



RECOGNISE, RESPOND, REFER

A review of the approaches used by frontline HSE staff to ask about domestic, sexual and gender-based violence



Final Report

Foreword

Our office commissioned this review in early 2020, not knowing then, the significant and unpredictable challenges that lay ahead with the onset of the COVID-19 pandemic. Isolation, restrictions on movement and educational and economic shutdowns imposed a never before seen change in our psychosocial environment. Violence against women increased to record levels around the world following lockdowns to control the spread of COVID-19. The United Nations called the situation a 'shadow pandemic' in a 2021 report about domestic violence in 13 nations.

Now, as we recover from the COVID-19 crisis, our focus is on the outcomes of this report and how we respond to what we've been told. This review allowed us the opportunity to listen to how staff respond to a person presenting as a victim/survivor of domestic, sexual and gender based violence (DSGBV) and how a victim/survivor experiences that response. The review highlights issues experienced by staff as they work in the demanding and challenging environment of frontline health and social care service. It demonstrates staff willingness to support someone who discloses they are a victim of DSGBV. It also demonstrates the factors that enable a victim/survivor to avail of that support.

The report seeks to inform future discussions among stakeholders, with new perspectives on the approaches that are required to respond to DSGBV as a health service. It will also inform our implementation of actions under the Third National DSGBV Strategy. The voice of the survivor in this report, is a powerful reminder of our core HSE values of care, compassion, trust and learning and how staff supported to embed those values can make a meaningful difference in someone's experience of our care. As we move towards full implementation of Sláintecare, the principle of the patient being paramount to everything we do, will be integral to our response to DSGBV.

Joseph Doyle,

*National Social Inclusion Lead
HSE National Social Inclusion Office*

List of Acronyms

HSE	Health Service Executive
DSGBV	Domestic, Sexual and Gender-Based Violence
WHO	World Health Organisation
SATU	Sexual Assault Treatment Unit
ED	Emergency Department
MARAC	Multi-Agency Risk Assessment Conference

Note re terminology

In the context of the health services, the term 'victim' is used in this report to denote a person who has been subjected to domestic, sexual or gender-based violence. The term 'survivor' is also used in some contexts in this report. The author notes the potential sensitivity of these terms and that people who have experienced DSGBV may prefer the use of one term over the other, or may not agree with the use of either.

Disclaimer

In accordance with convention, quotations from individual informants that appear in the text are anonymised, although their organisational role /status may be mentioned where relevant within the narrative.

Unless specifically indicated, the author is responsible for all opinions and observations contained in this report, and these should not therefore be taken to represent the official position of the Government of Ireland, the Health Service Executive or other official body.

Acknowledgements

The author would like to thank all the individuals and organisations who participated in this review. The timing of the review coincided with the COVID-19 pandemic. Frontline health staff and specialist DSGBV support services were asked to take part in this review at a time of unprecedented challenge and stress for staff. The hospital staff who completed the survey and the health staff who participated in the qualitative study did so in extraordinary circumstances and made it possible to complete this review despite the challenges of the COVID-19 pandemic.

Sincere thanks to the victims/survivors who participated in the second phase of this review and shared their insights. Their courage and willingness to speak about their experiences has ensured that the impact of the health staff response to DSGBV on victims/survivors has shaped the recommendations of this review.

Thank you to the gatekeepers who provided expertise, guidance, support staff, and sites for the research. Their support was invaluable to this research.

Thank you to stakeholders and key informants who generously gave their time and expertise to support this review process.

Finally, thank you to the research ethics committees who reviewed the research design, provided valuable feedback and granted ethical approval:

Irish College of General Practitioners Research Ethics Committee

Tusla Research Ethics Committee

HSE Research Ethics Committee for the Midlands Area and Corporate Division (Regional Health Area B)

Eithne Tiernan

Contents

1	Introduction	5
2	Methodology	7
	2.1 Approach	8
	2.2 Process	8
	2.3 Limitations of the Research	9
3	Policy Context	10
	3.1 National Policy Context	11
	3.2 International Policy Context	12
	3.3 Policy Theme: Integrated Service Response	14
4	Survey of Acute Hospitals: Main Results	15
5	Qualitative Study of Frontline Staff: Key Findings	22
	5.1 Recognise: Asking about DSGBV	23
	5.1.1 When do staff ask about DSGBV?	23
	5.1.2 How do staff ask about DSGBV?	24
	5.1.3 Asking about DSGBV: Enablers and Barriers	24
	5.2 Respond and Refer	27
	5.2.1 How do staff respond?	28
	5.2.2 Responding to DSGBV: Enablers and Barriers	29
6	Qualitative Study of Victims/Survivors: Key Findings	32
	6.1 Enablers: Key factors necessary/helpful for disclosure and asking for help	33
	6.2 Barriers: What made it difficult to disclose and get support?	35
	6.3 Issues requiring further research	37
7	Conclusions	38
8	Final Recommendations	40
9	References	44
10	Appendix 1: Topics to Include in a Protocol/SOP	47
11	Appendix 2: Preliminary Recommendations (arising from the first phase of research)	49
12	Appendix 3: Feedback from Consultation on Preliminary Recommendations	52

1

INTRODUCTION

This review was conducted to implement Action 2:400 of the *Second National Strategy on Domestic, Sexual and Gender Based Violence 2016-2021*¹:

To review current approaches and outcomes in respect of domestic, sexual and gender-based violence (DSGBV) questions used by all staff in different community and hospital contexts / environments and with specific target groups:

- Child Protection and Welfare
- Pregnant women
- Addiction services
- Accident and emergency services
- Mental health services
- Primary care services
- Maternity services
- Social inclusion services

agree further actions and consistency of approaches as appropriate.

The Health Service Executive (HSE) has responsibility for the implementation of this action. The review was commissioned by the HSE National Social Inclusion Office and carried out by the author- an independent social policy consultant. As it happened, the study contract was awarded within weeks of the onset of the COVID-19 pandemic in early 2020. The climate of uncertainty and disruption which ensued meant that all aspects of the review's process were adapted by mutual agreement between the consultant and the HSE National Social Inclusion Office, in response to the unfolding realities nationally.

By agreement, the review was conducted in two phases. The first phase was designed to review the approach used by frontline HSE staff to domestic, sexual and gender-based violence (DSGBV) across the named services and to map the policies and protocols used in acute hospitals. The experiences and views of survivors were the focus of the second phase of the review, which began in June 2022.

The key steps during **Phase 1** (2020/21) were:

- Desk study of relevant background documentation on recent policy and practice relating to DSGBV in the Republic of Ireland (see 'References' section)
- An on-line survey of acute hospitals
- A qualitative study of front-line health staff
- Preparation of a Preliminary Report and Recommendations

The key steps during **Phase 2** (2022/23) were:

- A qualitative study of victims and survivors of DSGBV.
- Stakeholder Consultations on recommendations contained in the Phase 1 Preliminary Report

This report presents the findings of both phases of the review and makes recommendations to the HSE to address the issues identified. These recommendations are based on the findings of the review and analysis of the independent consultant.

1 The final versions of The Second National Strategy 2016-2021 and the final Action Plan can be downloaded by clicking these links: [Second National Strategy on Domestic, Sexual and Gender-based Violence 2016 - 2021](#), [Second National Strategy Action Plan](#)

2

METHODOLOGY

2.1. Approach

A mixed-methods approach was used for the review. This approach was chosen as it allowed the researcher to examine the context in which staff are working in acute hospital settings in Ireland and to examine the experiences and insights of staff and victims/survivors.

Consultations with stakeholders informed the approach to the review. The process of consultation included members of the Monitoring Committee of the *Second National Strategy for Domestic, Sexual and Gender-Based Violence 2016-2021*, as well as additional key informants with relevant expertise in research, advocacy, service provision, education, and training.

2.2. Process

Survey of Acute Hospitals

A survey of acute hospitals was conducted in 2020. The purpose of the survey was to collect headline data on domestic and sexual violence policies, protocols, staff training, specialist staff roles and referral pathways in acute hospitals in Ireland. The survey was conducted online and was initially sent to the Directors of acute hospital groups in August 2020 for circulation to the individual hospitals within each group. The use of an online survey meant that every hospital could be included in the sample in order to maximise response. As the timing of the survey coincided with the COVID-19 pandemic, hospitals were not expected to complete the survey within the original timeframe (September 2020). Reminders were issued to allow hospitals to participate in the survey if resources allowed and collection continued into the first quarter of 2021. Ten of the 50 acute hospitals in Ireland took part in the survey.

Qualitative Study of HSE frontline health staff:

The sample was designed to include participants from contexts relevant to the groups specified in Action 2:400 of the National Strategy:

- Acute hospitals
- Child protection and welfare services
- Addiction services
- Mental health services
- Social inclusion services, e.g. homeless services
- Primary care
- Sexual Assault and Treatment Units (SATUs)

Invitations to take part in the research were emailed by the HSE National Social Inclusion Office to HSE managers in the relevant health services, who acted as gatekeepers and circulated to staff. Staff were invited to email the researcher directly to express

their interest in participating. The invitation included a participant information leaflet explaining that participation was voluntary and confidential. Consent was obtained using a consent form.

Qualitative interviews were conducted with 18 frontline health staff working in a range of roles and settings to collect data on their approach to enquiring and responding to DSGBV. The interviews were semi-structured and explored the experiences and views of staff in relation to current practice, training, referral pathways, challenges, and positive developments. Interviews were transcribed, coded, and analysed using qualitative analysis software. The data was analysed using a thematic analysis approach, (Braun & Clarke, 2006).

Ethics approval for the qualitative research was received from the Irish College of General Practitioners Research Ethics Committee. The study design included the following strategies to recognise the possible sensitivity of the subject matter:

- Participants will be asked to sign a consent form that will explain the purpose of the study and will confirm that the information they provide will be treated as completely confidential.
- Participants will be given information on the availability of support services should they find themselves affected by any issues raised during the discussion.
- Participants will be reminded at the beginning of the interview that they can pause or end the interview at any time without giving any explanation to the interviewer.
- Interviews will be conducted by the principal researcher who is experienced in conducting interviews with service providers and survivors of sexual violence.
- Approximately 5 minutes after the interview begins, the interviewer will ask participants if they are comfortable to continue.
- Any personal data arising in the study will be anonymised to ensure that no participant can be identified from the transcript of their interview. Participants will be identified by a unique identifier. Documentation linking names to unique identifier will be encrypted and stored separately to transcripts. In order to achieve the objective of the study participants will be asked to indicate the age group to which they belong. They will also be asked to identify if they are working in an urban or a rural location. The findings of the study will be presented to ensure that no individual participant can be identified in the report.

Participants from the following staff types and settings took part in the qualitative study, showing a broad disciplinary/occupational spread:

Staff Types:

- Clinical Nurse Manager
- Clinical Nurse Specialist
- Counsellor
- Dietician
- General Practitioner
- Midwife
- Project Worker Addiction Services
- Psychologist
- Psychiatrist
- Social Worker
- Specialist Registrar

Settings:

- Addiction Services
- Adolescent Mental Health Services
- Adult Mental Health Services
- Emergency Department
- Maternity Services
- Primary Care
- Psychology Service International Protection Applicants
- Sexual Assault Treatment Units
- Social Inclusion Services

Preliminary Recommendations

An interim report and preliminary recommendations were finalised at the end of phase 1. A consultation process then took place to invite stakeholders from the Monitoring Committee of the Second National Strategy on DSGBV to provide their feedback on the preliminary recommendations (See Annex 2). This feedback informed the final recommendations of the review.

Qualitative Study of Victims/Survivors:

A qualitative study designed to explore the experiences and insights of victims/survivors in relation to the approach to DSGBV questions used by health staff took place in 2022. Ethical approval for this research was provided by the Tusla Research Ethics Committee and the HSE Research Ethics Committee for the Midlands Area and Corporate Division (Regional Health Area B).

Specialist DSGBV service providers were contacted by the HSE National Social Inclusion Office to ask them to act as gatekeepers for this phase of the review. The gatekeepers are not named to protect the identities of the participants who were service users at the time of the research.

Gatekeepers were asked to share an invitation letter, participant information leaflet and consent form with service users who were engaged with counselling services. The invitation letter included an information sheet to explain the purpose of the research, the confidential nature of the research and its outputs, the voluntary nature of their participation, and their right to withdraw at any stage.

The following measures were included in the study protocol to ensure that the safety of participant's was prioritised:

- To ensure immediate access to support services was available if required, participants were required to be engaged with specialist support services.
- The gatekeeper organisations had discretion to share the opportunity to participate with their service users who were, in the professional opinion of their counsellor/support worker, able to participate safely in the research and capable of making an informed decision to participate.
- The decision to participate and the consent process was discussed between the potential participant and their counsellor/support worker.
- Participants were provided with a debriefing session with their counsellor/support worker following their interview or focus group.

Six semi-structured qualitative interviews and one focus group took place. Topics included experiences of disclosure, referral, outcomes, barriers, and enablers. Recordings were transcribed, coded, and analysed using qualitative analysis software. The data was analysed using a thematic analysis approach, (Braun & Clarke, 2006).

2.3. Limitations of the Research

The review had to be conducted against the backdrop of the COVID-19 pandemic. This meant that significant changes to the design and the timelines of the review were required. Conducting research involving hospitals and frontline health staff during this time presented many challenges, in particular in administering the survey, recruiting participants for interviews and focus groups and securing ethical approval.

The response rate for the hospital survey was low and the results cannot necessarily be considered representative or generalisable. As participants in the qualitative study of health staff self-selected, the possibility of selection bias must be considered, as participant's willingness to take part may have indicated a particular interest or commitment to the issue of DSGBV.

3

POLICY CONTEXT

3.1. National Policy Context

The approach of staff is central to the HSE's vision for the health sector's response to DSGBV.

