

Guidelines for developing  
protocols on intervention and  
management of family and  
domestic violence for hospitals  
in Western Australia

Department of Health Western Australia

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A Steering Committee guided the development of these standards and protocols.

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# *Introduction*

## **Background**

Family and domestic violence has been identified as a major issue impacting on the well-being of a significant number of people in Western Australia. In 1998 the Australian Medical Association (AMA) issued a position statement calling for better recognition and intervention for victims of domestic violence. Similarly, in 1997 the Health Department of Western Australia (HDWA) reiterated its commitment to collaborate with other Government departments in reducing the occurrence of spouse abuse (HDWA 1997).

The HDWA Family and Domestic Violence Strategy seeks to:

- contribute to a reduction in spouse abuse through policy and program mechanisms;
- provide high standard services within government health facilities;
- collect systematic data that will contribute to the development and evaluation of strategies to address the problem of spouse abuse; and
- cooperate with the private sector, non-government agencies and health providers in ensuring access to services for those experiencing spouse abuse.

In 1997 HDWA outlined its purchasing function as follows:

- purchasing plans will reflect national and state policy on spouse abuse;
- contracts for the purchase of services, where relevant, to reflect health goals for families suffering abuse;
- coordinating development of longer term preventive strategies towards spouse abuse in the health sector; and
- monitoring and evaluation of the implementation and outcomes of strategies.

It is important to understand that the Government has made a commitment to respond effectively to family and domestic violence. As a result, health services

are required to adopt policies, and develop procedures and programs in keeping with the 1997 HDWA Family and Domestic Violence Action Plans.

## How to use these guidelines

This document provides guidelines for developing protocols for hospitals attending patients presenting with physical and non-physical signs of Family and Domestic Violence (FDV). It suggests a general framework as to how hospitals can recognise and respond better to FDV. The document outlines areas of responsibility for management and hospital staff and further highlights a multidisciplinary and inter-agency response to FDV. The guidelines are intended to improve the management of FDV cases, and also to identify the cases that currently go undetected.

The document is accompanied by a resource manual containing examples of performance information to meet each standard. It also provides detailed explanations and resource information on effective hospital interventions for patients who have experienced FDV.

Hospitals should develop and adapt their own protocols according to the appropriate performance indicators. It is encouraged that each hospital establish a multidisciplinary working party which will coordinate the development and implementation of hospital-based protocols on domestic violence.

## Definition

Effective intervention for victims of FDV can only happen if staff have a comprehensive understanding of what constitutes domestic violence. This understanding assists in detecting cases of FDV, especially as symptoms often go beyond physical injuries.

FDV is a crime. It occurs when one person attempts to control and dominate another in an intimate or familial relationship. Numerous studies have established that FDV is a gendered crime, perpetrated mainly against women and children. However, it is important to recognise that a minority number of men also experience violence in the home. FDV manifests in a variety of forms which

include physical, psychological, economic, social and sexual violence.

## Prevalence of Domestic Violence in the community

In Australia, several studies have confirmed that:

- about one in three assaults against women are perpetrated by a spouse (Stuart 1996; Bates et al 1995);
- about 40% of female homicide victims are killed by their male partners, compared to 10% in the case of men (Stuart 1996; Bates et al 1995);
- over 90% of abusers are men, while those subjected to violence are predominantly women and children. This fact highlights the gendered nature of domestic violence (The Royal Australian College of General Practitioners 1994);
- of the women who had experienced violence, in 42% of cases, violence occurred while they were pregnant (ABS 1996; Stuart 1996); and
- a significant number of women who had been subjected to physical violence often live in fear. This fear includes worrying about reprisals, fear of leaving their house, fear of men in general, and fear for children's safety. 73% of these women reported specifically living in fear of their spouses (ABS 1996; SA Domestic Violence Prevention Unit undated).

FDV occurs across all social, cultural, economic and religious groups. It affects families in metropolitan and country areas. The Royal Australian College of General Practitioners note that domestic violence is likely to be under-reported. It is important to recognise that **episodes often escalate in intensity and frequency.**

## Your role as a health professional

Health care providers form a key link not only in the treatment of immediate symptoms, but also in arranging follow up support and specialised counselling available from service providers outside the health system itself. Apart from

# 1.0 Detection

counselling, women experiencing FDV may need support with accessing the family court system, accommodation and financial support. Hence, enabling an effective referral system plays a part in empowering those affected to break the cycle of violence in their lives.

