AMA

SUPPORTING PATIENTS EXPERIENCING

FAMILY VIOLENCE

A RESOURCE FOR MEDICAL PRACTITIONERS

About this resource

The medical profession has a key role to play in the early detection, intervention and treatment of patients who have experienced family violence.

Responding effectively to family violence requires knowledge of the physical and emotional consequences of the violence, an understanding of appropriate and inappropriate responses, and having good networks with local family violence services.

This resource has been developed to assist medical practitioners in identifying and responding to patients who have experienced or are experiencing family violence. The information is drawn from a range of sources. It also provides information about specialist support services, including health, mental health, drug and alcohol, legal, family support and child protection services.

Family violence affects people of all genders, sexualities, ages, socio-economic backgrounds and cultures. However it is clear that the overwhelming majority of people who experience such violence are women, and this resource recognises that your patients who are most likely to experience family violence are women and children.

Law Council
OF AUSTRALIA

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1 What is family violence?

Family or domestic violence is an **abuse of power** within a close relationship, or after separation. It involves one person dominating and controlling another, causing **intimidation and fear.**

It is **not necessarily physical** and can include:

- sexual abuse,
- emotional or psychological abuse,
- verbal abuse,
- spiritual abuse,
- stalking and intimidation,
- social and geographic isolation,
- financial abuse,
- cruelty to pets, or
- damage to property.

Often the terms 'family violence' and 'domestic violence' are used interchangeably. 'Domestic violence' is most commonly used to describe violence perpetrated by an intimate partner. 'Family violence' is sometimes thought of as the broader term, covering intimate, family and other relationships of mutual obligation and support.

Family violence is often experienced as a pattern of abuse that escalates over time.

Women are at greater risk of violence from intimate partners during pregnancy, or after separation.[1] A safety survey conducted by the Australian Bureau of Statistics in 2012 found that 25% of women who had experienced violence from a partner during a relationship, experienced it for the first time during pregnancy.[2]

1 J Campbell, D Webster, J Koziol-McLain et al. 'Risk factors for femicide in abusive relationships: results from a multisite case control study', *American Journal of Public Health*, 93(7), 2003, pp. 1089–1097
2 Australian Bureau of Statistics (2012), op cit.

Indicators

The following are indicators associated with victims of family violence.

Indicators in adults

Physical

- Unexplained bruising and other injuries
- Bruises of various ages
- Head, neck and facial injuries
- Injuries on parts of the body hidden from view (including breasts, abdomen and/or genitals), especially if pregnant
- 'Accidents' occurring during pregnancy
- Miscarriages and other pregnancy complications
- Injuries to bone or soft tissues
- Injuries sustained do not fit the history given
- Bite marks, unusual burns
- Chronic conditions including headaches, pain and aches in muscles, joints and back
- Ulcers
- Dizziness
- Sexually transmitted disease
- Other gynaecological problems

Psychological / behavioural

- Emotional distress e.g. anxiety, indecisiveness, confusion, and hostility
- Sleeping and eating disorders
- Anxiety / depression / pre-natal depression
- Psychosomatic and emotional complaints
- Drug abuse
- Self-harm or suicide attempts
- Evasive or ashamed about injuries
- Multiple presentations at the surgery / client appears after hours
- Partner does most of the talking and insists on remaining with the patient
- Seeming anxious in the presence of the partner
- Reluctance to follow advice
- Social isolation / no access to transport
- Frequent absences from work or studies
- Submissive behaviour / low self esteem
- Alcohol or drug abuse

Indicators in children

Physical

- Difficulty eating / sleeping
- Slow weight gain (in infants)
- Physical complaints
- Eating disorders

Psychological / behavioural

- Aggressive behaviour and language
- Depression, anxiety and/or suicide attempts
- Appearing nervous and withdrawn
- Difficulty adjusting to change
- Regressive behaviour in toddlers
- Delays or problems with language development
- Psychosomatic illness
- Restlessness and problems with concentration
- Dependent, sad or secretive behaviours
- Bedwetting
- 'Acting out', for example cruelty to animals
- Noticeable decline in school performance
- Fighting with peers
- Overprotective or afraid to leave mother
- Stealing and social isolation
- Abuse of siblings or parents
- Alcohol and other drug use
- Psychosomatic and emotional complaints
- Exhibiting sexually abusive behaviour
- Feelings of worthlessness
- Transience

Frequently there are no visible signs of assault or rape in domestic violence presentations. This does not mean that the emotional or psychological effects of the assault are… any less devastating to the victim.[3]

3 J London, *Abuse and Violence: Working with Our Patients in General Practice*, 3rd Ed, Victoria: Royal Australian College of General Practitioners, 2008.

