Quality in Practice Committee

Domestic Violence: A Guide for General Practice

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This guidance represents the view of the ICGP which was arrived at after careful consideration of the evidence available.

The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

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.

In this document you will see that evidence and recommendations are graded according to levels of evidence (Level 1 – 5) and grades of recommendations (Grades A-C) respectively. This grading system is an adaptation of the revised Oxford Centre 2011 Levels of Evidence.

LEVELS OF EVIDENCE

Level 1: Evidence obtained from systematic review of randomised trials

Level 2: Evidence obtained from at least one randomised trial

Level 3: Evidence obtained from at least one non-randomised controlled cohort/follow-up study

Level 4: Evidence obtained from at least one case-series, case-control or historically controlled study

Level 5: Evidence obtained from mechanism-based reasoning

GRADES OF RECOMMENDATIONS

A Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (Evidence levels 1, 2)

B Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation. (Evidence levels 3, 4).

C Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (Evidence level 5).

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1. Introduction

1.1 Background

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. Other terms are also used in the literature. These include: domestic abuse, sexual violence/abuse, and gender based violence. The Report of the Task Force on Violence Against Women (1997) [1] defines domestic violence as:

> *"...the use of physical or emotional force or the 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. 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."*

Domestic violence can be physical, sexual and/or psychological. It is common, serious and often not identified. 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 [2].

Domestic violence can occur in any intimate relationship. While men may be the victims, most severe domestic violence is perpetrated by men against women and their children. In the international literature, the vast majority of victims of domestic violence are women (Level 4) [1,3,4]. The WHO estimates that 20% of women face some form of violence during their lifetime, in some cases leading to serious injury or death (Level 4) [5]. An EU report (2013) acknowledges the difficulties in estimating prevalence of intimate partner violence and the incompleteness of the picture provided by national crime statistics but cites these as best data currently available. This report found that the victims of intimate partner violence are women in 70–90% of cases according to national crime statistics in the EU 27 (Level 5) [6]. A similar pattern is seen in US crime statistics [7].

In the Irish context, the National Study on Domestic Abuse reported that 15% of women and 6% of men had experienced severe abuse (Level 4) [8]. This study also reports that women are twice as likely to experience severe physical abuse, seven times more likely to experience sexual abuse and three times more likely to experience severe emotional abuse than men. Irish research has reported the prevalence of domestic violence against women from 18% [9] to 39% (Level 4) [10].

For the majority of victims, violence is endured as a chronic long-term condition that escalates over time. By the time a victim's injuries are visible, violence may be a long-established pattern. For some victims, escalation is fatal. The ultimate preventable outcome can be homicide. One hundred and eighty six women have been murdered in the Republic of Ireland since 1996 [11]. One hundred and fifteen (62%) were killed in their own homes. In the resolved cases, 71 women (53%) were murdered by a partner or ex-partner and a further 47 were killed by someone they knew (e.g. brother, son, neighbour).

While domestic violence is prevalent, it may not be recognised for a variety of reasons. Victims of domestic violence are not likely to disclose unless directly asked and the strongest determinant of disclosure is clinician inquiry (Level 4) [12].

Why victims don't tell

- The reasons are often complex
- Clinicians don't ask directly
- Clinicians had insufficient time
- Fear of legal involvement
- Concerns about confidentiality (Level 4) [12].

Why clinicians don't ask

- Lack of time
- Behaviours attributed to women living with abuse (frustration that they stay in an abusive situation)
- Lack of training
- Language/cultural practices
- Partner presence
- Lack of resources
- Lack of space /privacy
- Discomfort with topic (Level 4) [13].

Societal factors

- Family violence challenges our sense of security as the home should be the basis of a good community rather than the site of greatest danger
- The high level of violence we tolerate as a society (e.g. some sports, film and TV) can be seen as normalising this behaviour (Level 4)[14].

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Women are not likely to disclose domestic violence, particularly in the early stages. If a woman decides to disclose, her GP is the most likely professional to whom she will disclose (Level 4)[9]. Therefore it is important that GPs have confidence in dealing with cases when they do arise and respond appropriately. The central role of the GP is recognised in the 1997 Task Force Report on Violence Against Women[1].

Most of the literature cited in this guideline refers to research that has been carried out with women victims. For these reasons, the guideline refers predominantly to those experiencing domestic violence as women and those perpetrating it as men. Current literature has identified differences in presentation, severity and outcome between female and male victims. Therefore, it may not be appropriate to assume that findings from research on female victims inevitably apply to male victims.

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

Due to the very nature of domestic violence, most studies are conducted using qualitative research, and this dictates that the levels of evidence quoted are of a lower level.

1.2 Aims of this Document

This document will provide primary care practitioners (GPs and practice nurses) with:

- Understanding of the nature of the problem of domestic violence
- Confidence on when and how to ask a patient about violence and/or abuse
- Knowledge of the appropriate care and supports for a patient who has disclosed violence
- Support in improving the quality of service for those who have experienced domestic violence.

