Accompanying Resource Manual for Family and Domestic Violence Protocols for Hospitals in Western Australia

Department of Health Western Australia

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Contents

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This document was developed by the Eastern Perth Public and Community Health Unit, for the Health Department of Western Australia. The document was written by Pendo Mwaiteleke. This followed an extensive literature review and an audit of local and international hospital protocols on family and domestic violence. A broad based consultation with hospital and community stakeholders was also undertaken.

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

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Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Teams
AMA	Australian Medical Association
CALD	Culturally and Linguistically Diverse
DVPU	Domestic Violence Prevention Unit
ED	Emergency Department
EPPCHU	Eastern Perth Public and Community Health Unit
FDV	Family and Domestic Violence
GPs	General Practitioners
HDWA	Health Department of Western Australia
MHSB	Metropolitan Health Services Board
NGOs	Non-Government Organisations
RCGP	Royal Australian College of General Practitioners
SADVPU	South Australia Domestic Violence Prevention Unit

Introduction

Background

Family and domestic violence (FDV) 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 (HDWA, Family and Domestic Violence Action Plan 1997).

It is important to understand that the Government has made a commitment to respond effectively to FDV. As a result, health services are required to adopt policies, and develop procedures and programs in keeping with the State Family and Domestic Violence Action Plans.

This resource manual is an accompanying tool to the document titled **'Guidelines for developing protocols on intervention and management of family and domestic violence for hospitals in Western Australia'**. The document provides comprehensive guidelines in terms of policy position, definition, identification, and intervention of FDV. Furthermore, it outlines area of responsibility for management and hospital staff, and highlights a multidisciplinary and inter-agency response to FDV. The document includes a comprehensive checklist of what to do when FDV is present or suspected. This manual offers a general framework as to how your hospital can recognise and respond better to FDV at an organisational level. The extensive performance information outlined is aimed to assist you in looking at best ways of meeting your hospital standards.

Definition

Effective intervention for victims of FDV can only happen if staff have a good understanding of what constitutes FDV. 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 clearly established that FDV is a gendered crime, perpetrated mainly against women and children. It manifests itself in a variety of forms which include physical, psychological, economic, social and sexual violence. The following details help to clarify this further (ABS 1996; DVPU 1998).

Physical abuse

Physical abuse is defined as the use of physical force with intent to harm or frighten. It includes:

- Pushing, grabbing, shoving, slapping, kicking, and hitting - a victim may be hit with items such as a bat, hammer, belt, pot, ruler, etc;
- Punching, knocking against walls;
- Choking - by hand, rope, tie, etc;
- Beating; or
- Using weapons including knifes, guns, etc.

Sexual violence

Sexual violence, also termed marital rape, includes attacks on the victim's genitals or breasts, sexual sadism, and forced sexual activity. This violence is a method of aggression used to humiliate, hurt, degrade and dominate the woman.

Psychological abuse

Systematic use of fear, for example, threatening to harm or kill, threats to abduct or harm children, hurting or killing pets, threatening with guns or other weapons, or prolonged silence aimed at frightening the spouse.

Social abuse

Social abuse involves manipulation, isolation and/or intimidation. Often the woman may be prevented from making contact with family and friends. It commonly involves persistent behaviour preventing a woman from using a telephone or the family car. It also includes insults aimed at shaming, belittling and humiliating. Social and emotional abuse can be easily overlooked, yet its impact on mental and psychological well being is enormous.

Economic abuse

Examples include controlling money, denying access to a bank account, forcing the surrender of bank account/ bank card to enable the man to gain control of income or social security payments, preventing a woman seeking or maintaining employment, and denying input into important family financial decisions.

Prevalence of Domestic Violence in the Community

The Royal Australian College of General Practitioners noted that, FDV is likely to be under-reported. Furthermore, it is important to recognise that **episodes often escalate in intensity and frequency** (RACGP, undated).

A 1996 Australian Bureau of Statistics (ABS) nationwide survey on women's safety revealed that 38% of women aged 15 years and over, had experienced one or more incidents of violence: 33% had experienced physical violence, while 18% had been subjected to sexual violence (ABS 1996).

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 (RACGP 1994);
- Of the women who had experienced violence, in 42% of cases, violence occurred while they were pregnant (ABS 1996; Stuart 1996);
- A significant number of women who had been subjected to physical violence often live in fear. 73% of these women reported specifically living in fear of their spouses. This fear includes worrying about reprisals, fear of leaving their house, fear of men in general, and fear for children's safety (ABS 1996; S.A. Domestic Violence Prevention Unit, undated); and
- Women experiencing domestic violence or sexual assault in the home tend to take more time off work. ABS data indicate that 28% of women in violent relationships were found to be absent from work in a 12 month duration compared to 8% of women in a non-violent relationship (ABS 1996).

FDV occurs across all social, cultural, economic and religious groups. It affects families in metropolitan and country areas. In assisting people experiencing domestic violence, you must take account of the social, cultural, economic and religious factors impacting on the individual.

Children who witness incidents of violence in the home often suffer the psychological effects from witnessing this abuse (Yates 1996; Thormaehlen 1994).

Your role as a health professional

Health care providers form a key link both in the treatment of immediate symptoms, and in arranging or providing follow up support and specialised counselling from service providers outside the health system. Apart from counselling, women experiencing FDV may need support with accessing the family court system, accommodation and financial support. Hence, enabling an effective referral system plays an important part in empowering women 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 health care services. A contributing factor to under-detection is lack of disclosure, however it has been reported that doctors fail to identify FDV in up to 95% of cases (Goldber and Tomlanovich 1984; Roberts et al 1993; Mcleer 1989). Research suggests that early identification and intervention with victims of FDV by the 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 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);
- Almost a quarter of injuries suffered by women presenting at hospitals are attributed to domestic violence (Bates et al 1995; Stuart 1996);
- Victims of FDV also present in disproportionately larger numbers at non-trauma services (RACPG, undated); and
- In a significant number of cases, doctors have not presented an opportunity for victims to bring up the question of FDV (RACGP, undated).

Policy Statement

In 1997 the HDWA restated the intention to work towards a reduction in FDV in WA through its policies, programs and specific services (HDWA, Family and Domestic Violence Action Plan 1997). To this end, the HDWA outlined its purchasing function as follows:

- Purchasing plans to 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.

