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**Domestic Violence in Ireland:
an overview of national strategic policy and relevant
international literature on prevention and
intervention initiatives in service provision**

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February 2008



National University of Ireland, Galway
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Domestic Violence in Ireland – an overview of national strategic policy and relevant international literature on prevention and intervention initiatives in service provision

Introduction

In order to address the problem of domestic violence from a strategic and evidence-based perspective it is necessary to have a broad understanding of the current national and international policy and practice initiatives relating to this issue. In developing strategies to guide future service planning and provision it is important to be cognisant of contemporary findings from academic and practice arenas and incorporate key learning into service development at the strategic and front-line levels. Therefore, the purpose of this document is two-fold:

(i) to provide a detailed account of the Irish legislative and institutional context in which those planning for, and providing services to, victims and perpetrators of domestic violence operate; and

(ii) to present a conceptualisation of domestic violence as a means of understanding its causes, consequences, and prevention and intervention strategies based on a review of international literature. In particular, the role of the health services and health professionals in developing and implementing such strategies is outlined and discussed.

It is envisaged that the in-depth nature of this review, taking into account current policy and practice trends and developments, both nationally and internationally, will provide strategic direction to those responsible in the HSE for developing and providing domestic violence services. More specifically, the objectives of this review are:

(a) To inform HSE service providers on the current strategic policy regarding domestic violence in Ireland;

(b) To contribute to operational policy and planning regarding domestic violence service provision in the health and social services;

(c) To facilitate HSE management and health and social service professionals in the development and enhancement of prevention and intervention initiatives regarding domestic violence.

The document is divided into three sections. The first section provides a summary of the Irish policy context relating to domestic violence. In particular, it examines the following themes:

- Definitions of domestic violence in use in Ireland;
- The extent of domestic violence in Ireland;
- Major policy and legislative initiatives in place to address domestic violence;

- A brief account of statutory and voluntary service provision to victims of domestic violence.

The second section details key points of learning extracted from a search of international theoretical and evidence-based literature. It describes the key findings from the international literature on the prevention and intervention of domestic violence in developed countries. The literature was sourced through extensive library searches using electronic databases including: Academic and Business Source Premier (EBSCO), JSTOR, Zetoc, Web of Science (ISI), and ScienceDirect (Elsevier). The Google Scholar web based search engine was also used. Some of the main areas covered in this section include:

- The extent of health outcomes for women and children resulting from domestic violence;
- Conceptual frameworks regarding the problem of domestic violence;
- Universal and targeted strategies utilised to address both victims and perpetrators of domestic violence;
- The role of health professionals in addressing domestic violence;
- The Criminal Justice approach and interventions;
- Evaluative work relating to domestic violence prevention and intervention strategies.

The third section concludes with a brief overview of the strategic policy context of domestic violence. A series of high-level strategic points emanating from sections 1 and 2 are then summarised. Nine core principles are then outlined from the relevant literature, as a normative guide to those working in the highly sensitive area of domestic violence. The frameworks with which to address the problem, namely the public health approach, the ecological model, and the three prevention levels are then reiterated. Based on these an action model for domestic violence service provision is outlined.

This report was drafted and initially circulated to the HSE National Strategy Group on Domestic Violence for comment and opinion. As a result, the third section of the report was redrafted as outlined above in partnership with the strategy group, based on their desire for translating the key findings of the report into a framework for practice.

Section 1: Review of the Irish Policy Context Relating to Domestic Violence

1.0 Introduction

Only in recent years has the issue of domestic violence appeared on the political agenda. Changes in societal values and norms have resulted in the evolution of new perspectives on the family and its relationship with the state, accompanied by new legislative instruments which serve to protect individuals within the home. The development of domestic violence legislation in Ireland can be seen as part of this change with the Department of Justice, Equality and Law Reform taking a lead role. This is typified most recently by the establishment of COSC – the Irish Office for the Prevention of Domestic Violence - under the aegis of this Department. It is noteworthy that the role of other state departments and agencies, notably the Department of Health and Children, pertains to the funding of services for domestic violence as outlined in the National health strategy *Quality and Fairness* (2001), while a more strategic role is notably absent. Furthermore, frontline services for victims of domestic violence are almost exclusively provided by voluntary bodies.

The purpose of this section is to provide an account of the development of domestic violence policy in Ireland, its current standing and related research into the topic undertaken in this country. In this light Section 1 is divided into 4 parts: The first part discusses different definitions of domestic violence in use in Ireland, particularly in government reports; the second section addresses the prevalence of domestic violence in Ireland, detailing recent statistics on its incidents in Ireland; the third part examines the legislative and policy context of domestic violence, highlighting recent laws enacted and new institutional developments; the final part discusses the role of state and voluntary organisations in providing services to victims of domestic violence, and includes information on a recent audit conducted on behalf of the Council of Europe (Hagemann-White 2006) on domestic violence services in member countries including Ireland.

1.1 Domestic Violence: What is it?

There are several competing definitions of domestic violence adopted in Irish Research. The Irish government established a Task Force to formulate recommendations on the future direction of domestic violence policy in Ireland. In publishing its recommendations in 1997 the Task Force provided a definition of domestic violence which has underpinned institutional developments in recent years:

“the use of physical or emotional force or threat of physical force, including sexual violence, in close adult relationships. This includes violence perpetrated by spouse, partner, son, daughter or any other person who is a close blood relation to the victim” (Report of the Task Force on Domestic Violence 1997: 27).

The Task Force definition of domestic violence and the existing Irish legislation on domestic violence can be said to be gender-neutral. Although widely acknowledged that the majority of victims of domestic violence are women, it is important to recognise that victims can also be men. In a review of international gender-neutral research of domestic violence, McKeon and Kidd (2002) support this position.

The comprehensive Task Force definition of Domestic Violence highlighted above has subsequently influenced our research and is generally accepted as the standard definition in use in Ireland today.

Despite its use in government documents there are, however, alternative definitions in use. Watson and Parsons' report for the National Crime Council (2005) on rates of domestic abuse amongst men and women in Ireland defines domestic abuse as:

“a pattern of physical, emotional or sexual behaviour between partners in an intimate relationship that causes, or risks causing, significant negative consequences for the person affected.”

Their conceptualisation of domestic abuse does not incorporate singular incidents of abuse unless they lead to physical injury or “high levels of fear or distress.” Furthermore, the impetus for the report, which contains the most recent figures from a national survey on prevalence of, and attitudes to domestic abuse, comes from a concern for victims and their interaction with the criminal justice system; so while the goals of primary interventions (such as educational and informational campaigns) are mentioned they are not at the forefront of this research. Nevertheless, the conceptualisation of domestic abuse as a pattern reflects similar thinking in international research where domestic violence/abuse is seen as a process and not just a collection of incidents (Lundgren 1995; Report of the National Task Force on Domestic Violence 1997).

Whilst acknowledging that there are various phrases in use in contemporary literature – domestic violence, family violence, violence against women, spouse abuse, wife abuse, battered wives, battered women, gender-based violence, and intimate partner violence – the report *Making the Links*, written for Women's Aid notes that “domestic violence is the term most frequently used [...] because it is seen as covering *all* domestic relationships” (Kelleher and Associates, and O'Connor 1995: 4, author's emphasis). For the purposes of their research they define domestic violence as encompassing mental, physical and sexual violence, actual or intimidated, along with

“being made to have sex without giving consent, mental cruelty, isolation from family and friends, deprivation of family income or car, prevented from taking up employment, or attending education or training; deliberate damage to pets, clothes, property or other personal items” (Kelleher and Associates, and O'Connor 1995: 12).

A study of the interaction of violence and poverty and its affects on women in the west of Ireland (Clancy and Ward 2005) indicates an aspect of violence that is not always explicitly considered in many treatments of domestic violence, particularly the standard government definition – the control of economic resources. Building on the work of Kelleher and Associates, and O'Connor, their conceptualisation of domestic violence incorporates economic abuse as a specific tactic utilised by abusers, particularly in lower socio-economic groups.

Furthermore, there are several international documents which provide definitional perspective on domestic violence. The United Nations Declaration on the Elimination of all forms of Violence against Women (CEDAW), as part of the convention on the

elimination of all forms of discrimination against women, provides a comprehensive definition of violence against women, viewing it as

“gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty” (1993: Article 1 of the Convention).

In addition, the Beijing Declaration and Platform for Action, signed by the Irish government in 1995, highlights violence against women a key concern of its work. It’s lengthy definition of violence against women

“means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.”

In what is possibly the widest definition of such violence, the Declaration considers violence within the home, violence occurring within the community and violence perpetrated or condoned by the state as falling into this category.

1.2. The Prevalence of Domestic Violence in Ireland: A Review of the Statistics

Four major sources provide statistical information of the prevalence rates of domestic violence and other types of related abuse in Ireland. These are *Making the Links* (1995), annually compiled figures by the Gardai, The SAVI Report (2002), and Watson and Parsons (2005). *Making the Links*, a report written by Kelleher and Associates, and O’Connor (1995) attempted to gauge the degree of violence experienced by women in the home and detected significant trends. Of those surveyed, 18% reported that they had been subjected to some form of violence which included mental cruelty, actual physical violence, threats of physical violence, sexual violence and damage to pets, property and other items. The report noted that in line with much international literature violence against women in Ireland is not something which affects particular socio-economic groups of people, or those based in particular geographic areas of the country.

The results of the report also revealed that female victims of domestic violence mainly disclose such violence to family and friends, while lower rates were recorded for disclosure to doctors and police.

Another source of figures on the prevalence of domestic violence in Ireland is data published in the annual reports of An Garda Síochána. Figures set out below detail the number of *reported* domestic violence incidents to Gardai over the last 8 years. However, it should be noted that these figures represent what is reported rather than the number of incidents which actually occur.

Table 1: Garda Figures on Domestic Violence 1999-2006

| | 2006 | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 | 1999 |
|---------------------------|------|------|------|------|--------|------|-------|-------|
| Incidents reported | N/A | 5459 | 4911 | 8452 | 10,248 | 9983 | 10877 | 10110 |
| Injured victims | N/A | N/A | N/A | 1364 | 1050 | 1147 | 1112 | 1334 |

Source: An Garda Síochána Annual Reports 1999-2006

It should be noted that the compilation and publication of statistics relating to reported incidents of domestic violence to the Gardaí has, since 2006, been undertaken by the CSO. The method by which the CSO quantifies domestic violence incidents is different to that previously used by the Gardaí. Hence the 2006 figures below in Table 2 are provisional and relate to designated domestic violence incidents as outlined:

Table 2: Domestic violence figures (provisional) 2006

| | Number |
|--------------------------------------|--------|
| Family Law Cases | 88 |
| Child Neglect and Cruelty | 269 |
| Abandoning a child | 34 |
| Allowing a child (u-16 years) to beg | 1 |
| Bigamy | 2 |
| Breach of an interim barring order | 38 |
| Breach of a protection order | 335 |
| Breach of a barring order | 508 |
| Breach of a safety order | 305 |

Source: Correspondence with CSO August 2007

These figures are compiled on foot of information provided to the CSO by the Gardaí and are dependent on how the incidents are classified and reported by the Gardaí. While this is a positive development because it locates the task of recording and publishing such important information with the national statistical body, incidents of domestic violence may not be fully identifiable as they may be categorised as other forms of criminality, for example personal assault or minor assault.

McGee et al (2002) published a comprehensive account of Irish Experiences, Beliefs and Attitudes Concerning Sexual Violence in Ireland (The SAVI report). The prevalence of sexual violence experienced by women and men is evident from the figures below (See Table 3):

Table 3: SAVI Report: Sexual Assault and Contact Rates

| | Male (%) | Female (%) |
|---|----------|------------|
| Type of assault | | |
| • Contact sexual assault | 9.7 | 20 |
| • Unwanted non-contact sexual experience | 2.7 | 5 |
| Lifetime experience rate (as opposed to experience in the last 5 years) | 28 | 42 |

Source: SAVI Report (2002)

Over one fifth (23.6%) of those who perpetrated sexual violence against women were intimate partners or ex-partners. For male victims the main perpetrators were friends and acquaintances (42%).

Of those who disclosed their experiences, over half told a family member while over a quarter told a friend (these figures are for adult and child sexual abuse – no further differentiation is outlined in the report). Disclosure rates of experiences to professionals, including the medical, Gardaí and other health service staff, were found to be alarmingly low.

A major national survey into domestic abuse in Ireland was undertaken by the ESRI on behalf of the National Crime Council in 2003 and published in 2005 (Watson and Parsons 2005). This remains the most recent and detailed research into the experiences of victims of domestic abuse in Ireland. The findings reported relate to incidents of severe abuse as distinct from one-off events (see definition above). When the figures relating to severe abuse were analysed further the survey uncovered that of the 15% of women abused, just under half (7%) had experienced abuse in the last 5 years, with one fifth (3.2%) experiencing abuse in past twelve months. The corresponding figures for men were 4.2% and 1.6% respectively.

Table 4: Domestic abuse in Ireland 2005

| Type of abuse | Male % | Female % |
|---------------|-----------|-------------|
| Severe abuse | 6 | 15 |
| All incidents | 29 | 26 |

Source: Watson and Parsons (2005)

The impact of domestic abuse on victims is multifaceted as Table 5 below outlines.

Table 5: Impact of Domestic Violence

| Type of Injury | Male % | Female % | Total % |
|-----------------------|-----------------|-------------|------------|
| Physical | -- ¹ | -- | 54 |
| G.P/hospital visit | 59 | 23 | |
| Frightened/distressed | -- | -- | 84 |
| Major impact on lives | -- | -- | 73 |

Source: Watson and Parsons (2005)

Table 6 shows the percentages of victims who vacated the family home, remained in the home with the perpetrator, or remained in the home after the perpetrator left.

Table 6: Moved out of family home as a result of experiencing violence

| | |
|-------------------------|-----|
| Vacated the family home | 55% |
| Remained in home | 31% |
| Perpetrator moved out | 15% |

Source: Watson and Parsons (2005)

Table 7 indicates that of those who vacated the family home, a range of alternative accommodations were identified. The vast majority moved in with family or friends.

¹ -- implies not statistically significant

Table 7: Destination of those who vacated home

| Destination of those who vacated home | % |
|---------------------------------------|----|
| Family | 65 |
| Friends | 29 |
| Hotel/B&B | 12 |
| New Accommodation | 6 |
| Refuge | 5 |
| Homeless Hostel | 2 |
| Lived on the streets | 5 |

Source: Watson and Parsons (2005)

Victims of domestic abuse were likely to disclose their experiences to a wide variety of people and organisations. As with seeking alternative accommodation, a high percentage (43%) informed their immediate family of their experiences, with another 49% informing friends. Notably, one third told nobody.

The survey also addressed the matter of those at risk of experiencing domestic abuse in Ireland. However, it is noted by the authors that these figures are problematic and should not be viewed as indicating causation (i.e. simply deducing that because one is under 30, for example, one is more susceptible to domestic abuse). Instead this set of figures should be viewed as further illuminating the complexity of domestic violence and aiding a greater understanding of its occurrence.

Set out below are a number of tables which address risk of experiencing domestic abuse by age, marital status and economic status.

Table 8: Risk of domestic abuse by age

| Age Category (years) | Male | Female |
|----------------------|------|--------|
| Under 30 | 7.5% | 12.5% |
| 30-39 | 5% | 7.5% |
| 40-49 | 4% | 7% |
| 50-59 | 2% | 4% |
| 60 + | 1.5% | 3% |

Source: Watson and Parsons (2005)

Table 9: Risk of domestic abuse by marital status

| Marital Status | Male | Female |
|--------------------|------|--------|
| Never been married | 7% | 11% |
| Married | 2% | 4% |
| Separated/divorced | 15% | 21% |

Source: Watson and Parsons (2005)

Table 10: Risk of domestic abuse by economic status

| Economic Status | Male | Female |
|--------------------------------------|------|--------|
| Retired | 2% | 1% |
| Full-time work | 6% | 7.5% |
| Part-time work | 4.8% | 9% |
| Home Duties | -- | 6% |
| Unemployed/Physical Illness/Disabled | 3% | 11% |

Source: Watson and Parsons (2005)

By geographical location the survey found that there is a small increased risk of experiencing domestic abuse for those who live in urban areas as opposed to those

who live in rural areas or villages. Similarly, there is little statistical significance in the risk of domestic violence by socio-economic group.

1.3 The Policy Context of Domestic Violence: historical development and current standing

It is widely accepted that national policy relating to domestic violence underwent significant change in the 1990s, with the drafting of the Domestic Violence Bill in 1995 and its passing into law in 1996. Furthermore, the establishment and report of the National Task Force on Violence Against Women has served to underpin further developments in this policy arena. The most significant legislative developments in recent years have been the Domestic Violence Act 1996 and the Domestic Violence (amendment) Act 2002. These are now discussed in turn.

Domestic Violence Legislation Prior to 1996

The publication of the Domestic Violence Bill in 1995 was the first specific legislative instrument on domestic violence. Prior to 1976 victims of domestic violence had to pursue perpetrators through making a complaint to Gardaí and awaiting the initiation of criminal proceedings. They could also pursue perpetrators through the civil law system so long as injunctions were sought in a court higher than the district court. The Family Law (maintenance of spouses and children) Act 1976 introduced barring orders as legal instruments which offered some level of protection to victims of domestic abuse. While this was viewed as an inexpensive method by which perpetrators of violence could be removed from the family home it was only a temporary measure as the length of the order could only be a maximum of 3 months. In addition, implementation deficits and the potential for violence to be perpetrated in the period between instigation of court proceedings and final judgement were flaws in the legislation (Horgan 1998a: 6).

The Family Law (maintenance of spouses and children) Act 1981 served to address these weaknesses by extending the length of barring orders to a maximum of 12 months and introducing protection orders from the initiation of court proceedings. Yet difficulties persisted in the application of the law, with some judges unwilling to act on one incident of violence, while interpretation of law often failed to recognise any form of violence other than physical violence (ibid: 7). The Judicial Separation and Family Law Reform Act 1989 also offered a potential solution to some of the problems experienced by victims of domestic violence. This law permitted the granting of a decree of judicial separation for, amongst other things, the unreasonable behaviour of one spouse towards another. It also provided for the vacation of the family home by an offending spouse and the transferral of ownership of the family home in certain circumstances (Dail Debates 1995/1099-1100).

The Domestic Violence Act 1996

The introduction of the Domestic Violence Bill in 1995 represented a significant advance in the realm of civil law, and was heavily influenced by a number of reports, including the Second Commission on the Status of Women, the Kilkenny Incest report and submissions from the Law Reform Commission, Women's Aid and AIM (Action, Information, Motivation). When passed into law in 1996, the Act offered a number of interventions available to the courts. It provided for (Hogan 1998b:9):

1. the protection of spouses, children, dependents and other domestic relationships where their welfare or safety is in jeopardy because of the conduct of another person in the domestic relationship;
2. an increase of powers for Gardaí to arrest without warrant;
3. Legal/judicial hearings to be held simultaneously with hearings for other orders regarding custody and access, maintenance, childcare orders and conduct leading to the loss of the family home.

The Act also made a number of legal instruments available to the courts. These are:

1. Barring Orders – an order instructing the perpetrator to remain outside the family home for a defined period of time, and in certain cases, desist in the use, or threatened use of violence against the dependent person or complainant, molesting or frightening the complainant or any dependent, or be anywhere near the place of resident of the plaintiff or a dependent. A key issue here is the potential afforded to health authorities to apply for a barring order on behalf of, and in agreement with, a victim;
2. Interim Barring Orders – an instrument which aims to provide relief whilst the barring order is being determined. The court is empowered to introduce an interim barring order without notifying the respondent/perpetrator;
3. Protection Orders – a measure which does not remove the respondent/perpetrator from the home but instructs her/him not to use violence, molest or put spouse or other dependents in fear. Such an order is not a stand alone measure but rather is used until the outcome of an application for a barring or safety order had been resolved;
4. Safety Orders – similar to protection orders but available to a wider category of individuals than the previous three orders. Such categories include spouses, cohabitants for 6 of the last 12 months; a parent of an adult child, persons of full age residing in mainly non-contractual relationships; and a health board on behalf on an entitled aggrieved person (Horgan 1998b: 11-12).

Figures have recently been released by the Family Law Reporting Project on the use of these legal instruments in 2006 by victims of domestic violence. These figures are set out below in Table 11:

Table 11: Figures pertaining to 2006 use of legal instruments under Domestic Violence Act 1996

| Type of Order | Granted | Withdrawn/Struck out | Refused | Total application |
|-----------------------|----------------|-----------------------------|----------------|--------------------------|
| Interim Barring Order | 544 | 35 | 26 | 605 |
| Barring Order | 1357 | 1682 | 93 | 3132 |
| Safety Order | 1221 | 1726 | 103 | 3050 |
| Protection order | 2845 | 193 | 99 | 3137 |
| Total | 5397 | 3636 | 321 | 9924 |

Source: Family Law Matters Oct. 2007

However, a number of important omissions were highlighted by the Report of the National Task Force on Violence against Women (1997: 60). For instance, the Act does not cover certain categories of persons, including those who have a child

together but do not cohabit. Other exceptions highlighted include adult siblings who want a barring order or persons who reside with adult children in the latter's home.