1.3 Key Points

1	Domestic violence can be physical, sexual and/ or psychological. It is common, serious and frequently not identified. It can occur in any intimate relationship.
2	Both women and men experience violence. However, the prevalence of more serious abuse is far higher for women.
3	The first step is to identify domestic violence and then offer help. The aim is not to fix the problem but to acknowledge the issue, inform the victim about options and support their decisions.
4	Domestic violence may result in physical injury, chronic physical ill health and/or emotional and mental health difficulties. It may result in death. 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.
5	Victims may stay in abusive relationships for a number of different reasons.
6	A woman is most at risk when she decides to leave a violent relationship.
7	Violence can begin or escalate in pregnancy.
8	Children are affected by domestic violence. They may be victims, witnesses or forced to participate in the violence. Where a risk to children is identified, immediate action must be taken.
9	Contemporaneous medical records documenting injuries/incidents are helpful if legal action is subsequently taken.
10	Referral in the case of domestic violence may take the form of signposting specialist services such as the Women's Aid helpline (1800 341 900 *www.womensaid.ie*), Rape Crisis Centres through the Rape Crisis Network (*www.rcni.ie*) Dublin Rape Crisis Centre's 24hr Helpline 1800 77 88 88, Sexual Assault Treatment Units (*www.hse.ie/satu/*), Safe Ireland for contact details for refuges and support services around the country (*www.safeireland.ie*), and Amen (domestic violence support service for men experiencing domestic violence) 046-9023718.
11	Where a GP or practice nurse suspect domestic violence but there is no disclosure, it is important to keep the door open and signal willingness to help at any stage in the future.

2. Dealing with Domestic Violence

Possibly the most significant important role of the GP or practice nurse is to listen and support.

The approach to dealing with domestic violence can be summarised as follows:

Recognise:	know the signs, indications and sequelae of abuse
Respond & Record:	know how to deal with the issue of abuse
Refer:	make a good, appropriate referral
Review:	ensure that patient is encouraged to return for follow up

2.1 Recognise

What is domestic violence?

Violence is best viewed as a continuum, a 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 domestic violence outlined in Chapter 1. It encompasses mental, physical, economic and sexual abuse.

Who is at risk of violence?

No individual is immune to domestic violence.

It is common, serious, and often not identified. 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.

There are certain societal groups who are statistically more likely to be victims. The greatest risk factor is being female and the majority of published evidence relates to women as the victims of male intimates. A WHO multi-country study reported a lifetime prevalence of domestic violence in 25,000 women in 10 countries that ranged from 15% to 71% (Level 3)[15].

Men may be victims of female intimates. Domestic violence may also occur in same-sex relationships. There is much less published evidence on these categories of domestic violence.

How do abused women present? (Level 3)[3, 14]

- no disclosure and no single 'event', but possible frequent presentation with one or more medical/ psychological problems
- with mental health problems caused by, affiliated with, or masking domestic violence
- no disclosure but presentation after an event, needing medical care
- injuries seem inconsistent with the explanations
- evidence of multiple injuries at different stages of healing
- use of the 'calling card' of seemingly minor complaints
- 'by proxy' e.g. frequent visits for minor complaints in a seemingly well child
- make a verbal disclosure about violence with no physical injuries
- make a verbal disclosure whilst needing care for injuries.

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.[16] (Level 4)

How do abused men present?

Men are less likely to be victims of domestic violence than women (Level 4)[4–8]. Where they are victims, the patterns of abuse and health consequences are different. Male victims are less likely to have been repeatedly abused or seriously injured and are less likely to request medical treatment for their injuries(Level 4)[8, 17]. The limited literature on this topic provides conflicting evidence with regards to the likelihood of male victims disclosing details of the abuse. The Irish National Crime Council study reports that the gender differences in terms of disclosing to friends or family are not statistically significant, but that women are more likely than men to report to the Gardaí (Level 4)[8]. This study does not report on the gender differences in disclosing to health care professionals. Other work suggests that men may be less likely to present to a GP as a consequence of the less serious nature of their physical injuries[17].

Children and Violence

Family violence and child abuse frequently co-exist (Level 4)[18]. A landmark study in Ireland in 1995 showed

that 64% of women who experienced violence reported that their children had witnessed the violence [9]. Children who have been exposed to family violence may have long-term physical, psychological and emotional effects (Level 4) [19, 20]. 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. 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)
- 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.

Requirements to report child abuse of any form are currently described in the Criminal Justice Act (2006) Part 15, Section 2(a): Reckless Endangerment of Children [21] and the The Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 [22]. It is a criminal offence to withhold information in relation to serious specified offences committed against a child or vulnerable person including sexual offences and offences causing harm, abduction, manslaughter or murder. The 2012 Act outlines a number of potential defences that a person may rely on for failing to disclose relevant information where the child or vulnerable person who revealed the information requests that it not be further disclosed. Defences will also be in place for those such as a parent, guardian or medical professional who does not disclose, believing they are acting in the interests of the health and well-being of the child or vulnerable person.

The legislation relating to reporting of reasonable concerns regarding child abuse is evolving in Ireland with a Children First Act likely to be enacted in 2014. This Act will establish the Children First National Guidelines on a statutory basis.

The Children First National Guidelines for the Protection and Welfare of Children 2011 are issued by the Department of Children and Young Adults and deal with the recognition, reporting and management of child safety concerns [23]. Compliance is voluntary until the Children First Act is enacted. These guidelines provide general guidance and can be accessed at *http://www.hse.ie/eng/services/Publications/services/Children/cf2011.pdf*

Advice from medical indemnity organisations may be helpful in individual cases.

