

HSE Practice Guide on Domestic, Sexual and Gender Based Violence

For staff working with children and families



*"I said, Make your own f*ckin' tea. That was what happened. Exactly what happened. I provoked him. I always provoked him. I was always to blame. I should have kept my mouth shut. But that didn't work either. I could provoke him that way as well. Not talking. Talking. Looking at him. Not looking at him. Looking at him that way. Not looking at him that way. Looking and talking. Sitting, standing. Being in the room. Being.*

What happened?

I don't know.

The woman who kept walking into doors.

- How are you?

- Grand.

Ask me.

In the hospital.

Please, ask me.

In the clinic.

In the church.

Ask me ask me ask me. Broken nose, loose teeth, cracked ribs. Ask me."

From The Woman Who Walked Into Doors by Roddy Doyle (1996)

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FOREWORD

I commend this excellent practice guide to all staff within the HSE and other agencies dealing with survivors of domestic, sexual and gender based violence. This guide is comprehensive, sensitive and practical in its treatment of this critical area. It provides insight into international practice and trends in relation to presenting survivor patterns and associated service practice. The guide treats in detail the indicators for identification of potential survivors, the dynamics of the survivor's experience and the practices governing risk assessment and protection of both child and adult survivors. It outlines practices appropriate to the age, gender and ethnic group of the client presenting as well as dispelling many of the clichés and stereotypes that still exist within broader society in relation to survivors of both domestic and sexual violence. I wish to commend the author of this report, Kevin Webster, Social Work Team Leader, and also all the staff both within our own services and the wider domestic, sexual and gender based violence services who collaborated in the production of this guide.

A handwritten signature in black ink that reads "Gordon Jeyes." The signature is written in a cursive, slightly slanted style.

Gordon Jeyes, OBE
National Director, Children & Family Service
Health Service Executive
November 2012

BACKGROUND

The background to this Guide is that the local HSE children and families social work service in Dublin South West, as part of an aspiration to respond positively and creatively to the issue of domestic violence, decided to create a practice document and give a training input to induct staff as to best use of this tool. A multi-disciplinary working group was set up in January 2007¹ which developed a first version of the practice document. This was presented to all team members with training and the document was piloted for 6 months followed by a further review with the team. Improvements were made as a result of the pilot phase and consultation with Women's Aid and a final document was produced in March 2010. The service also undertook a small piece of research (Webster et al, 2011) to explore the impact of the document on practice in the team. The outcome was generally positive with a consensus that having the document as an agreed policy on the team had enabled workers to practise with more confidence and clarity. This, it was felt, contributed to better services and safety for families where domestic violence is an issue. Staff reported more active screening for domestic violence in their work and being more alert to cues from clients about the issue. One social worker said "It's always something you're open to when taking on a new case. There's an awareness generally, a checklist in my mind if needed". Better inter-agency collaboration was noted and consultation with and referral to support services appears to now be standard practice at every level of the service. The document was circulated to numerous professionals locally e.g. Gardaí and hospital staff and is used as a resource to social work students at TCD and UCD. The success at local level led to Kevin Webster from Dublin South West being asked to join a national working group to adapt the original document to create this national guide for all HSE staff.

PURPOSE & SCOPE OF THE GUIDE - POLICY CONTEXT

All professionals have a responsibility for responding appropriately to domestic abuse. It is an inevitable issue in our work. This is a good practice guide for HSE staff working with children and families experiencing domestic violence. The guide focuses on addressing concerns about domestic violence and child protection. Historically getting this balance right has been a dilemma, particularly for statutory child protection services. However much we wish to support adult survivors of domestic violence, social care and health professionals are regularly faced with the obligation to make children's safety our paramount concern. Often in practice these can be seen as competing demands. It can be a struggle to hold on to the idea that protecting and supporting the adult survivor of domestic abuse is the most effective long term way of protecting children. Children First (Dept of Children and Youth Affairs, 2011) states "a proper balance must be struck between protecting children and respecting the rights and needs of parents/carers and families. Where there is conflict, the child's welfare must come first". The safety of the child overrides the issue of confidentiality.

This guide is a significant resource to the implementation of the HSE Policy on Domestic, Sexual and Gender Based Violence (2010) and to the National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014. It forms part of the 'Train the trainer' information pack for the roll out of national HSE training on domestic sexual and gender based violence and is also a link with the Children First Protection and Welfare Practice Handbook 2011. Some of its content has also been drawn from a previously published guide "Domestic Violence: A Guide for General Practice" by the Irish College of General Practitioners in association with the HSE and national NGO's.

Where possible this guide is 'gender sensitive' and refers to survivors of domestic abuse in a non-gender specific manner. However, the guide includes some gender specific research, references and models specific to women survivors. There is little research on male survivors. Domestic Violence is the most familiar term used but others e.g. Domestic, Sexual and Gender Based Violence are becoming more common. This guide predominantly uses the terms 'Intimate Partner Violence' (IPV) and 'Domestic Abuse'. The guide does not address other forms of family abuse e.g. elder abuse² or abuse of parents by teenagers. The term 'victim' is also familiar but where possible in this guide the more positive term 'survivor' is used. This document is structured using the 3 R's format of Recognise, Respond, and Refer(Review) with themes on specific areas of interest e.g. Children. We hope it will have a positive impact on our future practice.

The Working Group, November 2012

¹ See membership of working group in Acknowledgements on page 59

² Elder Abuse is: "A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights" (*Protecting Our Future, the Report of the Working Group Report on Elder Abuse*, WHO, 2002) and used in the HSE policy "Responding to Allegations of Elder Abuse" (2008).

CORE PRINCIPLES FOR DEVELOPING GOOD PRACTICE RESPONSES

Preparatory research commissioned for the HSE Policy on Domestic, Sexual and Gender Based Violence suggests that “central to strategic planning and provision of prevention and intervention initiatives regarding domestic violence are the principles which underlie such an approach”. These core principles underpinning our good practice response are identified as:

Principles	Description
Human rights	Domestic violence is a human rights issue affecting both men and women, however, the vast majority of survivors are women.
Safety	The primary objective must be securing the safety of people experiencing domestic violence, and ensuring service providers are not put in a potentially violent situation.
Empowerment	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	Consultation and interaction with domestic violence survivors should be respectful of privacy and confidentiality, and cognisant of the real dangers if these are breached.
Responsibility	An act of violence committed against any person is an offence punishable by law and must be treated as such. Perpetrators must be held accountable for their actions and bear the consequences.
Multi-sectoral and multi-dimensional collaboration	Approaches involving a myriad of agencies and disciplines are required to adequately address the complexity of the problem.
Skills base and awareness	Those responding to domestic violence must have appropriate sensitisation training and on-going education to do so. Public awareness of the issue is another important consideration.
Respect	A supportive and understanding ethos should underpin all service responses, thereby building a culture of empathy and trust amongst domestic violence survivors and those providing interventions.
Diversity	Service responses should be mindful of the culturally diverse nature of the population.

Kearns et al 2008

SECTION 1 – RECOGNISE

1.1 DEFINITION OF DOMESTIC VIOLENCE

In recent years there has been a growing awareness of the prevalence of domestic violence in Irish society. Domestic violence takes many forms and can be perpetrated by various family members. It is recognised that domestic violence is not confined to any particular social class and that it occurs in both rural and urban areas. The HSE Policy on Domestic, Sexual and Gender Based Violence (2010) states: “The majority of victims are women, but a significant number of men are affected and abuse also occurs in same-sex relationships. The Women’s Health Council (2009) outlines that international research literature shows that minority ethnic women are at increased risk of domestic violence and/or sexual violence, and that they face a range of barriers to accessing relevant services”.

Domestic violence³ is understood to encompass mental, physical, economic and sexual violence. The Report of the Task Force on Violence Against Women (1997) defines domestic violence as: *‘The use of physical or emotional force or threat of physical force, including sexual violence, in close adult relationships. This includes violence perpetrated by a spouse, partner, son, daughter or any other person who has a close or blood relationship with the victim. The term ‘domestic violence’ goes beyond actual physical violence. It can also involve emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transport and the telephone.’* (p. 27)

The Report also states that in the majority of incidences of violence against women, including that of sexual assault, the attacker is not a stranger but is known to the victim. Whether it be sexual assault, rape, physical assault or emotional abuse, women are at greater risk from husbands, boyfriends, male relatives and acquaintances than from strangers. Violent attacks of this nature are rarely once-off occurrences, but are likely to be persistent and frequent with the objective of instilling fear in the victim. (p.27)⁴

It is important to differentiate between relationship difficulties/disputes and domestic abuse. In the former there is generally capacity for negotiation and compromise between the two parties; in domestic abuse situations one party seeks to control the other through the instilling of fear as a mode of control.

An Irish survey (Watson & Parsons 2005) found that 15% of women and 6% of men experience severe abuse. This violence and abuse may include:

- Being hit, kicked, punched, raped or sexually assaulted
- Doors or walls being punched, furniture being broken
- Emotional blackmail, using intimidation or threats, coercing someone into doing something they don’t want to do
- Withholding or controlling money
- Using children
- Isolating, blaming, denying, minimising, putting her down, playing mind games

3 Domestic Violence has been the most familiar term in use but this guide primarily focuses on ‘Intimate Partner Violence’ (IPV) and uses this term or ‘Domestic Abuse’.

4 See Power & Control wheels in Appendix i for more information on the nature of domestic violence.

1.2 IMPORTANT FACTS REGARDING INTIMATE PARTNER VIOLENCE

- Physical and sexual assault is a crime.
- 1 in 5 Irish women have experienced abuse from a current or former intimate partner in their lifetime (Kelleher & Associates and O'Connor 1995) and 1 in 16 men have experienced abuse (Watson & Parsons 2005).
- When a woman decides to leave a violent relationship she is at most risk.
- Leaving the situation does not necessarily end the violence. For example, access and contact with the children post separation can be used to continue abusive behaviour.
- A woman is also at higher risk when she is pregnant. Of women experiencing domestic violence, 25% are assaulted for the first time during pregnancy (Royal College of Midwives 1997). One in eight women attending the Rotunda Hospital suffered abuse during pregnancy (O'Donnell 2000).
- 39% of women attending a group of Dublin GP practices reported experiencing domestic abuse (Bradley 2002)
- 90% of women who are murdered are murdered by men, most often a family member, spouse or ex-partner.
- Since 1996, on average one woman per month is murdered in Ireland. In the resolved cases, 51% of women were murdered by a partner or ex-partner and in all resolved cases 99% of perpetrators were men (Women's Aid Female Homicide Watch 2009).
- On average a woman is assaulted 35 times before she comes forward to make a complaint to the Gardai (Yearnshire 1997).
- No other crime has as high a rate of repeat victimisation (Povey et al 2009).
- One evaluation found that child welfare workers failed to identify domestic violence in 71% of cases where caregivers had reported it (Journal of Interpersonal Violence 2008).
- Up to 52% of social work cases include an element of domestic violence (Radford & Hestor 2006, Holt 2003).
- The Sexual Abuse and Violence in Ireland (SAVI) Report (McGee 2002) highlighted that 24% of women and 1% of men reported sexual abuse by their partner or ex-partner.
- One Irish study found 75% of men compared to about 50% of women told someone about the abuse they were experiencing within a year (Watson & Parsons, 2005 in Allen 2012)
- Men who are abused by their partners are less likely to suffer severe injuries and are less likely to require medical treatment for their injuries. Men are more likely to experience minor cuts, scratches or grazes - as compared with women, who are more likely to experience bruising, broken bones, loss of consciousness or miscarriage (Watson & Parsons 2005).

MYTHS ABOUT INTIMATE PARTNER VIOLENCE

- Only a small percentage of women are victims of violence.
- There are no male victims of intimate partner violence.
- Domestic abuse does not have an impact on children.
- Nobody has the right to interfere in the domestic affairs of a couple.
- Women sometimes deserve to get raped and beaten; they provoke the assault by their behaviour and clothing.
- It's just the odd domestic tiff - not as bad as they make out.
- Physical violence is unlikely to get worse over time.
- Only poor women are abused.
- If there were no visible injuries then the assault cannot have been that bad.
- Nobody ever gets killed as a result of intimate partner violence.
- Victims of intimate partner violence can always leave home if they want to.
- Anyone who is abused comes from an abusive family background.
- Violence only occurs in working class and Traveller families.
- If a victim leaves the abusive relationship the abuse will stop.
- Anyone who experiences intimate partner violence is weak.

- Alcohol misuse causes wife battering.
- Couple counselling will help resolve the abuse.
- Women and children frequently lie about sexual violence.
- Abused women abuse their children.
- Perpetrators of violence are mentally ill or have low self esteem.
- Anyone who is violent comes from an abusive family background.
- Abusers cannot control their violence; they have anger management problems.
- Abusers are easy to identify. They are physically violent all of the time and to everyone.

1.3 BARRIERS TO DISCLOSURE

Some of the factors that may mitigate against intimate partner violence disclosure are a combination of:

- What the survivor may bring (i.e. Why do survivors not tell?)
- What the professional may bring (i.e. Why do professionals not ask?)
- What the agency may bring (i.e. Do agencies promote domestic abuse screening with guidelines and education?)
- What society brings (i.e. What do state agencies bring to support disclosure?)

WHY SURVIVORS DON'T TELL & WHY THEY STAY WITH THEIR PARTNER:

- A fear that disclosure will jeopardise their safety
- A fear that their children will be removed, as threatened by their partner
- Feelings of shame, stigma, guilt and humiliation
- Beliefs and cultural issues around what constitutes abuse
- Protection for the maintenance of the family unit - Security
- Fear that they won't be taken seriously
- Belief that the abuse is the victim's 'own problem'
- Belief that they are provoking the abusive behaviour - Blame themselves
- Belief that nothing can be done about the abuse
- Reluctance to lose their intimate relationship - They love their partner but not the behaviour
- Persistent hope that the abuse will stop
- Fear of poverty/lack of financial independence - Benefit payments
- Fear of the unknown
- Stigma - Status
- Because they are intimidated
- They hate to think they have made a mistake
- No support due to being isolated - No friends
- Low self-esteem - Insecurity
- Being afraid they have to go back to country they came from - Refugee status
- Nowhere to go
- Don't want to be alone
- Pressure from family/ friends
- Farming – Family business
- Fear of being killed

WHY PROFESSIONALS MAY NOT ASK:

- Their own beliefs, experiences and cultural background
- Lack of awareness, understanding and training
- Fear they may insult the survivor if they are wrong by asking the question
- Disbelief
- Lack of resource tools for identification and screening
- Operating from a medical model and treating the symptoms and not the problem
- Poor recognition of the physical, psychological and social costs of domestic, sexual and gender based violence
- Blaming the survivor and annoyed by the behaviour – ‘why don’t they just leave?’
- Groomed by the abuser
- May find the disclosure painful, feels helpless, anxious, and fearful of what might need to happen next and so engages in avoidance behaviour
- Perceived or real lack of time.
- The belief that they do not have the skills to handle the situation properly.
- The feeling that they may not be helping anything by asking.
- Concerned/don’t know how to respond if someone were to disclose.
- They may be in an abusive relationship themselves.

(Adapted from Royal Australian College of General Practitioners 1998)

WHAT THE AGENCY MAY BRING:

- Poor recognition and acknowledgement of the problem of domestic abuse and its effects.
- Lack of information, training, and awareness programmes for staff.
- Support for the medical model.
- Absence of good policy, procedure and best practice guidelines.

WHAT SOCIETY MAY BRING:

- What messages are given at a national level through government policy and the legal system in response to domestic abuse?
- What are society’s values, customs, and culture in respect to violence?
- How is the issue attended to in the media?
- Do we as a society glorify violence by encouraging and tolerating the behaviour in our communities?
- Are we tolerant of violence in the entertainment industry promoting it as entertainment all the while developing a pervasive desensitisation and acceptance?

