violence against women and domestic violence</i>).</p> <p>These new provisions include the criminalisation of forced marriage and remove the underage marriage exemption to help protect minors against forced marriage. Ireland signed the <i>Council of Europe Convention on preventing and combating violence against women and domestic violence</i> in November 2015. The act improves the protections available to victims of domestic violence by introducing a new emergency barring order, in exceptional circumstances. It also aims to make the court process easier for victims of domestic violence, for example, by giving them the right to be accompanied to court by a family member, friend or support worker. A victim will also be able to give evidence by live television link. In addition, the act allows for restrictions on attendance at both civil and criminal court proceedings, and protections for the victim’s anonymity.</p>

<p><b>Criminal Justice (Victims of Crime) Act 2017</b>  <b>(Office of the Attorney General)</b></p>	<p>This act introduces minimum standards on the rights, support and protection of victims of crime. This act introduces a number of statutory rights for victims of crime, including the right to comprehensive information on the criminal justice system, the right to information on victim support services, the right to be kept informed on the progress of the investigation and any court proceedings, the right to an individual assessment of their protection needs and measures to safeguard them from further victimisation and intimidation, the right to be informed of a decision not to institute a prosecution and the right to request a review of that decision, and the right to receive information in clear and concise language and to interpretation and translation, where necessary.</p>
<p><b>Criminal Law (Sexual Offences) Act 2017</b>  <b>(Office of the Attorney General)</b></p>	<p>This act will enhance and update laws to combat the sexual exploitation and sexual abuse of children, including new offences relating to child sexual grooming, and new and strengthened offences to tackle child pornography. The act also criminalises the purchase of sexual services, introduces new provisions regarding the giving of evidence by victims in sexual-offence trials, and introduces a new offence addressing public indecency. Other provisions include maintaining the age of consent to sexual activity at 17 years of age, and for a new 'proximity of age' defence, as well as a statutory statement of the law regarding consent to sexual acts.</p>

**Child Care Act 1991, updated  
by the Children First Act  
2015 (Office of the Attorney  
General)**

The 1991 act is a wide-ranging piece of legislation, which, at its core, seeks to promote the welfare of children who may not receive adequate care and protection.

The legislation covers the following main areas:

- » promotion of the welfare of children, including the relevant functions of Tusla, the Child and Family Agency;
- » protection of children in emergencies, including Section 12, which governs the powers of An Garda Síochána to take a child to safety;
- » care proceedings, including the different types of care orders, which can be made by a court;
- » children in need of special care or protection;
- » private foster care;
- » jurisdiction and procedure, including provisions for the appointment of a guardian *ad litem* for a child (Section 26);
- » children in the care of the Child and Family Agency;
- » supervision of preschool services; and
- » children's residential centres.

Under the Child Care Act 1991, as amended by the Child and Family Agency Act 2013, Tusla (the Child and Family Agency) has a statutory duty to promote the welfare of children who are not receiving adequate care and protection. The definition of a child is a person under 18 years of age who is not or has not been married.

When carrying out its statutory duty, Tusla must have regard to the following:

- » It is generally in the best interests of the child to be brought up in his/her own family.
- » Having regard to the rights and duties of the parents, the welfare of the child is the first and paramount consideration and, as far as is practicable, the wishes of the child should be considered.

Among other things, Tusla is required to:

- » identify children who are not receiving adequate care and protection and coordinate information on children from all relevant sources;
- » provide child-care and family support services, with the aim of helping parents to care for their children and to avoid the need for such children to be taken into care; and
- » prepare an annual report on the adequacy of the child-care and family support services.



