

# Domestic Violence

## A Guide for General Practice

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QUALITY IN PRACTICE COMMITTEE



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive  
In association with  
Eastern Regional Planning Committee on  
Violence Against Women



DEPARTMENT OF JUSTICE, EQUALITY AND LAW REFORM  
AN ROINN DLÍ AGUS CIRT, COMHIONANNAIS AGUS ATHCHÓIRITHE DLÍ

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# Key to evidence statements and grades of recommendations<sup>1</sup>

## Levels of evidence

- 1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
- 1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
- 1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias
- 2++ High quality systematic reviews of case control or cohort or studies  
High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
- 2+ Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
- 2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
- 3 Non-analytic studies, e.g. case reports, case series
- 4 Expert opinion

## Grades of recommendations

- A** At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; *or*  
  
A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
- B** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; *or*  
  
Extrapolated evidence from studies rated as 1++ or 1+
- C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; *or*  
  
Extrapolated evidence from studies rated as 2++
- D** Evidence level 3 or 4; *or*  
  
Extrapolated evidence from studies rated as 2+

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## Preface

The Health Promotion Department of the Health Service Executive Dublin/North East and the Department of Justice, Equality and Law Reform, through the Eastern Regional Planning Committee on Violence Against Women, have jointly commissioned this education resource on domestic violence for General Practitioners (GPs) and Practice Nurses (PNs). The resource is the first of its kind in Ireland and it represents a practical outcome of partnership working and a tangible reflection of integrated cross-government intent to improve service provision for those who experience domestic violence.

General Practitioners (GPs) and Practice Nurses (PNs) have an important role to play in domestic violence services, not only because they deal with injuries and illness caused by domestic violence in their daily work, but also because they are often a woman's first or only contact with a professional who could provide a lifeline to safety. A full-time GP is likely to see one to two female patients each week who have experienced domestic violence.

Moreover, many of the health effects of domestic violence are treatable in the GP's surgery, and women will disclose to GPs and PNs because they generally have a long-term relationship with the family practice, because there is no stigma attached to visiting the surgery and because the surgery is readily accessible in the community.

This resource is intended to guide GPs and Practice Nurses in the identification and management of patients experiencing domestic violence.

The principle message for these two professional groups is to recognise domestic violence, respond with empathy and refer to services that are appropriate to the woman's needs.

The content of the resource has been guided by the expert advice of Women's Aid and the Rape Crisis Network of Ireland, as well as HSE healthcare professionals, Professional Development Co-ordinator for Practice Nurses, and staff from the ICGP.

The partnership between the Health Promotion Department of the HSE Dublin/North East and the Department of Justice, Equality and Law Reform, and the inter-agency approach of the steering committee has helped to produce a quality resource that will only impact positively on the one in five women - and their children - who experience domestic abuse at some point in their lives. I commend it to you.



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Dr. Nazih Eldin  
Head of Health Promotion  
HSE Dublin/North East

# 1. Introduction

## Background

It is estimated that 20% of women face some form of violence during their lifetime, in some cases leading to serious injury or death.<sup>2</sup> Violence against women is a universal phenomenon that persists in all countries of the world, and the perpetrators of this violence are often well known to their victims. Domestic violence, in particular, continues to be frighteningly common but is under-identified and continues to be accepted as “normal” within many societies. Violence between adult partners occurs in all social classes, all ethnic groups and cultures, all age groups, in disabled people as well as able-bodied, and in both homosexual and heterosexual relationships.<sup>3</sup> Violence against women is widely prevalent, causes serious psychological and physical damage, and brings women to the attention of the healthcare system on a daily basis.<sup>4</sup>

There is no universally agreed method of defining domestic violence, and assigning a definition in itself is complex, owing to societal values and interpretation. The terms “**domestic violence**” and “**intimate partner violence**” are both used to describe violence between two adults in an intimate relationship, and in this context we define domestic violence as:

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

(Report of the Task Force of Violence Against Women (1997): Government Publications Office, Dublin.<sup>5</sup>)

Intimate partner violence can thus be physical, sexual and/or psychological. It is common, serious and often not identified. Violence against women by partners, ex-partners or relatives is the most common form of physical interpersonal crime in the UK.<sup>6</sup> One in four abusers of adult women are intimate partners or ex-partners.<sup>7</sup> Domestic violence is a continuum but it is defined differently in different situations. Particular difficulties arise in clearly defining psychological abuse and inclusion or exclusion of activities such as shouting at a partner, insulting them or their family, controlling what they do or limiting their spending of family income have a profound effect on reported prevalence rates.<sup>8</sup>

For the vast majority of victims, violence is endured as a chronic long-term condition that escalates over time. By the time a woman’s injuries are visible, violence may be a long-established pattern. For some women, escalation is fatal. The ultimate preventable outcome is homicide. One hundred and thirty-eight women have been murdered in Ireland since data collection commenced at the end of 1995. This figure translates to **approximately one woman per month**; of these, 63% have been killed in their own homes. Of the resolved cases, 48% were killed by a partner/husband or ex-partner.<sup>9</sup>

Research in Ireland has revealed that nearly 1 in 5 of women who had an intimate relationship with a man had experienced domestic abuse by that partner.<sup>10</sup> Yet, only 12% of women reported that they had been asked by their general practitioner (GP) about violence. Of the women who had been injured by their partner, only 20% of them reported that their doctor had asked about violence.<sup>11</sup>

General practitioners are readily accessible to women. Therefore it is important that GPs respond appropriately to cases when they do arise. In addition, there may be a longstanding relationship of trust with a GP or practice nurse (PN). General practitioners are the first individuals women disclose to in circumstances of violence, outside of family members or close friends.<sup>10,12</sup> Thus it is incumbent upon GPs to have confidence in dealing with cases when they do arise. The important role of the GP is recognised in the 1997 Task Force Report on Violence Against Women.<sup>5</sup> Furthermore, primary care doctors are ideally placed for early intervention to minimise morbidity and mortality for their patients. This raises the question as to whether routine screening by doctors is helpful in reducing harm in these women. At present there is insufficient evidence to recommend that screening programmes for abuse be implemented in healthcare settings; however selective questioning by healthcare professionals does increase the identification of domestic violence and many women do not object to being asked.<sup>13</sup> In one Irish sample, 77% of women asked were in favour of routine questioning about intimate partner abuse by their general practitioner<sup>11</sup> and this positive attitude toward routine questioning has been reproduced in other settings.<sup>14,15</sup>

### **Domestic Violence at a Glance**

#### **Pattern**

% of DV which is an isolated event followed by resolution/permanent separation <sup>16</sup>	<10%
Average number of times a woman is assaulted before she seeks help <sup>17</sup>	35

#### **Mortality**

Women murdered whom were killed by a partner or ex-partner	
- UK <sup>18</sup>	50%
- Ireland <sup>9</sup>	48%

#### **First Disclosure**

% of women who report to GP <sup>10</sup>	29%
% of women who report to Police/other <sup>10</sup>	20%

Throughout this document the use of the pronouns 'she' and 'her' are used in reference to a victim of DV. Although indeed the term 'domestic violence' encompasses violence or abuse between any two individuals in an adult intimate relationship (including homosexual relationships, and those in which women abuse men), the overwhelming burden of partner violence is experienced by women and perpetrated by men.