The *HSE Policy on Domestic, Sexual and Gender Based Violence* (2010) presents this vision:

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

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

The *HSE Policy on Domestic, Sexual and Gender Based Violence* (HSE, 2010) recognises that people who are experiencing domestic or sexual violence access the services via many routes, e.g., family doctor, Accident and Emergency, reproductive health, mental health, family planning, sexual health, addiction services, paediatric services etc. In that context, the policy states that 'a comprehensive and appropriate health sector response is required from the health services at all points of entry'. Central to this policy is that to ensure victim safety, staff need to know the signs of abuse, how to respond, and be able to make referrals to a specialist service when that is appropriate. The document highlights a lack of education and training for healthcare professionals as 'a significant barrier in preventing and intervening in Domestic Violence and/or Sexual Violence'.

Training:

One of the key actions in the *Third National Strategy on Domestic, Sexual & Gender-Based Violence 2022-2026* is:

- Training healthcare workers to identify domestic violence and refer victims/ survivors to appropriate services

The strategy's *Implementation Plan* outlines key activities for 2022-2023 that reflect the recommendations made by this Consultant in the Interim Report (See Annex II):

- Establish multi-disciplinary working group to scope the development of a national training strategy.
- Design and implement a training needs analysis to define levels of training required, scope training already available, identify blocks to training and identify gaps in training provision.
- Define levels of training to meet the knowledge and skills required by staff responding to DSGBV

in defined roles and context in consultation with relevant stakeholders including staff working in specialist services and people using or who have used those services.

- Engage the expertise of key stakeholders currently providing specialist training on DSGBV to health staff.
- Design training content in consultation with key stakeholders to facilitate an integrated, inter-agency response for victims of DSGBV.
- Design training content to include lived experience perspective, in consultation with survivors of DSGBV.

A key focus of the *HSE Policy on Domestic, Sexual and Gender Based Violence* (HSE, 2010) is training healthcare professionals to provide them with basic skills and tools to enable them to recognise, respond and refer following a 3Rs approach:

Recognise: Recognise the signs, indications, nature and consequences of abuse

Respond: Know how to respond appropriately and effectively to ensure victim safety

Refer: Know how to make a referral to an appropriate service/agency

The *HSE Practice Guide on Domestic, Sexual and Gender Based Violence* (HSE, 2012), is a resource to implement the HSE Policy on DSGBV and is designed as a good practice guide for HSE staff working with children and families. The guide provides comprehensive information and practice guidelines based on the approach of "the Rs". It presents research and best practice in relation to children, intimate partner violence, addiction, mental health, disability, and cultural issues.

In April 2019, the HSE National Social Inclusion Office published the *HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual. Recognising and Responding to Victims of Domestic, Sexual and Gender-Based Violence in Vulnerable or At-Risk Communities*. The manual was prepared in partnership with Sonas, an organisation providing domestic-violence support services, as part of a train the trainer programme. The programme was designed to:

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

3.2. International Policy Context

Article 1 of the *Istanbul Convention*, which Ireland ratified in 2019 includes the following purposes:

- ‘Protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence’.
- ‘Design a comprehensive framework, policies and measures for the protection of and assistance to all victims of violence against women and domestic violence’.

The Convention specifies that:

‘Parties shall take the necessary legislative or other measures to ensure that victims have access to health care and social services and that services are adequately resourced and professionals are trained to assist victims and refer them to the appropriate services.’

The World Health Organisation (WHO) provides relevant policy and best practice guidelines in three key publications

- *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (WHO, 2013)
- These clinical and policy guidelines are the basis of the *clinical handbook: Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence A Clinical Handbook* (WHO, 2014)
- *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers* (WHO, 2017)

The guidelines (WHO, 2013) highlight the fact that ‘there are simple ways that every health-care provider – including those who are not specialists – can assist a woman subjected to violence’. The guiding principles of the WHO policy are:

- Woman-centred care
- A rights-based approach
- Gender sensitivity and equality

The manual for healthcare managers (WHO, 2017) recommends that:

Whatever model of care is used, the aim should be to reduce the number of visits and the number of providers that the woman has to contact (and tell her story to), and to facilitate access to services she may need, in a manner that respects her confidentiality and prioritises her safety.

The WHO recommendations are based on a protocol for providing first-line support (WHO, 2014). This protocol, known as LIVES, focuses on five simple

tasks designed to respond to emotional and practical needs:

- LISTEN** Listen to the woman closely, with empathy, and without judging.
 - INQUIRE ABOUT NEEDS AND CONCERNS** Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g., childcare)
 - VALIDATE** Show her that you understand and believe her. Assure her that she is not to blame.
 - ENHANCE SAFETY** Discuss a plan to protect herself from further harm if violence occurs again.
 - SUPPORT** Support her by helping her connect to information, services and social support.
- (WHO, 2014)

Screening:

The WHO clinical and policy guidelines (WHO, 2013) recommend that “‘Universal screening’ or ‘routine enquiry’ (i.e. asking women in all health-care encounters) should not be implemented.’ The arguments presented supporting this recommendation include:

- Universal screening can easily become a tick-box exercise ‘carried out in an ineffectual way’.
- In settings where referral options are limited and there are ‘overstretched resources/providers’... ‘focusing on selective enquiry based on clinical considerations is more likely to benefit women’.
- ‘Training providers to ask all women about violence when there are limited options to offer them has an important opportunity cost. It is preferable to focus on enhancing providers’ ability to respond adequately to those who do disclose violence, show signs and symptoms associated with violence, or are suffering from severe forms of abuse’.
- ‘Women may find repeated enquiry difficult, particularly if no action is taken. This may potentially reduce their uptake of health services’.

It is recommended instead that ‘focusing on selective enquiry based on clinical considerations is more likely to benefit women’ (WHO, 2013). In addition, there should be a focus on building the skills of healthcare professionals to respond to women who disclose violence or have signs or symptoms of violence.

However, the guidelines (WHO, 2013) note the following exceptions where questions on intimate partner violence could be included as part of standard practice:

- ‘There is strong evidence of an association between intimate partner violence and mental

health disorders among women. Women with mental health symptoms or disorders (depression, anxiety, PTSD, self-harm/suicide attempts) could be asked about intimate partner violence as part of good clinical practice, particularly as this may affect their treatment and care’.

- ‘Intimate partner violence may affect disclosure of HIV status or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies. Asking women about intimate partner violence could therefore be considered in the context of HIV testing and counselling, although further research to evaluate this is needed’.
- ‘Antenatal care is an opportunity to enquire routinely about intimate partner violence, because of the dual vulnerability of pregnancy’.

The guidelines (WHO, 2013) specifically recommend that health-care providers should ask about intimate partner violence when they are assessing conditions that could be caused or complicated by intimate partner violence when it is safe to do so:

WHO minimum requirements for asking about partner violence

- A protocol/standard operating procedure
- Training on how to ask, minimum response or beyond
- Private setting
- Confidentiality ensured
- System for referral in place

(WHO, 2013)

Protocols:

A key element of the process of improving service delivery described in the WHO manual (WHO, 2017) is the establishment of protocols or standard operating procedures. The manual provides details on the topics that should be included in the protocols, which include regulations and key principles of care; service provision (including referral pathways and access for vulnerable populations); and documentation, including data collection and management. There is an emphasis on the inclusion of stakeholders in the design of the protocols to ensure a sense of ownership. The main points are as follows:

- Standardised protocols or standard operating procedures (SOPs) are important to guide service delivery.
- Protocols/ SOPs support the delivery of safe, good quality, respectful and effective health care that is consistent across locations and over time. They are also useful as training tools.

- To foster ownership, protocols/SOPs should be developed through extensive consultation and consensus building with relevant stakeholders.
- Protocols/SOPs need to cover the processes involved in delivering services for women subjected to violence. See *Appendix 1*.

Training:

The WHO guidelines (2013) make several recommendations for training healthcare staff, stating that training should:

- enable healthcare staff to provide first-line support
- teach appropriate skills, including when and how to enquire about violence, the best way to respond, identification and care for survivors of intimate partner violence and clinical care for survivors of sexual assault
- include different aspects of the response to intimate partner violence and sexual assault (e.g., identification, safety assessment and planning, communication and clinical skills, documentation and provision of referral pathways)
- address: basic knowledge about violence, knowledge of existing support services, ‘inappropriate attitudes among health-care providers (e.g. blaming women for the violence, expecting them to leave, etc.), as well as their own experiences of partner and sexual violence’.
- ‘training for both intimate partner violence and sexual assault should be integrated in the same programme, given the overlap between the two issues and the limited resources available for training health-care providers on these issues’.

The WHO manual for health managers (WHO, 2017) recommends that training health-care providers on the response to violence against women should be an ongoing process, rather than a one-off event. Training should be viewed as a long-term investment in building the capacity, changing the attitudes and the clinical practice of health-care providers.

In 2019, the WHO published a training programme for healthcare staff based on the clinical and policy guidelines, *Caring for women subjected to violence: A WHO curriculum for training health-care providers*. This in-service curriculum aims to provide healthcare providers with the knowledge and basic skills to implement the WHO recommendations in their clinical practice. It is a comprehensive pack divided into 13 sessions and includes detailed timings, exercises, video links, handouts, slides, and evaluation forms.

A session titled “When and how to identify intimate partner violence” is designed to support participants to demonstrate clinical skills to respond to violence against women.

The session is focused on four key competencies:

- Understand the minimum standards that need to be met to enquire about and respond appropriately to violence against women.
- Recognise the signs and symptoms that suggest intimate partner violence.
- Understand when and how to ask about intimate partner violence.
- Demonstrate appropriate ways to ask about intimate partner violence

The curriculum includes a useful video from the Royal Australian College of Practitioners that presents examples of practitioners demonstrating these competencies. www.youtube.com/watch?v=Hu06nVCzih0&feature=youtu.be

3.3. Policy Theme: Integrated Service Response:

Article 7 of the *Istanbul Convention* states that:

Parties shall take the necessary legislative and other measures to adopt and implement State-wide effective, comprehensive and co-ordinated policies encompassing all relevant measures to prevent and combat all forms of violence covered by the scope of this Convention and offer a holistic response to violence against women.

The *HSE Policy on DSGBV* (HSE, 2010) recognises that ‘the approach to addressing Domestic and/ or Sexual Violence must be multi agency and cross sectoral’. The policy includes the objective that: ‘At a planning level, the health sector will actively work with relevant stakeholders to ensure more appropriate responses and positive outcomes.’

The mission statement of the *National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland)* (National SART Guidelines Development Group, 2018) is ‘to provide a range of specialist multi-agency responses following rape/sexual assault. These services are delivered in a respectful, non-judgemental and supportive manner by skilled, competent professionals.’

In the *Department of Health Policy Review: Sexual Assault Treatment Units (SATUs)* (Department of Health, 2019) the importance of multi-agency working was highlighted as an ongoing challenge. While the review was satisfied with the level of inter-agency working, one of the main findings of the review was that ‘boundaries between professionals and services make it too easy for patients to get “lost in the cracks”. Increasing awareness of SATU and coordination within health services and across social

services for patients is a primary step to improving this.’ The review found that there was a strong desire among management and staff for more defined inter-agency working. Training was an area specifically mentioned as an opportunity for further inter-agency coordination.

International Example: U.K.: MARACs:

One practical mechanism designed to give operational effect to a more integrated service response is illustrated by Multi-Agency Risk Assessment Conferences (MARACs). MARACs are meetings where all agencies involved in the highest risk domestic violence cases share information using a partnership approach to put together safety plans quickly and effectively. There are approximately 290 MARACs across England and Wales, with meetings usually taking place monthly or fortnightly. ([Latest Marac National Dataset](#) | [Safelives](#))

4

SURVEY OF ACUTE HOSPITALS: MAIN RESULTS

As part of Phase 1 of the Study, a survey of acute hospitals was carried out by the consultant in 2020. The purpose of the survey was to collect headline information on the approaches used in acute hospitals to domestic and sexual violence policies, training, referral, and specialist staff.

The survey was conducted online using Google Forms and was initially sent to the Directors of the six acute hospital groups in August 2020 for circulation to the individual hospitals for completion. As the timing of the survey coincided with the COVID-19 pandemic, it was necessary to recognise the exceptional pressure being experienced by acute hospital staff at that time, and so they were not expected to complete the survey within the original timeframe. Reminders were issued to allow hospitals to participate in the survey if resources allowed and collection continued into the first quarter of 2021. A total of ten hospitals took part in the survey, one fifth of the 50 acute hospitals in Ireland.