The Domestic Violence (amendment) Act 2002

The Domestic Violence (amendment) Act 2002 was drafted and passed in response to a legal ruling which stated that the provisions within the 1996 Act to permit the granting of Interim Barring Orders in the absence of, or without notifying the respondent, were unconstitutional as they then stood. The 2002 Act serves to remedy this finding while also allowing for granting of a protection order in the same circumstances.

Institutional Developments

The Task Force on Violence against Women was established in October 1996 on foot of a government desire to establish a joint committee on the subject. The prevalence of domestic violence as an issue during consultations on other policy documents, such as the Department of Health and Children's (DOHC) document on Women's Health (1999), was also a spur towards establishing the Task Force.

In making a number of key recommendations regarding the provision of services by statutory and voluntary organisations, the report calls for an integrated, holistic, approach to providing services for both victims and perpetrators of domestic violence. In particular, the report is aware of the significant and crucial role the Health services can play in coordinating and providing services. A number of important recommendations include:

- *Health Services*
 - a. Recognising that health care professionals will play a significant part in detecting domestic violence, training and appropriate guidance should be provided for such staff;
 - b. Observation spaces should be developed so as to accommodate those who present with symptoms of domestic violence;
 - c. The integration of medical social workers into Accident and Emergency core staff;
 - d. The provision by community based health services of information and to act as a gateway for service referral;
- *Publicity and Awareness*
 - a. Helplines should be freephone numbers, operated by trained staff and provided with guaranteed multi-annual funding;
 - b. One stop centres should be established providing information and advice on options available to women and children in particular areas;
 - c. A comprehensive publicity and awareness campaign about the helpline should be initiated.
- *The Gardaí*
 - a. Gardaí should establish Domestic Violence and Sexual Assault Investigation Units outside Dublin;²
 - b. Gardaí should develop strong links with other statutory and voluntary organisations dealing with violence against women in the local area;

² In 1993, the Gardaí established a Domestic Violence and Sexual Assault Unit in Dublin. This has since been incorporated into the work of the National Bureau of Criminal Investigation.

- c. Gardaí should develop information packs which detail local service providers and intervention programmes;
- *Accommodation*
 - a. Refuge accommodation should conform to minimum specified standards and provide a range of support services
 - b. Outreach services should be developed for those who have left, or who cannot or do not wish to enter a refuge;
 - c. Core funding should be provided conditional on specific criteria being met. Such funding should be multi-annual in nature;
 - d. Refuges and occupants be covered by an 'in-house' medical card and be attended by a public health nurse once a month;
 - e. The role of social workers vis-à-vis refuges should be clarified by the health services;
 - f. Children's educational needs should be maintained in a stable manner as far as is practicable;
- *Policy Implementation*
 - a. Establishing and pilot a local network in each health board region to underpin a community-based approach by the end of 1997;
 - b. Establishing a National Steering Committee to further develop policies in this area;
 - c. Establishing Regional Planning Committees to determine strategies at a regional level.

The Task Force report (1997) identified the need for coherent, coordinated service provision across a range of government departments. It also suggested levels of support which victims may find useful dependent on different situations of domestic violence experienced (1997: 35-6):

- In the situation of *emerging domestic violence* victims may use a number of supports. These include:
 - a. helplines and advice channels;
 - b. interventions which aid perpetrators to take responsibility for their actions;
 - c. legal instruments such as those available by way of the Domestic Violence Acts, or other legislation such as divorce;
 - d. access to medical care and/or counselling.
- In a *crisis situation*, the range of supports which may be used include:
 - a. The Gardaí;
 - b. Medical Care;
 - c. Accommodation with a view to returning the victim to their home, or sourcing longer-term accommodation.
- Following on from crisis situations, a range of *on-going supports* may be needed. These include:
 - a. Counselling;
 - b. Income support;
 - c. Housing;
 - d. Training, education and employment;

e. Childcare.

On foot of these recommendations the government established a National Steering Committee (NSC) in 1997. The functions of the committee are to:

- ensure the regional planning committees are established;
- develop public awareness campaigns;
- coordinate and advise on the distribution of funding, the development of policies relating to perpetrator programmes, wider services and supports and criminal justice intervention.

The NSC has also established three sub-committees on legal issues, public awareness and perpetrators.

Regional planning committees bring together statutory and non-statutory services, assess existing services and draw up local/regional strategies and implementation plans (CEDAW 4th and 5th periodic report: 120; O'Connor 2004: 3). They currently operate under the auspices of the Health Service Executive, having been previously established in the regional health boards. These regional committees have recently been underpinned by commitments in two Social Partnership documents, *Programme for Prosperity and Fairness* (2001) and *Sustaining Progress* (2003), which both contained commitments to improve funding for domestic violence and utilise the committees to oversee the dispersal of such funding.

It should be noted that despite these advances in the policy domain a number of authors, including O'Connor and Amnesty International, have been critical of the absence of a strategic approach to underpin the national and regional committees. This criticism has focussed on the potential of partnership to obscure the need of senior actors at the policy and practice level to be key parts of the process, empowered to take action and deliver resources where needed. Furthermore, the lack of a national strategy or action plan to address recommendations made in the Task Force report is a cause for concern, as is the need for service commissioners, planners and providers to be cognisant of issues relating to victims of domestic violence who are already marginalised. Such issues include difficulty of access to services, isolation of traveller women in the community, homeless women and women working in prostitution (O'Connor 2004: 5-9). The need for a national action plan was further underpinned by an Amnesty International report in 2005 which highlighted the potential for services to be duplicated across regional areas in the absence of such a plan. Additionally, the absence of clear budgetary allocations for each committee can result in a lack of proper strategic planning at the regional level and inhibit the committees from performing their functions satisfactorily (Women's Human Rights Alliance, cited in Amnesty International 2005: 10).

In addition to the establishment of the NSC and regional planning committees, the Irish government established a National Domestic Violence Intervention Agency in May 2003 under the aegis of the Department of Justice, Equality and Law Reform. The agency was established on a pilot basis in Dun Laoghaire and Bray and its functions were to coordinate the work of the Gardaí, criminal justice system, health services and support groups so as to ensure the safety of victims and the progression of perpetrators through appropriate rehabilitation programmes. However this agency announced its closure in January 2007 due to a lack of funding.

As part of the newly developed National Women's Strategy, launched in April 2007, a number of objectives were identified, including the combating of violence against women through improved services for victims and effective prevention and prosecution. Following on from this, the government established the new office for the prevention of Domestic Violence (COSC) in July 2007 under the aegis of the Department of Justice, Equality and Law Reform. Staff members of COSC are drawn from a number of state bodies, namely: the Department of Justice, Equality and Law Reform, the Department of Health and Children, the Department of the Environment, HSE, the Courts Service, Probation Service, the Gardaí, and local authorities.

The main objective of COSC is to achieve a significant reduction in the rates of domestic violence in Ireland through collaborating with service providers. Specifically, the functions of COSC are:

- To enhance cooperation and coordinate activities of departments, agencies and voluntary and community organisations in the area;
- To develop and deliver awareness programmes;
- Provide leadership and direction to the National Steering Committee (NSC) and sub-committees;
- Consider and facilitate the implementation of international best practice;
- Provide secretariat support to the NSC and related sub-committees;
- Further develop and implement grant funding schemes for perpetrator programmes.

1.4 The Role of the Statutory and Voluntary Sector in providing services for victims of domestic violence, and the extent of those services

Five government departments are identified by the state as having a remit in the domestic violence domain (CEDAW 4th and 5th periodic report Ireland 2003: 119-20):

- The Department of Health and Children is responsible for the provision of health and social services to victims of domestic violence while also providing funding for work undertaken by voluntary and community organisations in supporting victims. This situation has since changed with the establishment of the Health Service Executive (HSE) in 2005. The HSE is now the state agency responsible for the delivery of health and social services in Ireland. Through this remit the HSE provides a range of services which could potentially be used by victims of domestic violence, including emergency, short-term and long-term care, mental health services, pre and post-natal services, and GP services. In addition, the HSE, through its social work initiatives, provides care for children who experience domestic violence, either directly or indirectly. It also provides funding for voluntary services specifically targeted at victims of domestic violence. In 2007, the HSE allocation for funding such services was €16.5 million.
- The Department of the Environment, Heritage and Local Government provides funding for emergency accommodation for victims of domestic violence.

- The Department of Education and Science is responsible for developing education programmes which address the issue of domestic violence. Such programmes are delivered at secondary level.
- The Department of Justice, Equality and Law Reform is responsible for any necessary legislative instruments in the area of domestic violence, and the development of perpetrator programmes. The recently published National Development Plan, 2007-2013, outlines a strong funding commitment to tackle domestic violence. This provision of funding is for specific programmes focussed on awareness raising and perpetrator initiatives. The plan provides for €21 million, to be dispersed by the Department of Justice, Equality and Law Reform, and which is to be spent over the lifetime of the plan on combating domestic violence.
- The Department of Community, Rural and Gaeltacht Affairs provides funding for community development programmes and grant-aid local groups dealing with issues relating to domestic violence.

To date, figures on the provision of services and budgets for organisations responsible for the planning and delivery of services are difficult to attain. Whilst the Department of Justice, Equality and Law Reform commissioned an assessment of current responses and future needs of victims of domestic violence in 2002, it refrained from publishing the work. The department has not been forthcoming with the document despite a Freedom of Information request being made for it some time ago.³ However, it is possible to glean some information from a variety of sources regarding the level of service provision.

Hagemann-White (2006), on behalf of the Council of Europe (COE), compiled a stocktaking study of measures and actions taken in member states to combat domestic violence against women which was the culmination of government responses to a set of questions posed by the council about the implementation of its 2002 recommendations on Equality and violence against women. A number of positive messages were highlighted in this study. The study revealed that:

- the Irish government provides funds at national, regional and local level for support programmes for victims of domestic violence;
- a publicised national action plan is in place (However, we were unable to locate this plan. A press release from the Department of Justice, Equality and Law Reform indicated that a plan was under consideration by the National Steering Committee) ;
- the Gardaí record and investigate all reported incidents of violence within the family;
- protection and assistance is provided for children who witness violence against their mothers;
- 16 intervention programmes are in place for male perpetrators of domestic violence;
- 18 shelters exist in Ireland, providing 111 places which are free of charge;
- the existence of a governmental body to coordinate, implement and evaluate activities in preventing violence against women;

³ As of 18th October 2007

- the systematic collection of medical data relating to violence against women;?
- the presence of programmes and activities in schools to educate pupils on violence against women;
- and the availability of local protection orders for victims.

Despite these positive developments, the report also highlighted a number of gaps in services for female victims of domestic violence. While initial vocational training is available for social workers and Gardaí, the report highlighted that such training is absent for most medical professions, including physicians, therapists, psychologists, nurses, and teachers. Furthermore, there appears to be a lack of immediate medical care for victims of sexual assault and no evidence of systematic recording of such incidents. Safe accommodation is not available on a twenty-four hour basis, and the current geographic distribution of such services is not satisfactory. The report also highlighted an absence of publicised police data on the sex of the perpetrator, the victim, and their relationship, if any to each other.

Voluntary and community organisations play a significant role in the area of domestic violence service provision in Ireland. For instance, *Women's Aid*, a voluntary organisation which provides advice and support to women and children who are subjected to violence in their home, produce annual statistics on levels of usage of their freephone helpline. In 2006 the helpline received 24,146 calls and the organisation responded to 11, 994 calls. It is estimated that 48% of callers in 2006 were using it for the first time. The organisation also provides follow up one-to-one visits, court accompaniments and further telephone support (<http://www.womensaid.ie/pages/what/research/docs/stats2006.pdf>).

The Rape Crisis Network Ireland (RCNI) is a lobbying organisation representing a number of Rape Crisis Centres (RCCs) around the country. RCCs provide a range of supports including telephone helplines, medical services, advocacy services, counselling and advice for victims and those supporting victims, and in some cases training and education for professionals. Although statistics are not available for all RCCs, the Dublin centre has produced annual reports for the past number of years, detailing statistics of service use. In 2006, for example, 37, 266 calls were received by the centre. These calls covered the areas of advice, counselling, information, repeat calls and training and education inquiries.

The National Network of Women's Refuges and Support Services (NNWRSS) is an umbrella body representing 37 refuge and family services in the Republic of Ireland. Each individual service provides a range of supports including emergency accommodation, helplines, counselling, advocacy, advice visits, drop-in services and court accompaniments (<http://www.nnwrss.ie/index.htm>). There is at least one service provider linked to NNWRSS in every county with the exception of Cavan and Leitrim.

In addition to these services, a number of Community Development Projects and Family Resource Centres come into contact with victims of domestic violence in their daily work. For instance, in Galway two such initiatives are the Tuam Development Resource Centre and Domestic Violence Response in Oughterard. In addition, the establishment in 2005 of the Community Response to Domestic Violence Network, with support from the Family Support Agency, represents a significant advance in providing services. The network has drawn up a code of practice for those who work

with victims of domestic violence and members of the network undergo training provided by Women's Aid (Department of Community, Rural and Gaeltacht Affairs 2005). While the level of service provided by such organisations can vary, they nevertheless provide an important point of contact for victims who wish to source information or seek referrals to specific services in the area.

Current role of the HSE and future opportunities

It is clear that much good work is being done by the health services, and its personnel, in providing services to victims of domestic violence in Ireland. However, there is still room for significant improvement so as to ensure that victims receive the best possible care when interacting with health services. To this end, the HSE should begin to think strategically about the way in which it conceptualises domestic violence and the services it provides and funds. For instance, it should encourage its frontline and managerial staff to foster a culture whereby domestic violence is viewed as a public health issue and continually addressed in a sensitive manner. Organisationally, the HSE should think about the opportunities presented to it by recent institutional changes, namely its role in COSC and its responsibility for the regional planning committees, to shift the thrust of current policy towards viewing domestic violence as a health, social and legal issue requiring a range of both cross-sectoral and multi-disciplinary responses. Moreover, the concluding section of this report (Section 3) summarises a number of core implications for the HSE in strategically planning and delivering domestic violence services.

1.5 Summary

Despite a number of competing definitions identified above, the Task Force's definition has become the standard definition adopted by Irish governmental organisations and is the characterisation which we adopt in this document. Statistically, almost one fifth of Irish women experience domestic violence at some point in their lives, with over one quarter of Irish men and women experiencing incidents of domestic abuse during their lifetime, representing a significant proportion of the population. It is clear that change has taken place in the policy area of domestic violence in response to these, and other stimuli. The Domestic Violence Act 1996 is an important milestone in the development of a range of responses to domestic violence. Significant here is the role afforded by the legislation to the HSE to act on behalf of victims of domestic violence. Importantly, the establishment of a number of institutions, including regional planning committees, but most notably, the newly established Office for the Prevention of Domestic Violence (COSC), ensures the HSE is well positioned to bring its influence to bear on this area in a strategic manner. Such strategic intent can be strengthened and underpinned from learning extracted from a range of international literature, as outlined in Section 2 below.

Section 2 Review of International Literature on Domestic Violence Prevention and Intervention Initiatives

2.0 Introduction

In order to highlight domestic violence as a serious social problem, this review begins by establishing the extent of various health outcomes for women and children resulting from domestic violence. In strategic terms, a medico-legal framework within which the problem of domestic violence is contextualised comprises a public health approach and criminal justice approach. Much of the review is based on the public health approach which is strongly advocated in the literature as the most appropriate perspective in tackling domestic violence. In addition to this approach, the complex nature of domestic violence as a cross-sectoral and multi-dimensional problem, necessitating the involvement of many constituents in addressing the problem, is highlighted.

An outline of the core considerations regarding the prevention and intervention of domestic violence is provided. In particular, a conceptual framework of domestic violence based on the World Health Organisation (WHO) (2002) ecological model for understanding the causes, consequences, prevention and intervention is described. This comprises four levels ranging from the micro to macro: individual, relationship, community, and societal. Additionally, the crucial factor regarding the timing of preventions and interventions is outlined based on various life-stage/developmental stage prevention and intervention strategies. As well as such universal strategies, the requirement for selective interventions for high-risk groups is alluded to.

The review also highlights the salient role of health professionals in particular with regards to domestic violence. Examples of Gender Based Violence (GBV) projects which may be undertaken in the health arena are outlined, in addition to the need for baseline assessment of staffs' knowledge, skills, and attitudes, and the provision of training and continuing education in the area of domestic violence.

A number of core services required for domestic violence victims including screening, safe accommodation options and advocacy are outlined.

The role of the criminal justice system and various interventions are examined. Specific interventions for domestic violence perpetrators are outlined.

Finally, the review concludes with a discussion of evaluative work with regards to domestic violence prevention and intervention initiatives.

International Human Rights & Violence Prevention

Domestic violence breaches the United Nations Universal Declaration of Human Rights (1948), and in particular Article 5 which states that “*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment*”.

The UN Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) was ratified by Ireland in 1985. The UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) is the body of

experts that monitors states' compliance with the CEDAW Convention, and to whom governments must report every five years on their progress towards full compliance.

In its General Recommendation No. 19, the CEDAW Committee instructs states to take all necessary and effective measures to combat all forms of gender-based violence, which *“is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men”*. It urges governments to ensure that laws penalising violence in the family, rape, sexual assault and other forms of gender-based violence provide sufficient protection for all women and that women's integrity and dignity be respected. Victims are also entitled to services to assist in their recovery from violations of their human rights. Under this Recommendation, the state has a clear duty to provide and adequately resource *“[p]rotective measures, including refuges, counselling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence”* (Amnesty International: Irish Section, 2005)

2.1 Broad Health Consequences of Domestic Violence

Public health is concerned with providing the maximum health benefits at a population level, that is, for the greatest number of people. Given the magnitude of its occurrence and the extent of its consequences, violence is a global public health issue. It is a leading cause of death for people aged 10 –44 years, and results in annual death rates comparable to those of other major public health threats, such as tuberculosis, road traffic injuries and malaria (WHO, 2005).

Research indicates that women suffer disproportionately more from domestic violence than men, yet violence against women has only recently been recognized as a legitimate concern for societies (Sen and Östlin 2007). Women who have been the victims of intimate partner violence have poorer physical health overall, are at higher risk of homicide and suicide, and have a greater risk of developing mental health problems, reproductive health problems and somatic and medical symptoms (Pan American Health Organization, 2003 cited in Rutherford et al., 2007). Clearly therefore, the health consequences of violence have an impact far beyond the immediate injury and require knowledgeable care (Hagemann-White, 2006). Moreover, there is still a dearth of research on the health effects of violence on very young children and the full range of these effects over time (Humphreys et al., 2005).

The seriousness of the problem of interpersonal violence in terms of women's physical, reproductive, mental, behavioural and social health is succinctly documented by Heise et al (2002) and Stevens (2001) as set out in Tables 12 and 13 below.

Table 12 Health outcomes of violence against women (Heise et al 2002)

| | |
|----------------------------------|--|
| <i>Fatal outcomes</i> | Homicide Suicide Maternal mortality AIDS-related |
| <i>Nonfatal outcomes</i> | |
| Physical health | Injury Functional impairment Physical symptoms Poor subjective health Permanent disability Severe obesity |
| Chronic conditions | Chronic pain syndromes Irritable bowel syndrome Gastrointestinal disorders Somatic complaints Fibromyalgia |
| Mental health | Post-traumatic stress Depression Anxiety Phobias/panic disorder Eating disorders Sexual dysfunction Low self-esteem Substance abuse |
| Negative health behaviors | Smoking Alcohol and drug abuse Sexual risk-taking Physical inactivity Overeating |
| Reproductive health | Unwanted pregnancy STIs/HIV Gynecological disorders Unsafe abortion Pregnancy complications <ul style="list-style-type: none"> • Miscarriage/low birth weight Pelvic inflammatory disease |

Table 13 Health Effects of Gender-Based Violence (Stevens, 2001)

| Types of Violence | Reproductive, Behavioural, and Social Health Effects |
|--|--|
| <i>Childhood Sexual Abuse (for adolescent and adult victims)</i> | Gynaecological problems, STDs, HIV/AIDS, early sexual experiences, early pregnancy, infertility, unprotected sex, unwanted pregnancy, abortion, re-victimisation, high-risk behaviours, substance abuse, suicide, death. |
| <i>Rape</i> | Unwanted pregnancy, abortion, pelvic inflammatory disease, infertility, STDs including HIV/AIDS, suicide, death. |
| <i>Domestic Violence</i> | Poor nutrition, exacerbation of chronic illness, substance abuse, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, pelvic inflammatory disease, gynaecological problems, low-birth weight, miscarriage, adverse pregnancy outcomes, maternal death, suicide, death. |

2.2 Domestic Violence and Child Protection

International research has indicated a strong correlation between instances of domestic violence and child abuse. Although not the primary purpose of this document, it is important to consider the impact of domestic violence on children and the implications this has for both domestic violence and child protection services. In the past, children living with domestic violence tended to be neither the recipients of specific services or interventions nor focus of academic research. Indeed such children were the “forgotten victims” (Davies and Krane 2006) who were peripheral concerns of domestic violence interventions. However, with the broadening of child abuse definitions and an increased appreciation of children as victims of domestic violence, the experiences of children are now more central to the work of policy makers, practitioners and researchers in this field. One review of studies in the U.S. indicated that child abuse is 15 times more likely to occur in households with domestic violence than in households without (cited in Mills et al 2000), while another research piece indicated that child abuse and domestic violence cases overlap in 40% to 60% of cases (Garcia-Moreno 2002, cited in Women’s Health Council 2007). Barnish (2004: 64), in reviewing U.K. and international studies, comments that there is convincing evidence to suggest that “the presence of domestic violence is a risk marker for, and significant predictor of child abuse, and vice-versa.” This has been echoed by other researchers (Humphreys and Stanley 2006; Irwin and Waugh 2007).

