



Government of **Western Australia**  
Department of **Health**



# Reference Manual for Health Professionals

Responding to Family and Domestic Violence



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### Suggested Citation

Department of Health Western Australia. Reference Manual for Health Professionals - Responding to Family and Domestic Violence. Perth: Women's Health Clinical Care Unit, Women and Newborn Health Service, Department of Health Western Australia; 2014.

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# Contents

<b>1.0</b>	<b>BACKGROUND INFORMATION</b>	<b>6</b>
<b>1.1</b>	<b>Introduction</b>	<b>6</b>
	Definitions	7
<b>1.2</b>	<b>WA Health Policy</b>	<b>10</b>
<b>2.0</b>	<b>INDICATORS OF FAMILY AND DOMESTIC VIOLENCE</b>	<b>17</b>
<b>2.1</b>	<b>Facts about Family and Domestic Violence</b>	<b>17</b>
<b>2.2</b>	<b>Risk Indicators</b>	<b>18</b>
<b>2.3</b>	<b>Client's Presentation and History</b>	<b>20</b>
<b>2.4</b>	<b>Psychological and Emotional Indicators</b>	<b>21</b>
<b>2.5</b>	<b>Physical Signs and Symptoms</b>	<b>21</b>
<b>2.6</b>	<b>Pregnancy</b>	<b>22</b>
<b>3.0</b>	<b>WORKING WITH PEOPLE WHO HAVE EXPERIENCED FAMILY AND DOMESTIC VIOLENCE</b>	<b>24</b>
<b>3.1</b>	<b>Identification</b>	<b>24</b>
	Provide a Supportive Environment	25
	Communicating with the Client	25
	Screening for Family and Domestic Violence	26
	Communicating with Children	28
	Consultation with Health Professional Colleagues	30
	Consultation with Other Agencies	30
<b>3.2</b>	<b>Assessment</b>	<b>31</b>
	A General Guide to Assessment	31
	Physical Examination	33
	Mental Health Assessment	33
	Acting on Your Assessment	34
	Safety Planning	35
	Self-Care	36
	Safety of Health Professionals	36
	Supervision	37
<b>3.3</b>	<b>Referral</b>	<b>37</b>
	Making a Referral	37
	WA Police Service	39

	Department for Child Protection and Family Support (DCPFS)	39
	Sexual Assault Resource Centre	40
	Regional Sexual Assault Resource Centres	40
	Mental Health Services	41
	Domestic Violence Legal Unit (Legal Aid Western Australia)	41
<b>3.4</b>	<b>Documentation</b>	<b>42</b>
	Client Records	42
	Documentation of Physical Examination	44
	Medical Photography	44
<b>3.5</b>	<b>Longer Term Management</b>	<b>45</b>
	Case Management	45
	Multi-Agency Coordinated Care Model	46
<b>4.0</b>	<b>WORKING WITH PERSON RESPONSIBLE</b>	<b>47</b>
<b>4.1</b>	<b>Identification</b>	<b>47</b>
<b>4.2</b>	<b>Communicating with the Person Responsible</b>	<b>47</b>
<b>4.3</b>	<b>Referral</b>	<b>48</b>
<b>4.4</b>	<b>Documentation</b>	<b>49</b>
	Client Records	49
<b>5.0</b>	<b>SPECIALIST AREAS</b>	<b>51</b>
<b>5.1</b>	<b>Aboriginal People and Families</b>	<b>51</b>
	Practice Points	51
	Risk Issues to Consider	53
	Support Agencies	53
<b>5.2</b>	<b>Regional, Rural and Remote Areas</b>	<b>54</b>
	Practice Points	54
	Risk Issues to Consider	55
	Support Agencies	55
<b>5.3</b>	<b>Children and Young People</b>	<b>56</b>
	Practice Points	56
	Risk Issues to Consider	57
	Support Agencies	58
<b>5.4</b>	<b>Maternal Health</b>	<b>60</b>
	Practice Points	60
	Risk Issues to Consider	61
	Support Agencies	61

<b>5.5</b>	<b>Culturally and Linguistically Diverse (CaLD) People including Newly Arrived Refugees and Migrants</b>	<b>62</b>
	Practice Points	62
	Risk Issues to Consider	63
	Support Agencies	63
<b>5.6</b>	<b>People with Mental Health Disorders or Illnesses</b>	<b>65</b>
	Practice Points	65
	Risk Issues to Consider	66
	Support Agencies	66
<b>5.7</b>	<b>People with a Disability</b>	<b>67</b>
	Practice Points	67
	Risk Issues to Consider	67
	Support Agencies	68
<b>5.8</b>	<b>People of Diverse Sexuality and Gender</b>	<b>69</b>
	Practice Points	69
	Risk Issues to Consider	70
	Support Agencies	70
<b>5.9</b>	<b>Older People</b>	<b>72</b>
	Practice Points	72
	Risk Issues to Consider	73
	Support Agencies	73
<b>6.0</b>	<b>Integrated Service Delivery</b>	<b>74</b>
<b>6.1</b>	<b>The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework</b>	<b>74</b>
<b>6.2</b>	<b>Minimum Standard for Risk Assessment</b>	<b>74</b>
<b>6.3</b>	<b>Minimum Standard for Risk Management</b>	<b>75</b>
<b>6.4</b>	<b>Memorandum of Understanding: Information Sharing Between Agencies</b>	<b>75</b>
<b>7.0</b>	<b>LEGAL INFORMATION</b>	<b>76</b>
<b>7.1</b>	<b>Disclaimer</b>	<b>76</b>
<b>7.2</b>	<b>Client Confidentiality and Information Sharing</b>	<b>76</b>
<b>7.3</b>	<b>Disclosure by Consent</b>	<b>77</b>
	Consent of Client or Client's Legal Guardian	77
	Other Health Professionals	77
<b>7.4</b>	<b>Disclosure by Operation of the Law</b>	<b>77</b>
	Statutory Disclosure	77
	Child Safety and Wellbeing	78

	Firearms or Ammunition	78
	Subpoena	79
	Public interest disclosure	79
<b>7.5</b>	<b>Duty of Care</b>	<b>79</b>
<b>7.6</b>	<b>Client Consent to Treatment and Disclosure of Material Risks</b>	<b>80</b>
	Duty to Obtain Consent	80
	Informed Consent	80
	Legal Capacity to Consent	81
	Duration of a Client's Consent	81
<b>7.7</b>	<b>Female Genital Mutilation</b>	<b>81</b>
<b>7.8</b>	<b>Restraining Orders</b>	<b>82</b>
<b>7.9</b>	<b>Other Information</b>	<b>83</b>
<b>7.10</b>	<b>Memorandum of Understanding: Information Sharing Between Agencies</b>	<b>83</b>
<b>8.0</b>	<b>RESOURCES</b>	<b>84</b>
<b>8.1</b>	<b>Useful Telephone Numbers</b>	<b>84</b>
	Counselling Services	84
	Legal Information	85
	Mental Health Services	85
	Interpreter Services	87
	Women's Information Service	87
<b>9.0</b>	<b>REFERENCES</b>	<b>88</b>

## 1.0 Background Information

### 1.1 Introduction

Family and domestic violence (FDV) occurs amongst all groups in our society. It is an issue that is often hidden yet has a profound and lasting impact on the social, emotional, physical and financial wellbeing of many Western Australians. It affects all individuals, children and families, as well as whole communities and has intergenerational consequences.

WA Health recognises that Aboriginal\* people and families experience FDV at greater rates than the general population and that special consideration needs to be given as to how health professionals can best meet their needs.

FDV can be a direct or underlying reason why people seek assistance from health services. This manual and the policy aims to provide health professionals with an understanding of FDV, the impact it has on all family members and the wider community and to assist health professionals to make safe and effective interventions with adult and child victims of violence and abuse, and other vulnerable children in the household. It sets out principles of screening for violence and abuse, intervention and provides standard information applicable to the different settings within which health professionals operate. It also provides some guidance on responses to any person responsible for engaging in acts of violence and abuse.

WA Health is committed to working cooperatively with other agencies to enhance the safety of adults and children who are assessed to be at risk of harm, and to increasing accountability for the person responsible. Formalised, uniform arrangements for the exchange of information between government agencies have been established in order to reduce risks and enhance the safety of clients at high risk of FDV.

See **Operational Directive OP 0286/10** - Memorandum of Understanding: Information Sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia.

[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=12649](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12649)

Every effort has been made to use the common language that is recognised across government agencies.

It is anticipated that individual health services will formulate their own response, relevant to the particular circumstances of their community or region and use the Guideline for

Responding to Family and Domestic Violence Guideline and Reference Manual for Health Professionals as a guide to intervention.

\*Within Western Australia the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community (Operational Directive 0435/13).

## Definitions

### Family and Domestic Violence

The following definition for FDV is based on the WA State Government Strategic Plan for Family and Domestic Violence 2009-2013.

FDV is usually not an isolated event but is a pattern of ongoing, repetitive and purposeful use of physical, emotional, social, financial and/or sexual abuse used to intimidate and instil fear. Such behaviour enables the one person to control and have power over the other person in an 'intimate' or family relationship.


It is considered to be behaviour which results in physical, sexual and/or psychological damage, forced social isolation, economic deprivation, or behaviour which causes a person to live in fear. The term is usually used where abuse and violence take place in intimate partner relationships including same sex relationships, between siblings, from adolescents to parents or from family carers to a relative or a relative with a disability. A key characteristic of family and domestic violence is the use of violence or other forms of abuse to control someone with whom the perpetrator has an intimate or family relationship. However, abusive behaviours may occur without the intention to control another, particularly in the case of neglect or a mental health issue.

The term is usually used where abuse and violence take place in relationships including; intimate partner relationships, same sex relationships, between siblings, from adolescents to parents, or from family carers to a relative, or a relative with a disability.

The use of terms such as 'victim' or 'perpetrator' may be unhelpful, both in terms of stigmatisation of the parties involved and the potential for mislabelling in the case of complex interaction or what appears to be mutually abusive behaviours.

Both the terms 'violence' and 'abuse' are used in the manual. 'Violence' often equated with physical contact, whilst 'abuse' reflecting the broader scope of FDV in terms of neglect, financial, psychological and emotional trauma.





Aboriginal people generally prefer to use the term 'family violence'. This concept describes a matrix of harmful, violent and aggressive behaviours and is considered to be more reflective of an Aboriginal world view of community and family healing. However, the use of this term should not obscure the fact that Aboriginal women and children most often experience family violence.

### **Psychological/Emotional Abuse**

Psychological or emotional abuse is the systemic use of threats of physical or sexual violence, intimidation, harassment or damage to property that result in anguish and fear. It can include threats to harm or kill the client, threats with weapons, threats to abduct or harm children and hurting or killing pets. It includes acts or omission by partners or caregivers that result in serious behavioural, cognitive, emotional or mental health problems. It can involve a person deliberately causing confusion for a partner or family member, prolonged silences, withholding important information, excluding a partner or family member from decision-making, blaming the client for the violence and attacks on a person's self-esteem or social competence.

It includes stalking which is unpredictable, considered dangerous and can end in violence. This can occur during a relationship or after a relationship ceases, and involves harassment or threatening a person in a way that haunts that person. It can involve intense monitoring of the client's activities by phone, in person, via the internet or email (cyber-stalking), monitoring phone calls or unexpectedly showing up at a place where the client is currently attending, such as home, school or work.

Children exposed to domestic violence are at risk of psychological and emotional abuse.

### **Physical Abuse**

Physical abuse is the use of physical force with the intent to harm or frighten. Actions include restraint of a person, punching, beating, choking, kicking, biting, shaking or any other action that results in harm. It can include the use of weapons such as guns, knives, bats etc.

### **Sexual Abuse**

Sexual abuse is any unwanted sexual activity or behaviour to which the client has not consented or was not able to consent to. Activities can include unwanted sexual touching, being forced to masturbate, view pornography or perform sexual acts on oneself or others and sexual penetration by penis, object or other parts of the body into vagina, anus or mouth.



## **Neglect**

Neglect is the failure of a caregiver to provide for the basic physical, emotional, developmental, social, medical, educational, nutrition or shelter needs of a person.

## **Social Abuse**

Social abuse involves the manipulation, isolation and/or intimidation of a person and includes having their movements and contacts monitored, being prevented from making contact with family and friends, having the use of the telephone or the family car restricted and being prevented from having a job or other interests outside of the home.

## **Economic Abuse/Financial Exploitation**

Economic abuse is the control by one person over the finances of another, stealing from or defrauding a partner of money or assets, or taking advantage of that person for monetary gain or profit. The person responsible can deny access to bank accounts, force the surrender of bank cards to gain control of a person's income or social security payments, or prevent a person from seeking or maintaining employment. It can also include denying a person input into important financial decisions which directly affect them.

Note: It is important to be aware that many forms of FDV are a crime such as physical assault aggravated assault sexual assault and deprivation of liberty.

## **Child Abuse**

The physical, sexual or psychological/emotional abuse or neglect of a child by their parent/s, a carer or a person in a position of authority.

Note: For the purposes of this Reference Manual, the terms 'child' and 'children' is used to describe a young person or persons up to the age of 18 years.

Note: The term 'health professionals' refers to all Government of Western Australia health employees.

## 1.2 WA Health Policy

### **Introduction**

Family and domestic violence is a widespread health and social problem occurring across all cultural and religious groups, age, gender, sexual diversity groups and socio-economic levels of the Western Australian community. FDV is associated with other adverse social issues including child abuse, homelessness, physical and mental health issues, poverty and drug and alcohol misuse.

FDV is not a 'private' or 'family' matter; it is a major public and community health concern.

FDV is a gendered crime of violence, most often against women, when it is between men and women. It is also inclusive of other 'intimate' relationships such as in same sex partnerships, parent/child and extended family relationships where it enables a person to control and have power over another.

FDV is usually not an isolated event but is a pattern of ongoing and purposeful use of physical, emotional, social, psychological, financial and/or sexual abuse which is used to intimidate and instil fear.