Evidence indicates that the rate of detection for FDV in the health care system remains very low. This is despite the high contact women suffering violence in the home have with healthcare services. A contributing factor to this under-detection is lack of proper identification and non-disclosure. It is reported that identification rate for victims of domestic violence by doctors is very low with up to 95% of cases remaining undetected' (Golberg and Tomlanovich 1984; Roberts et al 1993; Mcleer 1989). Research suggests that early identification and intervention with victims of FDV by healthcare professionals in the health care system can save lives, as well as assisting in the post-trauma recovery. The importance of the health care system cannot be over-emphasised due to the following facts:

- victims consult doctors and attend emergency departments more often than they consult any other group of professionals (Bates et al 1995);
- the majority of victims seek medical assistance at least once (Bates et al 1995); and
- almost a quarter of injuries suffered by women presenting at hospitals are attributed to domestic violence (Bates et al 1995; Stuart 1996).

## Protocol Framework

The following is a framework for hospitals to consider in developing protocols. It is hoped that this guide will enhance quality, while recognising the level of diversity that exists across hospitals.

## 1.1 Principle

**Hospitals can play an important part in detecting and identifying victims of family and domestic violence.**

## 1.2 Standards

- 1.2.1 *Hospitals will take necessary practical steps to ensure **all** staff with patient contact are familiar with signs and symptoms of FDV.*
- 1.2.1 *In-depth screening for FDV will be undertaken for patients presenting with warning signs.*



## 2.0 Assessment

### 2.1 Principle

**Hospitals will undertake and/or coordinate a supportive holistic assessment that reflects physical, psychological and social needs of patients experiencing family and domestic violence. Patient's safety, dignity and privacy will be regarded as paramount.**

### 2.2 Standards

- 2.2.1 *Admission and triage documentation will identify patients who have suffered from FDV.*
- 2.2.2 *Hospitals will have clear and firm guidelines about excluding perpetrators during examination of patients presenting with suspected signs of FDV.*
- 2.2.3 *Hospitals should attempt to provide a private interview room for assessment of patients presenting signs of FDV.*
- 2.2.4 *Where relevant, and practical, female staff members will assess the patient.*
- 2.2.5 *Where necessary, referrals for comprehensive psychosocial assessment and support will be made to other experienced health professionals within or outside the hospital.*
- 2.2.6 *Hospitals will develop and distribute assessment checklist resources to their nursing and medical practitioners.*

## 3.0 Patient Safety

### 3.1 Principle

**Patients' current and future safety will be regarded as paramount in the intervention of family and domestic violence cases.**

### 3.2 Standards

- 3.2.1 *Hospital intervention goals should focus on promoting safety.*
- 3.2.2 *Patients who have suffered FDV should not be discharged without a written referral being made to the hospital social worker services or an alternative referral service, where these services are available.*
- 3.2.3 *Hospitals will develop resource information that promotes patient safety (including counselling, welfare, protection and legal services) available to their practitioners.*
- 3.2.4 *Discharge plans should incorporate goals that promote the future safety of patients.*
- 3.2.5 *Hospital referrals will aim to reduce unnecessary repeated admissions for patients presenting with injuries relating to FDV.*
- 3.2.6 *Hospitals will inform the Department of Family and Children services if there are concerns about children's safety.*

## 4.0 Referrals

### 4.1 Principle

**Promotion of multi-disciplinary intervention and appropriate inter-agency cooperation in the area of family and domestic violence is critical in enhancing patient outcomes. Information and resources provided to patients will be aimed at allowing them to make informed decisions about referral options.**