In terms of government goals, the HDWA 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 (NGOs) and health providers in ensuring access to services for those experiencing spouse abuse (HDWA, Family and Domestic Violence Plan 1997).

Value Framework

The following are the management principles underlying hospital and health care response to FDV:

- Patients will be treated with dignity and respect at all times;
- Patients' current and future safety will be regarded as paramount. Due regard of this will be given in the treatment and safety planning;
- Patients will be clearly provided with professional and appropriate information which encourages them to recognise that FDV is an abuse and a crime;
- Hospital patient intervention and management will focus on acknowledging and supporting the needs of the individual to safety, information and resources aimed at altering the prevailing violence perpetuating environment;
- Patients' privacy and confidentiality will be respected. The notion of confidentiality will be essential while at all times allowing patients to make informed choices aimed to minimise the likelihood of being subjected to further violence;
- Public hospitals will provide a supportive environment for patients presenting needs relating to FDV;
- In the delivery of services, hospitals will, at all times, acknowledge that the responsibility for violence or any other form of abuse lies with the perpetrator;
- Promotion of appropriate inter-agency cooperation remains critical in enhancing better patient outcomes;
- Hospital services will recognise and respond to the diverse nature of the client population, ensuring accessibility and relevance;
- Hospital management has the primary responsibility of ensuring that staff are supported to gain necessary skills in identification of and intervention in FDV; and
- Monitoring of the implementation of the protocols will be undertaken by hospitals with the support of HDWA.

1.0 Detection

1.1 Principle

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

1.2 Rationale

A narrow focus on physical injuries can limit detection of FDV. Detection plays an important part in the prevention of injuries and, in some cases, death. However, as with physical indicators, psychological and emotional signs are themselves not always specific enough to indicate abuse either. Abuse can only be confirmed after full assessment is made. Demographic and health factors are not full predictors of abuse. For this reason full screening is important, and where resources allow, doctors and nurses should be encouraged to assess for FDV as a matter of routine (Saunders and Hamberger1995).

1.3 Standards

1.4 Familiarity with FDV warning signs amongst staff

1.5 Targeted routine screening for FDV.

Indicators (Performance information)

1.4 Familiarity with FDV warning signs amongst staff

1.4.1 All staff with patient contact are familiar with presenting signs and symptoms of FDV, especially for ED, outpatient clinics, etc.

1.4.2 Staff induction and orientation will promote improved skills in detection of FDV.

1.4.3 Hospitals will display posters about FDV.

1.5 Targeted routine screening for FDV

1.5.1 In-depth screening for FDV will be undertaken for patients presenting with warning signs.

1.5.2 Where appropriate admission forms will include questions aimed at screening for FDV.

SIGNS AND SYMPTOMS OF FAMILY AND DOMESTIC VIOLENCE

Physical abuse signs and symptoms

- Head, neck and facial injuries.
- Unexplained physical injuries.
- Multiple and bilateral soft tissue injuries especially contusions and abrasions.
- Injuries on parts of the body hidden from view (eg injuries to breast, abdomen and/or genitals).
- Bruises of various ages.
- Ongoing complaints of poor health (eg. chronic pain syndrome).
- Previous history of violence in the family.
- Back pain.
- Neck stiffness.
- Ulcers.
- Headaches.
- Dizziness.
- Numbness.
- Palpitations.
- Miscarriage and other pregnancy complications.
- History of gynaecological problems.
- Injuries to breast, abdomen and/or genitals.
- Substantial delay between time of injury and presentation for treatment.

Psychological and emotional signs and symptoms

- Emotional distress ie. anxiety, indecisiveness, confusion, hostility.
- Unexplained somatic complaints.
- Repetitive visits to hospital Emergency Departments. Patients may not present FDV as a complaint or reason for visit.
- Sleep disturbances.
- Depression.
- Substance abuse, including prescribed drugs.
- Self-harm behaviours/suicide attempts.
- Withdrawal from touch.
- Client is evasive or embarrassed of injuries.
- Partner speaks for the client and/or insists on remaining with client.

Signs of homicidal risk

Any of these indicators should be taken seriously because they show that the homicidal risk is high:

- Availability of gun in the home.
- Perpetrator killed animal/pets with suspected intention to terrify spouse or family member.
- If victim reports high homicidal risk factor.
- Use of drugs and alcohol by perpetrator.
- Where perpetrator is violent to people outside his family.

Other

- Indicators for child abuse and neglect are detailed in the 1993 procedural manual *Guidelines for the Clinical Management of Child Abuse and Neglect* produced by HDWA.
- Similarly, indicators for elder abuse, are well detailed in the *Elder Protection Protocol*. All hospitals should keep copy of this document which may be obtained from the Office of Seniors Interests by telephoning (08) 9222 0111 or the Council on the Aging (WA) on (08) 9321 2133.

2.0 Assessment

2.1 Principle

Hospitals will undertake and/or coordinate a supportive holistic assessment that reflects the physical, psychological and social needs of patients experiencing FDV. Patients' safety, dignity and privacy will be regarded as paramount.

2.2 Rationale

A comprehensive assessment provides the basis for effective diagnosis and management of FDV cases. Assessment requires that hospital staff take time to explore the circumstances surrounding injuries and other warning signs of FDV. This includes making an assessment for patients suspected to experience FDV, who are presenting at hospitals for other apparently unrelated complaints.

2.3 Standards

2.4 Admission documentation

2.5 Assessment

2.6 Availability of assessment checklist resources

Indicators (Performance information)

2.4 Admission documentation

2.4.1 Where appropriate, admission forms will include questions on whether a patient has suffered FDV abuse.

2.4.2 Triage documentation will identify patients who have suffered from FDV.

2.4.3 Evidence that patients indicating signs and symptoms of FDV are fully screened.

2.5 Assessment

2.5.1 Hospitals will attempt to provide a private interview room for assessment of patients presenting signs of FDV.

2.5.2 Clear hospital policy and guidelines will be implemented to ensure that suspected victims of FDV are examined alone.

