

Domestic Violence - Identifying and Responding

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Functional Sub group Clinical/ Patient Services - Maternity
Clinical/ Patient Services - Incident management
Clinical/ Patient Services - Baby and child

Summary This policy outlines the characteristics and consequences of domestic violence and identifies the role of NSW Health generally and Area Health Services specifically, in recognising and responding to domestic violence. The policy introduces a new preventative strategy involving universal routine screening for domestic violence in services where significant numbers of women have been found to be at risk. The aims are twofold: to reduce the incidence of domestic violence through primary and secondary prevention approaches: and to minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches, ongoing treatment and follow-up counselling.

Replaces Doc. No. Domestic Violence - Identifying and Responding [PD2005_413]

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Affiliated Health Organisations, Affiliated Health Organisations - Declared, Community Health Centres, Ministry of Health, Public Hospitals

Audience Clinical staff -emergency departments and clinical settings that provide domestic violence services

Distributed to Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Government Medical Officers, Health Professional Associations and Related Organisations, NSW Ambulance Service, Ministry of Health, Public Hospitals, Tertiary Education Institutes

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Policy Manual Not applicable

Director-General **File No.** 04/432

Status Active

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

IDENTIFYING AND RESPONDING TO DOMESTIC VIOLENCE

The *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) provides a framework for informing domestic violence responses for staff in hospitals and community health services. This document's child protection focus has been improved by amendments as detailed below.

It is important to note the inclusion of the following additional text in *section 3.1 Identification of domestic violence* (page 9), procedures section after the paragraph commencing "Ask about safety":

"Ask about child safety:

- *Do you have children? (If so) have they been hurt or witnessed violence?*
- *Who is/are your child/ren with now? Where are they?*
- *Are you worried about your child/ren's safety?*

Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm."

Procedures in *Section 3.2.2, Counselling interventions with victims* (page 13) have also been amended by deleting and replacing dot point six under "Assess safety" with the following text:

"Are there children involved? Who is/are your child/ren with now? Are they safe? Was/were your child/ren nearby when your partner was violent to you?" Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm (refer to Section 4.5 – Children and domestic violence)"

It is recommended that any hard copies of the document *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) in circulation also be amended accordingly.

Living with domestic violence has a serious impact on short- and long-term psychological, emotional and physical health of victims and their children. The aim is to help reduce the incidence of domestic violence through the provision of primary and secondary prevention health care services, and to minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches including ongoing treatment and follow-up counselling.

The term "domestic violence" is used to refer to abuse and violence between adults who are partners or former partners. NSW Health has existing policies and strategies that address other forms of violence that are commonly experienced. Health workers may find this policy can provide guidance in responding to situations where similar dynamics occur, in particular the section on legal responses for domestic violence.

Title: Identifying and Responding to Domestic Violence

The policy and procedures were developed by the NSW Department of Health in consultation with Area Health Services, interagency partners and non-government organisations.

A core component of the policy is routine screening for domestic violence, which is to be implemented for women attending antenatal and early childhood health services and women aged 16 years and over attending mental health and alcohol and other drugs services in accordance with the policy.

Dr Richard Matthews
A/Deputy Director-General, Strategic Development

POLICY and PROCEDURES

for identifying and responding to
domestic violence

*'...there is evidence that
more medical treatment is
sought for injuries resulting
from domestic violence
than any other cause'*

ABS 1996

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October 2006

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Foreword

Domestic violence is unacceptable in Australian society; yet it is too often the reason for people (mainly women) seeking assistance from health and welfare services.

Violence within families is often hidden. Women who are abused are frequently treated within NSW Health services, however they generally do not present with obvious trauma, even in Emergency Departments. Domestic violence has profound effects on the physical and emotional health of large numbers of women in our community and on the children who experience it. These continue even after the abuse has ended.

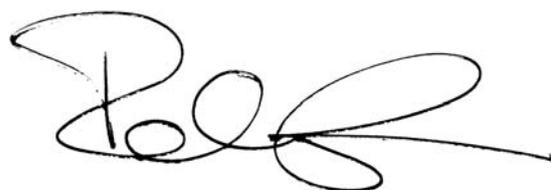
The aims of this policy are twofold:

1. To reduce the incidence of domestic violence through primary and secondary prevention approaches.
2. To minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches: ongoing treatment and follow-up counselling.

This policy outlines the characteristics and consequences of domestic violence and identifies the role of NSW Health generally and Area Health Services specifically, in recognising and responding to domestic violence.

The policy introduces a new preventative strategy involving universal routine screening for domestic violence in services where significant numbers of women have been found to be at risk. Some health workers may be reticent to directly address this issue, even though evidence supports a direct approach. To respond to this, sustainable staff training, safety, and coordination within the NSW Health system is required.

I welcome the *NSW Health Policy for Identifying and Responding to Domestic Violence* and accompanying Procedures document. The policy makes a major contribution to our understanding of the impact of domestic violence and provides a platform for better NSW Health responses.



Robyn Kruk
Director-General
March 2003

Explanatory note

This document contains both the *NSW Health Policy for Identifying and Responding to Domestic Violence* as well as the more detailed *Procedures for Identifying and Responding to Domestic Violence*.

Elements of the document that are replicated in the policy appear in a grey text box at the beginning of each section.

Section 12 – Program specific considerations and Section 13 – Diversity and effective service delivery of this document are discrete sections which provide specific direction to staff in different programs, and guidance in relation to working with groups who have particular needs.

The development of the procedures document, in addition to the policy, follows a recommendation of the Domestic Violence Policy Review Advisory Committee. It is based on extensive consultation with practitioners and is intended to avoid duplication of effort across Area Health Services.

Preface

Domestic violence is a term which can mean different things to different people. It is often understood to relate to all violence which occurs amongst family members or in the ‘domestic sphere’. Violence in the home can take many forms, including but not limited to partner abuse, abuse of parents by adult children, child physical abuse and neglect, sexual abuse of children or adults, abuse of older people and co-tenants in a household. Accordingly there are many possible victims who include children, parents and adults, or child siblings (See Figure 1). These forms of abuse or violence can also occur outside the home and between people who are unrelated. The term ‘family violence’ is preferred by many Aboriginal and Torres Strait Islander communities as it encapsulates the extended nature of Indigenous families and also the context of a range of forms of violence occurring frequently between kinspeople in Indigenous communities (Memmot & Stacy 1999).

In this document the term ‘domestic violence’ is used to refer to **abuse and violence between adults** who are partners or former partners (Refer to Section 1.2 – Definition of domestic violence).

NSW Health has existing policies and strategies which address other forms of violence which are commonly experienced. These include:

- *NSW Health Frontline Procedures for the Protection of Children and Young People*, 2000
- *NSW Health Physical Abuse, Emotional Abuse and Neglect of Children – Procedure Manual for Health Workers Providing Secondary Specialised Response*, 1997
- *NSW Health Child Sexual Assault Procedure Manual*, 1997
- *NSW Health Sexual Assault Services Policy and Procedure Manual (Adult)*, 1999
- *NSW Health Victims of Crime Policy*, 1995
- *NSW Aboriginal Family Health Strategy* 1995
- *Aging and Disability Department, Abuse of Older People: Inter-Agency Protocol*, 1995

Health workers may find this policy can provide guidance in responding to situations where similar dynamics occur, in particular the section on legal responses for domestic violence. However, it is beyond the scope of this policy to address the particular issues for responding to all forms of violence that are experienced by users of the NSW Health system.

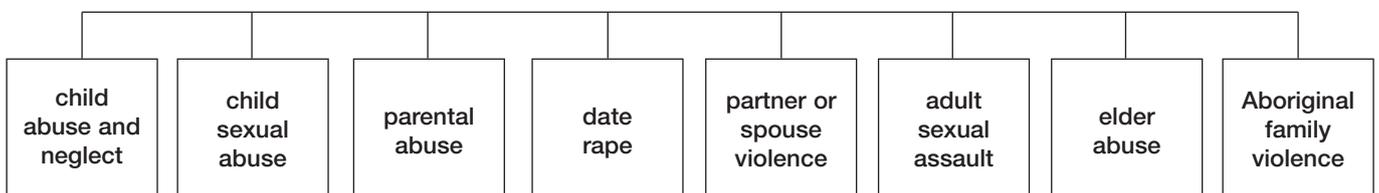


Figure 1. A typology of abuse in relationships

POLICY

1.1 The facts

- There is evidence that more medical treatment is sought for injuries resulting from domestic violence than from any other cause (ABS 1996).
- One in four women presenting to Emergency Departments in Australia have experienced domestic violence at some point in their lives (Bates et al. 1995).
- Being the target of violence puts women at increased risk of depression, suicide attempts, chronic pain syndromes, psychosomatic disorders, physical injury, gastrointestinal disorders, irritable bowel syndrome and variety of reproductive health consequences (WHO 2002).
- More than one in twenty women experience domestic violence during pregnancy (Stewart & Cecutti 1993; Gazmararian et al. 1996).
- Women abused in pregnancy are three times more likely to become a victim of attempted or actual murder (McFarlane, Campbell, Sharps & Watson 2002).
- Violence during pregnancy increases the risk of poor weight gain, anaemia, infections, preterm labour, and experiencing postnatal depression (Parker, McFarlane & Soeken 1994; Adams-Hillard 1985; Berenson, Wiemann & Wilkinson 1994). The infants are more likely to have a low birth weight and reduced head circumference (Quinlivan & Evans 1999).
- 17 percent of young people have witnessed their mother being hit (National Crime Prevention 2000).
- Physical abuse of children is fifteen times more likely in families where domestic violence is occurring (McKay 1994).
- Exposure to recurrent traumatic experience in early childhood, including domestic violence, places a child at much greater risk of long-term psychological, emotional and behavioural problems (Perry 1994).
- It is estimated that the cost of domestic violence in Australia to the business sector, not including the cost of services, policing or justice responses is \$1.5 billion annually (Henderson 2000).

1.2 Definition of domestic violence

Policy

For this policy, domestic violence is defined as:

Violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman.¹ Living with domestic violence has a profound effect upon children and young people and may constitute a form of child abuse.²

The above definition includes violence in same sex relationships. Domestic violence includes physical abuse; sexual abuse; psychological, emotional and verbal abuse; social abuse; economic abuse; and harassment and stalking (Refer to Appendix 1 – Forms of domestic violence). These various forms of abuse often occur simultaneously as a form of systematic abuse with the effect of coercing and controlling a partner. Many forms of domestic violence are offences under the *NSW Crimes Act 1900* (Refer to Appendix 6 – List of domestic violence offences).

Evidence from a range of sources including police records, indicates that 88 per cent to 92 per cent of victims of domestic violence are women (Bagshaw & Chung 2000). It is also known that violence by men towards female partners rather than vice versa is more likely to result in multiple assaults, injury, hospitalisation, death, and to continue post-separation (*National Crime Prevention 2000*, Mirrlees-Black 1999). In accordance with the *NSW Health Gender Equity Statement (2000)* identification of the differential needs of women and men is important in order to provide better-targeted health services.³ Both women and men may experience abuse and violence in relationships and the seriousness of violent behaviour by any person must not be minimised.

The principles and interventions described in this document are appropriate with both male and female victims.

1.3 Policy context

Policy

A growing body of research evidence is revealing that sharing a life with an abusive partner can have a profound impact on a woman's health. Violence has been linked to a significant number of different health outcomes, both immediate and long-term (WHO 2002).

Domestic violence is a problem which is both widespread and harmful, not only for the primary victims, but also potentially for the children who live in households where domestic violence occurs. Domestic violence often escalates over time. The community identifies health services as appropriate places to seek help after domestic violence occurs and yet identification of this problem by NSW Health services is low. Victims of domestic violence often feel unable to speak out about the violence due to feelings of shame, and fear of retribution from the perpetrator and/or negative community attitudes.

The responses of many victims who experience domestic violence are also complex, with continued involvement with a violent partner in many instances, as well as minimisation and justification by women of their partner's behaviour. Additionally, presentations relating to domestic violence may be confusing, as in some situations the perpetrator of violence may claim to be a victim.

This policy directs Area Health Services' responses to domestic violence. Any local procedures put into place by Area Health Services will be consistent with NSW Health Policy and Procedures.

The policy replaces the *NSW Health Domestic Violence Policy 1993*. The *NSW Health Guidelines for Health Worker's Contact with Perpetrators of Domestic Violence 1998* have been clarified and incorporated into these procedures.

NSW Health is a partner in the NSW Strategy to Reduce Violence Against Women and is a signatory to the *NSW Domestic Violence Interagency Guidelines 2003*.

1.4 Statement of principles

Policy

This policy reflects the following principles which are based on the principles contained in the *NSW Domestic Violence Interagency Guidelines 2003*:

- Women and children have a right to live safely and free of fear within their own homes – safety is paramount in any response.
- Existing societal conditions and social relations which reflect gender inequality and promote male power need to be challenged in order to undermine the supports for domestic violence.
- Appropriate community responses to domestic violence rely in part on education and programs which promote gender equality.
- Acts of domestic violence and its consequences are the sole responsibility of the perpetrator.
- Prevention of domestic violence is the ultimate objective.
- Essential to any response are early identification, appropriate intervention and long-term solutions to provide for the well-being and life chances of women and children who have experienced domestic violence.
- Domestic violence occurs across all cultural and socio-economic groups; language and cultural needs of women of non-English speaking background and Aboriginal women must be considered in any response.
- Any response to domestic violence requires a consistent planned approach across all sectors of the community and at all levels of government.

1.5 The role of NSW Health

Policy

NSW Health operates within the framework of NSW Government policy on domestic violence. Responses must be consistent with current NSW Government policies including the NSW Charter of Victims Rights (*Victims Rights Act 1996*) and the legislative requirements of other statutory agencies such as the NSW Police, the Department of Community Services and Attorney General's Department.

The role of NSW Health is to:

- identify resources needed to ensure a consistent high quality response to victims of domestic violence across all services.
- promote strategies targeting prevention as well as identification of families at risk and early identification.
- ensure effective collaboration between health service providers, as well as with government and non-government agencies, to address the needs of all victims and their children.
- ensure that services are provided in a manner that is linguistically and culturally appropriate.

