National Women & Infants Health Programme

National Clinical Practice Guideline

# Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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May 2024

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## Management of Domestic Violence (DV) in Maternity Services

Patient Care & Safety

Disclosure Friendly Environment

Staff Training on 3 R's

Staff Care & Safety

Child Safeguarding/ Children First

**Recognise**
Routinely screen all women
Know the signs/impact of DV
Focus on privacy and safety
Ask direct questions
Use interpreter if required

**Respond**
(If no DV concerns)
Monitor
Routine Screen
Provide information/resources
Document response

**Respond**
(If DV concerns identified)
Adopt non-judgmental approach
Listen
Assess immediate safety
Assess any injuries
Consider social admission to hospital
DV screen at every hospital appointment
Document findings on medical chart/ EHR

**Refer**
Refer to MSW
Refer to Tusla/Gardai if required
Provide information/resources
Document outcome on medical chart/EHR

# Key Recommendations

1. It is recommended that there is mandatory antenatal screening for domestic violence for all women attending public care, semi-private care, private care and all community settings. *Grade 1A*
2. It is recommended that all domestic violence screening should only be undertaken by trained staff. *Best Practice*
3. It is recommended that appropriate domestic violence training is provided to all staff in maternity settings. *Best Practice*
4. It is recommended that all domestic violence screening takes place face to face with the woman in a private setting where safe to do so. *Best Practice*
5. It is recommended that at least one individual consultation without the woman's partner present should be offered to all women during pregnancy. *Best Practice*
6. It is recommended that only professional interpreters/translators are used to screen for and discuss concerns relating to domestic violence. *Best Practice*
7. It is recommended that the introduction of the electronic healthcare record system to all maternity hospitals/units would ensure consistency in screening for domestic violence in pregnancy. *Best Practice*
8. It is recommended that a woman who makes a disclosure of domestic violence should be offered a referral to a Medical Social Worker. *Best Practice*
9. Child protection concerns relating to domestic violence are a mandatory referral to Tusla. *Grade 1A*
10. It is recommended that Gardaí/Sexual Assault Treatment Units should be contacted with the woman's consent following a physical/sexual assault. *Best Practice*
11. It is recommended that there are clear plans documented in the healthcare record for the woman's care including intimate care. *Best Practice*
12. It is recommended that all services have pathways in place to ensure the safety of the woman and of the staff taking care of her. *Best Practice*
13. It is recommended that postnatal screening of domestic violence for all women takes place prior to discharge from hospital, or community and domiciliary services. *Best Practice*
14. It is recommended that discharge packs should provide information on domestic violence, including information on local and community supports as well as supports in the maternity hospital/unit. *Best Practice*
15. It is recommended that disclosures of domestic violence are notified with consent to General Practitioners and Public Health Nurses in discharge letters to ensure further and ongoing support for women. *Best Practice*
16. It is recommended that there are Medical Social Workers in all maternity hospitals/units. *Best Practice*
17. It is recommended that Medical Social Workers are involved in the provision of multi-disciplinary training of and support for hospital staff. *Best Practice*

# Chapter 1: **Initiation**

The National Clinical Effectiveness Committee (NCEC) and Health Information and Quality Authority (HIQA) define clinical guidelines as systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and the woman's decisions about appropriate healthcare for specific clinical circumstances, across the entire clinical spectrum.[1]

## 1.1 Purpose

The purpose of this Guideline is to provide a comprehensive evidence-based guide for the screening, care and management of domestic violence (DV) in pregnancy and the early post-natal period. This Guideline is intended to guide clinical judgment but not replace it. Clinical care carried out in accordance with this Guideline should be provided in the context of locally available resources. It is noted that women can experience multiple forms of violence simultaneously and that inequalities related to ethnicity, nationality, (dis)ability, age, socio-economic/migration status, religion, sexual orientation, etc. can also lead to compounding factors that impact on health and help seeking behaviours by women. These Guidelines adopt an intersectional approach to understanding that the realities and lived experiences vary widely for people experiencing DV.

## 1.2 Scope

### Target Users

These guidelines are intended for all healthcare professionals who are working in the HSE and HSE funded maternity services, including Doctors, Midwives, Advanced Midwifery Practitioner[2], Nurses and Health and Social Care Professionals.

### Target Population

This Guideline is for women attending maternity services: antenatal care (including miscarriage and termination of pregnancy (TOP) services), intrapartum, and postnatal care in Ireland.

## 1.3 Objective

To provide evidence based recommendations for the screening and care and management of women who are experiencing or have experienced DV during and after pregnancy as well as promoting a standardised approach nationally across all maternity hospitals/units.

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1 NATIONAL CLINICAL EFFECTIVENESS COMMITTEE (NCEC) and HEALTH INFORMATION AND QUALITY AUTHORITY (HIQA) (2015) National quality assurance criteria for clinical guidelines. Version 2. Dublin: NCEC and HIQA. https://www.hiqa.ie/sites/default/files/2017-01/National-Quality-Assurance-Criteria.pdf

2 http://www.nmbi.ie/NMBI/media/NMBI/Advanced-Practice-(Midwifery)-Standards-and-Requirements-2018-final.pdf

## 1.4 Guideline development process

The Guideline Developers agreed to undertake this work under the direction of the Guideline Programme Team (GPT). An Expert Advisory Group (EAG) was commissioned by the GPT. Their role was to critically review the Guideline prior to submission to the National Women and Infants Health Programme (NWIHP) for final approval.

See Appendix 1 for EAG membership and Appendix 2 for Guideline Programme Process.

This Guideline was written by

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## 1.5 Stakeholder involvement

Stakeholders are people who have a common interest in improving health services. This includes persons that are responsible for delivering and those who receive services related to the clinical Guideline.

The Guideline Developers would like to thank Dr Ciara McCarthy General Practitioner, ICGP Women's Health Lead and Ms Mary O'Connor Director Centre of Midwifery Education (CUMH) for their input into the development of this Guideline.

The following additional stakeholders were consulted regarding this Guideline:

- Women's Aid
- Ms Olwen Halevy, School of Applied Social Studies University College Cork
- Professor Maeve Eogan, Consultant Obstetrician and Gynaecologist, National Clinical Lead Sexual Assault Treatment Units (HSE)

## 1.6 Disclosure of interests

Guideline developers and reviewers bring a range of experiences and perspectives to the work of the national Guideline Programme. It is likely that both Guideline developers and stakeholders/reviewers will have a variety of interests, arising from different contexts and activities done in a professional or personal capacity. These can include employment and other sources of income, speaking engagements, publications and research, and membership of professional or voluntary organisations. The involvement of individuals with relevant content expertise is essential for enhancing the value of Guideline recommendations, but these individuals may also have interests that can lead to conflicts of interest, as may peer reviewers, patient representatives and researchers.

All interests should be declared if, in the view of a reasonable person, they are relevant, or could be perceived to be relevant, to the work of the clinical practice guideline in question.[3] Declaring an interest does not mean there is a conflict of interest.

It is important that interests are openly declared so they can be appropriately managed. Conflicts of interest can bias recommendations and ultimately be harmful to women and the health system. Disclosures of interests and appropriate management of conflicts of interest, when identified, are therefore essential to producing high-quality, credible health guidelines.[4]

The Guidelines International Network (GIN), a global network of Guideline developers that aims to promote best practices in the development of high-quality guidelines, developed a set of 9 principles to provide guidance on how financial and non-financial conflicts of interest should be both disclosed and managed. It is recommended that Guideline developers follow the GIN principles.[5]

For this National Clinical Practice Guideline, all Guideline developers are asked to complete a conflict of interest declaration form. The response to declared interests will be managed by the Guideline programme team, in accordance with GIN principles. Conflicts of interest may be reported in the published Guideline and declarations of interest can be made available.

## 1.7 Disclaimer

These guidelines have been prepared to promote and facilitate standardisation and consistency of good clinical practice, using a multidisciplinary approach. Information in this Guideline is current at the time of publication.

The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the Clinician in light of clinical data presented by the woman and the diagnostic and treatment options available.

Clinical material offered in this guideline does not replace or remove clinical judgment or the professional care and duty necessary for each specific woman.

Clinical care carried out in accordance with this guideline should be provided within the context of locally available resources and expertise.

This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible for:

- Discussing care with women in an environment that is appropriate, and which enables respectful confidential discussion. This includes the use of interpreter services where necessary.
- Advising women of their choices and ensure informed consent is obtained.
- Provide care with professional scope of practice, meeting all legislative requirements and maintaining standards of professional conduct.
- Applying standard precautions and additional precautions, as necessary, when delivering care.
- Documenting all care in accordance with local and mandatory requirements.

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3 NICE (2019) Policy on declaring and managing interests for NICE advisory committees https://www.nice.org.uk/Media/Default/About/Who-we-are/Policies-and-procedures/declaration-of-interests-policy.pdf

4 CMAJ 2021 January 11;193:E49-54. doi: 10.1503/cmaj.200651 https://www.cmaj.ca/content/193/2/E49

5 Annals of Internal Medicine, Schünemann HJ, Al-Ansary, LA, Forland F, et al. Guidelines International Network: Principles for disclosure of interests and management of conflicts in guidelines, 163(7), 548-53. Copyright © 2015 American College of Physicians. https://www.acpjournals.org/doi/10.7326/m14-1885

## 1.8 Use of language

Within this guidance we use the terms 'woman' and 'women's health'. However, it is important to acknowledge that people who do not identify as cis-gender women are excluded from this descriptor, including people who identify as transgender, gender diverse and gender non-binary[6]. We also appreciate that there are risks to desexing language when describing female reproduction[7] [8].

Services and delivery of care must be appropriate, inclusive and sensitive to the needs of people whose gender identity does not align with the sex they were assigned at birth. This includes training and education regarding diverse pathways to pregnancy and the use of practices which affirm the sexual and gender identities of all people using Obstetrics and Gynaecology services. Finally, all those using maternal and reproductive healthcare and services should receive individualised, respectful care including use of the gender nouns and pronouns they prefer.[7]

Language use is key to effectively communicate options, recommendations, and respectfully accept a woman's fully informed decision[9]. With this in mind, the use of birth is preferable to the term delivery in all circumstances and is used consistently where possible throughout the guidelines. It is acknowledged that in some circumstances (e.g., in the case of a medically indicated intervention or surgery) and in some contexts, substituting with the term delivery is considered appropriate and this term may be used instead.

The Council of Europe Convention on preventing and combating violence against women and domestic violence – known as the Istanbul Convention defines "Domestic Violence" as all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim. Women are most likely to face violence perpetrated by someone they know and are disproportionately affected by domestic violence. This definition is utilised throughout this Guideline. It is noted that intimate partner violence (IPV) is also used to describe domestic violence. The World Health Organisation (WHO) describes intimate partner violence as behaviours: 'by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.'[10] [2]

Domestic violence during pregnancy is a complex health, social, human-rights and criminal justice phenomenon in addition to a serious risk factor that threatens both the health and life of mother and baby. Given the complexity and multifaceted nature of domestic violence and the severity of its impacts it requires a consensus and consultative approach to guideline development. Acknowledging the range of different terms used both nationally and internationally to describe this issue, the term domestic violence will be used for this guideline as the recognised and accepted legal phrasing in Ireland.

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6 Moseson H, Zazanis N, Goldberg E, et al. The Imperative for Transgender and Gender Nonbinary Inclusion. Obstet Gynecol. 2020;135(5):1059-1068. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170432/

7 Brotto LA, Galea LAM. Gender inclusivity in women's health research. BJOG: An International Journal of Obstetrics & Gynaecology. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.17231

8 Gribble KD, Bewley S, Bartick MC, et al. Effective Communication About Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language. Frontiers in Global Women's Health. 2022;3. Accessed June 9, 2022. https://www.frontiersin.org/article/10.3389/fgwh.2022.818856

9 https://blogs.bmj.com/bmj/2018/02/08/humanising-birth-does-the-language-we-use-matter/

10 World Health Organization (WHO), 2016, Global Plan of Action; Health systems address violence against women and girls.

# Chapter 2:
# Clinical Practice Guideline

## Background

Domestic Violence (DV) is recognised as a global public health and safety issue with potential for serious morbidity and mortality impacts during and after pregnancy. Acknowledging the range of different terms used both nationally and internationally to describe this issue the term DV will be used for this guideline as the recognised, utilised and accepted legal phrasing in Ireland. Data from the World Health Organisation (WHO) and its partners shows that one in three women worldwide have experienced physical or sexual violence, mostly by an intimate partner, and that this number has remained largely unchanged since 2011.[1]

According to the WHO, the role of the health sector in relation to preventing violence against women includes:

- Advocate to make violence against women unacceptable and for such violence to be addressed as a public health problem.
- Provide comprehensive services to sensitise and train healthcare providers in screening for and responding to the needs of those experiencing DV holistically and empathetically.
- Prevent recurrence of violence through early identification of women and children who are experiencing violence and providing appropriate referral and support.[2]

DV is a common experience for women in Ireland, survey data from 2005 by the ERSI indicates that 15% of women reported experiencing physical and/or sexual violence by a (current or ex-) partner since the age of 15.[3] However, more recently FRA reported that as many 26% of women in Ireland experience DV,[4] and the most recent CSO survey on sexual violence in Ireland found that 52% of women experienced sexual violence in their lifetime, with 79% knowing their perpetrator.[5] However, DV is likely to be underestimated in populations given that it is underreported, and victims may feel stigmatised and shame in disclosing their experiences.[6, 7] DV is implicated in poorer maternity and perinatal outcomes, poorer mental and physical health outcomes, including death by murder, suicide, and miscarriage; the harmful impacts of DV, with supporting empirical evidence, are listed in the National Maternity Strategy 2016-2026.[8] Healthcare professionals have an important role in screening for and responding to DV during pregnancy.[9, 10, 11]

DV in pregnancy can be a hidden and stigmatised complex social issue. It is known that women who experience DV have an increased likelihood of miscarriage, stillbirth, pre-term birth and low birth weight babies.[3, 12] In the context of injury related to domestic and sexual violence, miscarriage has been reported by women surveyed in Ireland.[3, 4] Pregnancy and early motherhood can be a time of increased risk for DV and for some women DV may commence and escalate during or soon after pregnancy/birth. Women who have experienced DV also have a greater number of gynaecology consultations and presentations including lower abdominal pain, dysmenorrhoea, dyspareunia, smear abnormalities, cancer concerns and bowel symptoms when compared to women not subjected to DV.[13, 14, 15]

Maternal death data in Ireland are collected and published by Maternal Death Enquiry – Ireland (MDE), these data are then collated with MBRRACE data and published on a triannual basis. The MBRRACE *Saving Lives, Improving Mothers' Care* report from 2015 clearly outlines the established connection between DV and maternal death[16] and the 2018 MBRRACE[17] report outlines the connections between maternal deaths by suicide where DV is known. MBRRACE reports state that healthcare professionals in maternity settings need to be alert to the symptoms or signs of DV and women should be given the opportunity to disclose DV in an environment in which they feel secure.[16, 17] They also outline how information on the supports available to those impacted by DV should be present and available in maternity healthcare settings. Due to the potential for increased interactions between healthcare staff and women during pregnancy and childbirth, there is an opportunity to screen for and identify women who are experiencing DV, which in turn may result in an increased number of disclosures, referrals and provision of support.