(Adapted from Belsky 1989)

1.4 GUIDING PRACTICE PRINCIPLES IN WORK WITH INTIMATE PARTNER VIOLENCE

- Intimate partner violence is predominantly about the abuse of power and control of one partner over another.⁵
- Once intimate partner violence is substantiated the perpetrator must be held solely accountable for the violence.
- Intimate partner violence occurs in all sectors of the community regardless of class, gender, sexuality or ethnic group.
- Intimate partner 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.
- Professionals should be aware of the possibility of being ‘groomed’ by the abuser⁶.
- Intimate partner violence is significantly harmful to children at least emotionally and often coincides with physical and sexual abuse of children.
- Services should take account of the links between intimate partner 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.
- Workers require clear policies, procedures and ongoing and accessible supervision, training and support.
- The safety of the survivor and the children should be paramount at all times.
- Once it is established to be appropriate all efforts should be made to keep children with the non-offending parent.
- People in intimate partner violence 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 survivor is paramount to good practice.
- Inter-agency collaboration is good practice with the responses to children, survivor and perpetrator often requiring separate interventions.
- In families where mutual violence is indicated all effort should be made to establish who the primary offender is and the dynamics underlying this.
- Careful consideration must be given to how professionals make contact with an adult survivor of domestic abuse in a safe manner which will not put them and their children at further risk e.g. making contact via the school.

⁵ See Power & Control wheels in Appendix i for more information on the nature of domestic violence.

⁶ See How and Why Professionals are Groomed on page 43

SECTION 2 – RESPOND

Historically practice has focused on encouraging women to immediately leave an intimate partner violence situation in order to protect her children. Research now tells us that the point of leaving can be an extremely dangerous time for women, and therefore children. As social and health care professionals we need to explore ways of helping a survivor to be safe, which may or may not involve leaving the relationship but if so to leave at a time when they are best prepared to do so in way that is protective to themselves and their children. The survivor is best placed to know when the time is right to act and we must show support, and trust their judgement of the situation. A different response may be required where there are concerns about children's safety (see Assessing Risk on page 15). Effective help must be directed towards enabling the survivor to take control of their own life, to offer realistic choices while accepting that the decisions are theirs alone and are always valid in their particular situation. Continuing understanding and support are vital as it may take a survivor demoralised by years of violence and abuse a long time to find the confidence and courage to make changes.

2.1 ASKING THE QUESTION

Responding to disclosures of intimate partner violence

- Listen
- Communicate belief (*'That must have been very frightening for you'*)
- Validate the decision to disclose (*'It must have been difficult for you to talk about this'*)
- Emphasise the unacceptability of violence (*'You do not deserve to be treated this way'*)
- Emphasise their right to confidentiality
- Document the abuse in the client's own words

The following questions imply that, somehow, the survivor was to blame for the violence and should not be used:

- Why do you stay with a person like that?
- What could you have done to avoid the situation?
- Why did s/he hit you?
- Why don't you leave him/her?

(DVIRC Professional Training Unit 2007)

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

(Adapted from: Responding to Domestic Abuse a Handbook for Health Professionals 2005)

PRACTICE RECOMMENDATIONS FOR INTERVIEWING A POTENTIAL SURVIVOR:

- Provide a private, quiet space where you will not be interrupted or overheard.
- Conduct the assessment with sensitivity and in a non-threatening manner.
- Interview potential survivor alone and think of a pretext if necessary.
- Develop trust by creating a climate of safety.
- Provide safe alternatives and access to domestic violence services.
- Avoid 'victim blaming' questions or statements.
- Be honest about why you are asking and explain that many women experience domestic abuse.

(Adapted from NHS Lothian 2007)

SUGGESTED INTRODUCTORY QUESTIONS IF THERE IS A CONCERN ABOUT DOMESTIC ABUSE:

“Tell me how you and your partner handle conflict in your relationship”.

“What are the good things about your relationship? What are the not-so-good things?”

If there is some concern raised, the worker can move on to using the following questions. Practitioners can either ask all the questions as a screening tool/routine enquiry or choose to ask some relevant questions from the list to explore the issue with a survivor. The questions can also be used by a worker to retrospectively assess a case file if there is a concern about domestic violence.

Suggested Questions for Asking about Intimate Partner Violence

These questions can be used at an initial meeting with a client or at a later time:		
1.	What happens when you have an argument or row at home? Does anyone criticise you, make fun of you or call you names?	
2.	Do you ever feel unsafe in your own home? Have the Gardai ever been called to your home due to a domestic disturbance?	
3.	Are you ever prevented from leaving your home, seeing your friends or family; prohibited from getting a job, socialising, or owning your own money?	
4.	Is there someone at home jealous or possessive of you, for example questioning your movements, checking your whereabouts, following you, believing you have other partners, checking your mobile phone, your email, computer use history or post?	
5.	Have you ever had your home/possessions damaged or a family pet harmed?	
6.	Have you ever been threatened with a weapon, hit, kicked, or hurt in any way at home?	
7.	Have you ever been threatened that your children will be taken away from you?	
8.	Have your children overheard, witnessed or experienced domestic violence?	
9.	Have you ever forced to engage in sexual acts against your will?	
10.	Do you feel safe going home and if not what would you need to happen to make it safe for you to do so?	
11.	Is there anything else that you would like to mention or add:	
FOR PRACTITIONER USE ONLY		
If there is a disclosure of domestic abuse it is important to assess whether the abuse took place over a period of time, so please evaluate for a history of:		
<input type="checkbox"/>	Childhood abuse	<p>Please remember to explain these points to the client:</p> <p>* Routine nature of assessment/enquiry</p> <p>* Confidentiality policy of service</p> <p>* Client's and their children's safety is the priority</p>
<input type="checkbox"/>	Past domestic abuse	
Is intervention necessary?	Is it immediate?	Is the referral to an outside agency?

Depending on a survivor's response to these questions (including a denial) the worker then assesses the likelihood of intimate partner violence being a factor. The 'Working from where the woman is at' model (page 18) provides additional information to help you support the victim sensitively and inform a good practice response.

It is important not to force a disclosure.

Even if the survivor does not disclose domestic abuse at this time you have at least acknowledged the situation. Let them know that you are:

- There to support them and their children.
- Flexible about where you can meet them.
- Willing to continue to monitor the home situation and to support them in the best/safest way possible.

IF DOMESTIC VIOLENCE IS CONFIRMED, SUPPLEMENTARY QUESTIONS IN RELATION TO CHILDREN'S SAFETY

(Remain supportive to the survivor so that they don't feel that the only interest is the children's safety.)

- Have the children intervened or been physically harmed during a violent assault?⁷
- Is the perpetrator physically or sexually abusing children?
- Have the children been used to intimidate the victim or as a trigger to the violence? (McGee 1997)
- How is the violence affecting the children? What do they do, how do they feel when the violence is happening?
- Has the abuser made threats of homicide or suicide?
- Does the abuser have access to dangerous weapons or firearms?
- Is the non-offending parent able to protect the child(ren)? How?

2.2 GOOD PRACTICE RESPONSES – DO'S & DON'TS

DO'S:

If a survivor does disclose intimate partner violence:

- Take them seriously and believe them
- Reassure them that the violence is not their fault
- Do provide a safe environment to disclose – remember if a survivor is accompanied by their partner it will not be safe for them to disclose – do **not** discuss with their partner
- Give priority to ensuring the survivor and their children's immediate safety whether they leave or not
- Do recognise their need for a positive response and offer your support
- Do remember that confidentiality is crucial to their safety
- Do remember that options may be limited by lack of resources for survivors
- Let them know that they are not alone in being abused

⁷ See Theme 1 – Children & Teenagers for further input on assessing children's experience

- Advise the survivor that they do not have to leave their home to talk to someone about their situation. Offer them information on different support options, for instance, to speak with staff in a domestic violence service or refuge (see Section 3 - Refer)
- Remember the decision to leave has to belong to the survivor
- Keep in regular contact with the survivor
- Make contact with the survivor in a way that will keep them safe – sending a letter to the home address could be intercepted and put them in danger
- Make a safety plan with the survivor (see page 21 and appendix ii)
- Consult with colleagues if you are not sure what to do
- Do document the disclosure
- Do work at the pace of the survivor

DON'TS:

- Don't ignore your intuition if you suspect someone is being abused
- Don't insist on joint meeting with them and their partner – there are potentially serious safety implications/repercussions from joint sessions
- Don't suggest couples or family therapy
- Don't make choices for them
- Don't give the partner the address or phone number of where the survivor is staying
- Don't promise to give a letter or message to the survivor from their partner or to facilitate contact in any way
- Don't give up on them because things are taking longer than you think they should (see Dealing with Your Frustrations on page 20).

2.3 CHILD WELFARE AND PROTECTION

'Woman protection is child protection' (Liz Kelly).

This also applies where the man is the survivor so 'survivor protection is child protection'. Every social and health care professional has the responsibility to endeavour to ensure the safety and wellbeing of children in the home. Intimate partner violence can increase the risk of all forms of child abuse. Children may witness, be forced to watch or participate in, or be victims of the violence. The impact of this on children can result in behavioural, social and emotional problems; cognitive and attitudinal problems; longer term psychological problems; and physical injury or death. Primarily, it is the man who poses this risk and the mother is the non-abusing parent, but this might not always be the case.

The risk of severe domestic abuse increases with the presence of children, with 75% of women seeking refuge being accompanied by children and the risk of severe abuse for women who have children increases by more than 50% at the point of separation (Watson & Parsons 2005).

The survivor may however be abusive to the children, possibly using physical abuse to control the children to prevent worse consequences for them from the perpetrator or due to the stress of their situation (Bragg 2003). The adult survivor's ability to adequately parent or protect the children may be affected by their experience of violence. It is essential that initial and ongoing assessment tools are used to measure the level of risk of all forms of abuse that the children are exposed to whilst in the home and who they are at risk from.

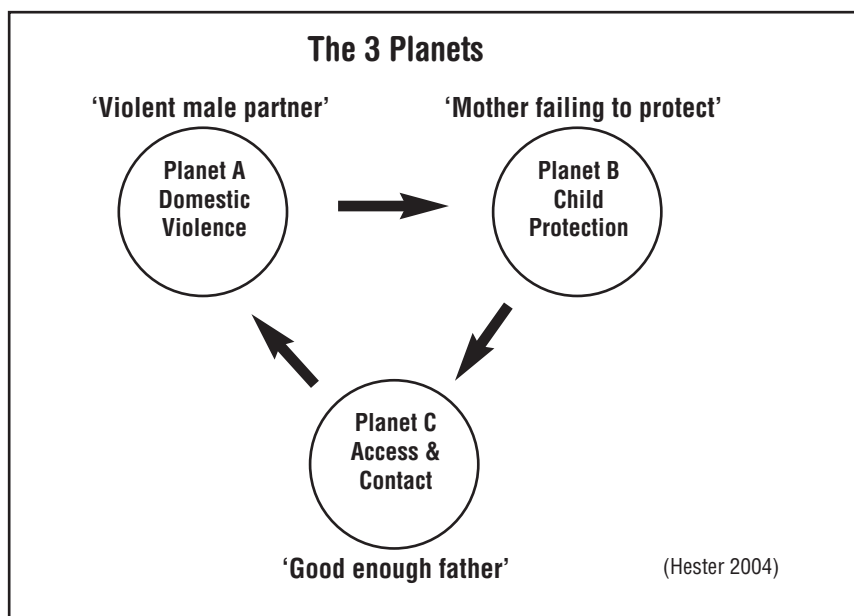
On a positive note, one study “revealed a significant improvement for women and children six months after the end of the violent relationship, as the women reported significant decreases in the rates of stress and depressive symptoms” (Holden 1998).

Fears of having children removed from their care result in survivors of domestic abuse experiencing statutory social work services as inherently threatening. Also, it is a false premise for professionals to equate separation with safety, as the research shows the violence often continues after the survivor has left the relationship (Stanley 2011).

David Mandel & Associates’ (2011) ‘Safe and Together’ model is behaviour-based and set on the premise that intimate partner violence is not located in the relationship but in the perpetrator’s choices and behaviour. Mandel argues that we have traditionally approached intimate partner violence through the lens of ‘why doesn’t the victim leave’ which inevitably leads to the non-offending parent being held responsible for keeping the child(ren) safe. Instead, the ‘Safe and Together’ model recommends a paradigm shift based on a greater focus on the role of the perpetrator. Practitioners can achieve this through the consideration of 2 questions when assessing intimate partner violence situations particularly where there are child welfare and protection concerns: Ask about the “perpetrator’s pattern of coercive control” and get details of the abuse so a full assessment of dangerousness and impact on the children can be made. Interventions with perpetrators are focused on changing these behaviour patterns. Also, seek to “partner with the non-offending parent as a default position” by asking about the “full spectrum of the non-offending parent’s efforts to promote the safety and well being of the child,” validating those strengths and collaboratively safety planning with non-offending parent. For further details on the model visit www.endingviolence.com

2.4 MOTHER BLAMING

The 3 Planets model explores professional approaches to domestic abuse, child protection and access/contact with regard to mothers specifically (see diagram below). On Planet A, the domestic violence planet, the father’s violent behaviour is seen as a crime and the woman is in need of protection. On Planet B, the child protection planet, the focus is on protecting the children. Professionals are likely to insist that the mother removes herself and the children from the violence and she may be seen as failing to protect the children if she does not. Finally, on Planet C, the visitation and contact planet, the father is seen as a ‘good enough’ parent to whom the children need to have a relationship. As Radford and Hester (2006) point out “the mother ends up in a particularly difficult dilemma” as she is first expected to leave her violent partner with her children for their safety and is then ordered to facilitate contact by her children with this same violent man.



Davies and Krane (2006) suggest that as a result of this dynamic “distrust is fostered between workers and clients. For some mothers, a sense of powerlessness can ensue and then provoke overt resistance to child protection interventions; over time, mothers’ relationships with their workers may be experienced as antagonistic or even volatile”. As social and health care professionals we must be mindful of our response to survivors of domestic abuse in child protection cases and how we might inadvertently hold them responsible for preventing violence they have no control over. We must attempt to work with the survivor in her own right, not just as a non-abusing parent or protective mother. Otherwise, if we only focus on the child(ren), as Brid Featherstone (NUI Galway) comments, women are often given the message by social and health care professionals: “Don’t get beaten up anymore because it’s affecting your child”. This concept can be linked to the idea of the ‘deficit model of mothering’ in the child protection arena which “shifts the focus away from men’s violence to emphasise women’s ‘deficiencies’ and ‘failures’ as mothers and leads to blaming practices” (Lapierre 2008). In this context, it is suggested that “it is not an accident that abusive men attack women’s abilities to mother, they know that this represents a source of positive identity, the thing above all else that abused women try to preserve, and also that it is an area of vulnerability” (Mullender 2002).

POST SEPARATION CONTACT

Professionals should also note that there is Irish and international research which challenges the notion that post-separation contact with violent fathers is automatically in the child’s best interest (Holt 2011, Holt 2011, Radford & Hester 2006 p83-102). This research finds that post-separation access and contact can provide opportunities for abusive fathers “to continue to compromise the welfare and protection of participating children and their mothers”.

ISSUES FOR STAFF

- Practitioners must balance the needs of the adult survivor in intimate partner violence cases with the statutory obligation to consider the needs of the children as paramount.
- An abuser will often threaten a survivor that the children will be taken away if the violence is disclosed.
- ‘Woman protection is child protection’. In other words, if we keep the woman safe, then her children will be safe also.
- Support and supervision for practitioners is essential in these cases because our concern for children’s safety can lead us to respond in a way that the survivor experiences as equally controlling.