Hospital Policy

Six of the ten responding hospitals reported that hospital policy did not include standard procedures or guidelines for enquiry about patient experiences of domestic or sexual violence (DSV). See Table 1

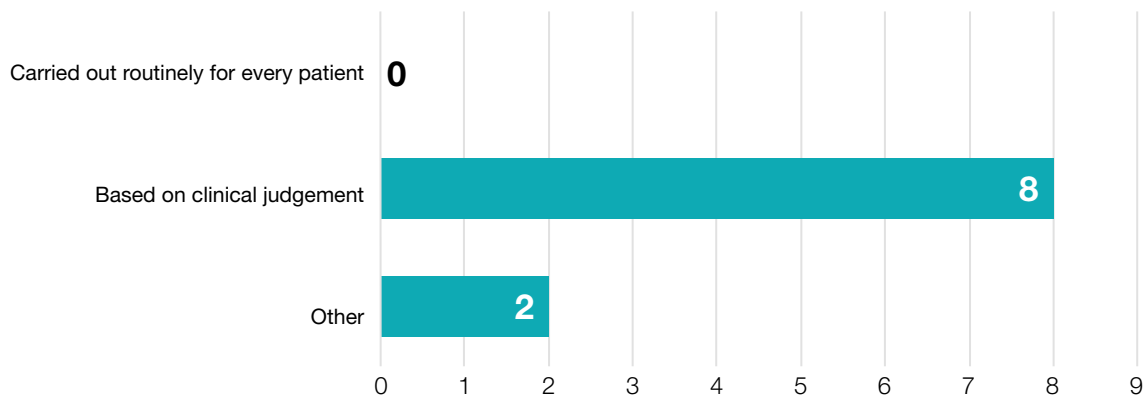
Table 1. Hospital policy includes standard procedures/guidelines for enquiry about patient experiences of DSV



n= number of hospitals

Hospitals were asked to indicate how screening or enquiry in relation to DSV was carried out in the hospital. Most (n=8) of the responding hospitals indicated that screening or enquiry was carried out according to clinical judgement. Two hospitals indicated a category of “other” in the survey, both specified that screening or enquiry was carried out for all ante-natal patients. Screening or enquiry was not carried out routinely for all patients in any of the responding hospitals. See Table 2

Table 2. Description of hospital policy for screening/enquiry for DSV



n= number of hospitals

Six of the ten responding hospitals did not have a specific policy for enquiry in relation to domestic and sexual violence in the Emergency Department. See Table 3

Table 3. Hospital has specific policy for enquiry in relation to DSV in Emergency Department



n= number of hospitals

Half of the ten responding hospitals (n=5) reported that enquiry in relation to DSV is carried out for all pregnant patients, and the remaining five hospitals reported that enquiry is not carried out. See Table 4

Table 4. Enquiry in relation to DSV is carried out for all pregnant patients

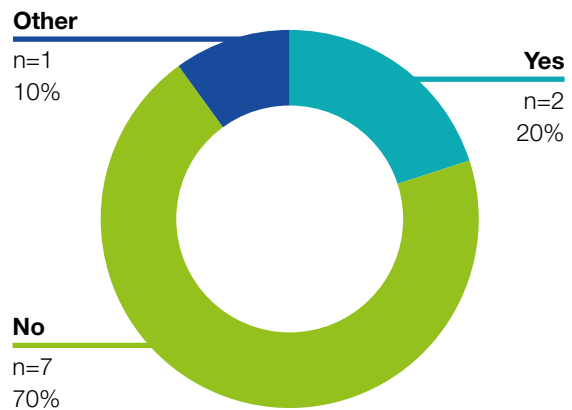


n= number of hospitals

Screening and Risk Assessment

Most hospitals in the survey (n=7) reported that they did not use a specific screening tool to screen patients for DSV. See Table 5

Table 5. Hospitals use a specific screening tool to screen patients for DSV



n= number of hospitals

Two hospitals indicated that they use a specific tool, in the form of a set of questions, to screen for sexual or domestic violence. One additional hospital indicated that, while a specific screening tool is not used, two specific questions are used to screen.

The following descriptions of the screening tools were provided:

- “Do you feel safe in your home and personal relationships?”
The responses to the question are coded to indicate that the question has been asked, the response, and whether action has been taken by hospital staff’.
- ‘The ante-natal set of questions are the tools used to identify past/current domestic, sexual and gender-based violence. If further assessment is required by the Medical Social Work Department, Social Workers undertake an assessment which include the 3 Rs model (recognise, respond, refer).’

Nine of the ten responding hospitals reported that staff carry out risk assessments when domestic violence is suspected or disclosed. See Table 6

Table 6. Staff carry out risk assessments when domestic violence is suspected/disclosed



n= number of hospitals

Follow-Up and Referral

Seven of the hospitals who participated in the survey have formal referral pathways into specialist support services for DSV. See Table 7

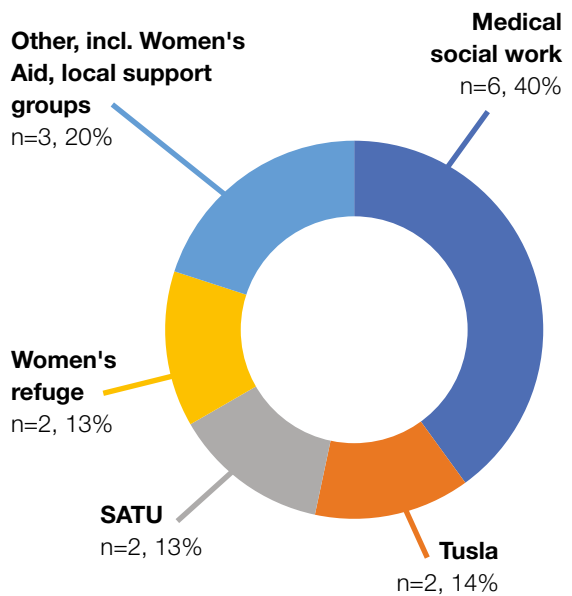
Table 7. Hospital has formal referral pathways into specialist support services for DSV



n = number of hospitals

Hospitals with formal referral pathways were asked to specify the specialist services used. These included internal and external pathways. Medical social work was the most common specialist service listed, reported by six of the seven hospitals using formal referral pathways. See Table 8 & Fig. 1

Table 8. Referral pathways to specialist support services used by hospitals*

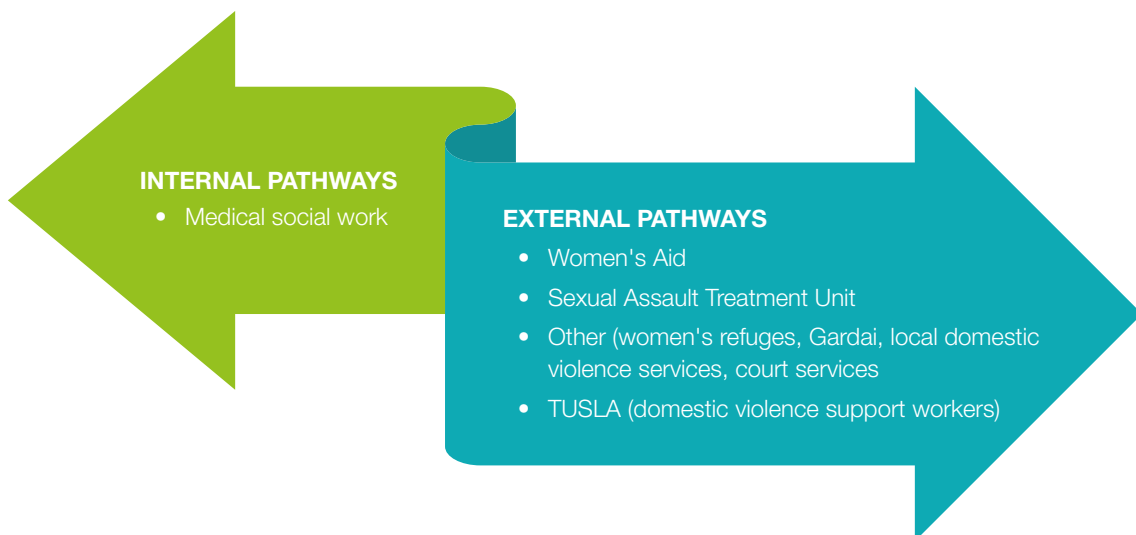


n = number of hospitals

*Hospitals may appear in more than one category, as more than one referral pathway may have been selected.

The specialist services are set out in the image below (fig. 1)

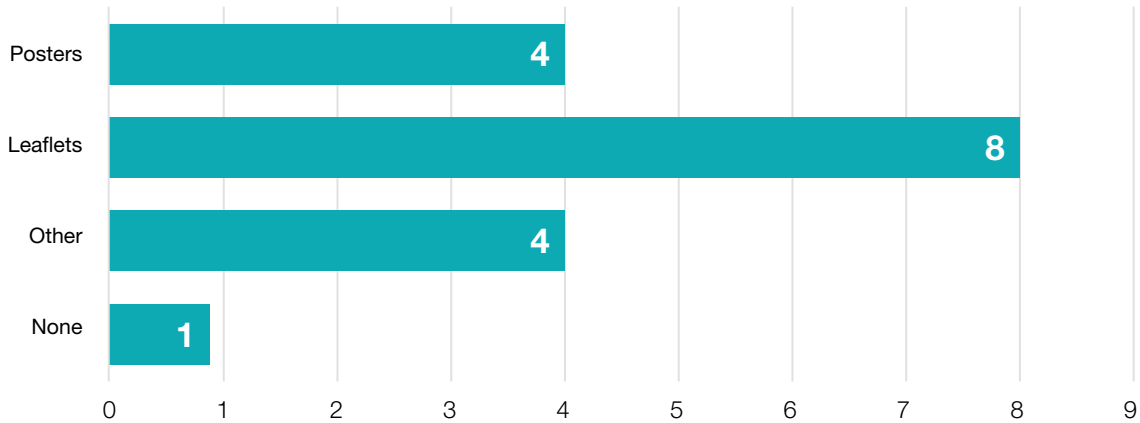
Figure 1



Information on specialist services for patients

Leaflets were the most common type of information provided for patients on specialist support services. (8 of 10 hospitals). See Table 9

Table 9. Type of patient information on domestic & sexual violence specialist services provided by hospitals

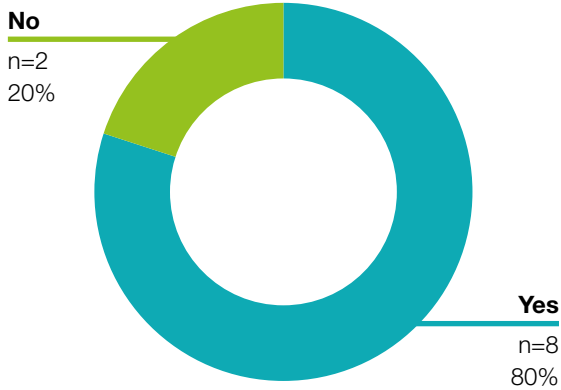


Training

Eight of the ten hospitals reported that frontline staff receive training in relation to DSV. The hours of the training varied (from 2 hours to full day). See Table 10

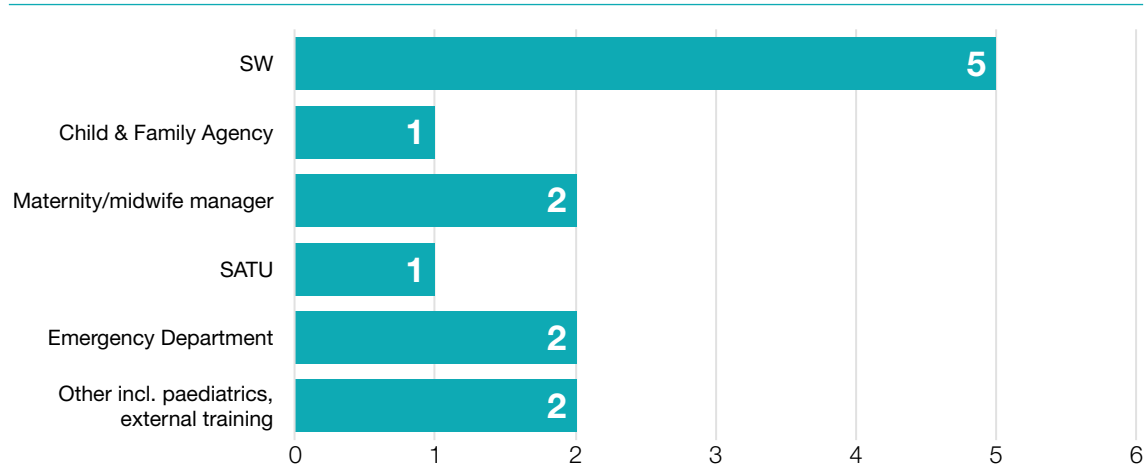
Table 10. Frontline staff receive training in relation to DSV

The providers of the training varied across hospitals. However, the medical social work team provided training in half of the responding hospitals. Additional providers included the maternity and emergency departments, SATUs and the Child and Family Agency. See Table 11



n= number of hospitals

Table 11. Providers of DSV training in hospitals



Number of hospitals (hospitals can be included in more than one category)

The staff in two of the ten responding hospitals receive intercultural awareness training. See Table 12

Table 12. Frontline staff receive intercultural awareness training



n= number of hospitals

Specialist Staff

More than half (n=6) of the ten responding hospitals reported that they employ staff in a specialist role relating to DSV. See Table 13

Table 13. Hospital employs staff in a specialist role relating to DSV

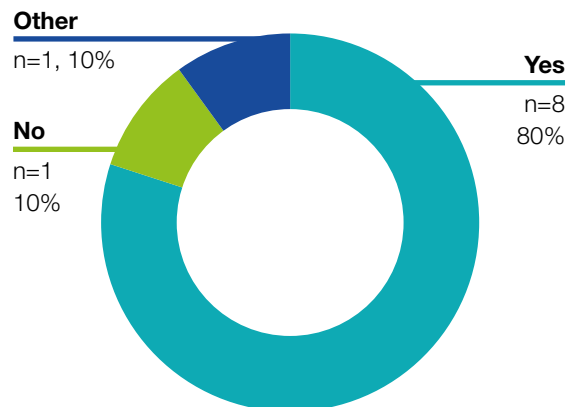


n= number of hospitals

Support for staff

Eight of the ten responding hospitals provide support for hospital staff who deal with disclosures of DSV, one does not, while the remaining hospital has plans to provide this support. See Table 14

Table 14. Support available for hospital staff who deal with disclosures of DSV



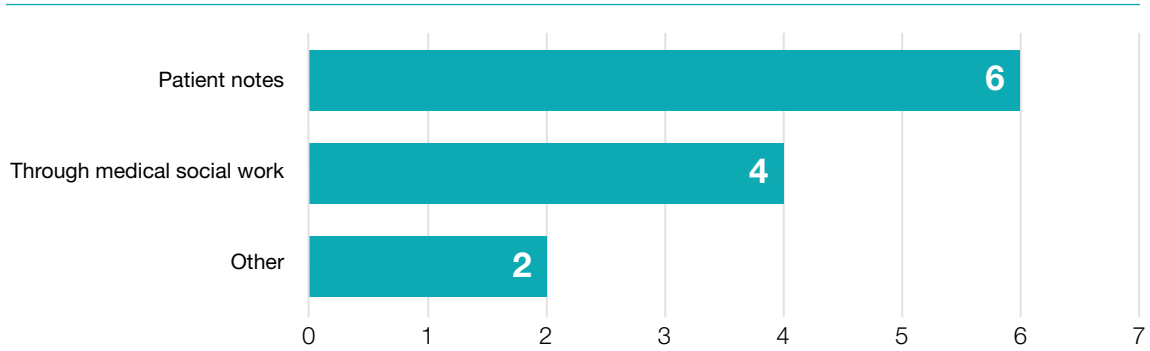
n= number of hospitals

Other = "there are plans to provide this support"