In developing strategies to address domestic violence the reported impact of such violence by children is important to consider. A number of international and Irish based research projects have identified several consequences for children who experience domestic abuse, either directly or indirectly. Notable here is the self-reported experiences of children and parents in identifying these detrimental impacts, and participation in the development of responses to them. Such impacts include (Buckley, Holt and Whelan 2006, 2007; Hogan and O’Reilly 2007; Hester et al 2000; McGee 2000):

- unplanned pregnancy;
- anxiety, fear and dread;
- loss of confidence and self-esteem;
- stigma and secrecy;
- feeling torn or caught in the middle of parental violence;
- a deterioration in familial and peer relationships;
- reduced educational performance;
- physical injury;
- developmental problems;
- aggression;
- self-harm;
- poor or highly-developed social skills;
- parenting problems.

To date, service responses to domestic violence and child protection have tended to be disconnected from one another. In particular, the tendency to deploy a narrow definition of domestic violence in their work has caused social care workers in some cases to inaccurately assess for its presence within a child’s home and hence miss its occurrence (Irwin and Waugh 2007). Many only contemplate children who see or

hear domestic violence as requiring intervention, rather than countenancing wider definitions such as those which place importance on emotional involvement and after effects (Bourassa et al 2006). Moreover, the gendered functions of care and responsibility result in many women – who are victims of domestic violence themselves – feeling like scapegoats and blamed for not protecting their children from such violence, and in some cases losing custody of children (Davies and Krane 2007; Nixon et al 2007).

Research with victims of domestic violence, conducted by Buckley, Holt and Whelan, identified the need for sensitive services to be developed which cater for children's needs and feelings, and be inviting and user friendly, especially for teenagers. In this light the importance of "listening to children and supporting mothers to connect with their children are key functions of agencies, creating opportunities to understand and enhance safety" (Irwin and Waugh 2007). Similarly, Hogan and O'Reilly's research with both children and parents identified the important work being undertaken by refuge services in addressing their needs. However, some participants felt that more could be done to make refuges more practical, such as staffed playrooms, and addressing the short-term nature of the intervention. Moreover, a noteworthy gap in service provision is the lack of appropriate crisis accommodation for teenage boys (Hogan and O'Reilly 2007). Furthermore, a significant proportion of children, particularly teenagers, desired a community-based suite of services and supports where advice and space to think options through would be available. The research participants identified that, at the moment, there is a dearth of such services. The authors also commented on the apparent lack of sufficient risk assessment procedures adopted by social care professionals working in the field, and the urgent need to address this gap.

Additionally, and as with more general services for domestic violence, the need to adopt a multi-agency approach is viewed as essential by many researchers, as is the need for the relevant authorities to develop adequate age-appropriate risk assessment methodologies which take account of the different dimensions of a child's life (Buckley, Holt and Whelan 2007). Sufficient training needs to be provided to social workers to broaden conceptualisations of child abuse and domestic violence, while also taking into account the challenges social workers face in performing their duties (Bourassa 2006). Crucially, there needs to be commitment from top-level managers and policy actors to integrate the work of domestic violence and child protection branches of organisations, and promote collaboration between all relevant agencies (Mills et al 2000).

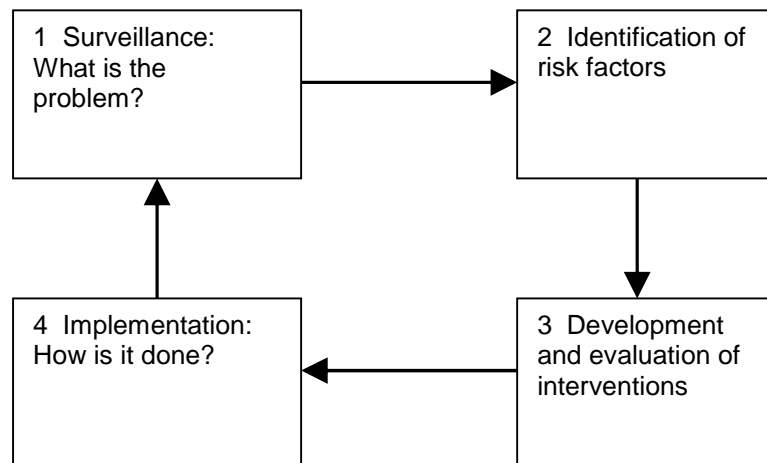
2.3 Strategic Perspectives of Domestic Violence

2.3.1 Medico-Legal Approaches to Domestic Violence – Public Health Approach & Criminal Justice Response

The World Health Organization describes domestic violence is a complex medico-legal issue involving both a public health approach and criminal justice approach (Butchart et al, 2004). The former requires the involvement of many sectors and disciplines both the prevent violence and to extend better care and safety to affected populations, with the health sector being the natural leader in this regard. In practice, the public health approach to the prevention of interpersonal violence outlined in

Figure 1 involves four distinct steps which provide a model for the design, evaluation and monitoring of domestic violence interventions (WHO, 2007).

Figure 1 The Public Health Approach (WHO, 2007)



1. The first step is to define the magnitude, scope, characteristics and consequences of such violence through the systematic collection of information.
2. The second step is to identify and research the risk and protective factors that increase or decrease the likelihood of violence, including those that can be modified through interventions.
3. The third step is to determine what works in preventing violence by developing and evaluating interventions tailored to the demographic and socioeconomic characteristics of the groups in which they are to be implemented.
4. The fourth step is to implement effective and promising interventions in a wide range of settings and, through ongoing monitoring of their effects on the risk factors and the target problem, to evaluate their impact and cost-effectiveness.

Under this public health approach to interpersonal violence prevention, the health sector is the natural leader, as it explicitly designed to define, understand, and address population-wide health challenges, and at the societal level it is the health sector that carries the major burden of care arising from the consequences of violence (Butchart et al. 2004).

Furthermore, domestic violence includes criminal behaviour that is a legitimate concern of the Criminal Justice System (Respect, 2000). The criminal justice approach attempts to deter potentially violent behaviour at the individual level with the threat of punishment for violent acts. It comprises policing and correctional approaches which encompass law enforcement, arrest policy, forensic services, community policing, domestic violence specialised units and officers, and courts. Morrison et al (2007) describe three dimensions regarding access to justice for women who have experienced gender-based violence. One dimension is offering protection to women from current and potential aggressors by improving laws and policies, mobilizing communities in defense of women's right to a life free of violence, and increasing knowledge of women's rights. A second is providing women with redress

by strengthening institutional responses - police, judiciary, forensic medicine, and legal aid - to gender-based violence. A third is raising the cost to men of engaging in gender-based violence by establishing or increasing criminal sanctions and mandating participation in treatment programs in the context of criminal prosecution of batterers.

While there is an overall trend towards broadening legal protection measures and establishing both a protective and punitive path of dealing with the problem, however, the criminal justice system is only one of the options to which women need access (Hagemann-White, 2006). A recognised criticism of such criminal justice interventions is their attempt to solve the problem through legal means alone. Since domestic violence is a complex, multi-dimensional and multi-sectoral issue, such a unitary approach is therefore problematic. A more detailed account of initiatives under this approach is discussed in the latter part of this document.

2.3.2 Domestic Violence as a Multi-Sectoral and Multi-Dimensional Problem

According to the public health approach, while a clearly identified lead agency, namely the health sector is paramount, the problem of domestic violence also requires addressing from a multi-sectoral and multi-dimensional perspective (Butchart et al. 2004). Indeed, numerous limitations of a single-agency response have been recognised at EU level, and since the early 1990s co-operative multi-agency approaches have been developed in a number of countries including the UK, Germany, Austria, and the Scandinavian countries (Hagemann-White, 2006). Types of services range from shelters, advocacy, support, group counselling for victims and perpetrators, engagement with the criminal and civil justice systems and with other voluntary and statutory sector agencies (Whitaker et al 2006; Hester and Westmarland 2005). Hester and Westmarland's (2005) review of Crime Reduction Programme (CRP) projects in the UK concluded that projects which they studied that were most successful in reducing on-going domestic violence combined intensive, pro-active, tailored and holistic advocacy and support with engagement with both the criminal and civil justice processes. In addition, it was explained that routine enquiry and primary prevention were also recognised as necessary for a comprehensive approach to tackling domestic violence. Punukollu (2003) highlights the need for a multidisciplinary team approach involving both institutional and community services in the provision of care services for abused women. Ellsberg (2006) notes that health programmes must coordinate closely with other social actors at national and local level to improve the response of governments and communities to violence against women. Butchart et al (2004) recommend that those planning health services for the victims of interpersonal violence must also take into consideration the non-medical needs of the injured and connect with the sectors responsible for meeting those needs. The authors (2004) point out that the policy decisions of various sectors as diverse as health, justice, social welfare, the working practices and programmes of civil society and for-profit service provider groups, and the institutional policies guiding domestic violence service provision (for example, in hospitals, medical and forensic services, police stations, counselling centres) are directly relevant to domestic violence victim support and care services.

Continuing the multi-sectoral and multi-dimensional vein, the Council of Europe identified six major areas of domestic violence services as follows:

1. victim protection,

2. advice and counselling,
3. policing,
4. health care,
5. child protection and
6. programmes for perpetrators.

According to the WHO (2002) the multifaceted nature of violence requires the engagement of governments and stakeholders at all levels of decision-making – local, national and international. The following recommendations reflect this need for multisectoral and collaborative approaches.

Recommendations for Action of the World Report on Violence and Health (WHO 2002)

- 1 Create, implement and monitor a national action plan for violence prevention
- 2 Enhance capacity for collecting data on violence
- 3 Define priorities for, and support research on, the causes, consequences, costs, and prevention of violence
- 4 Promote primary prevention responses
- 5 Strengthen responses for victims of violence
- 6 Integrate violence prevention into social and educational policies, and thereby promote gender and social equality
- 7 Increase collaboration and exchange of information on violence prevention
- 8 Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights
- 9 Seek practical, internationally agreed responses to the global drug trade and the global arms trade

More recently, the WHO Report on Violence against Women (2005 cited in Sen and Östlin, 2007) entitled ‘WHO Multi-country study on women's health and domestic violence - initial results on prevalence, health outcomes and women's responses’ sets out a total of 15 multi-level, multi-sectoral recommendations. From both a strategic policy and practice point of view, such recommendations are significant in addressing the problem.

WHO Recommendations regarding Violence Against Women (2005)

| |
|--|
| 1) Promote gender equality and women's human rights, |
| 2) Establish, implement and monitor multi-sectoral action plans to address violence against women, |
| 3) Enlist social, political, religious, and other leaders in speaking out against violence against women, |
| 4) Enhance capacity and establish systems for data collection to monitor violence against women, and the attitudes and beliefs that perpetuate it, |
| 5) Develop, implement and evaluate programmes aimed at primary prevention of intimate-partner violence and sexual violence, |
| 6) Prioritise the prevention of child sexual abuse, |
| 7) Integrate responses to IPV in existing HIV/AIDS prevention/adolescent health promotion programmes, |
| 8) Make physical environments safer for women, |
| 9) Make schools safe for girls, |
| 10) Develop a comprehensive health sector response to the various impacts of violence against women, |
| 11) Use reproductive health services as an entry point for identifying and supporting women in abusive relationships, and for delivering referral or support services, |
| 12) Strengthen formal and informal support systems for women living with violence, |
| 13) Sensitise legal and justice systems to the particular needs of women victims of violence, |
| 14) Support research on the causes, consequences, and costs of violence against women and on effective prevention measures, and |
| 15) Increase support to programmes to reduce and respond to violence against women. |

The many constituents who need to be involved in tackling domestic violence indicate the complexity of the problem. For instance Stevens (2001) recommends meeting with and involving the various stakeholders in the community including: politicians, local leaders, NGOs, local health managers, health ministers, police, religious leaders, community and voluntary activists and advocates, to discuss the problem of domestic violence with them, inform them of future developments in this area to be led by the health sector, and get their support.

Furthermore, there is a need to train particular groups including the police, physicians, lawyers, and judges and teachers. Evaluation of further training in several countries shows that it is most effective when specific typical situations are presented for practical application. There are examples of good training in different countries including Denmark, Germany, and Slovenia. However, there is room for improvement, and more use should be made of the transfer potential of toolkits, curricula and training methods and media from other countries (Hagemann-White, 2006).

In addition to the professional services and stakeholders, the need to develop approaches to preventing and tackling the problem of domestic violence requires the

embedding of real rather than rhetorical service user participation. Notwithstanding the potential sensitivities and difficulties of such involvement, Hague and Mullender (2006) explain that meaningful participation of service users and other abuse survivors in the policy process can be very significant for policy development, especially because individual accounts may highlight issues—including safety, fear, danger and confidentiality - that professionals may underemphasize.

The need to improve data collection is another core task with regards to addressing the problem of domestic violence. The WHO (2004; 2005) recommends that a surveillance system of information which defines and describes the magnitude, scope and characteristics of the problem of domestic violence, to include information on individual victims, perpetrators, risk factors (from census, demographic and health surveys, employment rates, government policy, legislative records, media), risk behaviours (physical fights, bullying, carrying weapons, alcohol abuse) should be established. There is a need to assess referral and intervention services currently available for domestic violence victims (Stevens, 2001). This will determine possible gaps in service provision and the need for immediate action from an ethical point of view so that crucial services are available to victims if required. The vital importance of data gathering and analysis is also outlined in the Section 2.5 of this report which discusses evaluation of domestic violence interventions.

2.4 Domestic Violence Prevention and Intervention Models, Approaches, and Programmes

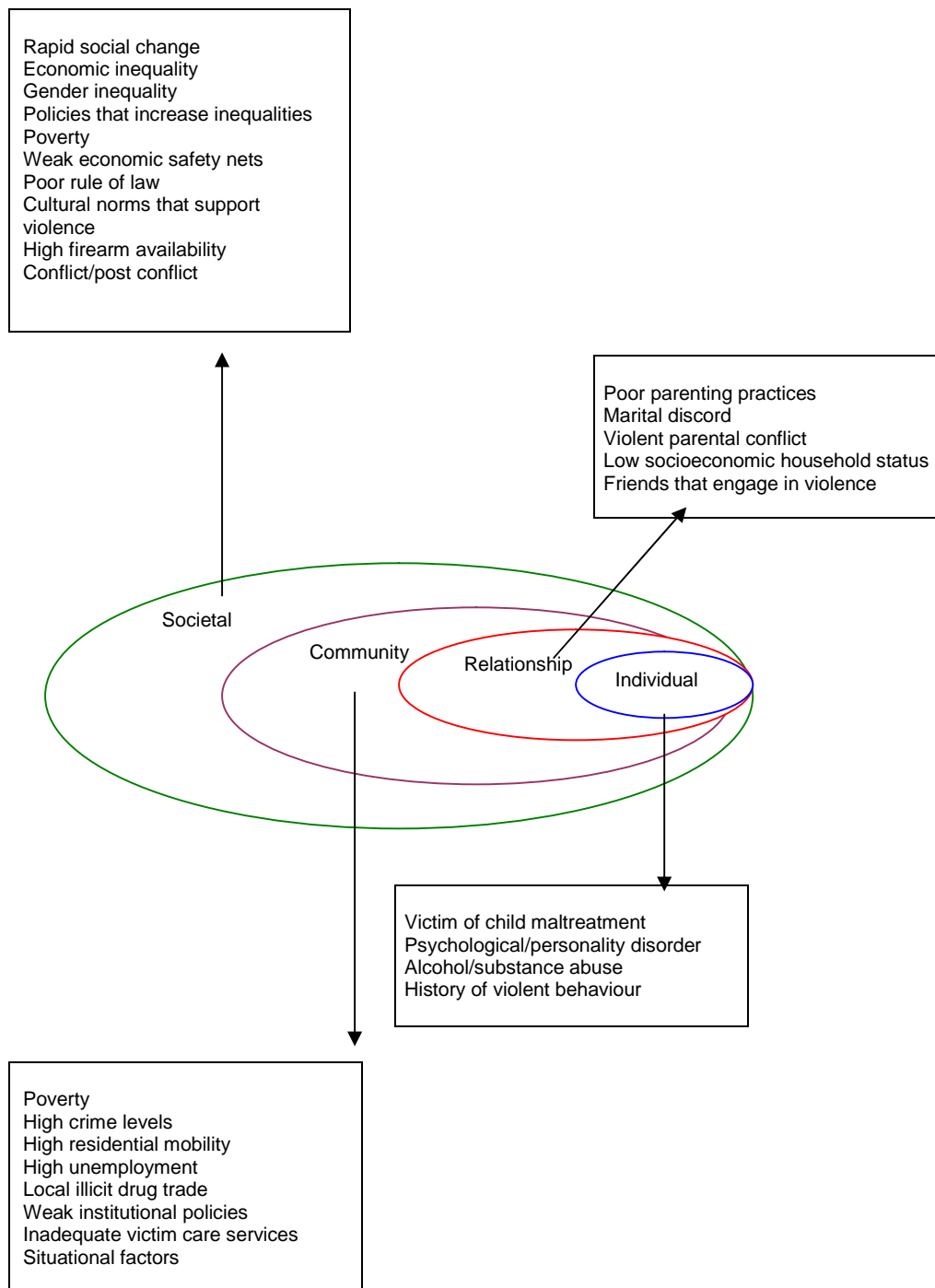
2.4.1 Ecological Model for Interventions to Prevent Domestic Violence

The *World Report on Violence and Health* (WHO, 2002) adopts an ecological model for understanding the causes, consequences and prevention of violence. The ecological model is based on evidence that no single factor can explain why some people or groups are at higher risk of interpersonal violence while others are more protected from it. Instead, the model views interpersonal violence as the outcome of interaction among many factors at four levels:

1. the individual
2. the relationship
3. the community
4. the societal.

In this model the interaction between factors at the different levels is just as important as the influence of factors within a single level (Butchart et al, 2004).

Figure 2 Ecological Model for Understanding Violence (WHO, 2002; Butchart et al, 2004)



The level at which domestic violence intervention programmes are targeted is an important factor since this influences the overarching aims of the programmes and the core factors which will be addressed in order to affect change. Based on an ecological perspective, A World Health Organization publication by Sethi et al (2004) distinguishes between four intervention levels with regards to domestic violence prevention programmes.

- *Individual* level interventions focus on changing the attitudes, beliefs and behaviours of individuals.

- *Relationship* level interventions seek to influence close relationships, such as those between parents and children, between intimate partners and between peers.
- *Community* level interventions address community level risks and the physical and social characteristics of settings such as schools, hospitals, neighbourhoods and workplaces.
- *Societal* level strategies focus on cultural, social and economic factors related to interpersonal violence, such as public awareness and accurate information about interpersonal violence, social policies around welfare, education, employment and gender, legislation relating to risk factors like alcohol and firearms, and criminal justice system reforms.