Vulnerable Groups

Pregnant Women

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 (Level 3) [24]. One in eight Irish women suffers abuse during pregnancy (Level 3) [25, 26].

GPs and practice nurses should have a heightened awareness of these facts during antenatal visits (Grade B).

Women with Mental Health Problems

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 (Level 3) [27]. 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.

Members of the Travelling Community/
Members of Migrant Communities/
Persons with disabilities

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 domestic violence:

- higher levels of dependency upon others, including their abuser
- higher incidence of socioeconomic deprivation
- relative isolation from friends, family, society, and services which may help them
- may hail from cultures which uphold a man's power over 'his' woman
- have real or perceived immigration/naturalisation issues
- may have lower literacy levels and/or fluency in English

If a language interpreter is required, employ a professional one – NOT a friend or member of the family (Grade B). If only a male interpreter is available, check with your patient if this is acceptable (Grade B).

Outcomes of domestic violence

The outcomes of domestic violence impose a substantial burden on the health and social services (Level 4) [14, 20]. Domestic violence may result in, or contribute to, a range of outcomes including:

Fatal outcomes

- Homicide
- Suicide
- Maternal mortality

Physical

- Injuries (fractures, cuts, knife wounds, lacerations, bruises, burns)
- Loss or impairment of hearing or vision
- Physical symptoms
- Poor subjective health
- Permanent disability
- Obesity

Chronic conditions

- Chronic pain syndromes
- Gastrointestinal disorders
- Range of somatic conditions

Mental health consequences

- Depression
- Anxiety
- Phobias
- Self-harm
- Post traumatic stress disorder
- Sexual dysfunction
- Substance misuse

Reproductive health effects

- Rape
- Unwanted pregnancy
- Pregnancy complications
- Miscarriage
- Low birth weight
- Unwanted abortion
- Sexually transmitted infections
- Pelvic inflammatory disease
- Recurrent urinary tract infections

Negative health behaviours

- Smoking
- Alcohol and/or drug misuse
- Physical inactivity
- Overeating
- Prostitution
- Frequently missed medical appointments
- Frequent appointments of self or children for apparently minor complaints
- Partner always/often present at consultation

Outcomes of domestic violence

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Abused women visited their GP almost twice as often than non-abused, in particular for social problems, substance abuse and reproductive health problems (Level 4) [28]. A literature review reports that "the outcomes of domestic violence in terms of physical and psychological injuries tend to be considerably more negative for women victims than for men victims" (Level 5) [29]. The National Domestic Abuse study in Ireland found that women are twice as likely as men to require medical treatment and ten times more likely to require a hospital stay (Level 4) [8].

Abusive men as patients

Some men may identify their abusive behavior directly and ask for help to deal with it. This is likely to have been prompted by a crisis such as a particularly bad assault, an arrest or ultimatum from the abused party. Such patients – even though they have come voluntarily – are unlikely to admit responsibility for the seriousness or extent of the abuse [20]. In Ireland, there are a number of specialist treatment services for male perpetrators of domestic abuse (listed in Appendix 3 and on *www.cosc.ie*).

Abusive men as partners of patients

You may encounter 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 surgery/hospital and be in the waiting room or want to stay with the woman at all times. You may have patients whom you know to be abusive because their partners are also your patients and they have told you about it. These men may appear to you to be caring and protective of their partners and very plausible [20].

2.2 Respond and Record

When the GP becomes aware of domestic abuse, the aim is not to "fix the problem" but to acknowledge the issue, inform the victim about options and support their decisions (Grade B). Continuing understanding and support are vital as it may take a victim, demoralised by years of violence and abuse, a long time to find the confidence and courage to choose a different life.

Ask

Clinicians should be prepared to ask simple, direct questions, if there is any clinical suspicion (Grade B) [20].

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 (Level 3) [30]. In cases where a patient's behaviour, symptoms or injury patterns give rise to suspicions but she does not discuss it, you may need to ask the question. The evidence regarding male victims is less clear. While men may be less likely to disclose domestic violence those who disclose may do so at an earlier stage (Level 4) [8, 17].

Disclosures of Violence

Responding to disclosures of violence (Grade B) [31]

- 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 the 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. 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 (Level 4) [4].

Patient screening or selective questioning?

- Screening/ routine enquiry may be defined as asking the question/set of questions of all women on at least one occasion.
- Selective questioning 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 (Level 5) [32].

While there is ongoing debate on which approach is most effective, recent randomised trial level evidence does not support universal screening (Level 1) [33, 34]. Many services in the UK still recommend routine enquiry. The Royal Australian College of General Practitioners recommend routine enquiry in pregnancy and selective questioning otherwise [14].

The majority of women do not object to being asked about domestic violence (Level 3) [13, 35]. In one Irish study, 77% of women were in favour of routine questioning [10] and this positive attitude toward routine questioning has been reproduced in the maternity hospital setting [26]. Only 12% of Irish women reported that they had been asked by their general practitioner about violence [9]. Of the women who had been injured by their partner, only 20% of them reported that their doctor had asked about violence [10].

GPs and practice nurses will need to apply clinical decision making in deciding how and when it is appropriate to ask about domestic violence issues (Grade A).