How to ask your patient

It is important to realise that women who have been abused want to be asked about domestic violence and are more likely to disclose if asked.[4]

If you have concerns that your patient is experiencing family violence, you should ask to speak with her or him alone, separate from the partner or any other family members.

You can always ask **broad questions** about whether your patient's relationships are affecting her or his health and wellbeing. For example:

- *'How are things at home?'*
- *'How are you and your partner getting on?'*
- *'Is anything else happening which might be affecting your health?'*

If appropriate, you can ask **direct questions** about any violence. For example:

- *'Are there ever times when you are frightened of your partner?'*
- *'Are you concerned about your safety or the safety of your children?'*
- *'Does the way your partner treats you make you feel unhappy or depressed?'*
- *'Has your partner ever physically threatened or hurt you?'*[5]
- *'Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.'* [6]

If you see **specific clinical symptoms**, you can ask **specific questions** about these (e.g. bruising). These could include:

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

4 Hegarty et al. 'Domestic Violence in Australia: Definition, Prevalence and Nature of Presentation in Clinical Practice' 2000, 173 MJA 363-367.

5 Kelsey Hegarty '25th Congress Medical Women's International Association' Sydney, 2001, http://www.regional.org.au/au/mwia

6 Kelsey Hegarty '25th Congress Medical Women's International Association' Sydney, 2001, http://www.regional.org.au/au/mwia

4 Responding to a disclosure

Key steps after a disclosure of family violence

Your immediate response and attitude when a patient discloses family violence can make a difference.

+ Listen

Being listened to can be an empowering experience for a patient who has been abused.

+ Communicate belief

'That must have been frightening for you.'

+ Validate the decision to disclose

'I understand it could be very difficult for you to talk about this.'

+ Emphasise the unacceptability of violence

'Violence is unacceptable; you do not deserve to be treated this way.'

+ Be clear that the patient is not to blame

Avoid suggesting that the patient is responsible for the violence or that she or he is able to control the violence by changing her or his behaviour.

Do not ask

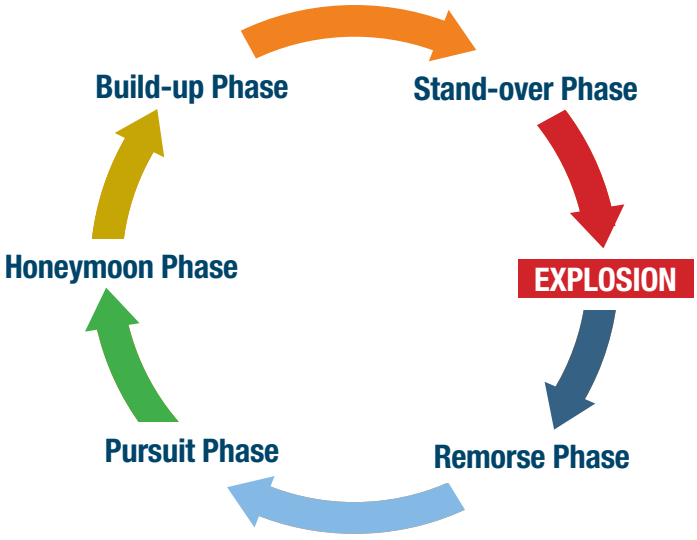
- *'Why don't you leave?'*
- *'What could you have done to avoid this situation?'*
- *'Why did she or he hit you?'*

The Cycle of Violence[7]

The cycle of violence model may be helpful in many cases to discuss with your patient common patterns of abuse.