### 4.2 Standards

- 4.2.1 *Hospitals will make use of a multi-disciplinary approach in addressing cases of FDV.*
- 4.2.2 *Patients will be provided with relevant information to assist them in reaching informed decisions about accessing available referral options.*
- 4.2.3 *Patients will be encouraged to receive follow-up support from either social work or community support agencies prior to being discharged.*
- 4.2.4 *Inter-agency cooperation will be maintained with a view of assisting patients to receive support from other agencies in order to address psychological, practical and legal needs where appropriate.*
- 4.2.5 *Hospitals should maintain information on local perpetrator programs for appropriate referral purposes.*
- 4.2.6 *All referrals to perpetrator programs will be done with the primary aim of enhancing family safety.*

## 5.0 Confidentiality

### 5.1 Principle

**Patient's privacy and confidentiality will be maintained. At the same time, their current and future safety will be regarded as paramount. Hence, the duty of confidentiality will be balanced against the notion of duty of care.**

### 5.2 Standards

- 5.2.1 *Access to patient information will be restricted to authorised staff.*
- 5.2.2 *Patients will be informed about the importance for practitioners to consult or share information with other staff on a need to know basis.*
- 5.2.3 *Patients will be asked to sign a consent form for information release.*
- 5.2.4 *In life-threatening FDV cases where consent has not been granted, staff should make a 'considered' professional decision about the relevance of notifying police authorities about the suspected assault committed.*
- 5.2.5 *Interpreters and other relevant hospital staff will be briefed by hospital staff about the importance of confidentiality.*
- 5.2.6 *Patients will be informed of their right to access medical records for legal purposes under the Freedom of Information Act 1992.*

## 6.0 Reporting to Police

### 6.1 Principle

**Family and domestic violence is a crime. The police have an important role to play in reducing violence.**

### 6.2 Standards

- 6.2.1 *Patient consent will be obtained before reporting to police. In life-threatening FDV cases where consent has not been granted, staff should make a 'considered' professional decision about the relevance of notifying police authorities about the suspected assault committed. If in doubt, it is essential for medical practitioners to do the following:*
- \* *confer with senior medical staff*
  - \* *clarify with the Medical Defence Association*
  - \* *document patients' refusal to sign consent form*
  - \* *document attempted methods used to persuade the patient to provide consent.*
- 6.2.2 *Hospital staff will allow police services to take the necessary forensic photographic evidence relating to injuries sustained after obtaining patient consent. Practitioners will make a 'considered' decision to authorise collection of this evidence in the absence of patient consent.*

## 7.0 Legal Issues

### 7.1 Principle

**Family and domestic violence is a crime. Access to the justice system is central in reducing the occurrence of family and domestic violence.**

### 7.2 Standards

- 7.2.1 *Hospital practitioners will be aware that documentation and proper recording are important from both professional and legal perspectives.*
- 7.2.2 *The admitting registrar will oversee that necessary documentation relating to the injury is completed.*
- 7.2.3 *Nursing staff will be authorised by medical staff to undertake follow up work with patients.*
- 7.2.4 *Staff will request police involvement where there is physical injury, after obtaining patient consent.*
- 7.2.5 *In life-threatening FDV cases staff will make a 'considered' professional decision regarding the importance of notifying police authorities about suspected assault and injuries sustained.*
- 7.2.6 *Staff will be aware that police involvement makes it easier for a victim to access the criminal injuries compensation.*
- 7.2.7 *Medical and nursing staff will understand that they are only one point of assistance for FDV patients. As far as practical, they will refer patients to social work or other related services to ensure patients are assisted in gaining access to the legal system.*
- 7.2.8 *Patients will be reminded of their rights to access medical records in the future if they so desired.*

## 8.0 Patient Records

### 8.1 Principle

**Maintenance of case records is important for the care of patients and long-term reduction of family and domestic violence.**

### 8.2 Standards

- 8.2.1 *Medical practitioners will record all relevant medical history obtained during assessment.*
- 8.2.2 *Relevant photographic evidence, body maps/schematic drawings will be used where relevant.*
- 8.2.3 *In the recording of information, practitioners will bear in mind that patients may access recorded information in the future.*
- 8.2.4 *Case notes will bear a name and signature of the practitioner or registrar who attended the patient.*

## 9.0 Accessibility of Services to a Diverse Population

### 9.1 Principle

**Hospital services will recognise and respond to the diverse nature of the client population, ensuring accessibility and relevance.**

### 9.2 Aboriginal Families:

Violence in Aboriginal community is a complex issue requiring a broader definition. Spouse abuse is located in a complex web of family violence encompassing a larger group of family members. This is related to socio-economic dislocation and historical effects which have led to the breakdown of traditional social control (Bolger 1991:3; DVPU 1998:6). Aboriginal families suffer higher levels of social and economic disadvantage which compound the problem of FDV. Statistics indicate that Aboriginal families are 53 times more likely to be victims of FDV than the rest of the population. In addition, hospital admissions relating to FDV are 12 times higher than the rest of the population (FDV Taskforce 1995:46; Crime Research Centre UWA 1993:20, 66).