Recording and sharing of information

Disclosures of DSV are most commonly (six of ten hospitals) recorded in the patient medical chart. Four hospitals reported that disclosures are recorded in the medical social work files. See Table 15

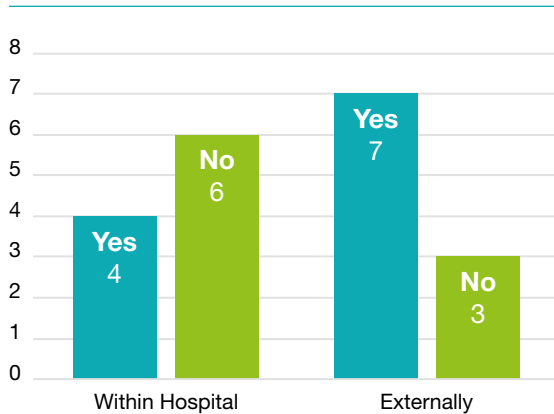
Table 15. How disclosures of DSV are recorded by hospital staff



Number of hospitals (hospitals can be included in more than one category)

Four of the hospitals in the survey reported that they had protocols for sharing patient information within the hospital (e.g., between departments) when DSV has been identified. Six did not have protocols. It was more common for hospitals to have protocols for sharing patient information externally (e.g., with GP) when DSV has been identified. Of the hospitals surveyed, seven had protocols and three did not. See Table 16

Table 16. Hospital has protocols for sharing patient information when DSV has been identified

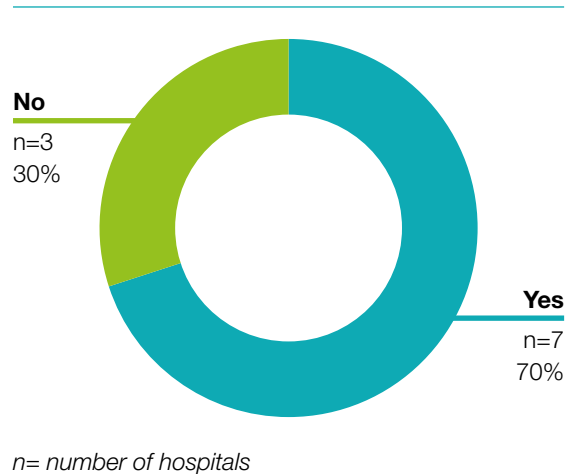


Hospital has protocols for sharing information when DSV identified

Inter-agency meetings, clinical forums and networks

Seven of the ten hospitals who responded to the survey reported that their staff participate in inter-agency meetings, clinical forums, or networks in relation to DSV. See Table 17

Table 17. Hospital staff participate in inter-agency meetings, clinical forums, or networks in relation to DSV



5

QUALITATIVE STUDY OF FRONTLINE STAFF: KEY FINDINGS²

² Quotes from participants are in italics. To protect the anonymity of participants, quotes are not attributed to a numbered participant or identified by staff type or setting.

5.1. Recognise: asking about DSGBV

I think people were amazed at how many women disclosed domestic violence when we started asking the question...we never realised this problem was so significant, because we never asked the question before...We are now reaching out to those women and normalising the fact that it's OK to tell us and we're here to help you and support you and protect you... It's kind of frightening to think that... previously this was going on in the background and we didn't know.

Participant in Qualitative Interview

5.1.1. When do staff ask about DSGBV?

Participants described enquiry about DSGBV in three scenarios:

- routine enquiry in maternity services
- included in routine assessment
- clinical judgement/recognising signs

Most participants who were not working in maternity services were unaware of, or unfamiliar with, any policy, guidelines, or standard operating procedures available in their workplaces in relation to DSGBV.

Routine enquiry:

Participants felt that questions about domestic and sexual violence were now an accepted part of the first ante-natal visit for staff and pregnant women.

So, I think it's pretty routine now. It's part of the fabric of the first visit as much as it can be...

Assessments:

Some participants reported that the assessment forms used by their service included questions about violence, safety, and relationships. These services included:

- SATUs
- Mental health services (roles included social worker and clinical nurse manager)
- Addiction services
- Reception centre for International Protection Applicants

The questions used were not standardised across services and usually did not refer to DSGBV specifically. Questions were mainly asked as part of the assessment process for new clients/patients of

the various services. Participants explained that it was quite common that a disclosure would not be made at this stage, as trust had not been established for the individual. Often participants saw signs subsequently that caused them to be concerned about DSGBV and they followed up by enquiring further with the person. Participants described some of the ways the signs of DSGBV are recognised:

I think as counsellors you're attuned to hearing hidden risks and you're sort of more alert to that.

...can often just come up in a kind of routine review, where somebody is telling us about the current background, their social circumstances, their relationship details, and it can come up in those sort of situations where maybe nobody had known before about it.

We do outreach and house calls... you pick up on stuff.

You can usually tell by children by their reaction when the presence of that person comes – they clam up. A smaller one who'll hold your hand, or not want you to leave.

Clinical Judgement:

Participants working in primary care and the ED reported that the approach to asking about DSGBV was usually based on clinical judgement. This depended on staff recognising the signs and enquiring as a result. Some participants spoke of their sense that they should be doing more to ask about DSGBV. One participant shared the difficulty they had linking the statistic that one in five women had experienced domestic violence, with the reality of the low number of cases they were identifying.

Yes, I would [ask about DSGBV], for example when somebody comes maybe for gynaecological problems. So, I would ask the women probably more than the men

Very rarely [asks about DSGBV]. Obviously if a woman comes in with a black eye, or a big trigger, someone is in distress, or you see something going on...I'd have to say that it would need to be ringing alarm bells right in front of me before I'd do it...

Several participants raised the issue that they felt questions about DSGBV were not being asked across the health services. As well as participants reporting their own discomfort, they also spoke of their sense that colleagues were uncomfortable asking questions about DSGBV and were not empowered to deal with it.

This doesn't happen across the board, I think. Even though there is a HSE policy in place we need to be asking ...I think some people are more comfortable asking the questions than others.

As clinicians we should know and understand it and we shouldn't be waiting on an expert. We should all be informed enough to be able to understand it. But I don't think that understanding is there and when I speak to my colleagues, I suppose I don't feel that they would feel empowered to deal with these things.

5.1.2. How do staff ask about DSGBV?

Participants described how they approached asking about DSGBV by trying to find a private space for the conversation, trying to put the person at ease, emphasising confidentiality and approaching the enquiry with sensitive, open questions that did not use terms like rape, intimate partner abuse, coercive control etc.

You're always trying to be curious, but not in an invasive way, not in an interrogation kind or way, you just kind of go at their pace.

Communication - might seem something very simple, but it's so important to get it right. And from a lot of our feedback from clients, communication is often the root cause of things not going well.

Try not to push it into a conversation in a way that the woman is made to feel your ticking a box... don't pick up the page and read it from it...Try to bring it into the conversation in that kind of a normal way that this is common, lots of women are going through this.

I can think of a few cases that I just knew by their silence that there was a story that they didn't want to say it. So, I just say "ok if you ever need to talk about that..."

...if I get the feeling there's something wrong and I would maybe start by saying, well, "is your partner treating you well?" or "are they supportive?" that kind of thing. And then ... if they say no, they're not really, then maybe I would ask.

It might come up again at a later visit when it's coming closer to delivery, I often find then they may just become distressed. And then again, I would broach it again and say, "Is there something in particular that's making you feel particularly anxious or worried about labour?" And then it can come up.

5.1.3. Asking about DSGBV: Enablers and Barriers

Enablers:

Professional skills and training

Confidence was linked to professional skills and training. Social workers and mental health professionals more commonly reported that their training helped them in their approach to asking about DSGBV. Primary care staff with previous experience working in mental health settings found that the skills they acquired in those settings helped them feel more confident asking the questions in their current roles.

As social workers, you know, in training we learn, we do a lot of interviewing skills and assessment skills and we learn about having to ask those difficult questions and, you know, not leaving an interview with a question mark about something in your in your mind.

When the patient picks up that we are comfortable talking about it, they are more likely to talk about it.

... reflective practice sessions that's a big thing in nursing, ... I think that can be good for building people's confidence, because they get to hear from other professionals ... I've seen that working when we've had difficult child sexual abuse cases and things like that.

It doesn't matter really what kind of experience we have we always need to train. You need to update, brush up on skills, keep oneself sharp.

Participants who had received specific DSGBV training reported that it was helpful. One participant had completed the HSE Train the Trainer for DSGBV and believed that training should be delivered widely. Other participants gave positive feedback on training they had done with Women's Aid and Rape Crisis Centres.

Routine enquiry:

Participants working in roles³ where asking about DSGBV was part of routine enquiry or assessment reported that over time, they had become more comfortable and confident asking the question. This was also related to their increasing confidence that it was acceptable and worthwhile asking women about domestic violence even if the answer was “no”.

So, it was kind of the belief that you were upsetting people by asking them about domestic violence rather than appreciating the fact obviously it's up to them if they want to disclose and the research would show that somebody can be asked numerous times and not disclose, but that's fine because you're really emphasising that I suppose, that they're not in isolation, that we're asking everyone as a result of it being something that is an issue for lots of women so it can give somebody a confidence around it. So, I think people are now quite comfortable [asking about DSGBV].

... the more you do it, the more you realise that at least if you ask the question then you know what's going on for the other person. If they're... able to respond to you, at least you have a base of which to build a support plan around.

One participant described working in the UK where standard questions were included in every intake assessment included a question on harm and sexual assault.

So, you automatically always ask that question in every assessment. And we were obliged to do it. ... That was a great way of trying to sort of make people feel aware that this was a space where they could talk about domestic violence or abuse that had been perpetrated against them. They kind of understood that we were able to hear that.

Environment/Setting:

A private space to ask about DSGBV was considered important by participants. Some spoke of efforts to ensure that partners or family members were not present.

I bring them into a room. Sometimes my office or somewhere private rooms that you're not going to be interrupted. And...then they're able to disclose this very sensitive information because they have been given the private space to do it.

Clinical supervision:

Some participants were in professions where they received regular clinical supervision and spoke of the value of this support.

Barriers:

Discomfort and fear

Participants worried that they were going to cause upset, make a situation worse, or appear to be speaking about something inappropriate

I think there's also a bit of personal cognitive barrier... Sometimes you nearly feel like you're accusing somebody when you're probing.

I feel that I don't want to get it wrong. People might be offended if I enquire in that direction. They might be insulted and say, "How dare you?". Particularly around sexual violence... people might consider it inappropriate, it's quite sensitive.

... a client could get very defensive about this. And therefore, you can't make assumptions. You might think something is happening, but you know... No, I wouldn't feel really comfortable enquiring. You would have to leave it up to the client, or you could ask a very sort of just probing question if they respond then great.

Dealing with the response:

Many participants spoke of the discomfort that exists around how to deal with a disclosure. There was a sense that intervention may not make a difference, that knowing what to do next was an issue, and that the practical implications of dealing with a disclosure was a barrier. Participants had frequent experiences of victims who did not want to report the crime, or who reported but then changed their minds.

It's the follow up afterwards that stops people asking the question.

If you ask a question, you need to be prepared to have to deal with the consequences... I think that might be the reason why maybe a lot of doctors don't go there so much is because of this anxiety to open a can of worms and then they know, oh, maybe I'm in here for the next hour because I have to unpick now what's going on and need to take action...because we all know that there isn't a straightforward [referral process] ...It is hard work, it's just that, there's no doubt about it...It shouldn't be that way.

3 Social worker, midwife, clinical nurse specialist, clinical nurse manager, psychologist, counsellor.

... it's not that people are uncomfortable, I would find, asking the question. It's that they don't know what to do with an answer. That can be a bigger concern.

And the other thing is, what can you do about it... In my experience, when I do come across physical violence is that by and large they're really very reluctant and don't want anything done about it. They're afraid, they don't want to go to the police, don't want to contact a social worker and just want to manage it by themselves. And I find that difficult.

Inexperience

Staff who were regularly asking the questions as part of assessment reported that they were more comfortable asking following years of experience. However, staff who were in roles that did not require them to ask the questions regularly as part of assessments reported discomfort and fear. Even experienced staff and staff who had been trained or were asking the questions as a routine part of their role referenced the fear and discomfort they had in their early careers of before they had gained experience.

So, the first time you ask that question means you haven't been through the other side of it before, you haven't supported somebody on the journey to recovery, so it's all unknown. Its [difficult] asking the question when you don't know the response. So it's scary as a human being to have to sit there and say "look, you have to ask this question".

It is quite daunting for young students coming on board to suddenly have to turn around and ask those kinds of questions that are very personal. And, you know, you're afraid you'll upset somebody. So, it definitely takes time, I think, to feel comfortable asking it

I know if somebody had come to me and told me that they were experiencing abuse I wouldn't have known what to do. I would have gone to my manager, but I'm not sure they would have known what to do.

Lack of awareness of forms of violence:

The ability of staff to recognise and enquire about DSGBV was dependent on their knowledge of forms of violence. This was particularly relevant in the case of coercive control and sex trafficking where the victim may not present with physical signs and may not be aware themselves that they are a victim of violence.

Some participants pointed out that they could only recognise or screen for the types of DSGBV that they were aware of. One participant reported that when they learned about coercive control, they began to identify cases:

I was just aware to dig a bit deeper with them, you know. Whereas I think [before]...I don't think I would have caught it because there wasn't physical abuse.

Setting – lack of privacy and time pressure

Some participants found accessing a private space to ask the questions was difficult as their work environment was not set up for private consultations.