However, it is acknowledged that it is not the same for everyone and some people may experience only some stages of the cycle (or not relate to it at all).

> Women with experience of intimate partner violence want doctors to be non-judgemental, compassionate and sensitive, acknowledging complexity but not medicalising the problem or applying pressure to make quick decisions.[8]



The Build-up Phase: This phase may begin with the relationship being normal but eventually tension begins with increasing verbal, emotional and/or financial abuse.

Stand-over Phase: The behaviour of the perpetrator escalates until a release of tension is inevitable. The person that is affected may feel that anything they do will only make the situation worse.

Explosion: This stage is marked by the peak of violence. It is the height of abuse by the person using violence to control and have power over others.
The violent perpetrator experiences a release of tension at this point, which may become addictive.

Remorse Phase: The person using violence is ashamed of their behaviour and tries to justify it to themselves and others.

Pursuit Phase: The person using violence in their relationship promises the affected person that they will never act that way/be violent again. They may blame their behaviour on things such as work stress, drugs or alcohol. They may purchase gifts, be more affectionate and/or alter their behaviour to show the affected person they have changed.

Honeymoon Phase: During this phase both people are in denial of the violence, often because they do not want to end the relationship. They hope that it will not happen again but after some time the cycle may begin again.

7 *Brisbane Domestic Violence Service, The Cycle of Violence*, from: http://www.bdvs.org.au/resource_files/bdvas/IR_5_Cycle-of-violence-factsheet.pdf

8 Feder, G., Hutson, M., Ramsay, J. & Taket. A. Women Exposed To Intimate Partner Violence. Arch Intern Med (2006) 166: 22-37.

5 Initial safety planning

> It is important to remember that the true goal… is to prevent violence, not predict it.[9]

Assist your patient to evaluate her or his immediate and future safety, and that of children. Best-practice risk assessment involves seeking relevant facts about a patient's particular situation, asking about her or his own perception of risk, and using professional judgement. You may need to refer your patient to a specialised family violence service. More information is provided in the RACGP white book *Abuse and violence: Working with our patients in general practice*.

Aspects of best practice risk assessment

For initial safety planning, you will at least need to:

- **Speak to the patient alone**
- Check for **immediate concerns**
  - + Does she or he feel safe going home after the appointment?
  - + Are the children safe?
  - + Does she or he need an immediate place of safety?
  - + Does she or he need to consider an alternative exit from your building?
- If immediate safety is not an issue, check her or his **future safety**
  - + Does the partner have weapons?
  - + Does she or he need a referral to police or a legal service to apply for a protection order?
  - + Does she or he have **emergency telephone numbers**?
    - > Police: 000 or 106 (TTY)
    - > **1800 RESPECT: 24 hour, National Sexual Assault, Family & Domestic Violence Counselling Line** (24/7 line for people experiencing domestic violence; translators available)
  - + Does she or he need a referral to a family violence service to help make **an emergency plan?**
    - > Where would the patient go if she or he had to leave?
    - > How would she or he get there?
    - > What would she or he take with them?
    - > Who are the people she or he could contact for support?
- Document any initial safety plans made, for future reference

Risk assessment is an ongoing process. You may need to check in on your patient to follow up on this initial safety plan.

9 Dutton, D. G. & Kropp, R. P. 2000, 'A review of domestic violence risk instruments', Trauma, Violence and Abuse, vol. 1, no. 2, pp.171-181, at 179.

6 Continuing care

'I dropped some hints to test the water. [The GP] was supportive without being interfering and because of this I made the decision to tell her. She was fantastic and told me about the [Domestic Violence Line] who I called and put me into contact with a women's refuge. I am rebuilding my life, and looking forward to a happy future'.[10]

- Consider your patient's safety as a paramount issue. Victims are usually a good judge of their own safety. You can help to monitor the safety of patients and children by asking about any escalation of violence.
- Empower the patient to take control of decision-making; ask what she or he needs and present choices of actions she or he may take and services available.
- Respect the knowledge and coping skills she or he has developed. You can help build on a patient's emotional strengths, for example, by asking 'How have you dealt with this situation before?'
- Provide emotional support.
- Ensure confidentiality – patients may suffer additional abuse if her or his partner suspects she or he has disclosed the abuse.
- Be familiar with appropriate referral services and their processes. Patients may need your help to seek assistance. Have information available for the patient to take with her or him if appropriate.