1.6 The role of Area Health Services

Policy

Area Health Services must ensure that responses to individuals at risk of, or having experienced domestic violence are provided in a range of settings, including community health services and hospitals, as there is no specialist service stream for victims of domestic violence.

The role of Area Health Services is to:

- plan and resource local health services to meet local needs.
- provide responses including prevention, risk identification, early intervention, crisis intervention, treatment and follow-up counselling.
- establish an ongoing training strategy to ensure that health workers receive up-to-date information about domestic violence that is relevant to their position.
- implement routine screening to targeted programs by 2004 to prevent and intervene early where violence is identified.
- ensure that crisis and non-crisis intervention, medical treatment, appropriate counselling, information and referral services are provided to victims and non-offending family members.
- ensure that responses to clients who are identified as perpetrators of domestic violence comply with NSW Health and NSW Government policy.
- encourage intragency and interagency collaboration in projects, committees, and initiatives at the local level.

POLICY and PROCEDURES

2

Prevention of domestic violence

Policy

Public health intervention is characterised in terms of three levels of prevention:

- primary prevention aims to prevent violence before it occurs
- secondary prevention focuses on the immediate responses to violence
- tertiary prevention focuses on long-term care for the effects of violence.

The three avenues for primary prevention of domestic violence for NSW Health services are firstly, through the development of local health promotion programs, secondly through identification of and intervention with children who are living with domestic violence and thirdly, through identification of people at risk of domestic violence. Intervention with victims represents important secondary and tertiary prevention.

Opportunities to prevent domestic violence should be maximised. In the course of their routine work, all health workers share responsibility for identifying people who may be at risk of domestic violence, to offer appropriate encouragement and support to those individuals, and to take action to appropriately investigate that risk.

Rationale

Current research indicates the value of programs to promote values and behaviours aimed at reducing violence and promoting resilience. Children who are exposed to domestic violence are at significant risk of being abused, developing long-term problems as well as learning or accepting violent behaviour (Office for the Status of Women 2000). Health workers can be pro-active with domestic violence by providing education and early intervention programs including screening of patients/clients at risk of domestic violence.

Procedures

NSW Health services will:

- develop local health promotion strategies to promote greater awareness within the community about the impact of domestic violence on families. This may include community education programs, preventative programs in schools and parenting support programs.
- work in partnership with other agencies on local health promotion and prevention strategies, through structures such as local domestic violence liaison groups and Regional Violence Against Women Strategy Coordination Committees.
- ensure that intake procedures include the prioritisation of the most vulnerable, and consider child protection issues, including exposure to domestic violence. Those who may be particularly vulnerable to domestic violence include young women, persons with an intellectual or physical disability or mental illness, and pregnant women.
- ensure that where children present to NSW Health services and indicators are present (Refer to Appendix 4 – Indicators of domestic violence), regardless of the reason for presentation, the possibility of exposure to domestic violence is considered.
- identify and provide appropriate intervention strategies for children who are affected by domestic violence at a range of ages and developmental stages.
- ensure staff are aware that adult clients should not be treated in isolation. The needs of children of clients need to be considered where domestic violence indicators are present.
- promote across the community a shift in attitudes, values and beliefs directed towards the elimination of domestic violence. Where health workers identify that a patient/client may be at risk of domestic violence, they should consider providing opportunities to discuss the situation further and/or provide appropriate information/referral options.

Intervention with victims of domestic violence

3

3.1 Identification of domestic violence

This section addresses who should be asked about the possibility of domestic violence, under what circumstances, and by whom. There are likely to be two main situations. Firstly, situations in which there are indicators of domestic violence, and secondly, circumstances in which screening about the possibility of domestic violence is adopted with all women patients who present to a service as a matter of routine. Approaches to both situations are outlined below.

Policy

Health workers are well placed to identify a risk of domestic violence, and to take action to intervene early. Where indicators or inconsistent histories are present, staff will ask direct questions about the cause of injury or the dynamics within relationships. This applies in a range of settings, even when domestic violence is not the reason for the presentation.

Rationale

Shame, fear of not being believed, and fears for their safety often prevent women from disclosing domestic violence. Direct questioning by primary health workers informs women that they are not alone, that there are supports available to them and that they are believed. There is evidence to suggest that naming domestic violence is instrumental in women escaping the violence. It is appropriate for primary health workers to suspect domestic violence where it is indicated that the client is exhibiting signs of psychosomatic illnesses, appears defensive to routine intervention or presents with injuries such as bruising or burns (Raphael 2000).

Procedures

- If a health worker suspects domestic violence may be occurring, or the victim has disclosed domestic violence, interviewing of the victim will occur in a safe and private place. The victim should be interviewed alone or given the option of having a nominated support person present.
- Suspected victims of domestic violence should never be asked about domestic violence whilst the suspected perpetrator is present. At times, it may be necessary to identify a medical or procedural reason to see the patient alone.
- Where English is not the victim's first language, ensure access to a professional interpreter wherever possible.
- If domestic violence is suspected but not disclosed a direct approach should be used. Frequently, those experiencing domestic violence are relieved to be asked directly how they have been hurt and by whom. The following approach is suggested:
 - Ask about any injuries
 - ◆ *Was anybody angry with you at the time you were hurt?*
 - ◆ *Many women who have injuries like this have been deliberately hurt. Did someone hurt you?*
 - ◆ *Your injuries do not seem to fit the explanation you've given...did something else cause them? Did someone do this to you?*
 - Ask about relationships
 - ◆ *A lot of women we see are sometimes frightened of their partner – Have you ever been frightened of your partner?*
 - ◆ *Are you having problems in your relationship at the moment?*
 - Ask about safety
 - ◆ *Do you feel safe at home?*
 - ◆ *Is it safe for you to go home today?*
- If the health worker suspects domestic violence, without a disclosure, the medical file should be checked for a history of presentations for similar injuries. If so, the victim should be questioned sensitively about this.

- Victims may continue to deny violence. If the health worker remains suspicious, the following options should be considered:
 - ◆ offer referral to a social worker
 - ◆ offer information about relevant local NSW Health services and other relevant services
 - ◆ offer information about legal options and protection available to people who experience violence
 - ◆ encourage the victim to return if they need assistance.

Health workers should document their concerns, assessment and any disclosure made by the victim in the medical/client record (Refer to Section 8 – Documentation).

Ask about child safety

- ◆ *Do you have children? (If so) have they been hurt or witnessed violence?*
- ◆ *Who is/are your child/ren with now? Where are they?*
- ◆ *Are you worried about your child/ren's safety?*

Health workers MUST make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm.

3.1.1 Routine screening to identify domestic violence

Policy

Routine screening for domestic violence is a prevention strategy which provides information to at risk populations, as well as an early intervention strategy which allows for identification and appropriate intervention.

Area Health Services will introduce routine screening for domestic violence in accordance with NSW Department of Health's protocols for all women attending Antenatal services and Early Childhood Health services and women 16 years and over attending Alcohol and Other Drugs services and Mental Health services. Routine screening will be fully introduced by December 2004.

Rationale

There is clear evidence that women are unlikely to disclose their experience of domestic violence unless the health worker directly asks them about it (Mazza et al. 1996; NSW Health). The research also suggests that women think it is appropriate for health professionals to ask them about domestic violence, whether they have been victimised or not. The low identification of domestic violence across the NSW Health system associated with high morbidity and costs resulting from domestic violence warrant the introduction of routine screening for women in key program areas where elevated vulnerability has been identified. Screening of all women presenting to key NSW Health services is increasingly being supported by peak groups including the Royal Australian and New Zealand College of Obstetrics and Gynaecologists and the American Medical Association.

Procedures

- Routine screening involves asking all women aged 16 years and over (and all Antenatal patients and Early Childhood Health service clients) presenting to key NSW Health services about recent experiences of domestic violence, regardless of whether or not there are signs of abuse, or whether domestic violence is suspected.
- Approaches to routine screening should employ validated screening questions and methodologies. NSW Health has developed, tested and validated a four question screening tool (Refer to Screening questions, page 11). These questions represent minimum standards.
- Routine screening for domestic violence should form part of normal medical history taking or assessment procedure for new clients/patients at face to face contacts. It is a six-stage process involving:
 1. Reading the preamble which explains screening.
 2. Asking the patient the domestic violence screening questions.

3. Taking action according to the outcome.
 4. Offering all women an information card.
 5. Documenting the outcomes in the patient/client's file.
 6. Providing follow-up as necessary.
- Routine screening will be carried out in accordance with the protocol and guidelines in the *Routine Screening for Domestic Violence in NSW Health: An Implementation Package*. The protocol for routine screening should be used in conjunction with specific training and support for all staff involved. Any new staff members should receive orientation/training using the Implementation Package prior to undertaking screening for domestic violence.
 - The Implementation Package includes the pilot evaluation report *Unless They're Asked: Routine Screening for Domestic Violence in NSW Health 2001*, NSW Health Screening for Domestic Violence Form, Routine Screening Protocol, Information Card for Women, Staff Learning Program, and the Manager's Implementation Guide. These documents may also be accessed at [internal.health.nsw.gov.au/policy/hsp/domestic violence](http://internal.health.nsw.gov.au/policy/hsp/domestic%20violence).
 - The introduction of routine screening must be handled with care: staff must be properly trained in how to use the screening tool and be able to respond appropriately and confidently. Careful planning, preparation and resourcing is needed. Questioning by unprepared staff, however well intentioned, can be damaging and leave the woman vulnerable.
 - Identification of referral procedures must be in place before the NSW Health service commences screening.
 - Routine screening must not be carried out in the presence of the partner or other family members, friends or children over the age of three years.
 - NSW Health services should document the process of the Routine Screening Project to assist with monitoring and improvement of the project.
- Area Health Services will provide reports on request by NSW Department of Health on the progress of implementation of screening. (Refer to Section 9 – Data collection).
 - Routine screening may also be introduced into the following service streams: Dental clinics, Child and Family, Women's Health Nurse services, Community Health centres, Gynaecology clinics and Sexual Health services. The same *Implementation Package* developed by NSW Health should be used for these program areas.
 - The extension of routine screening to other populations, for example, males, will not be introduced without further research validation.
 - Specific strategies to identify domestic violence in Emergency Departments will be developed in a process led by NSW Department of Health. These strategies will focus particularly on early identification of clinical indicators.

Screening questions

1. Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?
2. Are you frightened of your partner or ex-partner?
 - If the woman answers NO to both questions, give the information card to her and say: Here is some information that we are giving to all women about domestic violence.
 - If the woman answers YES to either or both of the above questions, continue to question 3 and 4.
3. Are you safe to go home when you leave here?
4. Would you like some help with this?

3.2 Support

3.2.1 Immediate/crisis intervention

Policy

NSW Health services will provide a respectful and non-blaming response to all persons who have experienced domestic violence, and will work to identify the best options to support the client's immediate and long-term needs, regardless of the number of presentations. Safety issues for the victim and any children need to be considered as a priority and where necessary, reports should be made to the Department of Community Services and NSW Police. Victims should be encouraged and assisted to make such reports on their own behalf. NSW Health services will provide crisis follow-up counselling to all patients where a presentation in an acute inpatient or Emergency Department results in identification of domestic violence. A follow-up response should be available within three days of the identification of violence.

Rationale

Victims who receive an initial positive response to disclosures of domestic violence are more likely to seek further help, and to actively take steps to protect themselves and their children. NSW Health services have a responsibility to ensure that safety and other issues are followed up after a disclosure which may often result from, or alternatively lead to a crisis for the victim.

Procedures

- If a woman discloses domestic violence, responses must be supportive and non-judgemental.

Acknowledge and validate the victim's experiences

- ◆ *It is good that you told me about this.*
- ◆ *No one has the right to hurt you.*

Name the violence

- ◆ *What you are telling me sounds like domestic violence...have you thought about this?*
- ◆ *We often see women who are experiencing domestic violence.*

Provide information

- ◆ *Violence is a CRIME.*
- ◆ *Domestic violence is not your fault.*
- ◆ *We regard this type of experience as a serious health problem.*
- Assess the victim's need for specific professional and personal support and provide options accordingly.
- Assess the need for immediate medical attention and ensure medical needs are met.
- Ensure that appropriate counselling and referral services are offered.
- Crisis intervention and follow up responses may be provided by a range of staff including social workers, midwives, mental health workers, drug and alcohol workers or nurses where appropriate.
- Where necessary, reports should be made to the Department of Community Services and to NSW Police (Refer to Section 4.2 – Reporting to police and Section 4.5 – Children and domestic violence). Women should be encouraged and assisted to make such reports on their own behalf.
- Document in the medical/client record, the disclosure in the patient's own words, as well as information obtained and any intervention undertaken.
- In some instances a mental health assessment will be the appropriate response where there are concerns for the vulnerability of the individual regarding issues such as suicide and/or self harm.
- A protocol needs to be established to ensure that all victims who present to acute services receive appropriate care.

3.2.2 Counselling intervention with victims

Policy

NSW Health services providing counselling for victims of domestic violence will prioritise issues of safety for victims, children and workers. Counselling will be provided in a manner that is respectful, empowering and clearly places the responsibility for the violence with the perpetrator. The statement of principles which underpin this policy form the basis for intervention.

Rationale

Domestic violence is potentially lethal and therefore safety is the first consideration.

Locating responsibility for the violence with the perpetrator and working to empower those who have been disempowered by violence is fundamental. Providing a safe environment in which victims can address the impact of violence on their lives is also critical.

Procedures

- Counselling intervention will be provided in a non-judgemental and supportive manner.
- The counsellor will provide clear messages and accurate information about their role and any limitations on services that can be provided.
- The counsellor will provide accurate information about resources, options and rights.
- Important messages to convey are:
 - ◆ *You are not alone and there is help available.*
 - ◆ *Domestic violence is serious and has serious consequences for health.*
 - ◆ *It is still OK to love your partner but this does not mean that violence is acceptable.*
 - ◆ *We all need help at times.*
 - ◆ *You are not responsible for the perpetrator's violence.*
- Counselling intervention should include the following steps:

Engage the client

- ◆ Convey involvement and acceptance.
- ◆ Convey beliefs that don't blame the person experiencing violence and abuse.