FDV seriously impacts on health and wellbeing. It decreases a parent's emotional availability to their children, reducing bonds of trust, safety and nurturing while instilling a legacy of fear, anxiety, unpredictability and 'normalised violence' into both adults and children at risk.

FDV can have an intergenerational pattern, threatening the ability of whole generations of people to form safe and trusting relationships and to raise and nurture a confident and healthy family.

The long-term impact on families and children of living in constant fear and anxiety is acknowledged at both State and Federal Government levels as a public health concern.

If the behaviour of the person responsible for the FDV goes unchallenged and unchanged, it can be normalised into family and community culture.

## Purpose

This policy sets out WA Health's approach to responding to FDV. It provides the foundation for the development of FDV related policies and procedures for each area health service. It also addresses the role of health professionals and the training, support, data collection and evaluation processes which combine to ensure that WA Health has a competent workforce to support adults and children at risk in addressing the physical and emotional costs, as well as for the person responsible.

## Governance

The Family and Domestic Violence Advisory Group (FDVAG) is comprised of senior representatives from each health service, and other relevant government services and non-government agencies, who are accountable to the Executive Director, Women and Newborn Health Service (WNHS). The FDVAG provides advice, coordinates and oversees WA Health policies and processes with regard to FDV.

## Relevant Legislation

- The *Restraining Orders Act 1997* provides a legal definition of family and domestic violence.
- The *Children and Community Services Act 2004* is the relevant Act concerning child protection.
- Family Law Amendment (Family Violence and Other Measures) Bill.
- *Restraining Order Amendment Bill 2011* (amends the *Restraining Orders Act 1997* and the *Criminal Investigations Act 2006*).

This policy is to be read in conjunction with the following frameworks and guidelines:

WA Health:

- Operational Directive OP 0286/10 - Memorandum of Understanding: Information Sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia.  
[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=12649](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12649)
- Guidelines for Protecting Children 2009.
- WA Department of Health Protection of Children Check and Policy.

[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=12441](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12441)

- Operational Circular OP 1821/04: Prevention of Workplace Aggression and Violence.

All WA Health professionals must act in accordance with these documents.

Other:

- Western Australian Strategic Plan for Family & Domestic Violence 2009 – 2013 – Department for Child Protection and Family Support.
- Safer communities, safer children (2007). Department of Indigenous Affairs, Perth: Government of Western Australia.
- Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children 2009. Aust. Government. Canberra.
- National framework for protecting Australia's children 2009–2020: protecting children is everyone's business. Council of Australian Governments (2009).

## Scope


This policy applies to all health professionals employed within WA Health, which incorporates the following entities:

- Department of Health
- Metropolitan Health Services
- WA Country Health Services
- Peel Health Services.

## Principles Underpinning WA Health's response and approach to Family and Domestic Violence

The following principles apply across WA Health:

1. FDV is a violation of basic human rights. Adults and children are entitled to live in dignity, free from fear and harm in their own home or domestic environment.
2. All forms of FDV are unacceptable and some acts are unlawful. WA Health does not condone any form of violence or abuse and does not accept any justification for its use.

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3. The person responsible for the FDV is the only person to be held accountable. No blame or responsibility for FDV is to be attributed to any person harmed or at risk and there is no excuse to minimise the intent, extent or degree of harm caused.
  4. The safety of adults and children experiencing FDV is paramount. The safety of a child takes precedence.
  5. Parents, families and other caregivers have the primary role in safeguarding and promoting the wellbeing of their children.
  6. Any clients who are responsible for FDV are supported to make decisions and take actions which promote the safety of the people they harm and their own ability to cease their violent and abusive behaviour.
  7. People have a right to the support of someone from their cultural and linguistic background. Services need to be accessible and equitable for all people.
  8. Clients have a right to privacy and confidentiality\*. However the right of adults and children to be safe and protected will take precedence in those instances where there are competing interests.
  9. Effective service provision relies on WA Health Professionals having an understanding of the impact of trauma on clients and the many detrimental effects of FDV on individuals and families.
  10. Effective intervention in FDV requires openness, collaboration and partnerships. WA Health will provide a better service when agencies, families and individuals work together with a focus on safety and creating opportunities for clients to rebuild a sense of control over their lives.

**\*Operational Directive 0286/10** - Memorandum of Understanding – Information Sharing between agencies with responsibility for preventing and responding to family and domestic violence in Western Australia.

**Information Circular 0022/07** – Guidelines for Transmission of Client Identifiable Health Information by Facsimile Machine.

**Operational Procedure 2050/06** – Patient Confidentiality and Divulging Patient Information

## Role of WA Health and Health Professionals

### The Role of WA Health

WA Health aims to ensure that responses to individuals at risk of, or having experienced or perpetrated FDV, will be appropriate and well-informed by policies, procedures and staff professional development and training opportunities.

WA Health supports, and is not limited to, the following strategies:


- All clinical staff have access to training\*. The workforce is supported to achieve and maintain relevant competencies and skills through professional development opportunities so that they can provide a competent and effective health service to those clients affected by FDV.
- A commitment to prioritising FDV as a preventable health issue, given the acknowledged cost to the Western Australian community in terms of direct health costs, including public health system costs associated with treating the immediate and ongoing effects of violence and abuse and pain, suffering and premature mortality.
- Undertaking routine screening amongst identified high risk groups and having clear pathways for ongoing service provision and/or referrals.
- Working in a trauma informed and client centred way with clients experiencing FDV.
- Undertaking health promotion on the prevention, early identification and intervention of FDV, including inter-sectoral cooperation with government, non-government and community organisations.
- Ensure that staff safety is a priority.
- Establish the ongoing systematic collection of data that will contribute to the development of strategies to address FDV.

Health professionals are well placed to engage in early identification and prevention and undertake referrals. Early intervention can reduce the immediate and longer-term impact of FDV and can decrease the cyclical and intergenerational nature of FDV.

The role of health professionals in the identification of FDV is to:

- Have knowledge in FDV issues and skills on managing and interventions.
- Ensure that pathways for follow-up service provision and/or referrals are known and adhered to.

**\*WA Health supports the premise of the World Health Organisation, “Violence Against Women: Global Picture Health Response, recommends that health providers receive training as a minimum requirement.**

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- Ensure that client service areas are conducive to the acknowledgement and disclosing of FDV, through the provision of safe, confidential areas that can facilitate safe discussion with the person alone; display of FDV material that promotes the view of WA Health on FDV as set out in this policy.


The role of health professionals with clients experiencing FDV is to:

- Focus on ensuring their immediate physical and psychological safety and initiate strategies to address present and future safety.
- Provide services in a respectful, non-judgemental and non-blaming manner.
- Work in a trauma informed and client centred way to create opportunities for clients to rebuild a sense of control over their lives.
- Ensure provision of medical treatment, appropriate crisis and non-crisis counselling, information, referral and accommodation services, as necessary.
- Ensure that services are provided in a manner that is culturally and linguistically appropriate and that recognise the different needs and circumstances of diverse populations, while never accepting that different cultural norms are an excuse for FDV.
- In consultation with line manager/social work/specialist FDV agency, notify the WA Police service when it is suspected or there is concern that a crime has been committed (as per the Restraining Orders Act 1997) and/or when extreme and immediate risk to the client (or children) has been identified.
- Endeavour to engage the person at risk in all aspects of decision-making and actively seek their input in steps necessary to manage their present and future health and well-being and/or that of any children.
- Keep the client fully informed of all processes and outcomes.
- Engage in effective collaboration, coordination and information sharing within WA Health and between health and other government and non-government departments and agencies.
- Ensure that the necessary training, supervision and other support is available and utilised in order to enable effective practice.

The role of health professionals working with children is to:

- Recognise the obligation to take action on behalf of a child believed to be harmed or is likely to be harmed, as a result of FDV.



- 
- Endeavour to engage with the child/children's caregivers to support and strengthen their capacity to provide adequate care and protection for that child. Remember, the best interests of the child are paramount.
  - If necessary, report concerns to the Department for Child Protection and Family Support and/or the WA Police.
  - Follow the mandatory reporting of child sexual abuse - [http://www.health.wa.gov.au/mandatoryreport/docs/Protection\\_of\\_Children\\_Policy.pdf](http://www.health.wa.gov.au/mandatoryreport/docs/Protection_of_Children_Policy.pdf). (See Guidelines for Protecting Children 2009).

The role of health professionals with person responsible for FDV is to:

- In consultation with line manager/social work or specialist FDV agency, notify the WA Police when it is suspected or there is concern that a crime has been committed (as per the Restraining Orders Act 1997) and/or when extreme and immediate risk to the client harmed (or children) has been identified.
- Engage in effective collaboration, coordination and information sharing within WA Health and between health and other government and non-government departments and agencies.  
(See Operational Directive OP 0286/10 - Memorandum of Understanding: Information Sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia.  
[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=12649](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12649))
- Make referrals as necessary or provide information.

### **Monitoring and Evaluation**

Women and Newborn Health Service takes leadership in the development of this policy which will be reviewed every three years to ensure content is consistent with current research findings on methods and models for responding to family and domestic violence.

The collection of relevant data is paramount to inform policy and practice for best health outcomes.

## 2.0 Indicators of Family and Domestic Violence

### 2.1 Facts about Family and Domestic Violence

- The Australian Bureau of Statistics estimate that 2.56 million or 1 in 3 Australian women have experienced physical violence at some stage in their life since the age of 15 years and that 1.47 million or 1 in 5 have been exposed to sexual violence<sup>1</sup>.
- A comprehensive study by Access Economics found that for the period 2002-03, the estimated cost of FDV to the Australian community was \$8.1 billion. The largest contributor is pain, suffering and premature mortality with an annual cost of \$3,521m. The estimated health cost is \$388m. These costs are associated with the provision of facilities, resources and services including GP consultations, accident and emergency, in client care, psychiatric care and alcohol and drug services.
- Between 2000 and 2009, 180 domestic homicides were perpetrated in Western Australia (an average of 18 per year)<sup>2</sup>.
- There is no doubt that FDV contributes to adverse mental health conditions, both for the person subjected to the violence and those who might witness it, such as children. They can similarly experience emotional problems such as feelings of helplessness and fear. It can also emanate in behavioural problems such as being in a constant 'state of alert' or difficulties in dealing with stressors later in life<sup>3</sup>.
- Nationally one in five women experience sexual violence during their lifetime. Most incidents occur in the home and by a person known to them<sup>4</sup>.
- The majority of violence inflicted on men is by other men, whereas the majority of violence inflicted on women is by a known male. The majority of violence inflicted on men (and boys) in a family context is by other males<sup>5</sup>.
- There is evidence that women who are sexually abused by a partner experience greater mental health consequences as opposed to women who are only physically

<sup>1</sup> Australian Bureau of Statistics 2006, Personal Safety Survey 2005 (Reissue) 4906.0, Canberra: Australian Bureau of Statistics

<sup>2</sup> Department for Child Protection (2011). The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework, Perth Western Australia: Western Australian Government. Available at: <http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/CRARMF.pdf>

<sup>3</sup> Laing L. Children, Young People and Domestic Violence: Issue Paper 2. Australia: Australian Domestic and Family Violence Clearinghouse; 2000.

<sup>4</sup> Australian Bureau of Statistics. Personal Safety, Australia. 2006 4906.0.

<sup>5</sup> Flood, M. (2012). He Hits, She Hits: Assessing debates regarding men's and women's experiences of domestic violence. Seminar, Australian Domestic and Family Violence Clearinghouse, Sydney, December 6.

abused. Impacts includes lower self-esteem and body image; increased levels of depression and increased severity of post-traumatic stress<sup>6</sup>.

- The National Drug Strategy Household Survey 2007 found that six in ten Western Australian females aged 14 years and over reported being physically abused in their own homes (64 per cent) by someone under the influence of alcohol or drugs<sup>7</sup>.
- Pregnancy is a time of heightened risk of FDV and there is a strong correlation between substance abuse and domestic violence, particularly during this time. Evidence suggests that abuse of drugs is a factor for pregnant women exposed to violence. The subsequent health outcomes for babies can include low birth weights and foetal contusions<sup>8</sup>.
- In 2007, of 1000 lesbian and bisexual women surveyed, a third were found to have experienced physical violence in a relationship and almost half of respondents had experienced some form of emotional abuse<sup>9</sup>.
- There is strong co-occurrence between FDV and child abuse and neglect<sup>10</sup>. It is estimated that children living in domestic violence situations are up to 15 times more likely to be abused or neglected than children from non-violent homes.

## 2.2 Risk Indicators

There are many indicators of FDV. One indicator in isolation may not necessarily indicate abuse therefore each indicator needs to be considered in the context of the client's personal circumstances and presenting issues.

There is no absolute indicator to determine the risk of homicide, however, the greater the number of high risk indicators, the greater the risk that a homicide may occur.

See 'Key Risk Indicators' in **Guideline for Responding to Family and Domestic Violence**.

<sup>6</sup> Australian Domestic and Family Violence Clearinghouse. Global Up-rising. Newsletter 52 Autumn 2013. 2013: 14. Available at: [http://www.austdvclearinghouse.unsw.edu.au/documents/Newsletter\\_52.pdf](http://www.austdvclearinghouse.unsw.edu.au/documents/Newsletter_52.pdf)

<sup>7</sup> Griffiths P, Kalic R, McGregor C, Gunnell A. National Drug and Strategy Household Survey 2007: Western Australian Households, DAO Surveillance Report: Number 05. Perth: Drug and Alcohol Office; 2011.

<sup>8</sup> O'Reilly, R. Domestic Violence against women in their child bearing years: A review of literature. Contemporary nurse: a journal for the Australian nursing profession 2007;25(1-2):199-208.

<sup>9</sup> Hyde Z, Comfort J, Brown G McManus, A Howat P. The Health and Wellbeing of Lesbian and Bisexual Women in Western Australia. Perth: WA Centre for Health Promotion Research Curtin University of Technology; 2007.

<sup>10</sup> Australian Institute of Family Studies. Domestic Violence as a Form of Child Abuse: Identification and Prevention. Issues in Child Abuse Prevention Number 2 July 1994. Found at: <http://www.aifs.gov.au/nch/pubs/issues/issues2/issues2.html#issue>



If a client:

- has received life threatening injuries
- has injuries have increased in frequency and severity over time
- is pregnant or has recently given birth/has a partner who is pregnant/given birth
- has recently separated from or is considering separating from an abusive partner.