7 Aboriginal and Torres Strait Islander patients and violence

While the statistics on family violence amongst Aboriginal and Torres Strait Islander families are poor, what is certain is that Indigenous women in particular are far more likely to experience violent victimisation, and suffer more serious violence, than non-Indigenous women.[11]

Australia's National Research Organisation for Women's Safety[12] has identified that:

- Indigenous people are two to five times more likely to experience violence than non-Indigenous people, and
- Indigenous women are five times more likely to be homicide victims than non-Indigenous women.

Indigenous women experience up to 38 times the rate of hospitalisation of other women for spouse/domestic partner inflicted assaults.[13]

10 C George et al, *Domestic Violence: A Report from the BMA Board of Science*, 2007. British Medical Association.

11 M Willis, *Non-disclosure of violence in Indigenous communities*, Trends and issues in crime and criminal justice, no. 405, Australian Institute of Criminology, Canberra, 2011, p. 1.

12 ANROWS, *Indigenous family violence*, Fast facts, ANROWS website, May 2014.

13 F Al-Yaman, M Van Doeland and M Wallis, *Family violence among Aboriginal and Torres Strait Islander peoples*, Australian Institute of Health and Welfare (AIHW), Canberra, 2006, pp. 54–55, viewed 21 July 2011, http://www.aihw.gov.au/publication-detail/?id=6442467912

Cultural sensitivity in responding to the Aboriginal and Torres Strait Islander people who may have experienced family violence is essential. Knowing whether your patient identifies as Aboriginal and/or Torres Strait Islander is a first step. For a patient who discloses that they have experienced violence, it's important to establish whether they would prefer referral to a mainstream or Aboriginal-specific service.

Services will vary from region to region.

The Australian Government's National Sexual Assault Domestic Violence Counselling Service website – 1800RESPECT – provides a tool to search for local Indigenous health, mental health, Drug & Alcohol, Family Support, child protection and other services at: https://www.1800respect.org.au/workers/atsi/indigenous-services/

Culturally and linguistically diverse groups

Women and children from culturally and linguistically diverse (CALD) communities are less likely than other groups of women to report violence. These groups may face particular barriers to reporting family violence including language barriers, cultural stigma, financial insecurity and concerns about their visa or residency.

A patient's fluency in English may also be a barrier to discussing these issues. If so, you should work with a qualified interpreter. Don't use partners, other family members or a child as an interpreter. It could compromise the patient's safety, or make them uncomfortable to talk with you about their situation.

The Doctors Priority Line 1300 575 847 is a 24/7 free telephone interpreting service to assist GPs to communicate with patients from non-English speaking backgrounds.

The 1800 RESPECT telephone counselling line 1800 737 732 also offers a full translation service for people seeking information for themselves, family, friends or patients. The line provides free and confidential professional counselling and ongoing assistance, 24 hours a day, seven days a week.

The 1800 RESPECT website Services and Support page provides a tool to search for specialist domestic and family violence support services in each Australian state and territory, including CALD services: https://www.1800respect.org.au/service-support/

Immigration family violence provisions

There are special family violence provisions in immigration law that are intended to relieve the fear of a 'partner visa' applicant who may believe that she or he needs to stay in an abusive relationship in order to remain in Australia. These provisions allow certain applicants to obtain permanent residence even if the relationship with their Australian sponsor has broken down, where there is evidence of family violence by the sponsoring partner against the applicant or a member of the family unit.

Information is available at:

http://www.immi.gov.au/FAQs/Pages/how-does-family-violence-affect-my-application-for-a-partner-visa.aspx

However individuals should obtain legal advice prior to using the family violence provisions.

A report or statutory declaration from a doctor detailing physical injuries and/or treatment for mental health issues that are consistent with family violence may be requested as part of the evidence given to the Department of Immigration and Border Protection to access the provisions.