(SWAHB, Guidelines for Health Board Staff on Domestic Violence Information Leaflet)

2.5 ASSESSING RISK

Not all domestic conflicts warrant the involvement of a statutory child protection social work service. Assessing different levels of risk allows workers to match the level of risk or need to the appropriately targeted level of response. However, Children First (Dept of Children and Youth Affairs 2011) states “a proper balance must be struck between protecting children and respecting the rights and needs of parents/carers and families. Where there is conflict, the child’s welfare must come first”⁸.

8 The Children First Child Protection and Welfare Practice Handbook gives more information and guidance in Section 3.2.2 Domestic and Sexual Violence pp 61-67.

RISK ASSESSMENT NEEDS TO TAKE THE FOLLOWING INTO ACCOUNT⁹

- The possibility that if a parent is abused then the perpetrator may also be physically or sexually abusing the child.
- Children who overhear or witness intimate partner violence are seldom passive bystanders.
- Intimate partner violence can affect the survivor's capacity to parent, undermining their relationship with the children.
- Any escalation in the frequency and severity of violence.
- Recent separation.
- Intimate partner abuse can begin and/or escalate during pregnancy.
- Previous criminality or breach of court orders.
- Child abuse or previous contact with a child protection agency.
- The degree of isolation and vulnerability of the adult survivor.
- The fact that women aged 16 to 44 years report more intimate partner violence (Garcia-Moreno 2005).
- The availability of practical community/cultural supports and resources.

2.6 INDICATORS OF DANGEROUSNESS

The greater the number of following indicators the more likely a severe or life threatening attack by the perpetrator will occur:

- Threats or thoughts of homicide or suicide by perpetrator.
- Use of weapons.
- Extreme possessiveness, jealousy or obsession with survivor.
- Physical attacks, verbal threats & stalking during separation or divorce.
- Kidnapping or hostage taking.
- Sexual assault or rape.
- Prior abusive incidents that resulted in serious injury.
- History of violence with previous partners and children.
- Mental health disorders.
- Substance abuse.

Attempted strangulation has a high risk of fatality. There may be few or no external injuries but victims of this method of abuse warrant special attention. (International Association of Forensic Nurses 2006)

INDICATORS FOR A REFERRAL TO A CHILDREN & FAMILIES SOCIAL WORK SERVICE FOR ASSESSMENT:

1. A caretaker is physically or sexually abusing the child.
2. The child has physically intervened in an incident of intimate partner violence.
3. The child has been physically injured because of intervening in or being present during a violent incident.
4. The child exhibits significant emotional, psychological or physical effects due to the intimate partner violence.
5. The presence of any the above Indicators of Dangerousness.

(based on Bragg, 2003)

⁹ See Safety Planning on page 20 and Appendix ii

In all such cases referred to a Children and Families Social Work Service: “children are to be assessed in terms of the impact of domestic violence on them. Aspects to be considered include:

- An assessment of the child’s safety and risk from the perpetrator
- An assessment of the impact of domestic violence on the child
- As assessment of the level of emotional abuse on the child.”

(HSE Cavan/Monaghan 2004)

COPING STRATEGIES SURVIVORS USE TO PROTECT THEMSELVES AND THEIR CHILDREN:

- Complying, placating or colluding with perpetrator.
- Minimising, denying or refusing to talk about abuse for fear of making it worse.
- Leaving or staying in relationship so the violence does not escalate.
- Fighting back or defying the abuser.
- Sending children to neighbour or family member’s home.
- Engaging in manipulative behaviours.
- Refusing or not following through with services to avoid angering the abuser.
- Using or abusing substances to numb physical or emotional pain.
- Lying about abuser’s criminal activity or abuse of the children to avoid a possible attack.
- Trying to improve the relationship or finding help for perpetrator.

The UK guide Working Together to Safeguard Children recommends that “one serious or several lesser incidents of domestic violence where there is a child in the household indicate that children’s social care should carry out an initial assessment of the child and family, including consulting existing records” (HM Government 2006). The HSE Child Protection and Welfare Practice Handbook (HSE 2011, pp 61-67) gives detailed advice about intimate partner violence as a risk factor in child protection assessments. The Handbook has sections on: communicating with the child, obtaining a detailed history of the child’s experience of intimate partner violence, the impact on the non-abusing parent/carer’s ability to parent and protect the child, other important issues to consider during the assessment and what are the outcomes for this child? It also includes some information on perpetrator risk assessment.

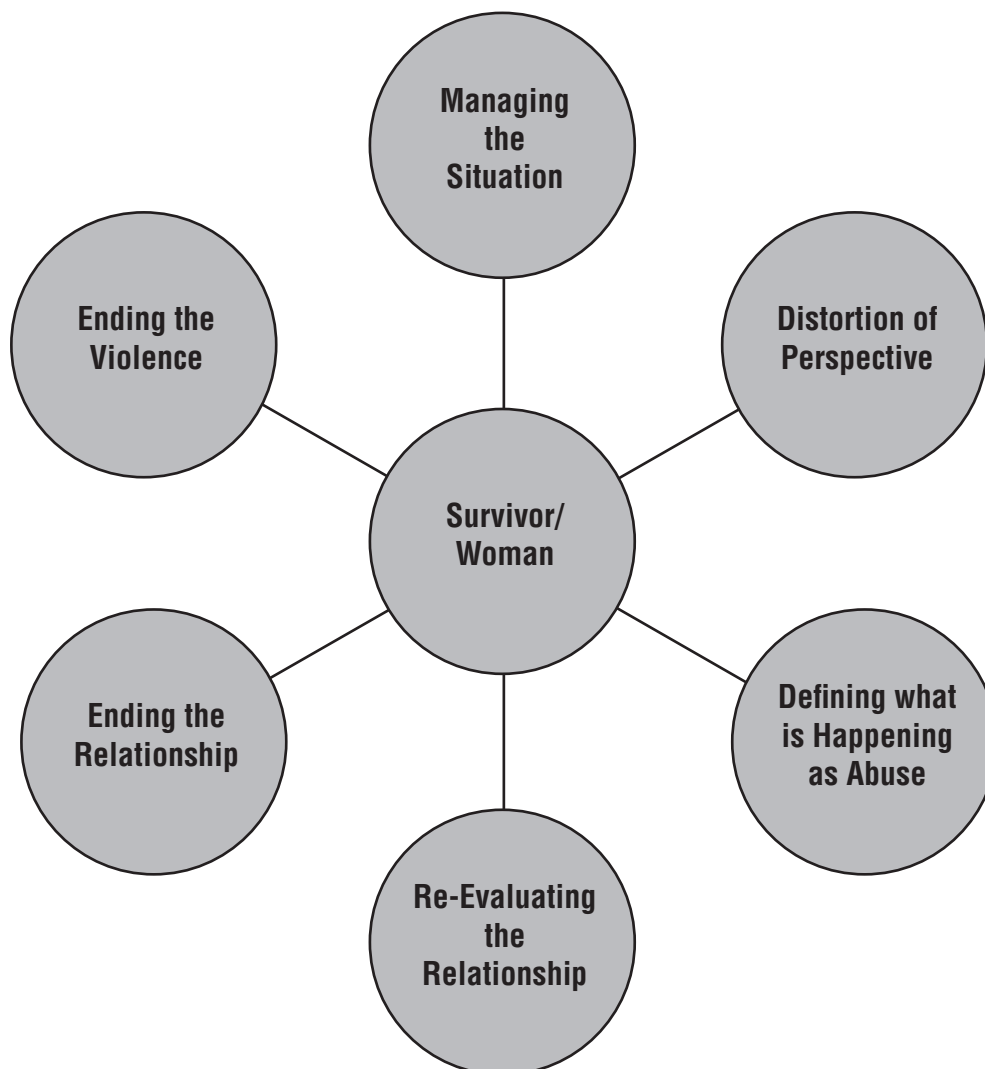
2.7 READINESS TO CHANGE

A continuing part of the assessment process involves measuring change before and after a period of intervention. This involves looking at indicators of change for the survivor and the child(ren). It is important for professionals to understand the leaving process in intimate partner violence – that it can take many attempts for a survivor to leave. It is equally important to understand that the many attempts are a normal part of this process and not a pathological indication of incapacity to change. Adults experiencing violence in an intimate relationship do not always want to leave but do want the violence to end. You will need to assess their readiness to change their situation through conversation and experience. The emphasis should be on empowering the survivor to make changes, not to hold them responsible for ending the violence. The model overleaf refers to women survivors of intimate partner violence but might also apply to men survivors.

WORKING FROM WHERE THE WOMAN IS AT (CRISIS INTERVENTION)

This model focuses on women survivors, adapted by Women's Aid from a conference presentation by Dr. Liz Kelly¹⁰. There is no existing model for male survivors.

- The Crisis Intervention model highlights the different processes a survivor experiences and 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, e.g. 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 women 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



Intimate Partner Violence: Working from where the woman is at' Adapted from Dr. Liz Kelly¹¹

¹⁰ Kelly, Dr. L. (2005) *Beginning Where Women and Children are: Outreach and Advocacy Approaches to Domestic Violence. Conference Presentation*. Dublin, Trinity College
¹¹ Dr. Liz Kelly is Professor of Child & Women Abuse Studies Unit in London Metropolitan University. She has a range of experience over many years, including working in refuges as well as researching and publishing on the subject.

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, the majority do not.
- The survivor may find, or accept an explanation for the incident, which allows for a future (e.g. takes the blame, minimises seriousness of the 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 it's her fault.
- She may now begin to use strategies to manage the situation to limit the potentials for conflict, e.g. 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 the perpetrator is telling her about herself.
- She continues to manage her anxiety and tries to make sense of what is happening.
- 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, e.g. she might talk to others.
- She may consider leaving the relationship, short term or for good.
- She may engage in formal processes to limit and contain the violence, e.g. 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 never leave. Reasons for staying, or returning to relationship can include: Nowhere to go, no money to leave (housing and money)¹²; Promises to change; Pressure from children, family and friends; Absence of effective protection (Granting of Barring Orders by the Courts is not guaranteed, depends on evidence available etc)¹³.

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 violence will end.

Contrary to popular myth, attempting to leave the relationship / end the violence may place women in more danger and at a greater risk of serious and even fatal assault.

12 O'Connor & Wilson (2004) Safe Home; Kelleher & Associates and O'Connor, M (1995)

13 The Courts Service Annual Report (2010). In 2010 1,064 out of 2,726 applications for Barring Orders were granted.

2.8 DEALING WITH YOUR FRUSTRATIONS

Adults victimised by intimate partner violence very often stay in abusive relationships, seemingly not allowing intervention by professionals. This can be exhausting, frustrating, and difficult to understand. Though you may feel frustration, you may be the first and only point of contact and it is important to inform the survivor of an 'open door' policy in terms of coming to you for help.

- Realise early that a survivor may never leave their abuser.
- Recognise that leaving is a process, not an event; the timeline from the beginning of abuse to the point of leaving may take decades.
- You don't have to act alone for the survivor; remember that there are specialised intimate partner violence support services that will help you to support them (see Section 3 Refer).
- Get to know as much as you can about how intimate partner violence is being responded to at a local level, e.g. the details of support agencies in the area, so that you can provide accurate information for the survivor¹⁴.
- Don't feel you have to know everything there is to know about intimate partner violence. Listening and communicating support and accurate contact details for an external support agency is better than not talking about it at all.
- Workers should be aware of their own safety needs: Perform a safety review for yourself frequently. Should a violent incident occur, perform a staff debriefing session. Violence affects everybody differently.
- Look after yourself: Working with the effects of intimate partner violence professionally can bring to the surface personal issues – particularly if you are experiencing or have experienced abuse yourself. Remember, as well as supervision, it is possible to contact your local HSE employee assistance programme.

(Adapted from Kenny & ni Riain 2008)

"The real question is not if she will go back to him but rather how is it that many skilled offenders manage to get the woman to stay or come back" (Hennessy 2012).

2.9 SAFETY PLANNING

"Safety planning for all involved in the case is essential." (Bragg 2003)

"Will my intervention leave this woman and her children in greater safety or greater danger" (UK Dept of Health 2005). The HEVI Handbook (Allen 2010) states that "It is essential to make a safety plan with all women presenting with intimate partner violence related injuries or distress, and those who disclose such abuse. This should always be done in a collaborative non directive manner. After having evaluated her situation and having established the dangerousness of the perpetrator it is important to draw up an individual safety plan together with the woman. Discuss with the woman how she can protect herself and her children". The Handbook identifies various factors to consider: anticipating violence, escape routes, dangerous places, leaving the house, protecting oneself during a violent incident, talking to the children about situations in which it might be necessary to leave the home as quickly as possible and agreements with trustworthy neighbours/friends/relatives.

¹⁴ See page 26 for local & national contacts

The following are some steps that might be of help in safety planning¹⁵:

FOR THE SURVIVOR

- If in immediate danger – get out.
- Awareness of perpetrator's aggression triggers.
- If/when physical abuse starts advise survivor to curl up in a ball with hands over their head.
- Scream/Shout loudly whilst being hit.
- Places to avoid when the abuse starts (e.g. the kitchen where there are potential weapons).
- Pack an emergency bag with important documents, important phone numbers and hide it.
- Save money that your partner doesn't know about.
- Put aside money/credit card/mobile phone & charger in same kit.
- Think about escape routes.
- Plan for who to ring/where to go e.g. refuge, secret safe location.
- Access to purse/wallet and keys near exit in case survivor needs to escape an incident.
- How to keep children safe when abuse starts.
- Inform neighbours, if appropriate of situation and ask them to contact authorities if they are concerned re survivor's and children's safety.
- Teach children how to seek help and who to seek help from, if appropriate e.g. How to make an emergency call.
- Identify a code word with the children to alert them to put their safety plan into action.
- Identify safe haven if survivor has to leave, e.g. family, friend, shelter.
- Tell children to retreat to safety, e.g. their room, neighbours / friends house and NOT to intervene during an attack.

FOR THE CHILDREN (IF APPROPRIATE)

- During an argument retreat to safe place and don't intervene.
- Call for help as soon as I hear code word.
- Stay on the line until help arrives.

WORKER SAFETY

- Conduct all interviews in a safe location.
- Be aware of environment, e.g. when doing a home visit park car in the direction you will be leaving.
- Notify co-worker/managers of your whereabouts and planned time of return, plan a course of action if you fail to return, e.g. call mobile, safety code word.
- Ensure access to exits.
- Avoid verbal confrontations with perpetrator.
- Visits to be conducted in pairs if necessary, and/or with Gardai.
- Awareness of Indicators of Dangerousness (see page 16).
- Consider the need to refer to children and families social work service for child safety (see page 16 for indicators for a referral to a children & families social work service for assessment).

¹⁵ See appendix ii for examples of safety plans.

2.10 RECORDING

The HEVI Handbook (Allen & Perttu 2010) states that “recording injuries and disclosures of intimate partner violence is an important task for health and social work personnel for a number reasons:

1. These records may be necessary as evidence in a court case, if a woman seeks a civil protection order or if her partner is charged in the criminal system.
2. They may be necessary if there are legal proceedings regarding custody of and access to children if the couple separate.
3. Having a record within the hospital system ensures that future injuries (or death) are examined with the possibility of intimate partner violence in mind.
4. Keeping a record of attendance at a clinic can provide a red flag regarding escalating risk.

Document the evidence – the nature and location of all injuries, new injuries and old injuries, use Body Maps¹⁶, and use detailed verbal descriptions.”

The Pilot Policy for Cavan/Monaghan Social Work Department on Domestic Violence (HSE 2004) suggests the following with regard to recording information:

- Explain that it is important to document the violence which has occurred for any future legal proceedings that may take place.
- Record details of the current incident and background history
- Record details of whether there have been any witnesses to the incident including children
- Use the precise words of the woman to describe her feelings

WHEN RECORD-KEEPING CONSIDER THE FOLLOWING:

- Keep detailed, accurate records about a woman’s injuries and what she reveals to you.
- Ensure that records are safe from interception/sighting by a third party e.g. in the case where entire families are included in one file.
- Keep a record of content of discussion as statements made may be later admissible as evidence of ‘recent complainant’, i.e. such evidence whilst not corroborative may assist in deciding the weight to be attached to the survivor’s testimony.
- Use client’s own words. Avoid words like alleges and claims, they imply disbelief. For example write “Mary told me that...”
- Even if your suspicions of abuse haven’t led to a disclosure, keep a record of what was discussed.