Violence between adults in an intimate relationship is the focus of this guide; detailed discussion on sexual violence, child abuse, and elder abuse is beyond the scope of this document.

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patients. Throughout this document you will see levels of evidence (indicated by roman numerals e.g. Ia), and grades of recommendation (indicated by alphabetical letter, e.g. A).<sup>1</sup>

Due to the very nature of violence, there are no randomised controlled trials in existence on the subject, and this dictates that the levels of evidence given are, for the most part, III or lower. Consequently recommendations given are generally graded below grade A.

See **inside cover** for tables of evidence and recommendations.

## Aims of this Document

Until now there has been no systematic approach to the issue of violence against women in the Irish general practice setting. This document will provide primary care practitioners (GPs and PNs) with:

- An understanding of the nature of the problem of intimate partner violence
- Confidence on when to ask a patient about violence and/or abuse
- Confidence on how to ask a patient about violence and/or abuse
- Knowledge on the appropriate care and support of a patient who has disclosed violence and/or abuse

The principle message for health professionals is the 3 R's

<b>Recognise:</b>	know the signs, indications and sequelae of abuse
<b>Respond:</b>	know how to deal with the issue of abuse
<b>Refer:</b>	make a good, appropriate referral

***Possibly the most significant important role of the GP in this setting is to listen, and support.***

## Evidence Based Medicine

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

Throughout this document you will see levels of evidence (indicated by roman numerals, e.g. 1a) and grades of recommendation (indicated by alphabetical letter, e.g. A)<sup>1</sup>.

## II. Dealing with Domestic Violence

### A. Recognise

#### Domestic Violence – What is it?

Violence is best viewed as a continuum – defined as continuous sequence in which adjacent elements are not perceptibly different from each other, but the extremes are quite distinct. This is reflected in the definition of DV given previously in this document<sup>5</sup>:

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

#### Who is at risk of violence?

No individual is immune to Domestic Violence.

It is common, serious, and often not identified. It may affect all sexualities, ages, races, nationalities, religious and ethnic groups, socio-economic groups, cultures and lifestyles.

Whilst anybody is at risk, however, there are certain societal groups who are statistically more likely to be victims. Firstly, victims are overwhelmingly more likely to be female. Approximately 95% of victims of domestic violence are women and these figures are reproducible in practically all studies worldwide.<sup>5,16,19</sup> (Level III)

#### Why don't we see it that often?

According to statistics, we do see it. We may not be aware of it, however, for a variety of reasons.

Why victims don't tell

- persistent hope that the abuse will stop
- belief that the abuse is the victim's 'own problem'
- belief that she is provoking the abusive behaviour
- belief that nothing can be done about the abuse
- shame/stigma of the abuse prevents her talking about it
- belief that the issue isn't serious enough to warrant attention
- the desire to deal with the problem herself
- the belief that the doctor won't believe her or won't be able to help her
- inability to disclose: she is subject to bullying, or her abuser is always present at the surgery
- fear of consequences of disclosure: escalation of violence, disruption of family unit
- fear of losing (custody of) her children
- economic consequences of separation
- reluctance to lose her intimate relationship
- pride prevents her

### Why doctors/nurses don't ask

- haven't considered it as a possibility
- have considered it but own prejudices sway their beliefs
- perceived or real lack of time
- the belief that (s)he doesn't have the skills to handle things properly
- the feeling that they may not be helping anything by asking

### How society plays a part

- 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' i.e. in the difficulties of others

(Adapted from: Women & Violence<sup>20</sup> & Women's Aid ) (Level III)

### How do women present?

- make a verbal disclosure about violence with no physical injuries
- make a verbal disclosure whilst needing care for injuries
- no disclosure but presentation after an event, needing medical care
- no disclosure and no single 'event', but possible frequent presentation with one or more medical/psychological problems
- use of the 'calling card' of seemingly minor complaints
- 'by proxy' e.g. frequent visits for minor complaints in a seemingly well child
- with mental health problems, caused by, affiliated with, or masking domestic violence
- groups for particular consideration (see page 18)