<p><b>Children First Act 2015 (Office of the Attorney General)</b></p>	<p>The Children First Act 2015, which was signed into law on 19 November 2015, puts elements of the <i>Children First: National Guidance for the Protection and Welfare of Children</i> on a statutory footing. The legislation was a key Programme for Government commitment and forms part of a suite of child protection legislation, which includes the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012-2016 and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.</p> <p>The act provides for a number of key child protection measures, as follows:</p> <ul style="list-style-type: none"> <li>» a requirement on organisations providing services to children to keep children safe from harm and to produce a child safeguarding statement;</li> <li>» a requirement on defined categories of persons (mandated persons) to report child protection concerns over a defined threshold to the Child and Family Agency;</li> <li>» a requirement on mandated persons to assist the Child and Family Agency in the assessment of a child protection risk, if requested to do so by the Agency; and</li> <li>» putting the Children First Interdepartmental Implementation Group on a statutory footing.</li> </ul> <p>The act also includes a provision that abolished the common-law defence of reasonable chastisement in relation to corporal punishment.</p> <p>The legislation operates in tandem with the existing <i>Children First: National Guidance for the Protection and Welfare of Children</i>, which outlines the non-statutory obligations that will continue to operate administratively for all sectors of society.</p>
<p><b><i>Children First: National Guidance for the Protection and Welfare of Children, (Department of Children and Youth Affairs, 2017)</i></b></p>	<p>The primary reference herein is to report concerns in relation to child welfare and protection, and it includes the new legislative obligations. It sets out the requirement for mandated persons and organisations under the Children First Act 2015, and provides information on how to respond to concerns.</p>
<p><b>National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (Office of the Attorney General)</b></p>	<p>The National Vetting Bureau (Children and Vulnerable Persons) Act 2012 provides a statutory basis for the vetting of persons carrying out relevant work with children or vulnerable persons. The act also creates offences and penalties for persons who fail to comply with its provisions.</p> <p>The act stipulates that a relevant organisation shall not permit any person to undertake relevant work or activities on behalf of the organisation unless the organisation receives a vetting disclosure from the National Vetting Bureau in respect of that person.</p> <p>Garda vetting is conducted on behalf of registered organisations only, and is not conducted for individual persons on a personal basis.</p>

<p><b>Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 (Office of the Attorney General)</b></p>	<p>Under the provisions of this act, it is an offence to fail to disclose to An Garda Síochána, without reasonable excuse, information concerning certain serious criminal offences where such offences are committed against a child or a vulnerable adult. These offences include most sexual offences and offences such as assault causing harm, causing serious harm, cruelty to a child, abduction of a child, manslaughter and murder.</p>
<p><b>Ireland's second National Action Plan on Women, Peace and Security (2015-2018) (Department of Foreign Affairs and Trade, 2015)</b></p>	<p>This plan aims to strengthen women's leadership and participation in decision-making in conflict and post-conflict situations; to ensure that a gender perspective is incorporated into Ireland's engagement in overseas humanitarian and development aid, peace-keeping, governance, post-conflict activities and interventions; to bolster Ireland's ongoing work on protection from and prevention of gender-based violence; and leverage Ireland's participation in global and regional fora to champion the implementation of the Women, Peace and Security resolutions.</p>
<p><b>National Traveller and Roma Inclusion Strategy 2017-2021 (Department of Justice and Equality, 2017d)</b></p>	<p>This strategy identifies people with a migrant background as a vulnerable group regarding knowledge and information about sexual health and crisis pregnancy prevention services, and accessing sexual and reproductive health services. The strategy contains recommendations for at-risk or vulnerable groups.</p>
<p><b>The Migrant Integration Strategy: A Blueprint for the Future (Department of Justice and Equality, 2017a)</b></p>	<p>This strategy provides a framework for a range of actions to support migrants to participate fully in Irish life. The actions proposed are designed to support the integration process and are also intended to identify and address any remaining barriers to integration. <i>The Migrant Integration Strategy: A Blueprint for the Future</i> foresees actions applicable to all government departments and those intended to address particular issues, such as information in different languages, cultural awareness training, signage on where translation services are available, and clarity on how to report racist incidents.</p>
<p><b>National Strategy for Women and Girls 2017-2020: creating a better society for all (Department of Justice and Equality, 2017c)</b></p>	<p>This strategy is intended to respond to women's needs across a diversity of identities and situations, through six high-level objectives. Objective 5 is specifically on violence against women, and specifically mentions the accompanying training programme.</p>
<p><b>Better Outcomes, Brighter Futures: The national policy framework for children &amp; young people 2014-2020 (Department of Children and Youth Affairs, 2014)</b></p>	<p><i>Better Outcomes, Brighter Futures</i> represents the first overarching national children's policy framework comprehending the age ranges spanning children and young people (0-24 years). It adopts a whole-of-government approach and is underpinned by a number of constituent strategies in the areas of early years, youth and participation.</p> <p>This policy framework aims to improve outcomes for children and young people across five national outcomes – health; learning and development; safe and protected from harm; economic opportunity; and connected and respected – with the following areas of priority: supporting parents; early intervention and prevention; listening to and involving children; quality services; effective transitions; and cross-government and inter-agency collaboration and coordination.</p>