Professional sensitive enquiry about underlying social and health risk factors such as substance misuse and DV remains an important part of maternal health risk assessment and clinicians need to remain mindful as to reasons why such information may or may not be disclosed. The process of asking women about DV in the context of comprehensive maternity care may itself act as a reminder that DV is unacceptable, compromises maternal and foetal health and that supports are available to all women.[18, 19]

Maternity units need to be DV disclosure-friendly environments. This means that women feel comfortable, empowered, and confident to share with healthcare professionals if they are experiencing DV. Ensuring accurate, up to date and relevant information on DV including local supports and helpline services are visible and available and stating that staff will support them if a DV disclosure is made helps to create such an environment.[18, 15, 11]

## Legislation

Key relevant legislation in Ireland includes, but is not limited to:

- Non-Fatal Offences Against the Person Act 1997
- Criminal Law (Sexual Offences) Act 2017
- Criminal Justice (Victims of Crime) Act 2017
- Domestic Violence Act 2018
- Harassment, Harmful Communications and Related Offences Act 2021
- Health (Regulation of Termination of Pregnancy) Act 2018

On 01 January 2019, the Domestic Violence Act 2018 came into effect. It updated Irish legislation on DV, transposed elements of the Istanbul Convention into law and provides additional protections for victims of DV. Coercive control, defined as a pattern of intimidation, humiliation and controlling behaviour that causes fear of violence or serious distress that has a substantial impact on the victim's day to day activities is an offence described in this Act.[20]

A person commits this offense where:

a) He or she knowingly and persistently engages in behaviour that is controlling or coercive.

b) Has serious effect on a relevant person.

DV in pregnancy and child protection and welfare are interlinked. Children living with or in contact with parents in a context of DV may be at greater risk of abuse and neglect.[21] Healthcare professionals working in maternity units are 'Mandated Persons' under the Children First Act 2015[22] and are legally required to refer all child protection and welfare concerns to Tusla. Children First legislation defines a child as any person under the age of 18. If the pregnant person is under the age of 18 and there are concerns in relation to DV, a referral to Tusla must be completed in relation to both the mother and the child/unborn baby.

Under the Criminal Law (Sexual Offences) Act 2006,[23] the legal age of consent in relation to sexual activity is 17 years. While sexual intercourse involving a person under the age of 17 is illegal, it might not be regarded as child sexual abuse, under the Children First Act 2015. Mandated persons are required to report underage sexual activity to Tusla.

Infants and toddlers are totally dependent upon others for care and their lives are organised around the primary attachment relationship to a care-giver, usually their mother. Distress may manifest itself behaviourally in excessive irritability, regressed behaviour around language and toilet-training; sleep disturbances, emotional distress, and a fear of being alone.[21] One literature review concluded that a toddler's need for adults to provide structure because of their developmental inability to understand and control their own emotions, may be difficult for depressed and overwhelmed mothers to meet, thus impacting the child's experience of emotional expression.[24] All staff working in maternity care settings should be alert to these presentations by children who may be accompanying their mother to antenatal and other appointments.

## What is Domestic Violence?

DV is defined within the Istanbul Convention as 'all acts of physical, sexual, psychological, or economic violence that occurs within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.[25] See Table 1 for detailed list of forms of abuse.

*Table 1: Forms of abuse[26]*

| Physical/Sexual Abuse | Emotional/ Psychological Abuse | Financial/Social Abuse |
|---|---|---|
| • Pushing, throwing, kicking<br>• Slapping, grabbing, hitting, punching, beating, tripping, battering, bruising, choking, shaking<br>• Pinching, biting<br>• Holding, restraining, confinement<br>• Breaking bones<br>• Assaulting with a weapon, such as a knife or gun<br>• Burning<br>• Imprisoning<br>• Sexually assaulting "assaults, that have explicit content includes a variety of forms of including rape, sexual assault and sexual harassment (Department of Justice & Equality, 2010)<br>• Sexually harassing ridiculing another person to try to limit his/her sexuality or reproductive choices<br>• Sexually exploiting, such as forcing someone to look at pornography or participate in pornographic film-making<br>• Rejecting sex and intimacy – the opposite of the aforementioned – whereby the abuser withholds sex and intimacy as form of further abusing his/her partner. | • Threatening or intimidating to gain compliance<br>• Destroying of the victims personal property in his/her presence<br>• Yelling or screaming<br>• Name-calling<br>• Constantly harassing<br>• Embarrassing, making fun, of or mocking the victim, whether alone, within the household, in public, or in front of family or friends<br>• Criticising or diminishing the victims accomplishments or goals<br>• Not trusting the victim's decision making<br>• Telling the victim that she is worthless on his/her own, without the abuser<br>• Excessive possessiveness, (isolation from friends and family-telling someone where she can and cannot go, making up lies about family/ friends<br>• Excessive checking up on the victim, to make sure that she is at home or where she said that she would be<br>• Blaming the victim for how the abuser acts or feels<br>• Threatening/attempting self-harm or suicide, maybe in front of the victim<br>• Using children-undermining parenting or making threats to harm children. | • Withholding economic resources, such as money or credit cards<br>• Stealing from or defrauding a partner of money or assets<br>• Exploiting the intimate partner's resources for personal gain<br>• Withholding physical resources, such as food, clothes, necessary medications or shelter<br>• Preventing the spouse or intimate partner form working or choosing an occupation<br>• Limiting access to transport<br>• Limiting access to a car seat or buggy<br>• Monitoring or abusing through social media<br>• Locking doors-stops victim from leaving the home, or from supports gaining access thereto<br>• Social isolation<br>• Name-calling, intimidating family threats<br>• Highlighting flaws or belittling any supports. |

## What is Sexual Violence?

Sexual violence refers to assaults that have an explicit sexual content and includes a variety of forms including rape, sexual assault and sexual harassment. These forms of sexual violence can be perpetrated by family members, current and former sexual partners, other relatives and friends, acquaintances (including colleagues and clients), those in a variety of authority positions, and strangers. The many possible combinations of location and relationships mean that sexual violence can be in private or public locations, and in terms of rape, for example, can include many forms – marital rape, familial/incestuous rape, acquaintance/date rape, stranger rape, gang rape, custodial rape, and rape as a war crime.[26]

Sexual violence consists of an array of sexual coercion assaults, penetrative and non-penetrative – sexual violence can take the form of rape or sexual assault which involves sexual penetration, whether vaginal, and or oral through the use of an object or body parts, using force, coercion or by taking advantage of the vulnerability of the victim.[26]

There are six Sexual Assault Treatment Units (SATUs) in Ireland.[11] They provide specialist (clinical, forensic and supportive) care for women and men aged 14 years and over who have or think they have experienced sexual violence. Further information is available at hse.ie/satu. (Appendix 3)

## What is Coercive Control?

A Study on Familicide & Domestic and Family Violence Death Reviews 2023, a report commissioned by the Department of Justice, states that:

> *Coercive control refers to a pattern of controlling behaviours that creates an unequal power dynamic in a relationship that has elements of violence, intimidation, isolation, and control. These behaviours give the perpetrator power over their partner, making it difficult for them to leave.*[27]

Safe Ireland describes it as follows:

> *Coercive control is a persistent and deliberate pattern of behaviour by an abuser over a prolonged period of time designed to achieve obedience and create fear. It may include coercion, threats, stalking, intimidation, isolation, degradation and control. It may also include physical and/or sexual violence.*[28]

Coercive control is included and outlined in the Domestic Violence Act 2018 as an offence under section 39 of the Act (See page 10 – legislative framework).

11 https://www2.healthservice.hse.ie/organisation/national-pppgs/national-guidelines-on-referral-and-forensic-clinical-examination-following-rape-and-sexual-assault-ireland-5th-edition-2023/

**Clinical Question 2.1:** What is the recommended care for a woman when there is a disclosure or suspicion of DV at an antenatal booking appointment?

## Evidence Statement

Health and social care workers in maternity settings have a crucial role to play in recognising and responding appropriately to women who are experiencing DV. Midwives, Nurses, Doctors and health and social care professionals are required to be alert to the heightened risk of DV in pregnancy.[8, 29] Recognising, responding, and referring women experiencing DV in pregnancy is essential to ensure that women receive effective and prompt support from the appropriate services. NICE[30] and HIQA Standards[29] recommend routine questioning on DV by trained staff during the antenatal period. It is important that maternity hospitals and units have access to professional language, including Irish/International Sign Language, interpreting services which are readily available, easily accessible, accurate, and confidential as well as fit for purpose. Partners and family members should not be routinely used for translation or interpretation.

The National Maternity Strategy and Intercultural Health Strategy[8, 31] acknowledges the complex needs of all women and emphasises those from minority ethnic groups, members of the Traveller community and migrant women, who may have additional challenges including poverty, isolation, be experiencing racism, literacy issues, human trafficking, etc.[32] Healthcare professionals should be aware of the range of supports and referrals these women may require.

The WHO, NICE guidance and MBRRACE reports all outline the profound impacts that DV can have on women's mental health and subsequent mental health morbidity during and after pregnancy.[9, 33, 34] Cook et al. outline how psychiatric conditions such as depression, anxiety and PTSD may become more acute postpartum due to an intensification of abuse and violence.[35] It is important that presentations of mental health morbidity including suicide ideation during the perinatal period are responded to in the context of potential links with an experience of DV.[19]

The WHO and research in Ireland note the following are risk factors as listed below, which should be considered during consultation with the woman and particularity during history taking.[3, 36, 37, 38, 39] It is important to note that pregnancy does not act as a protective factor in relation to DV, indeed WHO and other studies on femicide acknowledge it as a risk factor for abuse and murder.[40]

## Clinical Practice

### Risk factors for experiencing DV

Clinicians should be aware of the risk factors associated with DV.

Note this list is indicative and not exhaustive:

- Being female
- Being pregnant/having children
- Having abusive parents, growing up in an environment of abuse
- Having a disability, including mental health issues
- One partner controlling decisions in the relationship, including money

- Social isolation, not having a supportive family or peer network
- Vulnerability or multiple vulnerabilities, for example addiction, homelessness, marginalised/ underserved groups
- Women of all social backgrounds can be victims of domestic violence.

The 'toxic trio' is the interaction of DV, parental substance misuse and parental mental health issues. These overlapping vulnerabilities can be detrimental to the woman's health and well-being and can have damaging consequences for the wellbeing and outcomes of children.[41]

### *Recognise*

It is essential that all women are screened for DV at the antenatal booking visit regardless of setting (hospital, community or domiciliary) in the absence of their partner and/or family members (including for example verbal children), or at a subsequent visit if their partner is present at the booking visit. It is essential that a professional, appropriate interpreter is used if required; taking into account where possible cultural, religion and gender needs.[42] Efforts should be made, foremostly, to secure a female interpreter to ensure the woman does not know the interpreter and is comfortable to proceed with the interpreter.[43]

Where antenatal booking appointments are by phone it is not safe to complete DV screening. DV screening should only be undertaken face to face and when the woman is on her own. It is helpful to introduce the subject of DV explaining that all women are routinely asked about DV during pregnancy since it is known that women who are already in abusive relationships, may experience an increase in abusive behaviours and as DV may commence during pregnancy. It is important to use clear terms and phrases when screening women to ensure comprehension of the questions posed and as women may be experiencing a range of abusive behaviours including coercive control and emotional/psychological abuse.

How DV is recorded is dependent on location and whether the maternity hospital/unit is using an electronic healthcare record (MN-CMS) or a paper healthcare record. The questions listed below have been agreed following an extensive review of screening questions across international literature and changes in national legislation.

When using a healthcare record, screen women for DV using the following questions.

- Do you feel safe in your current relationship? Yes/No
- Does your partner/ex-partner/father of your children ever hurt you or threaten to hurt you? Yes/No
- Does your partner/ex-partner/father of your children control what you do or who you see? Yes/No

In maternity units using paper healthcare records these codes are recorded in the social history section of the booking assessment.

Currently in the electronic record the following questions are used

- Do you feel safe in your current relationship? Yes/No
- Have you ever been emotionally, physically, or sexually abused by your current partner or someone in your current home? Yes/No

The codes V0-V2 below must always be used in recording of DV.

| | Code |
|---|---|
| Indicates the woman has been asked and denies DV | VO |
| Indicates the woman has been asked and discloses DV | V1 |
| Indicates DV has been confirmed and action has been taken by hospital staff | V2 |

Where the maternity hospital/unit is using MN-CMS, these codes should be carefully recorded where they can be seen by relevant hospital staff.

### *Response*

Always respond to any disclosure of DV in a non-judgemental and supportive manner. Reassure the woman that she can speak to someone in confidence and privately. However, she must be informed that confidentiality is not assured where there is an immediate risk to her safety or her unborn baby or other children. Consider scheduling appointments and seeing the woman more frequently for antenatal care appointments. Where possible, the return appointment should be with the Midwife/Doctor, or Medical Social Worker (MSW) with whom the disclosure was made.

- If there is a risk to the woman's immediate welfare and safety consider the need for admission to a maternity or other suitable ward.
- Discuss with the woman about informing her GP to provide additional supports especially on an ongoing basis for post-natal care.
- Establish a safe way to contact the woman.

For woman accessing community services it may feel appropriate that their care is transferred back into the hospital. This may not be suitable for all women due to the potential difficulties of getting to appointments. It is also important to be cognisant of the woman's preference about how she accesses her maternity care. All options should be discussed with the woman on where she continues to receive her antenatal care. A referral to the MSW should still be made.

If a woman screens negatively but the Midwife/Doctor have suspicions of DV

- Document concerns in her healthcare record.
- Refer to MSW.
- Arrange an earlier than scheduled return appointment.
- Appropriate Information is provided to women in an antenatal pack.

### *Refer*

- Refer to the MSW.
- If a MSW not available, explore if the woman has a safe place to go before she leaves the hospital/unit; provide support in accessing local DV supports and refuges.
- If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused this should be reported to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern.

- Refer to the Specialist Peri-Natal Mental Health Team (SPNMHT) where required.
- GPs and/or PHN can provide invaluable support to women who disclose DV during or after their pregnancy. It is essential that they are informed of all disclosures with consent.

### Recommendations

1. It is recommended that there is mandatory antenatal screening for DV for all women attending public care, semi-private care, private care, and community settings.
2. It is recommended that all DV screening should only be undertaken by trained staff.
3. It is recommended that appropriate DV training is provided to all staff in maternity settings.
4. It is recommended that all DV screening takes place face to face with the woman in a private setting where safe to do so.
5. It is recommended that at least one individual consultation without the woman's partner present should be offered to all women during pregnancy.
6. It is recommended that only professional interrupters/translators are used to screen for and discuss concerns relating to DV.
7. It is recommended that the introduction of the electronic healthcare record system to all maternity hospitals/units would ensure consistency in screening for DV in pregnancy.