(Adapted from Responding to Domestic Abuse, DoH 2005)

MENTAL HEALTH

In mental health services it is particularly important to record if intimate partner violence is a contributory factor in a person’s mental health difficulties. Otherwise, the abuser can use the survivor’s mental health record against them, for example as not being a fit parent in a custody and access court case. The HSE Mid West Area Adult Mental Health Services Violence Against Women Policy, Procedures & Best Practice Guidelines (2005) state “Personnel should be mindful that future legal proceedings may rely on information recovered in a client’s file and failure to document the experience of abuse may be used at a later date by the abuser to deny its existence”¹⁷.

16 See Appendix iii for examples of Body Maps

17 See Theme 4 – Mental Health on page 36 for more details on the link between domestic abuse and mental health

2.11 THE LEGAL FRAMEWORK

The main legislation governing the care and protection of children is the Child Care Act 1991. The main legislation relevant to domestic violence is the Domestic Violence Act 1996, and its Amendment (2002).

TYPES OF PROTECTION AVAILABLE UNDER DOMESTIC VIOLENCE LEGISLATION¹⁸:

- **PROTECTION ORDER**

A protection order is a temporary safety order. A court may make this order when a person applies for a safety and/or barring order. A protection order only lasts until the full court hearing of the application for a safety or barring order. Applicant and respondent can live in the same home.

- **SAFETY ORDER**

A safety order simply prohibits a person from using or threatening violence towards the person applying for the order and/or dependent children. If the parties live apart, the order prohibits the violent person from watching or being in the vicinity of the home.

- **INTERIM BARRING ORDER**

An interim barring order is a temporary barring order. A court may make this order when a person applies for a barring order. An interim barring order only lasts until the full court hearing of the application for a barring order and is only made in exceptional circumstances. This has the same powers as the barring order. If you are given an interim barring order, the full barring order hearing will be heard within 8 days

- **BARRING ORDER**

A barring order prohibits a person from using or threatening violence towards the person applying for the order and/or dependant children, and requires a person, against whom the order is made, to leave and stay away from the place of residence of the person applying for the order and/or dependent children.

FREQUENTLY ASKED QUESTIONS:

LENGTH OF ORDERS? The District Court can make a safety order for a five-year period and a barring order for up to three years. These orders may be renewed.

WHO CAN APPLY FOR AN ORDER? Married/co-habiting couples, same-sex couples including those who have not registered a civil partnership, parents of a child over 18 years, and the HSE. The Civil Law (Miscellaneous Provisions) Act 2011 amends the Domestic Violence Act 1996 so that:

- A parent may now apply for a Safety Order against the other parent of their child, even where the parents do not live together and may never have lived together. This ensures that the full protection of the law is available where access to a child is an occasion of intimidation or even violence by the abusive parent towards the adult survivor.
- The protections of the Act are available on the same basis to unmarried opposite-sex couples and same-sex couples who have not registered a civil partnership.
- For Safety Orders, couples are no longer required to have lived together for a minimum period of time before one of them can apply, so co-habiting couples no longer have to be living together for 6 out of the previous 9 months to apply.
- However, for Barring Orders couples who are not married or in a civil partnership must have lived together for 6 out of the previous 9 months and have equal or greater rights to the property in order to apply.

HOW ARE ORDERS SERVED? The conditions of the above orders only take effect when the respondent is notified – told verbally and the order handed to them. Copies of the above orders are sent to the applicant, respondent and Gardaí.

¹⁸ See further info on orders at http://www.legalaidboard.ie/lab/Publishing.nsf/Content/Leaflet_7

WHAT HAPPENS WHEN THERE IS A BREACH OF AN ORDER? Domestic violence has not been defined in legislation but the Garda Domestic Violence Policy states that “the Garda Síochána will take a pro-active approach towards arresting and charging where there are reasonable grounds to believe that a suspect has committed an offence and a power of arrest exists. The injured party’s attitude will not be the determining factor in respect of the exercise of such powers. The survivor should not be asked if the abuser should be arrested. If a breach of an order occurs or an offence has been disclosed by the survivor, the alleged abuser should be arrested”. The respondent is charged with the breach in custody and is brought before the next court sitting. It also states that it is the Gardaí policy NOT to give station bail to the respondent that is charged. The Legal Aid Board leaflet on Domestic Violence (2005) states that “regardless of whether or not court orders are made under the domestic violence legislation, physical and/or sexual violence is a crime”. The Gardaí have the power to arrest and charge a person who is violent e.g. under the Non-Fatal Offences Against the Person Act, 1997 if the Gardaí witness the assault or if there is a witness.

CHILDREN

The Children First Child Protection and Welfare Practice Handbook (HSE 2011, p144-151) summarises key legislation in relation to children, their welfare and protection, for example, the Child Care Act 1991.

SECTION 3 – REFER (REVIEW)

REFER: The approach when a disclosure is made should be to empower the survivor to undertake action that they deem appropriate at a time that they deem appropriate. The term 'refer' in this context is given to mean the intervention whereby a professional provides a survivor with support and information about the resources available to them, listens to them and encourages them to contact those specialist support or state agencies which are in a position to help them. Referral to another agency should have the approval or expressed consent of the client, as direct 'referral' of a survivor without their direct involvement is rarely helpful and potentially harmful (from Kenny & ni Riain 2008). Get to know where your local DV services are and what they provide (See page 16 for criteria for making a child protection referral).

There are over 40 HSE funded domestic violence services in Ireland. Half provide 24 hour emergency accommodation. All services are free and confidential. Services offer a range of emotional, practical, safety and child related supports to survivors and their children including:

- Safe, emergency, 24 hour accommodation (Refuge)
- Outreach
- Information and Advocacy
- Court accompaniment
- Accompaniment to other state agencies such as community welfare, housing officers etc.
- Helplines
- Childcare
- A range of supports for children
- Supported transitional housing
- Support groups

See overleaf for listings of local and national domestic, sexual and gender based violence support services funded by the HSE. Also see Cosc website www.cosc.ie for full details and information on services for domestic, sexual and gender based violence in Ireland.

REVIEW: It is important to 'keep the door open' for a survivor of domestic abuse. Let them know that they are welcome to make contact with you again. It is also important to follow up any referral you make on behalf of a survivor to try to ensure that they receive all necessary support.

3.1 LOCAL & NATIONAL CONTACTS FOR HSE FUNDED DOMESTIC VIOLENCE SERVICES

REFUGES & SUPPORT SERVICES FOR WOMEN SURVIVORS

All services are listed by their county location

National Freephone Helpline	10am-10pm (Women's Aid)	1800 341 900
Carlow	Carlow Women's Aid	1800 444 944
Clare	Clare Haven Services, Ennis (includes 24 hour refuge)	065 6822435
Cork	Cuanlee Refuge, Cork City (includes 24 hour refuge)	021 4277698
Cork	Mna Feasa,, Women's Domestic Violence Project, Knocknaheeny, Cork City	021 4211757
Cork	One Stop Shop, Cork City	1800 497 497
Cork	West Cork Against Violence Against Women, Bantry	1800 203 136
Cork	Yana, North Cork Domestic Violence Project, Mallow	022 53915
Cork	HSE Domestic Violence Social Work Service, Liberty Street House, Liberty St, Cork	021 4921728
Donegal	Donegal Women's Domestic Violence Service (includes 24 hour refuge)	1800 262 677
Donegal	Inishowen Women's Outreach	074 9373232
Donegal	Letterkenny Women's Centre (Counselling Service Only)	074 9124985
Dublin	Aoibhneas Women's Refuge, Dublin 5 (includes 24 hour refuge)	01 8670701
Dublin	Viva House, Blanchardstown Women's Refuge	01 8662015
Dublin	Dublin 12 Domestic Violence Service	01 4002085
Dublin	Inchicore Outreach Violence Against Women Centre	01 4545239
Dublin	Rathmines Women's Refuge (includes 24 hour refuge)	01 4961002
Dublin	Saoirse Womens Refuge, Tallaght (includes 24 hour refuge)	01 4630000
Dublin	Sonas Housing Association (Transitional supported housing only)	01 8309088
Dublin	Women's Aid, Dublin (including National Freephone Helpline 10am-10pm)	1800 341 900
Galway	Cope Waterside House Women's Refuge, Galway (includes 24 hour refuge)	091 565985
Galway	Domestic Violence Response, Oughterard, Co Galway	091 866740
Kerry	Adapt Kerry Women's Refuge & Support Service, Tralee (incl 24 hr refuge)	066 7129100
Kildare	Teach Tearmainn, Newbridge	045 438461
Kilkenny	Amber Women's Refuge, Kilkenny (includes 24 hour refuge)	056 7771404
Laois	Laois Domestic Abuse Service	057 86 71100
Limerick	ADAPT Services (includes 24 hour refuge)	1800 200 504
Limerick	Southill Domestic Abuse Project	061 313025
Longford	Longford Women's Link	043 3341511
Louth	Drogheda Women and Childrens Refuge (includes 24 hour refuge)	041 9844550
Louth	Women's Aid, Dundalk (includes 24 hour refuge)	042 9333244
Mayo	Mayo Women's Support Services (includes refuge)	094 9025409
Meath	Meath Women's Refuge & Support Service (includes 24 hour refuge)	046 9022393
Monaghan/Cavan	Tearmann Domestic Violence Services (Monaghan & Cavan)	047 72311
Offaly	Offaly Domestic Violence Support Service, Tullamore	057 9351886
Roscommon	Roscommon Safe Link	071 9664200
Sligo/Leitrim/West Cavan	Domestic Violence Advocacy Service, Sligo, Leitrim & West Cavan	071 9141515
Tipperary	Ascend Women's Support Services, Roscrea	0505 23999
Tipperary	Cuan Saor Refuge & Support Service, Clonmel (includes 24 hour refuge)	1800 576 757
Waterford	Oasis House, Waterford City (includes 24 hour refuge)	1890 264 364
Westmeath	Esker House, Athlone (includes 24 hour refuge)	090 6474122
Westmeath	Mullingar Women in Crisis	044-33868/1850 214814
Wexford	Wexford Women's Refuge, Wexford Town (includes 24 hour refuge)	053 9121876
Wicklow	Bray Women's Refuge (includes 24 hour refuge)	01 2866163

National Representative Body for Refuges/Support Services: **Safe Ireland, 27 Church Street, Athlone, Co Westmeath**
Tel 0906-479078 Email info@safeireland.ie

SUPPORT SERVICES FOR MALE SURVIVORS

Amen Support Services (National) - St Anne's Resource Centre, Navan, Co. Meath	046 9023718
Cork One Stop Shop, Cork City	1800 497 497

RAPE CRISIS CENTRES (provide services to women and men)

National Rape Crisis 24 hour Helpline (operated by Dublin Rape Crisis Centre)	1800 77 88 88
Athlone Athlone Midlands Rape Crisis Centre, 5/6 Town House Centre, Saint Mary's Square, Athlone	090 6473815
Carlow Carlow and South Leinster Rape Crisis Centre 72 Tullow Street Carlow	059 9133344
Cork Sexual Violence Centre, 5 Camden Place, Cork	021 4505577
Donegal Donegal Sexual Abuse & Rape Crisis Centre, 2a Grand Centre, Canal Rd, Letterkenny	074 9128211
Dublin Dublin Rape Crisis Centre, 70 Lower Leeson Street, Dublin 2	01 6614911
Galway Galway Rape Crisis Centre, 7 Claddagh Quay, Galway	091 583149
Kerry Kerry Rape & Sexual Abuse Centre Ltd, 5 Green View Terrace, Princes Quay, Tralee	066 7123122
Kilkenny Kilkenny Rape Crisis & Sexual Abuse Counselling Centre, 1 Golf View, Off Granger Rd Kilkenny	056 7751555
Limerick Rape Crisis Midwest, Phoenix House, Punch's Close, Rosbrien Road, Limerick	061 311511
Louth Rape Crisis North East, 59A Anne Street, Dundalk, Co Louth	042 9339491
Mayo Mayo Rape Crisis Centre, Newtown, Castlebar Co Mayo	094 9025657
Offaly Regional Sexual Abuse & Rape Crisis Centre Tullamore, 4 Harbour View, Store St, Tullamore	057 9322500/1
Sligo, Leitrim and West Cavan , Rape Crisis & Sexual Abuse Counselling Centre, 42 Castle St, Sligo	071 9171188
Tipperary Tipperary Rape Crisis and Counselling Centre, 20 Mary Street, Clonmel, Co Tipperary	052 6127676
Waterford Waterford Rape and Sexual Abuse Centre, 2A Waterside, Waterford	051 873362
Wexford Wexford Rape and Sexual Abuse Centre, Clifford Street Wexford	053 9122722

National Representative Body for Rape Crisis Centres: Rape Crisis Network Ireland, The Halls, Quay Street, Galway
091 563676

SEXUAL ASSAULT TREATMENTS UNITS – SATU's (provide services to women and men)

Cork	South Infirmary – Victoria University Hospital, Old Blackrock Rd, Cork	021 4926100
Donegal	Letterkenny General Hospital, Co Donegal	074 9104436
Dublin	Rotunda Hospital, Parnell Square, Dublin 1	9.00am - 4.30pm, Monday – Friday: 01 8171736 (Outside of the above hours: 01 8171700)
Galway	Hazelwood House, Parkmore Road, Galway	091 765751
Waterford	Waterford Regional Hospital, Dunmore Rd, Waterford	051 842157
Westmeath	Midlands Regional Hospital, Mullingar	044 9394239

SECTION 4 – THEMES

4.1 – CHILDREN & TEENAGERS

Domestic violence and child abuse frequently co-exist. (UNICEF 2005)

A landmark study in Ireland in 1995 showed that 64% of women who experienced violence reported that their children had witnessed the violence. (Kelleher Associates & O'Connor 1995). Children who have been exposed to domestic abuse may have long-term physical, psychological and emotional effects. The longer domestic abuse is experienced, the more harmful it is. Children may blame themselves for the violence or for being unable to prevent it, they may try to intervene and be injured themselves, and they may become confused by torn loyalties. Mertin and Mohr (2002) found that witnessing abuse or experiencing the abuse has similar effects on children.

International research has indicated a strong correlation between instances of intimate partner violence and child abuse. One research piece indicated that child abuse and intimate partner violence cases overlap in 40% to 60% of cases (Garcia-Moreno 2002, cited in The Women's Health Council 2007).

Policy and legislative developments have increased the level of accountability of those responsible for the welfare of children.