Assess the situation

- ◆ What has been happening?
- ◆ Has there been actual physical violence, threatened violence, damage to property, verbal abuse, emotional abuse, financial abuse, sexual assault?

Assess safety

- ◆ Stress the need for the woman and her children to be safe.
- ◆ Where is she living? Is she safe?
- ◆ Has the perpetrator made any threats to harm himself, the victim or their children?
- ◆ Are they still living together?
- ◆ Does she have an Apprehended Domestic Violence Order?
- ◆ Are there children involved? Who is/are your child/ren with now? Are they safe? Was/were your child/ren nearby when your partner was violent to you? Health workers **MUST** make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm (refer to Section 4.5 – Children and domestic violence).
- ◆ Have the Police ever been called? If yes, what did the Police do?
- ◆ Does the perpetrator have access to a gun? Do the Police know about it?
- ◆ Has she been hurt recently? Has she seen a doctor?

Find out what action she may consider

- ◆ Does she want to remain in the current situation?
- ◆ What action has she taken in the past? Who did she see? Were they helpful? Why?

Explore this situation

- ◆ Acknowledge her feelings and validate them.
- ◆ Explore the implications of her feelings.
- ◆ Reduce anxiety and blame.

Explore alternatives and develop an action plan

- ◆ Explore with the victim her resources and needs.
- ◆ Assist in identifying strengths and resilience.
- ◆ Generate alternatives which will develop skills and reverse helplessness.
- ◆ Aim to diminish isolation.
- ◆ Explore the level of commitment/energy required to pursue these options and whether she sees them as viable.
- ◆ Explore both short term and long term options. Short term options may be a refuge, social security, Police, medical attention, safety and/or legal advice and long term options may be social security, public housing, on-going counselling and/or a support group.
- ◆ Clarify the need for continued support and develop an agreement about what the counsellor can provide and what steps the client can take.

3.3 Provision of information

Policy

NSW Health services will ensure that victims of domestic violence are assisted to access information in relation to their legal rights and supported to exercise these rights and options. Other information to be provided may include the effects of domestic violence on victims including children, and the range of services that may be accessed.

Rationale

Victims of domestic violence may have complex social, physical, financial, emotional and legal needs. In order to ensure their safety, and to provide appropriate support to enable them to leave a violent relationship, their range of needs must be met. Health workers have a duty of care to ensure that victims of domestic violence are fully informed, and assisted where possible, to access services they require.

Procedures

- Victims of domestic violence, whether acknowledged or suspected, should be provided with information about:
 - ◆ counselling offered by NSW Health services
 - ◆ other NSW Health services that may be required
 - ◆ the availability of a social worker for support and assistance
 - ◆ the Department of Community Services Domestic Violence Line which provides 24 hour support and assistance
 - ◆ other local services and welfare agencies for further support, assistance, accommodation and information.
- Victims of domestic violence should be informed of their rights to:
 - ◆ make a statement to the Police with a view to Police charging the offender
 - ◆ apply for an Apprehended Domestic Violence Order (ADVO).

(Refer to Appendix 5 – Legal options for domestic violence and Appendix 8 – Referral and resource information).
- In cases where the victim decides not to take legal measures to protect themselves, information should be provided about safety strategies that may offer some protection in the future in case she needs to escape quickly.
- Document briefly in the medical/client record what information has been given to the victim.

3.4 Referral

Policy

Victims of domestic violence may require access to a range of services including accommodation, counselling, parenting support and information, Mental Health services, Drug and Alcohol services, legal information and financial assistance. Health workers will work with victims to identify their immediate needs.

Rationale

Victims of domestic violence usually experience powerlessness and sometimes depression as a consequence of being abused. Health workers will assist victims of domestic violence to access appropriate supports and advice. This may also assist women to leave a violent relationship in a safe, planned way.

Procedures

- Health workers will refer victims and their children to appropriate services to assist them to access ongoing safety.
- NSW Health services should identify local referral procedures and services as well as statewide telephone services.
- NSW Health services that may provide direct responses or consultation include Social Work services, Sexual Assault services, Community Health, Child and Family services and Aboriginal Health workers including Aboriginal Family Health Strategy funded services. Additional advice may be drawn from external agencies such as the NSW Police and Family Support Services. A local referral list should also include contacts for accommodation and counselling options including where appropriate the Victims of Crime Approved Counselling Scheme (Refer to Appendix 8 – Referral and resource information), and local Chamber Magistrate.
- Health workers should encourage women to make these contacts themselves, but may assist where required. Health workers should only contact referral services with the agreement of the victim.
- Health workers should assess the need for emergency accommodation.
- Where the woman agrees, provide a referral to a social worker, to a Community Health centre or to an appropriate local welfare service.
- Document any action taken or referrals made in the medical/client record.

4

Legal obligations of Area Health Service staff

4.1 Limited confidentiality

Policy

When the safety of others is involved, the principle of confidentiality cannot be offered unconditionally. In situations where reports to the Department of Community Services and NSW Police are necessary, the consent of the person involved is not required.

Health workers who hold a genuine and realistic concern about harm to a person may inform the third party of that risk. Where this action is taken this is not considered a breach of confidentiality, as workers act with lawful excuse. This is known as a 'Tarasoff warning'.

Rationale

Due to the high level of risk posed by violent offenders to victims, children and other members of the community, the need to take steps to ensure safety may at times override confidentiality.

Health workers will make reports to NSW Police and the Department of Community Services as required in Section 4.2 – Reporting to police and Section 4.5 – Children and domestic violence.

In circumstances where concerns are held for the safety of a third person, information may at times be required to be provided to that person.

4.2 Reporting to police

Policy

Domestic violence poses such a significant risk to individuals that in some cases reports to NSW Police must be made, even where this is against the wishes of the victim. Health workers must report to NSW Police regardless of the victim's views where:

- serious injuries have been inflicted such as broken bones, stab and gunshot wounds
- the perpetrator has access to a gun and is threatening to cause physical injury to any person
- the perpetrator is using or carrying a weapon (including guns, knives or any other weapon capable of injuring a person) in a manner likely to cause physical injury to any person or likely to cause a reasonable person to fear for their personal safety
- an immediate serious risk to individual/s or public safety exists
- an offence has occurred on NSW Health premises, or in circumstances in which health workers are threatened because of their professional role.

Rationale

Health workers have an obligation to adhere to legal and duty of care requirements to ensure the safety and well-being of victims who have experienced domestic violence. Health workers also have an obligation to ensure that the working environment is safe for clients/patients and for other workers.

Procedures

- Victims have the right to report any offence to NSW Police. Any request by the victim to report to NSW Police should be facilitated immediately.
- In all situations where health workers are not required to notify NSW Police, the victim's right to pursue or not to pursue the crime with NSW Police and report the offence should be respected.
- Where health workers are required to report to NSW Police, the victim should be notified where possible of the intention to report to NSW Police prior to the report being made.
- Health workers may also provide information to NSW Police when they hold a genuine and realistic concern about harm to a person's safety. Where this action is taken this is not considered a breach of confidentiality as workers act with lawful excuse.
- Where a decision is taken to inform NSW Police or there is doubt as to what action is appropriate, management should be consulted.
- NSW Police employs specific positions for responding and attending to domestic violence matters. These positions are located within each Region. Health workers may contact directly a Domestic Violence Liaison Officer (DVLO) or where appropriate an Aboriginal Community Liaison Officer (ACLO) (Refer to Section 13.1 – Aboriginal or Torres Strait Islander communities), an Ethnic Community Liaison Officer (ECLO) (Refer to Section 13.2 – Culturally and linguistically diverse communities) and/or a Gay and Lesbian Liaison Officer (GLLO) (Refer to Section 13.4 – People in gay and lesbian relationships).

4.3 Firearms

Policy

The Firearms Act 1996 and the Firearms (General) Regulation 1997 state that medical practitioners, registered psychologists, registered nurses, enrolled nurses and persons who provide professional counselling services may inform the Commissioner of NSW Police that they are of the opinion that a patient is unsuitable to be in possession of a firearm:

- because of the patient's mental condition, or
- because the practitioner thinks that the patient might attempt to commit suicide, or would be a threat to public safety, if in possession of a firearm.

These provisions operate despite any duty of confidentiality, and any action taken by a practitioner under this section does not give rise to any criminal or civil action or remedy.

Rationale

Health workers are at times aware of situations which require action to secure the safety of their clients, colleagues and the general community.

Procedures

A medical practitioner, or other health practitioners (ie registered psychologists, registered or enrolled nurses, and persons who provide professional counselling services), should make a notification to NSW Police if they believe that a patient is unsuitable to be in possession of a firearm:

- because of the patient's mental condition
- because the practitioner thinks that the patient might attempt to commit suicide, or would be a threat to public safety, if in possession of a firearm.

4.4 Other legal responses

Policy

NSW Health services should ensure that victims of domestic violence are assisted to seek other advice where this is indicated, which may result in the implementation of protective measures, such as ADVOs.

Rationale

Victims of domestic violence may experience powerlessness and helplessness as a consequence of domestic violence. Fears for their safety may prevent them from leaving a violent relationship. Health workers have a responsibility to assist women to access information about legal assistance. This may assist women to leave a violent relationship in a safe and planned way.

Procedures

- NSW Health services should assist victims of domestic violence to access information on their rights to make a statement to NSW Police with a view to:
 - ◆ NSW Police charging the offender
 - ◆ applying for an ADVO
 - ◆ applying for Victims' Compensation.
- NSW Health services will provide information and assistance as appropriate to any person who is in fear or has experienced assaults or stalking and for which a report to NSW Police may be made or an ADVO sought (Refer to Appendix 5 – Legal options for domestic violence).
- NSW Health services will provide information and referral options to women who may require legal advice and assistance. Referral to appropriate community legal services should be considered (Refer to Appendix 8 – Referral and resource information).
- Any information or assistance provided to victims of domestic violence will be documented in the medical/client record.

4.5 Children and domestic violence

Policy

Health workers should consider and address the specific needs of children who are living with domestic violence. In accordance with Sections 23 (d) and 27 of the *Children and Young Persons (Care and Protection) Act 1998*, a person who delivers health care services wholly, or partly to children, must make a report to the Department of Community Services where there is a reasonable suspicion that as a result of living in a household where there have been incidents of domestic violence, a child is at risk of serious physical or psychological harm. The process by which such a report must be made is specified in Circular 03/16 – *Protecting Children and Young People*; refer also to the *NSW Health Frontline Procedures for the Protection of Children and Young People (2000)*.

Rationale

Exposure to domestic violence can constitute a form of child abuse. A national study of the prevalence of domestic violence in Australia found that 61 percent of women who reported violence by a current partner had children in their care at some time during the relationship (ABS 1996). Children may be affected by experiencing, or witnessing the violence or by living in a home where violence occurs. There is strong research evidence that exposure to domestic violence is likely to impact on a child's social, cognitive and emotional development (McIntosh 2000).

Procedures

- Children at risk through exposure to domestic violence may be clients of health services in their own right, or the offspring of a client of a health service. Health workers have a responsibility to consider the protection and safety needs of children of adult clients who attend health services where domestic violence is occurring.
- Where a health worker is aware that a client presenting as a result of domestic violence has children, the health worker should endeavour to support the child or young person as a part of their intervention with the client or by referral to an appropriate service. (Refer to Circular 03/16 – *Protecting Children and Young People*)
- In situations where there is a serious risk of harm, a report should be made to the Department of Community Services. Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* states that a child is considered at risk of harm if current concerns exist for the safety, welfare and well-being of a child because of the presence of one or more of the following:
 - a. The child's or young person's basic physical or psychological needs are not being met or are at risk of not being met.
 - b. The parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care.
 - c. The child or young person has been, or is at risk of being physically or sexually abused or mistreated.
 - d. The child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm.
 - e. A parent or other caregiver has behaved in such a way towards the child or young person that they have, or are at risk of suffering serious psychological harm.
- For the purposes of Section 23 (d) and in line with the *NSW Interagency Guidelines for Child Protection Intervention 2000*, serious psychological harm should be assumed in the presence of any of the following factors:
 - ◆ The repetition or an escalation in frequency or severity of domestic violence.
 - ◆ Where a child or young person has been physically harmed.
 - ◆ If a victim has required medical attention as a result of domestic violence.
 - ◆ Where a weapon has been used.
 - ◆ Where an ADVO has been issued and/or breached and there are indicators that a child is currently at risk.
 - ◆ Where there are threats to take or harm children.
- Serious psychological harm may also arise in circumstances where:
 - ◆ the parent or caregiver is unable to protect the safety, welfare or well-being of the child or young person due to the level of victimisation
 - ◆ domestic violence exists with one or more factors such as the hazardous use of alcohol or other drugs
 - ◆ the presence of other factors which may increase the vulnerability of a child or young person such as the presence of a mental health problem or a disability.
- Where health workers determine that a report needs to be made to the Department of Community Services, they should follow procedures as established in the *NSW Health Frontline Procedures for the Protection of Children and Young People (2000)* and NSW Health Circular 03/16 – *Protecting Children and Young People*.
- Where a report is to be made to the Department of Community Services, health workers should, where appropriate, involve the non-offending carer.
- Where a report is to be made to the Department of Community Services about a young person, health workers should involve the young person themselves in that report where appropriate.

- In situations where the health worker is aware of children living in a household where domestic violence has occurred but assesses that a risk of harm report to the Department of Community Services is not required at that time, consideration must be given to the need to provide additional support services for the child or young person. Referrals to a Youth Health service, Early Childhood Health service, Mental Health service, or a non-government agency such as a Family Support service may be appropriate.
- In situations where the health worker makes a report and the Department of Community Services does not become involved with the family, the health worker may need to reassess their work with the child or family. Health workers providing non-psychological services should continue to provide a service to the child or family. Health workers providing psychological services may need to cease therapeutic intervention but should maintain a support role with the child or family.
- Health workers should ensure that any further work with the child or non-offending carer does not place the client at further risk. This may mean that the health worker changes the method or place of service delivery, for example changing the venue of service from the client's home to the Community Health Centre, or the health worker provides a support service rather than a therapeutic intervention.
- In situations where a health worker has been providing a service to all members of the family, including an alleged domestic violence perpetrator, the health worker should consider if the dynamics of the violence indicate that the alleged perpetrator should receive an individual service, rather than a family service. Health workers may not contract with perpetrators to provide an intervention to address the perpetration of the violence (Refer to Section 5 – Intervention with perpetrators of domestic violence).
- Any additional information relating to a risk of harm to the child or young person elicited during the continued contact with the client is to be reported to the Department of Community Services and documented appropriately.
- Health workers should note that children under 16 years of age can be included in their parent's ADVO. Only police officers can apply for a separate ADVO for the protection of a child under 16 years.