## **Clinical Question 2.2:** What is the recommended care for a woman when there is a disclosure or suspicion of DV at an Emergency Room attendance?

### Evidence Statement

Women may present to the maternity hospital/unit's Emergency Room (ER) immediately following an assault, or sometime later. They may present alone, be brought in by a partner who has assaulted them, family member or friend or by the police/Gardaí. Women who delay in presenting might have been prevented from doing so by their partner or have been reluctant to attend for fear of exposing obvious signs of physical/sexual abuse i.e. black eye or bruises. Fanslow et al also observed Women assaulted by an intimate partner were more likely to present to ER after 6pm and before 6am than women who presented with unintentional injuries.[44]

When a woman has repeat presentations to the Emergency Room (ER) during her pregnancy communication is paramount between her Midwife, Doctor, and her GP with consent, to identify DV and "potentially prevent maternal deaths".[34, 45] Women may also present to the ER following sexual violence in the context of an intimate partner relationship.

### Clinical Practice

Not all women presenting to ER who experience DV will present with physical injuries, thus staff must be vigilant and alert to possible signs of DV including.[46, 47]

- Late booking and/or poor or non-attendance at antenatal clinics.
- Repeat attendance at antenatal clinics, the General Practitioner's (GP) surgery or Emergency Departments (ED) for minor injuries or trivial or non-existent complaints.
- Unexplained admissions.
- Non-compliance with treatment regimens/early self-discharge from hospital.
- Repeat presentation with depression, anxiety, self-harm, and psychosomatic symptoms.
- Injuries that are unintended and of several different ages, especially to the neck, head, breasts, abdomen, and genitals.
- Minimisation of signs of abuse on the body.
- Signs of sexual assault or injury. Sexually transmitted diseases and frequent vaginal or urinary tract infections and pelvic pain.
- Poor obstetric history (such as repeated miscarriage or termination of pregnancy, stillbirth or preterm labour, preterm birth, intrauterine growth restriction/low birth weight or unplanned pregnancy).
- The constant presence of the partner at examination, who may be domineering, answer all the questions for her and be unwilling to leave the room.
- The woman appears evasive or reluctant to speak or disagree in front of her partner.
- A partner insisting on acting as the translator for a pregnant woman for whom English is not their first language.

Women experiencing DV may not speak up when the subject is first raised but may choose to disclose later when they feel sufficient trust and confidence in the health professional, possibly at a subsequent visit with the same person. It is important for health professionals to enquire about DV in private and in a sensitive manner.

### *Recognise*

When a woman presents with an injury:

- Check her healthcare record to confirm DV screening has been carried out and if a risk of DV was already identified.
- Enquire about the injury as an another opportunity to further screen for DV. This should be done in a private room or space with the woman on her own.
- Refer to Clinical Indicators (Appendix 4).

When presented with a woman who has an injury the Midwife/Doctor should take a sensitive approach to enquiring about how it occurred. Some examples of questions include:

- I notice that you have some bruises on your arm. How did that happen?
- You seem to be sore, have you been hurt?
- Has someone hurt you?
- Are you afraid of anyone in your home?

The explanation may be consistent with the injury and the Midwife/Doctor may be satisfied that DV is not the cause, or a violent incident may have caused the injury and the woman may minimise what has happened or blame herself. The Midwife/Doctor needs to be aware that the women may feel ashamed or be fearful of disclosing their experience in case further violence is directed towards them. If the explanation does not match the injury, the Midwife/Doctor may continue to ask gentle probing questions and should be nonjudgmental about the woman's actions or decisions.

Some examples might include:

- Is there something you would like help with?
- Is there anything else you would like me to know?

It is important to document her injuries on the healthcare record and treat as indicated. Document the woman's account of what happened and if it conflicts with clinical findings that should be noted on the healthcare record.

### *Respond*

If a disclosure of DV is made healthcare staff should respond to women in a supportive manner, providing emotional support, validating her experience.

The following steps should be taken:

- Refer to MSW for urgent assessment (if within MSW working hours).
- Consider admitting the woman as an in-patient pending MSW assessment. This will offer her respite and enable her to meet with MSW prior to discharge to discuss her options and formulate a safety plan.
- If the woman is not for admission or not agreeable to admission, the Midwife/Doctor should explore safe discharge options with the women. Give information on local DV support services/refuge.
- If a rape or sexual assault as occurred, please be mindful of the need to document injuries (if present), preserve forensic evidence and with the woman's consent liaise with SATU and/or Gardaí in line with national PPPG.
- If a physical assault has occurred and with the woman's consent police/Gardaí should be called to photograph injuries and take a statement.
- All disclosures of DV should be recorded in the clinical notes on the healthcare record using the code V1.
- Professional interpreters/translators should be used for women whose first language is not English or who use Irish/International Sign Language and where communication challenges exist. Never use the person who accompanied the women to hospital as a translator, as it may place her at additional risks following discharge.

### *Refer*

- To a MSW
- If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused this should be reported to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate risk.
- SPNMHT review prior to discharge, if required.

- IF MSW is not available, discuss safety plan with the woman and encourage her to contact local support services/refuge.
- GPs and/or PHN can provide invaluable support to women who disclose DV during or after their pregnancy. It is essential that they are informed of all disclosures with the woman's consent.

**Recommendations**

8. **It is recommended that a woman who makes a disclosure of DV should be offered a referral to a Medical Social Worker.**
9. **Child protection concerns relating to DV are a mandatory referral to Tusla.**
10. **It is recommended Gardaí/SATU should be contacted with the woman's consent following a physical/sexual assault.**

## **Clinical Question 2.3:** What is the recommended management pathway where there is a disclosure or suspected case of DV during intrapartum care?

### Evidence Statement

As defined in Clinical Question 2.1 midwives/doctors/allied health professionals are necessitated to be vigilant for signs of DV. The MBRRACE report 2020, found that 61 women died as a result of DV in the period between 2016-2018, in pregnancy and up to 6 weeks afterwards in the UK and Ireland. A previous negative screening response at booking does not eliminate the need to be aware of the signs and presentations related to DV throughout pregnancy, including within challenging environments such as assessment, admission to labour ward and throughout intrapartum care. A woman may have already disclosed a history of DV, and an agreed pathway of care may be in place.

However, a previous negative response does not negate the requirement for further screening if the clinician is suspicious. Multiple studies have shown there is an openness and acceptance of DV screening by women within healthcare settings.[4, 48, 49] It is essential that those who are suspected of experiencing DV, but choose not to disclose, are respected and the option for future disclosure remains. Engagement in these circumstances provides an opportunity for the clinician to provide information and reassurance that if they do require support at a later stage it will be available. It is essential that all these interactions are recorded in the healthcare record including non-disclosure of DV.

Intrapartum care is holistic and a sensitive time for women. If a trusting relationship can be achieved during the intrapartum period it may increase the chance of a woman disclosing DV. Referral pathways and support options for women who disclose DV during pregnancy, intrapartum and the postnatal periods need to be clear and accessible to guide healthcare professionals to best support women.[50] This includes "out of hours", weekend and holiday supports at community level such as refuge housing, police/an Garda Síochána local contact details and 24 hour DV helpline information.[15]

Due to the fluctuating and high activity in these clinical environments, it is even more essential that Midwives/Doctors are alert to signs of possible DV. The maternity healthcare record may provide some indicators (See Appendix 4).[13, 35, 51]

## Clinical Practice

### *Recognise*

Other more immediate indicators of a woman experiencing DV during intrapartum care include:

- Bruising and/or injury to the body (Appendix 4).
- Difficulty with vaginal examinations (especially if history of sexual assault).
- A partner who refuses to leave the woman alone in the assessment area or on the ward.
- A partner who can appear domineering and continually answers questions on the woman's behalf.
- In the case of women whom English may not be their first language, their partner may insist on translating for them and refuse any alternatives.

### *Respond*

- Create an opportunity to speak with the woman on her own.
- Adopt a non-judgemental approach.
- Explore if she wishes for her partner to be asked to leave.
- Clearly document V1 on chart.
- All intimate care during the intrapartum period will be undertaken in line with local PPPG.
- If there is an immediate risk to the women's safety and her partner or baby's father is present. This may also include immediate risk to staff working in the ward/hospital/clinic.
- Contact hospital security.
- Contact the Garda Síochána if required.
- Notify the Director of Midwifery or the Assistant Director of Midwifery on duty.
- Once security officer present (consider risk assessment) ask partner to leave the ward.
- Contact MSW.
- Assess if the women and staff feel safe.

### *Refer*

- To a MSW.
- If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused this should be reported to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern.
- To SPNMHT as required.
- GPs and/or PHN can provide invaluable support to women who disclose DV during or after their pregnancy. It is essential that they are informed of all disclosures with the woman's consent.
- Update the obstetric team with view to plan of care for labour and birth.
- Non-judgemental approach.

### Recommendations

11. It is recommended that there are clear plans documented in the healthcare record for the woman's ongoing care including intimate care.
12. It is recommended that all services have pathways in place to ensure the safety of the woman and staff taking care of her.

## **Clinical Question 2.4:** What is the recommended management where there is a disclosure or suspicion of DV when the woman is an in-patient in a maternity hospital/unit?

### Evidence Statement

An in-patient admission at either antenatal or postnatal stage may offer the woman respite from DV and time away from her abuser to make decisions on her future and next steps. Repeated positive interactions with a woman may support her to disclose, or alternatively may give information to midwives/Doctors caring for her that DV is present in her life. It is crucial that midwives/Doctors and Health and Social Care Professionals (HSCP) staff recognise when a woman is at the point where she can no longer cope with the DV from their partner.[45] The HIQA standards note that pregnancy and birth can provide women with the opportunity to disclose DV, and access supports to enhance their safety and wellbeing.[29] The WHO multi-country study on violence against women identified that women are more at risk of experiencing DV in intimate relationships than anywhere else; and that there is a clear link between DV and physical and mental ill-health.

The fear of leaving a partner and parenting alone may prevent some women from leaving their partner. For others becoming a mother was the incentive they needed to disclose their abuse and seek help.[45] Women may be feeling very vulnerable before they leave the hospital with their baby, and, as Goodman notes, the postpartum period is an especially dangerous time.[52] Women who screened negatively during their earlier antenatal screen may now screen positively for DV.[45]

### Clinical Practice

#### *Recognise*

A review of healthcare records should provide information of previous positive or negative DV screens or whether previous interactions alerted staff to suspicion of physical or emotional indicators that a woman is experiencing DV.[13]

- Always screen the women when she is alone, and her partner is not present. If her partner is constantly with her create an opportunity to have time alone with her to screen for DV.
- Provision should be made for a quiet, private, and safe environment before inquiry for DV takes place. Recognising that facilitating this may not always be possible, every effort should be explored to do so.
- Similar to screening at booking history it might be helpful to frame the questions first, such as 'Many women experience DV, in fact more than 1 in every 5 in Ireland do, but some find it difficult to disclose, so I ask everyone about it'. Screen asking the same questions the women was asked at her antenatal booking.

  - Do you feel safe in your current relationship? Yes/No
  - Does your partner/ex-partner/father of your children ever hurt you or threaten to hurt you? Yes/No
  - Does your partner/ex-partner/father of your children control what you do or who you see? Yes/No
- All women should be screened for DV prior to being discharged from the maternity service including those under the care of a midwife in the Early Transfer Home, Community, self-employed community midwives.
- Discharge packs should provide information on DV, including information on local and community supports as well as supports in the maternity unit. This should be available in multiple languages.[41, 42]

### *Respond*

- Listen and be supportive, remember your response will make a difference.
- Inform Midwife Manager.
- Record disclosure on healthcare record using the code V1.
- Consider extending in-patient stay if possible.

Women who disclose DV following a postnatal screen should be seen by a MSW prior to discharge from the services.

### *Refer*

- To a MSW.
- If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused this should be reported to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern.
- SPNMHT review prior to discharge, if required.
- If MSW is not available, discuss safety plan with the woman and encourage her to contact local support services.
- GPs and PHN can provide invaluable support to women who disclose DV during or after their pregnancy. It is essential that they are informed of all disclosures with the consent of the woman.

### Recommendations

13. **It is recommended that postnatal screening of DV for all women takes place prior to discharge from hospital, or community and domiciliary services.**
14. **It is recommended that discharge packs should provide information on DV, including information on local and community supports as well as supports in the maternity hospital/unit.**
15. **It is recommended that disclosures of DV are notified with consent to GPs and PHNs in discharge letters to ensure further and ongoing support for women.**

## **Clinical Question 2.5:** What is the Medical Social Worker's Response to Domestic Violence in a Maternity setting?

### Evidence Statement

The MSW is uniquely placed within a maternity setting to respond to the needs of women who are experiencing DV. Given their training and skillset MSW have the ability to assess risk and form appropriate DV interventions. These include safety-planning, referrals to Tusla, coordinating multi-disciplinary services within and outside of the hospital to ensure the safety of the woman and her children.

Creating a Better Future Together: The National Maternity Strategy states that *"MSW… support women and their infants and families to achieve health and wellbeing through practical and therapeutic interventions from preconception, throughout antenatal care and into the postnatal phase as part of the wider multi-disciplinary team"*[8]. For women experiencing DV, pregnancy and birth can provide an opportunity for them to access support for their safety and wellbeing, and that of their baby.

MSW act as coordinators of service provision for women experiencing DV. Services may include medical teams, SPNMH team, Tusla, refuges and other community based supports. Coordinated interagency responses to DV are recognised as key to effectiveness in providing services to those affected by DV.[53]

MSW will support women experiencing DV at all times using a person-centred approach.[54] This will include providing ongoing counselling support, liaising with medical staff and hospital management to ensure that the woman's pregnancy journey and birth plan are safely managed from a hospital perspective. Advocacy programs, in the context of DV services, encompass a broad range of services designed to empower survivors by connecting them with community resources. Specific activities of advocacy services include support for safety planning, legal assistance, housing and financial advice, emergency housing, informal counselling, and ongoing support.[55]

A further action undertaken by health practitioners to enhance their readiness to address

DV involves their collaboration with their team members internal to their organisations and with specialist professionals outside their team.[56] Multi-disciplinary Meetings are a regular feature of patient care in maternity settings. These are attended by MSWs with other key stakeholders within the hospital. MSW manage and coordinate the DV and psychosocial high-risk cases at these meetings. The purpose of these meetings are to ensure that relevant staff are aware of the concerns and to plan for how to best support the woman during admission, delivery and at discharge.