- The "Keeping Children Safe" report (Ferguson and O'Reilly 2001) provided evidence of the prevalence of intimate partner violence in child protection work. In 7% of 286 cases referred to social work teams, intimate partner violence was the main reason for the referral. In a further 19% of cases, intimate partner violence was cited as a child protection concern. This increased to 32% upon investigation.
- This report also highlights the fact that cases drawn into the child protection net receive the bulk of services, while children in need and suffering a range of adversities impacting on their welfare including domestic abuse receive little or no service.
- In 2004 the Department of Health & Children (in Rivett & Kelly 2006) found that there has been considerable expansion of the range and quality of child and family services in Ireland. However, domestic violence services for children are linked to services for their mothers, with children interfacing with a range of services responding to violence against women.
- One Irish study (Holt 2008) looked at the impact of exposure to intimate partner violence on children and adolescents and found they "are at increased risk of experiencing emotional, physical and sexual abuse, of developing emotional and behavioural problems." It also highlights a range of protective factors that can mitigate against this impact, in particular a strong relationship with and attachment to a caring adult, usually the mother.
- 'Listen to Me!' (Buckley 2006), an Irish study of children's experience of domestic abuse, found that "children are significantly affected by living in situations where violence is present".
- A Northern Ireland study (Devaney 2008) expresses concern that "children are conceived of as innocent bystanders caught up in the crossfire rather than as victims in their own right" and finds that there was a clear association between child protection registration for physical abuse and physical abuse between adult household members with 72% cross over.
- Serious Case Reviews in the UK have found clear evidence that intimate partner violence in combination with addiction and mental health has been a significant factor in cases of child deaths and serious injuries to children (UK DSCF 2009). The National Review Panel 2010 (Buckley 2011) gives some detail on the Irish context.
- "Domestic violence appears to be equally likely to be witnessed/experienced by boys and girls. However it is important to note that although the prevalence between genders is very similar, the impact on the different genders could be distinctly different depending on a number of factors such as context, society and the individuals themselves." Children in Northern Ireland Domestic Violence and Professional Awareness <http://www.ofmdfmi.gov.uk/domesticviolence.pdf>

CHILDREN’S & TEEN’S EXPOSURE TO INTIMATE PARTNER VIOLENCE

Children who live in homes where a parent or caretaker is experiencing abuse have been called “child witnesses”. Although parents frequently believe they are protecting their children from witnessing their abuse, children living in these homes report differently. U.S. research (Bragg 2003) found that 80% to 90% of children in homes where intimate partner violence occurs can provide detailed accounts of the violence in their homes. 32% to 53% of all families where women are being physically beaten by their partner, the children were directly subjected to violence and abuse by the abuser.

U.K. research (National Children’s Resource Centre 2003) reveals that in 90% of intimate partner violence incidents, children were either present when the assault was occurring or in the next room and able to overhear the conflict.

Children’s exposure to intimate partner violence typically falls into three primary categories:

- Hearing a violent event.
- Being directly involved as an eye witness, intervening, or being used as a part of a violent event (e.g. being used as a shield against abusive actions or having to protect a parent).
- Experiencing the aftermath of a violent event.

Other categories include:

- Physical injuries
- Being used as a spy by violent parent against other parent
- Being forced to watch or participate in the abuse of the survivor
- Being physically, emotionally or sexually abused by perpetrator in an effort to intimidate and control partner
- Being used as a pawn by the abuser to coerce the survivor to return to the violent relationship
- Being made to “keep the secret” putting huge strain and stress on the child.

A UK study (Abrahams 1994) highlighted a number of factors, which affect the impact on children and their responses to the violence they witness:

- The frequency and severity of violence children have witnessed being inflicted on their parent, either through overhearing or through observation.
- The length of time child has been exposed to such violence.
- Issues relating to race, culture, age, gender, disability, sexual orientation and socio-economic factors.
- Whether the child has any outside support from extended family, friends or community.
- The nature of external interventions from agencies or community, e.g. a sympathetic teacher, while not able to prevent domestic violence, can do much to boost a child’s self esteem.
- Whether children blame anyone, including themselves for the violence.
- Whether children perceive violence as a way of getting their needs met.
- Whether there is inconsistent punishment from the mother or father.
- Whether the abusive parent manipulates family relationships.
- The quality of the mother’s relationship with the child.

It is recognised that the formation of healthy attachments and the promotion of resilience in children are fundamental to their psychological and emotional development. Helping children and young people overcome emotional problems and resulting behaviour in the wake of domestic abuse is one of the most important challenges for families and workers alike.

Children exposed to violence need to be able to speak openly with a sympathetic adult about their fears and concerns and also, ideally, have someone intervene to improve the situation. Workers involved in intimate partner violence cases must familiarise themselves with the areas of impact on children and aim to provide support services for children. There appears to be a distinct lack of Irish services expressly focused on this work. Workers should also be aware that abusive parents may prevent children from using support services or won’t consent to them attending.

IMPACT OF INTIMATE PARTNER VIOLENCE ON CHILDREN

IMPACT ON CHILDREN'S DEVELOPMENT

The impact of witnessing and/or experiencing intimate partner violence on a child's development is far reaching. There is a strong relationship between domestic abuse and child development outcomes; development may be delayed or arrested at all stages as a result of exposure to traumatic and violent incidents. There is a need to consider a child's/teenager's developmental stage when looking at the impact of domestic abuse as children are unique individuals with unique responses.

INFANTS

A study conducted in the Rotunda Maternity Hospital (O'Donnell 2000) found that in a sample of 400 pregnant women, 12.5% had experienced abuse while they were pregnant. These experiences of violence will have physiological impact on the mother and in turn the baby, so it may be suggested that some children are impacted even prior to their birth. Miscarriage resulting from abuse has also been widely reported.

Infants exposed to violence may have difficulty developing attachments with their caregivers and in extreme cases suffer from "failure to thrive". A parent experiencing intimate partner violence may be unable to provide the structure for a baby to learn to self-regulate their emotions and behaviours. This may lead to problems with excessive irritability, sleep disturbance, emotional distress and fear of being alone.

Infants are highly likely to develop disorganised attachments to their mothers in domestic abuse situations. If unabated such attachments result in the infant being chronologically overwhelmed and if uninterrupted, this pattern has devastating developmental consequences for the child. They may have difficulty developing a logical approach for getting comfort when they need it, resulting in a constant state of anxiety and fear, both in the presence of their mother as well as in the presence of the perpetrator of the violence.

TODDLERS AND PRE-SCHOOLERS

Evidence has shown that pre-schoolers who witness violence have more behavioural problems (aggressive and possessive behaviour), social problems (poor social skills), post-traumatic stress symptoms (which may explain the frequency of illness in these young children), greater difficulty in developing empathy, and poorer self-esteem than children who have not had these experiences.

SCHOOL-AGED CHILDREN

The crucial development of a more sophisticated emotional awareness of themselves and others will be impacted by witnessing intimate partner violence. At this stage, children will have an ability to think in more complex ways about the reasons for the violence and they may try to predict and prevent the abuse on this reasoning.

TEENAGERS

Teenagers who live in a domestic abuse environment are exposed to age inappropriate experiences and their global development will be different to a peer who has not had similar experiences. Adolescence is already a difficult stage for teens and parents alike. The impact of intimate partner violence often extends beyond the boundary of the family. Adolescents may have difficulty forming healthy intimate relationships with peers due to the models they experienced in their family.

IMPACT ON CHILDREN'S BEHAVIOUR

Most children rely on one or both parents to provide nurturing support in the face of crises and emotionally challenging situations, but ongoing exposure to violence may hamper the parent's abilities to meet these needs. Of course, the child's relationship with both parents will be changed by domestic abuse. Trust may be impacted; the ability to form relationships outside of home may be impaired.

Non-abusing parents living with chronic violence may feel emotionally numb, depressed, irritable, or uncommunicative, and thus may be less emotionally available to their children. This in turn removes an important source of role-modelling for the child and reduces the child's network of emotional support. The child may suffer from guilt if they cannot protect their abused parent or prevent assaults.

Witnessing physical violence or emotional abuse towards a parent has many of the same effects as being a direct target of the abuse. Some children will exhibit through their behaviour their level of stress, often resulting in behavioural problems and relationship difficulties between parent and child, some children will internalise their feelings, in both cases the negative impact of intimate partner violence on the child is reinforced.

IMPACT ON TEENAGERS' BEHAVIOUR

One report found that 40% of violent juvenile offenders come from homes where there is intimate partner violence and 50% of children who come before children's juvenile court have been exposed to violence in the home (The Saartjie Baartman Centre for Women and Children). Adolescents who have grown up in violent homes are at risk of recreating the abusive relationships they have observed. Witnessing or experiencing intimate partner violence has been found to be the best predictor of adolescent male abusive behaviour in a close relationship with a girl and a significant predictor of male and female experiences of victimisation in a close relationship with a member of the opposite sex (Wekerle & Wolfe 1998).

INDICATORS THAT CHILDREN MAY BE EXPERIENCING VIOLENCE (AS WITNESS OR VICTIM) INCLUDE:

- Aggressive behaviour and language, precocious language – often the only indicator of violence in the home
- Anxiety, appearing nervous or withdrawn
- Difficulty adjusting to change
- Psychosomatic illness
- Restlessness
- Bedwetting and sleeping disorders
- 'Acting out', e.g. cruelty to animals
- Excessively 'good' behaviour

(Adapted from Royal Australian College of General Practitioners, 1998)

CHILDREN & ADOLESCENTS MAY RESPOND WITH FEELINGS OF:

<ul style="list-style-type: none"> • Intense fear • Horror • Confusion • Children can become withdrawn from their non-abusing parent, usually their mother • They may suffer from post-traumatic stress disorder • Depression • Substance abuse • Temper tantrums • Severe anxiety • Low self-esteem • Blame themselves for the situation • Some of the children will have difficulties with sleeping or have nightmares • Regression to earlier developmental stage • Over achieving • Girls may marry men who are similar to their abusive fathers • Stealing or other juvenile crimes • Denial of any problem • Anger 	<ul style="list-style-type: none"> • Distress • Helplessness • Physically attack their non-abusing parent, usually their mother • Medical problems e.g. asthma, arthritis, ulcers, headaches, stomach aches • Bullying (bullying others or being bullied) • Eating disorders • Inability to concentrate • Suicidal thoughts/attempts • Children may feel ashamed • Isolation from friends • They may lose interest in school or have poor school attendance/performance • Experience multiple school problems • Side with perpetrator • Boys as adults may see it as normal behaviour to abuse their girlfriend or wives • Eating disorders • Girls at risk of early pregnancy as a possible escape from home situation
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POSITIVE OUTCOMES

While many studies suggest a connection between violent experiences as a child and subsequent violent adult behaviour, not all children will replicate the cycle of violence as adults. “Children may learn to accept, admire, emulate or expect such behaviour, but they may also be repulsed by it and reject it’s use.” (Dobash & Dobash 1979).

One of the most difficult issues for a child who has experienced domestic abuse is the “inevitability” of a violent future. More research is required focusing on the factors which enable people to overcome an unpromising start to life. Support received, how the events were handled by parents and family, resilience, coping strategies and levels of self-esteem are among the factors which will reinforce or reduce the effects of an abusive childhood.

Rutter and Madge (1976) emphasise children raised in the most deplorable circumstances develop into what they describe as normal children. Their key point is that we need to examine the factors which mediate the bad experiences of childhood and facilitate a break with the “cycles of disadvantage”.

An Irish study found that “in terms of investing in early interventions, violence prevention programmes targeted at children or those who influence them during early development show greater promise than those that target adults. Such early interventions have the potential to shape the attitudes, knowledge and behaviour of children while they are more open to positive influences, and to affect their lifelong behaviours. (Kearns 2008)

Research has found that children and young people want opportunities to talk about domestic abuse and wanted their accounts to be taken seriously (McGee 2000 and Mullender et al 2002).

PRACTICE RECOMMENDED FOR INTERVIEWING CHILDREN/TEENAGERS

- Interview child on their own without perpetrator parent or survivor parent present.
- Provide an atmosphere that supports children’s comfort in discussing sensitive issues.
- Validate the children’s feelings during the assessment interview.
- Provide safe and healthy coping skills and responses to domestic abuse.
- Begin direct inquiry regarding domestic abuse with a general statement.

OPEN-ENDED AND INVITATIONAL QUESTIONS THAT CAN BE USED TO EXPLORE THE IMPACT OF DOMESTIC ABUSE WITH CHILDREN:

- How do you sleep?
- Do you ever have nightmares?
- Tell me about your nightmares.
- What is the scariest thing that has ever happened to you?
- Do you ever get so angry that you want to hurt someone?
- Tell me about what you do.

(Faller 2003)

4.2 SEXUAL VIOLENCE IN INTIMATE RELATIONSHIPS

SEXUAL VIOLENCE DEFINITION & PREVALENCE

The World Health Organisation (WHO 2003) reports that the vast majority of victims of sexual violence are female, most perpetrators are male, and that most victims know their attacker. They add that this does not negate the fact that sexual violence against men and boys is also widespread. It is not always possible to distinguish data in relation to sexual abuse in general and in intimate adult relationships. The SAVI Report (McGee 2002) highlighted that in Ireland, 24% of women and 1% of men reported sexual abuse by their partner or ex-partner. The Rape Crisis Network Ireland reports that 4 out of 10 female survivors were subjected to sexual violence as adults and 6 out of 10 as children; and 1 out of 10 male survivors were subjected to sexual violence as adults and 9 out of 10 as children. These figures support the SAVI findings that male vulnerability to sexual violence decreases as males' age, while female vulnerability does not decrease with age to the same extent. Some other pertinent RCNI statistics are: 90% of perpetrators were known to the survivors; 3% of children were subjected to violence by strangers; 20% of survivors of child sexual abuse said that the perpetrators were under 18; 30% of survivors reported the sexual violence to the police; 15% of males were subjected to the sexual abuse in a school setting; and 10% of female survivors who were raped became pregnant as a result (RCNI 2011). 56% of women trafficked into Ireland were raped in transit or once they had reached this country (Pilinger & O'Connor 2009).

40% to 45% of women who experience intimate partner violence are forced into sex by their partners (Campbell 1998).

MYTHS AND FACTS ABOUT RAPE

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.

(WHO 2003)

RAPE CRISIS CENTRES

Rape Crisis Centres (RCC) offer survivors of sexual violence the care, support and information they may need to help them respond to what has happened to them. They offer counselling; accompaniment for a survivor to the police, the court, the doctor or a sexual assault treatment unit; advocacy; face-to-face support; and health and legal information. Rape Crisis Centres see male and female survivors, teenagers and adults, and survivors of recent and historical sexual violence. Rape Crisis Centres also provide support to those who are supporting victims of sexual violence e.g. family and loved ones. Counselling and support: a counsellor helps survivors to explore how they are affected and how to learn to be free of the impacts of an experience of sexual violence. A counsellor also provides a safe place for survivors to explore their choices and to be supported in those decisions.

RCC's role and services are explained on their app for Smartphones. These descriptions might be useful to staff for their own information and to pass onto service users. Staff might find it useful to have service contact details on their phone to hand out to service users. There is also a useful guide on the app on how to respond to a disclosure and other issues that might arise. www.rcni.ie/apps (See page 27 for local and national contact details).

SEXUAL ASSAULT TREATMENT UNITS (SATU's)

Sexual Assault Treatment Units (SATU's) offer services for men and women over the age of 14 years. Children aged less than 14 years are generally seen in the Emergency Departments of children's hospitals. SATU's aim to provide an easily accessible, holistic service for survivors of sexual crime by addressing medical, psychological and emotional needs while being cognisant of the place of forensic examination to aid the legal process and to provide all treatment in a non-judgemental manner, conveying that no one deserves to be raped and that the patient is not responsible for the alleged assault. SATU's have separate areas for interviewing the patient, for physical and forensic examination as well as bathroom and shower facilities. (See page 27 for local and national contact details).

CHILDREN

The correlation between violence in the home and sexual abuse of children is significant, with one study finding that in 69% of cases of sexual abuse of children by fathers or father figures, the same perpetrators engaged in intimate partner violence (Hester and Pearson 1998, cited in Buckley et al 2006). Other international research indicates that four-fifths of children and adolescents, who disclose sexual abuse, are also living with domestic abuse (Kellog and Menard 2003). Some high profile child abuse cases in Ireland have also borne this out, including the McColgan case, the Kilkenny incest case and the Roscommon case.

Some studies found that violence to mothers can serve to distance them as a source of support for their children, so that the male perpetrator can more easily continue their sexual abuse of the children. Hooper (1992), for instance, found that the violence to mothers often preceded the sexual abuse of the children and usually continued alongside it.