Sethi et al (2004) usefully outline examples of the various types of intervention programmes at each of these levels as set out in Table 14 below (pp.33-34):

| Individual level Interventions |
|---|
| <i>Interventions using treatment and rehabilitation</i> <ul style="list-style-type: none"> • Treatment for adolescents with conduct disorders • Individual counselling and social casework • Treatment and rehabilitation services for victims of violence • Treatment and rehabilitation services for perpetrators of violence • Treatment of child abuse offenders • Probation or parole programmes • Residential programmes in psychiatric or correctional institutes |
| <i>Educational interventions</i> <ul style="list-style-type: none"> • Providing incentives for youths at high risk of violence to complete secondary schooling Higher/vocational training • Academic enrichment programmes (including pre-school enrichment) |
| <i>Skills development programmes</i> <ul style="list-style-type: none"> • Skills programmes for younger children (5–12 yr) • Skills programmes for teenagers (13–18 yr) • Sexual abuse prevention skills training • Life skills approach |
| <i>Other individual-level interventions</i> <ul style="list-style-type: none"> • Hotlines • Training in the safe use of guns • Programmes modelled on basic military training • Trying young offenders in adult courts • Social development programmes • Conflict resolution and anger management |

| Relationship level Interventions |
|---|
| <i>Skills development</i> <ul style="list-style-type: none"> • Parent skills training • Conflict resolution for child minders of pre-school children • Mentoring • Home–school partnership programmes to promote parental involvement • Peer mediation • Peer linkage • Peer education |
| <i>Home visits, care groups, services</i> <ul style="list-style-type: none"> • Parent education and home visitation • Day care • Multidisciplinary intervention teams for caregivers of the elderly or disabled |
| <i>Interventions using treatment / therapy</i> <ul style="list-style-type: none"> • Family therapy and additional support for at-risk families • Cognitive treatment for behavioural disorders in children • Treatment for the families of adolescents with conduct disorders |

| Community level Interventions |
|---|
| <p><i>Empowerment</i></p> <ul style="list-style-type: none"> Community empowerment interventions to address underlying causes of violence (poverty, gender inequality) |
| <p><i>Media campaigns for:</i></p> <ul style="list-style-type: none"> interpersonal violence in general child abuse and neglect youth violence intimate partner violence sexual violence elder abuse other |
| <p><i>Community based campaigns</i></p> <ul style="list-style-type: none"> Rights-based campaigns School violence prevention curricula |
| <p><i>Reform of institutional settings</i></p> <ul style="list-style-type: none"> Schools-based anti-bullying interventions Workplace violence prevention Reforming hospitals and long-term care institutions |
| <p><i>Screening in primary care settings for</i></p> <ul style="list-style-type: none"> domestic violence elder abuse youths at high risk for violence |

Strategies and special services to enhance community safety

- Community policing
- Police clampdown on gang activities
- Reducing availability of alcohol
- After-school programmes
- Buying back guns
- Increasing the availability and quality of child care facilities
- Increasing the availability and quality of pre-school enrichment programmes
- Providing after-school programmes to extend adult supervision
- Improve lighting on dark streets
- Install CCTV cameras on high-risk areas
- Create safe routes for children and youth

| Societal level Interventions |
|--|
| <ul style="list-style-type: none"> • Reduction of income inequality • De-concentrating poverty • Enforcing laws prohibiting the illegal transfer of guns • Strengthening and improving police and judicial systems • Reforming educational systems • Establishing job creation programmes for the unemployed |

Social support and access to community resources are both well supported in the literature as potential mediators of intervention effects on quality of life. Such supports and resources are particularly vital for victims of domestic violence who are frequently isolated by their abusive partners. Social supports, i.e. education, employment, child care, provide the means for women to broaden their social network, thus, bringing new sources of support into their lives. Access to community resources can specifically serve to protect women from abusive partners. Whether those resources include police protection, restraining orders, safe housing, employment, transportation, etc., adequate access to community commodities and opportunities have been hypothesized to shield women from violence by intimate partners and ex-partners (Bybee and Sullivan, 2002)

2.4.2 Levels of Prevention of Domestic Violence and Life Stage Interventions

The level of prevention - primary, secondary, tertiary - is another salient factor with regards to addressing domestic violence. Appelt and Kaselitz (2000) explain that the 3-level model of prevention dates from the year 1964 and was developed by Paul Caplan for use as a prophylactic strategy in the context of psychiatry. Nevertheless, a number of experts (for example Godenzi, Taskinen and Heiliger) have adapted it to the needs of a systematic approach to dealing with violence. The three levels concerned relate primarily to the time sequence within which the various courses of action are adopted:

- Primary prevention: action to obviate violence before it occurs
- Secondary prevention: action to detect violence in time or to terminate it at the earliest possible juncture
- Tertiary prevention: action to prevent a renewed outbreak of violence or to soften the impact of violence.

Wolfe and Jaffe (1999) usefully describe how various initiatives may be addressed based on the three prevention levels.

Primary prevention strategies can introduce new values, thinking processes, and relationship skills to particular population groups that are incompatible with violence and that promote healthy, non-violent relationships. These efforts can be targeted at populations that may be at risk for violence in their intimate relationships but who have not yet shown symptoms of concern, or they can be directed universally at broad population groups, such as school-age children or members of a particular community.

In contrast to a population-based focus, *secondary prevention* efforts in domestic violence address identified individuals who have exhibited particular behaviours associated with domestic violence. An example of secondary prevention is a clear protocol for the way teachers can assist students who have discussed witnessing domestic violence in their homes but who do not show serious signs of harm.

Tertiary prevention efforts are the most common and emphasise the identification of domestic violence and its perpetrators and victims, control of the behaviour and its harms, punishment and/or treatment for the perpetrators, and support for the victims. Intensive collaboration and coordinated services across agencies may be vital in tertiary prevention efforts to address chronic domestic violence and to help prevent future generations of batterers and victims. However, tertiary efforts can be very

expensive and often show only limited success in stopping domestic violence, addressing long-term harm, and preventing future acts of violence.

Applying principles of prevention in the field of injuries and violence is an unfamiliar approach for many government ministries (Brown et al, 2007). Appelt and Kaselitz (2000) point out that secondary and tertiary prevention are virtually synonymous with intervention. In practice primary and secondary prevention tend to overlap, because those working in the primary prevention field frequently come across victims who then turn to them for support. The authors contend that action in the fields of secondary and tertiary prevention will not eradicate violence. It is capable only of acting as an early warning system for violence in the social environment, providing prompt intervention, protection and security, and lowering the risk of recurrent violence.

Life/developmental stage: Butchart et al (2004) point out many interventions are developmental stage specific (for example, infancy, adolescence, adulthood, old age) and hence the timing of their delivery is crucial. The authors emphasise the importance of preventing the development and perpetration of violent behaviour in the first place, through the promotion of primary prevention initiatives. Based on the ecological model, Table 15 below presents a range of strategies for the different stages of development which are deemed necessary for the effective primary prevention of violence.

The authors discuss several overarching multi-sectoral approaches to the primary prevention of violence, based on scientific literature relation to epidemiology, aetiology and prevention of violence, namely:

- investing in early interventions;
- increasing adult involvement;
- strengthening communities;
- changing cultural norms;
- reducing income inequality;
- improving the criminal justice and social welfare systems.

In terms of *investing in early interventions*, violence prevention programmes targeted at children or those who influence them during early development show greater promise than those that target adults (see also Debbonaire, 2004). Such early interventions have the potential to shape the attitudes, knowledge and behaviour of children while they are more open to positive influences, and to affect their lifelong behaviours.

Increasing adult involvement is promoted on the basis that inadequate monitoring, supervision and parental involvement in the activities of children and adolescents are well-established risk factors for youth violence. Conversely, there is evidence that a warm, supportive relationship with parents or other adults is protective against anti-social behaviour.

Strengthening communities. The community is the environment in which individuals and families interact, and the extent to which it condones or censures violence and its associated risk behaviours (for example, drunkenness) will be an important consideration in prevention efforts.

The cultural context also plays an important role in violent behaviour, hence the need to *change some cultural norms*. Cultural tradition and social norms are sometimes used to justify practices such as female genital mutilation, abuse of women, the severe physical punishment of children and physical violence as a means of conflict resolution among young males. Cultural norms can also be a source of protection against violence, as in the case of long-held traditions that promote equality for women or respect for the elderly.

In terms of *reducing income inequality*, although poverty itself does not appear to be consistently associated with violence, the juxtaposition of extreme poverty with extreme wealth appears to be universally associated with interpersonal and collective violence.

Finally, *improving the criminal justice and social welfare systems* is important, since cross-national studies show that the efficiency and reliability of criminal justice institutions and the existence of programmes that provide economic safety nets are associated with lower rates of homicide.

Table 15 Prevention strategies by developmental stage, ecological context and effectiveness (Butchart et al., 2004)

Dark grey box – strategies demonstrated to be effective in reducing violence or risk factors for violence

Light grey box - strategies have shown promise in reducing violence or risk factors for violence

Italics - strategies demonstrated to be ineffective in reducing violence or risk factors for violence

| Ecological Context | Developmental Stage | |
|-----------------------------------|---|---|
| | Infant & Toddler (aged 0-3) | Childhood (aged 3-11) |
| Individual | <ul style="list-style-type: none"> • Reduce unintended pregnancies • Increase access to prenatal/postnatal services • Treatment programmes for victims of maltreatment to reduce consequences • Services for children who witness violence | <ul style="list-style-type: none"> • Social-developmental training • Pre-school enrichment • School-based child maltreatment prevention programmes • <i>Drug-resistance education</i> • <i>Gun-safety training</i> |
| Relationship (e.g. family, peers) | <ul style="list-style-type: none"> • Home visitation services • Parenting training • Therapeutic foster care | <ul style="list-style-type: none"> • Mentoring • Home-school partnership programme to promote parental involvement |
| Community | <ul style="list-style-type: none"> • Lead monitoring and toxin removal • Screening by health-care providers for maltreatment | <ul style="list-style-type: none"> • Safe havens for children on high-risk routes to and from schools • After-school programmes to extend adult supervision • Recreational programmes |
| | <ul style="list-style-type: none"> • Community policing • Improving emergency response and trauma care • Training for healthcare providers in the detection and reporting of child maltreatment • Promotion of safe storage of firearms and other lethal weapons • Prevention and educational campaigns to increase awareness of child maltreatment • Child-protection service programmes • Services for incarcerated perpetrators • <i>Gun buy backs</i> | |
| Societal | | <ul style="list-style-type: none"> • Reduce media violence • Public information campaigns to promote pro-social norms |
| | <ul style="list-style-type: none"> • Strengthen police and judicial systems • De-concentrate poverty • Reduce income inequality | |

| Ecological Context | Developmental Stage | |
|-----------------------------------|---|---|
| | Adolescence (aged 12-29) | Adulthood (aged 20 and over) |
| Individual | <ul style="list-style-type: none"> • Social-development training • Educational incentives for at-risk, disadvantaged high-school students • School-based dating violence prevention programmes • Academic enrichment programme • Individual counselling • Shock probation or parole • Residential programmes in psychiatric or correctional institutions • Gun-safety training • Boot camping • Trying young offenders in adult court • Drug-resistance education • Programmes modeled on basic military training | <ul style="list-style-type: none"> • Incentives for post-secondary education or vocational training • Services for adults abused as children • Treatment for children and intimate partner abuse offenders • Waiting periods for firearm purchases • Owner liability for damage by guns |
| Relationship (e.g. family, peers) | <ul style="list-style-type: none"> • Mentoring • Family therapy • Temporary foster-care programmes for serious and chronic delinquents <p><i>Peer mediation, counselling</i></p> | |
| Community | <ul style="list-style-type: none"> • Recreational programmes • Reduce alcohol availability • Train health-care professionals in identification and referral of high-risk youth and victims of sexual violence • Metal detectors in schools • Multi-component gang-prevention programmes | <ul style="list-style-type: none"> • Reduce alcohol availability • Establish adult recreational programmes • Shelters and crisis centres for battered women and victims of elder abuse • Criminal justice reforms to criminalize child maltreatment, intimate-partner violence, and elder abuse • Mandatory arrest policies for intimate-partner violence • Public shaming of intimate partner violence offenders • Services for identifying and treating elder abuse • Train healthcare professionals in identification and referral of battered women, victims of elder abuse, and victims of sexual violence • Laws permitting gun carrying in public |
| | <ul style="list-style-type: none"> • Community policing • Improving emergency response and trauma care • Disrupt illegal gun markets • Forbid firearm sales to high-risk purchasers • Mandatory sentences for gun use in crimes • Coordinated community interventions for violence prevention | |

| | | |
|---------------------------|---|--|
| | <ul style="list-style-type: none"> • Prevention and educational campaigns to increase awareness of youth violence, intimate-partner violence and elder abuse • <i>Gun buy backs</i> | |
| Ecological Context | Developmental Stage | |
| | Adolescence (aged 12-29) | Adulthood (aged 20 and over) |
| Societal | <ul style="list-style-type: none"> • Reduce media violence • Enforce laws prohibiting illegal transfers of guns to youth | Establish job-creation programmes for the chronically unemployed |
| | <ul style="list-style-type: none"> • Strengthen police and judicial systems • Promotion of safe storage of firearms • De-concentrate poverty • Reduce income inequality • Change cultural norms that support violence and abuse of children and adults | |

In a similar manner to Butchart et al (2004) utilising a public health model, the authors Wolfe and Jaffe (1999) set out various domestic violence prevention and intervention initiatives in terms of different life stages. This is presented in Table 16, which uses the primary, secondary, and tertiary prevention paradigm to categorize a broad range of domestic violence prevention strategies, several of which are currently being tried in the United States and Canada.

Table 16 A Public Health Model for Domestic Violence Prevention (Wolfe and Jaffe, 1999)

| Life Stage | Primary (Targeted to Populations Before DV Occurs) | Secondary (Targeted to Individual, Following Early Signs of DV) | Tertiary (Targeted to Victims and Perpetrators After DV is Evident) |
|--|--|--|---|
| Infants and preschoolers (0-5 years) | Home visitation. Public health nurses and trained paraprofessionals assisting new parents. | Home visitation with high-risk families. Support and services for family members identified as being at high risk of perpetrating or becoming victims of DV. | Home visitation with abused victims and their children. Specialized services for those identified by DV specialists as having been harmed by DV. |
| School-age children (6-12 years) | School-based awareness and skill development. Collaborative efforts by schools and communities to teach violence awareness and alternative conflict-resolution skills. | Community-based early intervention. Children exposed to violence are offered crisis support, individual counselling, and educational groups. | Disorder-based treatment services. Children who show emotional and behavioural problems are offered specific mental health services that address the underlying trauma. |
| Adolescents and high-school-age youths (13-18 years) | School-based awareness and skill development. Same as school-age above, with emphasis on issues related to dating violence and forming healthy intimate relationships. | Community-based early intervention. Same as above, tailored for adolescents exposed to violence and emphasizing dating relationships. | Disorder-based treatment services. Same as above, with the possible involvement of juvenile justice system as an identification and access point for treatment. |
| Adults (18+ years) | Public education. Media campaigns promoting awareness of domestic violence and providing information about local resources and how to respond to domestic violence situations. | Community-based early intervention. Individuals exposed to violence are identified at the earliest possible opportunity and provided with appropriate, coordinated services. | Community-based intervention for chronic DV. Intensive police, court, and community collaboration to address situations of chronic and dangerous DV. |

Cognisant of the life stage approach, the societal level context and rigorous approaches, Rutherford et al. (2007) point out that developing prevention and intervention strategies, particularly in the last two decades, has demonstrated that:

- interventions delivered during infancy and in childhood and those sustained over time are more likely to be effective than short-term programmes;
- proven and promising interventions with adolescents and young adults include providing at-risk disadvantaged high school students with incentives to complete their education; and
- comprehensive, scientifically based programmes are more likely to be successful.

2.4.3 Selective Interventions for High-Risk Groups Regarding Domestic Violence

In addition to the life stage and ecological approach outlined above, domestic violence may be conceptualised in terms of population groupings. It is difficult to specifically position the problem of domestic violence within one particular group and many of the interventions to prevent the problem are of a universal nature, covering entire populations irrespective of differences in risk between subgroups (Butchart et al, 2004). However, the literature highlights a number of particularly high risk categories susceptible to domestic violence which include: those in dating relationships (particularly teens and younger adults) (Cornelius and Resseguie 2006; Whitaker et al 2006), pregnant women (Lynch 2006; Ellsberg 2006), aging women (Phillips 2000; Teaster et al 2006), prostitutes (Stanko, 2006), women accessing substance use (Galvani, 2006), women from low income backgrounds (Bybee and Sullivan 2005), ethnic-racial minority groups (Humphreys et al., 2005); and children living in families where there is domestic violence (Hagemann-White, 2006; Respect, 2000). It is important, therefore, to develop targeted primary prevention and intervention programmes to such populations, taking into account the differing needs of these heterogeneous groups. Such selective interventions work with population subgroups known to be at elevated risk of being subject to interpersonal violence (Butchart et al, 2004).

It is useful to reflect on the findings of the evaluation of the Crime Reduction Programme (CRP) part of which involved 27 domestic violence projects by Hester and Westmarland (2005) which identified indications of effective primary interventions and approaches in relation three main groups that were in contact with the CRP projects: children and young people, women experiencing domestic violence but not actively seeking help, and women who have been subject to repeat victimization and are actively seeking help.

Selective interventions for children and young people in schools who may or may not be living with domestic violence

Primary prevention in schools:

this should involve a cross-curricular approach and include student-centred interactive lessons on relationships and abuse, visual input such as drama, plus training for teachers and multi-agency support.

Individual and group work:

specific support for children and young people should include work on being safe, self-esteem, feelings and past experiences, school and family, as well as use of video input and discussion. Group work may be preceded by one-to-one (or individual work) work and be more appropriate for those already in a safe environment.

Selective interventions for women who are experiencing domestic violence but not actively seeking help

Publicity campaigns:

these should use a wide range of media such as radio, television, posters and stickers. They should aim to educate local residents and staff across agencies that domestic violence is a public crime and indicate local sources of support. Targeted publicity for Black and other minority ethnic women should be included.

Routine enquiry :

this may effectively be carried out by health and other practitioners regularly seeing women on their own. It requires at least one day of training for practitioners in awareness of domestic violence and how to ask about it, as well as good multi-agency relationships and referral systems. The Duluth 'power and control' and 'equality' wheels can be useful tools to enable women to recognise they are in an abusive relationship.

Outreach :

this should involve advocates or outreach workers regularly visiting community groups and agencies to discuss domestic violence and publicise local projects/support as well as aiding development of close multi-agency referral systems. Outreach should also be targeted at Black and other minority ethnic women where appropriate.

Supporting women to report to the police:

this requires advocacy and support that includes legal support and close links with the police. Police should collect a wide range of evidence including photographic evidence. Tackling Domestic Violence: effective interventions and approaches.

Selective interventions for women who have been subject to repeat victimisation, and who are actively seeking help

Publicity campaigns:

these should use a wide range of media such as radio, television, posters and stickers to publicise local sources of support; and should include targeted publicity for Black and other minority ethnic women.

Outreach :

this should include advocates or outreach workers regularly visiting community groups and agencies to provide a link to local projects/support for women in rural areas and other isolated communities. There should also be targeted outreach for Black and other minority ethnic women where appropriate.

Advocacy and support:

together advocacy and support should be wide ranging, pro-active, holistic and comprehensive, and preferably based in a one-stop-shop. Advocates should help women navigate the criminal and civil justice systems and other agencies as they attempt to access needed resources. Women should have the same advocate or support worker available over time, who may focus on their specific needs and enable them to deal with fear and safety issues. Workers may assist women end their emotional attachments to the violent partner by encouraging them to invest emotionally in learning new life skills and skills which assist them in finding paid employment.

Supporting women to engage with the criminal and civil justice systems:
advocacy should include legal and emotional support. Close links with the police, CPS, and with family law solicitors should be established. Women should be accompanied by an advocate to court. Police should collect a wide range of evidence including photographic evidence. There should be training on domestic violence and multi-agency links for magistrates and judges.

Staying safe:

advocates, support and outreach workers should carry out regular risk assessments with women and their children, including assessing potentially changing tactics by perpetrators. Safety planning should be carried out. Target hardening measures should include panic alarms and home security.

Moving on:

once women have been able to deal with immediate issues and are ready to 'move on' they should be offered groupwork to enable them to deal with emotional issues arising from the domestic abuse and to meet other women with similar experiences. Groupwork should take a structured approach and preferably be at least ten weeks in length.

2.4.4 The Role of Health Professionals

The unique and important position of health care professionals with regards to contact with victims of domestic violence, and particularly those working in women's health services, is widely acknowledged (Butchart et al, 2004; Stevens 2002; Buel, 2002; Ellsberg 2006; Guedes et al 2002; Heise et al 2002; Short et al 1998). It is pointed out that health care professionals are often the first point of contact by women who have experienced interpersonal violence. Battered women tend to use primary and secondary health services more than non-abused women (Ellsberg 2006). However, a major problem is the low detection rate regarding the problem of domestic violence in the health care arena and in criminal justice/police services (Lazenbatt et al 2005; Butchart et al. 2004). Notwithstanding this, considerably more cases of interpersonal violence come to the attention of health-care providers than to the police (Butchart et al, 2004). While domestic violence may often be perceived as a hidden problem as a result of such under-reporting, Stanko (2006) is critical of the lack of exploration of information and evidence pertaining to violence against women existing in either the form of official documentation from police records and social services files, or from that held informally by family and friends. She questions the implications of not acting on what we already know about the problem.

In light of the problem of under-reporting, the importance of asking victims about their experiences of domestic violence cannot be over-emphasised. A range of possible contributory factors have been linked to the problematic identification of domestic violence including predisposing factors, namely inappropriate attitudes, stereotypes, myths amongst health professionals (Corbally, 2001; Ellsberg, 2006; Guedes et al 2002; Acosta, 2002; Thompson et al 2000). Stevens (2001) discuss a range of common attitudes which health providers have about Gender Based Violence (GBV) which can inhibit them from addressing this topic and thus stop them from assisting women who are victims of GBV. These include:

- Denial – the provider distances themselves by acting as if GBV were not occurring.
- Rationalisation – providers can find reasons for not addressing the violence by stating that this is not something they deal with in their roles.
- Minimisation – the seriousness of GBV is ignored as is the important connection between the victim's past and the present day physical and psychological symptoms.
- Identification – in some cases identification can feel uncomfortable and the provider distances him/herself from the victim.
- Intellectualisation – the provider takes on the role of the “expert” who diagnoses what is going on and tells the victim what to do.

One extremely important preventive measure in the field of the health services is thus the sensitisation and training of medical staff, who must learn not only how to identify evidence of violence but also to understand the specifics of an abused woman's predicament and how difficult it is to talk about the violence she has suffered and to leave an abusive relationship. Only if medical staff understand and empathise with the specific mechanisms of control and violence at work in partnerships can they provide the appropriate help for the woman concerned (Appelt and Kaselitz, 2000).