MSW will work with a woman to devise a safety plan which looks at ways to protect her, her unborn baby, and children. The safety of women and children in abusive situations is a priority and any interventions in which the supportive person or health/social-care professional has considered the risks posed to enhance the safety of a woman and her children. It is important to recognise that although a safety plan can reduce the risks of violence, it cannot completely guarantee safety. Risk is changeable, particularly if a woman is considering leaving the relationship. Therefore, safety planning needs to be completed on an ongoing basis, where possible.[26]

In many hospitals, MSW have responsibility as Designated Liaison Person (DLP). The DLP is responsible for ensuring that reporting procedures within the organisation are followed, so that child protection and welfare concerns are referred promptly to Tusla.[57] The National Maternity Strategy states that *"While the medical social worker is the key contact point with the Child and Family Agency, all staff need to be alert to child welfare and protection concerns"*.[8]

## Clinical Practice

### *Recognise*

Medical Social Workers may recognise women experiencing DV in the following ways:

- Women who are referred directly to MSW by members of the medical team/hospital staff for concerns regarding suspected/confirmed/historic domestic violence.
- MSW may encounter women who have been alerted for domestic violence concerns on the hospital patient management system as appropriate to local policies and procedures.
- While working with a woman, MSW may note concerns in relation to suspected/confirmed/historic domestic violence.

### *Respond*

The MSW response to DV concerns may include the following:

- Check healthcare record to confirm DV screening has been carried out and if a risk of DV was already identified.
- Check if the woman is previously known to MSW service and review previous files, as appropriate.
- If the woman is an outpatient, do not make contact with the woman unless it is safe to do so. Some liaison with the medical team may be required in terms of safely bringing the woman back to the hospital for MSW assessment.
- If the woman declines a MSW referral, the MSW will ensure a) to ask the referrer to provide contact details of local community support agencies to the woman, b) the case remains open for the duration of the pregnancy and c) any child protection or welfare concerns are referred to Tusla under Children First 2015.
- If the woman agrees to a referral, MSW will clarify their role and limits of confidentiality at the beginning of the assessment.
- Assess as soon as possible post the incident of abuse and try to establish as much information as possible, allowing the woman to tell what happened in her own words and time-lines involved.
- Be mindful of mandated responsibilities under Children First 2015.
- Complete a psychosocial assessment with the woman. This should include thorough screening and risk assessing for DV and coercive control, child protection concerns, mental health screen and screening for substance misuse in pregnancy as well as identifying social and family networks and any protective factors.
- MSW will liaise and/or co-work cases as appropriate with the SPNMH team where the woman's mental health is a significant factor.
- As part of the MSW psychosocial assessment, MSW can use the crisis intervention model. The Crisis Intervention Model highlights the different processes that a survivor experiences, her comprehension of these, how she manages the situation, and how her perception may be distorted due to the impact of the perpetrator's abuse. (Appendix 5).

- Make the woman aware of DV legislation and availability of various Court orders that can be applied for.
- Complete a detailed Safety Plan with the woman (See Appendix 10).
- Establish a care/safety plan specifically for her involvement with the maternity unit. MSW can explore with the woman how her safety can be increased during antenatal attendance, delivery and stay on postnatal ward. This may include establishing safe times for contacting the woman, organising in-patient/social admissions, where necessary and establishing who the woman wishes to be with her in the delivery suite. If she does not want her partner present at antenatal appointments, delivery and in-patient admissions, MSW can liaise with hospital management, medical team and security, as appropriate, to ensure the woman's safety.
- Ensure safe record keeping practices are in place in line with local PPPGs and practices. MSW files should be stored separately to the woman's main healthcare record or stored on private MSW file on MN-CMS.

***Refer***

- Refer any child protection concerns arising from MSW to Tusla under Children First mandated responsibilities.
- If a physical or sexual assault has taken place refer to the Gardaí/SATU with woman's consent.
- Liaise with hospital management and organise in-patient stay if needed.
- Assist the woman with and/or complete onward referrals to local and national DV support services and refuges as required. Provide the woman with safe phone and room if necessary. MSW can follow up with these services with the woman's consent.
- Provide woman with leaflets/written information about supports and services as required.
- MSW can liaise with GP with the woman's consent.
- Complete referrals to appropriate services as needed (E.g. Perinatal Mental Health Team (SPMHT), addiction services, homeless services etc.)
- Refer to PHN.

## Recommendations

16. **It is recommended that there are MSWs in all maternity hospitals/units.**
17. **It is recommended that MSWs are involved in the provision of multi-disciplinary training of and support for hospital staff.**

# Chapter 3: Development of Clinical Practice Guideline

## 3.1 Literature search strategy

A comprehensive literature review was undertaken which included national and international publications.

PubMed, CINAML, MIDRIS, The Cochrane Library, Psych INFO and Lenus were searched using terms relating to DV and pregnancy. The literature search was initiated using the words 'Domestic Violence' 'Domestic abuse' 'Intimate partner violence' 'Pregnancy' 'Screening' 'Antenatal Care' and 'Prenatal care' 'Postnatal Care' and further combined searches were then undertaken to narrow the search results. A lack of literature in an Irish Context was identified early on and date limitations were expanded going back to 2000 to incorporate the limited Irish studies that were available.

Websites such as Google and Google scholar were searched using key words and Google was also used to obtain access to grey literature such as Irish Government and Health Service Executive policies, The National Office for the Prevention of Domestic, Sexual and Gender-based Violence (formerly Cosc) publications and both national and international guidelines. Searches were limited to humans and English language articles. International Guidelines on responding and managing DV in pregnancy were also reviewed.

## 3.2 Appraisal of evidence

Following a comprehensive literature review the quality, validity and relevance of the evidence gathered were critically appraised by the Guideline developers under the following headings:

- Study design
- Relevance of primary and secondary outcomes
- Consistency of results across studies
- Magnitude of benefit versus magnitude of harm
- Applicability to practice context

Several evidence-based recommendations for management of DV in pregnancy were agreed upon. They have been adapted to reflect care in the Irish healthcare setting.

## 3.3 AGREE II process

While being developed, the Guideline was assessed using the AGREE II checklist (Appendix 6) as recommended by the Department of Health in the 'How to Develop a National Clinical Guideline: a manual for guideline developers', 2019[12].

12 Department of Health (2019). How to develop a National Clinical Guideline: a manual for guideline developers. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/

The purpose of AGREE II is to provide a framework to:

1. Assess the quality of guidelines.
2. Provide a methodological strategy for the development of guidelines.
3. Inform what information and how information ought to be reported in guidelines.

## 3.4 Literature review

Details of supportive evidence-based literature for this Guideline are reported in chapter two.

- The review of the literature was conducted by JW between April 2022 and January 2023.
- The final documents selected were reviewed by JW and ML.
- There was substantial evidence available to answer the clinical questions proposed.
- The quality of evidence varied however for the most part, there was strong evidence to support clinical practice.
- The evidence reviewed comes from both national and international studies and was subsequently adapted to fit the Irish context.
- Literature was used when the evidence was relevant, strong and although there are some obvious gaps from an Irish research perspective, the literature used for this guideline was applicable to the Irish setting and omitted when this was not the case.

## 3.5 Grades of recommendation

GRADE offers a transparent and structured process for developing and presenting evidence summaries and for carrying out the steps involved in developing recommendations.[13]

While we acknowledge that for this particular work an extensive GRADE approach is not possible, we have used the suggested language set out in the GRADE table when making recommendations.[14] (Appendix 7)

## 3.6 Future research

An important outcome of the Guideline development process is in highlighting gaps in the evidence base. There is limited published data on prevalence rates of DV in Ireland and significantly less on the prevalence of DV in pregnancy in Ireland. It is acknowledged that DV is under-reported making the collation of accurate data challenging.

However, to further improve service provision and clinical best practice national data on screening women for DV, prevalence rates and adverse outcomes of DV on pregnancy need to be collected and audited. The roll out of the electronic healthcare record nationally will assist with this.

13 Guyatt, Gordon, et al. "GRADE Guidelines: 1. Introduction – GRADE Evidence Profiles and Summary of Findings Tables." Journal of Clinical Epidemiology, vol. 64, no. 4, 2011, pp. 383-94, https://doi.org/10.1016/j.jclinepi.2010.04.026.

14 SMFM adopts GRADE (Grading of Recommendations Assessment, Development, and Evaluation) for clinical guidelines. Society for Maternal-Fetal Medicine (SMFM), Chauhan SP, Blackwell SC. Am J Obstet Gynecol. 2013 Sep;209(3):163-5. doi: 10.1016/j.ajog.2013.07.012. PMID: 23978245 https://pubmed.ncbi.nlm.nih.gov/23978245/

# Chapter 4: Governance and Approval

## 4.1 Formal governance arrangements

This Guideline was written by the Guideline developers under the direction of the Guideline Programme Team (GPT). An Expert Advisory Group was formed to review the Guideline prior to submission for final approval with the National Women and Infants Health Programme. The roles and responsibilities of the members of each group and their process were clearly outlined and agreed.

## 4.2 Guideline development standards

This Guideline was developed by the Guideline Developer Group (GDG) within the overall template of the HSE National Framework[15] for developing Policies, Procedures, Protocols and Guidelines (2016) (Appendix 8) and under supervision of the Guideline Programme Team.

A review was conducted by a group of experts, specialists and advocates (the EAG) prior to approval by the Clinical Advisory Group (CAG) of the National Women and Infants Health Programme (NWIHP) with final sign off for publication by CAG Co-Chairs, the Clinical Director of NWIHP and the Chair of the IOG. See Appendix 9 for list of CAG members.

15 Health Service Executive (2016). National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs). Available from: https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/

# Chapter 5: Communication and Dissemination

A communication and dissemination plan for this Guideline has been developed by the GPT and endorsed by NWIHP.

Effective ongoing clear communication is essential in explaining why the Guideline is necessary and securing continued buy-in. It provides an opportunity to instil motivation within staff, helps overcome resistance to change and gives an opportunity for feedback[16].

The Clinical Guideline will be circulated and disseminated through the Guideline Programme Team as well as through the professional networks who participated in developing and reviewing the document.

Senior management within the maternity units are responsible for the appropriate dissemination of new and updated guidelines. Local hospital groups including Guideline committees are also instrumental in the circulation of new and updated guidelines and promoting their use in the relevant clinical settings.

The HSE will make this Guideline available to all employees through standard networks as well as storing it in the online PPPG repository. Electronic versions available on the NWIHP https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/ and RCPI websites (https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/) and other communication means can be used to maximise distribution. The NWIHP website will also provide a training webinar introducing each Guideline and where relevant a downloadable version of the recommended algorithm will be available.

In the case of this Guideline we will disseminate it to the Institute of Obstetricians and Gynaecologists (IOG), Midwifery and Nursing Boards and the HSCP office HSE and ask that it is made easily accessible to their members.

16 Department of Health (2018). NCEC Implementation Guide and Toolkit. Available at: https://health.gov.ie/national-patient-safety-office/ncec/

# Chapter 6: **Implementation**

## 6.1 Implementation plan

Implementation was considered at the beginning, and throughout the Guideline development process. The local multidisciplinary clinical team, senior executive and clinical management in each maternity and gynaecology unit are ultimately responsible for the appropriate structured adoption and implementation of the Guidelines within their area of responsibility. They must ensure that all relevant personnel under their supervision have read and understood the Guideline and monitor both its effectiveness and adoption.

Within each site, local multidisciplinary teams are responsible for the clinical implementation of Guideline recommendations, and ensuring that their local clinical practices and processes reflect and are aligned with the Guideline recommendations.

The following have been put in place to help facilitate the implementation of this Guideline.

- Quick Summary Document (QSD) for clinical staff (includes key recommendations, auditable standards, algorithms and recommended reading)
- Clinical Guideline mobile application
- Plain language summary

## 6.2 Education plans required to implement the Guideline

It is acknowledged that this Guideline should be complemented by on-going education, training and assessment where required.

This Guideline's education plan includes:

- Develop a multi-component education and training programme for the Multi-Disciplinary Team.
- Mandatory training for the awareness, screening, recognising, responding and referring of DV for all Midwives, Nurses, Doctors and Health and Social Care Professionals and students working in maternity settings. In line with programmes underway with Women's Aid and the HSE.
- In person and online modules.
- Identification of local facilitators and local champions in relation to DV awareness.
- Maintain records of staff training.
- Audit and evaluation of training

## 6.3 Barriers and facilitators

To ensure successful implementation of guidelines, it is first necessary to look at potential barriers and facilitators. Taking these into account when developing the implementation plan should improve levels of support from relevant users. (DOH 2018, 2019)

Barriers may be categorised as internal (specific to the Guideline itself) or external (specific to the clinical environment).

The Guideline Development Group has aimed to address any internal barriers during the development of this Guideline.

Potential external barriers include:

- Structural factors (e.g. budget or service redesign)
- Organisational factors (e.g. lack of facilities or equipment), support in the immediate aftermath of disclosure, time constraints, privacy, partners being in attendance.
- Individual factors, a lack of training, development of policies and staff resources.
- Staff's lived experiences of DV may present as a barrier to screening.
- Women's perceptions, stigma, fear of not being taken seriously, victim blaming and cultural belief issues, were some of the reasons outlined by survivors as reasons they might not disclose.
- Access to emergency accommodation.

In the case of this Guideline, it will be necessary to examine possible barriers and consider implementation strategies to address them. By example, this may include discussion with relevant management groups with regards budgetary impact or providing training to the relevant staff. A quality improvement assessment of Irish maternity units' protocols for victims of domestic, sexual and gender based violence took place in February 2024. The suggested recommendations as a result of this audit support and align with this Guideline.[17]

### *Possible facilitators*

- Evidence has shown that raising awareness and screening women in pregnancy does increase positive disclosure.[19, 58, 59]
- Pregnancy is an opportunity for women to reassess their lives and consider and how to possibly make the steps forward towards a life free of abuse.[45, 38]
- Be present, good communication is essential, make the woman feel you really want to know the answers to her responses.
- Facilitation of training/education, development of policies, and staff resources.
- Consider cultural and language difficulties, prior to booking history does the woman have access to an approved professional interpreter/translator?
- Adopting a multi-disciplinary and/or multi agency approach.

17 Dever, N. & Dunne, C. (2024) *Quality improvement assessment of Irish maternity units' protocols for victims of domestic, sexual and gender based violence*. Dublin: Health Service Executive.

## 6.4 Resources necessary to implement recommendations

The implementation of this Guideline should be undertaken as part of the quality improvement of each hospital. Hospitals should review existing service provision against this Guideline, identifying necessary resources required to implement the recommendations in this Guideline.

In the case of this Guideline the following resources are required to fully implement the guideline

- Adequately staffed MSW services in all maternity hospital/units.
- Staff receive protected time to attend DV training.
- Roll out of the electronic healthcare record nationally to ensure consistency of care, documentation and future auditing and research purposes.

# Chapter 7: Audit and Evaluation

## 7.1 Introduction to audit

It is important that both implementation of the Guideline and its influence on outcomes are audited to ensure that this Guideline positively impacts on the woman's care. Institutions and health professionals are encouraged to develop and undertake regular audits of Guideline implementation. Personnel tasked with the job of conducting the audit should be identified on receipt of the most recent version of the Guideline.

## 7.2 Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary. Audit should also be undertaken to provide evidence of continuous quality improvement initiatives.