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 [4, 20]

Do not ask a patient about violence unless the patient is alone and you cannot be overheard. (Grade B).

Sample questions (Grade B)[31]

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?

In response, a patient may confirm that there is indeed a violent relationship. Several professional bodies (support agencies, An Garda Siochána) use Risk Assessment Tools at this point to allow them to make a calculation of predicted future risk for the victim. 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. Where domestic violence is disclosed safety and escape planning should be discussed, either by the GP or by support agencies (Level 3) [4, 14, 20, 31]. Safety and escape planning is discussed on *page 9*.

Training and support for primary health care practitioners improves identification and referral of those suffering domestic violence (Level 2) [36]. Brief counselling provided by trained GPs is recommended in a cluster RCT from Australia as it has been shown to reduce depression at 12 months, but it did not improve quality of life, safety planning or behaviour (Level 2) [37]. The Readiness to Change models could be used (Appendix 1) [38].

No disclosure

If the patient does not disclose domestic violence, accept no as an answer and continue to be supportive [4]. Deal with any immediate healthcare needs [20]. If you suspect that violence has taken place then consider giving contact details for support agencies "just in case she or someone she knows ever needs it". Reassure her that she can come back at any time. However, if you suspect that children are being abused or are at risk of abuse, then you should follow child protection guidelines [23].

Confidentiality

Confidentiality is particularly important in the general practice setting, where other members of a victim's family – possibly including the perpetrator of violence – may also receive treatment. It is not a conflict of interest to continue providing care for the abuser at the same time as caring for the victim (Level 5) [39].

Consulting Environment (Grade C)[4]

- Ensure that all reception staff are aware of how to handle sensitive situations e.g. a woman attending in crisis without an appointment.
- Never ask a patient about violence unless the patient 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 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.
- Information literature and details of support agencies can be displayed in the waiting room and/or toilet facilities.

Record-keeping (Grade C)

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

- Keep detailed, accurate records about a victim's injuries and what is revealed 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 [4].
- 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 in legal proceedings i.e. such evidence may assist the jury in deciding the weight to be attached to the victim's testimony [40].

- Even if your suspicions of abuse haven't led to a disclosure, keep a record of what was discussed.
- Information about managing and protecting personal health information is given in the guide to data protection guideline by the GPIT group in the ICGP[41]. *http://www.icgp.ie/go/in_the_practice/information_technology/data_protection*
- Certified GP software products provide different levels of access to data and sensitive data can be stored at heightened privacy level.

Recommendations for Note-keeping[4] (Grade C)

- 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/injures
- 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. (Template body maps are included at Appendix 2)
- 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.

Photographic Evidence (Grade C)

- Photographic evidence may be of benefit if legal proceedings are subsequently taken
- The management of images by a GP from taking the photo on a smart phone or camera, uploading the photo to their desktop or laptop, storing and sharing the photo, is fraught with technical and confidentiality issues
- Current SATU guidelines[42] recommend that the most appropriate person to take photographs in the case of sexual assault cases is a Garda Photographer
- Photography of injuries by a Garda Photographer supports safe practice with regard to patient consent and continuity and storage of evidence
- GPs can discuss photography of injuries with a victim where appropriate
- Be aware of confidentiality and privacy issues
- Practice software systems are not enabled as photo management systems
- A victim may decide to photograph their own injuries and could email those photographs to their own email account as a repository of evidence
- If a GP decides to take photographs this should be done with consent from the patient
- Consider burning the photographs onto a CD and storing somewhere physically safe
- Be aware that sending photographs by normal email to patients (or other parties) would risk a breach of confidentiality.

Sharing Information

- No third party – apart from the Courts – may obtain access to a person's medical file without their consent. (Freedom of Information Acts 1997, 2003 and Data Protection Legislation)[43–46].
- 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 2003; the right of access is the same for both types of records[46].

If involving an external agency in the immediate phase, (e.g. domestic violence agency, the Garda Síochána) it is often advisable to encourage your patient to make the contact herself (Grade C)[4]. 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 patient with another body, **ask permission first**. Information may be required by the law (Garda Síochána 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 patient who makes a disclosure to you, that there are **limits to confidentiality**[23, 47]. This is particularly true in cases where you suspect that a child might be at risk of abuse or neglect.

Consider discussing with your medical indemnity organisation prior to disclosure of information to a third party.

Safety and Escape Plans

(adapted from UK Department of Health Guidelines)[4]

In most cases domestic abuse occurs repeatedly, and in most cases the woman returns home to the setting in which it occurs (Level 4). Any woman who discloses abuse should have **safety** and **escape** plans discussed with her in a collaborative, non-directive manner – either by a support agency representative or the GP (Grade C).

For most women it is safer not to take away a written plan with them (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
- identify 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 them 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.

2.3 Refer

Referral, in the context of victims of 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 patient to undertake action that she deems appropriate at a time that she deems appropriate (Grade B) [4, 14, 20, 31].

The term 'refer' in this context describes the intervention whereby a doctor provides a patient with information about the resources available, 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.

Referral to another individual or agency should have the approval or expressed consent of the patient, as 'referral' by the GP to an agency or an Garda Síochána without the patient's direct involvement is rarely helpful and potentially harmful. It is often advisable to encourage your patient to make the contact herself (Grade C) [4]. This may take the form of a telephone call in the privacy of your consulting room with your encouragement.