As mentioned previously, there is substantial evidence that intimate partner violence continues beyond separation and may be exacerbated by it. Richards (2004) reviewed 241 cases of domestic sexual assault reported to the police in London and discovered that half the couples in her sample were in the process of separating or had separated. Her study also highlighted that in ten per cent of cases children were reported as witnessing the sexual assault. A US study of 37 children with sexual behaviour problems (Silovsky and Niec 2002) found that while most did not have substantiated histories of sexual abuse, over two-thirds had been exposed to domestic abuse or domestic abuse and physical abuse.

Young women living in the care system participating in one study (Wood et al 2011) were especially vulnerable to sexual violence, often from older men. Many of them had been exposed to domestic abuse in their parents' relationships.

4.3 ADDICTION

INFORMATION ABOUT INTIMATE PARTNER VIOLENCE AND ADDICTION

- Alcohol is not a cause of intimate partner violence, (Lehman and Krupp 1984) but it is frequently used as an excuse. “Dis-inhibition theory” suggests the physiological effects of alcohol, including a state of lowered inhibitions, means an individual can no longer control their behaviour and is therefore less accountable for their behaviour when they are under the influence of alcohol. The alcohol provides a ready and socially acceptable excuse for their behaviour.
- Abused women report even if partners appear “uncontrollably drunk” during a physical assault, they routinely exhibit the ability to “sober up” quickly with outside interruption e.g. police.
- Many people who misuse alcohol do not abuse their partners.
- 76% of physically abusive incidents occur in the absence of alcohol use.
- However, it must be noted that “domestic violence and addiction can be a lethal mix. The loss of control and effects of alcohol and drug abuse contribute significantly to the severity of beatings in abusive relationships” (Mackey 1996).
- Evolving from the belief that alcohol causes intimate partner violence is the belief that treatment for alcohol will stop intimate partner violence. However, abused women report that during recovery the abuse not only continues but often escalates, creating greater levels of danger. And, in cases where women report less physical violence, they report increase in coercive control and abuse – threats, manipulation and isolation intensify.
- Perpetrators who are also alcohol or drug dependent need to address both problems concurrently – this maximises the survivor’s safety and prevents domestic abuse from precipitating relapse or otherwise interfering with the recovery process.
- There is a myth that abused women are “co-dependent” and thus contribute to the continuation of abuse.
- There is a myth that drunk or stoned women ask/deserve to be attacked/abused.
- 45% of female alcoholics start out as abused women. One hospital study found that women who experienced intimate partner violence were 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs, and rates of abuse rose after the first episode of violence. (Stark and Flitcraft 1996).
- Substance misuse is frequently observed as self-medication to cope with the traumatic response to intimate partner violence.
- In cases of parental substance misuse, children and parents report sometimes being physically or emotionally unavailable to children.
- The sadness and isolation that many survivors experience can be perpetuated by the stigma and secrecy that surrounds intimate partner violence and substance misuse.
- 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 e.g. what they are going to do.

(National Children’s Bureau May 2004)

The Stella Project, part of Against Violence and Abuse in London, focuses on the “development of inclusive and responsive services for people affected by drugs, alcohol and domestic violence”. The project provides a toolkit for workers with sample documents including a domestic abuse risk indicator checklist and a drug and alcohol risk assessment form. Details are available on their website: www.avaproject.org.uk

4.4 MENTAL HEALTH

Workers should consider that a client's mental health difficulty may be the result of intimate partner violence; be aware of symptoms masquerading as the problem.

People who experience intimate partner violence are at an increased risk for the development of physical, medical, psychological and/or mental health difficulties (Williamson 2000). The destructive influence of domination on a person's wellbeing 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.

Women who experience intimate partner violence have higher rates of mental illness - 18% will attempt/commit suicide, 64% experience Post Traumatic Stress, and 48% depression (www.womensaid.org.uk). 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 & 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 partner; 40% 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 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.

Individuals with a pre-existing mental health condition who are now in an abusive relationship may experience their 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 their partner, thus beginning a vicious cycle. Applying a diagnosis of mental illness for a patient without acknowledging intimate partner violence in the formulation, may have far-reaching consequences for the survivor as it plays into the hands of the perpetrator by giving them another 'stick with which to beat their partner'. The perpetrator can now officially criticise their 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 they experience further abuse by the very service they sought help from.

Adult mental health service professionals in particular would therefore 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 the possible devastating consequences for their patients who experience intimate partner violence, on their psychological, spiritual and physical wellbeing. Not to do so, and address only the signs and symptoms that were screened and observed, may inadvertently contribute to furthering the abuse for these service users.

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 i.e. diabetes, seizure control
- Psychosomatic disorders
- Autoimmune disorders
- Rape, miscarriage/premature delivery
- Sexual dysfunction
- Traumatic brain injury
- Death by homicide

PSYCHOLOGICAL/MENTAL HEALTH SIGNS AND SYMPTOMS:

- Helplessness, hopelessness, frozen or 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

THESE SYMPTOMS MAY CONTRIBUTE TO THE DEVELOPMENT OF A:

- Mood disorder
- Panic disorder
- Sleep disorder
- Paranoid disorder
- Psychotic disorder
- Suicidal thoughts
- Acts of deliberate self harm
- Post-traumatic stress disorder
- Complex post-traumatic disorder
- 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 Mental Health Training Module 2: Domestic Violence and Mental Health 2007).

4.5 DISABILITY

An Irish study (Watson and Parsons 2005) found that “health problems and disability are associated with severe abuse but not with minor incidents”. Compared to people in good health, those who rate their health poor have a 76% increased risk of abuse. “Increased risk is also associated with having an ongoing condition or disability and the risk increases with the level of limitation associated with the condition. Those with a condition that does not severely limit their daily activity face a 58% greater odds of severe abuse, while for those who are severely limited the odds of severe abuse are 186% greater”. The study also reports that people with health problems or disabilities are likely to face greater difficulties in leaving an abusive relationship. The equivalent British Crime Study (Povey et al 2009) reached similar conclusions. It found that disabled women are twice as likely to experience intimate partner violence than non-disabled women. They are also likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence.

The Survivor’s Handbook (Women’s Aid UK) advises that “if you are disabled, your abuser may also be your carer, or your personal assistant and you may be reliant on him/her for personal care or mobility. You can be subject to physical, psychological, sexual or financial violence in any or all of the ways that non-disabled women are abused, but in addition you may experience the following forms of abusive behaviour:

- Your abuser may withhold care from you or undertake it neglectfully or abusively.
- Your abuser may remove mobility or sensory devices that you need for independence.
- Your abuser may be claiming state benefits in order to care for you - enabling him to control your finances more effectively.
- Your abuser may use your disability to taunt or degrade you.
- If you are experiencing domestic violence and you are disabled, you may find it harder to protect yourself or to access sources of help.
- You may be more physically vulnerable than a non-disabled woman.
- You may be less able to remove yourself from an abusive situation.
- You may be socially isolated both because of your disability and as a result of your abuser's control of your social relationships.
- You may find it harder to disclose abuse because you have no opportunity to see health or social care professionals without your abuser being present.

If you are disabled, you may have particular concerns about moving out of your home: it may have been specially adapted for you, or perhaps a care package has been organised and you are worried that you will lose your current level of independence if you are forced to move elsewhere. You may be reluctant to report domestic violence from a partner whose care you depend on, and which you believe enables you to stay out of institutional care”.

Nicky Stanley reports that a survey of intimate partner violence and disability agencies in North-East England (Radford et al 2006) “found both types of organisation reported limited contact with disabled women experiencing domestic violence. Disability agencies tended to describe emotional abuse and controlling care as neglect rather than as domestic violence or abuse, while domestic violence services, which were frequently housed in old buildings, acknowledged that their services were often inaccessible for women with disabilities. The needs of children arising from exposure to domestic violence in these families may therefore go unrecognised”.

Parental learning difficulties

Stanley also reports that “while there is limited evidence concerning the actual prevalence of domestic violence among people with learning difficulties, it is known that women with learning difficulties experience high levels of violence and sexual assault generally and rates of domestic violence are likely to be high in this group of families” (Sobsey 2000).

4.6 CULTURAL ISSUES¹⁹

VIOLENCE AGAINST WOMEN IN MINORITY ETHNIC GROUPS INCLUDING TRAVELLERS

The situation for Traveller women and migrant women can be quite different due to language and residency status but some issues are common for minority ethnic women.

- Violence is not inherent in minority ethnic cultures
- For many minority ethnic groups, be it Travellers or migrant communities, their relationship with police and statutory services can be based on fear and mistrust. This puts minority women under pressure when trying to find support.
- Limited knowledge of (and hence access to) the legal system creates added barriers for women.
- Inaccurate information about rights and entitlements is of advantage to perpetrators and might cause obstacles in the process of finding help.
- Language can be a significant barrier to seeking support and access to culturally appropriate and multilingual information is vital. If a language interpreter is required, employ a professional one – NOT a friend or member of the family. If only a male interpreter is available, check with the woman if this is acceptable²⁰.
- Women from minority ethnic groups often rely on their own communities (possibly including their abuser) for support. They may also seek advice and support from their pastor, priest or religious leader and value their opinion highly in relation to family matters, including domestic violence.
- Support services need to work in solidarity and partnership with minority ethnic groups to remove barriers and improve services.
- Acknowledge these women as experts on the issues of violence against women as it affects their lives.
- Develop specialist expertise towards minority ethnic groups and recognise and plan for diverse needs.
- It is important to find balance between recognising a woman's right to live a life free of violence and affirming ethnic identity and different needs.

(Based on Pavee Point)

RESIDENCY/LEGAL STATUS

- Women may fear jeopardising their residency status, work permit or their asylum claim if they report intimate partner violence. This fear may be particularly acute if the woman is living in Ireland on the basis of a spouse dependant visa. They also may not want to endanger their partner's residency status by reporting him to the authorities.
- Women may fear deportation from Ireland as a result of reporting intimate partner violence or engaging with support services. They may also fear the deportation of their children and partner to potentially dangerous situations in their country of origin.
- A lack of extended family and supports may mean that migrant women are isolated, lonely and more vulnerable to violence in Ireland.
- Migrant women may feel intense pressure from family and extended family in their country of origin to remain with their abuser. They may fear alienation, shame and estrangement from family in their home country if they leave their partner due to violence.
- It is imperative that service providers are aware of information and support services available for migrant women regarding issues such as; residency status, asylum, visas, etc. in order to be in a position to refer clients to the appropriate and relevant agencies and NGOs.

(AkiDwA 2009)

¹⁹ For more detail see Women's Health Council Report: *Translating Pain into Action - A Study of Gender-based Violence and Minority Ethnic Women in Ireland*, 2009.

²⁰ Women's Aid has an interpretation service for women experiencing intimate partner violence via its National Freephone Helpline 1800-341-900. The service gives helpline workers the ability to connect women, with limited or no English, to an accredited professional interpreter who can facilitate translation between the woman and the helpline worker, so that the woman can access support and information appropriate to her needs.

NEEDS, GAPS AND DEFICITS

Traveller and migrant women have a number of issues that need attention within the Irish system.

1. Literacy (for Traveller women) and language difficulties (for migrant women) present serious challenges for them in accessing Court Orders.
2. Discriminatory views by settled service providers also proved to be a challenge for Traveller and migrant women. This needs to be addressed with training and cultural awareness.
3. The cultural norms in Traveller and migrant communities leave women vulnerable to abuse and control. Patriarchal views of women's roles, and the view that marriage is indissoluble creates major barriers for women from these communities.
4. Greater involvement by members of their own communities in service provision would help overcome some of the issues allied to both discrimination and cultural barriers.
5. Specific housing for Traveller women, as they themselves suggest, would help reduce their fear of leaving their marriages, and allow them to live in a manner which would not stigmatise them in the eyes of their own community.
6. The reform of the asylum system, in which migrant women have to live with their partner in hostel style accommodation, while awaiting decisions on their asylum process, would help to reduce the tensions that may add to domestic violence levels and provide women with independence and safety.
7. The involvement by religious leaders of all faiths in discussing the issue of woman abuse in their Churches and Mosques would also help to remove any religious support for cultural norms which support the control and abuse of women in those communities.

(Adapted from Allen and Foster 2007)

HOW CULTURE PLAYS A PART IN DOMESTIC VIOLENCE

- Some cultures still actively ignore or even condone a man's abusive power over his wife or partner.
- Commonly-held belief that sexual contact is a man's 'right' within his relationship.
- Structures within society may not facilitate financial stability for the woman who wishes to break away from an abusive relationship.
- Existence of a cultural norm of 'don't interfere' in the difficulties of others.

(Adapted from Royal Australian College of General Practitioners 1998)

The HSE Policy on Domestic, Sexual and Gender Based Violence (2010) states that "there are other forms of violence experienced by women, men and children in Ireland today e.g. trafficking, forced prostitution and female genital mutilation. For example, 56% of women trafficked into Ireland were raped in transit or once they had reached this country (Pilinger & O'Connor 2009)."

Ruhama is a Dublin based NGO which works on a national level with women affected by prostitution and other forms of commercial sexual exploitation. They provide a range of services including outreach, advocacy, court accompaniment and emotional support to women who are currently involved in prostitution, women who are victims of sex trafficking, women who have a history of prostitution or women who are high risk of prostitution. For further details see www.ruhama.ie, email admin@ruhama.ie or telephone 01 8360292.

MALE SURVIVORS

Amen reports that through their work, migrant male survivors are more likely to speak to their pastor or church leader and try to resolve the issue within their own community before seeking outside help.

4.7 PERPETRATORS

As practitioners we have an obligation to address the issues and needs of the whole family including alleged perpetrators in intimate partner violence cases. In practice we focus on the survivor and children, but we should be aware of the need to hold the perpetrator accountable for the abuse. We should be in a position to offer an intervention to protect survivors and particularly children in the current situation, but also be mindful that abusers may move into another family and reoffend. Perpetrators also have a lot to gain in terms of the quality of their own lives by engaging in work towards change.

WORKING WITH PERPETRATORS

- Plan for worker safety.
- Engage alleged abuser in an assessment that is structured and respectful.
- Clarify goals and format.
- Establish goals e.g. to decrease abuser-generated risks to children and survivor.
- Hold abuser accountable for abusive behaviours.
- Avoid victim-blaming language directly and in record keeping (see Asking the Question on page 10 for examples of victim blaming and appropriate questions).
- Name specific tactics used as safety threats.
- Document effects of these tactics on survivor/children.
- Educate on damaging effects of domestic abuse on children and hold abuser responsible for the impact they have as a parent.
- Child protection workers should never confront the alleged perpetrator with information provided by the survivor. Use third party reports and other evidence.
- Inform the perpetrator that information from them pertaining to risk to the survivor/children will be shared with the survivor.
- Consider that prior intimate partner violence does not prove that violence occurred in the incident being assessed.
- Do not share survivor safety plan with the alleged perpetrator.
- Where at all possible involve specialist services for perpetrators of intimate partner violence and work closely with them.

A Scottish Domestic Abuse Guide for health service staff (NHS Lothian 2007) advises that in some cases of domestic abuse “men may say they are victims of their (female) partner’s violence. While any such allegations must be treated seriously, research indicates that a significant number of male victims are also likely to be perpetrators of domestic abuse”. The guide also suggests that staff may encounter abusive men who “insist on accompanying their partners to appointments or who want to talk for their partners. They may have driven the woman to the hospital and be in the waiting room or want to stay with the woman at all times. These men may appear to you to be caring and protective of their partners and very plausible”.

INTERVENTION PROGRAMMES FOR MALE PERPETRATORS

There are two types of programmes working with abusive men; criminal justice programmes where abusive men are mandated to attend as part of a criminal sentence or probation order, with sanctions attached if abusers do not attend or make progress; and community based programmes where men voluntarily join a group or are referred by statutory agencies. There is no consensus on these two approaches. One argument is that abusive men can not be held accountable without some legal sanction and some commentators question the overall effectiveness of perpetrator programmes; expressing concern for consequent increased risk to survivors (Dobash & Dobash 1979). The other argument is that in order to keep women and children safe it is important to try to engage with abusive men in what ever way possible.