**Note:** Separation is a time of extreme danger. Separation includes the client leaving the relationship or the person responsible for the abuse being removed from the home against their will as a result of a violence restraining order or police charges.

The person responsible:

- has access to weapons, particularly firearms and other lethal weapons;
- has used a weapon in most recent event
- has previously tried to harm/kill the client
- has previously threatened to harm/kill the client
- has previously harmed or threatened to harm/kill children or other family members
- has harmed/killed pets or other animals
- has threatened to harm/kill pets
- has previously threatened or attempted suicide
- has sexually abused the client
- misuses drugs and/or alcohol
- has or is stalking the client
- uses obsessive/jealous/controlling behaviour towards client
- is unemployed
- has previously had Violence Restraining Orders taken out against them
- has previously or is in current breach of a violence restraining order
- has financial difficulties
- has depression or other mental health illness.

Note: The presence of a mental health illness needs to be carefully considered in relation to the co-occurrence of other risk factors. A client is at high risk if, for instance, the person responsible for the ongoing abuse has paranoia and identifies the client as hostile.


## 2.3 Client's Presentation and History

The client is:

- hesitant or evasive when describing injuries
- minimises injuries/pain
- distress is disproportionate to injuries, e.g. client shows extreme distress over minor injury
- explanation is inconsistent with injury, e.g., "I walked into a door"
- uncomfortable or anxious in the presence of their partner
- makes excuses for the person's violent behaviour
- withdraws from touch
- substantial delay before seeking medical treatment
- multiple presentations at health services for vague symptoms
- partner or family member presents with the client, insists on remaining with the client and speaks on the client's behalf
- record of or suspicion of previous abuse
- misusing drugs and/or alcohol including prescribed drugs
- not in secure housing
- experiencing financial problems.

Always consult with line manager/social work/FDV specialist agency and consider the safety of the client, their dependents and yourself as paramount.

Many people experiencing abuse often describe the person they fear as capable of being 'caring' but also capable of abuse and violence. Many display 'loving' behaviours toward their partners and want to continue the relationship, but want an end to the violence.



Typically the level of violence in FDV increases and becomes more damaging and severe over time and occurs more frequently. Early detection and intervention can lessen the risk of more severe harm or even homicide of the client and/or children.

## 2.4 Psychological and Emotional Indicators

Recurring abuse can lead to other illness and emotional problems that on the surface may not appear related to FDV. Indicators include:

- post-traumatic stress disorder involving increased psychological arousal
- intrusive thoughts and flashbacks
- sleeping difficulties and nightmares
- difficulty with concentrating
- hyper-arousal and hyper-vigilance
- disassociation
- repeated visits to a Health Service or general practitioner for stress-related symptoms
- emotional distress such as anxiety, indecisiveness, confusion, hostility, panic attacks
- depression
- self-harming behaviours
- suicidal thoughts and/or attempts
- unexplained somatic complaints
- drug and or alcohol misuse including dependence on tranquillisers and alcohol.

## 2.5 Physical Signs and Symptoms

Physical signs and symptoms are not in themselves evidence of FDV. However, the indicators may raise suspicion that it is present. Client presents with:

- injuries to the head, face, neck, chest, breast, abdomen or genitals;
- unexplained physical injuries
- patterns of repeated injury or neglect
- ruptured eardrums
- multiple and bilateral soft tissue injuries especially contusions and abrasions


- lacerations, bruises, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures
- bruises of various ages and multiple injuries such as bruises, burns and scars in different stages of healing
- signs of hair being pulled out
- signs of sexual violence
- lethargy
- a history of gynaecological problems, miscarriages, chronic pelvic pain
- illnesses including:
  - headaches, migraines, dizziness
  - insomnia
  - musculoskeletal complaints
  - chronic pain
  - malaise, fatigue
  - neck stiffness
  - numbness
  - chest pain, palpitations
  - gastrointestinal disorders
  - hyperventilation
- ongoing complaints of acute or chronic pain (eg. chronic pain syndrome), without evidence of tissue injury
- eating disorders.

## 2.6 Pregnancy

Women are at increased risk of FDV commencing or increasing during pregnancy. Women abused during pregnancy are at even greater risk of violence in the postpartum period.

Factors to consider include:

- minimal or late attendance for antenatal care
- unintended or unwanted pregnancy
- injuries or vaginal bleeding during pregnancy
- miscarriage or other pregnancy complication

- 
- low birth weight of infant
  - seeking a termination of the pregnancy.



## 3.0 Working with People who have Experienced Family and Domestic Violence

This section should be read in conjunction with the **specialist group** section.

Any intervention with Aboriginal clients needs to take into account and not diminish or threaten their cultural rights, expectations or practices. The causes of family violence in Aboriginal communities are complex and must be understood in the context of a long history of racism, dispossession, marginalisation, poverty and separation of children from their parents.

### 3.1 Identification

Clients may not readily talk about their experience of FDV, but may discuss it when asked simple, direct questions in a non-judgemental manner and in a confidential setting. It is important to gain a client's trust through patience and support and to be open and honest as to what can or cannot be done to assist them.


Where possible, clients suspected of experiencing FDV must be given frequent opportunity to discuss the abuse. For instance, pregnancy offers an ideal opportunity for women to be

#### **Legal information – Duty of care**

Health professionals have a duty to take reasonable care for the welfare of their clients. Generally, the duty of care will arise when a person presents to a health service for medical attention and that health service expressly or impliedly accepts responsibility for the treatment of that person.

The health professional also owes a duty to third parties where it is reasonably foreseeable that a person under their control may harm the third party.

A health professional may be liable for negligence where they fail to take the steps that a reasonable person would to prevent a reasonably foreseeable risk of harm to a person to whom they owe a duty of care. It is arguable that a health professional's duty extends to taking reasonable care by predicting whether a child client is at risk of harm from abuse if discharged into the custody of the parent/carers. The court will consider all the circumstances of the case when deciding whether a health professional has acted reasonably, including the nature and extent of the risk of harm and the resources available to deal with the risk. The health professional will only be liable for a breach of the duty of care where they have not acted reasonably, the breach has caused injury or loss to the person to whom the duty is owed and that injury or loss is not considered too remote.



screened at several intervals when they attend antenatal appointments.

### **Provide a Supportive Environment**

- Providing a supportive, safe and private environment is essential.
- Conduct the interview in a private room where possible.
- Do not talk to the client in the presence of the person suspected of the abuse.
- Interview the client alone, unless a specific request is made for another person, such as an advocate to be present.
- Be firm about excluding others whose presence could interfere with or influence the assessment. The presence of a third party can result in the client withholding information or being coerced to disclose information they would prefer not to reveal.
- Be aware that young children who are present during the interview may relay information back to the person responsible for the abuse.
- Provide same-sex staff where possible and when requested by the client.

### **Communicating with the Client**

Disclosing FDV is a big step and carries an element of risk for the person. They cannot be sure of how the disclosure will be received or what will be the consequences. Conveying a genuine attitude that is gentle, welcoming, caring, non-judgemental, non-blaming, respectful and reassuring will help the client develop a sense of trust in the health professional.

- Do not rush the client but allow them time to think about and respond to questions in their own time.
- Be sensitive to the emotional distress or fear the client might be experiencing.
- Listen to what the client is saying:
  - Acknowledge what they have told you, “That must have been frightening for you”.
  - “You are a strong person to have survived that ...”
- Affirm that the client has made an important step by talking about the abuse.
- Validate the client’s experience:
  - Reassure the client that their reaction to the abuse is normal (e.g. physical, emotional, behavioural reactions).

- Reinforce with the client that the violence is not their fault, that there is no excuse for violence and that the responsibility lies with the person abusing.
- Let them know that some FDV acts are a crime.
- Inform the client she/he has a right to feel safe and live free from abuse or violence.

### **Screening for Family and Domestic Violence**

Due to the high prevalence of FDV, screening of clients from vulnerable groups (see specialist group section) and for people showing signs and symptoms, is recommended but not always possible. It is preferable that health professionals ask a series of questions to identify whether FDV or child abuse and neglect are present. These questions should be asked of mature minors and young people (both male and female) as well as adults.

An explanatory statement can be made to set the context such as,

“I am concerned about you because of ... (list indicators that are present) and would like to ask you some questions about how things are at home. Is that OK with you?”

or

“People are routinely asked these questions when they come in to see me.”

or

“When I see injuries like this I wonder if someone could have hurt you.”

The following are useful screening questions:

- Are you afraid of someone close to you (e.g. friend, partner, family member)?
- Has someone close to you hit, slapped, punched, kicked or otherwise physically hurt you?
- Has someone close to you put you down, humiliated or embarrassed you?
- Has someone close to you tried to control what you can do or say?
- Has someone close to you threatened you?
- Have you been hurt or threatened by someone in your family or household?
- Have you been forced into any sexual activities you did not want to do?

- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who makes you feel unsafe now?
- Would you like help with any of this now?

Refer to Resources – Screening and Referral for Family and Domestic Violence template in **Guideline for Responding to Family and Domestic Violence.**

It is useful to determine when the last incident of violence or abuse occurred.

### Children

If FDV is disclosed, the person should always be asked about any children or other people in the home, who may also be at risk.

Questions to consider include:

- Are you worried about your children (or someone else in your family or household)?
- How is this affecting your children?
- Has ... threatened to hurt your child?
- Has ... hurt you in front of your child?
- Has ... (the child) overheard the yelling/violence?
- Has ... (the child) tried to protect you/tried to stop the violence?
- Has ... (the child) been injured by ... or injured while trying to protect you?
- Is ... (the child) afraid to leave you alone?

Many people choose to remain in an abusive situation in the belief that keeping the family together is in the best interests of the children. It is helpful for clients to be made aware of the impact of violence on children and to be encouraged to discuss this with a professional who works with children or to seek counselling for the children.

The following questions can guide a client towards a greater understanding of the impact:

- How do you think ... (child) would describe life at home?
- What changes do you think ... (child) would like to happen?

- What is the reaction of ... (child) when ... (the person responsible) has been violent to you?

All children exposed to violence in the home are considered to be at some degree of risk, whether it be direct (for example physical harm) or indirect (for example emotional distress or worry). Changes to legislation have specifically highlighted the need to protect children from exposure to FDV in the home.

Refer to Specialist Areas – Children and Young People section

Where there are concerns about the parent's ability to protect the child due to an intellectual disability, a mental health illness, any substance misuse or poor parenting ability, consideration will need to be given to referring the family to the Department for Child Protection and Family Support.

Refer to **Guideline for Responding to Family and Domestic Violence**– Safety Planning section


It is important for an assessment to be undertaken when concerns for the safety and wellbeing of children are identified, a person discloses FDV or there are sufficient indicators that FDV is present.

Where possible, this assessment should be undertaken by a staff member with FDV experience, such as a social worker.

Refer to Assessment section

## **Communicating with Children**

It is not always appropriate to speak with children when dealing with adults in a risk situation. There are specialist services to undertake this role and consideration should be given to how interviewing any child is to be undertaken.



Age appropriate questions can be asked of children. Similar to working with adults, a supportive style should be used with children. Children will also need reassurance that they are not responsible for the abuse occurring in the family.

Examples of questions can include:

- Tell me about the good things at home?
- Are there things at home you wish you could change?
- What don't you like about home?
- Who makes the rules at home?
- What happens when you break the rules?
- What happens when your parents are angry with you?
- What happens in your house when people have an argument?
- What do you do when mum and dad are fighting?
- Do you get frightened?
- Do you have someone you can talk to such as an older sister/brother?

#### **Legal information – client confidentiality and information sharing**

Health professionals who have concerns or information relevant to the wellbeing of a child may report their suspicions to DCPFS by contacting DCPFS's Crisis Care Unit or its local district office. A child need not be at imminent, likely and serious risk of harm or neglect before a report to DCPFS is justified. Any decision to provide information to DCPFS in relation to the wellbeing of a child should be well documented and include the reasoning that led to the decision to notify DCPFS.

Section 124B of the *Children and Community Services Act 2004*, provides that a person who is a doctor, nurse or midwife who believes on reasonable grounds that child sex abuse is occurring or has occurred must report that belief to the CEO of DCPFS or their delegated authority.

For more information on responding to disclosures of abuse by children, refer to the WA Health Guidelines for Child Protection 2009.

## Consultation with Health Professional Colleagues

Health professionals must consult with a line manager/social worker/FDV specialist agency about the outcome of an assessment. This support should be sought by telephone if necessary.

Issues to be discussed include:

- The specific safety and risk indicators identified and how these should be addressed within the health service?
- What has been discussed with the client?
- Whether a referral should be made to an external agency?
- What external agency is the most appropriate one to use?
- Whether a referral should be made to the police or the police consulted?
- Whether a referral should be made to DCPFS or whether they should be consulted?
- Consult with an Aboriginal Liaison Officer/staff member if the client is Aboriginal.
- Consult with a cultural consultant if the client has a CaLD background.

## Consultation with Other Agencies

When health professionals are unable to consult with line manager/social work/FDV specialist agency, and where there is no available health service social work department to consult with, it may appropriate to consult and seek guidance from Crisis Care.

The WA Police and DCPFS work collaboratively towards managing FDV in the community, and in some regions a specialist FDV agency may be co-located with the Police.

The WA Police Service can be consulted where FDV is identified or suspected. After hours, Crisis Care provides practice support and guidance to health professionals.

Refer to Section – Integrated Service Delivery

## 3.2 Assessment

It is important that an assessment of clients who have disclosed or who are suspected of or have been identified as experiencing FDV be undertaken, in order to determine their immediate safety needs and the most appropriate referral options for them.

Where a health service has a social work department this support should be enlisted.

It is essential that health professionals use their professional judgement to conduct the assessment. This means using a combination of clinical judgement, consideration of risk indicators identified and seeking information and feedback from clients.

The key risk indicators are included as an attachment to the **Guideline for Responding to Family and Domestic Violence**.