Supports available to victims of domestic violence include:

Specialist agencies providing advice, counselling or treatment

- **Women's Aid** *www.womensaid.ie* provides information and support for women who have suffered domestic violence. Freephone Helpline 1800 341 900 (10am – 10pm, 7 days).
- **Dublin Rape Crisis Centre** Freephone Helpline: 1800 778 888 (24hrs)
- There are six **Sexual Assault Treatment Units (SATUs)** in Ireland. Contact details can be accessed at *http://www.hse.ie/satu/*
- **Rape Crisis Network Ireland** (umbrella body for the Rape Crisis Centres) provides information and resources on rape and all forms of sexual violence. *www.rcni.ie*
- **AMEN** *www.amen.ie* provides support services for male victims of domestic abuse. Tel: (046) 902 3718 (office hours)

Accommodation provision (women's refuges)

- **SAFE Ireland** www.safeireland.ie provides contact details for refuges around the country

Provision of protection (an Garda Síochána / Legal Aid / the Courts)

- You can locate your local Garda station contact details at *www.garda.ie*
- The Courts Service *www.courts.ie* provides information on how to apply for safety or barring orders
- Legal Aid Board *www.legalaidboard.ie* provides free legal aid in civil matters for those who can't afford to pay and also has useful information leaflets.

Supports available according to gender of victim:

	FEMALE VICTIM	MALE VICTIM
Advice, counselling or treatment	Women's Aid Rape Crisis Network Ireland / Dublin Rape Crisis Centre Sexual Assault Treatment Units	Amen Rape Crisis Network Ireland / Dublin Rape Crisis Centre Sexual Assault Treatment Units
Accommodation provision	SAFE Ireland	
Protection	An Garda Síochána Courts Service Legal Aid Board	An Garda Síochána Courts Service Legal Aid Board

Local services: 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.

Cosc (*www.cosc.ie*), the National Office for Prevention of Domestic, Sexual and Gender-based Violence, provides publications and links to services.

In the case of sexual assault, the patient may choose to report to the Gardaí. In these circumstances, a Garda accompanies the victim to the local Sexual Assault Assessment Unit (SATU). However, the patient may attend a SATU irrespective of whether the incident is being reported to the Gardaí.

Women should be advised to telephone ahead prior to accessing certain services; this is particularly true in the

case of refuges where accommodation facilities may be limited.

Appendix 3 provides details on a wider range of services.

Legal Aspects of Violence – Ireland

The Garda Síochána

The Gardaí may be the first point of contact for many patients in crisis. Their Domestic Violence Policy sets out a **pro-arrest** policy[48].

The Judiciary

The Domestic Violence Acts (1996 and 2002)[49,50] make provision for the protection of persons in domestic violence situations. The protection includes the provision of arrest without warrant of the perpetrator and court orders. The provisions are variously available to married persons, civil partners, co-habiting couples, non-co-habiting persons with a child in common and children and dependent persons. Specifications about orders are available from the Legal Aid Board[51]: *http://www.legalaidboard.ie/lab/publishing.nsf/650f3eecodfb990fca2569210006985 4/6faacc45f1a9512080257 1fd003d3f3f/$FILE/Leaflet%20no.7.pdf*

- **Safety Order:** This order prohibits a person from using or threatening violence towards the person who has been granted the order and/or any dependent children. 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. A safety order can last up to 5 years, but can be renewed.
- **Barring Order:** This order requires the person against whom the order is made to leave and stay away from the family home. A barring order can last up to 3 years, but can be renewed.
- **Interim Barring Order:** Granted in exceptional 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.
- **Protection Order:** This temporary safety 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.

There were 10,652 applications under the domestic violence legislation in 2011 and 6,413 domestic violence orders were granted[52]. Applications against spouses accounted for 52 per cent of all applications with applications against common law partners accounting for a further 35 per cent.

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. Further information can be obtained at *www.legalaidboard.ie* or from Citizens Information at *http://www.citizensinformation.ie/en/birth_family_relationships/problems_in_marriages_and_other_relationships/barring_safety_and_protection_orders.html*.

Court accompaniment services are available through various support agencies.

2.4 Review

Follow up and Ongoing Support

It is important to keep the door open where the GP suspects domestic violence but the patient does not disclose. It may be helpful to make it clear what your position is by saying something like

"If any person were suffering, I'd like to be able to help..."

Reassure them that they can come back any time to any doctor or nurse at the practice.