Intervention with perpetrators of domestic violence

5

Policy

The primary role of NSW Health services is to identify and intervene with people who are at risk of, or victims of domestic violence. Direct intervention with perpetrators is limited to:

- naming and identifying behaviours as domestic violence
- providing information regarding the nature and effects of domestic violence
- providing options for the safety and protection of the partner and their children
- taking any steps as necessary for the safety of victims.

It is not the role of NSW Health services to provide direct treatment to an individual for the perpetration of violence. However, it is recognised that the history and some solutions to violence within Aboriginal communities differ from those within the rest of the community. Programs funded under the *Aboriginal Family Health Strategy* or established in keeping with its objectives may provide interventions targeted at Aboriginal perpetrators who have committed acts of violence.

Further, health workers still have a duty of care in relation to the provision of other relevant health-related services for clients/patients who have perpetrated domestic violence. Action may be required to secure the safety of victims including children as well as staff where perpetration of violence is disclosed or suspected.

Rationale

Working with perpetrators for sustained behaviour change is complex and specialised, and requires a high degree of monitoring. Such programs are generally outside the range of services offered by NSW Health. Further, the efficacy of treatment programs for domestic violence perpetrators is in question, with a Commonwealth National Crime Prevention report suggesting that any intervention is likely to be most effective when conducted only within the context of a criminal justice system through mandatory programs. This report concludes that these programs' effectiveness in stopping domestic violence is not demonstrated compared to strong arrest and prosecution practices (Keys Young 1999). However health workers have important roles to play in providing information to clients about the nature and effects of domestic violence and taking steps to address the safety of those affected by violence.

Consistent with the NSW Health definition, a perpetrator of domestic violence is an adult who carries out violent, abusive or intimidating behaviour against a partner or ex-partner to control and dominate that person.

People who have committed acts of domestic violence may access the NSW Health system in a variety of ways. Health workers may receive requests for treatment or counselling for the perpetration of violence, or for issues such as anger management or relationship issues. Alternatively the violence may be revealed in the course of other intervention, or the perpetrator may be a visitor to a health facility. Whether identification of the perpetration of violence is confirmed, whether disclosure has occurred or not, and by whom, will influence the response.

5.1 Principles for contact with perpetrators of domestic violence

There are some specific programs where health workers have ongoing contact with perpetrators of domestic violence such as Physical Abuse and Neglect of Children (PANOC) services. Whilst not providing therapeutic interventions for the violence, the following principles provide a platform for any contact:

- Domestic violence is unacceptable and many acts of domestic violence constitute criminal offences. No intervention should minimise or substitute responses by the criminal justice system.
- Working towards the elimination of domestic violence, minimising risk and maximising the safety of victims and non-offending family members are the paramount concerns of any intervention with perpetrators of domestic violence.
- Responses for perpetrators must place the responsibility for the violence solely with the perpetrators.
- Responses for perpetrators should not be at the expense of resources for services for women and non-offending family members.
- Responses for perpetrators require an analysis of power and control in gender relations.³

These principles are based on and consistent with the *Principles for the Implementation of Perpetrator Programs* developed and adopted by the NSW Council on Violence Against Women in 1999.

5.2 Exceptions arising from the Aboriginal Family Health Strategy

The *NSW Aboriginal Family Health Strategy 1995* provides for programs developed specifically for and in collaboration with Aboriginal and Torres Strait Islander communities. These programs complement mainstream services and in some aspects differ from these services. A core element of these programs is the involvement of men in finding solutions to Aboriginal family violence while not detracting from the safety of women and children and from criminal responsibility,

where this is required. Programs funded under the Aboriginal Family Health Strategy, or established in keeping with its objectives by Aboriginal Health services may provide interventions targeted at Aboriginal perpetrators who have committed acts of violence.

5.3 Safety in relation to perpetrators

Where domestic violence is suspected or identified, health workers' primary concern must be the safety of victims and potential victims. Health workers may be required to take action to secure the safety of women and children experiencing domestic violence (Refer to Section 4.2 – Reporting to police and Section 4.5 – Children and domestic violence).

If a person who is known to have perpetrated domestic violence is attending a health service, staff should be aware of safety issues when considering the time and venue for provision of ongoing services. It is important that workers are familiar with safety procedures.

- Staff should be familiar with the policy guidelines in Circular 97/99 – *Critical Incident Manual: Policy and Guidelines*; *NSW Health Safety and Security Manual 1998*; Circular 01/22 – *Workplace Health and Safety: A Better Practice Guide* and Circular 02/19 – *Effective Incident Response: A Framework for Prevention and Management in the Health Workplace*. Staff should be aware of legal options available to staff and victims of violence including criminal charges and Apprehended Domestic Violence Orders.
- Staff should not try to deal with situations of risk in isolation. Management should be notified promptly where risk to client and/or staff safety is identified.
- Perpetrators may present to NSW Health services expressing suicidal intent. This should be managed according to suicide protocol (Circular 98/31 – *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities*).

5.4 Legal issues in relation to perpetrators

Domestic violence situations often raise complex issues regarding the legal responsibilities of health workers. Where there is concern about any situation while working with perpetrators of domestic violence, workers should consult management, ensuring that accurate records are kept in all of the following situations:

- Where the safety of others is involved, the principle of confidentiality cannot be offered unconditionally (Refer to Section 4.1 – Limited confidentiality).
- Health workers are required to report to the Department of Community Services when a child is at risk of serious or psychological harm as a result of living with domestic violence (Refer to Section 4.5 – Children and domestic violence).
- Requests for services for counselling and reports, prior to court appearances or sentencing for violent behaviour, are not uncommon. Providing reports in these circumstances is in general not an appropriate use of NSW Health services. This position should be conveyed to people seeking a health service where this appears to be the reason for presentation.

5.5 Duty of care in relation to perpetrators

NSW Health services still have a duty of care in relation to the provision of other relevant health-related services for clients/patients who have perpetrated domestic violence. For example, perpetrators of domestic violence with alcohol or other drug-related issues, mental health problems or physical health problems will still be offered relevant services as are other member of the community.

If a health worker has knowledge regarding a person being a domestic violence perpetrator, responsibilities and procedures for reporting to the Department of Community Services or NSW Police are outlined in Section 4.2 – Reporting to police and Section 4.5 – Children and domestic violence. Certain situations may trigger an escalation or increased risk of domestic violence. For example, the victimised partner

obtaining an ADVO initiating or continuing a separation or divorce; division of property; initiating a move out of the area; applying for child custody orders; applying for child support payments. Changes in the perpetrator's situation such as decreased stability or increased drug use may also escalate violence.

The duty of care of NSW Health workers extends to abusive behaviour of which the worker has reason to become aware.

5.6 Incidents on health service premises

Persons who have committed acts of domestic violence may come into contact with the NSW Health system by bringing their injured partner into the Emergency Department or by visiting them in hospital. Health workers should make time to sensitively clarify with the victim whether they would like staff to ensure that they are not left alone with the perpetrator anytime during the hospital stay.

Where any incidents of violence occur on health service premises, NSW Police should be notified immediately. NSW Police should also be notified if any incidents occur on NSW Health premises which breach an existing Apprehended Domestic Violence Order of which NSW Health staff are aware (Refer to Section 4.2 – Reporting to police). The agreement of the victim will be sought where appropriate. The circumstances at the time of the occurrence will also be taken into account in determining action to be taken.

5.7 Intervention

The three steps for responding to perpetrators are as follows:

5.7.1 Identification

Identification of domestic violence is not straightforward. Longstanding offenders may be adept at denying, minimising and shifting responsibility for their behaviour. Offenders may present to NSW Health services as a victim of violence, or make an unfounded allegation, diverting those who could intervene in the situation. When suspected, attempts should be made to clarify whether domestic violence is occurring. It is appropriate for health workers to ask

direct questions where domestic violence is suspected or alluded to by clients. Examples of the type of questions that may be suitable include:

- ◆ *How do you handle conflict in your relationship?*
- ◆ *Have there been incidents of violence with your partner?*
- ◆ *Have you hit or kicked your partner or anything like that?*
- ◆ *Have you ever threatened your partner?*
- ◆ *Has your partner ever left you, or threatened to leave because of abuse?*

5.7.2 Safety assessment

If domestic violence is identified it is important to assess the potential for harm by considering both capacity and likelihood of the person inflicting injury. This will assist the worker in identifying whether there is any need to make a report to NSW Police or the Department of Community Services. It may be appropriate for the health worker to directly question the person. Questions that may be suitable include:

Frequency and severity of violence:

- ◆ *When was the last incident? Have there been any incidents this week/month/year?*
- ◆ *How often does this happen?*
- ◆ *Have your partner or you ever been injured during an argument? How?*
- ◆ *Has medical assistance ever been necessary?*

Possession of weapons:

- ◆ *Have you ever threatened to use a weapon on your partner and children?*
- ◆ *Have you ever used a weapon or martial arts training on your partner or/and children?*
- ◆ *Have you threatened to get a weapon?*

History of violent crimes:

- ◆ *Is there or has there ever been an ADVO taken out against you?*
- ◆ *Have you been in trouble with the police for assault or domestic violence?*
- ◆ *Have the police ever been called or has anyone thought they should be involved due to violent incidents?*

5.7.3 Response

Within the terms of this policy, where domestic violence is identified, direct intervention with perpetrators is limited to:

- naming and identifying behaviours as domestic violence
- providing information regarding the nature and effects of domestic violence
- providing options for the safety and protection of the partner and their children
- taking any steps as necessary for the safety of victims.

The form of these responses will vary depending on whether the issue is raised in the context of a request for treatment for domestic violence or a disclosure by an existing client of the NSW Health service who is attending for a separate problem.

5.8 Responding to requests for treatment for the perpetration of violence

NSW Health services receive requests from persons for treatment or counselling for the perpetration of violence, or for issues such as anger management or relationship issues. Appropriate responses are as follows:

5.8.1 Name the behaviour

- Clarify the behaviours prompting the presentation.
- Name the behaviour as domestic violence where it meets the definition.
- Ask whether the person is currently facing criminal charges or other court proceedings.

5.8.2 Provide information

- Communicate that violence towards a partner/ex-partner is against the law.
- Provide information on how the behaviour affects others including health effects on adults and children.
- Explain that violence towards a partner can have serious legal consequences for perpetrators.

- Explain that public sector health services do not provide therapy for people who are violent towards their partners.
- Explain that safety of others must be the priority for health services
- Explain that the behaviour is an individual choice.
- Explain that providing reports for domestic violence offences for sentencing or court appearances is not consistent with NSW Health policy.
- Consider giving information on the services offered to victims of domestic violence.
- Consider providing information about other services such as appropriate perpetrators' programs⁴ or the 'Men's Line', which provides telephone counselling to men who are managing relationships with partners, ex-partners and children, especially following separation (Refer to Appendix 8 – Referral and resource information).

5.8.3 Provide options for safety

- Discuss steps the person could take to provide safety for the victims.
- Explain legal options available to interrupt violence.
- Make reports to the Department of Community Services or NSW Police where indicated.
- Document steps taken.

5.9 Responding to disclosure of perpetration by an existing client

When a health worker suspects that an existing client of the NSW Health service may be a perpetrator of domestic violence or a client discloses violent behaviour, health workers should use the steps listed above. In addition health workers should:

5.9.1 Name the behaviour

- Clarify where appropriate that the presenting issue for which the health service is being provided, is not an acceptable justification for domestic violence.

5.9.2 Provide information

- Explain the limits to confidentiality in relation to the safety of others.
- Ensure duty of care to the victims of domestic violence and explain that the safety of victims and their children must be a priority.

5.9.3 Provide options for safety

- Consider the safety of the client's partner and children.
- If appropriate seek permission to contact the partner.
- Explain that the services offered to the client will address the presenting issues and not the perpetration of violence.
- Outline the range of services available to the partner as a victim of domestic violence.
- If a genuine concern exists for the safety of another person there may be informed of the concern without the consent of the person who provided the information.
- Discuss the case with the manager if there are any concerns about violent or potentially violent behaviour or threats to staff or victim. Relatively few perpetrators are potentially lethal or highly dangerous, but it is important to take this possibility seriously.
- Consider the use of joint interventions with other workers, or setting contracts with the client about limits to their behaviour.

5.10 Relationship counselling

Relationship counselling for couples or families will not be provided where domestic violence is identified. All health workers should consider the possibility of domestic violence when couples and families present for counselling and include questions to identify domestic violence at intake or first visit. If domestic violence is disclosed it must be explained that conjoint relationship counselling will not be offered.

Disclosure of domestic violence in this situation by the victim may take considerable effort and make them vulnerable to retaliation by the perpetrator. Individual sessions should be offered in this situation.

6

Training

Policy

Area Health Services are responsible for providing domestic violence training for health workers and managers providing primary, secondary and tertiary services to victims. Each Area Health Service must have an ongoing training strategy to ensure that managers and frontline staff receive up to date information about domestic violence that is relevant to their position.

Rationale

Many women who disclose domestic violence to services report judgemental and unhelpful contacts (Laing 2001). Additionally, there is evidence that despite the known prevalence and incidence of domestic violence, many health workers are not skilled at identifying domestic violence. Without training, staff are often unaware of the complexity and impact of abusive relationships and the obstacles for women in trying to escape from violent situations. Training also provides health workers with skills to enable them to best meet the needs of their clients.