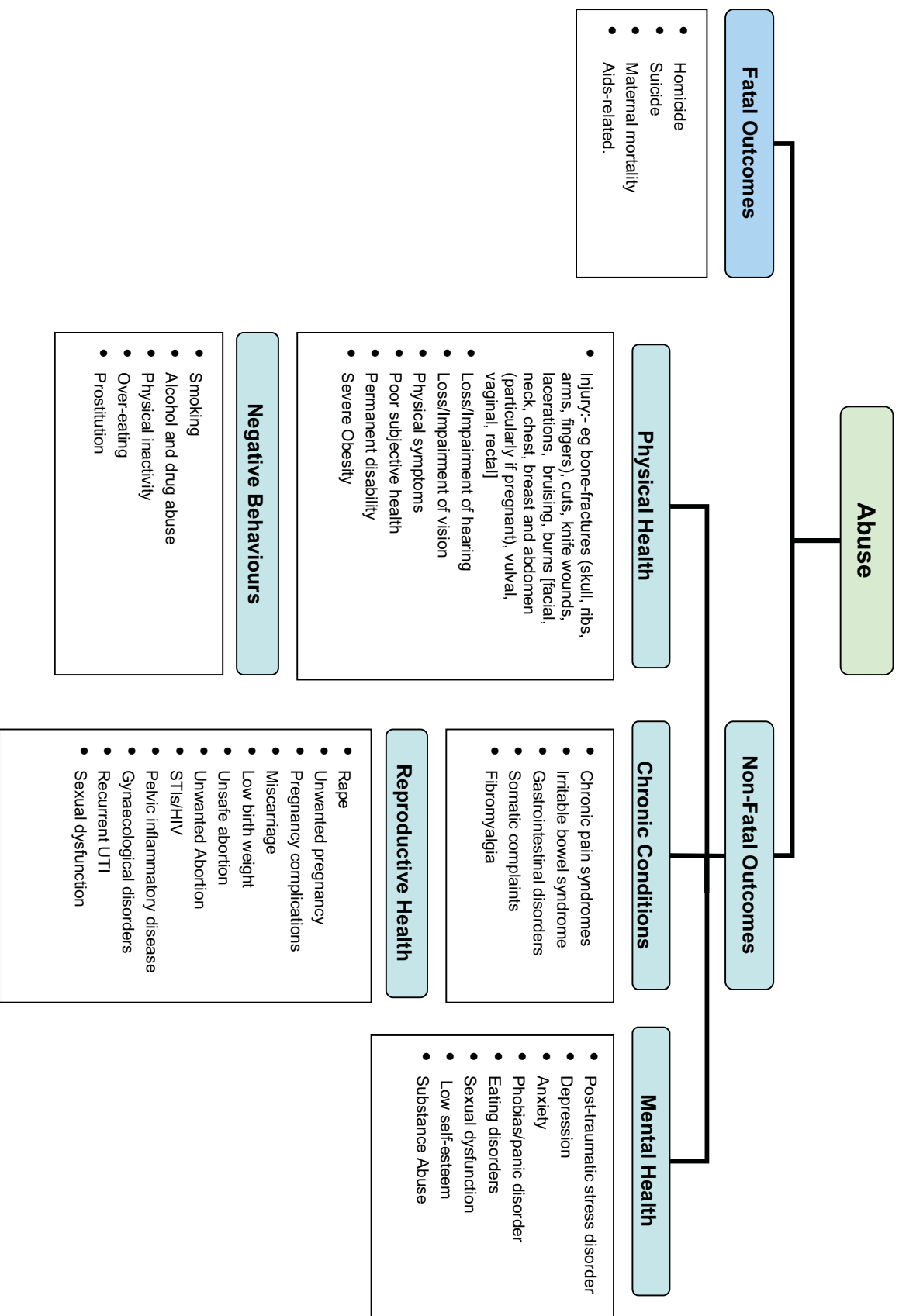
***Women who present as victims of choking or attempted strangulation warrant special attention as these injuries are 'red flag' indicators of a high risk abusive situation.<sup>21</sup>***

(Level IV)

### How do abused men present?

Men are less likely to be victims of domestic violence than women. Where they are victims, the patterns of abuse and health consequences are different. The limited literature on this topic suggests that men are even less likely to disclose the abuse.<sup>22</sup> (Level III).

## Health Outcomes of Violence Against Women



Adapted from: Centre for Health and Gender Equity (CHANGE) <sup>23</sup> (Level III)

### **Myths about Intimate Partner Violence**

- Only a small percentage of women are victims of violence
- Nobody has the right to interfere in the domestic affairs of a couple
- Women 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 domestic violence
- Battered women can always leave home if they want to
- Women who are abused come from an abusive family background
- Battering only occurs in working class and Traveller families
- If a woman leaves the abusive relationship the abuse will stop
- Women who experience domestic violence are weak
- Alcohol misuse causes wife battering
- Couple counselling will help resolve the abuse
- Women and children frequently lie about sexual violence
- Battered women batter their children
- Violent men are mentally ill or have low self esteem
- Men who are violent come from an abusive family background
- Abusive men cannot control their violence; they have an anger management problems
- Abusive men are easy to identify. They are physically violent all of the time and to everyone.

Adapted from: Women & Violence.<sup>20</sup> (Level III)

## B. Respond

### Open Disclosures of Violence

Effective help should be directed towards enabling the woman to take control of her own life, to offer her realistic choices while accepting that the decisions are hers alone and are always valid in her particular situation.<sup>16</sup> (Level IV) Continuing understanding and support are vital as it may take a woman demoralised by years of violence and abuse a long time to find the confidence and courage to choose a different life.

#### **Responding to disclosures of 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 her right to confidentiality

#### **Do not say**

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

These questions imply that, somehow, the victim was to blame for the violence.

(DVIRC Professional Training Unit)<sup>24</sup> (Level III) (Grade B)

***The most dangerous time for a victim of violence is when she is on the verge of leaving, and for six months afterwards.***

***Urging her to leave may precipitate a catastrophic event.***

(Adapted from: Responding to Domestic Abuse: a Handbook for Health Professionals)<sup>19</sup>  
(Level III) (Grade B)

### Non-disclosure

Few victims of domestic violence make disclosures in the early stages of the process. On average, a woman will endure 35 violent incidents before reporting it to the police.<sup>17</sup> (Level II).

In cases where your patient's behaviour, symptoms or injury patterns give rise to suspicions but she does not discuss it, you may need to ask the question.

#### **Patient screening vs. Selective questioning / Routine enquiry**

- **Screening** may be defined as asking the question/set of questions of all women on at least one occasion.
- **Selective questioning**, on the other hand, is a practice whereby a practitioner asks the question of a woman (s)he has concerns about, or at a particular time in a woman's life or at presentation of a certain type of injury or illness.<sup>25</sup> (Level IV)

The introduction of the of routine screening for DV in General Practice has been recommended in some countries and many studies have endeavoured to evaluate the merit of such practice. There is little evidence to suggest the benefit of routine screening for DV, in that there is no solid evidence that it reduces harm.<sup>13</sup> (Level II)(Grade B). There is, however, a role for selective questioning.

All GPs/PNs will need to use their own experience in deciding when it's okay to ask, and how.

Opportunities may present in the following circumstances:

- During antenatal/post-natal visits (risk is heightened during pregnancy).
- Signs of Injury.
- During visits for emergency contraception.
- Somatic complaints.
- Verbal clues.
- Partner behaviour e.g. a partner who insists on accompanying a woman to the surgery and who always stays close to her.<sup>4</sup>

**Do not** ask a woman about violence unless she is alone and you cannot be overheard. (Level III) (Grade B).

### Sample questions

#### Broad

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

#### Specifically linked to clinical observations

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

#### More direct questions

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

(DVIRC Professional Training Unit)<sup>24</sup> (Grade B)

In questioning a woman she may confirm that there is indeed a violent relationship. Several professional bodies (support agencies, an Garda Síochána) use Risk Assessment Tools at this point to allow them to make a calculation of predicted future risk for the woman. There are a number of tools in use but there is insufficient evidence at this point in time to support their use in General Practice.

Safety and escape planning is discussed on page 17.