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

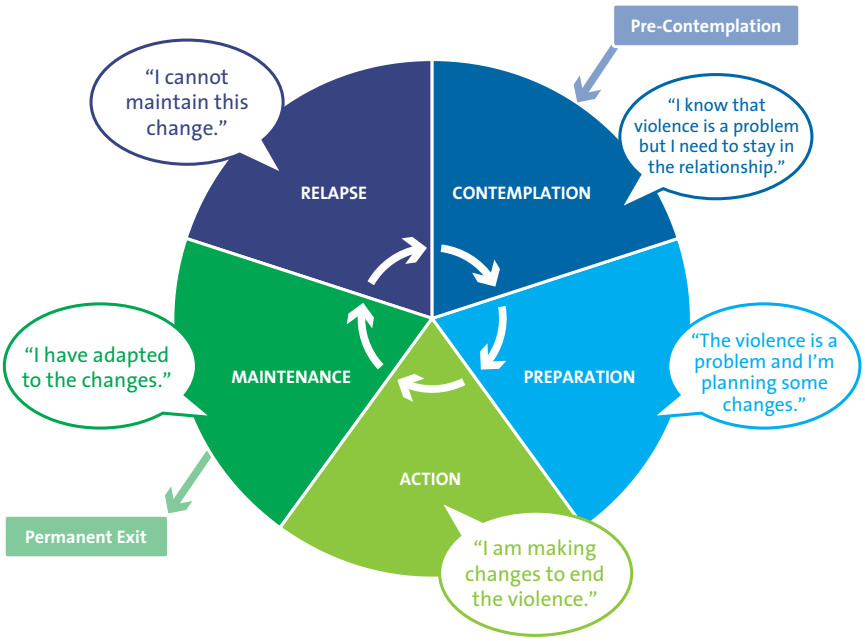
Dealing with your frustrations and taking care of yourself

Patients victimised by domestic violence very often stay in abusive relationships, seemingly not allowing intervention by you. This can be exhausting, frustrating, and difficult to understand. Though you may feel frustration, you may be her first and only point of contact.

- Realise early that a victim may never leave the abuser.
- Recognise that leaving is a process, not an event; the timeline from the beginning of abuse to the point of leaving may take decades.
- Don't act as a case-worker once you have referred the patient for help; remember that there are domestic violence agencies that fulfil that role.
- Get to know as much as you can about how domestic violence is being responded to at a local level. At a bare minimum you should know the domestic violence 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 domestic violence. Listening and communicating support and accurate contact details for an external support agency is better than not talking about it at all.
- GPs and practice nurses 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, arrange a staff debriefing session. Violence affects everybody differently.
- Look after yourself. Working with the effects of domestic violence 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 and practice nurse support in the directory at Appendix 3.

Appendix 1: Stages of Change

Almost all GPs/PNs will be familiar with the wheel of change, as described by Prochaska and DiClemente. The model defines five separate stages of change. Domestic violence is one of the conditions which where the authors have applied the model [53].