FDV intervention in Aboriginal families must also take account of the diversity that exist amongst Aboriginal communities. Their needs may be influenced by their geographical location, economic wellbeing, and language barriers. The family network may also assist or compound issues relating to domestic violence.

### 9.3 Standards

- 9.3.1 *Hospital staff should be aware of the complex nature of historical, economic, and socio-cultural factors contributing to FDV.*

- 9.3.2 *Where relevant, and practical, female staff members will assess the patient.*
- 9.3.3 *Practitioners will maintain cultural and social sensitivity.*
- 9.3.4 *Staff should find out which community the patient is from, and will assess if it is safe to go back.*
- 9.3.5 *Where practical, hospitals should provide a skilled Aboriginal support worker on-site, with a key role in advocating, supporting and monitoring the patient where appropriate and practical.*
- 9.3.6 *Hospital staff will be familiar with appropriate referral options for Aboriginal patients.*

#### 9.4 *Women from Culturally and Linguistically Diverse Backgrounds (CALD)*

Women from CALD background are not a homogenous group. Their needs vary and may be influenced by cultural barriers, level of education, length of residence in Australia, level of English fluency, family and social network, and economic independence.

#### 9.5 Standards

- 9.5.1 *Practitioners will inform patients of the availability of trained interpreters where the need arises.*
- 9.5.2 *Practitioners will request an interstate telephone interpreter when the patient may be concerned about confidentiality or where they feel vulnerable.*
- 9.5.3 *Staff should be trained and equipped to work with interpreters. They **must not** rely on partners, children or hospital staff as interpreters.*
- 9.5.4 *Hospitals should encourage equitable use of their services by using translated information/display posters specific to migrants where necessary.*

- 9.5.5 *Hospitals should maintain lists of migrant support services for referral and information purposes.*

#### 9.6 *Rural Women & Hospitals*

Women in remote and rural areas are vulnerable to FDV due to geographical isolation. In small towns, the social relationships can complicate matters when attending a patient. Boundaries can easily become blurred. FDV is a public health issue. As such, it must be responded to in a professional way.

#### 9.7 Standards

- 9.7.1 *Staff should be aware of factors that increase the vulnerability of people experiencing FDV in rural and remote areas.*
- 9.7.2 *Non-resident General Practitioners will ensure concerns raised by nurses relating to FDV are investigated and responded to appropriately.*
- 9.7.3 *Non-resident General Practitioners in hospitals will ensure nursing staff are authorised to make contact with appropriate referral services.*
- 9.7.4 *Hospitals should provide debriefing arrangements for staff dealing with cases of FDV.*
- 9.7.5 *Small town hospital staff are more likely to know the parties involved in FDV, therefore hospitals will ensure staff are supported to deal with safety and personal issues arising in the course of attending FDV cases.*

#### 9.8 Pregnant Women

It is important for health workers to be aware that pregnant women are a group at risk who can escape detection and appropriate intervention. Trauma and/or accidental injury complicates about 7% of all pregnancies. Apart from accidents and assaults, FDV contributes to this problem (Connolly 1997:331).

Violence towards pregnant women constitutes a reproductive risk. Women who experience FDV during pregnancy are four times more likely to have low weight babies (Valdez Santiago et al 1996:352). FDV experienced during pregnancy, contributes to both maternal and perinatal morbidity and mortality (Pearlman 1997:127).