2.5.3 Practitioners will be firm about excluding others whose presence could interfere with patient assessment.

2.5.4 Hospital practitioners will be familiar with physical injuries that are consistent with FDV.

2.5.5 Hospital practitioners will be aware of patient behaviours that indicate that FDV is present (see previous checklist on signs and symptoms of FDV).

2.5.6 Hospitals will, as far as practical, ensure practitioners undertake a comprehensive psychosocial assessment that takes account of patient's current social, economic and psychological well-being when FDV is suspected.

2.5.7 Staff will, as far as practical, assess patients suspected to experience FDV, who are presenting at clinics or wards with other, apparentley unrelated complaints.

2.5.8 Practitioners will also encourage patients to talk about FDV to assist in determining the history of violence, provide comprehensive assessment and identify further support needs and options for intervention.

2.5.9 Medical practitioners will ensure, where necessary, that referrals are made to other experienced health professionals within or outside the hospital setting for comprehensive psychosocial assessments and related support (ie. hospital social worker, nursing staff experienced in FDV, ACAT, or social worker/counsellor at women's health centres).

2.6 Availability of assessment checklist resources

2.6.1 Hospitals will provide their medical practitioners with samples of assessment checklist resources. See example in Appendix 2.

3.0 Patient Safety

3.1 Principle

Patients' current and future safety will be regarded as paramount in the intervention of FDV cases.

3.2 Rationale

Hospital patient intervention and management will focus on acknowledging and supporting the needs of the individual to safety, information and resources aimed at altering the prevailing environment which perpetuates violence. Patients will be assisted to make informed choices aimed at minimising the likelihood of being subjected to further violence.

3.3 Standards

3.4 Intervention goals to promote safety

3.5 Availability of resources that promote safety

3.6 Discharge plans

Indicators (Performance information)

3.4 Intervention goals to promote safety.

3.4.1 Hospital practitioners will discuss with the concerns for patient safety with patients.

3.4.2 Practitioners will ask the patient if the perpetrator has access to firearms or other dangerous weapons. Notify the police if this is the case (the question will be referred to senior staff where junior staff feel unsafe).

3.4.3 Inform the patient of her right to protection, and that of the children, and the purpose of obtaining a restraining order.

3.4.4 Patients will be assisted to explore safe accommodation options (eg. 'Is there anywhere safe where you may be able to spend the night? We can help you to find temporary accommodation.'). Patients will be provided with information about safe accommodation such as refuges.

3.4.5 Staff will be familiar with the Crisis Care Unit telephone number and other local crisis oriented services.

3.4.6 Inform the Department of Family and Children services if there are any concerns about children's safety.

Note: The time of separation is also associated with increased level of violence against women running away from spousal abuse. Every care should therefore be taken to promote the safety of women who are separating from their partners.

3.5 Availability of resources that promote safety.

3.5.1 Ensure patient is informed of local FDV services that provide long term support (eg. counselling, welfare support, legal support, etc).

3.5.2 Hospitals will prepare resource information for staff that promotes safety options for patients.

A list of other useful community resources is provided in Appendix 1.

3.6 Discharge plans

3.6.1 Patients who have suffered FDV will not be discharged without a written referral being made to the hospital social work services.

3.6.2 In the absence of hospital based social work services, hospitals will provide information to their practitioners about an alternative referral mechanism to a local FDV support service.

3.6.3 Detected cases of FDV in all hospital wards will be referred to social work services. Patients will, at all times, be reassured that staff will support them irrespective of the course of action they opt to take (ie. whether they return home or decide to leave).

4.0 Referrals

4.1 Principle

Promotion of multi-disciplinary intervention and appropriate inter-agency cooperation 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 Rationale

FDV is a complex problem which can only be combated through a multifaceted approach. The need to refer is partly a recognition of roles played by other disciplines and agencies. This may include assistance in finding safe accommodation, legal advice, children's services, financial and income support, counselling services and specialised information provision. Bates et al (1995) note that it is common for women frequenting hospitals to lack information about relevant FDV support services. They argue that hospital staff are well positioned to inform patients about local support services. The points below are useful in enabling an effective referral process.

4.3 Standards

4.4 Multi-disciplinary approach

4.5 Information provision

4.6 Inter-agency cooperation

4.7 Resources

4.8 Follow up

Indicators (Performance information)

4.4 Multi-disciplinary approach

4.4.1 Practitioners will be aware of their own professional limitations in addressing FDV.

4.4.2 Practitioners will assess if the patient requires crisis support.

4.4.3 Practitioners will assess whether to contact local crisis support services directly, or via the hospital social work department.

4.4.4 Practitioners will assess availability of on-site support eg. Aboriginal liaison personnel.

4.4.5 Medical and allied health practitioners will refer all detected cases of FDV to social work services or other appropriate services.

4.4.6 Where relevant, hospitals will revise multidisciplinary forms to incorporate FDV needs.

4.5 Information provision

4.5.1 Hospital practitioners will attempt to provide relevant information to patients to assist them reach informed

decisions about accessing referral options.

4.5.2 Practitioners will provide agencies receiving referrals with appropriate patient information aimed at enhancing effective referral outcomes.

4.6 Inter-agency cooperation

4.6.1 Hospitals and practitioners will recognise the scope and limitations of their role and knowledge in attending FDV cases.

4.6.2 Effort will be made to refer patients to other agencies that provide more intensive and long term support.

4.7 Resources

4.7.1 Patients will be provided with an information package regarding local community support services. This may prove influencial in educating the patient about her options in the long term.

4.8 Follow up

4.8.1 Follow up plans will be initiated prior to the patient being discharged.

IMPORTANT NOTE

Hospital staff should not refer couples in abusive relationships for joint or marital counselling. However, initial individual counselling may be appropriate to ensure the patient concentrates on her safety, while the perpetrator can concentrate on changing his abusive behaviour.

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, confidentiality will be balanced against the notion of duty of care.

5.2 Rationale

The principle of confidentiality is important. However, to make an effective referral some patient information may need to be divulged to another agency as a way of enhancing patient safety and to lessen the liklihood of violence re-occurring. The reason for sharing information needs to be explained to the patient and the patient's consent **must** be sought. In cases of FDV, workers may have to share information with:

- The police;
- Counselling agency;
- Support agencies; and/or
- The patient's GP.