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

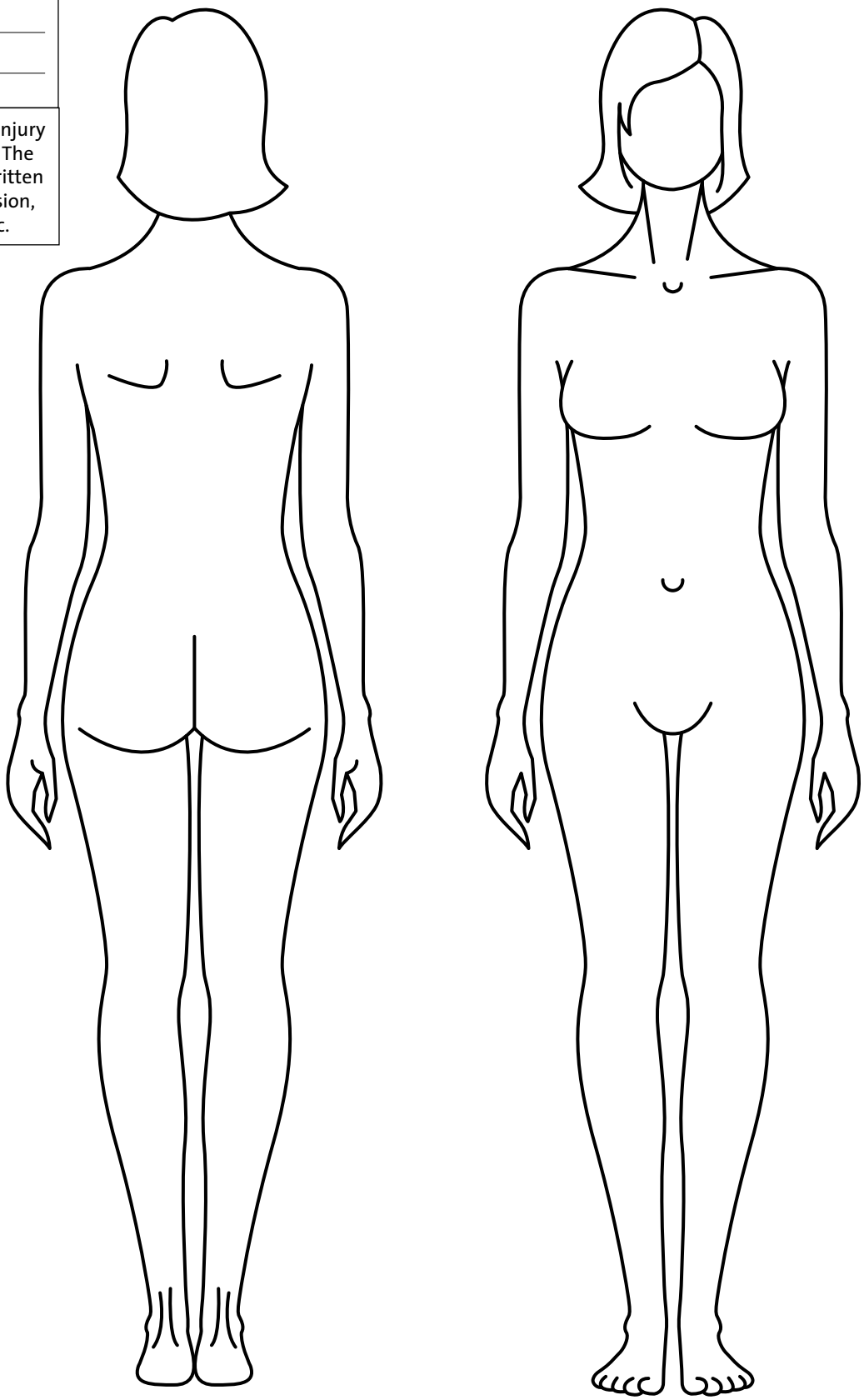
Appendix 2(a): Female body map

Name:

Date of examination:

Date(s) of injury:

Indicate the location of each injury by marking on the body map. The nature of the injury can be written beside the marking, e.g. abrasion, bruise, laceration, fracture, etc.



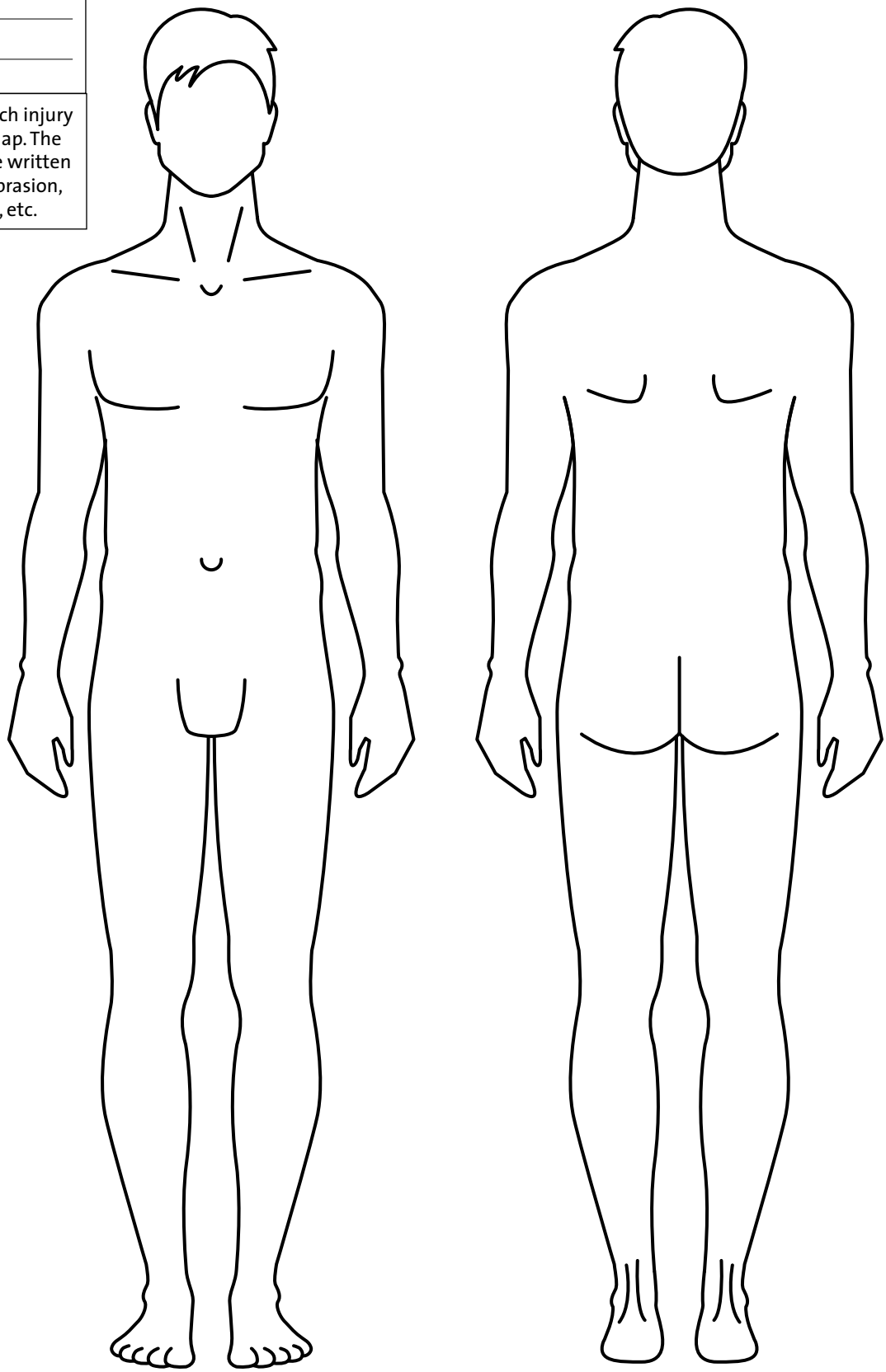
Appendix 2(b): Male body map

Name:

Date of examination:

Date(s) of injury:

Indicate the location of each injury by marking on the body map. The nature of the injury can be written beside the marking, e.g. abrasion, bruise, laceration, fracture, etc.