Procedures

- Area Health Services will ensure that training is provided to staff about the nature, extent and impact of domestic violence. This training will include how to recognise domestic violence, use interview techniques and respond appropriately. It will also include a cross cultural awareness component.
- NSW Health services will ensure that health workers, especially those in Maternity services, Early Childhood services, Mental Health services, Drug and Alcohol services, Emergency Departments and Community Health centres, attend this training.
- NSW Health services will ensure support is available to all health workers working with victims of domestic violence. Options for support for staff will be outlined in training.
- NSW Health services will facilitate referral to Employee Assistance Programs for workers where there is an identified need.
- Health workers will take responsibility for gaining skills in working with victims of domestic violence by accessing available training and support.
- A calendar of training provided by Area Health Services will include courses on domestic violence appropriate to a wide range of service providers.
- The Education Centre Against Violence is the NSW Health statewide service which provides training resources, packages and specialist training in response to domestic violence, sexual assault and child protection. (Refer to Appendix 8 – Referral and resource information).

Access and equity in Area Health Services

7

Policy

Each Area Health Service should ensure the timely, geographical and cultural accessibility and appropriateness of its service delivery to victims within the local community.

NSW Health services must:

- promote equity of access to all potential service users in the local community
- ensure that programs and services are appropriate to members of the diverse populations of the local communities
- collaborate with appropriate interpreting and translation services to enable access for people of all language groups in the community.

Rationale

Domestic violence occurs in all strata of society, regardless of age, sexuality, ability, ethnicity, socio-economic status, religion or culture.

Victims can often be marginalised and disempowered by their experience of violence. Those victims who are from culturally and linguistically diverse backgrounds are doubly disadvantaged. Proactive strategies need to be developed and implemented to ensure that services are accessible and equitable. Access implies recognising cultural diversity, and identifying and addressing barriers and structural disadvantages experienced by members of the community. Equity implies the fair treatment of all service users, a just allocation of resources and positive discrimination towards those facing additional barriers to services.

Procedures

- NSW Health services must promote equity of access to all potential service users in its local community through the development of relevant strategies.
- NSW Health services will ensure collaboration with local Aboriginal community controlled services and communities to ensure that services are accessible and delivered in a culturally sensitive environment for Aboriginal people.
- NSW Health services will ensure that staff who provide medical and counselling services to domestic violence victims receive cultural sensitivity training.
- Information on how to access services and what services are available should be accessible in a range of relevant community languages.
- Qualified and accredited interpreters will be used by health workers when an interpreter is needed (Refer to Circular 94/10 – *Standard Procedures for the Use of Health Interpreters*).
- Health workers will ensure that they have an awareness of cross-cultural issues and work sensitively with women from culturally and linguistically diverse backgrounds who are at risk of, or victims of, domestic violence.
- Health workers will also ensure that they have an awareness of issues of age, ability, sexuality and will work sensitively with these women who are at risk of, or victims of, domestic violence.
- Health services will ensure that programs and services are accessible to members of the diverse populations of the local communities.

8

Documentation

8.1 Documentation of health service presentations

Policy

Where any person is receiving a NSW Health service and indicates that they are currently experiencing or have committed acts of domestic violence, this information should be documented using the patient's own words in the patient record. All staff, including medical personnel, must carefully document all injuries.

Where domestic violence is suspected but not disclosed, the reasons for the suspicion must also be documented. Records of actual and suspected domestic violence must be consistent with the facility's record keeping system.

Rationale

Accurate documentation of presentations to NSW Health services is a fundamental responsibility for all health workers. Health workers should be aware that disclosures of domestic violence and documentation of injuries can constitute medico-legal evidence, which may be required in a range of legal proceedings. It is therefore imperative that documentation be accurate, timely and relevant.

Procedures

- All services delivered to any patient or client of a NSW Health service must be fully documented. This includes services delivered to victims of domestic violence.
- In order to provide a full and accurate record for each case in which domestic violence has been reported by the client/patient, domestic violence must be specified as part of the information recorded. Wording such as 'the client/patient states...', 'injuries are consistent with...' should be used when describing the situation.
- Essential points to document include:
 - ◆ the name of the victim
 - ◆ date and time of presentation
 - ◆ language spoken and need for interpreter
 - ◆ the location and severity of any injuries
 - ◆ the victim's statement as to the cause of injuries
 - ◆ if domestic violence is disclosed, the name of the perpetrator and relationship to victim (if known)
 - ◆ dates and times (if known) when abuse occurred
 - ◆ NSW Police information (eg police officer's name, police station), if relevant
 - ◆ mental state and physical symptoms
 - ◆ any additional non-physical indicators of abuse, such as torn or damaged clothing
 - ◆ any treatment or other services provided, information and referrals given
 - ◆ clinical observations consistent with the history given by the client/patient
 - ◆ the whereabouts and any safety concerns relating to the woman's child or children and any action taken by the health worker regarding notification to the Department of Community Services.
- Where visible injury occurs and legal action is likely, photography of a victim's injuries may be appropriate. In these instances:
 - ◆ prior to photographing, obtain the woman's consent, both verbal and written, to take photographs of injuries. The consent needs to stipulate for what purpose the photographs are being taken.
 - ◆ use a scale such as a small ruler or a coin to provide verification of the size of the injury.
 - ◆ take two sets of pictures. Sign each picture on the back including the client/patient's name, hospital identification number and the date.
 - ◆ offer the woman one set and keep the other in the clinical records file in a sealed envelope.

- Consider the use of ‘body maps’ to document the injuries.
- The documentation of injuries may provide medico-legal evidence for court at a later date. Medical reports are often a significant part of evidence in ADVO complaints and criminal charges. These reports can encourage the offender to consent to an ADVO and may be evidence in any future legal proceedings if the patient wishes to take legal action.
- If domestic violence is suspected but denied by the woman, health workers should clearly document their suspicions and the basis for their assessment. They should also note that the woman’s description of how any injuries were sustained, was not borne out by clinical examination.
- Health workers have a legal responsibility to document all contacts with clients/patients in the medical record. If the patient does not wish the information to be documented, reassure her/him that the medical records are confidential and cannot be accessed by anyone outside of the NSW Health service without the patient’s written consent except by the Department of Community services or by subpoena in accordance with NSW Department of Health Circular 99/18 – *NSW Health Information Privacy Code of Practice*.
- If the client/patient continues to be unsure about recording information in the file, explain that health workers are required to do so. Invite the patient to read the notes and add information if they wish. The patient’s comments should be attached as an addendum to the medical record.
- All medical records are confidential (Refer to Circular 99/18 – *NSW Health Information Privacy Code of Practice*). However, they can be released by subpoena and on request by the NSW Department of Community Services. Health workers are required by law to comply with subpoenas, but should be aware that appropriate steps should be taken to protect sensitive material or privileged communications. The *Evidence Act 1997* gives judges the ability to exclude evidence of any confidential communication occurring in a professional health relationship where they are satisfied that there is a likelihood of harm being

caused to the client if the evidence is admitted and the nature of the harm outweighs the desirability of the evidence being given. The NSW Department of Health Circular 98/29 – *Subpoenas* and Circular 99/18 – *NSW Health Information Privacy Code of Practice*, contain information on how to deal with subpoenas and other requests for information in the context of legal proceedings. Refer to *NSW Health Child Protection Frontline Procedures 2000* for responding to requests by the Department of Community Services under Section 248 of the *Children and Young Persons Care and Protection Act 1998*.

8.2 Preparation of legal reports

Policy

Health services will cooperate with the provision of medical notes and relevant reports for victims for legal purposes including compensation or Victims Impact Statements. Consultation with managers should occur in this process. The provision of reports may be important to assist victims in obtaining protection and or recognition of the impact of their abuse. Where reports are to be prepared, health workers should adhere to the instructions contained within the NSW Department of Health Circular 02/22 – *Charges for Health Records and Medical Reports* and Circular 99/18 – *NSW Health Information Privacy Code of Practice* (Refer also to Section 5 – Intervention with perpetrators of domestic violence).

Rationale

Health workers should be aware of their legal obligations, and the limitations of these obligations, in preparing court and legal reports. It is imperative that health workers provide reports which are professional, objective and relevant to the proceedings for which they are sought.

Procedures

- Health workers will provide assistance to victims of domestic violence to access their clinical notes and appropriate reports to enable protective, criminal or compensation procedures to be pursued.
- In general, if a health worker is asked to prepare a report, they should seek direction from their management as to whether it is appropriate to do so.
- Instructions on preparation of reports are set out in Circular 02/22 – *Charges for Health Records and Medical Reports*.
- When preparing a report for court, health workers should take care to ensure that they are qualified to prepare the particular report and confine themselves to commenting within their area of expertise.
- Victims of domestic violence should be made aware of the provisions under *The Victims Support and Rehabilitation Act 1996*, which include compensation for injury resulting from domestic violence or stalking offences. (Refer to Appendix 5 – Legal options for domestic violence.)
- In addition health workers need to comply with the ‘Victims Rights Charter’ which states:
 - ‘Victims should have access to information and assistance for the preparation of any victim impact statement authorised by law to ensure that the full effect of the crime on the victim is placed before the court.’ (Refer to Appendix 7 – *NSW Charter of Victims’ Rights*.)
- For more information refer to *Charter of Victims Rights Resource Kit*, available online from www.lawlink.nsw.gov.au
- Writing a report may place health workers in a position where they can be cross-examined about the information written. A report may be requested for civil claims (eg for Worker’s Compensation or in the context of Family Law or Children’s Court proceedings) or it may be requested for criminal proceedings.
- Health workers should ensure that the contents of their reports are professional, objective and confined to relevant material.
- NSW Health services should implement a process wherein reports are scrutinised and quality checked. A copy should be placed in the client record.
- Where civil proceedings take place before a criminal trial, the client’s consent to waive their privilege must be obtained in writing before any report is prepared. It may be appropriate in situations where a client’s solicitor has asked for a report, to provide them with a copy of the medical records instead. Before this can occur, the client must consent in writing to the access.
- It is not uncommon for perpetrators of domestic violence to request counselling, and subsequently reports, prior to court appearances or sentencing for violent behaviour. Providing reports in these circumstances is in general not an appropriate use of health services. This position should be conveyed to those seeking a service where this appears to be the reason for presentation. (Refer to Section 5.4 – Legal issues in relation to perpetrators, for requests for reports for perpetrators of violence.)

Data collection

Policy

The collection and validity of data on domestic violence is dependent upon NSW Health services accurately and consistently identifying incidents of domestic violence. NSW Health services should examine existing processes for gathering data on domestic violence and pursue opportunities for improving these. Concomitant with the introduction of routine screening, NSW Health services will need to establish mechanisms to report on the number of clients identified as experiencing domestic violence and actions taken as a result of the screening finding.

Rationale

The collection of accurate data in relation to domestic violence presentations is important to enable local and statewide planning and to facilitate targeted service delivery.

Procedures

NSW Health services should ensure that local data collection systems in place have the capacity to collect data about domestic violence presentations.

It is the responsibility of all health workers to ensure that, where data systems have the capacity to code and capture information about domestic violence presentations, this is fully utilised and accurate data is entered. This includes data on the victim's Aboriginality or language spoken at home. Area Health Services need to provide training to health workers on cultural sensitivity in approaching this question.

NSW Health services should use this data to assess the accessibility of their services, in light of the known incidence of domestic violence, and to inform service planning.

NSW Health services which are required by this policy to introduce routine screening for domestic violence will participate in data collection processes which document the level and outcomes of screening. Initially this will take the form of an annual snapshot over a one month period according to a format and a timetable provided by the NSW Department of Health.

10 Staff safety

Policy

Area Health Services must ensure that staff safety is a priority when responding to domestic violence. If a health worker is threatened with, or fears, personal violence as a result of, for example, making a report to the Department of Community Services or NSW Police, then the threat should be reported to the police. Health workers may apply for an Apprehended Personal Violence Order (APVO). Occupational Health and Safety procedures also require compliance. Health workers may also be victims or perpetrators of domestic violence themselves. Situations may arise in which a health worker's partner or ex-partner may pose a threat to safety in the workplace. Staff safety should be addressed in accordance with Circular 01/22 – *NSW Health Workplace Health and Safety: A Better Practice Guide*, Circular 97/99 – *Critical Incident Manual: Policy and Guidelines*; *NSW Health Safety and Security Manual 1998* and Circular 02/19 – *Effective Incident Response: A Framework for Prevention and Management in the Health Workplace*.

Rationale

Working with victims of domestic violence may place health workers at risk. Staff safety must therefore be considered a priority by health services.

Recent research suggests over 42 percent of health workers in Australia have experienced abusive relationships (Hegarty et al 1999). Health workers need support and debriefing to deal with (as well as where relevant, their own issues) the impact of working with people who have experienced trauma.

Procedures

- Health workers should be aware of and consider their own safety at all times. If at any time health workers feel unsafe or threatened, they should remove themselves from the situation.
- Health workers should remain alert to situations where domestic violence may be an issue, and assess potential risks to themselves and to the victim.
- Health workers must also assess the risk involved in domestic violence cases where the person who is violent accompanies the victim to the health service. Health workers should:
 - ◆ never place themselves physically between partners during a dispute
 - ◆ never try to mediate between partners where domestic violence is an issue
 - ◆ ensure that they are able to leave the situation quickly if it escalates and becomes dangerous
 - ◆ use interview spaces that maximise access by other staff.
- Health workers should inform their supervisors/managers prior to entering any situations where there is a known perpetrator of domestic violence.
- Where possible, all telephones within health services should be pre-programmed with the Security Service's telephone number for quick and easy access by staff. Duress alarms may also be appropriate for security purposes.
- To avoid possible threats or harassment from the person who is violent, health workers must never release the home phone number or address of any staff member.