The patient should also be reassured that information shared with hospital staff will not 'get out' into social circles. Hospitals in small communities need to take particular account of this.

5.3 Standards

5.4 Confidentiality

5.5 Safety

5.6 Access to personal records

Indicators (Performance information)

5.4 Confidentiality

5.4.1 Access to patient information will be restricted to authorised staff.

5.4.2 Patients will be informed about the importance for practitioners to consult or share information with other staff on a 'need to know' basis.

5.4.3 Interpreters will be briefed by hospital staff about the importance of confidentiality, and only trained interpreters will be utilised.

5.4.4 Patients will be asked to sign a consent form for information release.

5.5 Safety

5.5.1 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.

5.6 Access to personal records

5.6.1 Patients will be informed of their right to access personal 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 Rationale

Reporting to the police should be done with the patient's consent. However, if the attending practitioner believes the safety risk is high, then a professional judgement should be made about contacting police where this will enhance safety. Section 7 on legal issues details the factors to be taken into account when deciding to involve the police.

6.3 Standards

6.4 Patient consent

6.5 Reporting to police

Indicators (Performance information)

6.4 Patient consent

6.4.1 Practitioners will obtain patient consent.

6.5 Reporting to police

6.5.1 Staff will contact the police crisis or communications line.

6.5.2 In cases of physical abuse, staff will allow police to take the necessary forensic photographic evidence, after obtaining patient consent. Practitioners will make a 'considered' decision to authorise collection of this evidence in the absence of patient consent.

NOTE:

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 <u>essential</u> for medical practitioners to do the following:

- ***Confer with senior medical staff;***
- ***Clarify with the Medical Defence Association;***
- ***Document the patient's refusal to sign consent form; and***
- ***Document attempted methods used to persuade the patient to provide consent.***

7.0 Legal Issues

Relevant Acts and related areas of law:

- Criminal Code Section 338D.
- Family Law Act 1975 (*as ammended*)
- Evidence Act (*Second Schedule*).
- Restraining Orders Act 1997.
- Freedom of Information Act 1992.

7.1 Principle

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

7.2 Rationale

There are diverse professional standards that guide patient intervention. However, it is important to be aware that there are broad areas of law and the justice system that impact on FDV intervention.

7.3 Standards

7.4 Documentation

7.5 Multi-disciplinary approach

7.6 Police involvement

7.7 Referrals

7.8 Right to access personal medical records

Indicators (Performance information)

7.4 Documentation

7.4.1 Hospital practitioners will be aware that documentation and proper recording is important from a legal perspective.

7.4.2 The admitting medical practitioner will oversee that necessary documentation of injury is carried out.

7.4.2 Written and photographic evidence is collected by the hospital. This should happen irrespective of whether the offender is known.

7.5 Multi-disciplinary approach

7.5.1 Medical practitioners will involve social work or other appropriate services whose role is better suited to patient liaison and advocacy with other agencies.

7.5.2 Nursing staff trained and experienced in FDV will be authorised to undertake follow up work with patients.

7.5.3 Social workers will play a critical part in assisting in both gathering and 'preservation' of evidence. They will be aware that their work records are accessible to the courts through subpoena.

7.6 Police involvement

7.6.1 Staff will request police involvement where there is physical injury or bodily harm, after obtaining patient consent.

7.6.2 Where patient safety appears at risk, staff will request police involvement after making a 'considered' professional decision.

7.6.3 The police have a duty to take a statement from the patient.

7.6.4 Hospital staff will be aware that police services have a key information gathering role. They play an important part in the 'preservation' of evidence.

7.6.5 Staff will be aware that police involvement makes it easier for a victim to access criminal injuries compensation.

7.7 Referrals

7.7.1 Medical and nursing staff will be clear that they are only one point of assistance to FDV victims. They will refer patients for social work services or other assigned staff to ensure patients are assisted to gain access to the legal system, eg.

- General legal advice;
- Restraining orders; and/or
- Separate legal representation for children.

7.7.2 Effective intervention for FDV victims will be maximised through making patient referrals to women's health centres, women's refuges or other local services.

7.8 Right to access personal medical records

7.8.1 Patients will be reminded of their rights to access medical records in the future if they so desired.

Effective police intervention and the intervention of the criminal justice system leads to a reduction of violence and better safety outcome for the survivors.

8.0 Patient Records

8.1 Principle

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

8.2 Rationale

Proper documentation of the patient's situation is a central part in the integrated strategy in reducing FDV. Documentation should be done with a clear understanding that the information may be used for legal purposes in the future. Lack of 'preservation' of such evidence can easily allow perpetrators to deny being liable for abuse.

8.3 Standards

8.4 Contents of patient records

8.5 Patient right to access personal records

Indicators (Performance information)

8.4 Contents of patient records

8.4.1 Medical practitioners will record all relevant medical history obtained during assessment.

8.4.2 Use factual language and patient's own words (separate from your own assessment).

8.4.3 Medical practitioners will take relevant photographic evidence. Patient consent will be sought.

8.4.4 Patient notes/report will indicate if a photograph was taken.

8.4.5 Body maps/schematic drawing will be used where relevant.

8.4.6 Record the patient's suspected cause of injury.

8.4.7 Record patient's behaviour and reactions of other family members/partner.

8.4.8 Document details of police involvement where relevant (ie. name of attending police officer and unit involved in attending patient).

8.4.9 Make file notes of where referral is made and any resource information given (eg. women's refuge, Crisis Care Unit, or hospital social work services, etc).

8.4.10 Record the name and the signature of registrar who attended the patient.

8.4.11 In the recording of information, practitioners should bear in mind that patients may access their medical records in the future.

8.5 Patient right to access personal records

8.5.1 Hospitals will enable patients to access personal records.

9.0 Accessibility of Services to a Diverse Population

9.1 Principle

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

9.2 Rationale

Some groups in the community face varied levels of disadvantage and barriers in accessing services in general. These groups are not homogenous, but it is important to be conversant with some issues which could be applicable to them. Importantly, in some cases such groups represent a very significant number of FDV cases being attended by hospitals.