It's even to have a private place. Yes, I think that's huge. And, you know, for the person asking the question for the person answering, if you don't feel you're in a private space that you can answer without thinking there's someone at the other side of a curtain or there's a window there and someone's going to hear me. And I think that would be a huge barrier. So, the whole setup of where you are is really important.

Participants mentioned issues including short consultation times, busy waiting rooms and the pressure of running late in clinics.

Training:

Most participants had not received any DSGBV training in their roles in the HSE and said that it was needed. Those who had accessed training found it helpful in their approach to asking about DSGBV. The need for regular training to be available and provided by the HSE was also highlighted.

I think medicine is not very good in training doctors up to be... asking the questions in a way that you yourself feel comfortable with it and with the consequences.

...it's very hit and miss. There wouldn't be a proper, you know, proper training curriculum

...even a very general training would be great. Like how to approach this topic comfortably and competently. And then the supports available and how to act when you receive information. In relation to these issues.

When you're dealing with the public all the time, you know, I think you do have to kind of keep it at the back your mind, what signs and symptoms are. I think in order to do that, I would feel directly after doing that training you know you do feel like you're very aware of it. You're very conscious of it when you're chatting to people. And then ... by the time we get into a full year, you become more complacent about this and so I do think it's something that there needs to be maybe more regular conversation about or training.

Language and Interpreters:

Participants shared concerns about:

- access to interpreters
- qualifications and training of interpreters
- availability of female interpreters
- the challenge of enquiring about DSGBV through an interpreter, while ensuring questions were being accurately translated
- the difficulty of asking questions in a culturally sensitive way using an interpreter.

Assumptions/Bias:

Some participants mentioned the risk of being influenced by assumptions or bias and spoke about how that might happen. One participant highlighted how assumptions and bias about violence being more common in the Traveller community should not prevent staff from asking questions about DSGBV. Other challenges included:

- Barriers to asking men about DSGBV:

It is probably a bit of a cultural thing. You maybe think they're not that vulnerable.

- Barriers to asking homeless people or people with problem substance use:

One participant spoke about the biases that may make it easier not to recognise or follow up on a concern in a homeless person or someone who is using substances.

- Assumptions about domestic violence and poverty:

One participant spoke of the importance of prioritising training on DSGBV for staff in the HSE to counteract the assumption that:

sometimes it's seen as something that happens if somebody is poor.

Support for staff:

Some participants highlighted the effects of trauma and burnout for staff. They emphasised the importance of clinical supervision, training, and support for staff, including non-clinical staff responding to disclosures.

...what we're finding is or what you see happening is a client will disclose to a staff member, the staff member will do their very best from a caring place to help them. But all of a sudden, they're out of their depth and they're left wondering what happened to that client after they go home. And some staff members would often talk about feeling distressed, feeling upset, coming in the next day.

Organisational Culture:

Some participants shared a sense that organisational culture was a barrier to good practice in recognising and responding to DSGBV.

I do think there needs to be probably a cultural shift - working can be quite driven towards you get this many people in and out in a day. And if somebody comes to you with you know a concern about domestic abuse, you need to clear the decks for an hour or two until you figure out where this is going, and you need to do it now. Working in the HSE doesn't lend itself to that at all. You've got clinics back-to-back. If you feel that somebody is in a vulnerable situation you want to be able to keep them in the room with you until you've got a good plan. You don't want to be sending them back out without a plan and possibly further abuse.

So, we have to do training on Children's First and you have to do training on your workstation. You know, why are we not having training about recognising domestic violence and sexual violence? I view it as absolutely fundamental. But obviously it's not privileged, is it? It's not put up there like those other things.

5.2. Respond and Refer

... I might be the first person that they tell their story to. So, they need to know that it's OK to tell the story, that they're going to get a good reaction...It can be very difficult, very embarrassing for somebody to disclose sexual or domestic violence because, you know, life might appear perfect for them, but it's not...the reaction that they get from me will dictate how they move forward.

5.2.1. How do staff respond?

Participants described their responses to disclosures and concerns about DSGBV. While those working in maternity services were following guidelines, in most other cases clear guidelines were not available. The key themes identified were as follows:

Prioritise immediate safety and child safeguarding:

All participants described safety as their priority. Participants stated that they ask if there are children in the home or any other vulnerable people. They discuss immediate needs of the person and ask questions to find out if they are safe to go home following the conversation or not. They also discussed safety planning, contacting the Gardaí, contacting SATU, and finding suitable emergency accommodation.

Bear in mind, you know, having these discussions, the person leaves you and goes home, safety is hugely important... we need to work through a safety plan then and what's in a safety plan.

My first priority would always be trying to ascertain, are they safe to go home? And is there anyone else in the home that's not safe? That maybe not the first thing I'd ask, but certainly the first priority in my head that by the end of this discussion, I need to know is everyone in the situation currently, safe or is anyone is anyone immediately threatened by the situation.

Individual response - meeting the person where they are at:

Participants described showing sensitivity and empathy, while trying to listen to the individual needs of the person. Participants emphasised the importance of not imposing any of their own beliefs on the individual as to what should happen next or whether they should leave the situation. Rather, they saw their role as presenting options and supporting the person to consider the best option for them. Many described the challenges that a victim faces in responding to DSGBV. Context was an important issue, both the context the staff were working in and the context of the person who has made the disclosure.

Every response is individual and every care plan around it is individual.

Don't impose your expectations on someone. It might be you say something and start a process going of thinking – maybe a lightbulb moment.

We've seen people that have turned their life around, but it might have taken seven years. But that's ok. Go at the person's own pace.

... assessing and determining, you know, what the needs are, then very, I suppose, sensitive questioning around what's happening to the person and maybe the type of abuses involved, what's the severity of the situation and so on.

I suppose one has to realise, that you might be the first person that disclosure has been made to... So that sort of information that's been disclosed needs to be treated very sensitively.

Referral:

Participants described a process where referrals were usually made after staff had presented options to the victim and the victim had decided how to proceed.

- Child safeguarding concerns were referred to Tusla in line with the Children First legislation.
- The Gardaí were contacted if the person wanted to report, or in cases where a staff member believed that the risk to the patient was so great that they should break confidentiality. Participants also described contacting the Gardaí for confidential advice on how they might handle cases that they were very concerned about.
- The Gardaí usually organised emergency accommodation for homeless victims of sexual assault following treatment in a SATU.
- Social workers received referrals and supported victims of domestic violence as part of their role. Where necessary they referred to specialist organisations or emergency accommodation.
- Referrals included social work, mental health services, domestic violence refuges, Women's Aid, Rape Crisis Centres, Ruhama, Spirasi, and SATU.
- Formal pathways were rare. However, maternity staff reported that automatic referral to social work was hospital policy once a disclosure of domestic violence had been made.

5.2.2. How do staff respond? Enablers and Barriers

Enablers:

Clear referral pathways:

One participant gave an example of the effectiveness of a referral pathway from an International Protection Accommodation Centre to Ruhama and Spirasi:

“that’s wonderful. So, you fill in the referrals, we are notified if the referral is accepted, is being assessed. So that’s where it works properly”.

- SATU staff across the country run education, training, and awareness sessions with staff in hospitals, GPs, EDs as well as Traveller organisations, schools, and colleges to highlight the service and how to access it.
- Participants were aware of the formal pathway to SATUs, and many had used it.
- One SATU unit had set up a new direct pathway to inpatient mental health service for acutely unwell patients. For patients who do not need immediate admission, but there is still a concern, the psychiatric liaison nurse will attend the SATU to see the patient. Previously patients would have to go from the SATU to the ED and wait to be assessed.
- Participants found the Children First reporting process clear and viewed this as a helpful in their approach to child protection and safeguarding in relation to DSGBV.

Outreach service:

Participants spoke of how helpful it was to have outreach workers from specialist support services available to meet victims. Several participants highlighted how valuable it would be to have that referral option and expertise on site in hospital settings.

SATU Option 3:

Participants from SATUs reported that the availability of the care pathway “Option 3” allowed them to offer victims the space and time they required to consider how they wanted to proceed following a sexual assault. This meant that adult victims were not faced with making a decision about reporting to An Garda Síochána immediately after an assault. Staff could conduct an examination and collect forensic samples to be stored securely for up to a year.

Multi-disciplinary team:

Participants working in a multi-disciplinary team reported that this was helpful. Other participants

spoke of how helpful it was to have experienced and skilled colleagues to consult on their approach to DSGBV.

I think the multidisciplinary team approach is really beneficial... our social work colleagues here are so helpful in this area.

I think probably having really experienced clinicians on the team, like, we have really experienced social workers here who are also family therapists...

It’s very helpful because everybody comes from a slightly different training background. It means you miss an awful lot less - like having an addictions counsellor on your team when somebody is coming in with comorbidities of trauma and addiction is worth its weight in gold.

Access to expert advice:

Many participants described the advice and support they received from other professions and agencies in dealing with DSGBV concerns, including specialist service providers, the Gardaí, social work, local domestic abuse organisations, Traveller organisations, and organisations supporting migrants.

Electronic charts:

One participant described the advantage of electronic charts since they were introduced in a maternity hospital. Previously, to check if a person had previous admissions or any reference to domestic violence in their notes, the staff would have to go to a chart room and check handwritten notes. Since the introduction of electronic charts staff can easily see all the previous presentations, in one centralised system.

Barriers:

Lack of clear and available referral pathways:

Participants described the difficulty they have accessing services without a formal referral pathway. Some participants described a disjointed and time-consuming process of making multiple phone calls looking for advice, information, and appropriate services for victims. Several participants highlighted the need for centralised, coordinated referral pathways to access specialist support services and information. Some participants also referenced long waiting lists and a lack of available beds in domestic violence refuges. In one example, a participant described their frustration when only one suitable source of specialist counselling support was available for a victim in their own language. However, the waiting time for the service was a year.

One participant explained that the main referral route from the ED for victims of DSGBV was the hospital social work team. However, access to the team at night or weekends was not available. Patients who were victims of DSGBV would be offered the option of staying in the department overnight if staff had concerns for their safety or admitted through the clinical decision unit.

So, while we can teach people how to ask the question, we also need to teach people how to answer the question. Who do you refer to? That's where you need your signposting.

Especially when staff are moving around the country ...When you join a primary care team there isn't a list of: Here's who's in the primary care team, and here's their jobs. And here's all their criteria for referral and their mobile numbers. That information doesn't exist in the bundle together... if I need to find out about social worker on any one of my teams, it would take a series of telephone calls to even figure out if there was a social worker. So, if I was in that situation already with somebody sitting in the room with me and they were in stressful situation. And you know, I wouldn't necessarily be able to get advice.

Lack of referral options for vulnerable groups:

Many participants described the difficulties they faced accessing suitable services for referring victims of DSGBV. As well as waiting lists and a shortage of accommodation, the criteria for admission to these services was an issue. These challenges were particularly striking in accessing services for people with problem substance use, homeless people, migrant women, and International Protection Applicants living in direct provision accommodation. The challenge was even greater when looking for services for those with multiple vulnerabilities. When a victim had been actively using drugs around the time of referral, participants reported that it was extremely difficult to find referral options for specialist support services.

Referrals for people with problem substance use:

It's not a pleasant feeling when you know that somebody is in a situation, in a relationship that's causing them such psychological and physical damage and yet, there's limited advice that you can give, or limited effect from what you're advising. If there were very good, readily available supports in place, we might feel it would be more likely that people would engage with them and be able to find a way out of the situation that they're in.

We now have case managers who work with us here and they may have access to emergency accommodation, which is great. But the clients would be reluctant to go because they say, "I'm not going into a hostel, I'm not going into a hostel for a night, I'm safer on the streets" or "I'm safer at home than I am in a hostel". So that's why a lot of the referral pathways wouldn't necessarily be available to us or the safest options for our clients.

One participant spoke about the challenge of supporting vulnerable women in high-risk situations where no single intervention was ending the domestic violence:

...there has to be more than just saying: "Do you want to speak to the social worker?" or "I can refer you to [service for homeless women]" ...So, it's kind of almost like paying lip service to something that needs so much more. And it may be something that could have been made so much easier for her.

Referrals for those living in direct provision accommodation:

This is where the postcode lottery causes difficulty in Ireland. Someone might go to Cork and then they have access to primary care psychology... If they go to Kerry, they don't. We have access to particular services, in particular counties, and we have a national service that works with people, but they won't work with complex trauma, and they generally don't work with domestic violence either.

Mental health referrals:

- Participants spoke of the importance of avoiding hours of waiting in an ED to be referred to mental health immediately following an attendance in a SATU for sexual assault.
- Access to mental health services for homeless people, particularly as referrals are based on catchment areas and temporary accommodation may affect eligibility criteria.
- Access to mental health services with language services.

Emergency accommodation for homeless victims of DSGBV:

We have young women coming through here and we can only keep them for so many hours and then we're letting them out to go and find a doorway to sleep in. It's awful. It's just horrendous. We're trying to pack them up with, we have a supply of clothes here that we get, we're trying to put two or three jumpers on them and extra knickers and socks in their bags and toothpaste and stuff – they don't know where they are going, and you don't know where they're going. That's going to take a very long time to fix.

Time pressures:

Participants working in primary care faced a barrier in responding to victims of DSGBV when working in environments where there is a pressure to keep things moving, busy waiting rooms and short consultation times.

Lack of information and training in providing a culturally sensitive approach:

Several participants highlighted the lack of information they have available on a person's ethnic background when they are treating patients and they may not feel comfortable asking. This made providing a culturally sensitive approach very difficult without making assumptions that could be incorrect.

I'd be very nervous about asking somebody if they're a member of the Travelling community because it feels like a loaded question almost. ... I know they're an at-risk group, but there are definitely people who come in front of me who I never know are Travellers.