Appendix 3: Services and Resource Directory

National Helplines and Services

Women's Aid Freephone Helpline: **1800 341 900** (10am – 10pm, 7 days) *www.womensaid.ie*	Provides a national freephone helpline, one-to-one information and support and a court accompaniment service for women who have suffered domestic violence. They are advocates for developments in policy and services in the arena of domestic violence.
Rape Crisis Network Ireland *www.rcni.ie*	This is the umbrella body for Rape Crisis Centres and provides information and resources on rape and all forms of sexual violence. Contact details for all RCCs can be accessed on this site. Provide a free iPhone and Android app on sexual violence services that can be downloaded from their site.
Dublin Rape Crisis Centre Freephone Helpline: **1800 77 88 88** (24hrs) *www.drcc.ie*	Offers a free confidential, listening and support service for women and men who have been raped, sexually assaulted, sexually harassed or sexually abused at any time in their lives.
Safe Ireland *www.safeireland.ie*	Represents frontline domestic violence services. Contact details for refuges around the country can be accessed on this site. Provide a free iPhone app on domestic violence services that can be downloaded from their site.
Sexual Assault Treatment Units (SATUs) *www.hse.ie/satu/*	Provides contact details for the six SATUs in Ireland that provide services to women and men who have been recently assaulted or raped.
AMEN Tel: **(046) 902 3718** (office hours) *www.amen.ie*	Provides a confidential helpline and support services for male victims of domestic abuse and their children.
Childline Freephone helpline: **1800 66 66 66** (24 hrs) or text "Talk" to **50101** *www.childline.ie*	This support service for children is run by the Irish Society for Prevention of Cruelty to Children and can be accessed by telephone, text or online chat service.
Elder Abuse Information Line: **1850 241 850** (Mon–Sat 8am–8pm)	The HSE has a dedicated Elder Abuse Service, with Senior Case Workers in Elder Abuse now working in most Local Health Office Areas. See *http://www.hse.ie/go/elderabuse/*
Samaritans Helpline: **1850 60 90 90** (24 hrs)	Provides emotional support to anyone experiencing distress, despair or suicidal thought. You can access phone number for a preferred branch at *http://www.samaritans.org/your-community/samaritans-work-ireland*
National Counselling Service Freephone: **1800 477 477** (Wed–Sun 6–10pm)	HSE-funded free counselling for adults who have experienced any form of childhood abuse, giving priority to those who have been in state institutions. Further information at *http://www.hse-ncs.ie/en/* or *www.connectcounselling.ie*
Doctors' Health Programme	This service provided by the ICGP offers support for GPs and practice staff. Contact details for director and networks at *http://www.icgp.ie/go/in_the_practice/doctors_health*

Specialist services for perpetrators of domestic abuse

MOVE Ireland Tel: **(065) 684 8689** *www.moveireland.ie*	Works with men to help them address their violent or abusive behaviour towards their partners
North East Domestic Violence Intervention Programme (NEDVIP) Tel: **042 9359755**	Co-ordinates a programme in the north east to help men to stop being violent or abusive towards their partners.
South East Domestic Violence Intervention Project (SEDVIP) Tel: **051 844260** *www.mend.ie*	Co-ordinates four programmes in the south east to help men to stop being violent or abusive towards their partners.

Local Services

Local useful resources will vary according to your region. Directory of services can be found at *www.cosc.ie*

Sources of Information

Cosc *www.cosc.ie*	National office for the prevention of domestic, sexual and gender based violence. This executive office of the Department of Justice and Equality co-ordinates the Government's response to these issues. Site provides publications and links to local and national support services.
Legal Aid Board *www.legalaidboard.ie*	Provides free legal aid in civil matters to those who cannot afford to pay. Site also provides useful information leaflets..
An Garda Síochána *www.garda.ie*	Websites provides directory of local garda stations and policy documents.
The Courts Service *www.courts.ie*	For the Courts Service information on domestic violence, how to make an application for a safety / barring / protection order and all the relevant court forms. *http://www.courts.ie/__80256DEA003609EA.nsf/0/8315DE13ACEED033802577EA003EFBB6?Open&Highlight=0,barring,~language_en~*
Citizens Information *http://www.citizensinformation.ie*	For information on domestic violence and safety / barring / protection orders. *http://www.citizensinformation.ie/en/birth_family_relationships/problems_in_marriages_and_other_relationships/barring_safety_and_protection_orders.html*

Documents

National Strategy on Domestic, Sexual and Gender-based Violence (2010)	Cosc	*http://www.cosc.ie/en/COSC/Final%20Electronic%20NS%20full%20doc%203%20March.pdf/Files/Final%20Electronic%20NS%20full%20doc%203%20March.pdf*
Policy on Domestic, Gender and Sexual Based Violence (2010)	Health Service Executive	*http://www.hse.ie/eng/services/Publications/services/Children/HSE%20Policy%20on%20Domestic,%20Sexual%20and%20Gender%20Based%20Violence.pdf*
Children First Guidelines (2011)	Department of Children & Youth Affairs	*http://www.hse.ie/eng/services/Publications/services/Children/cf2011.pdf*

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