<p><b>National Sexual Health Strategy 2015-2020</b> (Department of Health, 2015)</p>	<p>This was the first national framework for sexual health and well-being to be delivered under the <i>Healthy Ireland</i> framework. Recommendations range from surveillance and prevention to treatment, counselling and supports, to educational and professional support. The HSE's Sexual Health and Crisis Pregnancy Programme is responsible for the majority of actions in this strategy, which also notes those with a migrant background as a vulnerable group.</p>
<p><b>Second National Action Plan to Prevent and Combat Human Trafficking in Ireland</b> (Department of Justice and Equality, 2016a)</p>	<p>This plan contains 65 actions designed to crack down on individuals and gangs involved in this crime, to support victims, to raise public awareness, and to enhance training for those likely to encounter victims.</p> <p>Part 1 of the plan outlines the structures and policies in place to address human trafficking and support its victims. Part 2 outlines the priorities identified to further address this issue and sets out clear targets for delivery, such as prevention strategies, support for victims, ensuring an effective criminal-justice response, ensuring compliance with human rights, coordination between agencies, increased knowledge in relation to emerging trends, and effective responses to child trafficking.</p>
<p><b>National Intercultural Health Strategy 2007-2012</b> (Health Service Executive, 2007)</p>	<p>This strategy sets out to address the health and support needs of people from diverse cultures and ethnic backgrounds. The four priorities in the strategy are: 1) information, language and communication; 2) service delivery; 3) changing the organisation (HSE); and 4) working in partnership with ethnic communities.</p>
<p><b>An Garda Síochána: Domestic Abuse Intervention Policy</b> (An Garda Síochána, 2017)</p>	<p>This policy document provides powers to Gardaí to investigate any breach of the Domestic Violence Act and use powers of arrest if suspicion that a criminal offence has occurred, without the victim having a domestic violence order in place. Victims should have access to a Garda of their gender, an ethnic liaison officer, if required, and a Garda to provide a list of available supports.</p>
<p><b>Garda Síochána Policy on the Investigation of Sexual Crime, Crimes against Children, Child Welfare</b> (An Garda Síochána, 2013)</p>	<p>This policy document outlines the procedures that An Garda Síochána members will adhere to when investigating crimes of a sexual nature and suspected child abuse. It incorporates information on Garda standards, procedures and legislation through to victim support with regard to such incidents.</p>
<p><b>Council of Europe Convention on preventing and combating violence against women and domestic violence</b>, aka the Istanbul Convention (Council of Europe, 2011)</p>	<p>The <i>Council of Europe Convention on preventing and combating violence against women and domestic violence</i> is based on the understanding that violence against women is a form of gender-based violence, committed against women because they are women. It is the obligation of the state to address it fully, in all its forms, and to take measures to prevent violence against women, protect its victims and prosecute the perpetrators. Failure to do so makes it the responsibility of the state.</p>

***RIA Policy and Practice  
Document on safeguarding  
RIA residents against  
Domestic, Sexual and Gender-  
based Violence & Harassment  
(Reception and Integration  
Agency, 2014)***

This is a policy and practice document on safeguarding RIA residents against domestic, sexual and gender-based violence and harassment. It was agreed between RIA, Cosc, and NGOs such as AkiDwA, Ruhama and the UNHCR.