Stevens (2001) usefully describe the core steps with regards to choosing a project option (A, B or C type) and developing and implementing a domestic violence service in reproductive health (RH) services (Tables 17 & 18), depending on the level of depth and resources available to address the problem. While developed for RH, such guidance is highly relevant for those working in other areas of the health care sector⁴. Some of the items listed shall be discussed in more detail later in this report.

Table 17 Choosing a GBV Project (Stevens, 2001)

| Project Choices | GBV Components |
|------------------------|---|
| Project A | <ul style="list-style-type: none"> • Assess availability of suitable local programmes to which victims of GBV can be referred • Sensitise all staff about GBV • Develop or purchase materials about GBV • Give out GBV material including referral information • Support staff by on-going sensitisation |
| Project B | <p>In addition to that listed in Project A:</p> <ul style="list-style-type: none"> • Training health care providers • Ask all clients who attend the facility about GBV in their lives • Document the answers to these questions • Refer victims of GBV • Support and supervise staff |
| Project C | <p>In addition to that listed for Projects A & B:</p> <ul style="list-style-type: none"> • Hire new staff or train existing staff to administer the in-depth assessment form to victims • Facilitate psychological treatment and other types of care of victims of GBV by offering external referral and/or on-site treatment |

⁴ The Guide was written primarily for reproductive and sexual health and maternal child health facilities

Table 18 Project Development Guide (Stevens, 2001)

| Project Type | Actions |
|--------------------------------|--|
| Project A Steps 1-11 | <ol style="list-style-type: none"> 1. Meet with stakeholders to both inform them and get their support 2. Assess staff capability 3. Assess financial resources 4. Assess referral services 5. Select type of GBV Project (see Table 17) 6. Create a work plan 7. Create a monitoring and evaluation plan 8. Set up a referral mechanism 9. Create GBV protocols and policies 10. Sensitize all staff 11. Develop or purchase educational material for clients |
| Project B Steps 1-17 | <ol style="list-style-type: none"> 12. Develop screening forms 13. Modify patient routing 14. Train clinical staff 15. Promote continuity of care and follow-up 16. Provide staff support, supervision and continued training 17. Educate the community |
| Project C Steps 1-18 | <ol style="list-style-type: none"> 18. Expand services and staffing |

More specifically, the need for relevant knowledge, information, skills, education and training for health professionals is a major theme in the literature (Punukollu 2003; Stevens 2002; Stevens, 2001; Bohn et al 2002; Benagiano 2002; Frank et al 2006; Short et al 1998; Hagemann-White, 2006). A significant barrier in preventing and intervening in domestic violence is the lack of appropriate education and training for health professionals (Stevens, 2002; Stevens, 2001; Acosta, 2002; Corbally, 2001; Frank et al, 2006; Short et al 1998), who therefore tend to feel inadequate in addressing the problem with their patients and clients. It follows that a useful starting point, is to assess staff and providers' knowledge about domestic violence (Stevens 2001) through well-know survey instruments such as Knowledge, Attitudes, Beliefs (KAB) (Thompson et al 2000) and/or Knowledge, Attitudes, and Practices (KAP) (Guedes et al 2002).

Following on from identifying the knowledge, attitudes and practices of healthcare staff through baseline surveys, programmes to educate health-care providers are an essential first step in violence prevention in this area (Butchart et al, 2004). Staff training functions as a mechanism to raise awareness and change attitudes regarding violence against women. It is of the highest importance that all relevant professionals receive basic knowledge about the nature of the problem during primary vocational or academic/professional training. Additionally, further or continuing education is needed both for those whose initial training did not cover this topic, and for all practitioners at different stages of their professional lives, including more in-depth education, specifically on methods of prevention and intervention (Hagemann-White, 2006). Continuous supervision and follow-up of providers are also necessary (Ellsberg 2006) in the health care practice arena, where in-service training and continuing education programmes are the predominant means (Short et al 1998).

In terms of content, specific training on violence includes issues such as: the concept of gender, all forms of violence, the situation of victims, their coping and their support needs, influence of violence on health, appropriate tools for identification of victims of violence, and means for securing evidence of violence. For some groups of professionals, training includes methods of consultation, rehabilitation, and/or social reintegration (Hagemann-White, 2006). Similarly, Stevens (2001) set out a broad range of issues to be covered in such violence sensitisation work with health professionals (Table 19). Such sensitizing helps to create an environment in which domestic violence can be openly and professionally addressed. In the absence of staff sensitisation and training, domestic violence interventions and services will continue to remain inadequate.

Table 19 GBV Topics for Sensitising All Staff (Stevens 2001)

| |
|--|
| • . Rationale for integrating GBV into reproductive health |
| • The concept of gender |
| • . Definitions of different types of GBV |
| • . Statistics |
| • . The laws against GBV in your country |
| • . Myths about GBV |
| • . The staff's own beliefs and attitudes about GBV |
| • The connection between reproductive health (RH) and GBV |
| • Why GBV occurs in society |
| • . The hidden nature of the problem |
| • . The effects of GBV on the survivor, her family and society |
| • . The dynamics of GBV |
| • . Symptoms that GBV victims manifest |
| • Barriers to talking about GBV |
| • The staff's roles with victims of GBV |

2.5 Overview of specific prevention and intervention initiatives

2.5.1 Screening

Screening by health professionals has been identified as a method of increasing the detection rate of domestic violence. Generally speaking, the argument for universal or routine screening amongst all women who attend health services, has been promoted as good practice by several health professional organisations and women's health and violence prevention advocates in the United States and United Kingdom (Butchart et al, 2004; Waalen et al 2000) on the basis that predicting which women will be affected is difficult (Punukollu, 2003). Such screening is considered the standard of care in the United States and many other industrialised countries (Ellsberg 2006). Rhodes and Levinson (2003) highlight several medical organisations' clinical practice guidelines and information sources on domestic violence interventions published in the United States and Canada. There are many validated screening

instruments/ protocols to detect violence against women (see Glowa et al 2002; Punukollu 2003).

Screening could be considered a starting point with regards to intervention. Screening for domestic violence needs to be followed up with referral and other intervention services such as physical therapy, mental health, counselling, legal and forensic, social and community services, and accommodation options, as a vital next step. In the absence of such referral and service provision, domestic violence victims remain in an extremely vulnerable situation from a health and safety point of view. From an ethical point of view, Waalen et al (2000) refers to the reluctance of health care providers to screen in settings where appropriate legal or social service follow-up is inadequate or inaccessible. Similarly, Ellsberg (2006) notes that some international experts question whether it is ethical to screen for violence if there is not a program in place and services to refer women to once they disclose violence.

2.5.2 Safe Accommodation Options

The complexity of the problem means that leaving a violent relationship is reliant on several interdependent factors spanning from the fear of the unknown, women's individual skills and competencies, to threats of further violence from their partner, availability and access to financial resources and social support, to religious and cultural barriers (Panchanadeswaran and McCloskey, 2007). Gathering the views and respecting the wishes of domestic violence victims with regards to this major decision as to one's accommodation options, and providing sound advice and tangible options is of critical importance in this regard.

Levison and Harwin (2000) point out that leaving the family home is usually a last resort for people experiencing domestic violence. It is possible that some who do leave would have stayed if improvements to the security of their current home had been made, and measures had been available to improve their personal safety. Examples include: personal alarms (usually linked to the police), mobile phones, closed-circuit television, prioritising repairs and providing door chains, extra locks and external security lighting. However, there is a lack of evidence about the effectiveness of such measures.

In the event that the domestic violence victim(s) leave the home, a survey by the National Crime Council (2005) found that informal supports are more commonly used than emergency accommodation, with family or friends cited as the most common option given in this regard.

A primary requirement for safety is ensuring the immediate access to temporary accommodation on a 24/7 basis for women and their children when they are no longer safe in their home. Shelter or refuge means a temporary accommodation for both women with children and women without children where they are safe from direct threat by the abuser and are offered qualified counselling and practical support, either in-house or by arrangement. Temporary housing alone, without qualified support, will not empower the victim of violence to claim her basic rights. Women who have been victimised face multiple and interlocking problems related to their health, financial survival, safety outside the home and well-being of their children. To provide safety, a shelter either includes or is linked to crisis services responding to the

immediate danger of a violent situation, accessible within a realistic travel time frame and around the clock (24/7) (Hagemann-White, 2006). Similarly, in their review of the Sonas Housing Association which provides supported transitional housing, O'Connor and Wilson (2004) highlight that fact that shelter and accommodation is only one aspect of meeting the needs of women and children homeless because of violence and abuse. In countries around the world, the most effective and cost-efficient form of service provision for immediate needs is ensured by having specifically trained professionals (or trained volunteers) work within accommodations that are designed to meet the safety needs of victimised women. Moreover, besides shelters, specific services to meet the needs of victims of rape and sexual assault are needed, in the form of rape crisis centres. Such rape and sexual assault services are in existence in Ireland, but not on a 24 hour basis (Hagemann-White, 2006).

O'Connor (2006) explains that in Ireland, many victims of violence are joint owners of a family home, and due to lengthy civil proceedings for separation or inadequate settlement from the sale of the home, they can find themselves in need of Local Authority housing on a temporary or long term basis. However, a significant barrier in this regard is the major gap between housing needs of applicants and the lack of housing units. It follows that both domestic violence *per se*, and the lack of affordable housing are primary reasons for homelessness⁵. A key policy failure with respect to victims of domestic violence in the Ireland is the lack of an integrated framework by Local Authorities and the health sector encompassing crisis refuge, supported housing and long term housing needs.

Safe accommodation services can be viewed from both short term and long term standpoints, and the majority of women seeking to escape from a violent relation require both types of accommodation if they are to successfully live independently of their abuser (Melbin et al 2003). First, safe accommodation services serve as an immediate, short-term remedy (Chanley *et al.*, 2001), enabling women and children to escape an abusive and/or violent relationship through the provision of temporary accommodation. Second, shelters provide long-term refuge enabling domestic violence victims to build new, independent lives, by accessing formal support and advice via various forms of statutory and public assistance, and social services, with regards to counselling/therapy, welfare, education, healthcare, the legal system and housing, and so on (Davies and Krane, 2006; Chanley *et al.*, 2001; Warrington, 2001). Such services for victims of domestic violence need to be comprehensively understood by professionals in order to develop guidelines for successful intervention services (Panchanadeswaran and McCloskey, 2007).

The literature alludes to this longer term service provision being more commonly pursued via transitional housing programmes. Melbin *et al.* (2003) examined best practices and policies which were implemented throughout the United States in relation to transitional supportive housing (TSH) programmes. The authors found that in addition to housing, all the programmes offered counselling, support groups, safety planning, and various forms of practical assistance (including transportation vouchers, telephones, referrals to other agencies, and limited advocacy). All the programmes also provided "case management" services, through which the TSH staff worked with the women to determine and meet their goals. Some programmes offered additional assistance, such as discretionary funds to meet women's individual needs

⁵ Established as part of the Government strategy on homelessness, the Homeless Agency is responsible for the management and coordination of services to people who are homeless in the Dublin area.

(e.g., to fix a car or to pay for prescriptions), workshops (e.g., educational, employment, budget, parenting, and nutrition), recreational activities (e.g., tickets to community events, social gatherings, and field trips for children), and partnerships with community agencies, businesses, and/or housing resources (e.g., free services for TSH participants). The critical value of the service was highlighted by many women who spoke of having few alternatives to the TSH programs, believing they would have either returned to their assailants against their own wishes or been homeless had the programme not been available to them. It was explained that for some women, the TSH programs may literally mean the difference between life and death. However it should be noted that transitional housing cannot work without permanent housing being made available when the support period is completed (O'Connor and Wilson, 2004). The provision of affordable and social housing by the local authorities is crucial in this regard.

A recent report commissioned by the Eastern Regional Planning Committee on Violence against Women notes particular problem regarding accommodation service provision for victims of domestic violence in Ireland is the failure to specifically define it within housing legislation that is, the 1997 Housing Act (O'Connor, 2006). Moreover, in the absence of overall code of guidance, County and/or City Councils are forced to develop custom and practice which evolves over time rather than clear policies defined and regulated according to rights and needs

Research pertaining to Ireland by O'Connor and Wilson (2004) highlighted a serious shortage of refuge space for women and children where they could access safe accommodation and avail of expert support and advocacy provided by frontline specialist services on violence against women. They found that many women and children were in inappropriate and unsafe emergency accommodation (often B&Bs i.e. bed and breakfast) (O'Connor, 2006). The report concluded with a series of specific policy and service recommendations, some of which are outlined below:

O'Connor (2006) states that in order to facilitate an appropriate, standardised approach to service provision for victims of domestic violence, policy guidelines regarding domestic violence should be developed by Local Authorities in conjunction with the health sector. Such guidelines could be modelled on the Homelessness Code of Guidelines for Local Authorities in the U.K. The code of guidance should include:

Policy Guidelines

Initial interview and assessment

- ☐ Risk assessment and safety plan protocols should be developed and agreed for use by all practitioners and agencies women encounter when they leave home.
- ☐ Safe appropriate referral mechanisms need to be developed with women's services, Health Services and the Gardai.
- ☐ Documenting and data recording systems should be put in place to provide an accurate assessment of need.

Training and support for staff

- ☐ All frontline staff should be trained in sensitive and safe interview methods.
- ☐ A system of support and supervision should be in place for all staff responding to domestic violence.

Assessment as homeless

- ☐ There should be a stated policy that all women out of home because of violence regardless of whether they are living with friends and family or in emergency accommodation should be considered homeless.
- ☐ Councils should develop reciprocal arrangements in relation to referrals from all refuges regardless of the woman's home of origin.
- ☐ The practice of some Councils to not consider women liable for rent when in emergency accommodation, should be applied by all Councils.
- ☐ Notice should be sent to all emergency accommodation services and providers regarding the above policy.

Housing Nominations

- ☐ The safety of women and children needs to be central in considering the long term housing needs of women who have been subjected to violence and continue to be at risk.
- ☐ Temporary lettings should be offered where a woman is in a protracted legal situation and cannot return to her family home.
- ☐ The legal base on which Local Authorities can request a portion of the money received by a woman from legal proceedings should be stated. A directive should also be issued in relation to this practice.

Refuge provision and transitional supported housing

- ☐ Clear targets, timeframes and budgets need to be put in place for the development of new refuges and transitional units.
- ☐ Where a refuge has been agreed and stated in the Local Area Development Plan, the HSE services plan or the Action Plan of the Homeless Agency a budget headline for 100% capital and revenue funding should be clearly defined.
- ☐ The recommendations in relation to standards and refuge provision outlined in the literature review urgently need to be resourced and implemented.

In terms of **transitional housing** the O'Connor's report (2006) recommends that:

- ☐ Practice agreements developed by some Councils in relation to nominations from Sonas housing should be considered as a model for the development of formalised policies by all Councils.
- ☐ Negotiated targets should be agreed between transitional housing providers and every Council.

Finally, O'Connor and Wilson (2004) cited research for the Office of the Deputy Prime Minister (ODPM) which found that Refuges were perceived by both users and professionals as providing a unique and highly regarded service (Levinson and Kenny, 2002). The authors recommend that an integrated and co-ordinated response to people out of home because of violence, which has been demonstrated as the most successful strategy in the U.K., should be adopted in Ireland, and would involve the Local Authorities, the HSE, and other statutory agencies and the voluntary sector. Additionally, responses by the housing and homelessness sectors should be informed by the body of knowledge and research on violence against women nationally and internationally.

Davies and Krane (2006) stress the need to be cognisant of the fact that mothers' and children's needs are not necessarily homogeneous, and consequently different

services will be needed for both. In Ireland, the Department of Health and Children recently launched a report which takes into account children's perspectives with regards to domestic violence *Listening to Children: Children's Stories of Domestic Violence* (Hogan and O'Reilly, 2007). The authors' main conclusion was that centres and services are needed for children being abused, with a particular urgent need for shelters for teenage boys who are at risk of becoming homeless as a result of domestic violence.

Other problems highlighted in the literature with regards to shelter and refuge accommodation are concerned with issues of isolation and invisibility of domestic violence victims. Ironically, the discrete and private nature of shelters results in a risk of service users becoming more cut-off from the assistance of social and health systems (Davies and Krane 2006) and formal agencies such as solicitors, social workers, housing officials (Warrington 2001), and informal networks such as family, friends and community (Haaken and Yragui 2003). As mentioned earlier, another issue highlighted was the need to involve service users in service planning and provision. Melbin et al (2003) stated it is critical that the design of transitional accommodation services involves the input of women who have abusive partners. The authors contend that it is only by acknowledging the individuality of each woman's experience that effective solutions will be created to address the complex housing needs of battered women.

In 1997 the European Commission started the DAPHNE Initiative, which supports transnational projects aimed at preventing and combating violence against women and children. Women's shelters, important institutions in the fight against domestic violence, should work according to certain quality standards (e.g. protection, security, empowerment etc.). In 2004 a European DAPHNE Project - WAVE - developed together with experts from different EU countries a manual for the setting-up and running of women's shelters, mentioning and explaining the most important quality standards. "IMPROVE quality services for victims' safety" is a one year DAPHNE project, coordinated by WAVE and runs from February 2007 until February 2008. 12 partner organizations comprising experts of women's shelters several European countries. The project aims to improve quality standards and services for victims of domestic violence by training and exchange of best practices in establishing and organization of women's shelters.⁶

2.5.3 Advocacy

The emphasis on rights and entitlements distinguishes advocacy from other forms of support (Kelly and Humphreys, 2001). The qualities of a good advocate identified in the literature include tenacity, patience, empathy and optimism. Useful skills include active listening, report writing, negotiation skills and a working knowledge of legislation (Brandon, 1995; Bateman, 2000 cited in Forbat and Atkinson, 2005). Forbat and Atkinson (2005) state that advocacy seems to be effective where people, for whatever reasons, lack the support of a network of friends and contacts to call upon at times of need. There is a view, often quite prevalent in social work and nursing, that practitioners are in a good position to 'advocate' on behalf of their clients (see Bateman, 2000; BASW's Code of Ethics, 2002; Jenkins and Northway, 2002). With regards to domestic violence specifically, advocacy is needed when the

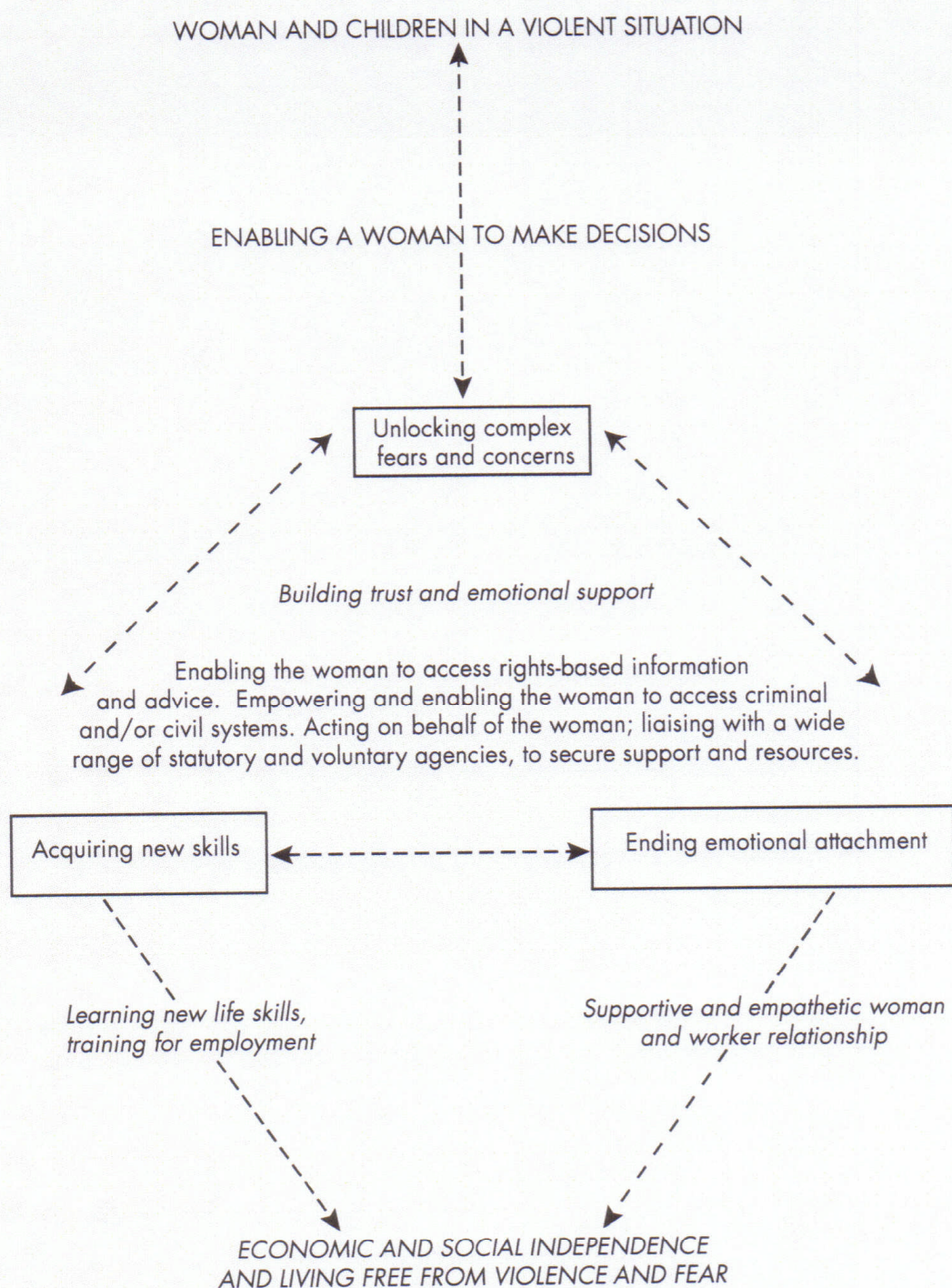
⁶ <http://www.wave-network.org/> accessed 21/1/08

perpetrator is to be prosecuted or the woman needs support to claim her legal and social rights (Hagemann-White, 2006).