- In undertaking home visits health workers should:
 - ◆ consider any potential risks prior to undertaking the home visit
 - ◆ provide information to their manager or delegate, as to their whereabouts
 - ◆ provide contact numbers and expected time of completion
 - ◆ leave immediately if violence is occurring when health workers arrive at the home, and notify the police.
- Home visits should not be made where:
 - ◆ threats have been made against staff
 - ◆ there are known or suspected weapons in the home and there is a history of domestic violence
 - ◆ a perpetrator is at home or likely to return during the visit
 - ◆ the health worker has reason to fear for their safety.
- Document all threats including:
 - ◆ the nature and wording of the threat
 - ◆ who made the threat
 - ◆ when the threat was made
 - ◆ who was notified about the threat.
- After any incidents in which health workers are threatened or feel harassed, intimidated or fear for their future safety, management should be advised and support arranged as soon as possible.
- If a health worker is threatened with or fears personal violence as a result of, for example, making a report to the NSW Department of Community Services or NSW Police, then the threat should be reported to the police. Health workers may also apply for an Apprehended Personal Violence Order.
- Health services and managers have a duty of care to ensure that the work environment is safe and supportive. Procedures and practices must be developed which protect and promote staff safety.
- Where staff are injured, threatened or harassed in the context of intervening with domestic violence, managers will address the staff member's need for protection and support as a matter of priority.
- The Employee Assistance Program (EAP) services provide counselling and support to employees who are adversely affected by some aspect of the situation they are dealing with, or by the inherent (and cumulative) stresses associated with dealing with victims of domestic violence and crisis situations.
- Where health workers identify that they have experienced abusive relationships themselves, managers should ensure that they are offered the option of counselling through the EAP services or other counselling services.
- Managers should also take all steps possible to address the workplace safety of staff members who identify themselves as being at risk from a partner or ex-partner.

11 Interagency collaboration

Policy

The *NSW Domestic Violence Interagency Guidelines 2003* outline an agreed framework and the roles of respective agencies in response to domestic violence. Area Health Services are expected to maximise opportunities for effective interagency collaboration and support government interagency strategies. Area Health Services will also ensure that General Practitioners and local Divisions of General Practice are aware of NSW Health policy and are involved in key strategies to prevent and respond to domestic violence.

Rationale

Dealing with domestic violence, like dealing with child protection, is a responsibility of the whole community and one shared by government and non-government agencies. No single agency has all the knowledge, skills or authority to safeguard victims of domestic violence and prosecute alleged offenders.

Procedures

- Responding to domestic violence requires collaboration and coordination. Area Health Services should ensure that this occurs on a regional/Area basis and at the service level involving individual health workers.
- As a basis for interagency domestic violence work and based on the *NSW Domestic Violence Interagency Guidelines 2003*, it is expected that Area Health Services will demonstrate:
 - ◆ an understanding of the aims of intervention and what constitutes good practice
 - ◆ an appreciation of and respect for different roles and different contributions of practitioners and agencies
 - ◆ a commitment to partnership between the government and non-government sectors in achieving good practice responses
 - ◆ an understanding of the context in which agencies work and acknowledgment of their constraints
 - ◆ preference for coordinated effort rather than unilateral action by a single agency or uncoordinated action by a number of agencies
 - ◆ a willingness to learn from each other
 - ◆ a belief in accountability to clients, to each other and to the community.
- Health services will ensure representation is provided to Local Domestic Violence Committees and NSW Strategy to Reduce Violence Against Women Regional Reference Groups. This will maximise effective referral and interagency collaboration.
- Area Health Services will ensure that General Practitioners and local Divisions of General Practice are aware of NSW Health policy and involved in key strategies to prevent and respond to domestic violence.

12.1 Emergency Departments

Emergency Departments are crucial points in the health system for identifying domestic violence. Women who are abused are frequently treated within health care systems, however, they generally do not present with obvious trauma, even in Emergency Departments (Roberts et al. 1993). Direct questioning is particularly important when there are physical and emotional/behavioural signs of domestic violence, which have not been disclosed by the victim.

Research has shown that:

- up to 25 percent of women who attend an Emergency Department have a history of domestic violence (Bates, Brown & Hancock 1995).
- 7 percent of women who present to Emergency Departments are presenting as a result of domestic violence (Abott et al. 1995).

Women often present to Emergency Departments between the hours of 5pm and 8am, when few or no social work services are available (Roberts et al. 1993, Bates, Brown & Hancock 1995).

This fact, coupled with the low identification and the prevalence of domestic violence indicate the need for training on this issue for doctors and nurses in Emergency Departments and for the provision of appropriate backup referral services such as after-hours social work services.

Possible Indicators

- Injury inconsistent with the account of what happened.
- Controlling or intrusive behaviour by partner.
- Serious bleeding injuries, especially to the face, head and internal organs.
- Single or multiple bruising to any or all parts of the body, fractures, lacerations, burns (including cigarette), haematoma, perforated ear drums, stabbing, gunshot wounds.
- Migraines.
- Haematuria.
- Mental health presentation.
- Repeated presentations.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Support, information and referral

- Where an injury is a confirmed or suspected result of domestic violence, give the woman a high priority and advise the emergency doctor.
- Where an immediate threat to safety is present, call security or police. Immediate steps to provide for the safety of the woman may be required which may include arranging for emergency accommodation. A social admission could be considered. No information should be given to other persons without the patient's consent, unless a report is required to be made to Department of Community Services or NSW Police.

12.2 Hospital Wards

Most often domestic violence will not be the presenting problem of adults who are admitted to hospital. Health workers need to be able to identify indicators of abuse and deal sensitively with them. If questions are not asked in a direct and sensitive manner, victims are unlikely to disclose domestic violence.

Research has consistently shown that:

- 28 percent of women visiting General Practitioners have experienced either physical or emotional partner abuse, or both, in the previous 12 months (Mazza, Dennerstein & Ryan 1996).
- 10 percent of women have been victims of severe physical violence (Mazza, Dennerstein & Ryan 1996).
- a history of victimisation is a strong risk factor for developing chronic mental health problems (Roberts et al. 1998).

Possible Indicators

- Discomfort on being questioned about injuries or living situation.
- Fearfulness.
- Apprehension/agitation by patient in relation to partner visits.
- Demands for premature discharge by partner.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Support information and referral

- If domestic violence is suspected or the woman has disclosed, a referral should be made to the social worker or other appropriately trained person.
- If a patient discloses she is experiencing domestic violence, staff should check if there are visitors she does not want contact with.
- Every effort should be made to discharge patients into a safe environment.
- Where staff are aware that a patient has taken out an ADVO which is breached during a hospital stay by a visit to the ward, the NSW Police should be called with the agreement of the patient, if appropriate. The circumstances at the time of the occurrence will also be taken into account. (Refer to Section 5.6 – Incidents on health service premises).

12.3 Hospital – Paediatric Wards

NSW Health staff need to be open and sensitive to the possibility that some children live with the trauma of being exposed to violence in the home. Children may find it difficult to verbalise that they are experiencing and/or witnessing domestic violence. Acting out behaviours may be the only way children can express their distress. In these situations, the child is seeking a way to cope with confusion, anxiety, tensions and situations that he/she can not comprehend.

Research has shown that:

- 17 percent of children witness their mother being hit by their father (National Crime Prevention 2000).
- 33 percent of children who live with domestic violence report having been hit by their fathers while trying to defend their mother or to stop the violence (Blanchard, Molloy & Brown 1992).
- 8 percent of adolescents attempting to intervene in interparental violence received injuries (Christian et al. 1997).

Possible indicators

Young children	School age children	Adolescents
<ul style="list-style-type: none"> ● Difficulties eating/sleeping. ● Delays or problems with language/motor skill development. ● Withdrawn or mute behaviour. 	<ul style="list-style-type: none"> ● Behaviour which is dependent, sad and secretive. ● Over-protective or afraid to leave mother. ● Anxiety. ● Aggression. 	<ul style="list-style-type: none"> ● Physical/verbal abusiveness/violence. ● Eating disorders. ● Depressed or suicidal behaviour. ● Alcohol or other drug abuse. ● Psychosomatic complaints. ● Exhibiting sexually abusive behaviour.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Support, information and referral

Where domestic violence is suspected, these concerns need to be raised sensitively with the non-offending parent. Extensive questioning of children should not be undertaken. Where domestic violence is suspected, health workers will consult with and consider referral to a social worker.

12.4 Maternity Services

Pregnancy itself is a time of heightened risk and the abdomen is targeted more frequently and more severely in pregnant women. Pregnancy may be a stimulus for the first episode of domestic violence or may prompt an escalation in an already abusive relationship.

The health and safety of two potential victims are placed in jeopardy when domestic violence occurs in pregnancy. The foetus may be indirectly harmed by women being prevented from seeking or receiving proper antenatal or postpartum medical care by their violent partners.

Research has shown that:

- domestic violence is linked to post natal depression, increased risk of having poor weight gain, anaemia, infections, or preterm labour low birth weight (Quinlivan & Evans 1999; Parker et al 1994; Adams-Hillard 1985; and Berenson et al 1994).
- the number of unwanted or unplanned pregnancies and terminations is higher among women experiencing domestic violence (Evins & Chescheir 1996; Glander et al. 1998).
- 20 percent of women experience domestic violence for the first time during pregnancy (ABS 1996).
- there is an elevated risk of domestic violence to pregnant teenagers as these young women are less likely to plan the pregnancy, present later for antenatal care and tend to have extended periods of hospitalisation (Quinlivan & Evans 1999).
- infants of women experiencing domestic violence in pregnancy tend to have smaller head circumference, which can be associated with difficulties in subsequent childhood development (Quinlivan & Evans 1999).

Possible Indicators

- Late or inconsistent attendance by the woman for antenatal care.
- Behaviour of the partner:
 - ◆ Wanting to speak for/make decisions for the woman.
 - ◆ Insisting on remaining with the woman at all times.
 - ◆ Making adverse comments about the woman in public.
 - ◆ Pressuring the woman to be discharged early following the birth.
 - ◆ Verbal abusiveness to staff.
- Woman wanting a longer hospital stay.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Routine screening

Area Health Services will introduce routine screening for domestic violence in accordance with related protocols for all women attending Antenatal services.

- Antenatal services may need to make adjustments to the sequence of the initial visits to maximise opportunities for the privacy needed to ask domestic violence screening questions.
- Routine screening for domestic violence should be incorporated into the social history at assessment.
- Repeat questioning at a later stage of the pregnancy is required because of pregnancy related onset of violence, the impact of repetition and improved rapport with the health worker.

Support, information and referral

- If domestic violence is suspected or the woman has disclosed, a referral should be made to a social worker or other appropriately trained person.
- If a patient discloses she is experiencing domestic violence, staff should check if there are visitors she does not want contact with.
- Every effort should be made to discharge patients into a safe environment.
- Consideration may need to be given to the need to make a prenatal report to the Department of Community Services where domestic violence is identified for pregnant women (Refer to Circular 03/16 – *Protecting Children and Young People*).

12.5 Early Childhood Health services

Living in a home where domestic violence is present may place children at risk of immediate and long-term physical or psychological harm. Even when children do not show outward effects of abuse, exposure to violence within their families is potentially very traumatic. Health workers are responsible for identifying the risk to children and making a report to Department of Community Services where indicated. Early Childhood services play an essential role in supporting women who are vulnerable and isolated due to domestic violence.

Research has shown that:

- infants of women experiencing domestic violence in pregnancy tend to have a significant reduction in head circumference, which can be associated with abnormalities in subsequent childhood development (Quinlivan & Evans 1999).
- physical abuse of children is 15 times more likely in families where domestic violence is occurring (McKay 1994).
- where domestic violence is present, children are three times more likely to be abused by their fathers (McKay 1994).

Possible indicators

Infants	Toddlers	Mothers
<ul style="list-style-type: none"> ● Evidence of injury to body. ● Fretful sleep. ● Developmental slowness. ● Lethargy. ● Physical neglect. ● Fearful reaction to a loud noise. 	<ul style="list-style-type: none"> ● Evidence of injury to body. ● Frequent illness. ● Severe shyness. ● Hitting. ● Biting. ● Bed wetting. ● Copying aggressive language and behaviour in their play. 	<ul style="list-style-type: none"> ● Unexplained injury. ● Non-breast feeding due to presence of partner. ● Anxiety about impact of baby's distress on other family members.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Routine screening

Area Health Services will introduce routine screening for domestic violence in accordance with related protocols for all women attending Early Childhood Health services. The introduction of routine screening in Early Childhood Health services will assist in assessment and appropriate interventions and consideration of possible child protection issues.

Support, information and referral

Where domestic violence is suspected, these concerns need to be raised sensitively with the mother. In such circumstances, health workers will consult with and consider referral to a social worker.

12.6 Physical Abuse and Neglect of Children (PANOC) Services

PANOC services assist children who have been physically or emotionally abused or neglected and their families or carers. Exposure to domestic violence is an issue for a significant proportion of children seen in these services. In this context staff are likely to come into contact with perpetrators of domestic violence who are involved in the re-establishment of safety for their children.

Possible Indicators

- Poor concentration.
- Disclosure of violence in the home.
- Marked changes in behaviour or mood.
- Unrealistic expectations of the child or young person by the parent.
- Attention seeking or risk taking behaviour.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Support, information and referral

PANOC services are only able to accept referrals from the Department of Community Services. These services are available for consultation with health workers.

PANOC services will prioritise the protection needs of children over those of adults. The steps in relation to responding to perpetrators (outlined in Section 5.7 – Intervention) apply in PANOC services as for other health services. PANOC services will address these steps and the prevention of further harm to children by:

- inviting parents/carers who perpetrated domestic violence to take responsibility for their violence and its impact on the mother and children.
- looking for active demonstration by the parent/carer that he is aware of his behaviour’s impact on the well being of his children and is taking steps to change these behaviours.
- assisting parents in domestic violence situations to understand the dynamics of the perpetrator’s behaviour and its impact on them and their children.
- assessing for the parent’s/carer’s ability to act as a protective ally to the children.
- assessing for the parent’s/carer’s ability to prioritise the children’s needs before his own wish to control his partner and children.

12.7 Child, Adolescent and Family Services

Children, young people and families may present to Child, Adolescent and Family services for assistance relating to the impact of domestic violence. Presentations may be in the guise of anger management, stress management, relationship issues or for undefined family issues. Child, Adolescent and Family services are well placed to provide support, advocacy and counselling services to children, young people and their non-offending carers who have been exposed to domestic violence.

Research has shown that:

- 17 percent of children witness their mother being hit by their father (National Crime Prevention 2000).