When your patient is the perpetrator

MensLine Australia offers 24/7 professional non-judgemental and anonymous support for any family violence concern. The line provides telephone anger management and behavioural change programs alongside a call-back service which can provide professional ongoing support. An online counselling service is also available.

Phone 1800 78 99 78 or visit the website at www.mensline.org.au

Consider the safety of victims and their children as the highest priority. Note that perpetrators of violence have a tendency to minimise the violence, or shift blame.

If violence is suspected and further information is needed, start with broad questions such as:

- *'How are things at home?'*

Then if violence is disclosed, ask more specific questions such as:

- *'Some people who are stressed like you hurt the people they love. Is this how you are feeling? Did you know that there are services that can help you?*

Acknowledge the existence of violence by statements such as:

- *'That was brave of you to tell me. Sometimes people who are stressed hurt the people they love. However, violent behaviour towards your partner and other family members is never acceptable. It not only affects your partner but your children as well. Did you know there are services which may be able to assist you?'*

There are programs, groups and telephone services that specifically deal with family violence issues.

When both partners are your patients

Special care is required if a patient discloses family violence, and the violent person is also your patient or is a patient within the same service.

If you have seen the victim or her or his children, your primary duty is to them. If the perpetrator is also your patient, consider referring one partner to another practitioner or another practice but not if this would require you to breach the confidentiality of your other patient.

If both partners remain within your practice, you will need to take extra caution, for example[14]:

- Establish staff protocols that ensure confidentiality of records.
- There should be no discussion about suspected or confirmed abuse with the violent partner unless the victim consents to it.
- If a patient agrees that you can talk with her or his partner about the violence, it is important that a safety plan is in place.

Couple or marital counselling is not appropriate in circumstances where there has been family violence, due to the power imbalance in the relationship and the threat to the victim's safety.

14 Based on Ferris, L.E., Norton, P.G., Dunn, E.V., Gort, E.H. & Degani, N., 'Guidelines for managing domestic abuse when male and female partners are patients of the same physician', *Journal of the American Medical Association*, vol. 278, no. 10, 1997, pp. 851-857.

Mandatory reporting of domestic violence – requirements

You should ensure that you are familiar with the mandatory reporting obligations that apply to doctors in your State or Territory. As at 31 May 2015, only the Northern Territory legislation has mandatory reporting provisions relating to violence between adults.

All States and Territories have different provisions about mandatory reporting by doctors relating to risks of harm to children. In some cases, exposure of children to family violence may be required to be reported.

Family violence relating to children[15]

Types of abuse or neglect that must be reported, by Australian jurisdiction

Jurisdiction	Physical abuse	Sexual abuse	Psychological/ emotional abuse	Neglect	Exposure to domestic violence
ACT	Yes	Yes	No	No	No
NSW	Yes	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	Yes	Yes
QLD	Yes	Yes	Yes	Yes	No
SA	Yes	Yes	Yes	Yes	No
TAS	Yes	Yes	Yes	Yes	Yes
VIC	Yes	Yes	No	No	No
WA	No	Yes	No	No	No
Cth	Yes	Yes	Yes	Yes	Yes

15 Tables extracted from: Mathews, B & Walsh K, Mandatory Reporting, in *Families, Policy and the Law*, 2014, (http://www.aifs.gov.au/institute/pubs/fpl/fpl14.html#table1)

Reporter's state of mind, extent of harm activating the duty, and application of duty to past or present abuse/injury, future abuse/injury, or both, by Australian jurisdiction