Assessment outcome recording document can be used as a resource during interview with the client to ensure an adequate assessment of the risk is completed.

Health professionals are not required to undertake an investigation into the suspected violence or abuse. This is the responsibility of the WA Police Service or the DCPFS (where children are involved).

Where it is believed that the person responsible poses an imminent risk to client and staff, safety arrangements in keeping with the health service's policy need to be actioned. This may involve knowing the current whereabouts of the person responsible and undertaking the assessment in a safe place away from that person, or arranging for security staff to be close by.


### **A General Guide to Assessment**

Assessment is a process that involves the health professional and the client working together to ascertain the level of immediate risk to the client and that of their children and other dependant people in the household, after the client leaves the health service. It is also important for the health professional to take into consideration each person's individual characteristics or indicators from which the likelihood and severity of further violence can be determined.

Prior to commencing the assessment, ensure that the client:

- has had their immediate medical needs addressed




- 
- feels and is psychologically safe enough to talk about the violence
  - has had urgent issues addressed, such as childcare arrangements
  - is able to communicate effectively so they will be understood, for instance an Auslan interpreter (Operation Directive 0346/11 Language Services Policy) may be required for someone who has a hearing disability
  - is engaged in a culturally sensitive manner
  - understands the role of the health professional undertaking the assessment
  - feels comfortable with the health professional.

The assessment should address the following:

- details of the most recent incident of violence or abuse
- a history of the violence or abuse
- identifying the presence of high risk indicators such as the person responsible having access to firearms or other weapons
- gathering information on any possible crime that may have been committed, for instance, a sexual assault, in which case involving the police should be discussed
- identifying whether the client is at immediate risk of suicide or serious self-harm
- identifying what action is required to address immediate safety, such as arranging safe accommodation or involving the police
- identifying existing protective factors, for example client has a current violence restraining order or a supportive social network
- identifying what services are currently involved with the family, such as a social worker from an external agency
- identifying whether there are children or other family members who are at risk.

It is important to encourage the client to tell her/his story and define the problem. Questions to open the discussion can include:

- Can you tell me what has been happening for you at home?
- Can you tell me about your relationship with ... (person responsible).



Once the client has provided some level of detail about their circumstances, questions can be more specific:

- Can you tell me what ... did to hurt you?
- How long has this ... (behaviour) been happening?

Refer to Indicators of Family and Domestic Violence section and use the indicators as a guide for asking appropriate questions or for identifying risk factors which will assist in collecting all the information required for this assessment.

**Note:** A client's own assessment of their level of fear or risk is usually accurate. However in some cases people cannot accurately describe their level of fear or assess their level of safety because they have been desensitised to the violence as a result of their history. Caution must therefore be taken when interpreting their response.

A useful way to assess the level of risk to a client or their level of fear is by using 'scaling' questions. For example, "On a scale of 1 to 10 with 1 being safe and 10 being very unsafe, where would you put yourself?"

## Physical Examination

Where necessary, arrange for the client to have a complete physical examination including a neurological examination. If appropriate, x-rays should be taken to determine whether old and new fractures are present.

## Mental Health Assessment

Where a client has a diagnosed mental health illness or is suspected of being mentally unwell, it is important to determine if they are currently or have previously been on medication or have been hospitalised. This information will inform any planning.

Where the client has a history of suicide attempts, has stated a wish to die, is self-harming or is depressed, the following questions can be asked to assess current state of mind:

- You sound really depressed. Have you ever thought about killing or hurting yourself?

- Have you hurt yourself before?
- What would you do to hurt yourself now?
- Have you a plan?

If a client is threatening suicide or is assessed to be at immediate risk of suicide or serious self-harm, an urgent referral for a psychiatric assessment is necessary.

### **Acting on Your Assessment**

Consideration of all identified risk indicators will help you determine if the client requires immediate assistance, or whether they require information and support.


Where the need for immediate action is identified, the health professional should work in consultation with the client to plan immediate interventions and referrals. Consultation must be undertaken with line manager/social work/FDV specialist agency or Crisis Care after hours.

Client consent will not always be a factor in determining the actions undertaken by the health professional. For instance, if the person responsible has threatened or attempted to injure or kill the client and/or their children, an immediate referral to the police must be discussed. Similarly, where immediate risk to children is identified, a referral must be made to the DCPFS.

Refuge or emergency accommodation can be considered if the client needs to leave their home for safety reasons. Crisis Care maintains a register of refuges with vacancies that is updated twice a day. Refuge staff will want to speak directly to the client before agreeing to provide accommodation.

**Note:** While it is preferable that referrals are made with the client's consent this is overridden by the health professional's duty of care to ensure the immediate safety of the client and others.

When FDV is identified and the client is choosing to return home, the client should be provided with information and support. A referral to the Social Work Department or to a specialist FDV service is indicated. Provide information on services available in your local area that specialise in counselling and support for clients of FDV. In some situations, providing a pamphlet or sheet of paper may cause concern for the client. Be prepared to offer



the information in alternative formats, such as wallet sized cards with a phone number only or by saving the number directly into their phone.

It may be appropriate to schedule a follow-up appointment for the client with services available. Ensure that the client is aware of any appointments made and has transport and ability to attend.

A safety plan can be developed with the client prior to them leaving the health service. (Refer to Safety Planning below) and in **Guideline for Responding to Family and Domestic Violence**.

Where a client does not disclose FDV although it is suspected, provide verbal and written information about appropriate support agencies, discuss a safety plan with them and offer the option of returning for another appointment. Ensure that their non-disclosure is documented clearly in the written record, along with the plans for follow up that were initiated.

**Note:** It is important to document the process taken and the outcome of the assessment on the client's records. If an FDV Assessment Outcome Record form is used this is to be included on the client's records.

Refer to **Guideline for Responding to Family and Domestic Violence** – Resource section for an example of an FDV Assessment Outcome Recording Template.

## Safety Planning

Safety planning occurs in discussion with the client. Areas to cover include:

- Safe accommodation. Identify options with the client, for example a trusted friend or family member or a refuge. Contact Crisis Care for information about refuge availability on 9323 1111 or free call 1800 199 008. In the absence of these options, consider an overnight social admission to hospital.
- Referral to a FDV service. Support on an emotional and practical level can be provided by specialist domestic violence services for men and women (usually community based and varies in each region), women's refuges, women's health centres, the

social work department of a hospital and counselling services. Check the Department for Child Protection and Family Support website for FDV services in the region.

- Providing written information and pamphlets on FDV services available in the region.

Many people choose to return to an abusive home environment. There are many reasons for this including fear of the person responsible who may have threatened to kill the client/ children if they leave, or fear that they will not be able to manage on their own. This is particularly true for people who may have limited access to financial resources, accommodation and support. This decision must be respected, however, safety planning should always be discussed to promote some level of safety and if any children are involved, then refer to **Guidelines for Protecting Children 2009**.

Refer to Resource section for pro-forma Safety Plans on:

- Increasing Safety in the Relationship
- Preparing to Leave the Relationship
- Living Safely after Separation

These can be developed with the client and taken away with them where it is considered safe to do so.

### **Self-Care**


Responding to FDV and child abuse and neglect can be overwhelming and stressful. It is recommended that health professionals debrief with their direct line manager or supervisor, a colleague or Employee Assistance Provider if they feel distressed after working with a client.

Health professionals may also be experiencing FDV in their own lives. Managers must be aware that this may be the case and act on it appropriately.

### **Safety of Health Professionals**

Any threats or violence towards health professionals must be reported to management and documented. A 'risk management strategy' should be developed within the health service to deal with individual situations.

All staff should be familiar with the WA Health 'Zero Tolerance'\* response to aggression and violence in the workplace. The zero tolerance response means that in all violent incidents,



appropriate action will be taken to protect staff, clients and visitors from the effects of such behaviour. In order to create and nurture a culture of zero tolerance, the active elimination of internal violence and aggression needs to be communicated and regularly reinforced to managers, staff, clients and visitors.

The 'Prevention of Workplace Aggression and Violence Policy and Guidelines' (2004) are available on line for staff to review.

**\*Operational Directive 1786/04 – Prevention of Workplace Violence and Aggression.**  
[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=11807](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=11807)

## Supervision

Supervision enhances good practice and provides an opportunity for extending and challenging the health professional's understanding and approach. Supervision is usually undertaken with a senior staff member and should incorporate the following:

- Overview of the case and the development of case plans.
- Overview of perceived level of risk to the client and children.
- Protective measures and practices that maximise the safety of clients, their children and workers.
- Overview of the role of external agencies that the health service's policies and procedures are understood and being followed to alert management to contentious and at risk cases/situations.
- to access debriefing for critical or traumatic incidents to be referred to an employee assistance program if requested or identified as appropriate.
- An opportunity for health professionals to ensure their own professional wellbeing recognising the complex and conflictual environment many people can be working within.

## 3.3 Referral

### Making a Referral

Referral plans can be initiated at any time. If the client is in a hospital setting, then referrals need to be completed prior to discharge.

- Outline the client's options to them and provide them with verbal and written information on appropriate referral agencies.
- Encourage and support the client's decision-making about the services available to them and support the client to self-refer. This should be done prior to them leaving the health service.
- If the client is not willing or not able to self-refer, obtain the client's consent and refer on their behalf.
- Provide information to the referral agency on the client, their history of FDV and significant issues, for instance that a Violence Restraining Order is in effect.
- Provide information on other services involved with the family.
- Provide information on safety of the client from self or others.
- Alert referral agency to any likely risk to staff by person responsible or others.
- Provide information on services provided to the client and/or family by the health service.

See **Guideline for Responding to Family and Domestic Violence** – Agency Referral Form template.

In accordance with interagency processes\*, information that can be exchanged or provided to other agencies can include:

- Basic demographic information.
- Information and circumstances that have led to an assessment of high risk of harm.
- Known details of family circumstances including history of violence.
- Health issues that may be contributing to the risk of harm, such as mental health, substance misuse or other medical issues.
- Criminal histories, details of violence or any existing restraining orders that are in place.
- Other information that might contribute to reducing the risk of harm to clients.

**\*Operational Directive 0286/10** – Memorandum of Understanding – Information Sharing between agencies with responsibility for preventing and responding to family and domestic violence in Western Australia.

### **WA Police Service**

The police can be consulted where FDV is identified or suspected.

Contact the police on 131 444, or the local police station during office hours. Each of the fourteen police districts has a dedicated Child Protection and Family Violence Officer. These officers can be contacted through the local police district office or through the State Co-ordinator for Family Protection on 9492 5485 (office hours). For urgent assistance ring 000. (Note that 000 cannot be called from mobile telephones).

### **Department for Child Protection and Family Support (DCPFS)**

See WA Health **Child Abuse Guidelines 2009**.

The DCPFS can assist with:

- Accommodation – referring clients to refuges or other appropriate accommodation.
- Transport – to enable the client to travel safely to a refuge or safe-house.
- Material assistance – this may include loans for furniture removal, food vouchers.
- Telephone connection.
- Information on how to access other types of assistance including legal advice.
- Counselling and support services, police assistance and income support.

After hours contact Crisis Care on 9223 1111 or Free call 1800 199 008. Crisis Care can also be consulted when FDV and child protection matters are identified or suspected.



## **Sexual Assault Resource Centre**

The Sexual Assault Resource Centre (SARC) is available for state-wide consultation on sexual violence. SARC provides a free 24 hour metropolitan based crisis medical, forensic and counselling service to females and males aged 13 years and over, who have been sexually assaulted within the previous 14 days.

Calls are taken by the SARC Duty Counsellor. Health professionals will be asked for details of the client and the incident and transferred to the SARC Duty Doctor. The SARC Duty Counsellor will also ask to speak with the client to give them information about SARC and obtain their consent for SARC services.

Clients initiating the call will be assessed by the SARC Duty Counsellor to determine whether they can safely be seen at SARC or need to go to a hospital emergency department.

Clients who are pregnant, have a serious medical condition, are psychotic, are seriously affected by drugs and/or alcohol or suffered injury and require medical attention cannot be safely managed at SARC. A forensic examination cannot be undertaken until medical issues have been addressed or the client is fully cognisant and able to consent.

When a client is referred to an emergency department, the SARC Duty Doctor will be contacted after the client has been medically assessed. The SARC Duty Doctor and Counsellor will see the client at the hospital if necessary.

A SARC Doctor is available 24 hours a day to provide guidance to rural health professionals on forensic examinations.

SARC can be contacted on 9340 1828 or Free call 1800 188 999.

## **Regional Sexual Assault Resource Centres**

There are five regional sexual assault resource centres throughout the state. They are located in Port Hedland, Kalgoorlie, Bunbury, Mandurah and Geraldton. They provide varying levels of support and should be contacted for immediate assistance and/or longer term management.

The contact details are as follows:

Acacia (Port Hedland)	-	9172 5022
Goldfields SARC (Kalgoorlie)	-	9021 4732
Chrysalis (Geraldton)	-	9938 0750



Waratah (Bunbury)	-	97912884
Allambee (Mandurah)	-	9535 8263

### **Mental Health Services**

Access to Mental Health Services differs from service to service. Always follow the recognised referral pathway within your organisation.

Emergency department services may have an onsite Psychiatric Liaison Nurse or Psychiatrist, however other areas may need to refer to Community Based Mental Health Services. After hours assessment and specialist intervention is available from the Mental Health Emergency Response Line (local call 1300 555 788 or free call 1800 676 822 from the Peel district).

When a client is identified as high risk of suicide or serious self-harm within a rural region, WACHS staff must:

- Alert medical staff immediately, for prompt assessment for consideration of referral under the Mental Health Act.
- Alert community mental health team/Rural Link (Free call 1800 552 002 – TTY 1800 720 101) as appropriate to day, time and site.
- Provide safe environment for client or others.

### **Domestic Violence Legal Unit (Legal Aid Western Australia)**

The Domestic Violence Legal Unit provides legal advice to women. They will also:

- Liaise with the police to ensure that appropriate criminal charges are laid against the person responsible.
- Advise and assist in obtaining restraining orders against the person responsible.
- Provide initial counselling on legal rights and options
- Represent women in court for Restraining Order hearings where legal aid has been granted.
- Provide initial advice and referral to clients trying to escape FDV. This includes family and property law matters and criminal injury compensation.