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## APPENDIX 2: LIVES

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First-line support involves five simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word 'LIVES' can remind you of these five tasks, which protect women's lives:

<b>Listen</b>	Listen to the woman closely, with empathy, and without judging.
<b>Inquire about needs and concerns</b>	Assess and respond to her various needs and concerns – emotional, physical, social and practical (for example, childcare).
<b>Validate</b>	Show her that you understand and believe her. Assure her that she is not to blame.
<b>Enhance safety</b>	Discuss a plan to protect herself from further harm if violence occurs again.
<b>Support</b>	Support her by helping her connect to information, services and social support.

Taken from World Health Organization (2014) *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*, Geneva: World Health Organization.

## APPENDIX 3: CRISIS INTERVENTION MODEL



This model focuses on women survivors, adapted by Women's Aid from a conference presentation by Professor Liz Kelly in Trinity College Dublin in 2005. There is no existing model for male survivors.

- » The Crisis Intervention Model highlights the different processes that a survivor experiences, her comprehension of these, how she manages the situation, and how her perception may be distorted due to the impact of the perpetrator's abuse.
- » The survivor may experience more than one process at a time, for example, managing the situation and defining what is happening as abuse. She may move in and out of the processes.
- » This model provides a tool to enable us, in our professional roles, to reflect on where the survivor is at and to inform our good-practice response.
- » When working with a survivor who is experiencing domestic violence, it is important to work with the woman from where she is at. For example, if we encourage her to leave the relationship when she has not yet defined what is happening as abuse, we may contribute to her distortion of perspective.

(Source: 'Intimate Partner Violence: Working from where the woman is at,' adapted from Dr Liz Kelly.)

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### **Intimate-Partner Violence: Working from Where the Woman is at**

The following are brief descriptions of the processes illustrated:

#### **Managing the Situation**

- » This process involves the point when the violence is first experienced and is a crisis in the relationship. The survivor will generally experience shock or disbelief. Some women may end the relationship at this point, but the majority do not.
- » The survivor may find or accept an explanation for the incident (for example, taking the blame, minimising the seriousness of the incident), which allows for a future incident. The next few incidents may test or reinforce this. She may believe that she is doing something to provoke the violence, and possibly believe that it's her fault.
- » She may now begin to use strategies to manage the situation to limit the potential for conflict. For example, she will try not to do anything to upset the perpetrator.
- » She attempts to anticipate and prevent or minimise the abuse.

#### **Distortion of Perspective**

- » Gradually, more and more of the survivor's daily life, routines and thought processes are affected by having to manage violence.
- » The woman's sense of self and of the violence may become profoundly distorted. She may begin to believe all the negative things that the perpetrator is telling her about herself.

- » She continues to manage her anxiety and tries to make sense of what is happening.
- » She continues to manage the abuse through attempting to anticipate, prevent and minimise it.

#### **Defining what is Happening as Abuse**

- » This usually does not happen until after a number of assaults.
- » The survivor may now start to define what is happening as abuse.
- » She may acknowledge her partner as an abuser and recognise herself as a survivor.
- » She may put responsibility for the abuse on the abuser, but the abuse may still continue.

#### **Re-evaluating the Relationship**

- » Once the relationship is understood as violent, a re-evaluation process may begin.
- » The woman may still stay in the relationship.
- » She may use strategies to cope. For example, she might talk to others.
- » She may consider leaving the relationship in the short term, or for good.
- » She may engage in formal processes to limit and contain the violence. For example, she may apply for court orders.

#### **Ending the Relationship**

- » Many women may make several attempts to end violent relationships.