## 9.9 Standards

- 9.9.1 *Women presenting with miscarriage and pregnancy complications where trauma and abuse is indicated should be fully screened for FDV.*
- 9.9.2 *Women presenting with gynaecological problems should be screened for FDV.*
- 9.9.3 *Practitioners should pay due attention to, and screen women who have presented with multiple abortions.*
- 9.9.4 *Referrals will be made to social work services for pregnant patients suspected or confirmed to be experiencing FDV.*

## 9.10 Elder Abuse & Protection

The Council on the Ageing and the Office of Seniors Interest have developed and published an *Elder Protection Protocol for Government Agencies*. The document details key identification, intervention and management issues to be aware of when dealing with elderly patients who may be facing abuse. It is important that staff familiarise themselves with this document.

## 9.11 Standards

- 9.11.1 *Hospitals will be familiar with the advice provided in the "Elder Protection Protocol for Government Agencies" (produced by the Council of the Ageing and the Seniors Interests Office 1997).*

**Information on The Elder Protection Protocol may be obtained by contacting the Council on the Ageing (WA inc) on 08 9321 2133.**

## 9.12 People with Disabilities

People with disabilities may also be at risk of experiencing family violence. Special consideration needs to be given to people who have physical, sensory, intellectual and psychiatric disabilities. Often, a person with a disability may be relying on the perpetrator for care and support. Their difficulties may also be compounded by limited access to services set up to support victims of FDV (DVPU 1998:17).

## 9.13 Standards

- 9.13.1 *Staff will be aware of the special needs of people with disabilities that may limit access to services.*
- 9.13.2 *Staff will take account of capabilities and limitations of a patient with disabilities when making intervention and management plans.*
- 9.13.3 *Hospitals will make necessary referrals for support services through social work or local support services.*

## 9.14 People with Mental Illness

Mental illness may present a risk factor of abuse to the person suffering the illness or other family members caring for a person with mental illness. On the other hand, it is not uncommon for women traumatised through domestic violence to be treated for mental illness, rather than receiving support to deal with their victimisation. An appropriate intervention depends largely on making appropriate assessment and intervention plans.

## 9.15 Standards

- 9.15.1 *During assessment, staff should take thorough histories of patients presenting with signs of FDV and mental illness.*
- 9.15.2 *Staff should be aware of the dangers of misdiagnosis.*
- 9.15.3 *Practitioners should avoid putting patients on unnecessary medication. Effort will be made to focus on the problem of FDV.*
- 9.15.4 *Information should be provided to assist patients understand their rights and options. Adequate time will be given to assist them to*

*explore their options.*

- 9.15.5 *Children and protection concerns will be notified to the Department of Family and Children services (families where a member has a mental illness are in a more vulnerable situation, hence, support from Family and Children services may be essential).*
- 9.15.6 *Hospitals will give priority in organising referral for the partner or carer of a patient where mental illness is a contributory factor to the violence in the family.*

### 9.16 *Same Sex Relationships*

FDV also occurs in same-sex couples. At the root of the violence are questions of power and control similar to heterosexual relationships. Hart defines this violence as when one partner 'seeks to control thoughts, beliefs or conduct of her intimate partner or to punish for resisting the perpetrators control over her' (in DVPU 1998:16). The violence may involve the same types of violence as heterosexual couples. In addition, threats of "outing" may also be used to force compliance.

### 9.17 *Standards*

- 8.17.1 *Staff will focus on the needs of the patients experiencing FDV and not their own attitudes on the issue of sexuality.*
- 9.17.2 *Staff will be aware that people in same sex relationships have limited legal rights compared to heterosexual couples under certain areas of law (eg. Family Law Act), and they may experience community isolation due to their same sex relationship.*
- 9.17.3 *Hospital staff will be aware of the threat of 'outing' to family or work colleagues which may be occurring in the relationship and form part of the abuse.*
- 9.17.4 *Hospital staff will provide patients with the contact number for support telephone counselling services for people in same sex relationships.*

### 9.18 *Children*

Children growing up in violent households can experience psychological and emotional damage. Whilst some children adjust fairly well, others can be at potential risk of becoming perpetrators or victims of abuse themselves. Understanding and responding to their needs is an important part of combating FDV. This involves detecting children who have been traumatised through witnessing FDV, and referring them to relevant support agencies where relevant (Thormaehlen 1994:355; Yates 1996:162).