Each service hospital/unit which implements the Guideline must ensure robust governance and accountability processes for monitoring and evaluation are established. Monitoring and review of compliance with the Guideline will be audited every 24 months at a minimum. It is recommended an initial audit takes place 3 months after full role out of the Guideline.

Auditable standards for this Guideline include:

1. Number of women screened for DV at Antenatal booking appointment
2. Number of women with outcome of DV screening recorded on her chart
3. Number of V1 responses
4. Number of women referred to MSW
5. Types, severity and complexity as per MSW records
6. Number of presentations to maternity hospital/unit following disclosure of DV
7. Number of women with postnatal screening for DV
8. Number of cases of DV referred to GP and PHN following disclosure on discharge.

## 7.3 Evaluation

Evaluation is defined as a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.[18]

Implementation of this Guideline will be audited periodically at national level, with standards for this set by the NWIHP. Evaluation of the auditable standards should also be undertaken locally by senior hospital clinical management to support implementation.

18 Health Information Quality Authority (2012). National Standards for Safer Better Healthcare [Internet]. Available from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

# Chapter 8: Revision Plan

## 8.1 Procedure for the update of the Guideline

It may be a requirement to amend, update or revise this Guideline as new evidence emerges. This Guideline will be reviewed at national level every three years, or earlier if circumstances require it, and updated accordingly.[19]

The Guideline Development Group will be asked to review the literature and recent evidence to determine if changes are to be made to the existing Guideline. If the Guideline Development Group are unavailable, the GPT along with the NWIHP senior management team will select a suitable expert to replace them.

If there are no amendments required to the Guideline following the revision date, the detail on the revision tracking box must still be updated which will be a new version number and date.

The recommendations set out in this Guideline remain valid until a review has been completed.

## 8.2 Method for amending the Guideline

As new evidence become available it is inevitable that Guideline recommendations will fall behind current evidence based clinical practice. It is essential that clinical guidelines are reviewed and updated with new evidence as it becomes available.

In order to request a review of this Guideline one of the following criteria must be met:

a) 3 years since the Guideline was published

b) 3 years since last review was conducted

c) Update required as a result of new evidence and/or new legislation

Correspondence requesting a review of the Guideline should be submitted to the National Women and Infants Health. Any such requests should be dealt with in a timely manner.

19 Health Service Executive (2016). National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs). Available from: https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/

# Chapter 9: **References**


1. World Health Organization (WHO) 2021 Devastatingly Pervasive; 1 in 3 women globally experience violence. WHO 9th March https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence
2. World Health Organization (WHO), 2016, Global Plan of Action; Health systems address violence against women and girls.
3. WATSON, D. & PARSONS, S. 2005. Domestic Abuse of Women and Men in Ireland: Report of the National Study of Domestic Abuse. Dublin: National Crime Council and Economic and Social Research Institute.
4. European Union Agency for Fundamental Rights. Violence Against Women: an EU-wide Survey. Luxembourg: Publications Office of the European Union; 2014.
5. OverallPrevalence–CSO–CentralStatisticsOffice[Internet].www.cso.ie.2023.Availablefrom:https://www.cso.ie/en/releasesandpublications/ep/p-svsmr/sexualviolencesurvey2022mainresults/overallprevalence/
6. Boyle M, Murphy-Tighe S. An integrative review of community nurse-led interventions to identify and respond to domestic abuse in the postnatal period. Journal of Advanced Nursing. 2022;78(6):1601-17.
7. O'Brien Green S. Domestic Violence and Pregnancy. Forum, Journal of the Irish College of General Practitioners. 2020;37(10):44-5.
8. DEPARTMENT OF HEALTH 2016, National Maternity Strategy, Creating a Better Future Together 2016-2026.
9. WORLD HEALTH ORGANIZATION 2005b. WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva.
10. MBRRACE UK – Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births 2015.
11. MBRRACE UK – Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births 2020.
12. WORLD HEALTH ORGANIZATION 2016 World Health Organization (2016) Violence against Women. World Health Organization, Geneva. http://www.who.int/en/news-room/fact-sheets/detail/violence-against-women
13. Cook, J., Bacchus, L., & Bewley, S. Domestic Violence in Pregnancy (Content last reviewed: 15th March 2020). In D. James, P. Steer, C. Weiner, B. Gonik, & S. Robson (Eds.), High-Risk Pregnancy: Management Options (pp. 34-44). Cambridge: Cambridge University Press.
14. NICE 2010. Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. London: National Institute for Health and Care Excellence.
15. O'Brien Green, S. "Domestic Violence and Pregnancy in Ireland" World of Irish Nursing & Midwifery (WIN): Journal of the Irish Nurses and Midwives Organisation. Vol 29 No. 9 November 2021.

16. MBRRACE Saving Lives, Improving Mother's Care. 2015.
17. MBRRACE UK, Saving Lives Improving Mother's Care 2018.
18. Sohal A, Johnson M. Identifying Domestic Violence and Abuse. In: Bewley S, Welch J, editors. ABC of Domestic and Sexual Violence. London: Wiley Blackwell; 2014.
19. Bacchus L, Mezey G, Bewley S. Domestic violence: prevalence in pregnant women and associations with physical and psychological health. European Journal of Obstetrics and Gynecology and Reproductive Biology. 2004;113(1):6-11.
20. DEPARTMENT OF JUSTICE AND EQUALITY 2018. Domestic Violence Act 2018. Dublin: Irish Statue Book.
21. Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect*, 32(8).
22. DEPARTMENT OF JUSTICE AND EQUALITY. Children's First Act 2015. Dublin: Irish Statue Book.
23. DEPARTMENT OF JUSTICE AND EQUALITY. Criminal Law (Sexual Offences) Act 2017. Dublin Irish Statue Book.
24. EDLESON, J. L. (1999). Children's Witnessing of Adult Domestic Violence. Journal of Interpersonal Violence, 14(8), 839-870.
25. Council of Europe Convention on preventing and combating violence against women and domestic violence. 2011.
26. Health Service Executive (HSE) National Domestic, Sexual and Gender-Based Violence Training Resource Manual: Recognising and Responding to Victims of Domestic, Sexual and Gender-Based Violence (DSGBV) in Vulnerable or At-Risk Communities. 2019. HSE National Social Inclusion Office and Sonas Domestic Violence Charity.
27. A Study on Familicide & Domestic and Family Violence Death Reviews (report commissioned by the Department of Justice), Ireland, May 2023.
28. Help Make her World Bigger Again: A Quick Guide to the Criminal Offence of Coercive Control, Safe Ireland, The National Social Change Agency, 2018 accessed online https://www.safeireland.ie/get-help/understanding-domestic-abuse/what-is-domestic-violence/ 29/11/2023
29. HEALTH INFORMATION AND QUALITY AUTHORITY 2016. National Standards for Safer Better Maternity Services. Dublin: HIQA.
30. NICE 2016. Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. London: National Institute for Health and Care Excellence.
31. HSE second National Intercultural Health Strategy 2018-2023.
32. WOMENS HEALTH COUNCIL 2009, Translating Plan Into Action; A Study of Gender Based Violence and Minority Ethnic women in Ireland.
33. NICE 2010. Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. London: National Institute for Health and Care Excellence.
34. MBRRACE-UK, KNIGHT, M., NAIR, M., TUFFNELL, D., SHAKESPEARE, J., KENYON, S. & KURINCZUK, J. (eds.) 2017. Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15. Oxford.
35. Cook SC, Schwartz AC, Kaslow NJ. Evidence-Based Psychotherapy: Advantages and Challenges. Neurotherapeutics. 2017 Jul;14(3):537-545.

36. WORLD HEALTH ORGANIZATION, Understanding and addressing violence against women, 2012.
37. Duxbury, F. (2014). Domestic violence and abuse. In: ABC of Domestic and Sexual Violence. S. Bewley and J. Welch. Chichester, John Wiley & Sons Ltd: p9-16. 2).
38. Morton, S, Gallagher, B. & McLoughlin, E (2023) 'You can't fix this in six months': Exploring the intersectionality of women's substance use in the Irish context. University College Dublin & Merchant's Quay Ireland: Dublin, Ireland.
39. Irish College of General Practitioners. Domestic Violence and Abuse Recognition and Management in General Practice. Quick Reference Guide. Dublin: May 2022.
40. Weil, S., Corradi, C. and Naudi, M (2018) Femicide across Europe: Theory, research and preventing on. Bristol University Press: Policy Press.
41. British Association of Social Work; https://www.basw.co.uk/resources/estimating-prevalence-%E2%80%98toxic-trio%E2%80%99
42. HSE use of intrepters On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services. HSE Social inclusion Office 2018.
43. NICE 2016, Domestic Violence and Abuse, Quality Standards.
44. FANSLOW, J. L. & ROBINSON, E. M. 2009. Help-Seeking Behaviors and Reasons for Help Seeking Reported by a Representative Sample of Women Victims of Intimate Partner Violence in New Zealand. Journal of Interpersonal Violence, 25, 929-951.
45. O'BRIEN GREEN, S, Domestic violence and pregnancy in Ireland: women's routes to seeking help and safety, Trinity College Dublin. School of Social Work & Social Policy, 2020. http://www.tara.tcd.ie/handle/2262/91289
46. MBRRACE Confidential Enquiry into Maternal and Child Health. Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer, 2003-2005.
47. MBBRACE Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. 2007; CEMACH: London.
48. Bradley F, Smith M, Long J, O'Dowd T. Reported frequency of domestic violence: cross section survey of women attending general practice. British Medical Journal. 2002;324:271-4.
49. McDonnell E., Holohan M., Reilly M.O., Warde L., Collins C., Geary M. Acceptability of routine enquiry regarding domestic violence in the antenatal clinic. *Ir. Med. J.* 2006;99(4):123-124.
50. WORLD HEALTH ORGANIZATION 2005a. WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization.
51. Alhusen JL, Ray E, Sharps P, Bullock L. Intimate partner violence during violence during pregnancy: maternal and neonatal outcomes. J Womens Health (Larchmt). 2015 Jan;24(1):100-6. doi: 10.1089/jwh.2014.4872. Epub 2014 Sep 29. PMID: 25265285; PMCID: MC4361157.
52. GOODMAN, P. E. 2009. Intimate Partner Violence and Pregnancy. In: MITCHELL, C. & ANGLIN, D. (eds.) Intimate Partner Violence: A Health-Based Perspective. Oxford: Oxford University Press.
53. Council of Europe Convention on preventing and combating violence against women and domestic violence (CETS No. 210) Istanbul Convention Article 15, (2) and Article18 (2)(2011).
54. People's needs defining change – Health Services Change Guide: Person-Centred Principles and Person-Centred Practice Framework (2016).

55. The Routledge International Handbook of Domestic Violence and Abuse; Edited by John Devaney, Caroline Bradbury-Jones, Rebecca J. Macy, Carolina Overlien and Stephanie Holt (2021).
56. Hegarty K, McKibbin G, Hameed M, Koziol-McLain J, Feder G, Tarzia L, Hooker L. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. PLoS One. 2020 Jun 16;15(6):e0234067. doi: 10.1371/journal.pone.0234067. PMID: 32544160; PMCID: PMC7297351.
57. Children First National Guidance for the Protection and Welfare of Children 2017 – Dept of Children and Youth Affairs.
58. Bewley S, Welch J, editors. ABC of Domestic and Sexual Violence. Chichester: Wiley Blackwell; 2014.
59. Evans MA, Feder GS. Help-seeking amongst women survivors of domestic violence: a qualitative study of pathways towards formal and informal support. Health Expectations. 2015;19(1):62-73.

## Bibliography

HEALTH SERVICE EXECUTIVE 2012. HSE Practice Guide on Domestic, Sexual and Gender Based Violence: For staff working with children and families. Dublin: Health Service Executive.

TUSLA 2016. Domestic, Sexual & Gender Based Violence Services Working Report on 2015 Services, Activities and use: Towards evidence informed services, Dublin: Tusla.

TUSLA 2017. Children First: National Guidance for the Protection and Welfare of Children. Dublin: Tusla.

Irish Statute Book, Domestic Violence Act 2018 https://www.irishstatutebook.ie/eli/2018/act/6/enacted/en/html

Health Information Quality Authority (2012). National Standards for Safer Better Healthcare [Internet]. Available from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

Scottish Intercollegiate Guidelines Network (SIGN). A guideline developer's handbook. Edinburgh: SIGN; 2019. (SIGN publication no. 50). [November 2019]. Available from URL: http://www.sign.ac.uk

Society of Maternal-Fetal Medicine. SMFM Clinical Practice Guidelines Development Process.

Department of Health (2018). NCEC Implementation Guide and Toolkit. Available at: https://health.gov.ie/national-patient-safety-office/ncec/

Department of Health (2019). How to develop a National Clinical Guideline. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/

Department of Health (2015). NCEC Standards for Clinical Practice Guidance. Available at: https://www.nmbi.ie/NMBI/media/NMBI/Forms/standards-for-clinical-practice-guidance-ncec.pdf

Health Service Executive (2016). National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs). Available from: https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/

Health Service Executive (2019). National Review of Clinical Audit. Available from: https://www.hse.ie/eng/services/publications/national-review-of-clinical-audit-report-2019.pdf

National Clinical Effectiveness Committee (NCEC) and Health Information and Quality Authority (HIQA) (2015) National quality assurance criteria for clinical guidelines. Version 2. Dublin: NCEC and HIQA.

Health Service Executive (2022), National Centre for Clinical Audit Nomenclature – Glossary of Terms, National Quality and Patient Safety Directorate. Available from: https://www.hse.ie/eng/about/who/nqpsd/ncca/

COSC. 2010. National Strategy on Domestic, Sexual and Gender Based Violence 2010-2014, Dublin: Government Publications Office.

COSC. 2016a. Action Plan: Second National Strategy on Domestic, Sexual and Gender Based Violence 2016-2021, Dublin: Government Publications Office.

O'BRIEN GREEN, S. 2018. "I Have a Story to Tell': Researching Migrant Women's Experiences of Female Genital Mutilation and Gender-Based Violence in Ireland and Europe. Social Work and Social Sciences Review, 19, 134-151.

Webster J (2019). A literature review of the views and experiences of midwives who screen for domestic violence. MIDIRS Midwifery Digest 29(2):183-8.

WOMEN'S AID 2016a. Behind Closed Doors: 20 years of the Women's Aid Femicide Monitoring Project 1996-2016. Dublin: Women's Aid.