- Provide information and referral on non-legal matters such as emergency and safe housing, Centrelink benefits, counselling and medical matters.

A Duty Lawyer is available at Central Law Courts between 9.00am and 11.00am daily. The Unit can be contacted on 9261 6254 during business hours.

## 3.4 Documentation

### Client Records

All client records and case notes must be clear, accurate, concise and objective.

The following information is to be relayed to clients in relation to their records:

- All contacts the client has with a health service are documented.
- Records are confidential and kept in a secure place.
- Confidentiality can be overridden where the record is subpoenaed to court.
- Clients have a right to access their personal health records under the Freedom of Information Act 1992.

#### **Legal information – client confidentiality, information sharing and exceptions**


Health professionals are under a duty of confidence in relation to all information that comes to them in the course of their health care relationship with clients. This duty of confidence applies to all persons who come into contact with information as part of the health care process, including administrative staff.

The duty of confidence can arise by statute, under the common law and in equity.

The unauthorised disclosure of confidential information by a health professional to third parties (including the police and the Department for Child Protection and Family Support (DCPFS)) will generally involve a breach of the duty of confidence.

A breach of the duty of confidence may lead to a civil action for damages against the individual who made the unauthorised disclosure and their employer. It may also be a matter for disciplinary proceedings by the employer of the individual who made the unauthorised disclosure and review by the relevant professional registration body, such as the Nurses Board.

There are a number of exceptions to the duty of confidence where otherwise confidential information may be disclosed to third parties. Check the Legal Information section to review the exceptions.



Standardised screening and reporting documents are attached to the **Guideline for Responding to Family and Domestic Violence** and represent the minimum standard in recording identified FDV events. Copies of all screening tools, risk assessment reports and agency to agency referral forms should be retained on the clients file.

Minimum standards for recording in a health record include:

- the date and time of contact with the client
- the date and time the entry was made on the file
- the name, signature and designation of the health professional
- the history provided by the client and relevant to the service they are receiving
- the outcome of consultation with staff members or external agencies
- intervention plans discussed with the client.

Completion of an Assessment Outcome Recording template included in the **Guideline for Responding to Family and Domestic Violence** will meet these minimum requirements and provide a sound basis for referral to other agencies.

Client records should be:

- Factual – accurate and objective recording of issues, information, action and observations. This includes the use of body maps. Note that opinions or judgements of clients, their actions or the truth of their statements should not be recorded either in words or by using exclamation marks. Be aware that records can be subpoenaed to court.
- Where professional opinion is recorded, this should be limited to the health professional's area of expertise.

## Documentation of Physical Examination

Record a description or make a detailed drawing of physical injury using a Body Map. Body Map templates are included in the **Guideline for Responding to Family and Domestic Violence**.

Depending on the profession of the staff person conducting the assessment, it may be necessary to request a medical staff member complete a body map for the record.

## Medical Photography

As the person taking photographs is required to swear in court that they took the photographs, it is appropriate that that person also complete the body map diagrams.

Photographs are highly recommended. Non-digital 35 mm cameras are preferred as digital images can be altered.

- Commence roll of photographs by photographing an identity plate which shows the name of the health professional, the name of person taking the forensic photographs if this differs, name of the client, date and time.
- Do not use a distracting background. Use a plain coloured sheet under the part of the body to be photographed.
- Take an overview shot of the injured limb or part of the body to identify the part of the body where the injury is located.
- Take 2 close up photographs of each injury at right angles to the injury.
- Take one photograph with a scale or ruler next to the injury.
- Take one photograph without the scale or ruler (to show the scale or ruler is not obscuring an underlying injury).
- Sign and record staff position, place of work and date and time the photograph was taken on each photograph.

**Note:** Medical photography is to be accompanied by a written description of the injury and body maps.

**Note:** The police are able to take forensic photographs if a camera is not available in the health service.

## 3.5 Longer Term Management

No agency alone can expect to provide the required diversity of support services a client experiencing FDV, or the person responsible, may need. FDV intervention is increasingly undertaken collaboratively within a multidisciplinary and an interagency framework. Participating agencies can include the WA Police, DCPFS, Department for Corrective Services, as well as non-government, community based organisations, such as refuges and FDV advice and referral services.

### **Case Management**

Clients who have experienced FDV and who have ongoing or regular contact with a health service may benefit from a case management model.

Case management can be facilitated by:

- A meeting of the health professionals involved with the client.
- Deciding on the health professional that will have case management responsibility within the health service.
- Identifying the specific role each person has with the client and/or family.
- Organising regular, scheduled, minuted meetings to discuss and record action plans.

Content of meetings can include:

- An update by each health professional on the outcome of previous action plans and the progress of the client.
- Referral to and involvement of other support agencies. This can include inviting external agency representatives to participate in meetings.
- Implementation of action plans and assessments.

Role of the Case Manager

- To coordinate and chair case discussions.
- Liaise with the client and/or family about the outcome of meetings.
- Work with client on an ongoing safety plan.
- Link any children into counselling services.

- Liaise with agencies involved with the client, the person responsible and/or family and feedback information to case management meetings.
- Consider strategies to prevent access to client by person responsible during any admission.
- Ongoing consultation with line manager/social work/FDV specialist agency.

When working with a client family over a long term period, it is important to repeat the referral phase if, at any point during intervention, concerns for the immediate safety of the client and/or children emerge, as a result of identification of high risk indicators or an escalation of concerns for the client and/or children's wellbeing.

### **Multi-Agency Coordinated Care Model**

In some regional areas, an interagency FDV service may utilise a co-located, model to facilitate information sharing across all government departments. This can entail a non-government FDV Specialist Agency and/or a team or representative from the DCPFS, working from the Police Service to collaboratively address FDV in the community. This approach ensures that appropriate information is shared between all agencies and standardises risk assessment processes.

Check with local agencies/line manager/social work to determine if a multi-agency model exists in your area and how contact can be made.

Where other agencies are involved in providing support to a family system experiencing FDV, the role for the health professional is to:

- Liaise with external agencies working with the client and/or family.
- Attend and participate in multi-agency meetings, as required in your region.
- Monitor and support client and/or family.

In addition, health professionals may be requested at times to provide office space or to facilitate contact between at-risk clients and external agencies.

## 4.0 Working with Person Responsible

### 4.1 Identification

There are a number of theories and commonly held beliefs as to why people perpetrate FDV. These include that it is learned behaviour and a person growing up in an abusive environment learns that violence is a legitimate way to resolve problems, or that violence within the family is a response to traditional beliefs about a role within a family and the community.

In Aboriginal communities oppression, dispossession, loss of identity, culture and continued racism are believed to be factors contributing to a sense of powerlessness which can lead to violence.

### 4.2 Communicating with the Person Responsible

There are times when a client themselves presenting to a health service is identified as the person responsible for the violence and abuse. Providing immediate medical attention to this person is fundamental. During the course of attending to medical needs, it may become important to address the issue of FDV.

It is appropriate to offer support when a person has identified their violence as a problem.

When meeting with people who are believed to be perpetrators of FDV, it is important to be aware that personal safety is the priority. Notify a line manager/social work and security staff or colleagues prior to commencing any meeting to discuss the violence for which they are responsible.

People can be polite and friendly or intimidating, threatening and violent towards the health professional.

Intervention with the person responsible is an area of expert practice and it is preferable this be undertaken by workers experienced in this area. However, in situations where the violence is discussed, consider the following:

- The abused client should not be present.
- Written information about the abused client should be stored safely where it cannot be accessed by the person responsible.
- Use a direct and calm approach.
- Frame the discussion about the FDV as a health care issue, for example, “There appears to be a lot happening in your life right now which can be stressful”.



- Advise the person that certain acts of FDV are a crime. This is particularly important for people from a CaLD background who may not be aware of the law in Western Australia.

Should the client display anger or resist or reject the discussion, bring the subject to a close and move back to the presenting issue. For example, “Your use of force against your partner and/or child is of concern and I will gladly assist with a referral or information whenever you want it.”

#### **Legal information – Disclosure by Operation of the Law – Firearms or Ammunition**

It is permissible under s23B of the *Firearms Act 1973* for a ‘health professional’ (defined to mean ‘medical practitioner’, ‘psychologist’, ‘registered nurse’, ‘prescribed class of social worker’ or ‘prescribed class of professional counsellor’) to inform the Commissioner of Police of their opinion that:


- because of the client’s physical, mental or emotional condition, it is not in the person’s interest or not in the public interest that the person possess any firearm or ammunition to which the client is believed to have access; or
- a person is seeking or has sought medical assistance for an injury in the infliction of which a firearm or ammunition is believed to have been involved.

### 4.3 Referral

Advise the client there are services which can assist when they are ready. Provide written information about support services in the region or of appropriate websites.

Support and information for people who are responsible for perpetrating FDV is provided by:

- Department of Child Protection and Family Support  
<http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/FamilyandDomesticViolence.aspx>
- Men’s Domestic Violence Helpline on 9223 1199 or Free call 1800 000 599 OR  
Women’s Domestic Violence Helpline on 9223 1188;  
<http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/SeekHelp.aspx>
- WA Police Service
- Breathing Space 9439 5707;  
<http://www.communicare.org.au/Therapeutic-Services/dv-outreach.html>



Counselling is provided by:

- Centrecare on 9325 6644
- Relationships Australia (Western Australia) Inc on 1300 364 277
- Anglicare 9263 2087 or Free call 1800 812 511.

## 4.4 Documentation

### Client Records

The same principles of documentation apply to working with clients who are believed responsible for FDV.

Client records and case notes must be clear, accurate, concise and objective.

The following information is to be relayed to clients in relation to their records:


- All contacts the client has with a health service are documented.
- Records are confidential and kept in a secure place.
- Confidentiality is subject to constraint and is overridden where the record is later subpoenaed for court.
- Clients have a right to access their personal health records under the *Freedom of Information Act 1992*.

Minimum standards for recording in a health record include the:

- date and time of contact with the client
- date and time the entry was made on the file
- name, signature and designation of the health professional
- history provided by the client and relevant to the service they are receiving
- outcome of consultation with staff members or external agencies
- intervention plans discussed with the client.

Client records should be:

- Factual – accurate and objective recording of issues, information, action and observations. This includes the use of body maps. Note that opinions or judgements of



clients, their actions or the truth of their statements should not be recorded either in words or by using exclamation marks. Be aware that records can be subpoenaed to court.

- Where professional opinion is recorded, this should be limited to the health professional's area of expertise.

## 5.0 Specialist Areas

### 5.1 Aboriginal People and Families

#### Practice Points

Aboriginal communities, while sharing much in common, are not a homogenous group. Aboriginal communities in Western Australia comprise distinct groups with rich and diverse cultural practices and the impact of FDV is different in each region.

Any intervention with Aboriginal clients needs to take into account and not diminish or threaten their cultural rights, expectations or practices. The causes of family violence in Aboriginal communities are complex and must be understood in the context of a long history of racism, dispossession, marginalisation, poverty and separation of children from their parents.

Aboriginal people take longer to trust people and can quickly identify if there is no care or commitment. They are also more attuned to body language. Ideally and in order to achieve the best outcome, a long term involvement with the client and/or family is recommended.

How families work must be viewed in the context of extreme diversity in terms of geographic location and family functioning. Many families live in rural and remote areas and can be mobile with children having moved more on average than children in the mainstream community.

Aboriginal families view their family structures and relationships differently to the mainstream community. For example, each child can have several 'grandmothers' and each female in an extended family can be a 'grandmother' to many children.

Key points to remember when working with \*Aboriginal people:


- Whole-of-life view of health – social, emotional and cultural wellbeing of not just the individual but the whole community and includes the cyclical nature of life-death-life.
- Self-determination – ownership solutions will ensure effectiveness.
- Working in partnership – building capacity to recover, re-empower and rebuild family and cultural relationships.
- Recognition of trauma and loss – acknowledgement of historical losses and grief.
- FDV is not part of traditional Aboriginal cultural practice.

\*NSW Department of Health (2011) NSW Health Aboriginal Family Health Strategy, Centre for Aboriginal Health, Sydney.

Australian Family Relationships Clearinghouse. Strengthening Aboriginal family functioning: What works and why?. Number 7, 2008.

What to consider:

- The safety and security of the client must be the priority.
- What are the safety sources in the community?
- There may be a preference for group or family approaches rather than individual 'counselling'.
- Is the language of the risk assessment appropriate for the client? Consider the use of an interpreter.
- Consult with Aboriginal staff where available and wherever possible, offer the choice of an Aboriginal health professional.
- Provide same-sex staff to assess and treat the client.
- Always look at the 'big picture' when working with Aboriginal clients. Be aware that FDV may not be the client's primary problem, but part of an underlying bigger problem.
- Consider historical impacts on Aboriginal society. Identify and take into account other forms of abuse which have previously been experienced by the client/family/ community.
- Be aware that Aboriginal clients may feel 'shame' about the violence.
- Be aware that Aboriginal clients may feel 'shame' and have difficulty talking about sexual interaction or sexuality as these are taboo subjects, particularly when liaising with someone of the opposite sex . They may not disclose physical injury to the private parts of their bodies.
- Clients will fully disengage if the subject is raised too early. The health professional may never actually reach a stage where the client is willing to talk on these matters.
- Identify the client's community and assess if it is safe for the client or their family to return to their community.
- Using legal services is especially problematic for Aboriginal people, not only because they fear reprisal but because they often do not understand their legal rights or the legal system. Aboriginal people may question the effectiveness of the police and the



mainstream legal system to protect victims or respond to domestic violence. How effective are mainstream interventions likely to be such as restraining orders?