ABORIGINAL FAMILIES

Violence in the Aboriginal community is a complex issue. 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 (Bolger1991; DVPU 1998). Aboriginal families suffer higher levels of social and economic disadvantage which compound the problem of FDV.

Aboriginal families are 53 times more likely to be victims of FDV than the rest of the population. Hospital admissions relating to FDV are 12 times higher than the rest of the population (FDV Taskforce 1995).

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

Aboriginal representative groups have communicated with government bodies that they prefer FDV intervention to involve the victim, perpetrator and other family members. They see the involvement of perpetrators in support programs as part of a holistic approach (FDV Taskforce 1995).

9.3 Standards

9.4 Knowledge

9.5 Additional assessment and intervention considerations

9.6 Referrals

Indicators (Performance information)

9.4 Knowledge

9.4.1 Hospital staff will have knowledge of the complex nature of historical, economic, and socio-cultural factors contributing to FDV. Additional information is provided in Appendix 3.

9.4.2 Hospital staff will have an understanding that while cultural considerations are important, safety will remain the overriding principle.

9.5 Additional assessment and intervention considerations

9.5.1 Where relevant and practical, female staff will assess and treat the patient.

9.5.2 Practitioners will maintain social and cultural sensitivity.

9.5.3 Practitioners will inform patients of the availability of trained interpreters where the need arises.

9.5.4 Practitioners will always find out which community the patient is from and assess if it is safe to go back to.

9.5.5 Hospitals must check safety aspects through female community leaders in remote communities (if abused patient is female from a remote community). This will assist in ensuring the patient is discharged to a safer environment.

9.5.6 Practitioners will inform victims of the criminality of the violence, and the right for individuals to live in a safe environment.

9.5.7 Where practical, hospitals should provide a skilled Aboriginal support worker on-site, with a key role in advocating, supporting and monitoring patients in need.

9.6 Referrals

9.6.1 Hospital staff will be familiar with appropriate referral options for Aboriginal patients.

WOMEN FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS (CALD)

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

9.7 Standards

9.8 Assessment and intervention.

9.9 Skills

9.10 Resources

Indicators (Performance information)

9.8 Assessment and intervention

9.8.1 Inform patient of availability of trained interpreter where need arises.

9.8.2 Request an interstate telephone interpreter when patient may be concerned about confidentiality or where she feels vulnerable.

9.9 Skills

9.9.1 Staff will be trained and skilled to work with interpreters. **They must NOT rely on partners or children, or hospital staff as interpreters.**

9.10 Resources

9.10.1 Staff will provide information on special services (eg. publications/material from Women's Multicultural Refuge Services).

9.10.2 Hospitals will use and display appropriate multilingual information/display posters specific to migrants.

9.10.3 Hospitals will keep a current list of migrant support services for referral and information purposes.

If unsure, consult with the Women's Refuge Multicultural Service on (08) 9325 7716. Whilst unable to provide on-site support for regional and remote areas, this service is experienced in the provision of telephone advice for victims of FDV.

RURAL WOMEN AND 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. For hospitals where emergency services are provided by GPs, the same procedures apply. It should be noted that many Aboriginal women should also be included in this category.

9.11 Standards

9.12 Patient issues

9.13 Staff issues

Indicators (Performance information)

9.12 Patient issues

9.12.1 Staff will be aware of factors that increase the vulnerability of FDV survivors and patients in rural and remote areas. See box below.

9.12.2 Medical practitioners will ensure concerns raised by nurses relating to FDV are investigated.

9.12.3 Women will be informed that FDV is a crime. This will assist women to become more aware of their responsibility in promoting their own safety.

9.12.4 The attending doctor must ensure nursing staff are authorised to make contact with appropriate referral services.

9.13 Staff issues

9.13.1 Hospitals will make any necessary debriefing arrangements for staff dealing with FDV cases.

9.13.2 Debriefing and support will occur for staff in isolated nursing posts.

9.13.3 Staff in regional hospitals may 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.

SPECIFIC PATIENT ISSUES IN REMOTE AND RURAL AREAS

- If the patients choose to leave, the move may require increased planning. There may also be additional considerations regarding arrangements for children.
- Be aware of isolation factors - this reduces access to services and increases the potential for social control from which the woman may find it harder to escape.
- The limited contact with other people also may mean lack of information on support services.
- Traditional conservative attitudes may lead to some rural women maintaining a 'utopian' view of the family, influencing their way of thinking.
- In rural areas there is less choice of support workers eg. priest/ teacher.
- Stronger gender stereotypes evident in attitudes and behaviours.
- Guns are more accessible in rural areas. This increases isolation due to feelings of vulnerability for victims of FDV.
- Check if there is a gun in the house. Assess risk and need to inform police authorities.
- Check for possible high levels of alcohol consumption and other drugs.
- Limited opportunity for women to let off steam due to isolation factors which can lead to high pressure build up.
- Migrant women may be further isolated by language and cultural barriers.
- Need to be aware of Aboriginal women's special needs (refer back to that section).
- Increased self harming behaviours may occur.

PREGNANT WOMEN

It is important for health workers to be aware that pregnant women are a group at risk who often 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). 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). Domestic violence experienced during pregnancy, contributes to both maternal and perinatal morbidity and mortality (Pearlman 1997).

9.14 Standards

9.15 Screening

Indicators (Performance information)

9.15 Screening

9.15.1 Women presenting with miscarriage and pregnancy complications will be screened for FDV.

9.15.2 Women presenting with gynaecological problems will be screened for FDV where this is deemed relevant.

9.15.3 Practitioners will pay due attention to, and screen, women who have presented with multiple abortions.

ELDER ABUSE AND PROTECTION

The Council on the Ageing (WA) defines elder abuse as the willful or unintentional harm caused to an older person by someone who is in a position implying trust. The abuse may include the following:

- Inflicting of physical pain/injury.
- Inappropriate or illegal use of older person's money or property.
- Emotional abuse which could include humiliation, harassment and threats. These could be verbal or non-verbal.
- Neglecting to provide a person with necessities of life such as food, relevant medical care, shelter, clothing, etc.
- Indecent assault or sexual harassment.

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.

9.16 Standards

9.17 Elder protection protocol

Indicators (Performance information)

9.17 Elder protection protocol

9.17.1 Hospitals will be familiar with the advice provided in the *Elder Protection Protocol*. All hospitals and ACATs should have copies of the protocol.