Jurisdiction	State of mind	Extent of harm	Past/present or future
ACT	Belief on reasonable grounds	Not specified: "sexual abuse ... or non-accidental physical injury"	Past/present
NSW	Suspects on reasonable grounds that a child is at risk of significant harm	A child or young person "is at risk of significant harm if current concerns exist for the safety, welfare or well-being of the child or young person because of the presence, to a significant extent, of ... basic physical or psychological needs are not being met ... physical or sexual abuse or ill-treatment ... serious psychological harm"	Both
NT	Belief on reasonable grounds	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child	Both
QLD	Becomes aware, or reasonably suspects	Significant detrimental effect on the child's physical, psychological or emotional wellbeing	Both
SA	Suspects on reasonable grounds	Any sexual abuse; physical or psycological abuse or neglect to the extent that the child "has suffered, or is likely to suffer physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy"	Past/present[a]
TAS	Believes, or supsects, on reasonable grounds, or knows	Any sexual abuse; physical or emotional injury or other abuse, or neglect, to the extent that the child has suffered, or is likely to suffer physical or psychological harm detrimental to the child's wellbeing; or the child's physical or psychological development if in jeopardy	Past/present[b]
VIC	Belief on reasonable grounds	Child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type	Both
WA	Belief on reasonable grounds	Not specified: any sexual abuse	Past/present
Cth	Suspects on reasonable grounds	Not specified; any assault or sexual assault; serious psychological harm; serious neglect	Both

Notes a: Also if "a person with whom the child resides (whether a guardian of the child or not) – (i) has threatened to kill or injure the child and there is a reasonable likelihood of the threat being carried out; or (ii) has killed, abused or neglected some other child or children and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person". b: Also if there is "a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides".

12 Referrals

Health professionals can be a bridge to resources within the community, but this requires knowledge of and liaison with those services.[16]

Here are some key contacts for patients, their friends, families and doctors. All URLs are correct at the time of publication, May 2015.

1800RESPECT

1800 RESPECT is the national family violence and sexual assault counselling service for people seeking information for themselves, their family, friends or patients. It is a free, confidential service available 24 hours a day, 7 days a week. Call **1800 737 732** to speak to a professional counsellor.

The 1800 RESPECT website provides a tool to search for specialist domestic and family violence support services in each Australian state and territory: https://www.1800respect.org.au/service-support/

Family Relationship Advice

The Family Relationship Advice Line provides information and advice on family relationship issues and parenting arrangements after separation. It can also refer callers to local services that can provide assistance. Call **1800 050 321** between 8 am and 8 pm, Monday to Friday, or 10 am to 4 pm on Saturday local time, except national public holidays.

Kids Helpline

Kids Helpline is a free, private and confidential, telephone and online counselling service specifically for young people aged between 5 and 25. Call **1800 551 800**, 24 hours a day, 7 days a week.

Lifeline

Lifeline provides crisis support services. Call **131 114**, 24 hours a day, 7 days a week.

Mensline Australia

Mensline Australia provides telephone and online support, information and a referral service. They provide counselling support for men to help deal with relationship problems in a practical and effective way. They also provide specialist support to those who experience family and domestic violence. Read more about this support on the Mensline Australia website or call **1300 78 99 78**.

White Ribbon

The White Ribbon website also provides a list of national and state based support organisations which may be of assistance where domestic and family violence is a concern: http://www.whiteribbon.org.au/finding-help

National Association of Community Legal Centres

Find free legal advice from specialist and generalist community legal centres in your local area. http://www.naclc.org.au/need_legal_help.php

16 Mazza, D., Lawrence, J., Roberts, G. & Knowlden, S. (2000) *What Can We Do About Domestic Violence?* Medical Journal of Australia. 173 (10) 532-535.

Resources

All URLs are correct at the time of publication, May 2015.

Royal Australian College of General Practitioners - *Abuse and violence: Working with our patients in general practice* (white book)

http://www.racgp.org.au/your-practice/guidelines/whitebook

For information on implementing a process for how general practitioners can respond to family violence, refer to the RACGP's *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* (the Green Book).

www.racgp.org.au/your-practice/guidelines/greenbook

Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf

Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians – this guide outlines information relating to management of the whole family.

http://www.latrobe.edu.au/__data/assets/pdf_file/0008/580265/Management-of-the-whole-family-when-intimate-partner-violence-is-present-guidelines-for-primary-care-physicians.pdf

Intimate partner violence: Identification and response in general practice

Reprinted from Australian Family Physician Vol. 40, No. 11, November 2011

http://www.racgp.org.au/afp/2011/november/intimate-partner-violence/

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Published in May 2015.

Available online at https://ama.com.au/article/ama-family-violence-resource