WOMEN'S AID 2016. Impact Report Summary 2015. Dublin: Women's Aid

Women's Aid 2018, Against the Odds Impact Study 2018

https://www.nice.org.uk/guidance/qs116

https://www.gov.ie/en/press-release/05eab-minister-harris-brings-study-on-familicide-and-domestic-and-family-violence-death-reviews-to-government/

## Supporting Evidence

GRADE: http://www.gradeworkinggroup.org/

AGREE: http://www.agreetrust.org/agree-ii/

HSE: https://www.hse.ie/eng/about/who/qid/use-of-improvement-methods/nationalframeworkdevelopingpolicies/

# Glossary
## (for the Purpose of this Guideline)

**AGREE** Appraisal of Guidelines for Research and Evaluation

**ACOG** American College of Obstetricians and Gynaecologists

**CAG** Clinical Advisory Group

**DSGBV** Domestic Sexual and Gender Based Violence

**DV** Domestic Violence

**DVA** Domestic Violence and Abuse

**EAG** Expert Advisory Group

**GPT** Guideline Programme Team

**GBV** Gender-Based Violence

**GRADE** Grading of Recommendations, Assessments, Developments and Evaluations

**HIQA** Health Information and Quality Authority

**HSCP** Health and Social Care Professions

**HSE** Health Service Executive

**ICGP** Irish College of General Practitioners

**IOG** Institute of Obstetricians and Gynaecologists

**IPV** Intimate Partner Violence

**FIGO** International Federation of Gynaecology and Obstetrics

**NICE** The National Institute for Health and Care Excellence

**NCEC** National Clinical Effectiveness Committee

**NMCMS** Maternal and Newborn Clinical Management System

**NWIHP** National Women and Infants Health Programme

**PHN** Public Health Nurse

**SPNMH** Specialist Perinatal mental health team

**PPPG** Policy, Procedures, Protocols and Guidelines

**RCOG** Royal College of Obstetricians and Gynaecologists

**RCPI** Royal College of Physicians of Ireland

**TOP** Termination of Pregnancy

**Tusla** The Child and Family Agency

**WHO** World Health Organization

**ETH** Early Transfer Home

**SECM** HSE Homebirth service, facilitated by Self-employed Community Midwives

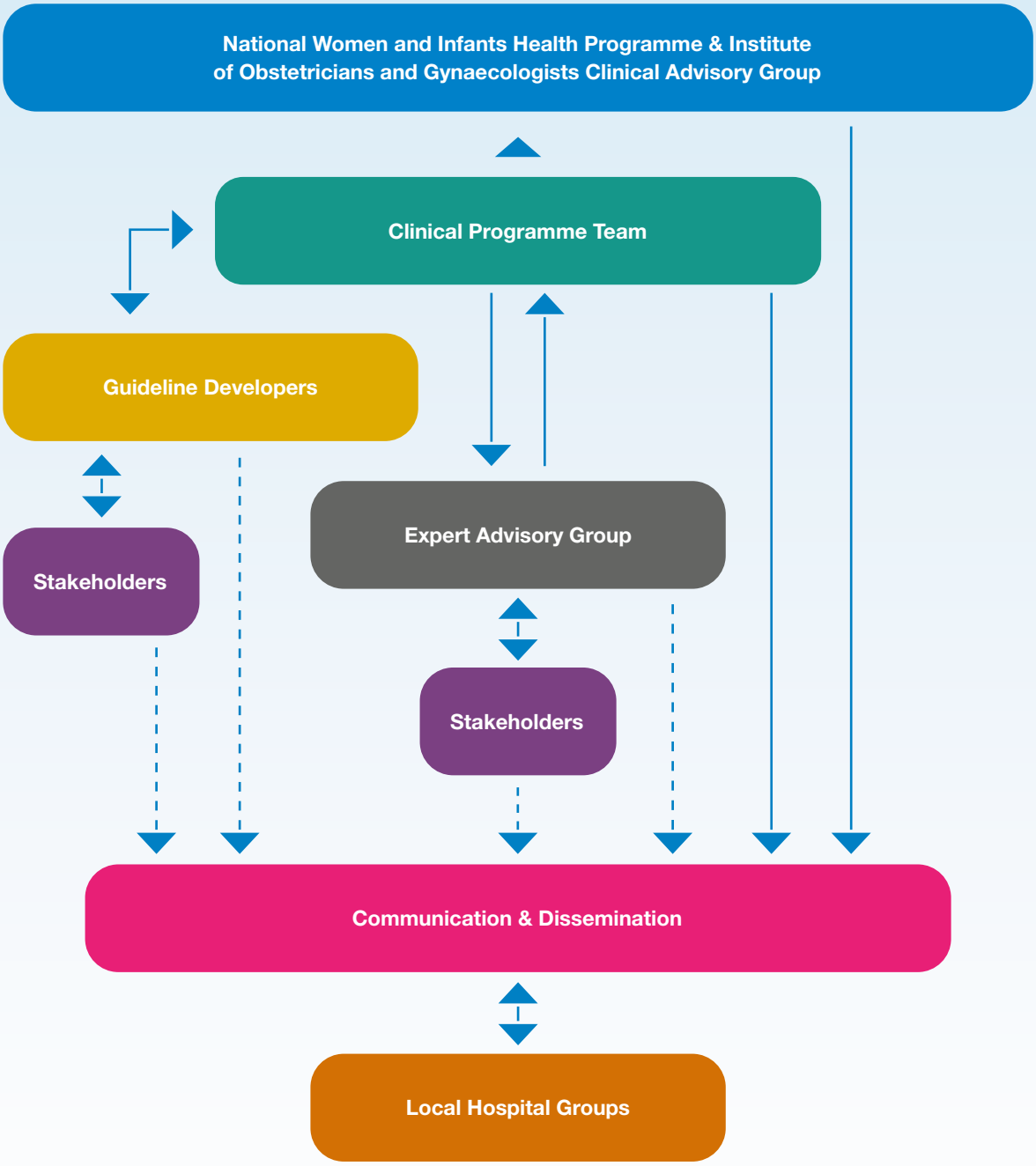
# Appendix 1:
# Expert Advisory Group Members 2021-

| Attendee | Profession | Location (2021) |
|---|---|---|
| Dr Fergus McCarthy | Consultant Obstetrician, Gynaecologist, Senior Lecturer and Maternal-Fetal Medicine Sub-specialist | Cork University Maternity Maternity unit, University College Cork |
| Dr Mairead Butler | Consultant Obstetrician and Gynaecologist | University Maternity unit Waterford |
| Prof. Declan Keane | Professor of Obstetrics and Gynaecology | National Maternity Maternity unit Dublin, Royal College of Surgeons in Ireland |
| Dr Katherine Astbury | Consultant Obstetrician and Gynaecologist Gynaecology Oncology Sub-specialist | University Maternity unit Galway |
| Dr Cathy Monteith | Consultant Obstetrician and Gynaecologist | Our Lady of Lourdes Hospital Drogheda |
| Dr Sarah Petch | Specialist Registrar, Obstetrics and Gynaecology | National Maternity Maternity unit Dublin |
| Dr Orla Donohoe | Specialist Registrar, Obstetrics and Gynaecology | Sligo University Maternity unit |
| Prof. John Murphy | Consultant Neonatologist and Clinical Lead for the National Clinical Programme for Paediatrics and Neonatology | National Women and Infants Health Programme |
| Ms Siobhan Canny | Group Director of Midwifery | Saolta University Health Care Group |
| Ms Fiona Hanrahan | Director of Midwifery and Nursing | Rotunda Maternity unit Dublin |
| Ms Margaret Quigley | National Lead for Midwifery | Office of Nursing and Midwifery Services Director |
| Prof. Valerie Smith | Professor of Midwifery | School of Nursing and Midwifery, Trinity College Dublin |
| Ms Triona Cowman | Director of the Centre for Midwifery Education | Centre for Midwifery Education, Coombe Women & Infants University Maternity unit |
| Ms Janet Murphy | Advanced Midwifery Practitioner | University Maternity unit Waterford |

| Attendee | Profession | Location (2021) |
|---|---|---|
| Dr Ciara McCarthy | General Practitioner and ICGP Women's Health Lead | Irish College of General Practitioners |
| Mr Fergal O' Shaughnessy<br>*And*<br>Dr Brian Cleary<br>*(Shared nomination)* | Senior Pharmacist, Honorary Lecturer<br>*And*<br>Chief Pharmacist, Honorary Clinical Associate Professor and Medications Lead, Maternal & Newborn Clinical Management System | Rotunda Maternity unit Dublin<br>Royal College of Surgeons in Ireland |
| Ms Marie Finn | Medical Social Work Counsellor | Saolta University Health Care Group |
| Ms Áine Kelly | Physiotherapy Manager | Coombe Women & Infants University Hospital, Dublin |
| Ms Marie Culliton | Scientific Lead | National Clinical Programme for Pathology |
| Ms Marita Hennessy | Post-Doctoral Researcher | Pregnancy Loss Research Group, INFANT Centre, University College Cork |
| Ms Niamh Connolly-Coyne *And*<br>Ms Mandy Daly<br>*(Shared nomination)* | Board of Directors | Irish Neonatal Health Alliance |
| Ms Caroline Joyce | Principal Clinical Biochemist<br>PhD Candidate | Cork University Maternity unit<br>University College Cork |
| Dr Richard Duffy | Consultant Perinatal Psychiatrist | Rotunda Maternity unit Dublin |
| Ms Sinéad Curran | Dietician Manager | National Maternity Maternity unit |
| Dr Nicholas Barrett | Lead for Obstetric Anaesthesiology services | Limerick University Maternity unit |
| Dr Brendan Fitzgerald | Consultant Perinatal Pathologist | Cork University Maternity unit |
| Dr Niamh Conlon | Consultant Histopathologist | Cork University Maternity unit |
| Ms Georgina Cruise | National Manager | Patient Advocacy Service |

# Appendix 2: **Guideline Programme Process**

*Guideline Programme Process*



# Appendix 3: Sexual Assault Treatment Units – Services and Referral Information

There are six Sexual Assault Treatment Units (SATUs) in Ireland. They provide specialist care for women and men aged 14 years and over who have recently been sexually assaulted or raped. SATUs are located in Dublin, Cork, Waterford, Mullingar, Galway and Letterkenny. In addition to these six SATUs, there is an out-of-hours service at the Mid-Western Regional Hospital in Limerick. There is no charge for any of the SATU services or follow-up appointments. The National Sexual Violence Helpline is operated by the Dublin Rape Crisis Centre. It is a free and confidential listening and support service for women and men who have been raped, sexually assaulted sexually harassed or sexually abused at any time in their lives. It is open 24 hours a day, 365 days of the year, and free to call on 1800 77 88 88. (REF – Sonas)

**A list of all sexual-violence services across the country is also available on HSE Website**

### *Cork SATU*

South Infirmary Victoria University Hospital.

Phone: **021 492 6297** weekdays from 8am to 4.30pm.

### *Donegal SATU*

Justice Walsh Road, Letterkenny.

Phone: **087 06 81 964** at any time. This is a direct line to SATU.

Phone: **021 492 6100** weekends and after 4.30pm, ask for SATU.

### *Dublin SATU*

Rotunda Hospital Campus.

Phone: **01 817 1736** weekdays from 8am to 5pm.

Phone: **01 817 1700** after 5pm and weekends, ask for SATU.

### *Galway SATU*

Galway SATU, The Willow Centre, Faustina House, IDA Small Business Centre, Tuam Road, Galway

Phone: **091 76 57 51** or **087 63 38 118** weekdays from 8am to 4pm.

Phone: **091 75 76 31** or **091 524222** after 4pm and weekends, ask for SATU.

### *Limerick*

Limerick, please call **112** or **999** to access a different out-of-hours service that can help you. This service provides forensic examinations also.

### *Mullingar SATU*

Midland Regional Hospital.

Phone: **044 939 4239** or **086 04 09 952** weekdays from 8am to 5pm.

Phone: **044 934 0221** after 5pm and weekends, ask for SATU.

### *Waterford SATU*

University Hospital Waterford.

Phone: **051 842 157** weekdays from 8am to 5pm.

Phone: **051 848 000** after 5pm and weekends, ask for SATU.

# Appendix 4: Clinical Indicators for Domestic Violence & Abuse[20]

### *History*

- Chronic unexplained pain including persistent headache, abdominal pelvic or chest pain.
- Chronic medical conditions such as chronic GI complaints, irritable bowel syndrome, chronic back or joint pains, chronic fatigue, various somatic complaints.
- Sexually transmitted diseases and exposure to HIV through sexual coercion.
- Multiple therapeutic abortions.
- Exacerbation of symptoms of a chronic disease such as diabetes or asthma.
- Intra-oral injuries, facial pain.
- Non-compliance with medical treatment, frequently missed appointments.

### *Psychological Symptoms*

- Insomnia, sleep disturbances
- Depression and suicidal ideation.
- Anxiety symptoms and pain disorder.
- Eating disorders.
- Substance abuse, including tobacco.
- Post-traumatic stress disorder.
- Somatoform disorders.
- Use of psychiatric services by victim or partner.

### *Physical Findings and Common Characteristics of Injuries*

- Any injuries especially to face, head, neck, throat, chest, abdomen and genital area
- Poor dental hygiene.
- Dental or temporomandibular joint (TMJ) trauma.
- Burns
- Signs of sexual assault.
- Central distribution of injuries, which can be covered up with clothing.
- Defensive injuries of the forearm.
- Wrist and ankle lacerations from being bound.

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20 Adapted from Brigham and Women's Hospital, Mary Horrigan Connors Centre for Women's Health, Domestic Violence – A guide to Screening and Intervention pg.4. 2005.

- Injuries that are not explained. Adequately or consistently.
- Injuries to multiple areas.
- Bruises of different shapes and sizes, reflecting types of weapons used.
- Bruises in various stages of healing.

### *Behavioural Indicators*

- Delay in seeking treatment.
- Repeated use of emergency services for trauma or primary care.
- Repeated DNAs
- Evasiveness during history taking or examination.
- References to partner's temper or anger.
- Reluctance to speak in partner's presence.
- Partner answers all questions for the woman or insists on being present when asked to leave exam room.
- Overly attentive or verbally abusive partner.
- Abuse or neglect of children, disabled person or elderly adult in the home.
- Abuse of pets.

### *Findings during Pregnancy and Childbirth*

- Frequently missed parental appointments, late or no prenatal care
- Low maternal weight gain
- Any injury including "falls" (1/3 of all trauma in pregnancy)
- Complications such as miscarriage, low birth weight, infant, premature labour, premature rupture of membranes and antepartum haemorrhage.
- Poor self-care or compliance.
- Substance abuse, including tobacco or alcohol during pregnancy.