## **Children and Violence**

Family violence and child abuse frequently co-exist<sup>26</sup> (Level III)

A landmark study in Ireland in 1995 showed that 64% of women who experienced violence reported that their children had witnessed the violence.<sup>10</sup> Children who have been exposed to family violence may have long-term physical, psychological and emotional effects. The longer family violence 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 with torn loyalties.

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

**GPs are mandated to report child abuse of any form.**

Criminal Justice Act (2006) Part 15, Section 2 (a): Reckless Endangerment of Children<sup>27</sup>

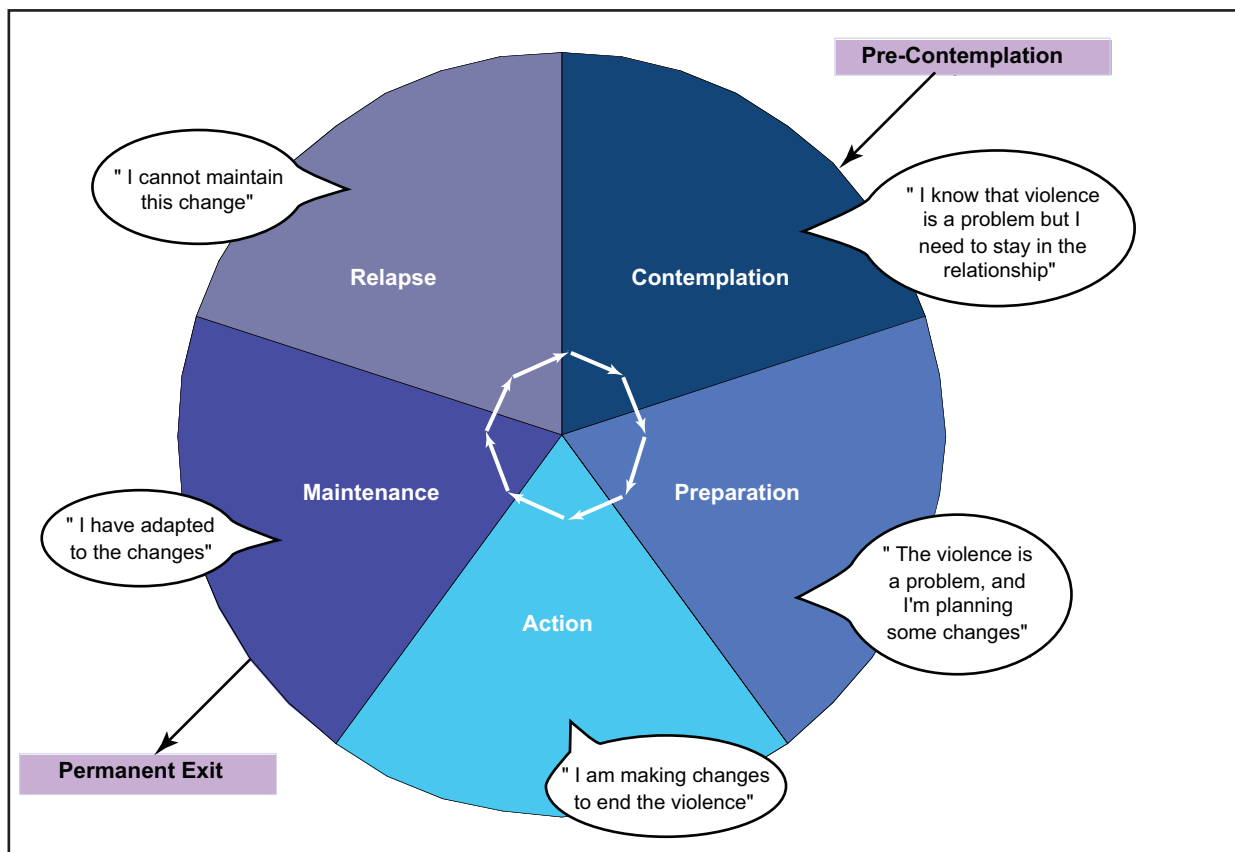
Guidance is available from "Children First" National Guidelines for the Protection and Welfare of Children 1999.<sup>28</sup> (Level IV).

## Readiness to Change

Women experiencing violence do not always want to leave but do want the violence to end. You will need to assess her readiness to change her situation through conversation and experience.

Almost all GPs/PNs will be familiar with the wheel of change, as described by Prochaska and DiClemente. (Grade D)

The model defines five separate stages of change.<sup>29</sup>



See **Appendix 1** for further explanation of the application of the wheel of change model to domestic violence.

Another intervention model adapted to domestic violence is described in **Appendix 2**.

## Good Practice Guidelines

The HSE Guidelines for Professionals (**Appendix 3**) provides a helpful summary of practical suggestions for managing disclosure.

## Confidentiality

Confidentiality is vital in dealing with domestic violence. This is particularly important in general practice, where other members of a woman's family – possibly including the perpetrator of violence - may also receive treatment. It is not a conflict of interest to continue providing care for her abuser at the same time as caring for her.<sup>30</sup> (Level IV)(Grade C).

### **Discussion / Consulting Environment<sup>19</sup>**

- Ensure that reception staff are appraised in handling sensitive situations e.g. a woman attending in crisis without an appointment.
- Never ask a woman about violence unless she is alone (this includes children). The only exception to this would be when a professional interpreter is present.
- Consider discussing an 'alibi' diagnosis for her to use in case she is questioned by her abuser about attending the surgery.
- Information about a patient should not be discussed with other staff members unless you have received permission from the patient.
- Should you find a need to discuss a patient with a colleague, anonymising the case may allow you to do so whilst retaining confidentiality.

(Grade C)

## Record-keeping

Clinical notes on disclosure or discussion of domestic violence are particularly sensitive.

- 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 paper file.<sup>19</sup>
- Remember that your clinical notes may be the only contemporaneous record of evidence in subsequent legal proceedings.
- Keep a record of the content of discussion as statements made may be admissible as evidence of 'recent complainant', i.e. such evidence may assist the jury in deciding the weight to be attached to the victim's testimony.<sup>31</sup>
- Even if your suspicions of abuse haven't led to a disclosure, keep a record of what was discussed.
- Some computer software packages provide varying levels of access to information and sensitive data can be stored at heightened privacy level. Information about managing and protecting personal health information is given in documentation by the GPIT group in the ICGP.<sup>32</sup> If in doubt, check with your software provider. A document has been written in anticipation of changes in certification requirements to existing and new GP software products; the changes to certification will require all software packages to provide different levels of access to data, and will take place June to October 2008.
- If you cannot guarantee confidentiality of records on her file in your computer software or your usual paper files, then keep separate paper records.