Information on the "Elder Protection Protocol" may be obtained by contacting the Council on the Aging (WA inc) on (08) 9321 2133. They may also provide specific training in elder protection.

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).

9.18 Standards

9.19 Awareness

9.20 Support

Indicators (Performance information)

9.19 Awareness

9.19.1 Staff will be aware that disability may limit the person's access to venues and information.

9.19.2 Staff will be aware that some individuals with disability may also suffer poor concentration.

9.20 Support

9.20.1 Staff will take account of capabilities and limitations of patients with disability when making intervention and management plans.

9.20.2 Staff will ensure assistance is provided to patients who are unable to make phone calls.

9.20.3 Hospitals will make necessary referrals for support services through social work or local support services (eg. preparing statements, filling in forms, routine follow up, etc).

For further advice, consult the Disability Services Commission on (08) 9426 9200. In cases where there are concerns about a patient's decision making capacity, you should also consult with the Office of the Public Advocate (08 9278 7300 or 1800 807 437).

MENTAL ILLNESS

Mental illness can be a risk factor for a patient being subjected to, or subjecting another family member to FDV. In addition, it is not uncommon for women traumatised through FDV to be treated as if they are mentally ill rather than getting support to deal with their victimisation. An appropriate intervention depends largely on making an appropriate assessment.

9.21 Standards

9.22 Assessment

9.23 Medication

9.24 Information

9.25 Referral

Indicators (Performance information)

9.22 Assessment

9.22.1 Staff will take a thorough history of patients presenting with signs of FDV and mental illness.

9.22.2 Staff will be aware of the dangers of misdiagnosis.

9.23 Medication

9.23.1 Where possible, practitioners will avoid putting patients on unnecessary medication.

9.23.2 Effort will be made to focus on the problem of violence.

9.24 Information

9.24.1 Information will be provided to assist patients understand their rights and options. People with mental illness are fairly vulnerable, therefore adequate time must be given to thoroughly assist them to explore their options.

9.25 Referral

9.25.1 Hospitals will maintain updated information on specialist crisis support services for use in emergency cases.

9.25.2 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.

9.25.3 Hospitals will organise referral for partner of a patient or other family members.

SAME SEX RELATIONSHIPS

FDV also occurs in same-sex relationships. At the root of the violence are questions of power and control similar to heterosexual relationships. Generally, same types of violence as heterosexual couples occurs, although threats of 'outing' may also be used to force compliance.

9.26 Standards

9.27 Awareness

9.28 Support

Indicators (Performance information)

9.27 Awareness

9.27.1 Staff will recognise that FDV does occur in same sex relationships.

9.27.2 Staff will focus on the needs of the patient experiencing FDV violence and not their own attitudes on the issue of sexuality.

9.27.3 Staff will be aware of the importance of asking direct questions.

9.27.4 Staff will be aware that lesbian and gay people have limited legal rights compared to heterosexual couples under the Family Law Act.

9.27.5 Staff will be aware of the threat of 'outing' to family or work colleagues which may be occuring in the relationship and form part of the abuse.

9.27.6 Staff will be aware of the community isolation that people in same-sex relationships may experience.

9.28 Support

9.28.1 Staff will accept the patient's story.

9.28.2 Provide same-sex hospital staff where possible.

9.28.3 Hospital staff will provide patients with the contact number for gay and lesbian telephone counselling services.

Treat any other issues as you would in heterosexual relationships. Gay and Lesbian Counselling service phone: (08) 9328 9044.

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 support agencies where relevant (Thormaehlen 1994; Yates 1996).

9.29 Standards

9.30 Psychological and emotional impact

9.31 Assessment skills

9.32 Protective action and clinical management guidelines

9.33 Resources for children

Indicators (Performance information)

9.30 Psychological and emotional impact

9.30.1 Staff will be aware that children who witness FDV may experience post-traumatic stress disorder (PTSD), separation anxiety and developmental delay.

9.30.2 Staff will be aware that children who witness FDV may also be victims of violence.

9.31 Assessment skills

9.31.1 Staff will be equipped with appropriate skills in taking a detailed case history:

- Knowing how to ask questions appropriate to age.
- Interpersonal skills that are age appropriate.
- Identifying old and new injuries.

9.32 Protective action and clinical management guidelines

9.32.1 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 receiving hospital care under Child Welfare Act 1947 S. 29 (3a).

9.32.2 Staff will be aware of the 1997 *Government of WA Reciprocal Child Protection Procedures* to which HDWA is a signatory.

9.32.3 Staff will be aware of the 1993 HDWA *Guidelines for the Clinical Management of Child Abuse and Neglect*.

9.32.4 Child protection issues will be referred to the Department of Family and Children services in line with existing reciprocal arrangements, as well as the guidelines mentioned above.

9.33 Resources for children

9.33.1 Every hospital will be aware of current local resources for children for referral purposes.

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 Rationale

Standardised data collection is an important part of the overall response to FDV. The availability of data will assist in monitoring the extent of the problem and effectiveness of intervention programs. The collection of this information will be crucial to future policy and program response.

10.3 Standards

10.4 Essential data

10.5 Responsibilities for implementation

Indicators (Performance information)

10.4 Essential data

10.4.1 Hospitals will ensure collection of essential data is maintained. The minimum requirement is for this information to include:

- Demographic data as per medical record requirements.
- Type of abuse.
- Injury suffered.
- Medical treatment needed.
- Use of weapon where relevant.
- Relationship to perpetrator.
- Gender.
- Ethnicity.
- Location of incident.
- Referral source.
- Type of intervention/service provided by hospital.

10.5 Responsibilities for implementation

10.5.1 Hospitals will ensure practitioners maintain up-to-date and accurate patient case notes.

10.5.2 Hospitals will ensure essential data is entered into the information system.

Note: The use of ICD codes to identify patients experiencing FDV can only be successful if practitioners maintain proper documentation regarding patient circumstances and intervention. Incomplete clinical documentation impacts not only on quality of patient management but also affects resource allocation and other policy and program considerations.

11.0 Professional Development

11.1 Principle

The hospital management system has the primary responsibility of overseeing that staff are supported to gain necessary skills in identification and intervention of family and domestic violence.