# Appendix 5: AGREE II Checklist[21]

### *AGREE Reporting Checklist 2016*

This checklist is intended to guide the reporting of Clinical Practice Guidelines.

| CHECKLIST ITEM AND DESCRIPTION | REPORTING CRITERIA | Page # |
|---|---|---|
| **DOMAIN 1: SCOPE AND PURPOSE** | | |
| **1. OBJECTIVES**<br>*Report the overall objective(s) of the guideline. The expected health benefits from the guideline are to be specific to the clinical problem or health topic.* | ☐ Health intent(s) (i.e., prevention, screening, diagnosis, treatment, etc.)<br>☐ Expected benefit(s) or outcome(s)<br>☐ Target(s) (e.g., patient population, society) | |
| **2. QUESTIONS**<br>*Report the health question(s) covered by the guideline, particularly for the key recommendations.* | ☐ Target population<br>☐ Intervention(s) or exposure(s)<br>☐ Comparisons (if appropriate)<br>☐ Outcome(s)<br>☐ Health care setting or context | |
| **3. POPULATION**<br>*Describe the population (i.e., patients, public, etc.) to whom the guideline is meant to apply.* | ☐ Target population, sex and age<br>☐ Clinical condition (if relevant)<br>☐ Severity/stage of disease (if relevant)<br>☐ Comorbidities (if relevant)<br>☐ Excluded populations (if relevant) | |
| **DOMAIN 2: STAKEHOLDER INVOLVEMENT** | | |
| **4. GROUP MEMBERSHIP**<br>*Report all individuals who were involved in the development process. This may include members of the steering group, the research team involved in selecting and reviewing/ rating the evidence and individuals involved in formulating the final recommendations.* | ☐ Name of participant<br>☐ Discipline/content expertise (e.g., neurosurgeon, methodologist)<br>☐ Institution (e.g., St. Peter's hospital)<br>☐ Geographical location (e.g., Seattle, WA)<br>☐ A description of the member's role in the guideline development group | |

21 AGREE Reporting Checklist is available on the AGREE Enterprise website, a free and open access resource to support the practice guideline field (www.agreetrust.org)

| CHECKLIST ITEM AND DESCRIPTION | REPORTING CRITERIA | Page # |
|---|---|---|
| **5. TARGET POPULATION PREFERENCES AND VIEWS**<br>*Report how the views and preferences of the target population were sought/considered and what the resulting outcomes were.* | ☐ Statement of type of strategy used to capture patients'/publics' views and preferences (e.g., participation in the guideline development group, literature review of values and preferences)<br>☐ Methods by which preferences and views were sought (e.g., evidence from literature, surveys, focus groups)<br>☐ Outcomes/information gathered on patient/public information<br>☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations | |
| **6. TARGET USERS**<br>*Report the target (or intended) users of the guideline.* | ☐ The intended guideline audience (e.g. specialists, family physicians, patients, clinical or institutional leaders/administrators)<br>☐ How the guideline may be used by its target audience (e.g., to inform clinical decisions, to inform policy, to inform standards of care) | |
| **DOMAIN 3: RIGOUR OF DEVELOPMENT** | | |
| **7. SEARCH METHODS**<br>*Report details of the strategy used to search for evidence.* | ☐ Named electronic database(s) or evidence source(s) where the search was performed (e.g., MEDLINE, EMBASE, PsychINFO, CINAHL)<br>☐ Time periods searched (e.g., January 1, 2004 to March 31, 2008)<br>☐ Search terms used (e.g., text words, indexing terms, subheadings)<br>☐ Full search strategy included (e.g., possibly located in appendix) | |
| **8. EVIDENCE SELECTION CRITERIA**<br>*Report the criteria used to select (i.e., include and exclude) the evidence. Provide rationale, where appropriate.* | ☐ Target population (patient, public, etc.) characteristics<br>☐ Study design<br>☐ Comparisons (if relevant)<br>☐ Outcomes<br>☐ Language (if relevant)<br>☐ Context (if relevant) | |

| CHECKLIST ITEM AND DESCRIPTION | REPORTING CRITERIA | Page # |
|---|---|---|
| **9. STRENGTHS & LIMITATIONS OF THE EVIDENCE**<br>*Describe the strengths and limitations of the evidence. Consider from the perspective of the individual studies and the body of evidence aggregated across all the studies. Tools exist that can facilitate the reporting of this concept.* | ☐ Study design(s) included in body of evidence<br>☐ Study methodology limitations (sampling, blinding, allocation concealment, analytical methods)<br>☐ Appropriateness/relevance of primary and secondary outcomes considered<br>☐ Consistency of results across studies<br>☐ Direction of results across studies<br>☐ Magnitude of benefit versus magnitude of harm<br>☐ Applicability to practice context | |
| **10. FORMULATION OF RECOMMENDATIONS**<br>*Describe the methods used to formulate the recommendations and how final decisions were reached. Specify any areas of disagreement and the methods used to resolve them.* | ☐ Recommendation development process (e.g., steps used in modified Delphi technique, voting procedures that were considered)<br>☐ Outcomes of the recommendation development process (e.g., extent to which consensus was reached using modified Delphi technique, outcome of voting procedures)<br>☐ How the process influenced the recommendations (e.g., results of Delphi technique influence final recommendation, alignment with recommendations and the final vote) | |
| **11. CONSIDERATION OF BENEFITS AND HARMS**<br>*Report the health benefits, side effects, and risks that were considered when formulating the recommendations.* | ☐ Supporting data and report of benefits<br>☐ Supporting data and report of harms/side effects/risks<br>☐ Reporting of the balance/trade-off between benefits and harms/side effects/risks<br>☐ Recommendations reflect considerations of both benefits and harms/side effects/ risks | |
| **12. LINK BETWEEN RECOMMENDATIONS AND EVIDENCE**<br>*Describe the explicit link between the recommendations and the evidence on which they are based.* | ☐ How the guideline development group linked and used the evidence to inform recommendations<br>☐ Link between each recommendation and key evidence (text description and/or reference list)<br>☐ Link between recommendations and evidence summaries and/or evidence tables in the results section of the guideline | |

| CHECKLIST ITEM AND DESCRIPTION | REPORTING CRITERIA | Page # |
|---|---|---|
| **13. EXTERNAL REVIEW**<br>*Report the methodology used to conduct the external review.* | ☐ Purpose and intent of the external review (e.g., to improve quality, gather feedback on draft recommendations, assess applicability and feasibility, disseminate evidence)<br>☐ Methods taken to undertake the external review (e.g., rating scale, open-ended questions)<br>☐ Description of the external reviewers (e.g., number, type of reviewers, affiliations)<br>☐ Outcomes/information gathered from the external review (e.g., summary of key findings)<br>☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations (e.g., guideline panel considered results of review in forming final recommendations) | |
| **14. UPDATING PROCEDURE**<br>*Describe the procedure for updating the guideline.* | ☐ A statement that the guideline will be updated<br>☐ Explicit time interval or explicit criteria to guide decisions about when an update will occur<br>☐ Methodology for the updating procedure | |
| **DOMAIN 4: CLARITY OF PRESENTATION** | | |
| **15. SPECIFIC AND UNAMBIGUOUS RECOMMENDATIONS**<br>*Describe which options are appropriate in which situations and in which population groups, as informed by the body of evidence.* | ☐ A statement of the recommended action<br>☐ Intent or purpose of the recommended action (e.g., to improve quality of life, to decrease side effects)<br>☐ Relevant population (e.g., patients, public)<br>☐ Caveats or qualifying statements, if relevant (e.g., patients or conditions for whom the recommendations would not apply)<br>☐ If there is uncertainty about the best care option(s), the uncertainty should be stated in the guideline | |
| **16. MANAGEMENT OPTIONS**<br>*Describe the different options for managing the condition or health issue.* | ☐ Description of management options<br>☐ Population or clinical situation most appropriate to each option | |

| CHECKLIST ITEM AND DESCRIPTION | REPORTING CRITERIA | Page # |
|---|---|---|
| **17. IDENTIFIABLE KEY RECOMMENDATIONS**<br>*Present the key recommendations so that they are easy to identify.* | ☐ Recommendations in a summarized box, typed in bold, underlined, or presented as flow charts or algorithms<br>☐ Specific recommendations grouped together in one section | |
| **DOMAIN 5: APPLICABILITY** | | |
| **18. FACILITATORS AND BARRIERS TO APPLICATION**<br>*Describe the facilitators and barriers to the guideline's application.* | ☐ Types of facilitators and barriers that were considered<br>☐ Methods by which information regarding the facilitators and barriers to implementing recommendations were sought (e.g., feedback from key stakeholders, pilot testing of guidelines before widespread implementation)<br>☐ Information/description of the types of facilitators and barriers that emerged from the inquiry (e.g., practitioners have the skills to deliver the recommended care, sufficient equipment is not available to ensure all eligible members of the population receive mammography)<br>☐ How the information influenced the guideline development process and/or formation of the recommendations | |
| **19. IMPLEMENTATION ADVICE/TOOLS**<br>*Provide advice and/or tools on how the recommendations can be applied in practice.* | ☐ Additional materials to support the implementation of the guideline in practice.<br>For example:<br>• Guideline summary documents<br>• Links to check lists, algorithms<br>• Links to how-to manuals<br>• Solutions linked to barrier analysis (see Item 18)<br>• Tools to capitalize on guideline facilitators (see Item 18)<br>• Outcome of pilot test and lessons learned | |

| CHECKLIST ITEM AND DESCRIPTION | REPORTING CRITERIA | Page # |
|---|---|---|
| **20. RESOURCE IMPLICATIONS**<br>*Describe any potential resource implications of applying the recommendations.* | ☐ Types of cost information that were considered (e.g., economic evaluations, drug acquisition costs)<br>☐ Methods by which the cost information was sought (e.g., a health economist was part of the guideline development panel, use of health technology assessments for specific drugs, etc.)<br>☐ Information/description of the cost information that emerged from the inquiry (e.g., specific drug acquisition costs per treatment course)<br>☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations | |
| **21. MONITORING/ AUDITING CRITERIA**<br>*Provide monitoring and/or auditing criteria to measure the application of guideline recommendations.* | ☐ Criteria to assess guideline implementation or adherence to recommendations<br>☐ Criteria for assessing impact of implementing the recommendations<br>☐ Advice on the frequency and interval of measurement<br>☐ Operational definitions of how the criteria should be measured | |
| **DOMAIN 6: EDITORIAL INDEPENDENCE** | | |
| **22. FUNDING BODY**<br>*Report the funding body's influence on the content of the guideline.* | ☐ The name of the funding body or source of funding (or explicit statement of no funding)<br>☐ A statement that the funding body did not influence the content of the guideline | |
| **23. COMPETING INTERESTS**<br>*Provide an explicit statement that all group members have declared whether they have any competing interests.* | ☐ Types of competing interests considered<br>☐ Methods by which potential competing interests were sought<br>☐ A description of the competing interests<br>☐ How the competing interests influenced the guideline process and development of recommendations | |

From: Brouwers MC, Kerkvliet K, Spithoff K, on behalf of the AGREE Next Steps Consortium. The AGREE Reporting Checklist: a tool to improve reporting of clinical practice guidelines. BMJ 2016;352:i1152. doi: 10.1136/bmj.i1152.

For more information about the AGREE Reporting Checklist, please visit the AGREE Enterprise website at http://www.agreetrust.org.

# Appendix 6: **Grades of Recommendation**[22]

| Grade of recommendation | Clarity of risk/ benefit | Quality of supporting evidence | Implications | Suggested Language |
|---|---|---|---|---|
| **1 A.** Strong recommendation, high-quality evidence | Benefits clearly outweigh risk and burdens, or vice versa | Consistent evidence from well-performed randomised, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk | Strong recommendations can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present | We strongly recommend…<br>We recommend that …should be performed/ administered…<br>We recommend that … is indicated/ beneficial/ effective…. |
| **1 B.** Strong recommendation, moderate-quality evidence | Benefits clearly outweigh risk and burdens, or vice versa | Evidence from randomised, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate | Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present | We recommend…<br>We recommend that … should be performed/ administered…<br>We recommend that … is (usually) indicated/ beneficial/ effective… |

22 SMFM adopts GRADE (Grading of Recommendations Assessment, Development, and Evaluation) for clinical guidelines. Society for Maternal-Fetal Medicine (SMFM), Chauhan SP, Blackwell SC. Am J Obstet Gynecol. 2013 Sep;209(3):163-5. https://pubmed.ncbi.nlm.nih.gov/23978245/

| Grade of recommendation | Clarity of risk/ benefit | Quality of supporting evidence | Implications | Suggested Language |
|---|---|---|---|---|
| **1 C.** Strong recommendation, low-quality evidence | Benefits appear to outweigh risk and burdens, or vice versa | Evidence from observational studies, unsystematic clinical experience, or from randomised, controlled trials with serious flaws. Any estimate of effect is uncertain | Strong recommendation that applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality | We recommend…<br>We recommend that … should be performed/ administered…<br>We recommend that … Is (maybe) indicated/ beneficial/ effective… |
| **2A.** Weak recommendation, high-quality evidence | Benefits closely balanced with risks and burdens | Consistent evidence from well-performed randomised, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk | Weak recommendation: best action may differ depending on circumstances or patients or societal values | We suggest…<br>We suggest that … may/might be reasonable… |
| **2B.** Weak recommendation, moderate-quality evidence | Benefits closely balanced with risks and burdens, some uncertainty in the estimates of benefits, risks and burdens | Evidence from randomised, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate | Weak recommendation; alternative approaches likely to be better for some patients under some circumstances | We suggest…<br>We suggest that … may/might be reasonable… |

| Grade of recommendation | Clarity of risk/ benefit | Quality of supporting evidence | Implications | Suggested Language |
|---|---|---|---|---|
| **2C.** Weak recommendation, low-quality evidence | Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens | Evidence from observational studies, unsystematic clinical experience, or from randomised, controlled trials with serious flaws. Any estimate of effect is uncertain | Very weak recommendation: other alternatives may be equally reasonable. | We suggest… is an option<br>We suggest that … may/might be reasonable. |
| **Best practice** | A recommendation that is sufficiently obvious that the desirable effects outweigh undesirable effects, despite the absence of direct evidence, such that the grading of evidence is unnecessary | | | We recommend…<br>We recommend that … should be performed/ administered…<br>We recommend that … Is usually) indicated/ beneficial/effective |

# Appendix 7: Policies, Procedures, Protocols and Guidelines Checklist

The PPPG Checklists were developed to assist staff to meet standards when developing Clinical PPPGs.