- 13 percent of children who have witnessed the physical and emotional abuse of their mother by their father qualify for a full Post Traumatic Stress Disorder (PTSD) diagnosis. A further 19 percent have traumatic avoidance and 42 percent display traumatic arousal symptoms (Graham-Berman & Levendosky 1998).

Possible Indicators

- Aggressive behaviour in children or adolescents.
- Defiance in school, particularly with female teachers.
- Stealing and lying.
- Eating problems or eating disorders.
- Reluctance to go home.
- Self-harming behaviours.
- Homelessness.
- Drug and/or alcohol abuse.
- Sexually abusive behaviour.

For a full list of indicators Refer to Appendix 4 – Indicators of domestic violence.

Support, information and referral

- Where a psychosocial assessment indicates the presence of domestic violence in the home, the safety of the child or young person needs to be considered. Many adolescents find it difficult to reveal they are living with domestic violence and are relieved that someone has asked them directly. Where possible, interview the child or young person alone and in private. If the perpetrator is present, it is unlikely that a child or young person will be able to discuss the violence.
- The experience or commission of abusive behaviour on the part of a young person in a current intimate relationship may also involve risks to that young person’s safety, which need to be considered. Intervention with adolescents who are vulnerable to developing abusive behaviour or entering abusive relationships may be an important form of domestic violence prevention.

12.8 Child and Adolescent Mental Health Services

Child and Adolescent Mental Health services play an important role in early intervention with young people who are at risk of long term problems. Exposure to domestic violence in parental relationships can lead to serious disturbance on the part of young people and the identification of domestic violence as a contributor to presentations will be useful in targeting interventions.

Research has shown that:

- psychopathology is four times more likely in children exposed to domestic violence than from non-violent homes (McIntosh 2000).
- 13 percent of children who have witnessed domestic violence qualify for a diagnosis of PTSD. A further 19 percent have traumatic avoidance and 42 percent display traumatic arousal symptoms (Graham-Berman & Levendosky 1998).

Possible Indicators

- Symptoms of Post Traumatic Stress Disorder (PTSD).
- Signs of depression.
- Drug abuse or non-compliance with medication.
- Suicidal behaviour.
- Homelessness.
- Violent or abusive behaviour towards other family members.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Support, information and referral

Many adolescents find it difficult to reveal they are living with domestic violence and are relieved that someone has asked them directly. Where possible interview the child or young person alone and in private. If the perpetrator is present, it is unlikely that a child or young person will be able to discuss the

violence. Where the psychosocial assessment indicates the presence of domestic violence in the home, the safety of the child or young person needs to be considered.

The experience or commission of abusive behaviour on the part of a young person in a current intimate relationship may also involve risks to that young person's safety which need to be considered. Intervention with young people who are vulnerable to developing abusive behaviour or entering abusive relationships may be an important form of domestic violence prevention.

12.9 Mental Health Services

Domestic violence can contribute to an acute episode of mental illness. Identification of domestic violence may be more difficult for persons with a mental illness as they are less likely to be believed or they may present to acute psychiatric units for admission as a means of seeking respite from the violence.

Research has shown that:

- a history of victimisation is a strong risk factor for developing chronic mental health problems (Roberts et al. 1998).
- women who have a history of violent and abusive relationships are more likely to be affected by a mental illness (Human Rights and Equal Opportunity Commission Report 1993).
- women who are reacting to a highly traumatic situation are at greater risk of being labelled as 'mentally ill' (Human Rights and Equal Opportunity Commission Report 1993).

Women with mental health problems may be more vulnerable to experiencing domestic violence and less able to take protective action for themselves or their children.

Mental illness in a perpetrator can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. The risks posed by the violent behaviour must also be addressed.

Possible Indicators

- Anxiety.
- Injuries.
- Suicide attempts.
- Drug and alcohol abuse.
- Psychosomatic complaints.
- Sleep disturbances including nightmares.
- Chronic users of tranquillisers.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence

Routine screening

Area Health Services will introduce universal routine screening for domestic violence in accordance with related protocols for all women 16 years and over attending Mental Health services.

- Inclusion of screening questions for domestic violence at the intake/assessment point for all mental health in-patients and outpatients will assist in diagnostic and safety considerations. Screening questions can be incorporated into the Mental Health Outcomes Assessment Tools (MH-OAT) assessment procedure.

Support, information and referral

- Disclosures of domestic violence may be interpreted as manifestations of a mental illness, however it is important to respond supportively. Staff should support victims’ right to access appropriate services including the police.
- Where mental health patients are identified as perpetrators of domestic violence and there are concerns about the safety of partners or any other family members, Mental Health services have a duty of care towards the partner and other family members, which may include reports to NSW Police and taking appropriate steps to address their support needs. (Refer to Section 4.1 – Limited confidentiality and Section 4.2 – Reporting to police.)

12.10 Drug and Alcohol Services

- Amongst the clients of Drug and Alcohol services are significant numbers of both victims and perpetrators of domestic violence. Responding to this latter group presents particular challenges for Drug and Alcohol workers.
- In the past few years, the law has changed to reflect the community’s view that self induced intoxication is no longer an excuse for the commission of most criminal offences. There is evidence to suggest that most drugs do not cause people to act violently, but rather influence their behaviour indirectly by symbolising ‘timeout’ from normal behaviour. The cultural context reinforces this idea. Perpetrators have been known to use alcohol and other drugs as excuses for their behaviour, even when their consumption is negligible.
- Attitudinal factors such as acceptability of violence, absence of sanctions and a limited sense of responsibility are better predictors of perpetration of domestic violence than substance use. Additionally, clinical practice demonstrates that indicators for substance abuse occurring in a family often mask indicators for domestic violence, as they are similar.
- Drug and Alcohol services should have a working knowledge of the effect of various drugs and related substance abuse issues for people (victims and perpetrators) affected by domestic violence. Chronic, untreated substance abuse may mean that some people have difficulty in planning, organising and achieving goals. It may also mean that victims are more vulnerable and less able to take protective action for themselves or their children. Similarly, the perpetrator’s behaviour may be more erratic, threatening and unpredictable.

Research has shown that:

- Women who have been abused are more likely to abuse alcohol and other drugs (Quinlivan & Evans 1999).
- 72 percent of women with drug and alcohol problems experience sexual or physical assault as adults, mostly in the domestic violence context (Swift, Copeland & Hall 1996).

Possible Indicators

- Frequent crisis states.
- Person blames partner for behaviour.
- Person forgets details of abusive incident.
- Isolation of non-abusive partner.
- Developmental immaturity.
- 'Loss of control' used as a coping mechanism.
- Impulsiveness and low self esteem among family members.
- Being forced to deal drugs by the partner.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence

Routine screening

Area Health Services will introduce routine screening for domestic violence in accordance with related protocols for all women 16 years and over attending Drug and Alcohol services.

The introduction of routine screening for women attending Drug and Alcohol services will assist in assessment, treatment, appropriate interventions and consideration of possible child protection issues. Screening questions to identify domestic violence will be included when possible in existing assessment forms in health services.

Support, information and referral

To provide optimal support and assistance staff should have a knowledge of:

- strategies for working with people with challenging behaviours related to alcohol and drug dependency
- available treatments and service options in order to make appropriate referrals and to assist in the support and counselling process.

12.11 Community Health Centres

Community Health Centres provide a non-stigmatising and non-identifying supportive health setting which is likely to be accessed by people who are experiencing violence.

Some domestic violence cases present as obvious abuse, however the majority remain hidden and unreported by women because of shame, fear they will not be believed, or because of fears about safety. Most often domestic violence will not be the presenting problem.

The provision of information and supportive intervention to victims of domestic violence, through one-off or ongoing counselling as appropriate, are important preventative strategies. The prevention of further violence and long term effects on victims including children may be achieved from this type of intervention.

Possible Indicators

- Panic attacks.
- Severe crying spells.
- Signs of depression.
- Low self-esteem.
- Relationship and/or parenting difficulties.
- Financial difficulties.
- Suicidal behaviour.

For a full list of indicators refer to Appendix 4 – Indicators of domestic violence.

Support, information and referral

Counselling intervention should be informed by the principles which underpin this policy. (Refer also to Section 3.2.1 – Immediate/crisis intervention and Section 3.2.2 – Counselling intervention with victims).

Relationship counselling and family therapy which include the perpetrator, should not occur where domestic violence has been identified. Referral to alternative services may be considered.

It is not uncommon for Community Health Centres to experience presentations by perpetrators of domestic violence seeking counselling for violence issues or other health problems (Refer to Section 5 – Intervention with perpetrators of domestic violence).

13 Diversity and effective service delivery

Issues such as ethnicity, race, gender and disability need to be considered in any integrated intervention rather than as stand-alone issues. Staff need to be able to identify, acknowledge and work sensitively with people with differing cultural beliefs, values and lifestyles. This includes working with:

1. Aboriginal and Torres Strait Islander communities
2. culturally and linguistically diverse communities
3. older and young people
4. people in gay and lesbian relationships
5. people with a disability
6. people living in rural and/or isolated areas.

13.1 Aboriginal or Torres Strait Islander communities

NSW Health recognises that many Aboriginal and Torres Strait Islander communities prefer the term 'family violence' to 'domestic violence' and that this term covers partner and ex-partner abuse in addition to the wider forms of violence experienced within extended families and communities.⁵

There is evidence to indicate that Aboriginal people are far more likely to experience violence and to die as a result of it (Atkinson 1996).

Over recent years Aboriginal communities have taken significant steps to address the unacceptable level of violence within communities and to adopt whole of family, whole of community, approaches to reducing the violence. Aboriginal men, women and children have expressed their commitment to work together with relevant agencies on local strategies with that common objective.

NSW Health recognises that the history and solutions to violence within Aboriginal communities differ from those within the rest of the community. The NSW Aboriginal Family Health Strategy provides holistic and family programs developed specifically for and in collaboration with Aboriginal and Torres Strait

Islander communities. These programs are to complement mainstream services and in some aspects differ from these services.

A core element of these programs is the involvement of men in finding solutions to Aboriginal family violence while not detracting from the safety of women and children and from criminal responsibility, where this is required. Programs funded under the *Aboriginal Family Health Strategy* or established in line with its objectives, by Aboriginal health services may provide interventions targeted at perpetrators who have committed acts of violence.

Principles of the NSW Aboriginal Family Health Strategy

- Solutions to family violence and sexual assault in Aboriginal communities are family health solutions.
- The leadership for solutions to family violence and sexual assault in Aboriginal communities will be found within Aboriginal communities.
- Solutions to family violence and sexual assault in Aboriginal communities are culturally and spiritually focused.
- Solutions to family violence and sexual assault in Aboriginal communities will be community devised, managed and implemented.
- The planning, management and implementation of community solutions will be based on representation from women as well as men.
- Victims have the right to seek help from the service of their choice for the protection, safety and wellbeing of themselves and their children.
- Perpetrators of violence are to accept responsibility for their violence, including criminal prosecution.
- Violence in the community is governed by criminal sanctions and victims of violence need to be informed of their rights before the law.
- The victim's wishes are to be taken into account when criminal prosecution is being considered.

- The ongoing safety of the adult or child who has experienced violence is the paramount consideration in any response.
- Education and follow up programs are priority strategies in the promotion of Aboriginal family health.

The NSW Department of Health and Area Health Services will work cooperatively with Aboriginal people and communities to assist people affected by family violence. NSW Health is committed to ensuring that staff will be knowledgeable and/or skilled in:

- the broad concept of ‘family’ in Aboriginal communities
- the dynamics of Aboriginal family and community violence
- supporting victims and referring to culturally appropriate agencies or staff, where available
- providing culturally appropriate referral to offenders, where available
- checking the suitability of any referral with the affected person in case there are issues of confidentiality, for example a family member working at the agency
- where appropriate, seeking information and support from Aboriginal and Torres Strait Islander colleagues
- an understanding and appreciation of the historical and ongoing issues of grief, trauma and loss affecting Aboriginal communities, including how these relate to ongoing economic and social deprivation, substance misuse and family and community violence.

Health workers are responsible for increasing their understanding of Aboriginal culture and of the fears and difficulties that Aboriginal people may have concerning the involvement of police, government, and welfare and community agencies in their families.

The NSW Police also employs Aboriginal Community Liaison Officers (ACLOs) who can provide advice, information, referral, and support. They are located within each Region.

13.2 Culturally and linguistically diverse communities

People from culturally and linguistically diverse communities are not a homogeneous group and their understanding of the law about domestic violence will be influenced by different factors. These factors include length of time in Australia, level of education, English language proficiency, religious background, community support infrastructure and personal experience.

Domestic violence happens across all cultures and in all countries. Domestic violence should not be tolerated in any culture. Responses may need to be different according to the individual’s needs. However, safety of women and children should be the focus of any intervention.

A research project studying the needs of people from a non-English speaking background found that powerful barriers to disclosure of domestic violence by victims included shame and disgrace, a strong sense of obligation and self-blame, fear of police and other authorities, and community expectations (Bagshaw et al. 1999). For some people who experience abuse in their intimate relationships, their sense of vulnerability is compounded by their residency status and/or because they are culturally and linguistically different from the mainstream community.

Health workers should:

- work sensitively with groups who have differences in culture, language, values, religion, countries of origin, traditions, practices, and beliefs
- be aware that newly arrived people and/or people with little English language may not have a good understanding of the Australian legal system and that this may cause mistrust and fear
- understand that refugees may have suffered torture and trauma prior to arrival in Australia and that domestic violence may be an additional trauma
- recognise the importance of the victim’s immigration status and how this may affect her decision making around the perpetrator
- wherever possible, use accredited professional interpreters. Avoid using family members; especially children or family members who may be perpetrators

- wherever possible, request a female interpreter for a woman client/patient
- be aware that people in a crisis may lose their English comprehension and speaking skills and that a qualified interpreter will greatly assist communication when dealing with complex issues.

The NSW Police employs Ethnic Community Liaison Officers (ECLOs) who can provide advice, information, referral and support. They are located within each Region.

13.3 Older people

Older and young women living in situations of domestic violence may experience particular barriers to addressing their problems and require different responses from those provided by mainstream services.