Victim's perception and recognition of abuse:

Participants described the challenge of supporting vulnerable people who had been subjected to DSGBV but did not recognise what had happened as abuse. They shared their experiences working with vulnerable people living in circumstances where DSGBV was common. There was a deep concern among these participants for these women and men, but a sense of dismay at how vulnerable they are to DSGBV and how unlikely they are to receive the support they need. Some of their experiences are included below:

Addiction and homelessness:

Violence is part and parcel of their everyday experience.

*I think abuse is defined in a very narrow way for some clients... So, they would have come from a lot of traumatic early years experiences... I just think that gives **a higher threshold of what a risk or what abuse is for clients.** I just think it completely changes their framework around it. Which is sad.*

*...but then they will disclose what happened, you know that it was actually a rape. It's more common than it should be. It's just shocking, really, you know, but for a lot of the clients, in their chaotic world, **it's almost an accepted part of their world.** ... they don't want to report for the very reasons that they don't want to be you know... not getting the results that they should be getting.*

*... it was a concern that that (pregnancy) was a result of sexual violence while she was sleeping rough. Even though she herself would say it was not. She would term it as that she was **misbehaving.***

International Protection Applicants:

*...when you think of particular countries like Somalia where rape is used as a form of sort of warfare, torture, and some of the girls would talk about it as if this is just a standard thing that they do, its part of their kind of armoury. And it is sort of minimised in a way which is just truly frightening. So frightening. But then these girls have grown up hearing about these things all of their lives as well. So, it almost becomes almost routine. **It's a terrible routine thing.***

Domestic violence and coercive control:

*...women who had lived in a domestic violence situation for many, many years... it can be difficult for them... and coercive control... it can be difficult for them to sort of articulate it as this was completely wrong. This should never have happened. You know, he should have been in prison, basically. I guess they've been so, so deflated for so, so long. **They can't see the wood for the trees anymore.***

Migrant women:

*A lot of our patients may be from migrant communities, they would come in and see us and then they might not turn up for follow up or they might not have access to a phone and things like that. And that's a difficulty. That can be a challenge. It can be a big challenge, actually... And **I worry about those patients. I think: "Gosh, are you slipping through the cracks?"** and how are we going to fix that?*

6

QUALITATIVE STUDY OF SURVIVORS: KEY FINDINGS⁴

⁴ Quotes from participants are in italics. To protect the anonymity of participants, quotes are not attributed to a numbered participant or identified by the service they were using.

THE HEALTH STAFF RESPONSE TO DSGBV: EXPERIENCES OF SURVIVORS

Participants described their experiences as victims/survivors of DSGBV in a range of circumstances and health settings. Their experiences include being asked about DSGBV by health staff and looking for help. They discussed the key factors that are necessary or helpful for disclosure and the barriers. The main settings described were:

- Hospital
- Emergency Department
- GP surgery
- Mental Health services
- Addiction services
- Social work services
- Maternity services
- SATU

6.1. Enablers: Key factors necessary/helpful for disclosure and asking for help

Safety

Safety was considered essential by participants to make it possible to disclose DSGBV. This included being made to feel safe by the staff, the environment, and knowing that they would receive help to keep them safe following disclosure.

When you when your safety has been taken away from you...your safety is key.

I think what I was looking for is the reassurance that if I did say who assaulted me and how it happened that I'd be safe saying what I needed to say, but I'd also be protected.

You need to feel safe before you can talk. If you do not feel safe, you can't say anything.

A nurse came and sat down with me, and I was checked in, even though the hospital was extremely busy, they made sure to keep checking in on me to see if I was OK. I was never left for long periods of time...

I would have gone to the hospital on numerous occasions, and at this particular stage, I went with broken ribs and (facial injuries), and they actually took me out of the waiting room and put me into a separate room, so nobody was staring at me... they made sure that I was comfortable. You know, because they obviously knew that ... I didn't want to be there, to want people staring at me ...

I feel I am somewhere that I feel safe. They take care of me. The nurse asked me a lot of questions ... just a little bit about your life before you come here. She asked me the question. That's why, I don't know, but that's why I tell her my situation is like that..

[Without the hospital checking to make sure I was going to a safe place] I could have left the hospital and went back ... and I could have been killed that night.

Confidentiality and Trust

Participants emphasised the importance of being able to speak to staff in confidence and how difficult it is to trust this as a victim/survivor of DSGBV.

That if you do say something, it's not going to get out to anybody on the streets. That it's confidential. Because if it did you could be beaten very bad and left in hospital or your life could be taken.

Approach used by Staff

A caring approach was particularly valued by many participants. When staff demonstrated warmth and took the time to listen this was reported as a positive approach that made it easier to ask for help.

You need somebody that's warm, ... that you can tell just by looking at them that they're there for you...not because they have to be there, because they want to hear your story.

.. I didn't like being touched, but they asked before they did it... they had boxes of tissues, and they were there to listen. And it didn't matter how long, how busy the place was. They made sure that they were sitting with you, and they put you at ease...They brought leaflets in which I found was helpful, and they asked to contact the Gardaí, if they needed the guards to come there. So just little steps that, they don't seem like a big deal, but are a massive deal.

They were prepared for me... So, when I got there... this thing of "I know your name" and that sounds very small, but that's huge. And then there was a delicacy with them, and there was an empathy. ... They were gentle, they explained everything... So it was a real uncommunicated understanding ... "We have to tick boxes. We all know this, but we're going to do it in the softest way ... and we're going to do it at your pace". (Description of experience being brought to a SATU from the Garda station).

Positive regard. It's the regard that's positive for you in that moment... that this is you in a situation and they're there to meet you...

If you pressurise me under that state of mind...I would have bolted before I even got medical treatment, because I would have felt like you were prying, not genuinely concerned. I think there's a certain approach and it needs to be gentler. [It can be] very clinical, and that's not what we're looking for. We're looking for ... that warmth ...so we can break down, we can cry, and we can let out what's happening...

And just to be treated like a human as well, like I'm coming from a place of addiction and sex work... and if we were treated like humans we'd want to come into your clinic.

I think it's the way that they speak to you. You know it's just having that little bit extra... If they were to say, "were you in an assault?", you're always going to say "no" straight away...Until somebody lets you know that it is a safe place, that you can stay where you need to stay and you're not going to be judged on it or that the guards are not going to be called and the kids taken out of the house.

Ability of staff to recognise the signs of DSGBV

Participants spoke positively about experiences when a staff member recognised the signs of DSGBV and responded accordingly. Key to this response was their approach to enquiry and demonstrating an understanding of the person's needs.

...so they knew and that that would be the biggest thing when I was going into the hospital ... my anxiety was high... if people were staring at me. ... it was the receptionist and then she called the nurse in straight away. So, they obviously knew the signs that they were looking at.

A participant described being in an ED with a nurse while her "abusive and scary" partner was in the waiting room:

She had access to the radio in the waiting room and I wasn't really able to talk with him there. And there was like a screen, but ... I was paranoid that he could see everything.

It was brilliant what she did. She just turned the radio [volume] up and said, "Do you feel safe?" And I [said] "no". It was brilliant, the way she did that. I just, I always remember that.

Staff experience and training

Participants described feeling reassured by health staff who demonstrated that they knew what to do. This could have been because of specialist training or following procedures. Experience, including lived experience, was also valued by some participants in finding it easier to talk to staff.

He must have had the training. I don't know that... but he was so understanding and from the off I never once felt like he was prying like he wanted information.

...a person who's been down the same road. The same as a person who has been abused. I'll go to her and ask her what did she do? ... she'll understand. She won't judge me.

Well, it was like she was able to communicate with me through just eyes...she was clearly well-informed and experienced. Experience is needed, I think.

You need to get someone who's experienced enough ...

Staff understanding of DSGBV

When the state of mind and the experience of the victim were understood by health staff, the experience of disclosure and response were reported as more positive.

A participant described the needs of women who have escaped from sex trafficking. The participant stated that although the priority for the woman is to see a doctor, the knowledge and understanding of the doctor is essential to their ability to provide an appropriate response.

The doctor needs to understand what type of situation this woman is coming out of and to understand...she is escaping.

He [GP] is very mindful of his patients who have reported traumas, anything like that. He's very good like that. He has never judged me for my drug addiction.

Support from specialist services

Specialist services were described as an essential source of support for victims/survivors.

And I'm just in a better place through the services. That's where the services are really helpful so you can rebuild your life.

I'm here, I'm able to talk today because [specialist service] gave me every support I need.

I needed the love and care that I got with refuges and refuge services and their key workers.

You're allowed up to 80 counselling sessions and that has an end date, and ... and that frightens me. ... I've come such a long way but ...it's still there though. I'm still scared.

The day I walked into that office...Yeah, it saved me. If every organisation could be like that...

A participant described the qualities of the specialist service they received support from:

Actually caring ... Letting the person know that they're being listened to. Understanding. ... They let you know they understand. You just feel comfortable there. It's safe...

6.2. Barriers: What made it difficult to disclose and get support?

Survivors described the barriers to disclosing DSGBV in a health setting and receiving support.

The impact of DSGBV: trauma, fear and self-blame

Participants described feeling traumatised, in fear for their safety, and blaming themselves. They explained the impact of this on being able to disclose to health staff or to answer questions about DSGBV. The fear of being judged and not being believed also prevented victims from disclosing. Some participants described the impact of DSGBV on addiction and using drugs to block out their trauma.

... I couldn't say the word... You know the trauma ... even though I knew. But the denial. It's unbelievable because you don't want to believe it.

... the person could have their abuser sitting out in the waiting room. They can't [tell anyone]. Like [they are thinking] "now I actually have to go home and get beaten tonight and then I'll come back in tomorrow". Really, like that's how they live.

I got kicked in the head ... and everything, but I was more thinking, if I do this and I say yes [disclose domestic violence], he's going to get arrested and then I'm going to have to face him again when I come out.

You know this is not right... Obviously, we know, but that's part of being in domestic violence. It's not just the violence, it's mentally draining for a woman to be abused mentally and physically. To where you cannot open your mouth to a person in the hospital, you're afraid for your life ... It takes time to get something like that out of a person, and if you're not willing to put that time in and you only spend five minutes with the person...

A participant described how difficult it was to disclose DSGBV if health staff only ask a direct question:

"Do I say it now or don't I say it?" And then I think if somebody had actually sat down and had made me feel like I could talk about it and I was comfortable talking about it instead of just [asking] "were you assaulted?" So maybe just gently prying a little bit more.

It's important to say women... who are traumatised, ... can present like they have mental health [problems]. And even if they do have mental health [problems], it's not OK. Women with mental health [problems] are more vulnerable than women without...

(Victim of trafficking describing her state of mind going to a GP following her escape).

At this time, I am so traumatised. I am scared of everything. Everything

So, the first thing they [health staff] need to understand is that person [victim of trafficking] is broken... broken completely. [She needs] help to have confidence and make sure she's able to get up out of this situation.

One of the big things that happens when you're traumatised is ...your brain goes off. So, you're not able to process this stuff. So, when they're asking ...you can't even think... You need the safety first and then you need a kind approach.

...because I don't know I am a victim of trafficking. I don't know because I never heard this before. I need somebody to come and explain.

Not being believed

A participant described not being believed by a doctor when she needed a termination of her pregnancy.

I kept explaining to the doctor that [the pregnancy] was from domestic violence. That it was from rape, and I couldn't go on with pregnancy because that would not help my mental health.

If you don't get a good reaction, you're going to get up and leave, and you're going to put yourself back in that situation. If I went there and they didn't believe me and they didn't listen to me. I would have walked out...

Lack of follow up

Participants described the impact of not receiving follow up from health staff, particularly in the context where a person may not be ready to disclose, but still needs care.

Even if they gave you a card..." we understand you might not be comfortable right now, but... when you feel good enough, this is your way out".

Let her make her mind up as to what she needs to do...don't give up on her.

I just walked outside, checked myself out and I was gone. Nobody followed up on me. So, I could have been dead.

(Describing leaving hospital in distress following a miscarriage and feeling too afraid to report a rape). No one came and counselled me.

Victims of trafficking emphasised their urgent need for ongoing mental health care in addition to their physical health care needs.

The problem is, inside I don't escape. My body escapes, but here [points to head], no. And it's too long before I get help.

It was the longest wait of my life. I was so consumed with...guilt, shame, regret, everything. I was self-medicating with drugs. I went from one drug to another to another. And...after waiting 6 or 8 months to get it [to have an appointment with a psychiatrist] ...I never heard from him again after. So I was like where is the help?

An additional issue raised by participants was that it was difficult to be treated by a male health staff member following DSGBV. They stated that it was also easier to disclose DSGBV to female health staff.

Barriers in response and referral:

There were lots of different, dismissive I suppose, unprofessional approaches...responses, actions, inactions to it [domestic violence].

Staff lacking experience and training

They're probably getting embarrassed too. I don't know. They probably don't feel confident enough.

... she [GP] was taken aback for sure she didn't have the experience or the training for that at all... And, yeah, the concern was there, but she was very much out of her depth with me walking in there. ... She didn't refer me anywhere for anything. And where could she refer me? What could she do? Probably nothing, so where were her resources then?

Education. And it's mad to say a doctor needs to learn. But the realness [of sex work and addiction] and how to talk to someone...

Like some would know more than others. Everyone should have an idea. But if someone was coming in with bruises all the time... [some health staff] wouldn't even clock that.

Description by a victim/survivor of sex trafficking of being advised to go walking by a GP following her disclosure:

But I can't go out. I stay suffering. He doesn't understand.

A focus on a justice response rather than a health response

Participants described their experiences of finding no alternative to reporting to the police and no support if they did not report.

...You don't want that pushed on you... "Get him arrested. He should be in jail". That is not what a woman needs to hear when she's gone through that. Because that's a fear she already has, and she's already stopped talking because of that. He's already stopped her talking.

Lack of visibility of services and lack of referral

Participants frequently reported that they could not find support services and did not know where to go for help.

I just think that there needs to be a lot more support for the mother who's in the domestic violent relationship to help her stay with her kids and that the offer is not just to help with the kids, but for her. Because if anything, that's what drew me back to drugs more severely was because the help wasn't there for me.