- » To leave, they usually need external support and resources.
- » Some women never leave. The reasons for staying in or returning to the relationship can include: nowhere to go, no money to leave (housing and money); promises to change; pressure from children, family and friends; and/or the absence of effective protection (the granting of barring orders by the courts is not guaranteed, as it depends on evidence, etc.).

#### **Ending the Violence**

- » This can be a very fast or very slow process.
- » Some women spend years managing and coping in isolation. Others may seek support quickly.
- » Legal intervention may be required.
- » Ending a relationship does not guarantee that the violence will end. Contrary to popular myth, attempting to leave the relationship or end the violence may place women in more danger and at a greater risk of serious and even fatal assault.

## APPENDIX 4: SAFETY PLAN WORKSHEETS

### SAFETY PLAN: WOMEN

A safety plan looks at ways to protect you and your children in the face of domestic violence.

Domestic violence is a crime. Your safety and that of your children is the priority. Call 999/112 in an emergency.

Safety in an abusive relationship	Thinking of leaving an abusive relationship	After you have left an abusive relationship
<p>Things to think about:</p> <ul style="list-style-type: none"> <li>» Isolation can be part of an abusive relationship. To increase your safety, it may help to talk to a trusted person.</li> <li>» Make a plan to get some time for yourself.</li> <li>» Living in fear can be draining and affect your health.</li> <li>» Learn more about domestic violence and support services at <a href="http://www.domesticabuse.ie">www.domesticabuse.ie</a>.</li> </ul>	<p>Things to think about:</p> <ul style="list-style-type: none"> <li>» Reviewing your safety plan with your support service – practise how you will exit the home, when you will leave, and where you will go. If possible, choose a time that will be safe for you and your children to leave.</li> <li>» Think of reasons why you need to leave the house.</li> </ul>	<p>Things to think about:</p> <ul style="list-style-type: none"> <li>» Be vigilant of your surroundings. This includes any public setting or work.</li> <li>» Be vigilant when online.</li> <li>» Consider varying your daily routine, e.g. use a different shop than your usual one.</li> </ul>
<p>Things you could do:</p> <ul style="list-style-type: none"> <li>» Have 999 on speed dial and call in an emergency, if you can.</li> <li>» Have a safety plan. Know how you would get out of the house and where you would go if/when you need to.</li> <li>» Know the warning signs that the situation is worsening.</li> <li>» When an abusive incident is occurring, avoid anywhere with access to weapons, e.g. bathroom, kitchen, shed.</li> <li>» Have a code word with family/friends, alerting them that you need help or need Gardaí to be called.</li> <li>» Call Sonas's advice line on 087 952 5217 to talk about what is happening or look at your options.</li> </ul>	<p>Things you could do:</p> <ul style="list-style-type: none"> <li>» Have relevant contact numbers saved in your phone, e.g. your local refuge, taxi service.</li> <li>» Reverse your car into the driveway, to get away quickly if you need to. Keep petrol in the car. Keep the car keys on you.</li> <li>» Have a bag packed with some clothes and comfort items for the children. Keep it in a safe place in the home or with a trusted neighbour/friend.</li> <li>» If you can, bring important documents when you leave, e.g. ID, birth cert(s), passport(s), Public Services Card (PSC), medical card(s), Irish Resident Permit, court orders.</li> <li>» Other things to bring, if you can, are: mobile phone and phone charger, money, keys and/or medications.</li> </ul>	<p>Things you could do:</p> <ul style="list-style-type: none"> <li>» Change the locks. Add an outdoor lighting/security system and/or smoke and carbon monoxide detectors.</li> <li>» Remove GPS from your phone.</li> <li>» Use an email account that the abuser does not know and change passwords, online account information, etc.</li> <li>» Change your phone number.</li> <li>» Inform school/childcare provider of who is allowed to collect your children.</li> <li>» Tell someone you trust at work of your situation. Calls could be screened, and staff could inform you if the abuser is in the vicinity.</li> <li>» Bring any domestic violence court orders to your local Garda station and keep a copy on your person.</li> </ul>