(Grade C)

### Recommendations for Note-keeping (Grade C)

(Adapted from Women's Aid, Responding to Domestic Abuse: a handbook for health professionals 2005)

- Date and time of consultation, date (and time if available) of incident(s) as reported to you.
- Names of victim, perpetrator, their relationship to one another, and any witnesses present – **not** 'she' or 'Mr. X'
- Specific details of abuse/injuries, preferably in the victim's own words using quotation marks.
- Use a body map to indicate injuries to the body, if appropriate. New body maps can be added to the file at a later date for separate incidents. (see **Appendix 5** for copy of same)
- Record your opinion at the time on whether the visible injury is consistent with the story as it has been told to you. If called upon to provide this opinion at a later time it may be difficult if your notes are incomplete.

### Recommendations for Photographing Injuries (Grade C)

(Adapted from Women's Aid, Domestic Violence & Sexual Assault Investigation Unit)

- Photograph visible injuries (with the patient's permission) where possible, using a Polaroid camera.
- If you do not have a camera which provides instant pictorial records, you may use a disposable camera but **do not** send it to an external film laboratory for processing (breach of confidentiality); if the images are required for evidence at a later time the camera can then be passed on to the Garda Síochána for processing.
- Avoid the use of a digital camera as the images produced may not be legally admissible as evidence.
- When taking pictures, the first in the sequence should be of the victim's face; the back of the picture should be numbered (1, 2, etc.), dated and timed, with your signature and if possible, the signature of the victim also. Proceed in this way with all photographs taken, numbering them in sequence.
- You must have the patient's explicit informed consent in order to take photographs; the individual should be made aware of the potential future use of the images as evidence and the fact that they may be viewed in an open forum e.g. courtroom. It is important to document the discussion and her agreement clearly in her medical record.

Offer her a chaperone in the room for photographing. She may or may not wish to have one. Be guided by what the woman wants at that time.

## Sharing Information

- No third party - apart from the Courts – may obtain access to a person's file without their consent. (Freedom of Information Acts 1997, 2003 and Data Protection Legislation)<sup>33-36</sup>
- Even if a third party somehow obtained consent to access a file, a GP can refuse to disclose the information if (s)he feels there is a possibility of harm resulting to his/her patient.
- The third party may appeal this by approaching the Data Protection Commissioner (in the case of Data Protection disclosure) or the HSE in the case of a GMS patient (Freedom of Information Act), but access is likely to be denied if it can be demonstrated that the patient provided consent to third party access under duress or that there was no valid reason for the third party having access.
- Electronic and paper records are protected similarly under the Data Protection Amendment Act 2002; the right of access is the same for both types of records.<sup>32</sup> (Grade B)

If involving an external agency in the immediate phase, (e.g. domestic violence agency, the Garda Siochana) it is often advisable to encourage your patient to make the contact herself.<sup>19</sup> (Grade C). This may take the form of a telephone call in the privacy of your consulting room with your encouragement.

If you intend to share information about the woman with another body, **ask permission first**. Information may be required by the law (Garda Siochana or the Courts), or may be needed by an agency in providing support for your patient.

However it is important to realise, and explain to a woman who makes a disclosure to you, that there are **limits to confidentiality**. This is particularly true in cases where you suspect that a child might be at risk of abuse or neglect.<sup>28</sup>

Consider liaising with your medical defence (insurance) body prior to disclosure of information with a third party.

## Safety & Escape Plans

In most cases domestic abuse occurs repeatedly, and in most cases the woman returns home to the setting in which it occurs.<sup>19</sup> (Level III). Any woman who discloses abuse should have **safety** and **escape** plans discussed with her – by her GP or a support agency representative.<sup>19</sup> (Grade C)

***For most women it's safer not to take away a written plan with them.***

***The most dangerous time for a victim of violence is when she is on the verge of leaving, and for six months afterwards.***

(Adapted from: Responding to domestic abuse: a handbook for health professionals)<sup>19</sup> (Grade C)

### **Safety plan discussion items:**

- places to avoid when the abuse starts (e.g. the kitchen where there are potential weapons)
- if/when abuse starts advise her to curl up in a ball with hands over her head
- scream loudly whilst being hit
- identification of individuals who might be called upon for help or when in immediate danger e.g. a neighbour
- asking neighbours/friends to ring 999 or 112 if they hear anything suggestive of danger
- places to hide important phone numbers
- how to keep children safe when abuse starts
- teaching children to find safety, or get help, teaching to ring 999 or 112
- keeping important personal documents in one place so that they can be taken quickly if a woman needs to leave immediately

### **Escape plan discussion items:**

- pack an emergency bag +/- important documents, and hide it
- put aside money/credit card/mobile phone in same kit
- plan for who to ring/where to go e.g. refuge, secret safe location

### **Follow-up safety:**

- changing landline and mobile phone numbers
- how to keep her location secret from abuser
- how to get a safety/barring/protection order
- plans for talking to children about safety

(Adapted from: Responding to domestic abuse: a handbook for health professionals)<sup>19</sup> (Grade C)

## Groups for Particular Consideration

<p><b>Pregnant Women</b></p>	<p>Pregnant women are particularly at risk of abuse by a partner. Of women experiencing domestic violence, 25% are assaulted for the first time during pregnancy.<sup>37</sup> (Level III). One in eight Irish women suffer abuse during pregnancy, according to a study conducted at the Rotunda hospital.<sup>38</sup> (Level III)</p> <p>GPs and PNs should have a heightened awareness of these facts during antenatal visits. (Grade B)</p>
<p><b>Mental Health Problems</b></p>	<p>Domestic Abuse is closely linked with mental health issues (including substance misuse problems). Up to 64% of hospitalised female psychiatric patients have histories of being physically abused as adults.<sup>39</sup> (Level III)</p> <p>Women with mental health problems (e.g. depression, learning difficulties) are more at-risk of domestic violence, as the nature of their problems renders them vulnerable and their partners may also have characteristics which increase the likelihood of them being abusers.</p>
<p><b>Members of the Travelling Community</b></p> <p><b>Immigrant Women</b></p> <p><b>Women with disabilities</b></p>	<p>These groups represent individuals who are marginalised in society, and may have some common risk factors and other inherent factors which present problems in dealing with DV:-</p> <ul style="list-style-type: none"> <li>• higher levels of dependency upon others, possibly including their abuser</li> <li>• higher incidence of socioeconomic deprivation</li> <li>• relative isolation from friends, family, society, and services which may help them</li> <li>• may hail from cultures which uphold a man's power over 'his' woman, or have real or perceived immigration/naturalisation issues</li> <li>• may have lower literacy levels and/or fluency in English</li> </ul> <p>If a language interpreter is required, employ a professional one – NOT a friend or member of the family. (Grade B)</p> <p>If only a male interpreter is available, check with your patient if this is acceptable. (Grade B)</p>