Currently there is one court mandated male perpetrator programme in Ireland, run by the Probation Service in Co. Louth. There are also community based programmes that accept men on a courted mandated basis, by referral from other agencies or by self referral. MOVE operate such programmes throughout the country and the MEND programme operates in the South East. The primary goal in all domestic violence perpetrator programmes is the safety and welfare of the women and children. As a result, best practice dictates that there must always be a thorough safety assessment of the man before acceptance onto a programme and support to their partners or ex-partners (and children) must be offered during the programme. There is also a recently established parenting programme Caring Dads (2006) working with abusive men based in North Tipperary. This is not a domestic violence perpetrator programme but can operate alongside such programmes. There are no programmes for women perpetrators.

GROOMING

The abuser treats his spouse as an object, an extension of himself, devoid of a separate existence and denuded of distinct needs. Family and friends are regarded as a threat. By intimidating, cajoling, charming and making false promises the abuser isolates his prey from the rest of society and thus makes their dependence on him total (Vaknin 1999). Don Hennessey (2004) suggests that “in the dynamic of domestic violence it is useful to describe the process of grooming as the deliberate use of certain tactics to gain compliance and to avoid disclosure”. This process includes the grooming of the professionals involved. These models describe the control of ‘target women’ by male perpetrators. There are no models which describe the behaviour of women abusers.

HOW AND WHY ‘TARGET WOMEN’ ARE GROOMED

- Adult targets of intimate partner violence offenders are groomed in a way that appears to deepen the intimate relationship while at the same time making the ‘target woman’ responsible for all the emotional inadequacies whether these inadequacies are real or imaginary. The long-term effect of this tactic is to ensure that the second aim of the process, avoiding disclosure, is also achieved.
- The effect of this onus of responsibility is that the target woman begins to feel inadequate and guilty. Because she sees herself as responsible for the emotional deepening of the relationship she continues to increase her efforts to meet her obligations.
- Because her abuser is only interested in making her feel inadequate he will continuously raise the bar or if it pleases him he will change the goalposts. He will then blame the target woman for her continuous failures. He does this to ensure that his victim will be reluctant to reveal the abusive behaviours.
- The target women begin to believe that their offenders can groom anyone who can support survivors. This gives another explanation as to why target women do not reveal the hidden abuse. They are convinced that no matter what the truth is, their offenders will manage to groom the listener into minimising or ignoring the reality of the abuse.

(Adapted from Don Hennessey 2004²¹)

21 For more information on male intimate abusers see Hennessey 2012

HOW AND WHY PROFESSIONALS ARE GROOMED

- When offenders meet professionals they begin the process of grooming us by getting us to like them (see tactics below). They set out to assure us that any information we already have or any conclusions we have drawn are inaccurate and that they know once we have met that we will see things a little more clearly.
- Perpetrators of intimate partner violence do not present themselves as having a problem with violence. Most try to explain their behaviour by blaming causes that are beyond their control.
- When the offender gets a sense that this initial attempt to groom us is not working he can switch from being polite and respectful to being intimidating and threatening in an instant.
- Once we have been groomed we automatically ignore the severity of the abuse. Most dangerously we begin to lose sight of the victim.”

(Adapted from Don Hennessey 2004)

OFFENDERS GROOM BOTH THE SURVIVOR AND THOSE WHO ATTEMPT TO ASSIST THEM

The process of grooming can take on two distinct tactics: Non-threatening and/or threatening behaviour.

Offenders will use non-threatening behaviour because they want you to:

- Like them, trust them, help them, have sympathy for them, believe them, make an exception for them
- They will be polite and respectful
- They will feel sorry for themselves
- They will present as the victim
- They will feign remorse
- They will deny, minimise
- They will blame the other person
- They will blame something else i.e. drink, drugs, stress

The behaviour may become more threatening with threats to you, your family and your property because:

- They want you to be afraid

Likewise, the Roscommon Inquiry (HSE 2010) and others, for example the Baby P Inquiry in England, have highlighted how professionals can be groomed by parents in child protection cases. The ‘rule of optimism’ concept suggests that child protection professionals can be unrealistic about parents’ capacity to change. For example, the Roscommon report states that workers were “constantly diverted and deceived by the parents and were unduly optimistic about the parents’ ability and willingness to care adequately for their children”. Such strengths-based approaches are rightfully central to any family work but good supervision is essential in providing proper scrutiny and risk assessment in such cases. The need for good supervision is equally important in work with intimate partner violence perpetrators.

SECTION 5 – REFERENCES AND APPENDICIES

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- World Health Organisation** (WHO, 2003) *Guidelines for Medico-Legal Care for Victims of Sexual Violence*, WHO
- Yearnshire S.** (1997) 'Analysis of cohort', in Bewley S, Friend J and Mezey G (Eds.) *Violence Against Women*. London. RCOG, 1997

RESOURCES FOR WORK WITH CHILDREN

Some suggested titles/resources for use in work with children/teenagers and parents focussing on the issues of domestic violence:

- "Talking to my Mum" A picture workbook for workers, mothers and children affected by domestic abuse Cathy Humphreys, Ravi K Thiara, Agnes Skamballis & Audrey Mullender. Jessica Kingsley Publishers
- "Talking about Domestic Abuse" A photo activity workbook to develop communication between mothers and Young People Cathy Humphreys, Ravi K Thiara, Agnes Skamballis & Audrey Mullender. Jessica Kingsley Publishers
- "It hurts me too" Children's experiences of domestic violence and refuge life (1995) Alex Saunders Women's Aid Federation England
- www.barnardos.ie Barnardo's National Children's Resources Centres
- "Picking Up The Pieces After Domestic Violence, A Practical Resource for Supporting Parenting Skills," Kate Iwi and Chris Newman, 2011, Jessica Kingsley.
- "Child Protection, Domestic Violence and Parental Substance Misuse", Cleaver, C., Nicholson, D., Tarr and Cleaver,C.,2007
- "Making an Impact, Children and Domestic Violence" 2nd Edition, Hestor, Pearson, Harwin, 2007
- Children in Northern Ireland Domestic Violence and Professional Awareness
<http://www.ofmdfmi.gov.uk/domesticviolence.pdf>

GLOSSARY OF TERMS

An Garda Siochana – the Irish police service

DSGBV - Domestic, Sexual and Gender Based Violence

HSE – Health Service Executive, the Irish health service agency

HSE children and families social work service – the Irish statutory child welfare and protection service, which is currently part of the health service structure.

IPV - Intimate Partner Violence

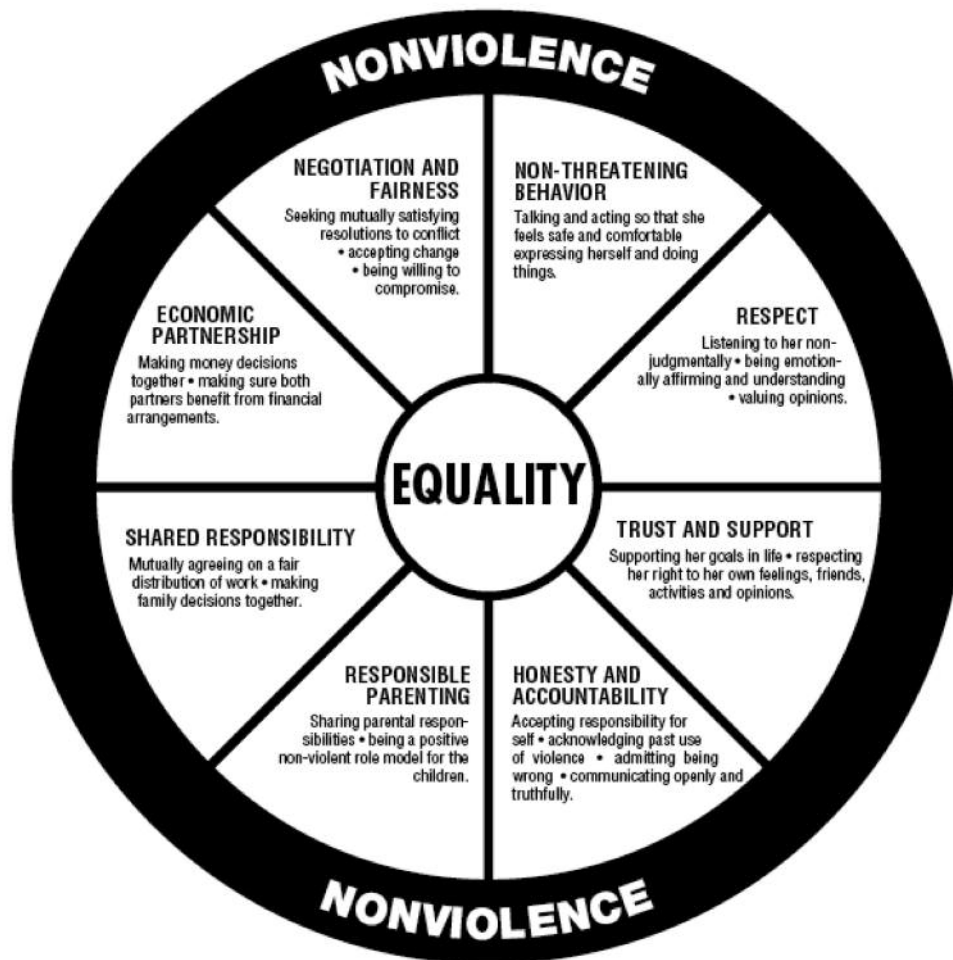
NSPCC – UK National Society for the Prevention of Cruelty to Children

5.2 APPENDICES

APPENDIX i – POWER AND CONTROL WHEELS



DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, Minnesota 55802



DOMESTIC ABUSE INTERVENTION PROJECT
 202 East Superior Street
 Duluth, Minnesota 55802



DOMESTIC ABUSE INTERVENTION PROJECT
 202 East Superior Street
 Duluth, Minnesota 55802
 218-722-2781

APPENDIX ii – SAFETY PLANS

For most survivors it's safer not to put the plan in writing

SAFETY PLAN 1: IF LIVING IN AN ABUSIVE RELATIONSHIP

If you are LIVING in an abusive relationship there are some steps you can take to increase your safety. You cannot always avoid violent incidents and do not have control over your partner's violence. You do have a choice how to respond and about getting yourself and your children to safety. Thinking through the following in advance can help:

- In an emergency what works best to keep me safe?
- Who can I call in a crisis, where can I call from?
- Would I call the Gardai, where would I call from, can I work out a signal with the children or neighbours to call the Gardai or get help? (It is important to teach the children how to call the emergency services)
- If I need to escape where can I go? – Think through places and write down the address and phone number.
- What are my escape routes from my house/flat/trailer?
- Can I remove any weapons from the house? Can I move to a safer place in the house when I expect an argument? (For example avoid rooms with items that can be used as weapons and without a phone or safe exit)

Remember to trust your own judgment about what to do – sometimes it is best to run away, sometimes to calm the violent person, anything that works best to protect yourself and your children.

If you have to leave think through having the following available:

- Some clothing for yourself and your children and some comfort items for the children. (You could keep a small bag packed near an exit in your home or with a trusted relative/friend/neighbour)
 - Passport, Birth Certificate, ID.
 - RSI/PPS Card, Social Welfare Book.
 - Essential medicines/medical card.
 - Welfare and Immigration Papers.
 - Marriage certificate.
 - Any Court Orders and Documents.
 - Bank details, pay slips.
 - Keys, some money.
 - Phone numbers of family/friends/refuge/community agencies.

*Remember **your safety comes first** and do not worry if you have to leave anything behind.*

You can ask the Gardai to come back with you later for protection

If an assault has occurred notify the Gardai and see your GP/hospital to ensure you are ok/safe and to have any injuries recorded and photographed.

Adapted from Women's Aid Handout 2001

SAFETY PLAN 2: IF LEAVING AN ABUSIVE RELATIONSHIP

If you are **LEAVING** an abusive and violent relationship you are likely to be at an increased risk. Reviewing the following may help you increase your safety at this risky time and help you in preparing to leave an abusive partner.

- Where is a safe place I can go?
- If I cannot get to this location where will I go? (Calling to any Gardai station is safe and they will access refuge/other accommodation for you and your children)
- How and when is it most safe for me to leave? How will I transport myself?
- Can I put some money aside/how will I access my money?
- Will I call the Gardai if I need them; is there a trusted neighbour or friend who will help me?
- What can I, and others I know, do to prevent my partner finding me?

Keeping a bag with necessities in an easy place to access quickly in your home or with a trusted relative, friend or neighbour can be very useful.

If you have to leave think through having the following available:

- Some clothing for yourself and your children and some comfort items for the children. (You could keep a small bag packed near an exit in your home or with a trusted relative/friend/neighbour)
 - Passport, Birth Certificate, ID.
 - RSI/PPS Card, Social Welfare Book.
 - Essential medicines/medical card.
 - Welfare and Immigration Papers.
 - Marriage certificate.
 - Any Court Orders and Documents.
 - Bank details, pay slips.
 - Keys, some money.
 - Phone numbers of family/friends/refuge/community agencies.

*Remember **your safety comes first** and do not worry if you have to leave anything behind.*

You can ask the Gardai to come back with you later for protection

If an assault has occurred notify the Gardai and see your GP/hospital to ensure you are ok/safe and to have any injuries recorded and photographed.

You might also then want to go through a safety plan for when you have left a violent relationship.

Adapted from Women's Aid Handout 2001

SAFETY PLAN 3: IF YOU HAVE LEFT AN ABUSIVE RELATIONSHIP

If you HAVE LEFT an abusive and violent relationship and are now living elsewhere or have had the violent person removed from the family home with an order, you may still be at risk of continuing violence. Going through the following can help to reduce this risk:

- Apply for a safety or barring order under the Domestic Violence Act. (Your local Domestic Violence Service will be able to inform you about this option)
- Bring any orders to your local Gardai station.
- Teach the children to call the Gardai or a trusted family member, friend or neighbour who can come to your address quickly in a situation of danger.
- Change locks on doors and windows.
- If possible install a better security system – for example put locks on windows and/or bars, have good lighting and an outside security light, a fire extinguisher and a safety chain on doors.
- Talk to the children's school/crèche and child minders about who has permission to pick up the children and think of other ways to protect the children.
- Link into support services for yourself and to help you explore issues of custody/access etc. in ways that will protect you and the children.
- Withhold your phone number – call blocking – if calling your partner or anyone who might pass the number on.
- If you need to meet your partner, arrange to meet in a neutral safe place for you.

Remember you are at the greatest risk in the weeks following separation/leaving.

Adapted from Women's Aid Handout 2001

SAFETY PLAN 4: FOR CHILDREN/TEENAGERS (Ensure the plan is age appropriate)

(Adapted from Child protection in families experiencing domestic violence U.S.A. Bragg, 2003)

FOR USE BY NON-ABUSING PARENT WITH THEIR CHILDREN

1. When my mother/father 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 or to a safe place, my mother/father and I have agreed on.
2. If I call the police for help, I will find a safe place to make a phone call; I will dial 999 and tell them:
 - My name is e.g. Patrick Murray
 - I need help
 - Send the police.
 - Someone is hurting my mother/father.
 - I will give them my address
3. My address is e.g. 501 Main Street Tallaght. I will remember not to hang up until the police get there.
4. My code word for help or if I am scared is _____. If my mother/father uses this code word, I know to try to get help.
5. My mother/father and I will practice our safety plans regularly.

Within the parent's safety plan, s/he needs to have agreed to do the following so that their child/teenager can implement their safety plan:

- Teach the child their name and address.
- Teach child how to use land line and mobile phone to call 999 and provide their name and address
- Agree a code word with child, relatives and friends so that they can call for help
- They must tell the children not to intervene when we are arguing or if a violent incident occurs.