Safety in an abusive relationship	Thinking of leaving an abusive relationship	After you have left an abusive relationship
<p>Things to remember:</p> <ul style="list-style-type: none"> <li>» When searching online, at options, find the setting and select 'incognito' or 'in private' to stop your search from being stored.</li> <li>» If you are assaulted, attend the hospital or a GP. Take photographs of your injuries.</li> </ul>	<p>Things to remember:</p> <ul style="list-style-type: none"> <li>» Limit the number of people you tell that you are leaving.</li> <li>» Getting to safety is the priority. You can always go back to the house to collect belongings in safety, with the Gardaí.</li> </ul>	<p>Things to remember:</p> <ul style="list-style-type: none"> <li>» Keep a diary of any incidents and report threats or suspicious activity to the Gardaí.</li> <li>» It will be an emotional time, and you need to take care of you. Keep linked in with your supports.</li> <li>» Post-separation is the most dangerous time for women experiencing domestic violence.</li> </ul>
<p>General Information:</p> <ul style="list-style-type: none"> <li>» There are various court orders available to protect you and your family. You can remain in the relationship and still apply for protection/safety orders.</li> <li>» In the event of an abusive incident, call Gardaí on 999, if you can. Tell them your 'personal safety is under threat' and if you have any court orders.</li> </ul>	<p>Warning Signs and Cycle of Abuse:</p> <p>Domestic abuse can follow a pattern of phases:</p> <ul style="list-style-type: none"> <li>A. tension-building phase;</li> <li>B. violent phase; and</li> <li>C. reconciliation phase.</li> </ul> <p>Once abuse has begun, it can, over time, increase in frequency and severity. As it continues, the aforementioned phases can begin to change, with decreases in tension-building and reconciliation and increases in violent phases.</p> <p>Know the warning signs that tension is increasing. Some signs include:</p> <ul style="list-style-type: none"> <li>» a feeling of tension or a familiar pattern of incidents;</li> <li>» the abuser's facial expressions, body language, and tone; and</li> <li>» any changes in the abuser's behaviour.</li> </ul>	<p>Useful Numbers:</p> <ul style="list-style-type: none"> <li>» Gardaí/Emergency Service: 999 24 hours, 7 days per week</li> <li>» Sonas Refuge: 01 866 2015 – change as relevant 24 hours, 7 days per week</li> <li>» Samaritans: 116 123 24 hours, 7 days per week</li> </ul>

## Safety Planning with Children

My name is \_\_\_\_\_ and this is my safety plan.

If there are angry words or actions happening around me, I can't stop them, but this is what I can do:

**1. Stay out of the way.**

**2. Find a safe place.**

This could be:

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

**3. If it is safe to do so, ring the Gardaí.**

Dial 999. → Tell them your name. → Tell them where you are. → Tell them what is happening. → Do not hang up!

**The people who know this plan are:**

Me \_\_\_\_\_

Family \_\_\_\_\_

Others \_\_\_\_\_

Our safe word is \_\_\_\_\_

**People who can help are:**

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

**Later, I can talk to:** \_\_\_\_\_

**If I am hurt, I will tell:** \_\_\_\_\_

**It is OK to feel:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## APPENDIX 5: DOMESTIC VIOLENCE ORDER INFORMATION

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Under Irish law, there are two main, different orders that provide protection and for which you can apply in the District Court.

All partners in an intimate relationship are eligible for **safety and protection orders**, with no need of cohabitation.

1. A **barring order** requires that the violent person leave the family home. It also prohibits the violent person from using or threatening to use violence against you and/or any dependent children. The court can direct the violent person, i.e. the respondent, not to attend, be near, or watch the place where the applicant (you) and any dependants (for example, your children) live. There is no minimum period of cohabitation required for cohabitant applicants.
2. A **safety order** prohibits the violent person from further violence or threats of violence. It does not oblige the violent person to leave the family home. If the abusive person does not live with you, the safety order prohibits him/her from being near or watching your home.