### **Risk Issues to Consider**

- Aboriginal people can experience difficulty leaving their community because of isolation, lack of transport, lack of safe spaces within the community to move to and a reluctance to leave or their dependence on the community/family ties.
- Be aware that for some Aboriginal people, English maybe their second, third or fourth language.
- Aboriginal women may leave a health service before they are medically well, because of fear of reprisal or because of concern for their children. A historical lack of trust in 'the welfare' and the fear of having children removed is a key constraint for many Aboriginal women reporting FDV.
- Leaving a violent relationship or going to the police may result in reprisal for the Aboriginal woman by extended family members. Is the client at risk of family retribution or ostracism from the community if legal intervention is initiated?

### **Support Agencies**

It is critical that approaches to services are flexible and adaptable to understand and meet the needs of the community and individual.

Aboriginal people should be offered a range of services and any choices made need to be respected.

## 5.2 Regional, Rural and Remote Areas

### Practice Points

There are a wide variety of people living in rural and remote areas of Western Australia. In addition to the diversity of the population, there are unique factors that people face such as geographical isolation, a lack of privacy in the community and limited service availability. They can also hold different value systems to those in metropolitan areas and there may be a culture of silence.

Professional roles can be complicated by the social or interpersonal relationship the health professional may have with a person who presents as either a client at risk or the person responsible for FDV. A client can feel embarrassed or humiliated.

Only limited services are available in rural and remote areas compared with the metropolitan region. Limited services coupled with the complications of working in small country regions and relationships, further limits choice and access to appropriate help.

Economic isolation is a common feature which can result from conservative values, traditional gender roles or lack of financial independence. There can be certain beliefs about rural 'masculinity' which encourages repressed emotions. Coupled with limited health facilities, rural men may require different assistance to men from urban areas to understand the use of violence against partners and families.

Poor roads, limited access to private vehicles and often non-existent public transport can complicate the means of escape from a violent relationship and lead to a greater sense of powerlessness for the client.


Inadequate access to telecommunications increases vulnerability.

Legal responses are not as accessible or as useful. For instance, in some areas there may not be a police presence or courts sit on a monthly basis, hence making it difficult to obtain an urgent violence restraining order.

Aboriginal and CaLD people can experience additional isolation as a result of language, cultural difference and access to interpreters.

There are several areas of high resource activity in Western Australia. Whilst research on FDV in mining communities is limited, a 2009 study in Queensland suggests higher rates of emotional/psychological abuse that anecdotally link to a culture of male dominance in mining areas and high prevalence in alcohol misuse.

Accommodation in many of these areas is often connected to the primary wage earners employment. Alternative accommodation can be difficult to source for a variety of reasons –



lack of refuge accommodation, financial resources of client at risk, which is most often a woman.

### **Risk Issues to Consider**

- Perceived difficulties maintaining confidentiality and safety.
- Be aware that guns are usually more accessible. Contact the police if a person responsible has ready access to a gun.
- Careful safety planning may need to involve the police.
- High levels of alcohol and/or drug use are common amongst some rural and remote areas and can increase the level of violence used and the level of retaliatory violence in defence or protection, especially if children are involved.
- A person's sense of isolation can increase risk of self-harming behaviours.
- Limited police presence, the need to wait for backup and long delays in travelling to remote areas puts clients further at risk.

**Note:** Health professionals may need support to deal with safety and personal issues arising from managing an FDV case. It is important to have a personal safety plan in place and to build on personal support networks, for example with other professionals in the area.

### **Support Agencies**

Refer to [www.womenscouncil.com.au](http://www.womenscouncil.com.au) for information on rural and remote refuges or [www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/FamilyandDomesticViolence.aspx](http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/FamilyandDomesticViolence.aspx) for information on services in the health service area.



## 5.3 Children and Young People

### Practice Points

Refer to the WA Health **Guidelines for Protecting Children 2009**.

Depending on the level of assessed risk to the child in either witnessing FDV, physical risk or involvement in the FDV, or neglect, the Department for Child Protection and Family Support should be contacted.

Children, especially very young children living with FDV, can experience life-long psychological and emotional damage, physical and psychosomatic disorders, behavioural problems and post-traumatic stress disorder. They can have poor educational achievements and experience difficulties with relationships in later life.

There is evidence that exposure to violence is just as damaging to children or a young person as being the direct target of abuse.

Evidence also suggests that enduring stress in the early years may have adverse effects on brain development and organisation.

A carers own victimisation impacts on their ability to be emotionally available to their children which can adversely affect the child's ability to achieve secure attachment.

Children may experience:

- high levels of anxiety and fear about their own and/or other's safety
- feelings of shame, guilt, self-blame, anger about what is happening in the family
- feelings and behaviours of withdrawal and hostility towards parents or others for the ongoing violence
- a sense of loss and grief in losing the family or their parent at separation
- learning difficulties, high levels of compliance, verbal and physical aggression due to hopelessness and despair that the violence or abuse will not end
- impaired neurological development
- increased vulnerability to substance misuse, crime and poor parenting practice in later life.



Refer to Communications section for interview questions with children.

Where appropriate and dependent upon the age of the children they should be told what is happening and be involved in decision-making that affects them.


Young people both male and female can experience dating violence. However, they are often not aware that this behaviour is unacceptable and that some behaviours are a crime. As with FDV, teen dating violence crosses all social and economic classes, races, cultures, genders, and sexual orientations. The abuse of young women in particular can lead to homelessness, pregnancy, serious long-term emotional problems and can be a key factor in young women developing eating disorders and drug and alcohol dependencies.

Young women who are pregnant can experience a higher rate of FDV and increased severity of abuse as well as significantly higher rates of single parenting, social isolation, homelessness and major psychosocial disorders.

### **Risk Issues to Consider**

The experience and impact on children living in a home where there is FDV can involve:

- Living in fear, with no ability to feel safe and secure.
- Being denied a safe and supportive environment in which to grow and develop.
- Fear and hopelessness/helplessness at witnessing a parent being abused.
- Being physically, verbally or emotionally abused when they attempt to intervene in the violence.
- Being denied extended family, peer and broader social support and connection as a result of social isolation imposed on them by the person responsible.
- Being denied the physical care and emotional support necessary for their wellbeing, when both parents are not physically nor emotionally available to care for them.
- Assuming a parental role over younger siblings when the non-abusing parent is neither physically nor emotionally able to care for them.
- Feeling compelled to try and protect a parent and younger siblings.
- Being subjected to death threats towards themselves, their siblings or the parent being harmed.
- Being pressured to maintain the family secret.


- 
- Young women often do not feel confident about accessing support or assistance. They should be provided with written information about services and be offered the opportunity to return to the health service at a later stage.

The response of the child living in a home where there is FDV can include:

- Feeling responsible for the violence or blaming siblings or the parent being harmed.
- Altered attachment dynamics, distorted cognitive processes, early post-traumatic stress, and primitive coping strategies.
- Infants show clear neurobiological disturbances in response to intimate partner violence from at least 6 weeks of age.
- The development of a child's nervous system can be affected by prolonged family violence in a similar way to the impact of inescapable shock, war or abduction.
- The non-abusive parent in the relationship can be rendered severely incapacitated or incapable of meeting the emotional and other needs of children due to the effects of family violence.
- Emotional distress and/or mental illness is four times more likely to occur with children who are subjected to abuse, than in children from homes where violence is not present.
- Violence against mothers during childhood is strongly associated with ongoing depression in adolescent girls.

## **Support Agencies**

- George Jones Child Advocacy Centre - 9391 1900
- Anglicare Children's Domestic Violence Counselling
- Albany Phone: 9845 6666; Joondalup Phone: 9400 7200; Karratha Phone: 9183 0511; Mandurah Phone: 9583 1400; Rockingham Phone: 9583 1400
- Pat Giles Counselling for Children 08 9328 1888 between 9am and 5pm.
- Relationships Australia Family Abuse Integrated Response (FAIR) 9489 6300
- Constable Care <http://www.constablecare.org.au/> - 9272 0000

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- Kids Help Line  
<http://www.kidshelp.com.au/kids/get-help/>  
1800 55 1800
  - Sexual Assault Crisis Line (Resource Centre)  
9340 1828 or 1800 199 888 (country callers)
  - Victim Support Service (Sexual Abuse)  
9425 2850 or 1800 818 988
  - Child Abuse Squad (Police)  
9428 1500  
0421 617 141 (on call number for urgent matters – 24 hours)
  - Child Assessment and Interview Team (CAIT) - Police & DCPFS  
9428 1666
  - Child Protection Unit, Princess Margaret Hospital  
9340 8646
  - After hours 9340 8222
  - Advocate for children in care, Department for Child Protection and Family Support  
1800 460 696 (Free call)  
0429 086 508 (mobile)

## 5.4 Maternal Health

### Practice Points

Violence often begins or increases during pregnancy. It is during pregnancy that chronically abused women are likely to, or be permitted to have regular contact with a health service. This provides a unique opportunity for women to ask for help and for routine screening for FDV and intervention to take place over an extended period.

Health services may have specific screening tools for women in the antenatal and post natal period. Screening should only occur if the partner is not present.

Refer to the WA Health **Guidelines for Protecting Children 2009**.


Any risk to unborn child must be reported to appropriate health professionals within the health service. In some instances, pre-birth planning may need to occur in order to safeguard an unborn child. The Guidelines have clear pathways for reporting and working with the Department of Child Protection and Family Support as needed.

Exercise caution:

- When asking questions in the presence of children as they may repeat to others.
- When providing written information to women identified at risk as other people can access it.
- When the partner attends every antenatal visit and speaks for the pregnant woman.

Examples of questions to use when screening for possible FDV:

- How do you feel about the pregnancy?
- Was the pregnancy intended?
- How does your partner feel about the pregnancy?
- How would you describe your relationship with your partner?
- What do you think your relationship will be like after the birth?
- Do you think you will have any concerns about your baby once it is born?



Counselling prior to labour can be valuable.

Women who have experienced violence may require particular sensitivity with respect to privacy and physical examinations. Individual concerns should be acknowledged and taken into account during care of the woman throughout the pregnancy.

### **Risk Issues to Consider**

Be aware that chronically abused women:

- Often obtain minimal or late antenatal care.
- Often seek terminations, especially younger women with unplanned pregnancies.
- Are less likely to have planned a pregnancy or to want a pregnancy.
- Are likely to develop coping strategies such as alcohol or drug misuse. This compounds the risk to the pregnancy and the woman's capacity to manage her health, the pregnancy and delivery and can lead to poor birth outcomes for the baby.
- Are at increased risk of poor weight gain, anaemia, infections, preterm labour, of bearing a low birth weight infant and of experiencing postnatal depression.
- Health professional safety in the context of caring for a woman with an abusive partner. Ready access to site support and security must be considered and actioned as required.

Discharge planning is very important, particularly for younger women and Aboriginal women, as they are less likely to stay in hospital for the recommended period and might be at risk of little or no support or of homelessness after discharge.

### **Support Agencies**

Local services, including local police stations for country regions, telephone help-lines.

## 5.5 Culturally and Linguistically Diverse (CaLD) People including Newly Arrived Refugees and Migrants

### Practice Points

The needs of people from a CaLD background are many and diverse as a result of cultural and religious beliefs and practices, race, levels of education, length of residence in Australia, circumstances under which they came to Australia, fluency in English, family and social networks, housing situations and economic circumstances.

CaLD people may not understand their rights or responsibilities or the law relating to violence and abuse in Australia. People may lack knowledge of the services available or how to access these services. Fear of government authority figures for example, police or government workers, can be experienced by people coming from repressive regimes.

Be aware that people may have survived human rights atrocities in their country of origin. Humanitarian entrants have often witnessed high levels of gender based violence in countries of origin. Their trauma related experiences, legal status and resettlement issues create greater challenges in being identified as having experienced FDV and supported.

Poor English language skills may prevent people from seeking support.

Religion and culture is not justification for violence.

Women from CaLD backgrounds are less likely than other groups of women to report cases of FDV. This is influenced by limited availability of interpreters; access to support services; cultural and/or religious shame and religious beliefs about divorce.

### Using Interpreters

Always use a trained interpreter. It is not appropriate to use partners or the client's children to interpret. A member of the client's community may also be inappropriate because of confidentiality. This can be dangerous and it may prevent the client from disclosing any abuse if confidentiality is not assured.

Use an interstate telephone interpreter if the client is concerned about confidentiality within his/her community group.

Use short sentences, speak clearly, do not use acronyms and focus on one point at a time. Talk directly to the client, not the interpreter.

See **Language Services Policy – Operational Directive 0346/11** (Includes use of interpreters).

### **Risk Issues to Consider**

- Violence can escalate as a result of migration and because of forced cultural change as gender roles shift with, for example, unemployment or a downward shift in employment status for men, or paid employment for women. Further, traditional hierarchies of age and gender can be eroded as the younger generation assimilate into the broader Australian culture.
- CaLD women are less likely to leave violent relationships. There is pressure to remain in a marriage because of their fear of bringing shame and dishonour to the family.
- Fear that the family in the home country will experience repercussions.
- Dependency on a spouse for residency status.
- Financial dependency on a spouse.
- Fear of isolation and lack of extended family support.
- Religious belief that marriage is a sacred vow and cannot be broken.
- Fear of being deported. People who are sponsored by Australian residents to enter a country on a temporary visa are particularly vulnerable due to their fear of deportation.
- Fear of a loss of anonymity.
- Fear of losing their children.
- The extended family of the person responsible can collude in the violence.
- Some migrant groups are not eligible for Centrelink benefits because of their visa status. Those escaping a violent relationship will not have access to an independent source of income. This in turn impacts upon their ability to access refuge accommodation.
- Be aware that suggesting a partner or family member leave the room in order to speak to the client alone can result in further violence against the client at a later point.

### **Support Agencies**

- Migrant Resource Centre – 9345 5755



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- Catholic Migrant Centre (Centrecare) – 9221 1727
  - Muslim Women’s Support Centre – 9451 5696
  - ISHAR Multicultural Women’s Centre – 9345 5335
  - The Multicultural Women’s Advocacy Service (9328 1200) provides specialist FDV services to CaLD women.
  - Community Midwifery WA – 9430 6882.

## 5.6 People with Mental Health Disorders or Illnesses

### Practice Points

FDV is often not identified in people with mental health disorders although it can be the precipitating factor behind a mental health diagnosis. Mental health disorders such as anxiety, depression and post-traumatic stress disorder are common consequences for people experiencing abuse, violence and/or neglect.