S.A.F.E. PLAN FOR CHILDREN/TEENAGERS

S...TAY OUT OF THE FIGHT

A...SK FOR HELP

F...IND AN ADULT WHO WILL LISTEN

E...VERYONE KNOWS IT'S NOT YOUR FAULT

APPENDIX iii – BODY MAPS

A. FEMALE BODY MAP

Name of the hospital _____
 Address of the hospital _____
 Phone/fax _____

Name
Identification

EXAMINATION:

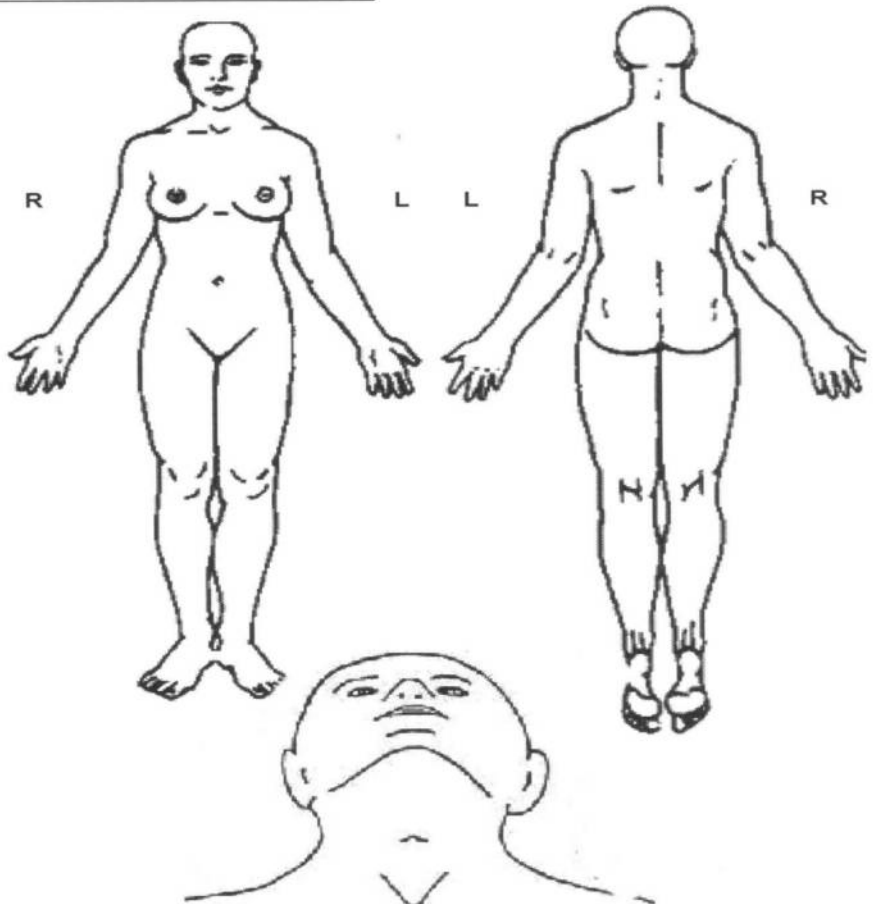
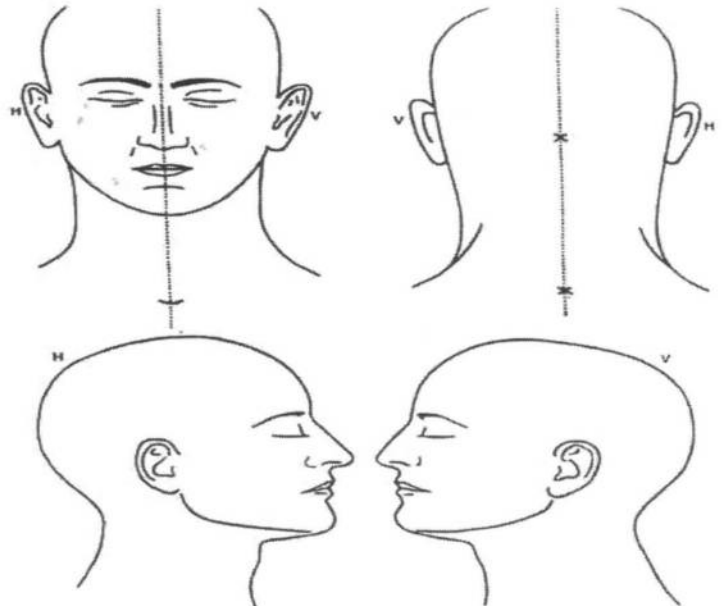
Date/time: _____
 Doctor _____
 Nurse _____

Photographs: yes _____ pieces no _____

DRAW THE INJURIES (INCLUDING THEIR MEASUREMENTS) ON THE DIAGRAMS:

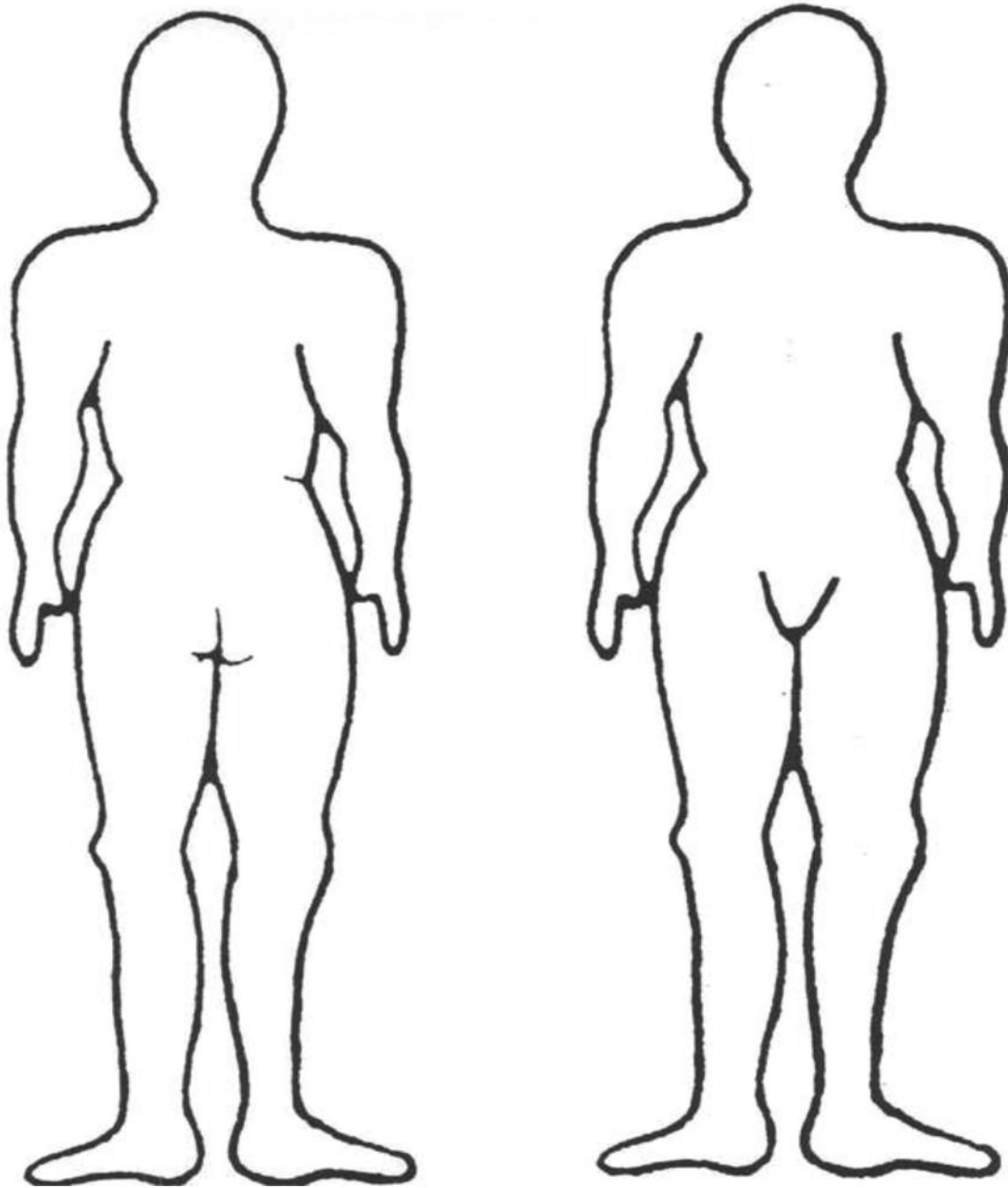
x bruise	--- scratch
● black mark	H cut
○ lump/swelling	/// pain
▲ fracture / luxation	

BODY MAP



From Perttu & Kaselitz 'Addressing Intimate Partner Violence - Guidelines for Health Professionals in Maternity & Child Health Care'

B. – MALE BODY MAP

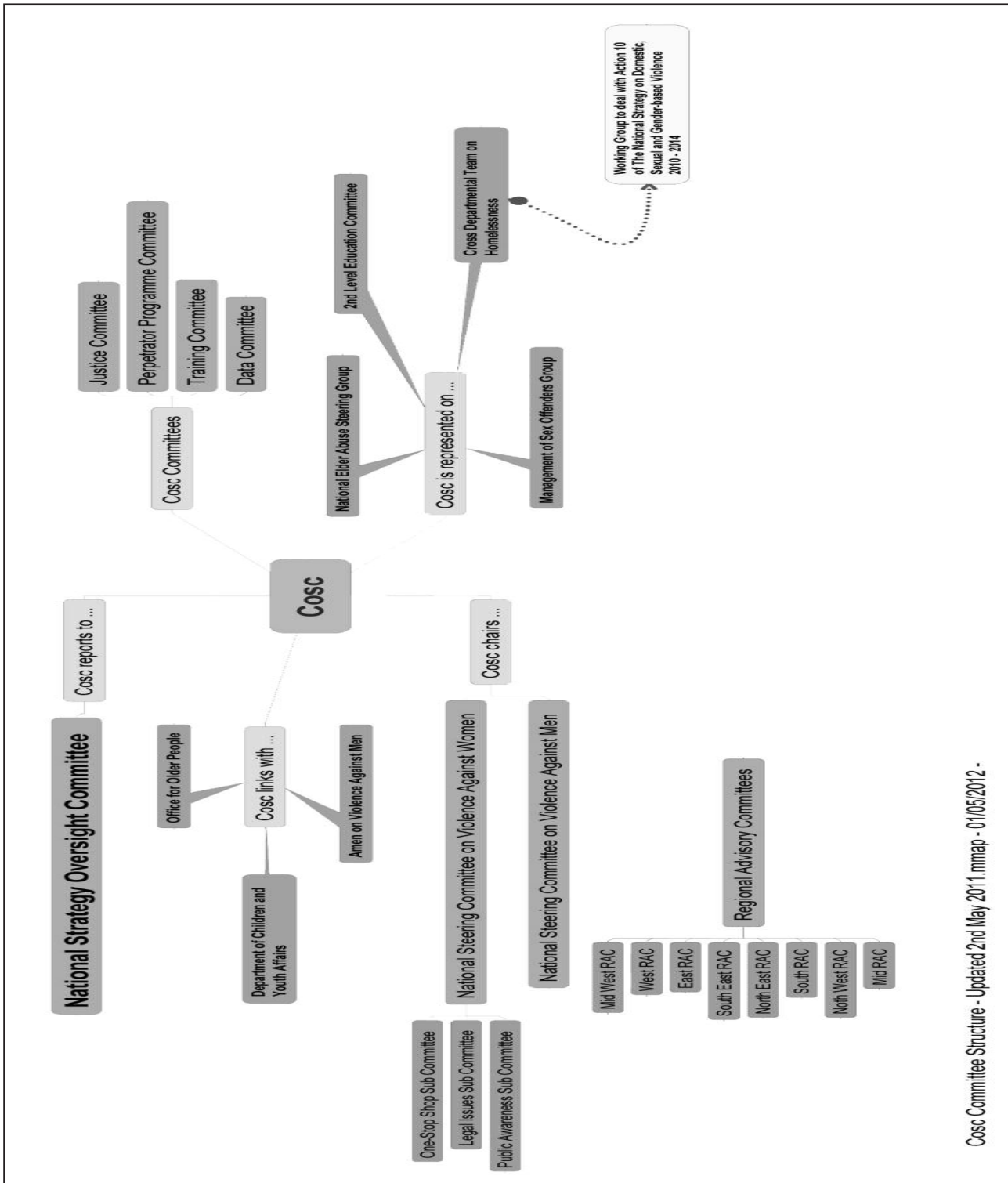


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APPENDIX iv – NATIONAL STRUCTURE

Cosc

Cosc, the Office for the Prevention of Domestic Violence, was established by the Government in 2007 with the key responsibility to ensure the delivery of a well co-ordinated "whole of Government" response to violence against women and domestic violence.



Cosc Committee Structure - Updated 2nd May 2011.mmap - 01/05/2012 -

ACKNOWLEDGEMENTS

The development of this Practice Guide was only possible due to the championing and dedication of a number of HSE staff both at local and at national level. This approach allowed for front-line expertise and national policy experience to combine. The Children and Families Social Work Service in HSE Dublin South West originally developed a local Practice Document launched in 2010 (HSE 2010) after two years of work piloting and improving the content.

The original local working group were:

- Mary Kate Barry, Senior Social Work Practitioner
- Lynn Bell, Social Worker
- Phil Devereux, Domestic Violence Project Worker
- Caroline Jordan, Family Support Co-ordinator (Co-chair)
- Deirdre Lawlor, Domestic Violence Project Worker (Co-chair)
- Claire McCabe, Social Work Team Leader
- Sandra McCann, Senior Social Work Practitioner
- Linda Mooney, Social Worker
- Anita O'Rourke, Community Child Care Worker
- Maria O'Gorman, Family Support Worker
- Ronelle Valentyn, Fostering Social Worker
- Kevin Webster, Community Work Team Leader (Co-chair)

Aisling Gillen, HSE National Specialist Family Support, then formed the following national working group which produced this guide:

- Margaret Costello, National Lead for Domestic Sexual and Gender Based Violence, HSE Dublin North East, (Chairperson)
- Brian Dunne, Clinical Psychologist, HSE West
- Colin Harrison, Child Care Manager, HSE West
- Una McHale, Child Care Training Officer, HSE South
- Mary Troy, Women's Health, Health Promotion, HSE Dublin North East
- Kevin Webster, Community Work Team Leader, HSE Dublin Mid-Leinster
- Alacoque Fitzsimons/Niamh O'Farrell, Amen

The working group consulted with Exchange House, Ruhama and Rape Crisis Network Ireland in relation to minority ethnic and sexual violence issues. The final draft was 'peer reviewed' by Mary Allen (School of Social Work, UCD), Stephanie Holt (School of Social Work, TCD), Liam Coen (Child and Family Centre, NUIG) and Sinead Harrison (Women's Aid). This national guide is based primarily on the original document with some additions and 'gender sensitive' proofing and is a consensus of the work from both working groups.

Slap

*Slap! A belt across the face with an adult hand
A beating painful; administered and planned
A lust-based love dissolves before a battered eye
Chaos causes corruption with an angry cry
Domestic violence; Imagine if you can
But be aware; this time the victim is a man*

Amen 2011

The HSE Vision in relation to Domestic Violence and/or Sexual Violence is to implement an integrated and co-ordinated health sector response to Domestic Violence and/or Sexual Violence in order to:

- Prevent Domestic Violence and/or Sexual Violence
- Ensure that all families experiencing or at risk of experiencing Domestic Violence and/or Sexual Violence will receive a continuum of supports from he and respond to the impact this type of violence has on health.



Féilmeannacht na Seirbhíse Sláinte
Health Service Executive

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