## C. Refer

Referral, in the context of women suffering from domestic violence, is different from the standard referral process familiar to GPs. The approach when such a disclosure is made should be to empower the woman to undertake action that she deems appropriate at a time that she deems appropriate. (Grade B). The term 'refer' in this context describes the intervention whereby a doctor provides a woman with information about the resources available to her, and encourages her to contact those specialist support or state agencies which are in a position to help her when she is ready to do so. Counselling is important in supporting the woman so that she may soon find herself in a position to make a change.

These supports take the form of

- Specialist agencies, providing advice and counselling about options (e.g. Women's Aid, Dublin Rape Crisis Centre)
- Accommodation provision / "safe house" (women's refuges)
- Provision of protection (an Garda Siochana / Legal Aid / the Judiciary)

Referral to another individual or agency should have the approval or expressed consent of the client, as direct 'referral' of a woman by GP to an agency or an Garda Siochana without the woman's direct involvement is rarely helpful and potentially harmful.

Women should be advised to telephone ahead prior to accessing certain services; this is particularly true in the case of women's refuges where accommodation facilities may be limited.

Accessibility of services varies depending on your location and it is important for you to familiarise yourself with local services, particularly when you move into a new practice. **Appendix 5** lists services on a national level and a guide to accessing local services appropriate for your use.

### Legal Aspects of Violence – Ireland

#### **The Garda Siochana**

The Gardai may be the first point of contact for many women in crisis. A Policy document on Domestic Violence Intervention was updated in 1997 and it sets out a **pro-arrest** policy. Some provisions of the policy are as follows:

- if a safety / barring / interim barring / protection order is in existence, the Gardai will always arrest where there is a reasonable cause for believing that the order has been contravened.
- on receipt of a complaint of domestic violence, the investigating officer should deal with the matter promptly, and on the basis that s/he is dealing with a crime and that life and property may well be at risk
- station bail should not be granted to the accused as the likelihood of intimidation to the injured party is extremely high
- The victim should be provided with information on the civil remedies available.
- the investigating Garda should give the victim his/her name in writing, along with the name of the station and telephone number (call card). The Garda should call back to the victim at least once in the following month.<sup>40</sup>

In the case of sexual assault, a Garda usually accompanies the victim to the local Sexual Assault Assessment unit (SATU). If the woman opts not to have contact with the Gardai she may access the services of the local SATU. See page 22 of document available at: <http://www.icgp.ie/index.cfm/loc/6-14-3/articleId/17E8DE25-A6A3-02CA-3DCDBB88C6767C80.htm> for flow-chart for guidance in these circumstances.<sup>41</sup>

## The Judiciary

The Domestic Violence Act (1996) and its Amendment (2002)<sup>42,43</sup> lay out provisions for civil legal processes available for implementation by a Court of Law. The Act considers cohabiting, yet unmarried, couples, differently and specifications about orders are available from Legal Aid at [http://www.legalaidboard.ie/lab/Publishing.nsf/Content/Leaflet 7](http://www.legalaidboard.ie/lab/Publishing.nsf/Content/Leaflet_7)<sup>44</sup>.

- **Safety Order**  
This order prohibits a person from further violence or threats of violence. It does not oblige that person to leave the family home. If the parties live apart, the order prohibits the violent person from watching or being in the vicinity of the home.
- **Barring Order**  
This order requires the violent person to leave the family home.
- **Protection Order**  
This order may be granted immediately in order to protect the victim whilst waiting for the courts to decide on an application for a safety / barring order. It has the same effect as a safety order and is intended to last until the court decides on the case.
- **Interim Barring Order**  
Granted in exception circumstances, this is as immediate order requiring the violent person to leave the family home, pending the hearing on an application for a barring order.

	<u>Applications</u>	<u>Granted</u>
Safety Order	3,050	1,221
Barring Order	3,132	1,357
Protection Order	3,137	2,845
Interim Barring Order	605	544

The latest available Irish statistics show that applications against spouses accounted for more than 50% of all applications made. Applications again 'common law' or cohabiting partners accounted for almost 33% of all applications.<sup>45</sup>

The Legal Aid board provides legal advice in civil cases to persons who satisfy the requirements of the Civil Legal Aid Act 1995. The applicant is means tested.

Court accompaniment services are available through various support agencies.

## Dealing with your frustrations

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

- Realise early that a woman may never leave her 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.
- Don't act as a case-worker for the woman once you have referred her to sources of help; remember that there are DV agencies that fulfil that role.
- Get to know as much as you can about how DV is being responded to at a local level. At a bare minimum you should know the DV support agencies in your area so that you can provide accurate information for your patients.
- Don't feel you have to know everything there is to know about DV. Listening and communicating support and accurate contact details for an external support agency, is better than not talking about it at all.
- GPs / PNs should be aware of their own safety needs; perform a safety review for the practice and its staff frequently. Should a violent incident occur at the Surgery, perform a staff debriefing session. Violence affects everybody differently.
- Look after yourself: working with the effects of DV professionally can bring to the surface personal issues – particularly if you are experiencing or have experienced abuse yourself. There are examples of agencies for GP/PN support in the directory at the back of this document.

## Appendix 1

### Stages of Change

Stages of Change	Patient's Belief	Physician "nudging" strategies
Pre-contemplation	"My relationship is not a problem"	Learn about the relationship. "Tell me how you and your partner handle conflict in your relationship".
Contemplation or ambivalence	"I know the violence is a problem, but I need to stay in the relationship."	Discuss the ambivalence. "What are the good things about your relationship?" What are the not-so-good things?" "How would you change things if you could".
Preparation	"The violence is a problem, and I'm planning some changes."	Offer support and encouragement. Clarify plans. List community resources. Provide anticipatory guidance.
Action	"I am making changes to end the violence".	Offer support and encouragement. List community resources. Provide anticipatory guidance. Review coping strategies.
Maintenance	"I have adapted to the changes."	Offer support. Review need for community resources. Discuss coping strategies.
Relapse	"I cannot maintain this change."	Remain positive and encouraging. Discuss lessons learnt from the effort. Review Safety Plan. Remain open for future discussions.