The non-identification of FDV in people presenting with a mental health concern can result in the deterioration of a client's health and well-being and a lack of appropriate intervention. There are increased barriers to appropriate services, lack of quality in service provision when FDV has not been recognised and the risk of the presenting mental health disorder being treated in isolation.

The link between a client's psychological distress and the violence and abuse they may be experiencing cannot be ignored. Psychological distress may be a response and way of coping with living in a constant state of fear. This can make the role of the person responsible invisible and places the client at increased risk of more serious abuse and mental illness, particularly if the partner or carer is identified as the primary resource.

What to consider:

- Take a thorough history of clients presenting with signs of FDV.
- Undertake an assessment of the safety and wellbeing of any children involved.
- Listen to the client's story of abuse. Do not automatically consider disclosures as being unreliable reports.
- Women in domestic violence relationships are more likely to be diagnosed with anxiety or depression. The anxiety or depression may be a direct result of the violence.
- It is important the client be treated for the harm and abuse they may be experiencing, with for instance, referrals to FDV services rather than being put on unnecessary medication.
- Supportive networks are one of the most effective cushions for managing depression.
- People with mental health disorders require adequate time to disclose their experience. Coercing them to speak about the abuse is detrimental. Work at the client's pace and assist them to feel in control of the process.

People may prefer to be referred to a mental health service in the non-government sector. Assess if this is an appropriate and safe option.



Any violence restraining orders in place needs to be ascertained as well as to whom it may apply.

### **Risk Issues to Consider**

Appropriate assessment of the injuries and client circumstances is essential. Where the risk of suicide or serious self-harm is identified, the client should be referred for assessment by a mental health service. Increased suicidal ideation and self-harming behaviours can result from the sense of entrapment experienced in violent relationships.

Coping strategies can include increased drug and/or alcohol use which can exacerbate the mental health disorder.

Discharge planning needs to take into consideration a person's safety if they are returning home.

If a violence restraining order against the person responsible is in place, holding a meeting with a couple could be a breach of the court order.

Alert senior staff to prepare other personnel to assist with any required emergency psychiatric treatment. Health professionals may consider referring to a personal threat emergency procedure site instruction.

For WACHS health professionals, consider contacting the police and/or security staff if safety is compromised.

### **Support Agencies**

**Note:** getting assistance for the person responsible is recommended due to the often complex dependency and care arrangements in family where there are mental health problems. If the person responsible is a male, he can be referred to the Men's Domestic Violence Helpline on 9223 1199 or Free call 1800 000 599.

## 5.7 People with a Disability

### Practice Points

The term 'disability' is wide-ranging and encompasses physical disability; chronic disease such as rheumatoid arthritis; congenital conditions such as cerebral palsy, sensory impairment to sight and hearing; mental and cognitive impairment and psychiatric disability. It can also be an acquired brain injury.


Disabilities can restrict capacity to move freely and/or communicate and/or understand.

What to consider:

- There is evidence that women with physical and/or intellectual disabilities are more likely than those without, to experience FDV to be more severe and to continue for longer.
- The disability may involve a reduced capacity for self-care/management, independence and mobility or communication. Dependence on the day-to-day care and support of a carer.
- Check a person's capabilities and limitations when making a safety plan or providing them with written information.
- A person with an intellectual or cognitive disability for instance, may have difficulty in accessing help, or may not be able to use the telephone or read pamphlets.
- Low self-esteem and lack of assertiveness.
- Access to services – may be perceived that mainstream services will not understand or be able to provide adequate support.
- People with a disability can sometimes be regarded as unreliable and their credibility questioned.
- International research suggest that as many as 90 per cent of women with developmental disabilities will experience sexual assault.

### Risk Issues to Consider

People with a disability are at increased risk of FDV as a result of the disability, isolation and dependence on others.



Be aware of a person's domestic situation and make provision to ensure their ongoing safety. This involves consideration of the whole context of the situation including the disability, any physical support the person may require and the type of FDV being experienced.

There are also forms of abuse which are unique to people with a disability because they may be dependent on others to meet basic health or social needs, which if ignored, result in neglect. Or people can be subject to threats such as being sent to an institution or withdrawing services of care.

### **Support Agencies**

When referring a person to another service, first check with the service that it is able to meet the needs of the person.

- For further information, consult the Disability Services Commission on 9426 9200.
- If there are concerns about a person's decision making capacity, consult the Public Advocate on 9278 7300 or Free call 1300 858 455.
- If a person has a hearing disability, contact Crisis Care on 9223 1111 or 1800 199 008 (country free call).
- Crisis Care can be accessed through the translating and interpreting service on 13 14 50.

## 5.8 People of Diverse Sexuality and Gender

### Practice Points

FDV occurs in diverse sexual gender relationships and there is some evidence to suggest that it occurs at a higher rate than the general population. This includes same-sex, transgender, bi-sexual, trans-sexual and intersex relationships and involves issues of power and control.

What to consider:

- Use of language and terms. The use of inclusive language is critical and a health professional can confidentially ask how people would like to be referred to. Ask directly how a person wishes to be described. This is important when people do not identify as either a 'male' or 'female' in a biological sense. 'Intersex' people refer to a diversity of physical characteristics and most intersex people identify as women or men. In Australia, people are classified at birth as either female or male and raised accordingly. Sometimes a female classified person who identifies as being a male might describe themselves as a 'trans woman'. The term 'trans' is sometimes used as an umbrella term for anyone whose gender characteristics are different from societal expectations. It is not appropriate to call someone a 'trans', 'transgender' or 'tranny'.
- Intersex and transgender people often describe their bodies in terms that match their gender identity and not in the terms that society may use. There is evidence that when health professionals describe body parts different to what the client may identify with, it creates a barrier to health service provision and can lead to poor health outcomes.
- There is evidence that the prevalence, types and contextual triggers of violence in male same-sex relationships parallel abuse in opposite sex relationships.
- When talking about people's relationships, health professionals can use inclusive language such as parent instead of mother/father, or partner instead of boyfriend/girlfriend, husband/wife.
- Some people may decline gender-affirming medical intervention due to religious, financial, medical or personal reasons.
- Community isolation may be experienced by people in diverse sexuality and gender relationships.
- There are limited support services and legal protection available for people who identify as having diverse gender. Limited availability of suitable crisis accommodation.
- The focus of intervention should be on enhancing the safety for the client.

- Fear of negative, stereotypical responses from mainstream providers.

### **Risk Issues to Consider**

In addition to the usual forms of emotional/psychological abuse, it may also involve homophobic control with threats of 'outing' or revealing their sexual identity made by the person responsible.

This can result in the client at risk fearing the loss of significant relationships and fearing discrimination in, for instance, the workplace.

Other issues to consider:

- Emerging sexuality and disclosure to others can be period of high stress for people who are often concerned about discrimination and related violence. The threat of 'outing' people's sexuality to friends, family or colleagues is specific to people with diverse sexuality and relationships.
- Threats to withhold access to children and pets.
- Explicit threats to pets, home, possessions, posting of personal photographs/images.
- Coercion to engage in risky sexual behaviour.
- Threats to alienate from religious community.
- Threats to self-harm, suicide.
- Heterosexism - a system of attitudes, bias and discrimination in favour of opposite-sex sexuality and relationships.
- Transphobia - is a range of negative attitudes and feelings towards trans-sexualism and transsexual or transgender people, based on the expression of their internal gender identity.
- Homophobia.
- Lack of appropriate refuges and lack of referral options for both female and male people who have been abusive within mainstream services.

### **Support Agencies**

Further information is available from:

- The Gay and Lesbian Community Services of WA (Inc.) 9420 7201 or Free call 1800 184 527.

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- Same Sex Domestic Abuse Group (SSDAG) [www.ssdag.org.au](http://www.ssdag.org.au)
  - Communicare - <http://www.communicare.org.au/>
  - <http://www.lgbthealth.org.au/>
  - <http://www.lgbthealth.org.au/mindout>
  - <http://www.lgbthealth.org.au/diversity#sexsexualitygender>



## 5.9 Older People

### Practice Points

Elder abuse is defined as, 'A single or repeated act, or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to the older person. Acts can include financial or material, psychological or emotional abuse, physical, sexual, social abuse and neglect' (APEA: WA, 2006).

Elder abuse may remain hidden due to the person's feelings of shame and guilt, lack of self-worth, feelings of powerlessness, fear of retribution and the resultant loss of support from their caregiver.


It is difficult for an older person to stand up for their own rights, as it is complex to disclose and deal with abuse by relatives and friends. This is because of the need of older people to rely on others for care, emotional support and social ties.

People may not be able to report abuse because of cognitive and physical impairment such as dementia or stroke and general frailty/disability.

Health professionals may see older people on a regular basis through a health service. In isolation, any one sign or symptom of abuse may not be evident or identified as abusive or violent behaviour. All incidents/actions/issues should be recorded as a longer term picture of concern may build overtime.

What to consider:

- There is evidence that the nature of abuse for older people may change overtime, for example, from physical and sexual abuse to more emotional and financial abuse.
- Older people may lack awareness of what constitutes abuse.
- Issues of social isolation.
- Having invested too much in family and partners to consider leaving.
- A perceived or actual lack of access to services.
- Abuse and neglect can sometimes be detected from the behaviour of the older person as well as from the more obvious physical signs and symptoms such as unexplained injuries (especially if they appear symmetrically on both sides of the body), report of drug overdose or failure to take medication regularly, broken glasses, signs of being restrained such as rope marks on wrists.
- Signs of emotional abuse can include behaviour that mimics dementia such as rocking, sucking or mumbling to oneself.

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- Signs of sexual abuse can include bruises around breasts or genitals, unexplained venereal diseases or genital infections, unexplained vaginal or anal bleeding, torn/stained or bloody clothing.
  - Neglect by caregivers or self-neglect can include unexplained weight loss/malnutrition/dehydration, unsanitary living conditions, being left dirty or unbathed, unsuitable clothing or covering for the weather, unsafe living.
  - Conditions (no heat, running water etc.), desertion of the person at a public place.
  - Financial abuse in all its forms is a key component in many elder abuse situations. Consider significant withdrawals from person's bank account, items of cash missing from personal items, addition of names to person's senior card and unpaid bills or lack of medical care.
  - Be aware of sudden and unusual behaviour patterns, such as fear of others, changed sleep patterns, thoughts of suicide, worry or anxiety for no apparent reason.
  - The older person's wish for an independent advocate of their choice should be respected.

### **Risk Issues to Consider**

- Risk factors associated with elder abuse can include carer stress, increased dependency, family conflict, isolation and addictive behaviours.
- Older people from culturally and linguistically diverse backgrounds are at increased risk of abuse as a result of language barriers, lack of traditional extended family support and the widening gap between generations.

### **Support Agencies**

- Office of Public Advocate – 1300 858 455.
- Advocare - (08) 9479 7566 (Office Hours) and country callers 1800 655 566.

## 6.0 Integrated Service Delivery

In Western Australia, government and non-government agencies are working towards integrating responses to family and domestic violence, including collaborative case management and coordinated regional and state planning.

### 6.1 The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework

The Family and Domestic Violence Common Risk Assessment and Risk Management Framework (CRARMF), refers to a standardised approach to identifying, assessing and responding to family and domestic violence.

### 6.2 Minimum Standard for Risk Assessment


Agencies that have a role in responding to family and domestic violence are encouraged to use a common approach to risk assessment and ensure that key risk indicators are included in their risk assessment procedures. The common approach includes:

- client assessment of the risk
- consideration of key indicators
- professional judgment.

The key risk indicators that must be incorporated into FDV risk assessments are included as a resource in the **Guideline for Responding to Family and Domestic Violence - Assessment Outcome Recording form**.

Health professionals conducting risk assessments must have an understanding of family and domestic violence, the patterns and dynamics, factors that affect risk and issues or factors that may make some population groups more vulnerable than others.

Once a risk assessment is complete the outcome should be used to inform the response (risk management).



Where immediate safety concerns are identified the agency will take all necessary steps to ensure the immediate safety of the client experiencing the violence and any accompanying children.

### 6.3 Minimum Standard for Risk Management

To manage identified risk, agencies are required to:

- work with the client to design, implement and monitor a personal safety plan
- work collaboratively with other agencies involved in the case in a formalised interagency response that includes design, implementation and monitoring of an interagency safety plan
- monitor and review the risk on a regular basis.

If referral or other offers of support are declined, services must:

- Provide standard information about sources of help and how to access them and make it clear that the client can return to the service at any time.
- In high risk cases, consider whether multi-agency case management is necessary and appropriate.

### 6.4 Memorandum of Understanding: Information Sharing Between Agencies

Formalised uniform arrangements for the exchange of information between government agencies have been established in order to reduce risks and enhance the safety of clients at high risk of FDV. When an individual or family system is assessed as being at high risk of harm, an integrated service delivery model can mitigate or reduce this risk.

See **Operational Directive OP 0286/10** - Memorandum of Understanding: Information Sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia.

[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=12649](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12649)

## 7.0 Legal Information

### 7.1 Disclaimer

The information contained in this section provides a summary and general overview on legal topics relevant to the operation of the Responding to FDV Guideline and Reference Manual. It is limited to the laws applicable within Western Australia only.

The law is dynamic and while we attempt to ensure the content is accurate, complete and up-to date, it cannot be guaranteed.

The information contained in this section is not intended to be comprehensive. Similarly, it is not intended to be, nor should it be relied upon as a substitute for legal or other professional advice. If you have a legal problem you should seek legal advice tailored to your circumstance from the Legal and Legislative Directorate at the Department of Health (or from the State Solicitor's Office in the case of teaching hospitals only), before acting or relying on any of the content of this section.

### 7.2 Client Confidentiality and Information Sharing

Health professionals are under a duty of confidence in relation to all information that comes to them in the course of their health care relationship with clients. This duty of confidence applies to all persons who come into contact with information as part of the health care process, including administrative staff.