11.2 Standards

11.3 Training attendance

11.4 Training frequency

11.5 Training content

11.6 Trainers and training resources

11.7 Staff debriefing and supervision

Indicators (Performance information)

11.3 Training attendance

11.3.1 Hospital staff (doctors, nurses, social workers and **all** ED staff including clerical) will attend FDV training.

11.3.2 Heads of social work services will ensure all staff are well acquainted with the dynamics and complexities of FDV as well as referral criteria for other services.

11.4 Training frequency

11.4.1 Training sessions will be organised at least twice a year to ensure new staff are provided an opportunity to attend.

11.5 Training content

11.5.1 Priority for training content will take account of the nature of the potential patient population represented in the use of hospital services.

11.5.2 Training on FDV will include specific practice needs such as detection, assessment and intervention.

11.5.3 Specific legal training is strongly recommended. This can be negotiated through the Legal Aid Commission's Domestic Violence Unit. This may cover:

- Court attendance for hospital staff.
- Knowledge of mandatory reporting.

- Taking of photographic evidence.
- Other evidence (eg. x-rays).
- Knowledge of legal standing for hospital staff treating FDV victims.

11.5.4 Training will include:

- Impact of FDV on children.
- Cultural awareness training specific to working with Aboriginal families experiencing violence.
- CALD issues. This will include providing information on how FDV is regarded in migrant communities.
- Issues in same-sex relationships.
- Issues relevant to disability, mental illness.

11.5.5 Hospitals will be aware of the coordinated training strategy available for elder abuse via the Council of the Aging.

11.6 Trainers and Training resources

11.6.1 HDWA FDV Training Kit can be accessed through the Health Department home page (www.health.wa.gov.au) or by contacting HDWA's Purchasing Unit on (08) 9222 2233.

11.6.2 Request can be made to training facilitators to run relevant training in your organisation.

11.6.3 Specific training in the area of sexual assault could be purchased or negotiated through SARC in your region.

11.6.4 Staff must know where a copy of the hospital's *Protocols Manual* is kept.

11.6.5 Hospitals will make sure all staff are aware of where copies of FDV training videos/ patient referral information packages are kept.

11.6.6 Hospitals will ensure that all resources and referral lists are kept current.

11.7 Staff debriefing and supervision

11.7.1 Hospitals will make appropriate debriefing and supervision arrangements for staff attending patients presenting with FDV.

12.0 Staff Safety

12.1 Principle

The hospital management has the primary responsibility of promoting a safe working environment for its staff dealing with 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;
- Alert system;
- Duress alarms;
- Police;
- First names only on name badges;
- Safe car parks; and
- Safe commuting for shift workers.

13.0 Monitoring

13.1 Principle

Monitoring of the implementation of protocols will be undertaken by hospitals with the support of HDWA.

13.2 Standards

13.3 Adoption of protocols

13.4 Hospital responsibilities in the implementation of protocols

13.5 Designation of a position to coordinate and monitor responses to all aspects of FDV intervention.

13.6 Review of protocols implementation

Indicators (Performance information)

13.3 Adoption of protocols

13.3.1 All hospitals will adopt FDV protocols. As prescribed, the protocols will be adopted to suit hospital settings and available personnel.

13.4 Hospital responsibilities in the implementation of protocols

13.4.1 Individual hospitals will develop a coordinated FDV framework.

13.4.2 Hospital management will ensure heads of clinical departments are involved in facilitating the implementation of protocols.

13.4.3 Hospitals will ensure staff use guidelines as intended.

13.4.4 Hospital management will ensure a well-established referral system is developed and maintained across disciplines (doctors, nurses, social workers and allied health professionals).

13.5 Designation of a position to coordinate and monitor responses to all aspects of FDV intervention.

13.5.1 It is recommended that hospitals designate a position to coordinate and monitor responses to all aspects of FDV intervention. Hospitals are advised to retain flexibility on who they assign, depending on the available personnel resources. It is recommended that the position has the following features and roles:

- The position will allow for direct liaison with hospital management and inter-agency contacts and initiatives. Cases of elder abuse will continue to be monitored through the regional Aged Care Assessment Teams who are well versed with the issues and needs;

- The hospital FDV contact person will ensure ED and other hospital health practitioners have access to information about local services for victims of FDV;
- The hospital FDV contact person will organise current resource information of relevant local referral agencies for practitioners;
- The hospital FDV contact person will promote strategies aimed at fostering a positive working relationship with outside support agencies; and
- The hospital FDV contact person will coordinate inter-agency initiatives.

Note: Any possible designated FDV position is primarily for monitoring and coordination purposes. Day to day intervention in FDV cases remains the responsibility of all staff undertaking patient work in their specific areas.

13.6 Review of protocols implementation

13.6.1 HDWA will conduct a coordinated, periodical review of protocol implementation on regular and timely basis.

The protocols are managed by HDWA General Health Purchasing Division. The contact number is (08) 9222 2233*.*

Support for protocol implementation:

Support for protocol implementation may be accessed via the Eastern Perth Public and Community Health Unit on (08) 9224 1625.

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Appendices

Appendix 1:

List of Community Resources and other Useful Information

This list represents some key linkages for families experiencing violence in WA metropolitan area. Each hospital must devleop and maintain a current resource/referral sheet of relevant local agencies to all appropriate staff for referral and liaison purposes.

Crisis accommodation and support

Women's Refuge Group of WA Inc **(08) 9227 1642**

Provides information on refuges and safe houses in WA.

Women's Refuges Multicultural Services **(08) 9325 7716**

An outreach, information, advocacy, referral and support service for women and children of non-English speaking Background leaving family violence.

Aboriginal Women's Refuge (Anawim) **(08) 9328 7562**

Crisis and information

Crisis Care Unit (24 hours) **(08) 9325 1111**

toll free **1800 199 008**

Provides a crisis line for families and children. Also provides practical assistance.

Legal advice and support

Domestic Violence Unit, Legal Aid Commission **(08) 9261 6320/ (08) 9261 6254**

Advises and assists women escaping domestic violence.