You can apply for *temporary* orders (**protection orders** or **interim barring orders**) to protect you and your dependants (for example, children) while waiting for your case to be heard. You can apply for a **protection order** or **interim barring order** in the District Court (each lasts eight days). The key difference between the two temporary orders is that the **interim barring order**

requires the violent person to leave the family home, whereas the **protection order** does not.

An **emergency barring order** gives time-limited protection where there is an immediate risk of significant harm to you, even if you have no legal or beneficial interest in the property (for example, if you do not own or co-own the home or do not have your name on the lease). You can apply for an **emergency barring order** where you have lived in an intimate and committed relationship with the perpetrator without being his spouse or civil partner or where you are the parent of an adult perpetrator. **Emergency barring orders** will only be granted where there are reasonable grounds to believe that a person is at immediate risk of harm. An **emergency barring order** may be granted without notice having been given to the person against whom it is sought and will have effect for up to eight working days. Once the **emergency barring order** has expired, another **emergency barring order** may not be made until one month after the expiry of the previous order, unless the court is satisfied that there are exceptional circumstances. This is to ensure that this order will operate as an emergency, temporary measure only.

For further information on domestic violence legal-order fact sheets, please see:

<http://www.domesticabuse.ie/legal/>

If you are assaulted and do not have a domestic violence order in place, the abuser can be arrested under the Non-Fatal Offences Against the Person Act 1997. The act applies to crimes of harassment, threats to kill, assault, coercion, stalking, endangerment and false imprisonment. The Gardaí/police have the power to arrest and charge a person under this act.

You can make a report at any Garda station if you think an offence has been committed against you under the Non-Fatal Offences Against the Person Act.

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## APPENDIX 6: THE IMPACT OF THE HABITUAL RESIDENCE CONDITION (HRC) ON TRAVELLERS AND ROMA

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### Briefing note - July 2014

#### The Impact of the Habitual Residence Condition (HRC) on Travellers and Roma

Habitual residence is a condition which applicants must satisfy in order to qualify for certain social welfare payments. Habitual residence essentially means an applicant must be able to prove a close link to Ireland. Five factors are considered to determine habitual residence:

- a. the length and continuity of residence in the state or in any other particular country;
- b. the length and purpose of any absence from the state;
- c. the nature and pattern of the person's employment;
- d. the person's main centre of interest;
- e. the future intentions of the person concerned as they appear from all the circumstances.

Pavee Point have noted that the application of HRC is having a disproportionate impact on Travellers and Roma in Ireland and raising serious human rights concerns. As a result of this condition, Traveller and Roma families affected are living without access to basic income and measures to address this need to be taken by the Department of Social Protection.

In a series of seminars held by Pavee Point and the Health Service Executive (HSE) in 2011/2012 on the experiences of Roma children in Ireland, HSE staff noted that the habitual residence condition is resulting in extreme child poverty for Roma children. A recurring issue at the seminars and in the interviews with professionals working with Roma was the extent of the deprivation some Roma families are experiencing as a result of not qualifying for social welfare assistance. Many practitioners expressed shock and concern at the living conditions of some Roma families, including substandard housing and no food, saying they have never seen such conditions before.

*"I've been working my whole life and never seen poverty like this before. We need to do something about it."*

The Special Rapporteur on Extreme Poverty and Human Rights, Magdalena Sepúlveda Carmona, has called on Ireland to review the impact of the condition as a matter of priority. In light of this Pavee Point calls on the Department of Social Protection to invest in and conduct a review and impact assessment of the habitual residence condition, in particular in relation to ethnicity and gender. Ireland has a responsibility to ensure policies are in line with human rights commitments. This means ensuring policy is not discriminatory.

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