I found the service provider by typing into Google: Prostitution. Dublin. Help. So that's how I found them. Never heard of them and I couldn't believe they existed... I feel like that because of the stigma around what they do. I feel like that they're almost hidden away...

There should be more things [information on where to get help] put up around areas...In all the health services and any services 'if you have any problems around violence'. Very clear. Because [the issue] is hidden so deep.

Who tells me where to go? Who's there? There is nobody there. In hindsight, do I ring [rape crisis centre] and ask them these questions? Yes. But did I know that at the time? no

The **assumptions and bias of staff** leading to a lack of investigation and inappropriate response. A participant described being referred to by her GP as "a prostitute" and never receiving any information or referral to specialist support services.

...they ask you about a bruise on your face or it could be on your arm. You know that they don't investigate as much as what they should. Because it's so easy for a [Traveller] woman to turn around and say she was in a fight... because they will believe that you will be fighting, but they don't follow up on it.

The **concerns of health staff about the legal process** leading to a lack of appropriate response.

I suppose doctors, ...it becomes quite legal what they record and the willingness for them to put themselves there... and when you do go to court, you realise that nobody wants to go to court, everybody says they want to help you, but nobody actually wants to turn up ...I respect their position, but they can't help you without connecting the information for that person. Like unless, in my experience, unless there was secondary proof from a doctor, from an investigator, from a Garda, from a social work department, et cetera, that that it's an allegation, and ... it still was buried.

6.3. Issues requiring further research:

Participants raised a number of issues that were beyond the scope of this report but should be considered as issues requiring further research in order to provide healthcare to victims/survivors of DSGBV.

The use of counselling and other medical records as evidence in court

Participants described experiences where counselling notes were used as evidence by the defence in sexual violence court cases.

They subpoenaed every one of my counselling notes and they trawled years of counselling notes. ... It's absolutely disgusting that that can be done to somebody.

A further issue was the importance of what is recorded by health staff as they may be important for the victim to use as evidence in court at a later stage.

[It's important] for those people that you are meeting [health staff] to be making good records. I'm not able to go home and write up stuff ... because I'm too upset.

Access to healthcare for victims of trafficking.

Participants emphasised that they could not access healthcare until they escaped. They described circumstances where traffickers refused to allow a visit to a doctor or a hospital when they were ill. Medicine was provided by the traffickers in some circumstances.

I have a lot of problems. He never sent me to see the doctor. He just brings you the medicine.

I am so bad. I am so sick. All my body is painful. I need to go to a doctor. And then she said no, you don't go to the doctor, you stay like this.

7

CONCLUSIONS

The voices of survivors in this review highlight the impact a skilled and empathetic approach by health staff can have on victims dealing with the trauma of DSGBV. The experiences they share illustrate how the approach of health staff can either support disclosure or present a significant barrier. Barriers to disclosure are barriers to safety, they are barriers to care and, therefore, their consequences for victims of DSGBV cannot be underestimated. A health service response to DSGBV must be committed to removing barriers to disclosure and providing pathways to care.

The findings of the qualitative study of survivors of DSGBV present the enablers that participants identified as helpful for disclosure and supporting victims. The enablers described demonstrate that the safety of victims must be prioritised in the approach of staff, the protocols used, and the environment of health service settings. The findings show that to enable disclosure, staff should be skilled, well informed, and have an empathetic approach. Survivors described the importance of staff being able to recognise the signs of DSGBV, taking time to enquire, and allowing the victim the time they need to respond. Survivors reported that follow up and referral are necessary following disclosure. In particular, they described the positive impact of the care provided by specialist DSGBV services.

The voices of health staff in this review reflect a clear willingness and desire to provide care for victims of DSGBV through the health service and an understanding of how that should be done. Despite the existence of HSE policy and practice guidelines, staff face significant barriers preventing them from providing a comprehensive and appropriate response. The barriers described by participants in this review present a picture of frontline health staff working in settings without clearly defined responsibilities, protocols, and care pathways for supporting victims of DSGBV. The survey of acute hospitals shows that six of the ten responding hospitals did not have a hospital policy that included standard procedures or guidelines for enquiry about domestic or sexual violence, six hospitals did not have a specific policy for enquiry in the ED, and seven did not use a specific screening tool. The survey also highlights that in eight of the ten responding hospitals screening or enquiry was carried out based on clinical judgement of health staff. However, the qualitative study shows that the ad hoc nature of skills and awareness training was a significant barrier to staff having the confidence to recognise and respond to victims. This finding links strongly with the emphasis placed by the WHO on systems strengthening and integrative training in response to the complex challenges presented by DSGBV (WHO 2013, 2014, 2017).

Frontline health staff need to be trained and supported to enquire about DSGBV. Policies and guidance must provide protocols for staff that are designed to be fully achievable in their specific role and setting. Without these protocols, existing barriers such as time and privacy will continue to be barriers to enquiry.

The survivors in this review describe the essential role of specialist DSGBV support services in providing the care and support they needed. Access to the services provided by these specialist organisations is central to a comprehensive healthcare response to victims of DSGBV and must be recognised in the design of that response. Formal referral pathways to specialist services for DSGBV, including rape crisis centres, domestic violence services etc., must be developed and incorporated into DSGBV protocols. The design of these pathways will require a multi-agency approach, working in partnership with the specialist service providers to ensure an integrated response for victims.

The barriers highlighted by staff in providing appropriate referrals for victims of DSGBV should be addressed. In particular, access to support services for vulnerable groups and victims facing multiple disadvantages should be incorporated into the development of referral pathways.

The results of the survey of acute hospitals highlights the significance of the medical social work role as a key referral pathway, source of specialist support, and provider of training. It was beyond the scope of this review to examine the implications of this in terms of resource and training requirements. This requires further research.

The HSE National DSGBV Policy sets out an ambitious goal of training all frontline health staff to respond to DSGBV. This goal should now be prioritised, and the scale of this task must be recognised and resourced. The commitment in the *Third National Strategy on Domestic, Sexual & Gender-Based Violence 2022-2026* to develop a HSE National DSGBV Training strategy is a welcome development and should be implemented in accordance with the timeline outlined in the implementation plan.

Finally, the *Third National Strategy on Domestic, Sexual & Gender-Based Violence 2022-2026* emphasises the importance of a victim/survivor-centred approach and codesign. An evidence-based approach to policy relies on high quality health research. If ethical, timely and high quality victim/survivor-centred research is to form part of this evidence base, the HSE must ensure that access to an appropriate research ethics committee is prioritised for this purpose.

8

FINAL RECOMMENDATIONS

If there's a clearly defined screening approach, a clearly defined responsibility to do it, and then clearly defined pathways out. So: "You're obliged to screen for this. This is how you do it. This is what you do with the outcomes". That would be hugely helpful.

Participant, qualitative interviews of frontline health staff

1. Develop Formal Referral Pathways for use by HSE staff accessing care for victims of DSGBV

- a. Referral, as a core part of the HSE 3Rs policy, should be facilitated by clear, accessible and integrated care pathways.
- b. The process of referral by HSE staff for victims of DSGBV should be reviewed to identify gaps and opportunities for replication of good practice across the HSE. This should include a specific focus on the practice of referral to specialist DSGBV service providers.
- c. Formal referral pathways should be developed to ensure an efficient and effective referral process to services within the HSE and to external service providers.
- d. Referral pathways should be designed in consultation with key stakeholders, including specialist domestic and sexual violence service providers, to ensure a coordinated, multi-agency response for victims of DSGBV.
- e. Referral pathways should be designed to ensure access to suitable specialist support services for vulnerable groups and victims facing multiple disadvantages.
- f. Referral pathways should include defined pathways for cases identified by HSE staff as high risk. The multi-agency response required for high-risk cases should be defined and a formal pathway developed in collaboration with relevant stakeholders. The suitability of replicating the U.K. Multi Agency Risk Assessment Conference in an Irish context should be considered.

2. Develop protocols for enquiry and response:

- a. Enquiry for DSGBV and response should be guided by clear protocols based on HSE policy and with a clearly defined purpose.
- b. Protocols should define the responsibilities of staff depending on their role and setting.
- c. Protocols should be designed in consultation with staff to be practical and appropriate for specific settings. This process should prioritise settings listed in the Council of Europe methodology: *Mapping Support Services for Victims of Violence against Women in Line with The Istanbul Convention Standards*.
 - Accident and Emergency
 - Mental Health
 - General Practitioners
 - Maternity
- d. Protocols should include referral pathways.
- e. In the absence of a centralised IT system that provides a unique patient health identifier, protocols should be established on sharing information to ensure an integrated response to providing services for victims of DSGBV while protecting confidentiality.
- f. These protocols should consider vulnerable and "hard to reach" victims of DSGBV who may not be registered with a G.P.
- g. Protocols should be available in an easily accessible format for staff to allow quick reference. The [reference card](#) format available from the National Healthcare Communication Programme provides resources for staff that can be downloaded to a mobile phone.

3. Develop a national HSE DSGBV Training Strategy

- 3.1 A comprehensive national HSE DSGBV training strategy should be designed to train all frontline health staff and implement High Level Goal 1, Objective 2 of the *HSE Policy on Domestic, Sexual and Gender Based Violence*: 'To deliver training in Domestic Violence and/or Sexual Violence to all HSE frontline staff'.
 - a. The training strategy should be based on a framework that identifies the knowledge and skills required by frontline health staff to follow the DSGBV protocols in their role and setting.
 - b. The training strategy should build on the *HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual: Recognising and Responding to Victims of Domestic, Sexual and Gender-Based Violence (DSGBV) in Vulnerable or At-Risk Communities*

- c. The strategy should be designed to provide defined levels of training to meet the knowledge and skills required by staff responding to DSGBV in defined roles and contexts. At a basic level, all staff should be trained to respond to a disclosure.
 - d. The training strategy should engage the expertise of domestic and sexual violence specialist service providers who are currently providing specialist training on DSGBV.
 - e. Training should be provided at regular intervals to ensure that skills and knowledge are regularly updated.
 - f. Training content should be designed in consultation with key stakeholders to facilitate an integrated, inter-agency response for victims of DSGBV that addresses existing barriers for victims/survivors and staff.
 - g. Training content should include lived experience perspective, designed and delivered in consultation with survivors of DSGBV.
 - h. Training should be designed to include evaluation.
- 3.2 A process of engagement with key stakeholders should take place to progress the inclusion of training on DSGBV as part of the undergraduate or pre-qualifying curriculum, and part of the continuing professional development, for health and social care professionals.

3.3 Intercultural awareness training should be completed by all frontline health staff in line with Goal 3 of the *Second National Intercultural Health Strategy 2018–2023*:

‘Provide intercultural awareness training to all relevant staff, and take into account the needs of staff who work with a diverse population’. A HSE Intercultural Awareness ELearning Programme is available on www.hseland.ie.

4. Ensure staff have access to DSGBV support services and information

- 4.1 The issues of self-care, trauma and burnout for staff should be recognised in HSE policy and guidance relating to DSGBV, and appropriate supports provided.
- 4.2 Staff who are victims of DSGBV should have access to specialist DSGBV support and information.

5. Record ethnicity data

5.1 Implement actions under Strategic Objective 1, Goal 4 of the *Second National Intercultural Health Strategy - 2018–2023*:

‘Work towards the development of high quality data collection, monitoring and evaluation to build an evidence base on minority ethnic health and ensure evidence-informed practice.’

5.2 Ongoing HSE plans to record ethnicity data should consider the value of collecting such data from service users so that health staff have correct individual information, avoid assumptions or bias in their engagements with service users, and ensure that they are meeting the needs of service users from diverse ethnic and cultural backgrounds appropriately.

5.3 HSE staff should undertake Introduction to Ethnic Equality Monitoring training accessible on www.HSEland.ie

6. Complete development of a model for interpreting provision across the HSE

a. Ensure completion of ongoing work to implement actions under Strategic Objective 2, Goal 1 of the *Second National Intercultural Health Strategy - 2018–2023*:

‘Develop a model for interpreting provision across the HSE’.

7. Ensure that the implications for the health service response to DSGBV are considered in relation to the disclosure of counselling and other medical records in domestic and sexual violence court cases

7.1 The HSE should be engaged as key stakeholders in the implementation of the following recommendations of the Review of Protections for Vulnerable Witnesses in the Investigation and Prosecution of Sexual Offences O’Malley Report:

‘Effective steps should be taken to bring the existence of section 19A of the Criminal Evidence Act 1992 regarding the disclosure of counselling records to the attention of victims and any persons who are advising them. It is important that victims should be aware of their right to object to the disclosure of such records.

Further consideration should be given to the question of whether the disclosure of medical records should be made subject to a statutory regime similar to that applicable to the disclosure of counselling records.’

a. The HSE should consider whether the disclosure of counselling records and medical

records, any changes to existing practice, has implications for consent policies in the health service or the training needs of health staff.

- b. The HSE should be engaged as key stakeholders in the Department of Health's review as part of the implementation of action 3.3.8 of the Third National Strategy on Domestic, Sexual & Gender-Based Violence Implementation Plan:

'Examine and review the rationale for the disclosure of counselling notes as part of court proceedings including a victim/survivor perspective.'

8. Ensure information on DSGBV and services for victims is visible and accessible in healthcare settings

- a. The HSE should implement action 2.1.6 of the Third National Strategy on Domestic, Sexual & Gender-Based Violence Implementation Plan:
'Ensure health facilities provide information about sexual and domestic violence services.'

9

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Appendix 1

Topics to Include in a Protocol/SOP

Extract from World Health Organisation (2017) *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers* pp. 26-27

Job aid 3.1

Topics to include in a protocol/SOP to address violence against women

Regulations and key principles of care

- Define key terms related to violence against women (see Annex 1, page 126).
- Operationalize the principles of woman-centred care based on human rights, gender equality, privacy, safety and confidentiality (see Chapter 1, pages 9–10).
- Identify what acts of violence against women are criminalized in the law.
- Identify what other laws (for example, related to forensic examination, abortion, mandatory reporting) have implications for providers of health care to women subjected to violence (see Chapter 6, pages 60–61).