Parmer et al (2005) explain that advocates may work from a centre base such as a:

- 'one-stop-shop';
- police station;
- voluntary organization;
- community centre;
- court.

Alternatively, they may provide outreach services to women who have difficulties accessing such centre-based resources. In this case, outreach workers support women in their own homes and communities. The authors devised the following model of advocacy and support outlined in the next page.

A model of advocacy and support

Evaluation findings on domestic violence services by the authors found that women preferred longer-term support from an advocate or support worker, rather than short-term crisis intervention. Such longer-term support enabled relationships of trust to develop between the woman and the advocate, and more positive legal outcomes were also achieved. Hagemann-White (2006) explains that recent research in the United Kingdom and the Netherlands demonstrates that advocacy is an essential and effective means of supporting women experiencing domestic violence throughout the criminal justice system and helping to prevent attrition. Women who receive support from specialised advocacy services are more likely to give evidence and more satisfied with the legal proceedings.

The multidimensional scope and complex nature of advocacy work is captured by Parmer et al (2005) who outline a broad list of examples of tasks carried out by advocates and support workers working on the Violence Against Women Initiative in the United Kingdom (Table 20).

Table 20 Types of Advocacy Tasks (Parmer et al 2005)

| |
|--|
| <ul style="list-style-type: none"> • Raising awareness of the issue of domestic violence in the local community. |
| <ul style="list-style-type: none"> • Raising awareness of the project amongst both statutory and voluntary agencies and committees. This can involve running regular workshops to agencies such as: the police, health visitors, GPs, midwives, social services, the Crown Prosecution Service (CPS), housing, solicitors, etc. |
| <ul style="list-style-type: none"> • Liaising with partner agencies and building good relationships with individuals who work in those agencies; to understand how they work and to enable women to gain access to a wide range of services. |
| <ul style="list-style-type: none"> • Building up a consistent and open relationship with the woman so that a feeling of trust is established. |
| <ul style="list-style-type: none"> • Conducting accurate risk assessments, and in response provide practical safety planning advice, ensuring that the immediate safety needs of the woman and her children are met. |
| <ul style="list-style-type: none"> • Understanding how assisting a woman's children is important and that responses need to be appropriate according to their age. |
| <ul style="list-style-type: none"> • Assessing the strengths and weaknesses of a woman's legal case and understanding how best to assist a woman within the criminal justice system. |
| <ul style="list-style-type: none"> • Understanding complex fears which the woman has developed. |
| <ul style="list-style-type: none"> • Encouraging women at times to reflect on their situation and, if necessary, challenge women's understandings of their situation. |
| <ul style="list-style-type: none"> • Provide practical and emotional support concurrently and allow time to build a rapport with women. |
| <ul style="list-style-type: none"> • Assist women with developing vital life-skills, for example, household financial management. |
| <ul style="list-style-type: none"> • Being proactive when assisting and supporting women. For example: maintaining regular contact by making phone calls to women, regardless of whether they are routinely accessing the service or not. |
| <ul style="list-style-type: none"> • Adhering to, and promoting, equal opportunities and the interests of women from all cultural and racial backgrounds. |

Additionally, Butchart et al (2004) highlight the fundamental role of advocacy from two perspectives. First, promoting the primary prevention of interpersonal violence, and second, for improvements in the provision of quality services to victims of violence.

Initiatives to promote the primary prevention of interpersonal violence

(1) Advocacy towards government

Advocacy groups outside government have a powerful role to play in promoting primary prevention. Victim associations, for example, may be formed by survivors of violence and relatives of people who have been murdered, raped or subjected to child abuse and neglect. In many countries, such groups regularly participate in initiatives to establish stronger controls over firearms, to prevent child maltreatment, and protect people from sexual violence.

(2) Advocacy by government towards the public

Government-sponsored advocacy campaigns should aim to correct public misconceptions about the causes and preventability of interpersonal violence, and should be coordinated with policy and legislative changes to heighten public awareness of new laws and policies. Such campaigns can promote and popularise the idea of preventing violence, and draw everyone into efforts to achieve this.

(3) Advocacy within the health department and towards other government

departments Applying primary prevention principles to the problem of interpersonal violence is likely to be a new idea to many government ministries and technical departments that are required to collaborate in policy change and programme implementation. Advocacy within government should aim to explain the public health approach to interpersonal violence prevention through seminars, workshops and newsletters informing relevant individuals about the prevention of violence, and inviting them to discuss their potential roles and responsibilities.

Initiatives to improve the provision of quality services to victims of violence

In terms of advocacy for improvements in the provision of quality services to victims of violence, Butchart et al (2004) state that this should take into account all levels of need (for example, medical, psychological, social, legal) and aim to promote a balanced system of provision founded on evidence-based services and interventions. It requires advocacy at the national, local and institutional level, and should include advocacy efforts with private practitioners and nongovernmental organizations as they too are likely to interact with the victims of violence. If no evidence exists to show that particular services, strategies or interventions are either effective or ineffective, planners should proceed carefully and base the planning process on expert consensus and operational research. Advocacy messages should include government responsibility to ensure adequate resource allocation for victim support and care services and ongoing research to facilitate improvements.

The health sector must advocate not only for improved health services for victims of violence, but also for improved psychological, social and legal services and more effective linkages between these services to make sure the full range of services required by victims is addressed. Where there are adequate services and support available, governments should disseminate messages that convey the importance of seeking care as quickly as possible following an act of violence.

As outlined in Section 1, a core advocate for women victims of domestic violence in Ireland is the Non-Governmental Organisation Women's Aid. The organisation supports approximately 8,000 women annually. The wide-ranging remit of its advocacy work in providing support to women experiencing domestic violence, children affected by domestic violence, and statutory and voluntary service providers is evident in terms of its service provision and involvement in:⁷

- A Freephone National Helpline (12 hours a day, 7 days a week, 364 days per year)
- One to one support for women giving them advice, information and support on financial, legal, housing and social welfare matters
- Support women through the court system
- Facilitation of access to crisis and long-term accommodation for women and children who have been abused
- Provision of training to statutory and voluntary agencies such as the Gardaí, medical and health professionals, Accident & Emergency unit staff, legal professionals and community workers on how to recognise and respond to women experiencing domestic violence
- Delivery of a special education and awareness programme on domestic violence to schools and community groups
- Delivery of creative personal development programmes for women and children who have been abused
- Assisting groups all over the country to set up services in response to domestic violence through Community Projects
- The provision of on-going support to women who move on to start new lives for themselves and their children with Starting Over Groups
- Women's Aid influence policy and lobby for improved legislation
- The provision of quality research and other publications and vital information to the media and public

2.5.4 Criminal Justice Interventions

Research and evidence have revealed that the time of attempting to leave the home and accessing the legal system is the most dangerous time of escalated physical violence and homicide for women (O'Connor, 2006). Some of the most common legal measures and criminal justice interventions in the EU to protect women against violence include arrests, barring orders, protection orders, specialised domestic violence units (DVUs) within the police, prosecution services or courts, domestic violence officers (DVOs)/liaison officer posts (Hagemann-White, 2006; Hague and Mullender, 2001; Hoyle and Sanders, 2000). Pro-arrest policies in the UK are based on mandatory or presumptive arrest initiatives and were first introduced in America after research suggested that arrest deterred domestic violence offenders from further offending (Sherman and Berk 1984; see also Dugan et al 2003). Barring orders evicting a perpetrator from the home are effective in protecting women from violence if they are imposed on the spot by the police. Their effectiveness is weakened when they are not enforced ex officio. Orders imposing a physical distance to the victim have also been introduced into criminal law (Hagemann-White, 2006). Court-issued protection orders tailored to meet the needs of the victim are essential to victim protection. They should be available both as emergency measures when there has

⁷ <http://www.womensaid.ie/> accessed 12/10/07

been no police intervention, and as medium- or long-term measures to safeguard the victim's right to safety from violence or the fear of violence. In the main, there are two types of orders available: occupation orders, which regulate the occupation of the family home, and non-molestation orders for protection against all forms of violence and abuse.

As described in Section 1, in Ireland the Domestic Violence Act 1996, outlines the following main legal instruments available to the courts: barring orders, interim barring orders, protection orders, and safety orders. Hagemann-White (2006) notes that the District Court has the power to issue non-molestation orders for up to five years, while the HSE can apply for either occupation orders or non-molestation orders on behalf of domestic violence victims. A key critique of the Irish civil and criminal justice system is its failure to provide immediate and effective protection for victims of domestic violence who in some cases have been left without any form of stable safe accommodation for periods of up to two years while protective orders, breaches of orders and legal separation issues are dealt with (O'Connor, 2006).

Moreover, the criminal justice system can only function to deter and punish violence against women if all cases are recorded and investigated and a significant proportion of cases are actually prosecuted. As already discussed, the statistics in this area are generally poor, and to the extent that data exist through research, they show that, for both sexual violence and rape and for domestic violence, there is substantial under-reporting, and only a very small proportion of the recorded cases ever go to court, of which, again, only a minority are actually punished (Hagemann-White, 2006). One potential way of dealing with this issue is that of making the reporting of such crime mandatory. However, mandatory reporting of domestic violence is regarded as controversial for a number of legal and ethical reasons (Corbally 2001). In particular, a lack of demonstrated effectiveness in reducing the risk of violence and because of the concerns about infringing on women's autonomy (Gielen et al 2000), and the potential to place a victim at risk of further violence if disclosure becomes known to the perpetrator (Waalén et al 2000) are some of the core dilemmas in this regard. The drawbacks of mandatory policies have one connecting consequence in that they may dissuade women experiencing domestic violence from reporting it to the authorities, social services, etc., thereby choosing to remain silent about the abuse (Goodman and Epstein, 2005).

The 'victim choice' position leads to very large numbers of women not seeking arrest or prosecution (Hoyle and Sanders 2000) and a study by Gielen et al (2000) found that support for a policy of mandatory reporting was not widespread in the sample, while more than half the abused women preferred a policy under which reporting abuse to the police is the women's decision. The authors emphasise the importance of listening to and understanding women's policy preferences with regards to such issues as mandatory reporting, under what is termed a victim empowerment model, whereby policy development would incorporate the intended audience and therefore be more widely supported.

2.5.5 Interventions for Perpetrators of Domestic Violence

In the last decade there has been a greater focus on perpetrators, with a view to preventing recurrent violence (Appelt and Kaselitz, 2000). The primary aim in working with perpetrators of domestic violence is to increase the safety and protection of women and children from violence (Hagemann-White 2006; Respect, 2000). Secondary aims are to:

- Hold men accountable for their violence towards women
- Promote respectful and egalitarian relationships
- Work with others to improve the community's response to domestic violence (Respect, 2000).

Hoyle and Sanders (2000) refer to domestic violence as a social problem, as well as a legal problem, which requires addressing from a rehabilitation perspective through interventions such as perpetrators' programmes. Hagemann-White (2006) notes that support, protection and helping (potential) victims are not enough to stop violence and abuse, it is essential to address the violent perpetrator. She explains that this can be done through agencies, programmes and activities to help men stop their violence, abuse and domination of women. The intervention or treatment programmes in question should be directly targeted toward men who use violence against women, and the content or methods be specifically constructed to change the behaviour, attitudes and beliefs of such men. The methods should be based on solid knowledge about violence, its effects on women and children and its social, gender-based and individual causes.

Rothman et al 2003 outline the broad mix of organisations and services which work directly with domestic abusers:

- Victim advocacy services;
- Mental health services;
- Probation or other criminal justice agencies;
- Social workers, other child protection services or family centres;
- Men's self help groups;
- Community groups;
- Addiction services;
- Religious organisations or networks.

Debates concerning perpetrator programmes have been associated with issues such as their purpose and effectiveness. For instance, there has been controversy about whether perpetrator treatment should be framed as resocialisation i.e. cognitive behavioural modification, or therapy i.e. addressing deeper psychological problems, and whether participation should be court-mandated or voluntary (Hagemann-White, 2006). Additionally, in evaluative terms, the effectiveness of domestic violence perpetrator programmes has not yet been proven, despite some encouraging signs (Mullender, 2001).

The Duluth Domestic Abuse Intervention Project was set up in the 1980s in Minnesota, United States and commonly regarded as one of the founding programmes in the area of perpetrator intervention. It is a coordinated approach which in addition to work with domestic abusers, includes support and advocacy for women, shared record keeping and case tracking between agencies, work with children, and the criminal justice system (Debbonaire, 2004).

Ireland is one of the few EU countries where perpetrator programmes have existed for more than 15 years, while in most other countries this work began after 2000, and recent research indicates that there are 16 specifically designed perpetrator intervention programmes in Ireland (Hagemann-White, 2006). The main categories of programmes in use in Ireland in the mid-2000s were, the MOVE Programmes⁸ and the CHANGE Programme⁹ (Debbonaire, 2004).

The organisation 'Respect' is a United Kingdom association for domestic violence perpetrator programmes and associated women's services, with members from the voluntary, private and statutory sectors as well as individuals from England, Wales, Northern Ireland and Scotland. Respect also has members based in the Republic of Ireland. Its "Statement of Principles and Minimum Standards of Practice" (2000) document refers to men's perpetrator programmes and associated women's services and is primarily concerned with intimate partner violence. The document states that perpetrator programmes should never be run in isolation. They should always be integrated with specialist, pro-active, associated women's services. The need for a coordinated approach is highlighted, whereby those seeking to establish work with perpetrators of domestic violence should engage in dialogue with all the relevant stakeholders in their area, in particular women's refuges, the police, probation service and the domestic violence forum co-ordinator (Respect, 2000).

Respect (2000) outline a number of key guidelines with regards to perpetrator work and associated coordination with women's services as outlined below.

Focus of perpetrator work

All perpetrator work should contain the following as core elements:

- An understanding of what constitutes violent behaviour
- That the perpetrator is 100% responsible for his behaviour
- That violent behaviour is a choice
- That violent behaviour is functional and intentional

Workers should challenge men's:

- use of physical violence
 - use of sexual violence, sexual abuse and coercion
 - expectations of power and control over (ex)partners
 - denial, minimisation, justification and/or blame
 - attitudes and beliefs which support domestic violence
- and:
- work in ways which are meaningful to men from different cultures and backgrounds
 - acknowledge and question the social and gendered context of domestic violence
 - develop men's capacity to understand the impact of their violence on their (ex)partners and children both in the long and short term
 - develop men's ability to have safe and appropriate contact with their children

⁸ The MOVE programme, is a 13 step programme, inspired and drawing on the work done by MOVE Bolton, UK. The programme comprises a written handout for each of the 13 steps. Most of the steps include a short activity relating to that topic, for the men to complete. These activities are suggested as homework for the men to complete between sessions, but can also be used during the group meetings. The programme is intended to be used as a rolling programme, so that men can join the group at any point, with facilitator discretion.

MOVE+ is a Programme with some additions and changes.

⁹ CHANGE programme – (Curran and Wilson, 1997). The programme was originally developed in Scotland for use as part of a sanction from the criminal justice system.

- encourage men to adopt positive, respectful and egalitarian ways of being
- focus on men as perpetrators and not as victims
- avoid collusion with perpetrators' justifications for their behaviour.

Associated Women's Services

Perpetrator programmes should provide their associated women's services with the contact details of all relevant women partners and ex-partners so that they can make pro-active contact with each woman.

Initial contact

Unless women directly and specifically request otherwise, they should be informed of the following, by post or telephone within one week of their (ex)partner's first contact with the project:

Information about the perpetrator programme:

- details of their (ex)partner's referral to the perpetrator programme
- information about the programme, specifically detailing how men may use and abuse the programme materials - for example by him telling her that her behaviour is abusive, telling her to take 'time-outs' or insisting that she needs therapy or counselling either during or after his attendance on the programme
- information about how they can access information about the programme and her (ex)partner's attendance
- information which promotes realistic expectations regarding men's likelihood of changing as a result of their attendance on the programme

Information about services available to women:

- details of the project's women's service / partner agency and how to access these services
- information about that service's confidentiality policy
- clear messages about men's violence and her and her children's rights
- details of other specialist services, including crisis services, such as the Police; Refuge Projects; advice services for legal, immigration and housing problems and other appropriate local and national services

Pro-active phone contact:

Women should be pro-actively contacted by phone in order to

- check that she received and understands the postal information
- reach out to her to offer support
- check out what her practical and emotional needs are
- check if she has any special needs (language, disability)

Projects should continue to attempt contact until contact is made. It is not enough to expect the woman to contact the women's service herself.

Pro-active phone work must take place within a clear safety procedure which minimizes risk to the woman and children.

Further contact

Women should also be informed within one week of the following by post or telephone call:

- significant absences in her (ex)partner's attendance
- when her (ex)partner is assessed as unsuitable for the programme
- when her (ex)partner completes the programme
- when her (ex)partner drops out of the programme
- when her (ex)partner is breached or suspended from the programme

Respect (2000) recommends that services to women should be available for at least four months after their (ex)partner has left the perpetrator programme. If at the end of this time the woman still has unmet needs, further work or appropriate referral to other services should be done.

'Good Practice Indicators' (GPIs) for Perpetrator Programmes

Other useful guidance can be obtained from a national survey of perpetrator programmes constituted one small part of a much larger mapping study domestic violence services in the U.K., funded by the Joseph Rowntree Foundation (Humphreys et al., 2000). The research resulted in the publication of a set of eight 'good practice indicators'(GPIs) (Humphreys et al., 2001) which Mullender and Burton (2001) in turn applied to perpetrator programmes.

Good Practice Indicator 1

Definitions: Setting the Parameters – It is essential to work within an agreed definition of domestic violence and its causes so as to “set parameters for policy and practice development in the organisation and multi-agency context” (Humphreys et al., 2000, p.52). Understandings of domestic violence should be gendered and concur with Respect's approach to perpetrator work which relates it clearly to “men's expectations of power and control over partners” and to “the social and gendered context of domestic violence” (Respect, 2000, p.7).

Good Practice Indicator 2

Monitoring and Screening: Knowing the Extent of the Problem – It is essential that domestic violence is separately “recorded, studied and assessed” so that the issue can be named, including by survivors (Humphreys et al., 2000, p.52). The process of recruiting men into perpetrators' programmes necessarily involves such a process of naming the problem and stage this takes place.

Good Practice Indicator 3

Policies and Guidelines: Guiding the Work to be Done – The overall mapping survey concluded that domestic violence policies and guidelines are fundamental because they “provide a consistent framework for the work to be undertaken” (Humphreys et al., 2000, p.52). In relation to perpetrator programmes themselves, it makes sense to adopt the Respect (2000) practice principles and minimum standards.

Good Practice Indicator 4

Safety Measures and Safety-orientated Practice– Working with perpetrators is futile if survivors are not safe. This means that partners should be told about men's progress in the group, and particularly about anything said or done there that might indicate a current risk. Respect holds to the principle that operating a parallel support service for partners is the only way of ensuring a minimum standard since it can

guarantee effective lines of communication and help for women and children who are facing continuing or recurrent danger (see Good Practice Indicator 8, below).

Good Practice Indicator 5

Training: Raising Awareness, Exploring Values, Developing Skills – Humphreys et al. (2000) conclude that it is training which embeds policy in practice. Respect is equally clear that “It is the responsibility of Projects and practitioners to ensure they have sound training relevant to their methods of working” (Respect, 2000, p.9). They emphasise, within this, adequate training for programme delivery (a minimum of five days’ preparation), which should build on more general training, including on domestic violence awareness and child protection issues.

Good Practice Indicator 6

Evaluation: Ensuring Effective Provision – Respect states that “Some process of internal or external evaluation is essential and integral to this work. This work should include measuring ways in which the safety and quality of life of women and children is increased, based on women’s reports” (Respect, 2000, p.9). Survivor reports are crucial in defining success since measures based on participants’ self-reports or police records are liable to extreme underreporting. Humphreys et al. (2000) recognise further considerations in evaluating perpetrator programmes (see summaries in Mullender, 1996, and Mullender and Burton, 2001). Most evaluations in the UK to date have been small-scale and few have employed adequate follow-up periods to establish whether perpetrators sustain any change in their behaviour.

Good Practice Indicator 7

Multi-agency Co-ordination: Working Together – Policy and practice, however well developed, need to be integrated with those of related agencies if they are to be effective in tackling domestic violence (Humphreys et al., 2000). The perpetrator programme survey found high usage of a designated liaison person to local domestic violence for a, while additional links with relevant local organisations, mainly in the voluntary sector, were also mentioned. These ranged from a fathers’ group to an NSPCC women and children’s group. Other examples of good practice in interagency work included probation, social services, police and health jointly resourcing Women’s Aid to offer a partner support group and joint domestic violence training for magistrates alongside Women’s Aid, the Police and the Crown Prosecution Service.