"Stages of change" for women affected by domestic violence (Prochaska et al, 1994)<sup>46</sup> (Level IV).

## Appendix 2

### Working from where the woman is at (crisis intervention) <sup>47</sup>

This model is adapted by Women's Aid from a conference presentation by Dr. Liz Kelly

- The Crisis Intervention model highlights the different processes a victim 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 victim 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 victim is at and to inform our good practice response
- When working with a victim 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



Fig. 1 Intimate Partner Violence: Working from where the woman is at Adapted from Dr. Liz Kelly

## Appendix 2 (continued)

### Intimate Partner Violence: Working from where the woman is at

The following are brief descriptions of the processes illustrated in Fig. 1

#### Managing the Situation

- This process involves the point when the violence is first experienced and is a crisis in the relationship. The victim will generally experience shock or disbelief. Some women may end the relationship at this point, the majority do not
- The victim 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 victim'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 victim may now start to define what is happening as abuse
- She may acknowledge her partner as an abuser, and recognise herself as a victim
- She may put responsibility for the abuse on the abuser, but the abuse may still continue.

#### Re-evaluation 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); 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.)

#### 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.*

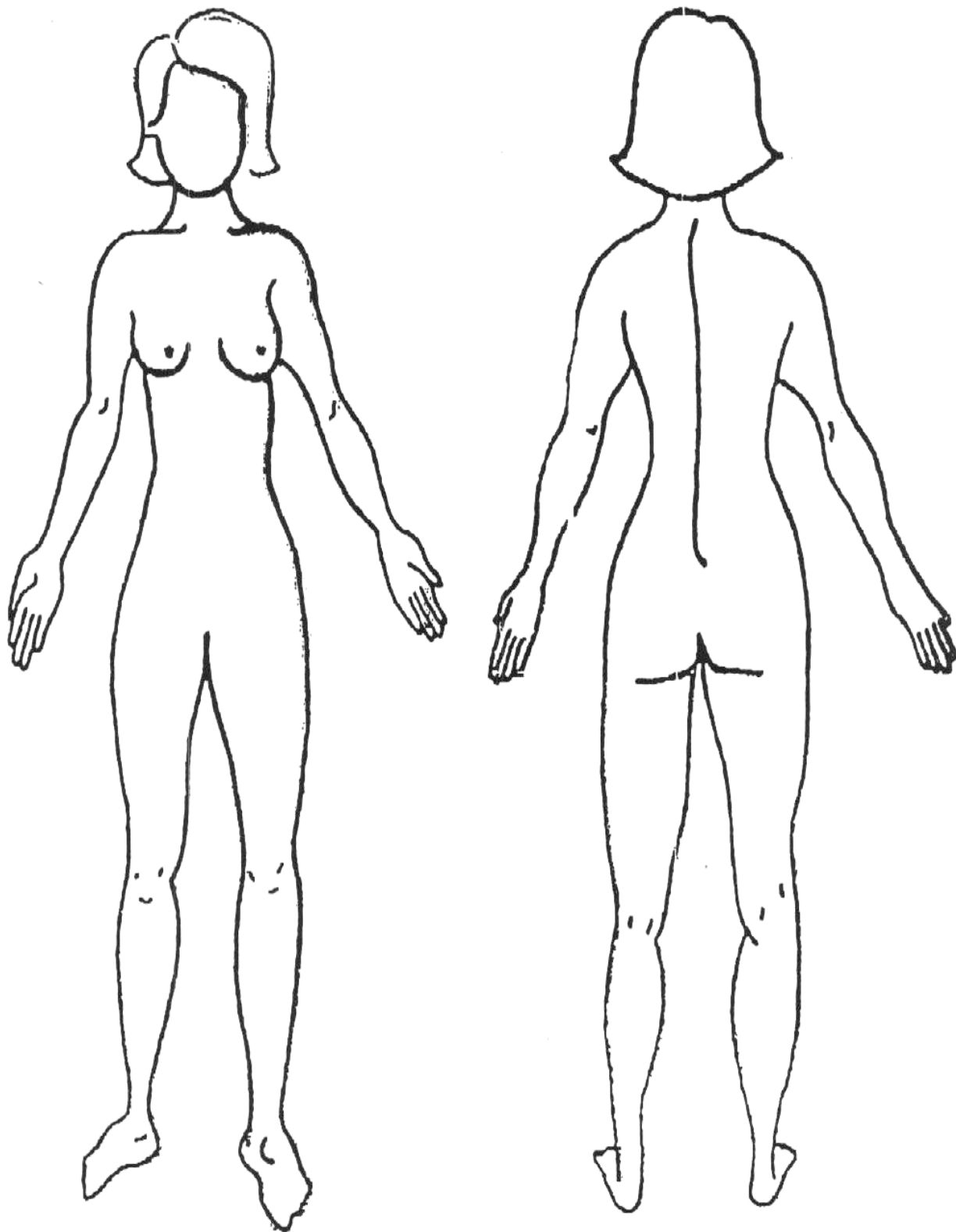
## Appendix 3

### Good Practice Guidelines<sup>47</sup>

- Confidentiality is crucial and must be in keeping with current legislation, service protocols and good practice
- Recognise her need for a positive response and your support
- Priority must be given to ensuring woman's immediate safety
- Examine and record appropriately
- Observe ethical and statutory codes pertaining to information about children
- Help her explore ways of maximising her safety – whether she leaves home or not
- Consult with appropriate agencies/individuals for info. and services available
- Check if it is safe to contact her by post or phone
- Give written information to patient e.g. leaflet or even telephone number
- Make your practice 'disclosure-friendly' – display posters and leaflets in waiting room, place literature/telephone number in ladies' toilet.
- Adopt an anti-racist code of practice
- Be sensitive to and discuss her concerns
- Take her seriously, believe her, create the necessary conditions to disclose
- Keep in contact with her if possible
- Keep appropriate records
- Be aware of current legislation