| Standards for developing clinical PPPG | |
|---|---|
| **Stage 1 initiation** | **Checklist** |
| The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described. | ☐ |
| Synergies/co-operations are maximised across departments/organisations (Hospitals/ Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise. | ☐ |
| The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG. | ☐ |
| The target users and the population/patient group to whom the PPPG is meant to apply are specifically described. | ☐ |
| The views and preferences of the target population have been sought and taken into consideration (as required). | ☐ |
| The overall objective(s) of the PPPGs are specifically described. | ☐ |
| The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care). | ☐ |
| Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups. | ☐ |
| Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant. | ☐ |
| The PPPG is informed by the identified needs and priorities of service users and stakeholders. | ☐ |
| There is service user/lay representation on PPPG Development Group (as required). | ☐ |
| Information and support is available for staff on the development of evidence-based clinical practice guidance. | ☐ |

| **Stage 2 development** | **Checklist** |
|---|---|
| The clinical question(s) covered by the PPPG are specifically described. | ☐ |
| Systematic methods used to search for evidence are documented (for PPPGs which are adapted/ adopted from international guidance, their methodology is appraised and documented). | ☐ |
| Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described). | ☐ |
| The health benefits, side effects and risks have been considered and documented in formulating the PPPG. | ☐ |
| There is an explicit link between the PPPG and the supporting evidence. | ☐ |
| PPPG guidance/recommendations are specific and unambiguous. | ☐ |
| The potential resource implications of developing and implementing the PPPG are Identified e.g. equipment, education/training, staff time and research. | ☐ |
| There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care. | ☐ |
| Budget impact is documented (resources required). | ☐ |
| Education and training is provided for staff on the development and implementation of evidence- based clinical practice guidance (as appropriate). | ☐ |
| Three additional standards are applicable for a small number of more complex PPPGs: | ☐ |
| Cost effectiveness analysis is documented. | ☐ |
| A systematic literature review has been undertaken. | ☐ |
| Health Technology Assessment (HTA) has been undertaken. | ☐ |
| **Stage 3 governance and approval** | **Checklist** |
| Formal governance arrangements for PPPGs at local, regional and national level are established and documented. | ☐ |
| The PPPG has been reviewed by independent experts prior to publication (as required). | ☐ |
| Copyright and permissions are sought and documented. | ☐ |

| **Stage 4 communication and dissemination** | **Checklist** |
|---|---|
| A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages. | ☐ |
| Plan and procedure for dissemination of the PPPG is described. | ☐ |
| The PPPG is easily accessible by all users e.g. PPPG repository. | ☐ |
| **Stage 5 implementation** | **Checklist** |
| Written implementation plan is provided with timelines, identification of responsible persons/ units and integration into service planning process. | ☐ |
| Barriers and facilitators for implementation are identified, and aligned with implementation levers. | ☐ |
| Education and training is provided for staff on the development and implementation of evidence- based PPPG (as required). | ☐ |
| There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care. | ☐ |
| **Stage 6 monitoring, audit, evaluation** | **Checklist** |
| Process for monitoring and continuous improvement is documented. | ☐ |
| Audit criteria and audit process/plan are specified. | ☐ |
| Process for evaluation of implementation and (clinical) effectiveness is specified. | ☐ |
| **Stage 7 revision/update** | **Checklist** |
| Documented process for revisions/updating and review, including timeframe is provided. | ☐ |
| Documented process for version control is provided. | ☐ |

To view in full refer to website: https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/

# Appendix 8: **NWIHP/IOG CAG membership (2023)**

Dr Cliona Murphy (Chair, 2023-). Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital. Clinical Director, National Women and Infants Health Programme.

Dr Sam Coulter-Smith (2023-). Consultant Obstetrician and Gynaecologist, Rotunda Hospital. Chair, Institute of Obstetricians and Gynaecologists.

Dr Venita Broderick (2024-). Clinical Lead Gynaecology, National Women and Infants Health Programme.

Dr Brian Cleary (2023-). Chief Pharmacist, Rotunda Hospital. Medications Lead, Maternal and Newborn Clinical Management System Project.

Angela Dunne (2023-). Director of Midwifery, National Women and Infants Health Programme.

Prof. Seán Daly (2023-). Master, Consultant Obstetrician and Gynaecologist, Rotunda Hospital.

Prof. Maeve Eogan (2023-). Consultant Obstetrician and Gynaecologist, Rotunda Hospital. Clinical Lead, Sexual Assault Treatment Units, National Women and Infants Health Programme.

Prof. Richard Greene (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Director, National Perinatal Epidemiology Centre, University College Cork.

Prof. John Higgins (2023-). Cork University Maternity Hospital, Consultant Obstetrician and Gynaecologist, Clinical Director, Ireland South Women and Infants Directorate.

Prof. Shane Higgins (2023-). Master, Consultant Obstetrician and Gynaecologist, National Maternity Hospital.

Dr Mendinaro Imcha (2023-). Clinical Director, Consultant Obstetrician and Gynaecologist, University Maternity Hospital Limerick.

Prof. John Murphy (2023-). Clinical Lead Neonatology, National Women and Infants Health Programme.

Dr Aoife Mullaly (2023-). Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital. Clinical Lead, Termination of Pregnancy Services, National Women and Infants Health Programme.

Prof. John Morrison (2023-). Consultant Obstetrician and Gynaecologist, University Hospital Galway. Clinical Director, Saolta Maternity Directorate.

Kilian McGrane (2023-). Director, National Women and Infants Health Programme.

Dr Peter McKenna (2023-). Clinical Lead, Obstetric Event Support Team, National Women and Infants Health Programme.

Prof. Keelin O'Donoghue (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Lead, National Guidelines, National Women and Infants Health Programme.

Dr Suzanne O'Sullivan (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Director of Education and Training, Obstetrics and Gynaecology, Institute of Obstetricians and Gynaecologists.

Prof. Mike O'Connell (2023-). Master, Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital.

Dr Vicky O'Dwyer (2023-). Consultant Obstetrician and Director of Gynaecology, Rotunda Hospital.

Prof. Nóirín Russell (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Director, Cervical Check.

Dr Orla Shiel (2024-). Consultant Obstetrician and Gynaecologist, National Maternity Hospital

Ms Clare Thompson (2023-). Consultant Gynaecological Oncologist, The Mater, Dublin.

Prof. Mary Wingfield (2024-). Clinical Lead Fertility, National Women and Infants Health Programme.

# Appendix 9: Contact details for support (from ICGP, 2022)

| Referral/Service | Finding you local support |
|---|---|
| **Shelter/Housing** | https://www.safeireland.ie/get-help/where-to-find-help/ |
| **Domestic Violence Support Services** | https://www.womensaid.ie/get-help/support-services/ |
| **Financial Aid** | https://mabs.ie/ |
| **Legal Aid** | https://www.legalaidboard.ie/en/ |
| **An Garda Síochána** | Emergencies 999 or 112<br>https://garda.ie/en/ |
| **Sexual Assault** | Rape Crisis Centre freephone (24hr helpline) 1800 77 8888<br>https://www.rapecrisishelp.ie/ |
| **Other contacts** | **AkiDwA** https://akidwa.ie/<br>Call 08 834 9851 Email info@akidwa.ie<br><br>**Aoibhneas women's and children's refuge**<br>Call 1800 767 767<br>Email helpline@aoibhneas.ie<br><br>**Childline** Call 1800 66 66 66<br><br>**CHO** https://www2.hse.ie/mental-health/services-support/ncs/<br><br>**Connect** Counselling service for any adult who experienced abuse, trauma or neglect in childhood. Call 1800 235 235<br><br>**Elder Abuse Call** 1800 700 700<br>https://www.hse.ie/eng/services/publications/olderpeople/<br><br>**HSE National Counselling Service** Call 1800 252 524<br><br>**Immigrant Council of Ireland** Call 01 674 0200<br>https://www.immigrantcouncil.ie/<br><br>**LGBT advice line** 1800 929 529<br><br>**Male advice line** 1800 816 588<br><br>**Men's Aid Ireland** Call 01 554 3811 Email hello@mensaid.ie<br>https://www.mensaid.ie/<br><br>**Men's Development Network** Call 051 844260/1<br>Email men@mensnetwork.ie<br>https://mensnetwork.ie/<br><br>**Safe Ireland**<br>https://www.safeireland.ie/<br><br>**Women's Aid Call** 1800 341 900 (24/7availability)<br>https://www.womensaid.ie/get-help/support-services/ |

# Appendix 10: **Safety plan**[23]

| Safety in an abusive relationship | Thinking of leaving an abusive relationship | After you have left an abusive relationship |
|---|---|---|
| **Things to think about:** | **Things to think about:** | **Things to think about:** |
| • Isolation can be part of an abusive relationship. To increase your safety, it may help to talk to a trusted person.<br>• Make a plan to get some time for yourself.<br>• Living in fear can be draining and affect your health.<br>• Learn more about domestic violence and support services at www.domesticabuse.ie. | • Reviewing your safety plan with your support service – practise how you will exit the home, when you will leave, and where you will go. If possible, choose a time that will be safe for you and your children to leave.<br>• Think of reasons why you need to leave the house. | • Be vigilant of your surroundings. This includes any public setting or work.<br>• Be vigilant when online.<br>• Consider varying your daily routine, e.g. use a different shop than your usual one. |
| **Things you could do:** | **Things you could do:** | **Things you could do:** |
| • Have 999 on speed dial and call in an emergency, if you can.<br>• Have a safety plan. Know how you would get out of the house and where you would go if/ when you need to.<br>• Know the warning signs that the situation is worsening.<br>• When an abusive incident is occurring, avoid anywhere with access to weapons, e.g. bathroom, kitchen, shed.<br>• Have a code word with family/ friends, alerting them that you need help or need Gardaí to be called.<br>• Call Sonas's advice line on 087 952 5217 to talk about what is happening or look at your options. | • Have relevant contact numbers saved in your phone, e.g. your local refuge, taxi service.<br>• Reverse your car into the driveway, to get away quickly if you need to. Keep petrol in the car. Keep the car keys on you.<br>• Have a bag packed with some clothes and comfort items for the children. Keep it in a safe place in the home or with a trusted neighbour/friend.<br>• If you can, bring important documents when you leave, e.g. ID, birth cert(s), passport(s), Public Services Card (PSC), medical card(s), Irish Resident Permit, court orders.<br>• Other things to bring, if you can, are: mobile phone and phone charger, money, keys and/or medications. | • Change the locks. Add an outdoor lighting/security system and/or smoke and carbon monoxide detectors.<br>• Remove GPS from your phone.<br>• Use an email account that the abuser does not know and change passwords, online account information, etc.<br>• Change your phone number.<br>• Inform school/childcare provider of who is allowed to collect your children.<br>• Tell someone you trust at work of your situation. Calls could be screened, and staff could inform you if the abuser is in the vicinity.<br>• Bring any domestic violence court orders to your local Garda station and keep a copy on your person. |

23 Liz Kelly, TCD, 2005 HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual – recognising and responding to Victims of Domestic Sexual and Gender-Based Violence (DSGB) in Vulnerable or At-Risk Communities. 2016.

| **Safety in an abusive relationship** | **Thinking of leaving an abusive relationship** | **After you have left an abusive relationship** |
|---|---|---|
| **Things to remember:** | **Things to remember:** | **Things to remember:** |
| • When searching online, at options, find the setting and select 'incognito' or 'in private' to stop your search from being stored.<br>• If you are assaulted, attend the hospital or a GP. Take photographs of your injuries. | • Limit the number of people you tell that you are leaving.<br>• Getting to safety is the priority. You can always go back to the house to collect belongings in safety, with the Gardaí. | • Keep a diary of any incidents and report threats or suspicious activity to the Gardaí.<br>• It will be an emotional time, and you need to take care of you. Keep linked in with your supports.<br>• Post-separation is the most dangerous time for women experiencing domestic violence. |
| **General Information:** | **Warning Signs and Cycle of Abuse** | **Useful Numbers:** |
| • There are various court orders available to protect you and your family. You can remain in the relationship and still apply for protection/safety orders.<br>• In the event of an abusive incident, call Gardaí on 999, if you can. Tell them your 'personal safety is under threat' and if you have any court orders. | Domestic abuse can follow a pattern of phases:<br>A. tension-building phase;<br>B. violent phase; and<br>C. reconciliation phase.<br>Once abuse has begun, it can, over time, increase in frequency and severity. As it continues, the aforementioned phases can begin to change, with decreases in tension-building and reconciliation and increases in violent phases.<br>Know the warning signs that tension is increasing. Some signs include:<br>• a feeling of tension or a familiar pattern of incidents;<br>• the abuser's facial expressions, body language, and tone; and<br>• any changes in the abuser's behaviour. | Please refer to appendix 9. |

# Appendix 11: **Crisis intervention model**[24]


This model focuses on women survivors, adapted by Women's Aid from a conference presentation by Professor Liz Kelly in Trinity College Dublin in 2005. There is no existing model for male survivors.

- The Crisis Intervention Model highlights the different processes that a survivor experiences, her comprehension of these, how she manages the situation, and how her perception may be distorted due to the impact of the perpetrator's abuse.
- The survivor may experience more than one process at a time, for example, managing the situation and defining what is happening as abuse. She may move in and out of the processes.
- This model provides a tool to enable us, in our professional roles, to reflect on where the survivor is at and to inform our good-practice response.
- When working with a survivor who is experiencing domestic violence, it is important to work with the woman from where she is at. For example, if we encourage her to leave the relationship when she has not yet defined what is happening as abuse, we may contribute to her distortion of perspective.

24 Liz Kelly, TCD, 2005 HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual – recognising and responding to Victims of Domestic Sexual and Gender-Based Violence (DSGB) in Vulnerable or At-Risk Communities. 2016.

### Intimate-Partner Violence: Working from Where the Woman is at

The following are brief descriptions of the processes illustrated:

#### *Managing the Situation*

- This process involves the point when the violence is first experienced and is a crisis in the relationship. The survivor will generally experience shock or disbelief. Some women may end the relationship at this point, but the majority do not.
- The survivor may find or accept an explanation for the incident (for example, taking the blame, minimising the seriousness of the incident), which allows for a future incident. The next few incidents may test or reinforce this. She may believe that she is doing something to provoke the violence, and possibly believe that it's her fault.
- She may now begin to use strategies to manage the situation to limit the potential for conflict. For example, she will try not to do anything to upset the perpetrator.
- She attempts to anticipate and prevent or minimise the abuse.

#### *Distortion of Perspective*

- Gradually, more and more of the survivor's daily life, routines and thought processes are affected by having to manage violence.
- The woman's sense of self and of the violence may become profoundly distorted. She may begin to believe all the negative things that the perpetrator is telling her about herself.
- She continues to manage her anxiety and tries to make sense of what is happening.
- She continues to manage the abuse through attempting to anticipate, prevent and minimise it.

#### *Defining what is Happening as Abuse*

- This usually does not happen until after a number of assaults.
- The survivor may now start to define what is happening as abuse.
- She may acknowledge her partner as an abuser and recognise herself as a survivor.
- She may put responsibility for the abuse on the abuser, but the abuse may still continue.

#### *Re-evaluating the Relationship*

- Once the relationship is understood as violent, a re-evaluation process may begin.
- The woman may still stay in the relationship.
- She may use strategies to cope. For example, she might talk to others.
- She may consider leaving the relationship in the short term, or for good.
- She may engage in formal processes to limit and contain the violence. For example, she may apply for court orders.

### *Ending the Relationship*

- Many women may make several attempts to end violent relationships.
- To leave, they usually need external support and resources.
- Some women never leave. The reasons for staying in or returning to the relationship can include: nowhere to go, no money to leave (housing and money); promises to change; pressure from children, family and friends; and/or the absence of effective protection (the granting of barring orders by the courts is not guaranteed, as it depends on evidence, etc.).

### *Ending the Violence*

- This can be a very fast or very slow process.
- Some women spend years managing and coping in isolation. Others may seek support quickly.
- Legal intervention may be required.
- Ending a relationship does not guarantee that the violence will end. Contrary to popular myth, attempting to leave the relationship or end the violence may place women in more danger and at a greater risk of serious and even fatal assault.