Good Practice Indicator 8

Guidelines for Practical Working with Women and Children – Emergency and outreach services to women and children who are experiencing and surviving domestic violence, lie at the heart of any community response; and work with men, no matter how effective, must never compete with or cut across them. It is important that any national moves towards expanding perpetrator provision should not be made at the expense of, or in isolation from, essential emergency, outreach, aftercare and partner support services for those they have abused.

2.6 Evaluation of Domestic Violence Prevention and Intervention Initiatives

A consistent theme in the literature is the dearth of evaluative work on the effects and effectiveness of the various domestic violence intervention initiatives and programmes (Cornelius and Resseguie, 2007; Rutherford et al., 2007; Dugan et al 2003; Ellsberg 2006; Rhodes and Levinson 2003; Butchart et al, 2004; Short et al 1998). It should be noted however, that the WHO is currently attempting to address this through the implementation of guidelines for the systematic documentation of interpersonal violence prevention programs (Sethi et al, 2004).

At the moment, the resulting lack of a strong evidence-base has significant implications for improving the quality of services available to both victims and perpetrators of domestic violence. According to Rhodes and Levinson (2003), for battered women and children, evaluation should assess domestic violence services in terms of their effect on a variety of short and long-term safety and quality of life outcomes. For perpetrators of partner violence, research should focus on evaluating the effectiveness and safety of interventions not only for court-mandated batterers but also for those willing to disclose problems with violence to physicians and other members of the health care team.

According to Sethi et al (2004) violence prevention programmes are only worthy of implementation if they are effective in reducing the level or consequences of violence. This can only be scientifically proven if they have been evaluated rigorously. Programme evaluation can be defined as the systematic process of collecting and analysing data using a science-based methodology to determine whether the programme is achieving its stated objectives. The authors outline four main reasons for evaluation:

1. to make decisions of quality or worth;
2. to improve programmes;
3. to generate knowledge; and
4. to gain knowledge on whether a programme can be repeated effectively elsewhere.

From a practical perspective, Sethi et al (2004) describe the various areas that need to be considered when undertaking an evaluation, the key steps involved, and some basic questions to be asked.

Basic questions regarding the evaluation process that may be asked include: (Abramson & Abramson, 1999 cited in Sethi et al 2004)

- *Relevance* – is there a need for this programme?
- *Quality* – how satisfactory is the process, that is, performance of activities? How satisfactory are the facilities, staff component and office space? How satisfactory are the outcomes, and have the desired effects been achieved?
- *Efficiency* – how efficiently are resources used?
- *Replicability* – can this programme be repeated elsewhere?

The following areas need to be considered in terms of **what is evaluated**:

| |
|--|
| a. what is the programme, what are its objectives, and in what context does it exist; |
| b. what aspects of the programme will be considered when judging its performance; |
| c. what standards (i.e. type or level of performance) must be reached for the programme to be considered successful; |
| d. what evidence will be used to indicate how the programme has performed; |
| e. what conclusions regarding programme performance are justified by comparing the available evidence of the selected standards; |
| f. how will the lessons learned from the inquiry be used to improve its effectiveness? |

The following **key steps are involved in evaluation practice** (Centres for Disease Control and Prevention, 1999 cited in Sethi et al 2004)

| |
|---|
| a. Engage the stakeholders, who are those involved, those affected by the programme, and the intended users of the evaluation. |
| b. Describe the programme in terms of need, the expected effects, the activities, resources, the stage of the programme, the context and the theoretical model. |
| c. Focus on the design of the evaluation by considering and agreeing on its purpose, how to engage the users, to what uses the evaluation will be put, the questions being asked, and the methods to be used. |
| d. Gather credible evidence. Consideration must be given to indicators, sources of information, its quality, its quantity, the logistics of obtaining it and whether attention has been given to potential sources of error, such as due to confounding and bias. |
| e. Justify the conclusions. Rigorous standards should be used, with a thorough analysis, unbiased interpretation, judgement on strengths and weaknesses, and recommendations. |
| f. Disseminate to the stakeholders with feedback and follow up. |

Butchart et al (2004) discuss the issue of evaluation of interpersonal violence prevention from two perspectives: improving data collection capacity and supporting primary prevention demonstration programmes.

Improving Data Collection Capacity

Evaluation of both the process of creating an information-gathering system to provide a complete picture of the problem, and the resulting policies, programmes and interventions resulting from the information developed to address the problem are core evaluative dimensions. In turn, the authors explain that based on the evidence produced during the evaluation process, modifications to the data-collection system may be made as necessary.

Supporting Primary Prevention

With regards to promoting primary prevention, there is a need to evaluate primary prevention demonstration programmes which are intended to serve as test-beds for the implementation and evaluation of proven and promising interventions from other settings, and as model programmes to encourage others to adopt and tailor them to their own settings. The establishment of a primary prevention consortium including members of the community, national and local government, researchers/research councils, the police, health services, and other interested parties is advised where existing programmes do not have the potential to serve as primary prevention demonstration programmes.

Similarly, a number of insightful reflections on evaluation measures and approaches are made by Hester and Westmarland (2005) based on the findings of the evaluation of the Crime Reduction Programme (CRP) part of which involved 27 domestic violence projects:

- While domestic violence remains an under-reported crime, an increase in police recorded domestic violence incidents is a more appropriate performance indicator than a decrease. Projects should therefore aim to increase reported (recorded) incidents as an intermediate aim and decrease reported (recorded) incidents as a longer-term aim.
- Data gathering and analysis in order to assess attrition is key to the evaluation of projects involving legal advocacy. Being able to track cases from police report to final outcome is a crucial aspect of this. Setting up systems to allow attrition to be easily reviewed on a regular basis should be one of the first priorities at the project development stage. It may be difficult to sustain reductions in attrition in the longer term and regular reviews of the various stages and, crucially, acting on the results are important in this respect.
- Evaluation approaches to assess attrition should also use and record the impact of evidence on pleas entered and court outcome. This would address the question raised in this overview of how much/what evidence is needed to 'prove' domestic violence in court and might help prevent evidence being used by the defense specifically with the aim of discrediting witnesses.
- Further research on repeat victimisation should use self-report diaries as well as police recorded incidents in order to measure 'true' repeat victimisation.
- If possible, research evaluating the impact of domestic violence interventions should use a 'matched cases' experimental design with adequate sample sizes where comparison can be made between those who do and those who do not have access to the interventions. However, this design should not be used if it raises ethical issues.

Section 3 Domestic Violence Service Provision: Core Principles, Frameworks and Model for Action

3.0 Introduction

Domestic violence is a human rights issue. Morbidity and mortality data indicate that domestic violence is an extremely serious public health problem in contemporary society, and the urgency of addressing this problem cannot be overemphasised. In light of this, the final Section of the Report sets out a brief overview of the current strategic policy context pertaining to domestic violence. Such contextualisation is necessary in order to understand the issue from the outset, and the key agencies both nationally and internationally with responsibility for domestic violence. Following this, a series of high-level strategic points emanating from sections 1 and 2 are summarised. A series of core principles are then outlined from the relevant literature, as a normative guide to those working in the highly sensitive area of domestic violence. This section reiterates the interrelated frameworks or lenses through which the problem of domestic violence needs to be tackled, namely the public health approach, the ecological framework, level of prevention, life/developmental stages, and universal or targeted provision. Following on from this, based on consultation with key actors in the HSE, an action model is presented which details specific inter-sectoral, inter-agency interventions at primary, secondary and tertiary levels.

3.1 Strategic Policy Context

In order to provide a comprehensive contextual account of the problem of domestic violence, this review has examined domestic violence from a macro perspective, focusing on national and international strategic policy, legislation and practice. Significant strategic policy development and practical service guidance at international level with regards to the issue of domestic violence are outlined in this report, in particular, drawing on work of key bodies such as the World Health Organisation (WHO) and the Council of Europe. This high-level strategic thinking and evidence-based advice forms a sound basis for the development of related policy and strategy in Ireland. In order to contextualise the situation in Ireland, the roles and responsibilities of key bodies including Irish governmental departments (in particular the Department of Justice, Equality and Law Reform, and the Department of Health and Children), the HSE, and agencies and advocacy groups in the community and voluntary sector, has been outlined.

It is important to understand that domestic violence is situated in a medico-legal context, based on both public health and criminal justice approaches. Moreover, domestic violence is a complex, multi-dimensional problem that requires addressing in a multi-sectoral and multi-disciplinary manner. Notwithstanding this, overarching responsibility for domestic violence needs to be led by one statutory body, with the international literature suggesting that the Departments/Ministries of Health are best suited to this. With regards to Ireland, is the Department of Health and Children, and its associated service provision and implementing body, namely the HSE. Additionally, a significant policy development in terms of the recent establishment of the Office for the Prevention of Domestic Violence – COSC - under the aegis of the Department of Justice in July 2007 is noteworthy. The multi-sectoral nature of COSC membership which includes representatives of the HSE and the Department of Health

and Children provides an important opportunity to adopt a public health and multi-disciplinary approach to the problem.

However, the absence of a national inter-Departmental strategy and action plan for domestic violence in Ireland, incorporating tangible targets, timeframes, budget allocation, and assigned responsibility continues to be a major deficiency, and is a serious challenge for the HSE in strategically planning and developing domestic violence services. A critical requirement in this regard is the collection and availability of baseline data on existing domestic violence services and rates of usage in the health and voluntary sectors. However, currently such data is very scant and that which is collected is done so in an ad hoc manner at both national and regional level.

3.2 Summary Points in Relation to Understanding and Responding to Domestic Violence

- Domestic violence is a complex, multi-dimensional problem with many negative consequences for society.
- Domestic Violence requires an intersectoral response at policy level and interagency and interdisciplinary responses at service level, inclusive of key community and voluntary sector providers.
- The serious Public Health consequences of Domestic Violence place a particular responsibility on the HSE to be a lead organisation in this area.
- As evidenced in this report, the HSE response must be strategic, targeting different levels of need and working at different levels of prevention.
- A foundation of any HSE strategy will be the full engagement with the issue of Domestic Violence by all of its staff and staff in the many organisations it funds. Developing their knowledge and awareness of the issue, and role-specific skills in responding to it, is crucial.
- The experiences, needs and preferences of adults and children who have experienced Domestic Violence should drive policy and service provision. In order for this to happen, structures and processes for their participation in policy and service development and implementation will be required.
- In order to develop effective policies and services to tackle Domestic Violence comprehensive information collection systems and processes are necessary, both in establishing the extent of the problem, and the nature and extent of existing services.
- In order to achieve the highest quality service standards, a culture of continuous monitoring and evaluation needs to be embedded in all organisations delivering domestic violence services. Monitoring and evaluation processes require that all domestic violence services should have an 'outcomes' or 'impact' focus against which their effectiveness can be measured.

3.3 Core Principles of Good Practice

Central to strategic planning and provision of prevention and intervention initiatives regarding domestic violence are the principles which underlie such an approach. The following are a series of core principles extracted from several relevant documents pertaining to domestic violence details of which are outlined in Appendix 1.

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

3.4 Frameworks for Tackling the Problem of Domestic Violence

The complexity of the problem of domestic violence and the consequential challenges associated with addressing it have been highlighted in this report. With this in mind, it is essential to address the problem of domestic violence and the development of prevention and intervention services through a series of interlinked lenses or frameworks. These centre on the following:

- The Public Health Approach
- The Ecological Model
- Levels of Prevention
- Life/Developmental Stage
- Universal/Targeted Nature

3.4.1 The Public Health Approach

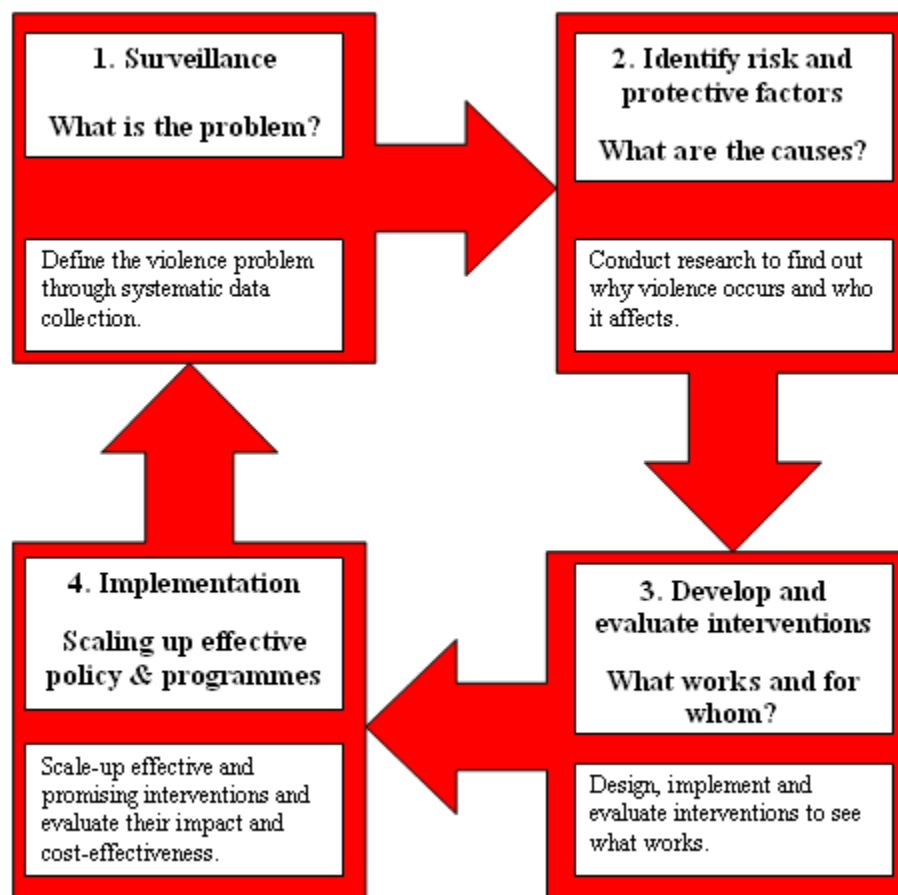
In order to understand the complexities of domestic violence, prevent the problem, and provide services tailored to the needs of victims of domestic violence, it is necessary to adopt a Public Health Approach. While acknowledging the requirement for multi-agency and multi-sectoral working to address the issue, this approach asserts that the natural leader in this regard is the health sector.

Indeed, a recent publication by the Women's Health Council (2007) asserted that there is timely opportunity in Ireland to adopt a comprehensive health response to this devastating social problem within the HSE, with its strong Population Health approach, and the recently established agency to address domestic violence and related issues, COSC.

The public health approach is directly linked with the primary prevention of violence, and addresses the issue at a population-level, seeking to improve the safety of all individuals by addressing underlying risk factors that increase the likelihood that the individual will become a victim or perpetrator of violence. It consists of four steps:

1. Surveillance
2. Identification of risk and protective factors
3. Development and evaluation of interventions
4. Implementation

Figure 1 (repeated) The Steps of the Public Health Approach



WHO (2007)

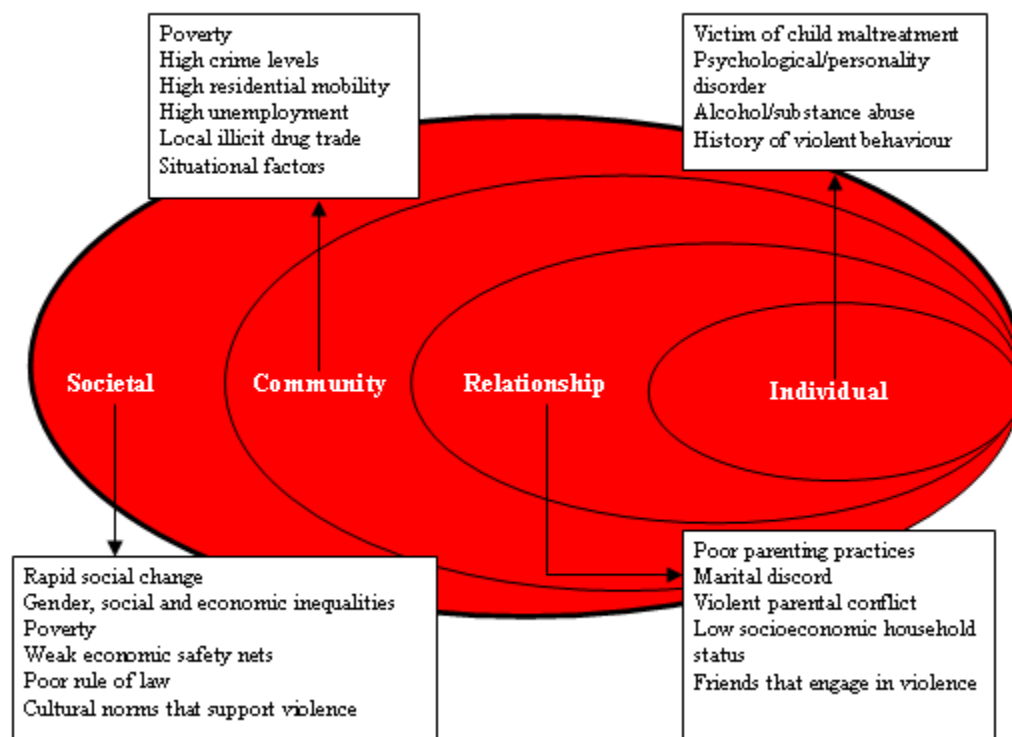
<http://www.who.int/violenceprevention/en/> accessed 18/01/08

3.4.2 The Ecological Model

Another key framework for addressing domestic violence is the ecological approach which is based on evidence that no single factor can explain why some people or groups are at higher risk of interpersonal violence, while others are more protected from it. Instead, from the ecological perspective, interpersonal violence is viewed as the outcome of multiple factors at four levels:

1. The individual
2. The relationship
3. The community
4. The societal

Figure 2 (repeated) The Ecological Framework: examples of risk factors at each level



WHO (2002)

<http://www.who.int/violenceprevention/approach/ecology/en/index.html>

It follows that prevention and intervention initiatives need to be developed from this broad framework in order to ensure that addressing the problem of domestic violence is not just reactive, based on crises which occur when victims of domestic violence are in fear of their lives. Rather, this ecological model contextualises and broadens the nature of the problem so that wider community and social issues are addressed at a population-level, and risks are identified and dealt with at earlier stages.

3.4.3 Levels of Prevention, Life/Developmental Stage & Universal or Targeted Nature

Other key considerations regarding the development of domestic violence concern the timing of prevention and intervention initiatives, and their universal or targeted nature. “Prevention concentrates upon identifying ways to keep people from committing acts of violence and of stopping the events that lead to unintentional injuries from occurring. It is achieved by removing or reducing the underlying causes and risk factors” (WHO, 2007).

Three core levels of prevention are: primary, secondary and tertiary:

1. *Primary prevention* is a population-based approach which may be directed universally at broad populations groups, i.e. the public at large, or targeted at populations who may be at risk of violence in intimate relationships but have

not shown any symptoms of concern. It focuses on promoting healthy lifestyles and community action.

2. *Secondary prevention* efforts are directed towards identified individuals who have exhibited symptoms or behaviours associated with domestic violence.
3. *Tertiary prevention* efforts are the most common and focus on support for the victims and prosecution and/or treatment for the perpetrators.

In addition, there are two principle types of intervention:

- Universal interventions cover entire populations irrespective of differences in risk between subgroups
- Selective interventions work with population subgroups known to be at elevated risk of perpetrating or being subjected to interpersonal violence.

The evidence in the relevant literature supports the development of initiatives and programmes at the earliest possible stage i.e. primary prevention, amongst children and adolescents, and universal targeting of the population at large as the most effective means of preventing the problem of domestic violence. Once the problem of domestic violence has manifested itself, it requires highly intensive and often selective intervention, mainly with adults, based on both multi-sectoral and multi-agency approaches. High risk groups susceptible to domestic violence and therefore requiring targeted intervention include:

- Those in dating relationships (particularly teens and younger adults)
- Pregnant women
- Aging women
- Prostitutes
- Women accessing substance use
- Women from low income backgrounds
- Ethnic-racial minority groups
- Children living in families where there is domestic violence

However, the evidence base regarding the effectiveness of such intervention is frequently lacking.

3.5 Action Model for Addressing the Problem of Domestic Violence based on Consultation with the HSE

The following model of service provision was based on consultation with a number of key service providers and managers with responsibility for domestic violence both nationally and locally. The model is based on the framework outlined in the document which focuses on the following dimensions:

- The public health approach
- The ecological model
- Levels of prevention, life/developmental stages, and universal/targeted interventions.