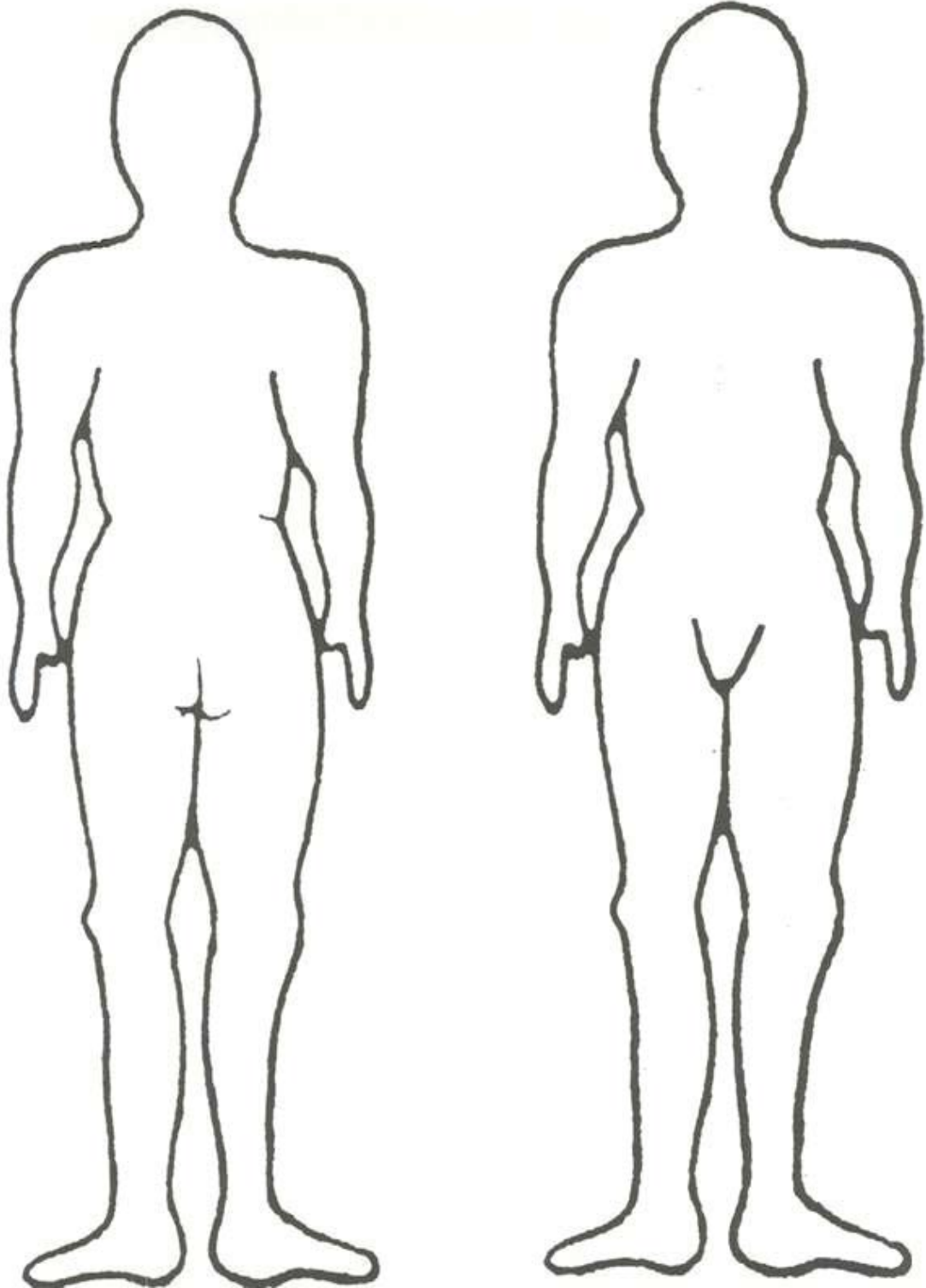
Appendix 4

a. Female body map



Appendix 4

b – Male body map



## Appendix 5

### Useful Contacts

#### National / Freephone Contacts

<b>Women's Aid</b>	47 Old Cabra Road Dublin 7	<b>Freephone: 1800 341 900</b> (10am – 10pm, 7 days)	<a href="http://www.womensaid.ie">www.womensaid.ie</a>
<b>National Network of Women's Refuges and Support Services</b>	27 Church Street Athone Co. Westmeath	<b>Telephone: (090) 647 9078</b> (office hours)	<a href="http://www.nnwrss.ie">www.nnwrss.ie</a>
<b>Dublin Rape Crisis Centre</b> <i>(provides services for women and men)</i>	70 Leeson Street Lower Dublin 2	<b>Freephone: 1800 778 888</b> (24 hours, 7 days) <b>Telephone: (01) 661 4911</b>	<a href="http://www.drcc.ie">www.drcc.ie</a>
<b>Rape Crisis Network Ireland</b>	The Halls Quay Street Galway	<b>Telephone: (091) 563 676</b> (office hours)	<a href="http://www.rcni.ie">www.rcni.ie</a>
<b>Sexual Assault Treatment Unit</b>	Rotunda Hospital Dublin 1	<b>Telephone: (01) 873 0700</b> (24hours, 7 days)	
<b>AMEN</b> <i>(supports male victims of domestic abuse)</i>	St. Anne's Resource Centre Railway St. Navan Co. Meath	<b>Telephone: (046) 902 3718</b> (office hours)	
<b>Childline</b>		<b>Freephone: 1800 666 666</b> (24 hours, 7 days)	
<b>Samaritans</b>		<b>Freephone: 1850 609 090</b> (24hours, 7 days)	
<b>National Counselling Service</b> <i>(HSE-funded free counselling for adults &gt; 18yrs who have experienced any form of childhood abuse)</i>		<b>Freephone: 1800 235 235</b> (office hours)	
<b>Legal Aid Board</b>			<a href="http://www.legalaidboard.ie">www.legalaidboard.ie</a>
<b>Language Interpretation Services</b> <i>(Provided by HSE Primary care unit to GMS-contracted General Practitioners)</i>		<b>Telephone: (01) 460 9667</b> (office hours)	
<b>Health in Practice Programme</b> <i>(support for GPs and practice staff)</i>		<b>Telephone: (01) 676 3705</b> (office hours)	<a href="http://www.icgp.ie/hip">http://www.icgp.ie/hip</a>

#### Local Contacts

Local useful resources will vary according to your region.

Log onto [www.hse.ie](http://www.hse.ie) and enter **domestic violence** in the search box on the homepage;

or click [http://www.hse.ie/eng/Find\\_a\\_Service/Children\\_and\\_Family\\_Services/Domestic\\_Violence\\_and\\_Sexual\\_Violence/](http://www.hse.ie/eng/Find_a_Service/Children_and_Family_Services/Domestic_Violence_and_Sexual_Violence/) to bring you directly to the page. Your region is listed, just click on it to obtain details.

(listings are given in Adobe format, and may take some minutes to upload onto your screen).

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