### 9.19 *Standards*

- 9.19.1 *Staff should be aware of the psychological and emotional impact that children growing up in violent households may experience.*
- 9.19.2 *Staff should be equipped with appropriate assessment skills in taking case histories.*
- 9.19.3 *Staff will be equipped to identify new and old injuries.*
- 9.19.4 *Every hospital should be aware of current local resources for children for referral purposes.*
- 9.19.5 *Staff will be aware that whilst there is no legal mandatory reporting requirement for children experiencing abuse, hospital practitioners have responsibility to take protective action on behalf of children under Child Welfare Act 1947 S. 29(3a).*
- 9.19.6 *Staff should be aware of the 1997 "Government of WA Reciprocal Child Protection Procedures" to which HDWA is a signatory (see resource manual for detail).*
- 9.19.7 *Staff should be aware of the 1993 HDWA "Guidelines for the Clinical Management of Child Abuse and Neglect".*
- 9.19.8 *Child protection issues will be referred to the Department for Family and Children services in line with existing reciprocal arrangements, as well as the mentioned guidelines.*

## 10.0 Data Collection

### 10.1 Principle

**Hospital services will ensure that the identified admissions relating to family and domestic violence are accurately reported in data collection systems.**

### 10.2 Standards

- 10.2.1 *Hospitals will ensure collection of essential data is maintained.*
- 10.2.2 *Hospitals should ensure all staff involved in documentation of case notes are trained in understanding the importance of maintaining complete and accurate patient records to ensure an effective base for data collection.*



## 11.0 Professional Development

### 11.1 Principle

**The hospital management will support their staff to gain necessary skills in identification and intervention of family and domestic violence.**

### 11.2 Standards

- 11.2.1 *The hospital management system will, as far as practical, support their staff to gain necessary skills in identification and intervention of FDV.*
- 11.2.2 *Hospital staff (doctors, nurses, social workers and all ED staff) should attend FDV training.*
- 11.2.3 *Training sessions should be organised at least twice a year to ensure new staff are provided with an opportunity to attend.*
- 11.2.4 *It is recommended that training cover:*
- \* *clinical aspects of FDV intervention ie. detection, assessment and intervention;*
  - \* *legal issues;*
  - \* *impact of FDV on children;*
  - \* *supporting patients from a diverse population base; and*
  - \* *impact on workers handling FDV cases.*

## 12.0 Staff Safety

### 12.1 Principle

**The hospital management has the primary responsibility of promoting a safe working environment for staff who are treating and assisting victims of family and domestic violence.**

### 12.2 Standards

- 12.2.1 *Hospital management will ensure workers attending victims of FDV are themselves provided with debriefing and supervision support.*
- 12.2.2 *As far as practical, hospital management will integrate or develop a 'risk management strategy' that limits staff exposure to threats from perpetrators of violence. Examples of such measures include:*
- \* *use of security guards;*
  - \* *security screen alert system;*
  - \* *duress alarms;*
  - \* *police;*
  - \* *first name only on name badges;*
  - \* *safe car parks; and*
  - \* *safe commuting for shift workers.*

## 13.0 Monitoring

### 13.1 Principle

**A coordinated monitoring of the implementation of protocols will be undertaken by hospitals with the support of HDWA.**

### 13.2 Standards

- 13.2.1 *Hospitals will adopt/adapt FDV guidelines. The guidelines will be adjusted to suit hospital settings and available resources.*
- 13.2.2 *After developing individual protocols, hospitals will monitor their FDV protocols on a regular and periodical basis.*
- 13.2.3 *Hospital management should ensure heads of clinical departments are involved in facilitating the implementation of protocols.*
- 13.2.4 *It is recommended that hospitals designate an existing position to coordinate and monitor responses to all aspects of FDV intervention.*
- 13.2.5 *Hospitals will ensure staff use protocols as intended.*
- 13.2.6 *HDWA will conduct a coordinated periodical review of protocol implementation on a regular and timely basis.*

**[The protocols are managed by HDWA Operations Division. The contact number is (08) 9222 2233].**

**[Further support on developing and implementing hospital-based protocols may be obtained at the Eastern Perth Public Health Unit. The contact number is 9224 1648 or 9224 1625].**

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