Service provision

- Specify the role of each health worker from the time the woman enters the facility to the time she leaves (see Chapter 4, pages 38–39).
- Indicate how providers will be supported in self-care and coping with burnout.
- Define the core elements of an essential package of services (see Chapter 7, page 76).
- Describe patient flow and procedures that promote privacy and eliminate waiting time for women who have experienced violence.
- Provide a simple pictorial reference for health-care providers that depicts the flow diagrams or algorithms (see Annex 2, page 129).
- Specify both internal coordination, referral pathways and partnerships within the health sector and external coordination with other sectors (see Chapter 8, page 82).
- Specify the equipment, commodities and communication materials that will be needed (see Chapter 5, page 56).
- Specify any special measures to be taken to promote access and adapt service delivery for especially vulnerable populations (for example, women with disabilities, ethnic minorities,

women who cannot pay for health services, sex workers, women who are migrants).

Documentation, including data collection and management

- Specify where and how information about violence is to be recorded and stored and what information will be shared with whom, including chain of custody for forensic specimens (see Chapter 9, pages 103–108 and Annexes 9 and 10).
- Specify how confidentiality of records will be maintained, including who in the health-care system has access to records (see Annex 11, page 155).
- Specify what information will be compiled, reported and how frequently for purposes of monitoring and improving quality of care (see Chapter 9, pages 106–107).

Appendix 2:

Preliminary Recommendations (arising from the first phase of the research)

1. Develop Formal Referral Pathways for use by HSE staff accessing care for victims of DSGBV

- a. Referral, as a core part of the HSE 3Rs policy, should be facilitated by clear, accessible and integrated care pathways.
- b. The process of referral by HSE staff for victims of DSGBV should be reviewed to identify gaps and opportunities for replication of good practice across the HSE.
- c. Formal referral pathways should be developed to ensure an efficient and effective referral process to services within the HSE and to external service providers.
- d. Referral pathways should be designed in consultation with key stakeholders to ensure a coordinated, multi-agency response for victims of DSGBV.
- e. Referral pathways should be designed to ensure access to suitable specialist support services for vulnerable groups and victims facing multiple disadvantage.
- f. Referral pathways should include defined pathways for cases identified by HSE staff as high risk. The multi-agency response required for high-risk cases should be defined and a formal pathway developed in collaboration with relevant stakeholders. The suitability of replicating the U.K. Multi Agency Risk Assessment Conference in an Irish context should be considered.

2. Develop protocols for enquiry and response:

- a. Enquiry for DSGBV and response should be guided by clear protocols based on HSE policy and with a clearly defined purpose.
- b. Protocols should define the responsibilities of staff depending on their role and setting.
- c. Protocols should be designed in consultation with staff to be practical and appropriate for specific settings. This process should prioritise settings listed in the Council of Europe methodology: *Mapping Support Services for Victims of Violence against Women in Line with The Istanbul Convention Standards*.
 - » Accident and Emergency
 - » Mental Health
 - » General Practitioners
 - » Maternity
- d. Protocols should include referral pathways.
- e. In the absence of a centralised IT system that provides a unique patient health identifier, protocols should be established on sharing information to ensure an integrated response to providing services for victims of DSGBV while protecting confidentiality. These protocols should

consider vulnerable and “hard to reach” victims of DSGBV who may not be registered with a G.P.

- f. Protocols should be available in an easily accessible format for staff to allow quick reference. The reference card format available from the National Healthcare Communication Programme provides resources for staff that can be downloaded to a mobile phone.

3. Develop a national HSE DSGBV Training Strategy:

- 3.1 A comprehensive national HSE DSGBV training strategy should be designed to train all frontline health staff and implement High Level Goal 1, Objective 2 of the *HSE Policy on Domestic, Sexual and Gender Based Violence*: ‘To deliver training in Domestic Violence and/or Sexual Violence to all HSE frontline staff’.
 - a. The training strategy should be based on a framework that identifies the knowledge and skills required by frontline health staff to follow the DSGBV protocols in their role and setting.
 - b. The training strategy should build on the *HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual: Recognising and Responding to Victims of Domestic, Sexual and Gender-Based Violence (DSGBV) in Vulnerable or At-Risk Communities*
 - c. The strategy should be designed to provide defined levels of training to meet the knowledge and skills required by staff responding to DSGBV in defined roles and contexts. At a basic level, all staff should be trained to respond to a disclosure.
 - d. The training strategy should engage the expertise of key stakeholders currently providing specialist training on DSGBV to health staff.
 - e. Training should be provided at regular intervals to ensure that skills and knowledge are regularly updated.
 - f. Training content should be designed in consultation with key stakeholders to facilitate an integrated, inter-agency response for victims of DSGBV.
 - g. Training content should include lived experience perspective, designed and delivered in consultation with survivors of DSGBV.
 - h. Training should be designed to include evaluation.
- 3.2 A process of engagement with key stakeholders should take place to progress the inclusion of training on DSGBV as part of the undergraduate or pre-qualifying curriculum, and part of the continuing professional development, for health and social care professionals.

3.3 Intercultural awareness training should be completed by all frontline health staff in line with Goal 3 of the *Second National Intercultural Health Strategy 2018–2023*:

‘Provide intercultural awareness training to all relevant staff, and take into account the needs of staff who work with a diverse population’. A HSE Intercultural Awareness ELearning Programme is available on www.hseland.ie.

4. Ensure staff have access to DSGBV support services and information:

4.1 The issues of self-care, trauma and burnout for staff should be recognised in HSE policy and guidance relating to DSGBV, and appropriate supports provided.

4.2 Staff who are victims of DSGBV should have access to specialist DSGBV support and information.

5. Record ethnicity data

5.1 Implement actions under Strategic Objective 1, Goal 4 of the *Second National Intercultural Health Strategy - 2018–2023*:

‘Work towards the development of high quality data collection, monitoring and evaluation to build an evidence base on minority ethnic health and ensure evidence-informed practice.’

5.2 Ongoing HSE plans to record ethnicity data should consider the value of collecting such data from service users so that health staff have correct individual information, avoid assumptions or bias in their engagements with service users, and ensure that they are meeting the needs of service users from diverse ethnic and cultural backgrounds appropriately.

5.3 HSE staff should undertake Introduction to Ethnic Equality Monitoring training accessible on www.HSElanD.ie

6. Complete development of a model for interpreting provision across the HSE

a. Ensure completion of ongoing work to implement actions under Strategic Objective 2, Goal 1 of the *Second National Intercultural Health Strategy - 2018–2023*:

‘Develop a model for interpreting provision across the HSE’.

Appendix 3:

Feedback from Consultation on Preliminary Recommendations

A stakeholder consultation process invited feedback on the preliminary recommendations (see Appendix 2) of the interim report from the first phase of the research. Submissions were invited from the members of the monitoring committee for the 2nd National Strategy on DSGBV. Four organisations provided comments, which informed the final recommendations of the review. Comments received are summarised below. The organisations who provided feedback were:

- An Garda Síochána
- Womens Aid
- Pavee Point
- Dublin Rape Crisis Centre

Recommendation 1: Develop Formal Referral Pathways for use by HSE staff accessing care for victims of DSGBV

- Identify if there is liaison Garda member for each hospital district and build working relationship with same.
- Traveller organisations and organisations working with Roma must be involved in consultation processes, particularly in process of referrals and referral pathways, to ensure that Traveller and Roma victims of DSGBV needs and issues are included and responded to in an appropriate way.
- Develop and use accessible visual information/referral materials that can be used with service users with limited literacy or English language skills.
- Ensure the use of interpreters when referring victims with little/no English language.
- Make sure that specialist domestic and sexual violence services are named as stakeholders.
- Referral pathways to include out of hours services - collaborate with specialist services to include on site outreach e.g. as pilots or starting in bigger hospitals.
- If HSE staff are referring to specialised support organisations, specifically name agencies like rape crisis centres, men's support services and LGBTI+ support services.

Recommendation 2: Develop protocols for enquiry and response

- The HSE should work towards a centralised IT system which would support seamless information sharing to ensure appropriate and timely enquiry and response of HSE staff throughout the country, while taking the confidentiality and data protection concerns of victims into account.

- There is a need to include consent of patient to sharing information and a clear policy on confidentiality which includes clarity on circumstances when it may be breached. Also clarity on where/how to record disclosures in a way that both communicates need to other health practitioners but is extremely sensitive to patient confidentiality, especially where there may be coercive control and monitoring by an abuser.
- Adult survivors of childhood sexual abuse can be triggered by pelvic and breast exams, genital and rectal exams, so consideration as to how such exams could trigger patients also needs to be built into the protocol for enquiry and response.

Recommendation 3: Develop a national HSE DSGBV Training Strategy

- Suggestion to incorporate the following: Traveller and Roma organisations should be involved in the consultation process to develop the DSGBV training strategy as it relates to Traveller and Roma communities. Training must be compulsory and continuous - as part of initial and ongoing training - and should coincide with promotional opportunities. Monitoring and evaluation of the training should be carried out to ensure that knowledge, confidence and skills built during training are visible and carried out in practice.
- HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual: Recognising and Responding to Victims of Domestic, Sexual and Gender-Based Violence (DSGBV) in Vulnerable or At-Risk Communities should be reviewed in active consultation with organisations representing minority ethnic communities.
- In line with the upcoming National Action Plan against Racism, review, redevelop and reframe the 'intercultural' training. Develop, deliver, evaluate and monitor training on anti-racism, interculturalism and human rights to staff, and ensure this is reflective of anti-Traveller and Roma racism. Training should be delivered to all staff in the settings - not just front-line staff who may witness violence or abuse or who may be disclosed information of abuse/violence. Training should not only provide skills and knowledge for staff but the values and approaches that should guide staff in recognising, responding and referring, including human rights, equality and anti-racism.
- In line with Public Sector Duty, ensure training on this Duty to HSE staff.
- The lack of explicit mention of specialist DV training providers. Women's Aid have decades of experience developing and delivering training

to multiple stakeholders, including a wide range of health professionals. All the recommendations are clear regarding the importance of providing DSGBV training to health and social care professionals but no specification as to who should develop and deliver this training. There needs to be a recognition of expertise held by DV & SV services and especially those that have a dedicated training function.

- There is nothing in this section on training explaining the importance of any training having a gendered analysis of domestic abuse, and the need not to pathologize those whose suffering is as a direct result of a third party's actions, which is critically important to ensure meaningful and appropriate interventions.
- The conclusion highlights the fundamental problem, in our view, that there is a reliance on clinical judgement on whether patients are asked about DVA. But if clinicians don't know how to spot the signs or don't understand the dynamics of abuse then inevitably many victims will be missed. Quote from Conclusion emphasises this issue. The survey also highlights that in eight of the ten responding hospitals screening or enquiry was carried out based on clinical judgement of health staff. However, the qualitative study shows that the ad hoc nature of skills and awareness training was a significant barrier to staff having the confidence to recognise and respond to victims.
- Training should also include something about one's understanding of attitudes, beliefs, biases which in turn can impact on the varying levels of sympathy victim/survivors may receive, depending on their circumstances and on the context of the DSGBV.
- The importance of self-care should not be underestimated.

Recommendation 4: Ensure staff have access to DSGBV support services and information

- Garda information leaflet provided for hospital staff to hand out to possible victims of Domestic Abuse
- Pavee Point supports recommendation 4
- 4.2 re staff survivors needs to be much stronger. The majority of staff in these settings are women and many statistically will have experienced domestic and/or sexual abuse. Hospitals should, if they do not already have these in place, develop and implement domestic abuse workplace policy including dv leave, supports etc... as a matter of priority.
- Add a new recommendation on collecting anonymous data on how many patients

disclosed domestic abuse and/or sexual violence. Data should include sex/gender of patient, relationship with abuser and referrals pathways (e.g. internal to social work or other and external to specialist support service or gardai). This is also useful to design response, for example to see if an on-site outreach project from a specialist domestic violence service would be useful as well as providing essential data on extent and effects of DV & SV on health, including mental health.

- In addition to supporting, staff too should be aware of and be supported in accessing any support services they need.

Recommendation 5: Record ethnicity data

- Pavee Point supports recommendation 5, as it is in line with Public Sector Duty and Ireland's international human rights obligations.
- Ethnic identifier should align with Census 2022 ethnicity question (inclusive of Roma). EEM training must be compulsory and continuous for HSE staff and online training should also be followed by more in depth in person training. Training must include support for staff in implementing EEM e.g., analysing and utilising ethnic data to inform policy, practice and budgets. Ensure ethnic equality monitoring takes place in line with human rights standards. Develop and implement accessible awareness raising activities/resources with service users to promote self-disclosure.
- The Istanbul Convention emphasises the importance of data collection and the need for States to have robust mechanisms to gather and analyse information on DSGBV. Ethnicity data feeds into data obligations and ensures service users are receiving the services they need.

Recommendation 6: Complete development of a model for interpreting provision across the HSE

- Pavee Point supports recommendation 6. Lack of interpreter services is a significant barrier to equal access, participation and outcomes in health and DSGBV services for Roma and other groups.
- In the development of an interpreter model it is important to ensure: anti-racism and anti-discrimination training for all interpreters and HSE staff; training for all HSE staff on working with interpreters; ensuring that Roma interpreters are included as an option within the list of language choices. This would allow Roma patients to access interpretation in Romani

language/to speak to someone from in their own community.

- Patients to be informed of their right to an interpreter, this should be easy to request, and without long waiting times.
- We support any initiatives which will make all services more accessible.
- Dublin Rape Crisis Centre have developed a training course entitled 'Interpreting sensitively with migrants, refugees and asylum seekers who have experienced sexual violence and other trauma'. If we can help each other through support or shared learnings, please do ask.

Other comments:

- Include a recommendation/action on undertaking special measures to train and recruit Travellers, Roma and other minorities in HSE services/frontline staff.