The duty of confidence can arise by statute, under the common law and in equity. The unauthorised disclosure of confidential information by a health professional to third parties (including the police and the Department for Child Protection and Family Support (DCPFS)) will generally involve a breach of the duty of confidence.

A breach of the duty of confidence may lead to a civil action for damages against the individual who made the unauthorised disclosure and their employer. It may also be a matter for disciplinary proceedings by the employer of the individual who made the unauthorised disclosure and review by the relevant professional registration body, such as the Nurses Board.

There are a number of exceptions to the duty of confidence where otherwise confidential information may be disclosed to third parties.

The relevant exceptions to sharing information with third parties are discussed below.

## 7.3 Disclosure by Consent

### Consent of Client or Client's Legal Guardian

In general, if a mentally competent adult client consents to the disclosure of confidential information, then the health professional(s) to whom consent has been given may disclose the information. The health professional may only lawfully disclose the information falling within the scope of the consent and only to those individuals or institutions in respect of which consent has been given.

Where the client is a minor, the appropriate person to provide consent to the release of information relating to that minor will ordinarily be the client's parent or other legally appointed guardian. However, a minor is capable of giving informed consent to the release of confidential information on her/his own behalf where she/he has sufficient understanding and intelligence to enable her/him to understand fully what is proposed and the possible consequences (see 'legal capacity to consent' section information below).

### Other Health Professionals

People who have a legitimate therapeutic interest in the care of the client may have access to confidential information concerning the client relevant to the care being provided. Consent to disclosure of confidential information in such circumstances will generally be implied.

If a health professional wants advice, or simply wishes to talk over the client's treatment with a colleague who is not involved with the client's care but the client has not expressly consented, then identifying information should not be given.

## 7.4 Disclosure by Operation of the Law

### Statutory Disclosure

Where confidential information is disclosed pursuant to a statutory obligation or in accordance with statutory authority, there will be no breach of confidence. However, the information disclosed should be limited to that necessary to comply with the statutory obligation or to that permissible under the relevant statutory provision. An example of this is at s 276 of the *Health Act 1911*, which requires a medical practitioner or nurse practitioner who forms the opinion that a client of the practitioner has an infectious disease, to notify the Executive Director, Public Health.

## Child Safety and Wellbeing

It is permissible under s129 of the *Children and Community Services Act 2004*, for an individual to give information in good faith to the Chief Executive Officer or another officer of the DCPFS about any aspect of a child's wellbeing. Information may also be disclosed in connection with an unborn child, if the investigation is being carried out under s33B. Section 23(3), (4) and (5) of the *Children and Community Services Act 2004* also permit the disclosure of such information in good faith in compliance with a request from the Chief Executive Officer or an authorised officer of the DCPFS. A person is generally considered to be acting in good faith where he or she acts honestly and without improper motive.

Health professionals and other confidants who have concerns or information relevant to the wellbeing of a child may report their suspicions to DCPFS by contacting DCPFS's Crisis Care Unit or its local district office. A child need not be at imminent, likely and serious risk of harm or neglect before a report to DCPFS is justified. Any decision to provide information to DCPFS in relation to the wellbeing of a child should be well documented and include the reasoning that led to the decision to notify DCPFS.

Section 124B of the *Children and Community Services Act 2004* provides that a person who is a doctor, nurse or midwife who believes on reasonable grounds that child sex abuse is occurring or has occurred must report that belief to the CEO of DCPFS or their delegated authority.

## Firearms or Ammunition

It is permissible under s 23B of the *Firearms Act 1973* for a 'health professional' (defined to mean 'medical practitioner', 'psychologist', 'registered nurse', 'prescribed class of social worker' or 'prescribed class of professional counsellor') to inform the Commissioner of Police of their opinion that:

- because of the client's physical, mental or emotional condition, it is not in the person's interest or not in the public interest that the person possess any firearm or ammunition to which the client is believed to have access; or
- person is seeking or has sought medical assistance for an injury in the infliction of which a firearm or ammunition is believed to have been involved.

## Subpoena

A health professional may be required by subpoena to produce documents to a court and/or attend court to give oral evidence. Where a health professional divulges confidential client information to the court in response to a valid subpoena, they will not be in breach of their duty of confidence. Failure to comply with a subpoena (or similar court order) can amount to a contempt of court resulting in a prison sentence or fine.

## Public interest disclosure

The 'public interest' exception to the duty of confidence recognises that there may on occasion be a need to breach confidentiality because of an overriding public interest favouring disclosure of the information to a third party. In such circumstances, the disclosure of the information to a responsible authority may be justified.

The law in the area of what constitutes a 'public interest' is complex. The decision to disclose otherwise confidential information should be made at a senior level within the relevant public health authority's administration. Wherever practicable, it is recommended that there be consultation with the treating medical practitioner. The factors taken into account in reaching a decision to disclose confidential information in the public interest should be well documented. It is recommended that advice be sought before disclosure is made in the 'public interest'.


## 7.5 Duty of Care

Health professionals have a duty to take all reasonable care for the welfare of their clients. Generally, the duty of care will arise when a person presents to the health service for medical attention and that health service expressly or impliedly accepts responsibility for the treatment of that person. The health professional also owes a duty to third parties where it is reasonably foreseeable that a person under their control may harm the third party.

A health professional may be liable for negligence where they fail to take steps that a reasonable person would to prevent a reasonably foreseeable risk of harm to a person to whom they owe a duty of care. It is arguable that a health professional's duty extends to taking reasonable care by predicting whether a child client is at risk of harm from abuse if discharged or left in care of the parent/carers.

The court will consider all the circumstances of the case when deciding whether a health professional has acted reasonably, including the nature and extent of the risk of harm and the resources available to deal with the risk. The health professional will only be liable for a





breach of the duty of care where they have not acted reasonably, the breach has caused injury or loss to the person to whom the duty is owed and that injury or loss is not considered too remote.

## 7.6 Client Consent to Treatment and Disclosure of Material Risks

### **Duty to Obtain Consent**

Except in an emergency situation, a health professional has a legal obligation to obtain the client's voluntary consent before any physical examination, test, procedure or other treatment is provided.

### **Informed Consent**

A health professional has a duty to inform the client in broad terms about the general nature of the proposed treatment, including any material risks inherent in the treatment, so that the client understands to what they are consenting.

A health professional may be liable for negligence where a client has been informed of the type of treatment to be undertaken but has not been told of the material risks involved. Before providing any treatment, the health professional providing the treatment should provide the following information to the client in terms that they will understand:

- an explanation of the client's condition
- the reasons for the proposed treatment or care
- the risks involved, including any significant long-term physical, emotional, psychological, social, sexual or other risks
- the expected benefits (noting that the results of treatment can never be guaranteed)
- alternative treatment options, including the likely result of 'no treatment'
- whether the treatment is irreversible
- the time involved in the treatment
- the likely recovery period
- any follow-up care that may be required.

Matters that have been discussed should be accurately documented in the client's file, including any questions asked by the client and the answers to those questions.

## Legal Capacity to Consent

A client must have legal capacity to consent to the treatment to be performed. A client will have capacity to consent where they are able to understand in broad terms the nature and consequences, including the risks, of the proposed treatment.

In the case of medical treatment to children (persons under 18 years of age), the appropriate person to consent to the treatment of that child will ordinarily be the child's parent or other legally appointed guardian.

However, a child is considered to be a 'mature minor' where the child is capable of giving informed consent to treatment and where that child has sufficient understanding and intelligence to enable her or him to understand fully what is proposed and the consequences of it. The assessment of a child client as a 'mature minor' involves the health professional making a judgment about the client based upon the circumstances of the individual case.

Any assessment of a child client as a 'mature minor' and that child's consent to treatment should be clearly documented in that client's medical file.

## Duration of a Client's Consent

A health professional's duty to disclose material risks and obtain a client's consent for treatment is a continuing obligation and should occur as close as is reasonably practical to the commencement of the treatment. The health professional should also be mindful of any changed circumstances, which may require further discussion.

## 7.7 Female Genital Mutilation

In Western Australia, s306 of the *Criminal Code* provides that a person who performs 'female genital mutilation' on another is guilty of a crime and is liable to imprisonment for 20 years. The fact that the person or their parent or guardian consented to the 'female genital mutilation' is no defence.

Section 306 also provides that a person who takes a child from Western Australia or arranges for a child to be taken from Western Australia, with the intention of having the child subjected to female genital mutilation is guilty of a crime and is liable to imprisonment for 10 years.

Where it is suspected a person has been subjected to female genital mutilation Legal and Legislative Services are to be contacted for advice.

## 7.8 Restraining Orders

A court may make a violence restraining order under s11A of the *Restraining Orders Act 1997* if it is satisfied that:

- the respondent has committed an act of abuse against a person seeking to be protected and the respondent is likely again to commit such an act against that person; or
- a person seeking to be protected, or a person who has applied for the order on behalf of that person, reasonably fears that the respondent will commit an act of abuse against the person seeking to be protected and that making a violence restraining order is appropriate in the circumstances.


An 'act of abuse' means an 'act of family and domestic violence' or 'act of personal violence'. The terms 'act of family and domestic violence' and 'act of personal violence' are defined in s6 of the *Restraining Orders Act 1997*. The acts that comprise an 'act of family and domestic violence' involve conduct that occurs in a family and domestic relationship. The acts that comprise an 'act of personal violence' involve conduct that does not occur in a family and domestic relationship.

A court may, if it is satisfied of certain matters, make a violence restraining order for the benefit of a child under s 11B of the *Restraining Orders Act 1997*. A police officer may, under s30A of the *Restraining Orders Act 1997*, make a police order in certain circumstances if the officer reasonably believes that:

- It would not be practical for an application for a violence restraining order to be made in person because of;
  - the time when, or the location at which, the behaviour complained of occurred, is occurring or is likely to occur; or
  - The urgency with which the order is required, or
- There is some other factor that justifies making a violence restraining order as a matter of urgency and without requiring the applicant to appear in person before a court, and the making of the order is necessary to ensure the safety of a person.

A police order is to be either a 24 hour police order or a 72 hour police order. The duration of a police order cannot be extended or renewed and another police order cannot be made in relation to the same facts.

On client request, the social work section of the Health Service may be able to assist a client in obtaining a violence restraining order. Health professionals may also call the Legal Aid



Domestic Violence Unit or the WA Police for information and assistance in relation to restraining orders.

## 7.9 Other Information

If children are attending court, court preparation and support is available from the Child Witness Service of the Department of the Attorney General.

## 7.10 Memorandum of Understanding: Information Sharing Between Agencies

Formalised uniform arrangements for the exchange of information between government agencies have been established in order to reduce risks and enhance the safety of clients at risk of FDV. When an individual or family system is assessed as being at high risk of harm, an integrated service delivery model can mitigate or reduce this risk.

The MOU is a statement of the intentions of the signatory agencies. It does not create a contractual relationships and is not binding on the parties in law.

See **Operational Directive OP 0286/10** - Memorandum of Understanding: Information Sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia.

[http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ\\_ID=12649](http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12649)



## 8.0 Resources

### 8.1 Useful Telephone Numbers

#### Counselling Services

##### **Centrecare**

9325 6644 (Perth)

9091 1833 (Goldfields)

9721 5177 (Bunbury)

##### **Domestic Violence Children's Counselling**

9328 1888

##### **Incest Survivors Association**

9227 8745

##### **Relationships Australia**

1300 364 277

##### **Sexual Assault Resource Centre**

9340 1828 or Free call 1800 199 888

##### **Victim Support Service**

9425 2850 or Free call 1800 818 988

##### **Yorgum Aboriginal Counselling Service**

9218 9477

#### **Crisis Services**

##### **Crisis Care**

9223 1111 or Free call 1800 199 008

##### **WA Police Service 131 444**

##### **Child Protection Squad**

9492 5444



### **Domestic Violence Unit**

9250 3948

### **Family Protection Unit**

9492 5485

### **Legal Information**

#### **Domestic Violence Advocacy Support Central (DVAS)**

Police support with VRO applications

9226 2370

#### **Domestic Violence Legal Unit (Legal Aid Western Australia)**

9261 6254

#### **Legal Services Branch**

#### **Department of Health**

9222 4038

#### **Women's Law Centre**

9272 8800 or Free call 1800 625 122

### **Mental Health Services**

#### **Mental Health Emergency Response Line (previously PET)**

1300 555 788 or Free call 1800 676 822

#### **Aboriginal Activity Centre (Graylands Hospital in client service only)**

9347 6868

#### **WA Transcultural Mental Health Centre**

9224 1760

#### **Princess Margaret Hospital (Child and Adolescent Mental Health Service – Acute Services – Paediatric Consultation Liaison)**

9340 8373



## **Youth Link**

1300 362 569 or Free call 1800 803 356

## **Princess Margaret Hospital 9340 8222**

### **Child Protection Unit**

9340 8646 (Fax 9340 8822)

### **Social Work Department**

9340 8920

### **Emergency Department**

9340 8222 (After hours)

## **24 Hour Help Lines**

### **Alcohol and Drug Information Service**

9442 5000 or Free call 1800 198 024

### **Family Help Line**

9223 1100 or Free call 1800 643 000

### **Kid's Help Line**

Free call 1800 55 1800

### **Life Line**

131 114

### **Men's Domestic Violence Help Line**

9223 1199 or Free call 1800 000 599

### **Parenting Line**

9272 1466 or Free call 1800 654 432

### **Salvo Care Line**

9442 5777

### **Women's Domestic Violence Helpline**

9223 1188 or Free call 1800 007 339



## **Financial Information**

### **Centrelink**

131 021 for appointment with a social worker

## **Interpreter Services**

### **Telephone Interpreter Service**

131 450 (All hours)

### **National Relay Service – TTY-voice-modem**

133 677

### **Deaf Society of WA**

9441 2655 (TTY)

0410 017 540 (Emergency Service)

## **CaLD Services**

Multicultural Women's Advocacy Service

9328 1200

## **Women's Information Service**

6217 8230 or Free call 1800 199 174

## **On Line Resources**


### **Department for Communities website**

[www.community.wa.gov.au/onlineresourceguide/](http://www.community.wa.gov.au/onlineresourceguide/)



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