Action Model for Domestic Violence Prevention & Intervention

Tertiary Prevention (Selective)

- Crisis accommodation - 24/7 shelters/refuges (short term)
- Transitional accommodation (medium term)
- Improve A&E response & trauma care
- Legal & economic support & protection - links with police, family law, courts, social welfare system
- Child protection services
- Home visits with abuse victims & children
- Disorder based/cognitive treatment for children with emotional/behavioural problems resulting from trauma
- Health & juvenile justice systems collaborate in referrals
- One-stop-shop range of holistic outreach services
- Services for adults abused as children
- Residential programmes in mental health/correctional institutes
- Perpetrator conviction and rehabilitation programmes

Secondary Prevention (Selective)

- Community-based early intervention for children/adolescents exposed to DV - crisis support, counselling, social casework, education groups, dating relationships
- Community-based intervention for adults - outreach, advocacy services
- Criminal justice reforms - criminalise child maltreatment, intimate partner violence, and elder abuse
- Supervised child access
- Educational incentives for at risk teenagers
- Home visits with high-risk families (risk assessment, safety planning)
- Routine screening for maltreatment in primary care settings such as GP surgeries, reproductive and sexual health services
- Follow-up treatment programmes and social, economic and legal services for victims
- Therapeutic foster care for high-risk children/teenagers and temporary foster care
- Information on outreach and advocacy services from GPs, PHNs, CWOs, Citizen Advice Bureau, Money Advice and Budgeting Service etc.
- Hotlines - telephone helplines providing information, counselling, support, advice

Primary Prevention (Universal &/Or Selective)

- Public awareness: rights based publicity/media campaigns regarding child maltreatment, youth violence, intimate partner violence and elder abuse, workplace violence, disseminate information regarding local DV resources and how to respond. Also local community campaigns.
- Strengthen informal supports for victims of violence as family and friends are often the first 'port of call'
- Sensitisation and training of health professionals to detect, report and refer DV and child maltreatment
- Training of other professionals such as the police, lawyers/solicitors, teachers, childcare workers, carers
- Ante-natal screening, increase access to pre and post-natal services
- Home visits for new parents by PHNs or other health and social care professionals
- Parenting skills training programmes
- Home-school partnership programmes, after-school programmes, and recreational programmes
- Programmes to target early school leavers
- School-based violence awareness, prevention, and skills development e.g. conflict resolution, anger management, dating violence, healthy intimate relationships, peer mediation/education, mentoring, anti-bullying
- Education, training, skills development and job creation for the unemployed
- Reduce unintended pregnancies
- Target vulnerable groups suffering or at-risk from poverty and social exclusion such as lone parents, unemployed, ill/disabled, elderly, children, ethnic minorities
- Strategies to enhance community safety: community policing, citizen protection, crime reduction, improve safety of physical environment/public spaces (lighting, CCTV cameras, safe routes etc.)
- Reduce alcohol, drug, and firearm availability
- Reduce media violence - on television, cinema, playstation games etc.

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Appendix 1 – Principles Regarding Domestic Violence

Principles of Good Practice Regarding Domestic Violence

World Report on Violence and Health (WHO, 2002)

- Actions to address violence should take place at both national and local level
- The involvement of women in the development and implementation of projects and the safety of women should guide all decisions relating to interventions
- Efforts to reform the response of institutions –including the police, health care workers and the judiciary – should extend beyond training to changing institutional cultures
- Interventions should cover and be coordinated between a range of different sectors

Important Principles for Action to Prevent Violence

Fröschl / Löw, Gegen Gewalt an Frauen handeln. Ausbildungskonzept für Trainerinnen, Vienna 1996 cited in Appelt and Kaselitz 2000 Prevention of Domestic Violence Against Women: European Survey, Good Practice Models, WAVE Training Programme (Vienna, 2000)

1. Protection and security

Every woman has the right to integrity of her person, liberty and security and to a life free of any form of violence or the fear of violence. The primary objective of intervention must be to safeguard the immediate and sustained security of women and their children.

2. Responsibility

No woman ever "deserves" to be subjected to violent acts, and there can never be any justification for such acts. An act of violence committed against a woman is an offence punishable by law and must be treated as such. An act of violence is never susceptible to justification, and the responsibility for it always lies with the person who commits it. Violent men must bear the consequences of their actions. Approaches to counselling or therapy which tend to exonerate the perpetrators, play down the seriousness of their offences or relieve them of responsibility are not helpful in any attempt to prevent violence occurring.

3. Empowerment

Intervention is intended to strengthen and support battered women and their children. This support is designed to help them to build up a new life which they determine for themselves.

4. Complexity

Violence against women occurs in all social classes and in all cultures. In the planning and running of training courses it is thus important also to take due account of such factors as social milieu, age, disabilities, the plight of migrant women etc.

5. Social responsibility

As members of society we all of us bear responsibility for eliminating violence against women. This violence will end only when society stops tolerating violence.

Principles of Conduct

- Ensure that the safety of the woman (and of any dependent children) is the paramount consideration.
- Treat people with respect and dignity at all times; listen to what they are saying and do not be judgmental, establish empathy and trust.
- Seek to empower people to make informed decisions and choices about their lives, and do not try to make decisions on their behalf.
- Respect confidentiality and privacy, and recognise the real dangers which may be created if this is breached.
- Recognise the skills and contributions which other agencies are able to make, and co-operate with them.
- Ensure that you do not place yourself or your colleagues at risk in a potentially violent situation.

Aspects of Good Practice

- **See the woman on her own.** The presence of a partner or a relative may constrain discussion of domestic violence because, regrettably carers are often perpetrators, and could place the woman in greater danger. Discussion should also not take place in the presence of children. Seeing a patient on their own may sometimes be difficult without arousing the suspicions of a partner, but it can be stressed that this is routine practice, or a reason can be found to divert the partner elsewhere (such as asking them to help fill in documentation). In maternity services there is an increasing emphasis on seeing the woman and her partner together, and the requirement to see the woman alone may be felt to undermine this principle. However, health professionals should understand the importance of seeing the woman alone at least once.

- **Consider the need for an interpreter.** Some people may need someone else to be present (preferably of the same gender) either as an interpreter (for different spoken languages, or as sign language interpreters), or as advocates (particularly if the person has a learning disability), or for moral support. The person who is used as an interpreter should be independent and a professional interpreter; it is unacceptable to use family members or friends in this role, or to use staff who happen to have these skills but are not employed (or trained) to use them.

- **Ensure privacy.** The consultation should take place in a room in which confidentiality can be assured, and where the patient cannot be overheard or seen from outside the room, and where there will not be disturbance or interruption of the interview.

- **Emphasise confidentiality,** but be clear about its limits, and explain these to the woman (for example, if there are reasons to believe that a child may be at risk).

- **Consider the welfare of any children.** Whenever there is any suspicion of domestic violence, there should be awareness of the potential risks to any children. Children who have witnessed or experienced a violent episode may also need an immediate response to address their own needs and fears.

Principles for all local domestic abuse policy

- The safety of women and children is the primary concern in any initiative.
- Patients should be listened to with respect and dignity and without judgement.
- Health professionals should empower women to make their own decisions and not make decisions on their behalf.
- They should not extend their role to include in-depth support where other agencies might have more experience.
- Information sharing is beneficial if carried out appropriately and safely.
- Appropriate levels of confidentiality should be respected.
- Staff should not put themselves or their colleagues at risk in a potentially violent situation.

Indicators of good practice in domestic abuse

- 1 Developing a definition of domestic abuse in conjunction with appropriate service provision.
- 2 Overarching domestic abuse policies and guidelines which include vulnerable adult and child protection issues.
- 3 Prioritising safety.
- 4 Awareness raising, education and training.
- 5 Evaluation, auditing processes and data collection.
- 6 A multi-agency strategy.

Women's Aid (Ireland) works from the principles of:

- empowerment,
- collective action,
- self-help and mutual aid,
- inclusion and
- equality.

Women's Aid (Ireland)

Principles of Knowledge (O'Connor and Wilson, 2002)

1. Violence against women is about power and control.
2. Men's violence is systematic and takes many forms.
3. Men's violence is of a sexualised nature.
4. Violent and abusive men are dangerous to women.
5. The emotional and psychological impacts of violence and abuse are some of the most devastating consequences for women.
6. Men's violence and control extends to the woman as a mother and indirectly and directly to children.
7. Women are not passive victims.
8. Institutional collusion justifies men's use of violence and blames women.
9. The combination of sexism and discrimination, which can take many forms, can have a major impact on the outcomes for women.
10. Collective action challenges the structures of power that create the conditions in which men's violence against women exist.

Good Practice Guidelines

1. Maximises women and children's safety.
2. Understands the trauma of violence and abuse and supports women's increasing autonomy.
3. Is informed and knowledgeable about the rights, entitlements and options for women and ensures referral is appropriate and responsible.
4. Advocates for women's rights.
5. Addresses additional barriers and discriminations that women experience.
6. Is committed to ensuring justice for the victim and accountability of and sanctions against violent men.
7. Recognises that the best form of child protection is woman protection.
8. Supports women to move from crisis to safety and independence.
9. Commits to action for political and institutional change.
10. Encompasses feminist principles within the philosophy and ethos of the organisation.

National Women's Strategy (Department of Justice, Equality and Law Reform 2007)

The work of the **Women's Health Council** is guided by three principles:

- Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women;
- Quality in the provision and delivery of health services to all women throughout their lives; and
- Relevance to women's health needs.

In line with policy development generally, at international and national level, the emphasis today is on the incorporation of a gender perspective into mainstream health policy and the implementation of positive action measures to ensure that the health of women in this country is promoted and protected.

Principles of Gender Mainstreaming

1. Understanding the policy environment – what is the legislative and institutional framework?
2. Consulting men and women, boys and girls: special care must be taken to ensure that women's and girls' needs are articulated
3. Assessing gender differences and inequalities in roles, responsibilities, needs, constraints and access to opportunities and resources
4. Disaggregating data by sex
5. Setting explicit gender equality objectives
6. Developing gender equality indicators to measure progress
7. Supporting gender sensitive monitoring and evaluation systems
8. Drawing together good practice and lessons learned
9. Building alliances with likeminded partners and encouraging co-ordination
10. Promoting positive images of women and men and avoiding stereotypes
11. Using gender sensitive language in all communications

Appendix 2 Examples of Specific Domestic Violence Interventions based on Populations Groups, by Ecological Levels, Prevention Levels, and Universal/Targeted Approaches

Tables 14 and 15 in Section 2 identified a number of strategies and interventions related to the different stages of the ecological model and the lifestages approach as outlined by the WHO (Sethi et al, 2004; Butchart et al., 2004). Outlined below are a series of reconfigured tables adapted on the basis of specific interventions associated with each population group i.e. pre-natal/infant/toddler, children, adolescent, adults.

Those highlighted in *black* are strategies demonstrated to be effective in reducing violence or risk factors for violence. Those highlighted in *grey* are strategies which have shown promise in reducing violence or risk factors for violence. Those with *no highlighting* are a range of other strategies and interventions detailed in Table 14. Further to this, each intervention is categorized by prevention level and whether it is targeted or universal:

Table 21A Interventions for Pre-natal/Infant/Toddlers by Ecological Levels, Prevention Levels, and Universal/Targeted Approaches

| POPULATION GROUP: Pre-natal/Infant/Toddler | |
|---|---|
| Ecological Level | Interventions P1 = Primary, P2 = Secondary, P3 = Tertiary, U = Universal, T=Targeted |
| Individual | <ul style="list-style-type: none"> • Reduce unintended pregnancies (P1, U) • Increase access to prenatal/ postnatal services (P1 U) • Treatment programmes for victims of maltreatment to reduce consequences (P2, T) • Services for children who witness violence (P2, T) • Individual counselling and social casework (P3, T) • Treatment and rehabilitation services for victims of violence (P3, T) • Academic enrichment programmes (including pre-school enrichment) (P1, U) |
| Relationship | <ul style="list-style-type: none"> • Home visitation services (P2 T) • Parenting training (P2, T) • Therapeutic foster care (P2, T) • Day Care (P1 U) |
| Community | <ul style="list-style-type: none"> • Lead monitoring and toxin removal (P1 U) • Screening by health-care providers for maltreatment (P1 U) • Community policing • Improving emergency response and trauma care • Training for healthcare providers in the detection and reporting of child maltreatment • Promotion of safe storage of firearms and other lethal weapons • Prevention and educational campaigns to increase awareness of child maltreatment • Child-protection service programmes • Services for incarcerated perpetrators |
| Societal | <ul style="list-style-type: none"> • Strengthen police and judicial systems (P1 U) • De-concentrate poverty (P1 U) • Reduce income inequality (P1 U) • De-concentrating poverty (P1 U) • Enforcing laws prohibiting the illegal transfer of guns (P1 U) • Strengthening and improving police and judicial systems (P1 U) • Reforming educational systems (P1 U) • Establishing job creation programmes for the unemployed (P1 T) |

Table 21B Interventions for Children by Ecological Levels, Prevention Levels, and Universal/Targeted Approaches

| POPULATION GROUP: Children | |
|-----------------------------------|---|
| Ecological Level | Interventions P1 = Primary, P2 = Secondary, P3 = Tertiary, U = Universal, T=Targeted |
| Individual | <ul style="list-style-type: none"> • Social-developmental training (P1 U) • Pre-school enrichment (P1 U) • School-based child maltreatment prevention programmes (P2 T) • Individual counselling and social casework (P3 T) • Treatment and rehabilitation services for victims of violence (P3 T) • Academic enrichment programmes (including pre-school enrichment) (P1 U) • Skills programmes for younger children (5–12 yr) (P1 U) • Hotlines (P3, U) • Treatment for children and intimate partner abuse offenders (P3 T) |
| Relationship | <ul style="list-style-type: none"> • Mentoring (P1 U) • Home-school partnership programme to promote parental involvement (P1 U) • Peer mediation (P1 U) • Peer linkage (P1 U) • Cognitive treatment for behavioural disorders in children (P1 T) |
| Community | <ul style="list-style-type: none"> • Safe havens for children on high-risk routes to and from schools (P1 U) • After-school programmes to extend adult supervision (P1 U) • Recreational programmes (P1 U) • Media campaigns for child abuse and neglect (P1 U) • School violence prevention curricula (P1 U) • School-based anti bullying interventions (P1 U) • After-school programmes (P1 U) • Create safe routes for children and youth (P1 U) |
| Societal | <ul style="list-style-type: none"> ○ Community policing (P1 U) ○ Improving emergency response and trauma care (P1 U) ○ Training for healthcare providers in the detection and reporting of child maltreatment (P1 U) ○ Promotion of safe storage of firearms and other lethal weapons (P1 U) ○ Prevention and educational campaigns to increase awareness of child maltreatment (P1 U) ○ Child-protection service programmes (P3 T) ○ Services for incarcerated perpetrators • Strengthen police and judicial systems • De-concentrate poverty • Reduce income inequality • Reduction of income inequality (P1 U) • De-concentrating poverty (P1 U) • Enforcing laws prohibiting the illegal transfer of guns (P1 U) • Strengthening and improving police and judicial systems (P1 U) • Reforming educational systems (P1 U) • Establishing job creation programmes for the unemployed (P1 U) |

Table 21C Interventions for Adolescents by Ecological Levels, Prevention Levels, and Universal/Targeted Approaches

| POPULATION GROUP: Adolescents | |
|--------------------------------------|--|
| Ecological Level | Interventions P1 = Primary, P2 = Secondary, P3 = Tertiary, U = Universal, T=Targeted |
| Individual | <ul style="list-style-type: none"> • Social-development training (P1 U) • Educational incentives for at-risk, disadvantaged high-school students (P2 T) • School-based dating violence prevention programmes (P2 U) • Academic enrichment programme (P1 U) • Treatment for adolescents with conduct disorders (P2 T) • Individual counselling and social casework (P2 T) • Treatment and rehabilitation services for victims of violence (P3 T) • Treatment and rehabilitation services for perpetrators of violence (P3 T) • Treatment of child abuse offenders (P3 T) • Probation or parole programmes (P3 T) • Residential programmes in psychiatric or correctional institutes (P3 T) • Providing incentives for youths at high risk of violence to complete secondary schooling Higher/vocational training (P2 T) • Academic enrichment programmes (including pre-school enrichment) (P1 U) • Skills programmes for teenagers (13–18 yr) (P1 U) • Life skills approach* (P1 U) • Hotlines (P2/3 U) • Programmes modelled on basic military training (P2 T) • Trying young offenders in adult courts (P3 T) • Social development programmes (P1 U) • Conflict resolution and anger management (P2 U) |
| Relationship | <ul style="list-style-type: none"> • Mentoring (P3 U) • Family therapy (P2 U) • Temporary foster-care programmes for serious and chronic delinquents (P2 T) • Parent skills training (P1 U) • Mentoring (P1 U) • Peer mediation (P1 U) • Peer linkage (P1 U) • Peer education (P1 U) • Parent education and home visitation (P2 T) • Parent education and home visitation (P2 T) • Multidisciplinary intervention teams for caregivers of the elderly or disabled (P2 T) • Treatment of families of adolescents with conduct disorders (P2 T) |
| Community | <ul style="list-style-type: none"> • Recreational programmes (P1 U) • Reduce alcohol availability (P1 U) • Train heal-care professionals in identification and referral of high-risk youth and victims of sexual violence (P1 U) • Metal Detectors in Schools • Community policing (P1 U) • Improving emergency response and trauma care (P1 U) • Disrupt illegal gun markets (P1 U) |
| Community (contd) | |

| | |
|----------|---|
| | <ul style="list-style-type: none"> • Mandatory sentences for gun use in crimes (P1 U) • Coordinated community interventions for violence prevention (P1 U) • Prevention and educational campaigns to increase awareness of youth violence, intimate-partner violence and elder abuse(P1 U) |
| Societal | <ul style="list-style-type: none"> • Reduce media violence (P1 U) • Enforcing laws prohibiting illegal transfers of guns to youth • Strengthen police and judicial systems (P1 U) • Promotion of safe storage of firearms (P1 U) • De-concentrate poverty (P1 U) • Reduce income inequality (P1 U) • Change cultural norms that support violence and abuse of children and adults (P1 U) • Reforming educational systems (P1 U) • Establishing job creation programmes for the unemployed (P1 U) |

Table 21D Interventions for Adults by Ecological Levels, Prevention Levels, and Universal/Targeted Approaches

| POPULATION GROUP: Adults | |
|---------------------------------|--|
| Ecological Level | Interventions P1 = Primary, P2 = Secondary, P3 = Tertiary, U = Universal, T=Targeted |
| Individual | <ul style="list-style-type: none"> • Incentives for post-secondary education or vocational training • Services for adults abused as children • Treatment for children and intimate partner abuse offenders • Waiting periods for firearm purchases • Individual counselling and social casework (P3 T) • Treatment and rehabilitation services for victims of violence (P3 T) • Treatment and rehabilitation services for perpetrators of violence (P3 T) • Treatment of child abuse offenders (P3 T) • Probation or parole programmes (P3 T) • Residential programmes in psychiatric or correctional institutes (P3 T) • Sexual abuse prevention skills training (P2 T) • Life skills approach (P1 U) • Hotlines (P2/3 U) • Programmes modelled on basic military training (P2 T) • Social development programmes (P1 U) • Conflict resolution and anger management (P2 U) |
| Relationship | <ul style="list-style-type: none"> • Parent skills training (P1 U) • Conflict resolution for child minders of pre-school children (P1 U) • Mentoring (P1 U) • Home-school partnership programmes to promote parental involvement (P1 U) • Peer mediation (P1 U) • Counselling (P2/3 T) • Peer education (P1 U) • Parent education and home visitation (P2 T) • Multidisciplinary intervention teams for caregivers of the elderly or disabled (P1 U) • Family therapy and additional support for at-risk families (P2 T) • Treatment for the families of adolescents with conduct disorders (P2 T) |
| Community | <ul style="list-style-type: none"> • Shelters and crisis centres for battered women and victims of elder abuse • Criminal justice reforms to criminalize child maltreatment, intimate-partner violence, and elder abuse • Mandatory arrest policies for intimate-partner violence • Reduce alcohol availability • Establish adult recreational programmes • Public shaming of intimate partner violence offenders • Services for identifying and treating elder abuse • Train healthcare professionals in identification and referral of battered women, victims of elder abuse, and victims of sexual violence • Community policing (P1 U) • Improving emergency response and trauma care (P1 U) • Disrupt illegal gun markets (P1 U) • Mandatory sentences for gun use in crimes (P1 U) • Coordinated community interventions for violence prevention (P1 U) • Prevention and educational campaigns to increase awareness of youth violence, intimate-partner violence and elder abuse (P1 U) • Rights-based campaigns (P1 U) • Workplace violence prevention (P1 U) • Reforming Hospitals and long term care institutions (P1 U) |
| Community (contd) | |

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| | <ul style="list-style-type: none"> • Screening in primary care settings for domestic violence and elder abuse (P1 U) • Community policing (P1 U) • Police clampdown on gang activities (P1 U) • Increasing the availability and quality of childcare facilities (P1 U) • Improve lighting on dark streets (P1 U) • Install CCTV on high-risk areas (P1 U) |
| Societal | <ul style="list-style-type: none"> • Establish job-creation programmes for the chronically unemployed (P2 T) • Strengthen police and judicial systems (P1 U) • Promotion of safe storage of firearms • De-concentrate poverty (P1 U) • Reduce income inequality (P1 U) • Change cultural norms that support violence and abuse of children and adults (P1 U) • Reduction of income inequality (P1 U) • De-concentrating poverty (P1 U) • Enforcing laws prohibiting the illegal transfer of guns (P1 U) • Strengthening and improving police and judicial systems (P1 U) • Reforming educational systems (P1 U) • Establishing job creation programmes for the unemployed (P1 U) |