Legal Aid Commission (country) **1800 804 616**

Women's Legal Services Inc

- General inquiries **(08) 9221 5011**
- Requests for referral - Information line open weekdays

9.00 am - 12.00 noon **(08) 9221 5122**

Provides legal advice to women.

North Perth Migrant Resource Centre Legal Service **(08) 9328 2699**

A solicitor is available to provide legal advice and support to migrant clients by appointment only.

Information and initial advice

Women's Information Service **(08) 9222 0444**

Provides initial counselling and support.

Police intervention

Police Communications (24 hours) **(08) 9222 1111**

Police Child Abuse Unit **(08) 9227 8111**

Sexual assault support service**

The Sexual Assault Resource Centre (Crisis line) **(08) 9340 1828**
(country) toll free **1800 199 888**

***Some regional areas have local Sexual Assault Resource Centres.*

May provide consultation/ advice when dealing with patients whose decision making faculties are impaired.

Relationships counselling services

Relationship Australia **(08) 9470 5109**

Parent Help Centre **(08) 9272 1466**

Centrecare - check white pages for local number

Hospital social work services - can provide referral to local counselling services

Services providing programs for children and families include:

Relationship Australia **(08) 9470 5109**

Parent Help Centre **(08) 9272 1466**

Centrecare - check white pages for local number

Hospital social work services

Perpetrator programs

Men's Domestic Violence Helpline. toll free **1800 000 599**

Hospital social work services and the FDV contact person will keep a list of local perpetrator programs.

Other

Translating and Interpreting (24 hours) **13 14 50**

Guardianship and Administration Board **(08) 9278 7350**
toll free (country) **1800 191 009**

Note: This information was prepared in May 1999. Every effort has been made to ensure accuracy of this information, however services may have changed.

Appendix 2:

Assessment Guide

If patient suffered injuries, explore the following:

- Are injuries consistent with cause described?
- Are injuries on an area of body normally covered by clothing?
- Was there a delay between time of injury and that of reporting?
- Are there any signs of previous unexplained injuries or wounds?
- Does patient seem embarrassed, evasive or ashamed of injuries?
- Any previous history of suspicious injuries or other symptoms?
- Is there a noted pattern of repeated use of emergency department services?

Be aware of:

- FDV victims often present with minor complaints without visible injuries.
- The decision to present at the hospital is a major step for the victim already feeling very helpless.
- The perpetrator may accompany victim to hospital.
- The patient may appear uneasy about leaving hospital.

Pregnant women:

For pregnant women, further observation is necessary in the following areas:

- Notable problems during pregnancy such as pre-term abortion, bleeding, intrauterine growth retardation, hyperemesis and other injuries.
- Self induced abortions or multiple therapeutic abortions or miscarriages.
- Consider rating of safety risk.

Direct questions are more productive in eliciting required information.

Questions exploring psychosocial situation:

The process of listening and validating may also be therapeutic in itself (Stuart 1996).

Other questions may also be asked in the following areas:

- Onset of FDV.
- Types of abuse.
- Assessment of social situation ie.
  - Type of relationship.
  - Are there any children in the family.

- Current financial circumstances.

- Support network.

- Patient's psychological health - psychological resources, self esteem, sense of control over one's life.

The following direct questions provide a good starting point:

- How are things between you and your partner?
- Are things stressful for you at home at present?
- People in relationships can often argue. What happens when you and your partner disagree?
- What happens when your partner becomes angry?
- Does your partner threaten you?
- Does he put you down?
- Are you scared at home?
- Do you feel safe when your partner is at home?

Provide a supportive environment:

- Interviews will be conducted in a private room for patients suspected to suffer from FDV problems.
- Patient will be interviewed alone, unless specific request is made for a second party to be present (eg. advocate).
- Exclude perpetrator from attendance at interview.
- Provide same-sex staff where deemed appropriate.
- Staff will use engaging skills that validate and affirm the experience of patients presenting with FDV.

Engaging tools (support):

Gaining cooperation of a person who has suffered FDV can be difficult. The victim may require a lot of validation and affirmation:

- In the process of identifying and managing FDV, it is critical to remain sensitive and non-judgemental.
- Accept the patient's story and let the patient know that you accept her story.
- Reinforce that FDV is against the law, and inform her that she does not have to live with the violence.
- Inform patient that she is not alone, there are other women experiencing FDV.
- Affirm that patient has made an important step in seeking help at the hospital.
- Reinforce that patient should learn not to self blame, and that the abuser ought to be taking responsibility for the violence.

Appendix 3:

Aboriginal Families

Violence in the Aboriginal community is a complex issue requiring a broader definition. First, the violence goes beyond spouse abuse. In practice spouse abuse is also located in a complex web of family violence encompassing a larger group of family members. This ought to be seen in the context of socio-economic dislocation and historical effects which have led to the breakdown of traditional social control (Bolger 1991; DVPU 1998).

Family violence is very prevalent amongst Aboriginal families. Studies estimate that 90% of the Aboriginal population suffer from family violence (Atkinson et al 1993; Baldini 1993).

While women may also be involved in fights or 'acting as helpers', they are more likely than men to suffer both minor and serious injuries.

In the Northern Territory, 79% of all chargeable homicides were committed against Aboriginal women (Atkinson et al 1998). In other states the figure is estimated around 70% (ACT Community Law Reform1992).

More women have died through violence than deaths in custody in two states (Atkinson 1990).

88% of physical and sexual assault go unreported for fear of community reaction, fear of partner and perceived lack of police action (Baldini 1993).

Aboriginal women constitute 50% to 75% of residents at women's refuges in Australia (Baldini 1998).

The link between FDV, self-harm and suicide is much more pronounced in the Aboriginal community when compared to the rest of the population (Atkinson et al 1998).

Appendix 4:

Perpetrator programs

There is conflicting information about the success rate of 'abuser treatment programs'. Success rate is reported to vary between 5% to 65%. Brown (1997) emphasises that to break the cycle of violence, intervention measures should be given due regard. However, victim saftey should take precedence over such intervention. More importantly, referrals for such support should only be done after intense screening of the perpetrator.

Referrals

Hospital referrals to perpetrator programs will go through the social work hospital services. Depending on the hospital personnel resources, arrangements may be made for such referrals to be handed via the Director of Nursing.