Data from *Women's Safety Australia* (ABS 1996) showed that one in three women over the age of 45 years had experienced domestic violence, and 1.2 percent of women over 55 years experienced partner abuse in the past 12 months. Women who have been victims of domestic violence for many years may continue to be abused in their old age. In addition, some elderly victims are frail and may be dependent on the offending partner for care.

For many older women experiencing domestic violence, the option of leaving their partner is problematic (Office of the Status of Women 2001). The opportunity to rebuild a financial base is severely limited, particularly if there is little chance of gaining employment or they are in their retirement years. Many are anxious about possible estrangement from adult children (and grandchildren) and the loss of long-standing social networks (Office of the Status of Women 2001).

Abuse of an elderly person may at times not represent domestic violence, but be a reaction to the stress of the carer role. In such cases consideration may need to be given to the demands on and needs of the carers. Where elderly victims are frail and dependent on the abusive partner for care, they may require additional support.

Health workers should ensure that:

- the abused partner's safety is the key priority
- aged care and domestic violence services work together to develop appropriate responses.

13.4 People in gay and lesbian relationships

Attitudes to homosexuality in the community have meant that lesbians and gay men sometimes experience difficulty in having their sexuality taken into account in health care settings, and this tends to make such services alienating to gays and lesbians experiencing domestic violence (Bagshaw & Chung 2000).

There are common issues for gay men and lesbians, when seeking help through services. There are also differences between them. Changes in the relationship due to illness can sometimes mark the onset of violence. A significant factor is the potential for 'HIV-related abuse'. Research suggests that there is a relationship between disclosure of HIV and the onset of domestic violence (Schembri 1995). The nature of HIV as a highly stigmatised disability makes it an especially effective tool of abuse. Further, HIV-positive status will create additional obstacles for the victim and may aggravate the consequences of such abuse (Hanson et al. 1999).

For many in same sex relationships, barriers to seeking help include issues of confidentiality in often small communities, fear of being ostracised by their community, fear of a homophobic backlash, and a lack of understanding and support from extended families (Bagshaw & Chung 2000).

Health workers should:

- explore the dynamics of the relationship to uncover the tactics of violence, and understand who the victim of violence is and act accordingly
- ensure that the focus of attention and support remains on the risk and safety needs of the victim and his/her children
- be aware that gay and lesbian families may have a more extensive and non-traditional understanding of 'family' that is socially as well as biologically based.

The NSW Police employs Gay and Lesbian Liaison Officers (GLLOs) who can provide advice, information, referral and support. They are located within each Region.

13.5 People with a disability

Approximately 18 percent of all women living in Australia have a disability, and women with disabilities experience violence at a rate at least twice that experienced by women without disabilities (Frohman 2001). Many of the women affected do not access information and education about domestic violence (Office of the Status of Women 2001).

Health workers should:

- recognise that although a person may have a physical and /or intellectual disability, the issue of domestic violence should be the focus and not the person's disability
- be aware that a disability may make the person more vulnerable to experiencing domestic violence and less able to take protective action for themselves or their children
- ensure that any information and support is tailored to meet the person's specific intellectual/physical needs. Staff should be aware of the effects of the woman's disability or disabilities particularly in relation to communication, for example, the ability to make or take a phone call, or to write messages or statements, the effect of short term memory problems on decision making, physical access issues. These may affect her ability to utilise health and other support services including NSW Police and legal services
- recognise the additional concerns and support needs that having a child with a disability may present for mothers
- understand and work closely with the range of specialist services, support and advocacy groups that represent specific disability groups
- be aware of services like the national relay service for hearing and speech impaired people.

13.6 People living in rural and/or isolated areas

Women and children living in rural/remote areas face particular problems that may increase their risk of domestic violence and affect their decision-making. These include:

- increased isolation from friends and extended family
- having limited or no access to health, counselling and support services in their area
- having heightened concerns around confidentiality arising from living in a small community
- having limited or no access to public transport that reduces the ability of the women to seek safety or receive assistance
- lack of safe emergency and longer term housing options in the area
- the greater risk of injury for families living on farms or in isolated dwellings due to longer police travelling times
- the loss of support networks when leaving an abusive relationship means having to leave the area
- the widespread availability and serious risk posed by firearms.

Health workers should:

- address the specific confidentiality concerns related to the provision of services by victims in small communities
- make use of telephone services to ensure access by isolated victims to services
- consider specific safety issues faced by isolated victims.

Appendix 1

Forms of domestic violence

Physical abuse

Physical abuse includes slapping, punching, kicking, choking, or use of weapons to inflict injury. Physical abuse also includes a wide range of intimidating behaviours such as driving dangerously, the destruction of property, physical assault of children, locking the victim out and sleep deprivation.

Sexual assault

Sexual assault is a criminal offence. It includes a range of sexually abusive and exploitative behaviours including rape, indecent assaults, and forced viewing of pornography. These behaviours can be used to instil fear and to maintain control.

Psychological, emotional and verbal abuse

Psychological, emotional and verbal abuse includes: attribution of blame and guilt for family problems; emotional withdrawal; verbal attacks which may focus on the partner's intelligence, sexuality, body image or capacity as a parent; threats to family member's well being and safety; and abuse of pets in front of family members.

Social abuse

Social abuse refers to isolation which impedes or curtails access to family, friends, community agencies or places of worship.

Economic abuse

Economic abuse refers to controlling or withholding access to family resources, including money and ownership of goods and property. In some instances, the perpetrator controls all access to food.

Harassment and stalking

Harassment and stalking refer to constant threatening contact such as telephone calls or letters, following the victim or continually photographing them. The perpetrator may watch or wait for the victim and children at their home, work or place of leisure. Such behaviour can occur during a relationship or once it has ended.

Health consequences of domestic violence

<p>Physical</p> <ul style="list-style-type: none"> ● Abdominal / thoracic injuries ● Bruises and welts ● Chronic pain syndromes ● Disability ● Fibromyalgia ● Fractures ● Gastrointestinal disorders ● Irritable bowel syndrome ● Lacerations and abrasions ● Ocular damage ● Reduced physical functioning 	<p>Psychological and behavioural</p> <ul style="list-style-type: none"> ● Alcohol and drug abuse ● Depression and anxiety ● Eating and sleep disorders ● Feelings of shame and guilt ● Phobias and panic disorder ● Physical inactivity ● Poor self-esteem ● Post-traumatic stress disorder ● Psychosomatic disorders ● Smoking ● Suicidal behaviour and self-harm ● Unsafe sexual behaviour
<p>Sexual and reproductive</p> <ul style="list-style-type: none"> ● Gynaecological disorders ● Infertility ● Pelvic inflammatory disease ● Pregnancy complications / miscarriage ● Sexual dysfunction ● Sexually transmitted diseases, including HIV/AIDS ● Unsafe abortion ● Unwanted pregnancy 	<p>Fatal health consequences</p> <ul style="list-style-type: none"> ● AIDS-related mortality ● Maternal mortality ● Homicide ● Suicide

Source: Krug, E. G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B. & Lozano R. (2002), *World Report on Violence and Health*, World Health Organisation, Geneva.

Appendix 3

Extent and impact of domestic violence

Violence is a major concern for the community. According to a study of over 500 research reports worldwide on violence against women by the John Hopkins School of Public Health (1999), at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime, most often by a member of her own family.

Domestic violence is one of the most common forms of violence in our society, although its occurrence and effects are often hidden from view (WHO 2002).

There are substantial economic costs for government and community services addressing the consequences of domestic violence. Australian estimates annually range from \$7 million in the Northern Territory (KPMG 1996) to \$400 million in New South Wales (Distaff Associates 1991).

Domestic violence is increasingly acknowledged as a major public health concern in Australia. Women may present to health care settings before they present to criminal justice or social services agencies, and if abuse is identified they can receive interventions that increase their safety and improve their health.

Incidence and prevalence

The incidence and prevalence of domestic violence in NSW cannot be accurately stated as a result of inconsistent data collection methods and victims' reluctance to report.

In a national survey of over 6,000 women, the Australian Bureau of Statistics (1996) found that:

- 23 percent of women in Australia who have ever been married or in a de facto relationship, experienced violence by a partner at some time during the relationship
- 48 percent of women physically assaulted by a man in the previous 12 months sustained physical injuries in the last incident.

Other examples include:

- a Melbourne study of 2,181 women attending 15 general practices, found that in the previous year 28 percent had experienced either physical or emotional abuse or both (Mazza, Dennerstein & Ryan 1996).
- studies on domestic violence in gay and lesbian couples indicate that violence in homosexual relationships is not uncommon. It is estimated that between 11 to 20 percent of gay men and lesbians are abused by their partners each year (Bourg and Stock 1994; Island and Letellier 1991; Renzetti 1998).
- research undertaken by the Australian Institute of Criminology found that 60 percent of all female victims of homicide in Australia from 1989 to 1996 were killed by their partners or ex-partners (Australian Institute of Criminology 1998).

It has been recognised at national and state health forums that the severity of family and community violence in Aboriginal communities requires urgent attention. Data in relation to the prevalence of violence in Aboriginal communities is not reliable for a number of reasons, including identification issues, under-reporting and a general lack of trust by Aboriginal victims to report violence.

Health effects

The short and long-term negative health effects which directly result from domestic violence include psychological trauma, physical injury and death (Dearwater et al. 1998; Campbell and Lewandowski 1997).

The injuries, fear, and stress associated with intimate partner violence can result in chronic health problems such as chronic pain (eg headaches, back pain) or recurring central nervous system problems including fainting and seizures. Women who experience domestic violence also have significantly more than average self-reported gastrointestinal symptoms

(eg loss of appetite, eating disorders) and diagnosed functional gastrointestinal disorders (eg chronic irritable bowel syndrome) associated with chronic stress (Campbell 2002).

Depression and post-traumatic stress disorder are the most prevalent mental health effects of intimate partner violence (Golding 1999; Cascardi et al. 1999; Campbell, O'Leay and Schlee. 1997). Some women may have chronic depression that is exacerbated by the stress of a violent relationship but there is also evidence that first episodes of depression can be triggered by such violence and longitudinal evidence of depression lessening with decreasing intimate partner violence (Campbell 2002).

Women with post-traumatic stress disorder have used drugs or alcohol to calm or cope with the specific groups of symptoms associated with their disorder, which include intrusion, avoidance, and hyperarousal (Kilpatrick et al. 1997).

Domestic violence also has an impact on people who may be indirectly involved. There is an expanding body of current evidence linking exposure of children to domestic violence with serious medium and long-term effects. As research in this domain has become more sophisticated, it is increasingly clear that children whose mothers are experiencing domestic violence do not have to witness violence to be significantly affected (Laing 2001). The *Women's Safety Australia* showed that 46 per cent of women who experienced violence by a previous partner said their children had witnessed the violence (ABS 1996). Child abuse can be seen as an indicator of domestic violence in the family and vice versa (Edleson 1999; Falshaw, Browne and Hollin 1996; Margolin 2000).

Appendix 4

Indicators of domestic violence

Indicators associated with domestic violence – One indicator in isolation may not imply that domestic violence is occurring. Each indicator needs to be considered in the context of the individual situation and the presence of other indicators.

Indicators in children and adolescents as victims	Indicators in adults as victims	Indicators of perpetrator behaviour in adults
<p>Physical</p> <ul style="list-style-type: none"> • Difficulty eating/sleeping • Slow weight gain (in infants) • Physical complaints • Eating disorders <p>Social /psychological</p> <ul style="list-style-type: none"> • Depression • Anxiety • Regressive behaviour in toddlers • Delays or problems with language development • Dependent, sad or secretive behaviours • Academic achievement problems • Poor concentration • Disruptiveness • Defiance in school, particularly with female teachers • Poor school attendance • Fighting with peers • Over protective or afraid to leave mother • Physical/verbal abusiveness • Stealing • Social isolation • Abuse of siblings or parents • Depression or suicide attempts • Alcohol and other drug use • Psychosomatic and emotional complaints • Exhibiting sexually abusive behaviour • Feelings of worthlessness • Absence from school • Transience 	<p>Physical</p> <ul style="list-style-type: none"> • Unexplained bruising and other injuries • ‘Accidents’ occurring during pregnancy • Repeated presentations at Emergency Departments • Injuries to bone or soft tissues • Abdominal, breast or perineal bruising, especially if pregnant • Bite marks • Unusual burns caused by cigarettes/top of stove/hot grease/acids • Injuries sustained do not fit the history given/client appears after hours/client delay in coming in for treatment • Nutritional/sleep deprivation • Sexually transmitted disease • Vaginal and/or rectal bruising • Issues in pregnancy such as stillbirths/miscarriages • Pre-term babies/low birth weight babies • Repeat visits to facilities and history of injuries over time <p>Social /psychological</p> <ul style="list-style-type: none"> • Social isolation • Never making a decision without referring to partner • No access to transport • Frequent absences from work or studies • Anxiety/depression/post natal depression • Suicidal ideation/suicide attempts/anorexia or bulimia • Behaviour/withdrawn or submissive behaviour/low self esteem • Alcohol or drug abuse • Fears of reprisal • Psychosomatic and emotional complaints 	<p>Physical</p> <ul style="list-style-type: none"> • May show physical signs of the victim fighting back, such as facial scratches/injuries to hands • Visible rough handling of victim / children <p>Social /psychological</p> <ul style="list-style-type: none"> • Values about ‘ownership’ of partner and/or children • Controlling behaviour • Maintaining secrecy about the extent of the violence • Always speaking for partner • Describing partner as ‘incompetent’ ‘stupid’ or other derogatory terms • Being overly concerned about suspected victim • Minimising the extent of the violence • Admitting to some violence but minimising the frequency and severity • Holding to rigidly stereotyped sex roles • Jealousy of partner, lack of trust in her or anyone else • Not allowing a partner or child to access service providers alone • Inability to control angry outbursts • Presenting as the victim of abuse, discrimination or an allegation of abuse • Attempting to disarm those with the potential to intervene in the situation by inviting fear or sympathy

Legal options for domestic violence

There are a range of civil and criminal options to protect victims, allow intervention and prevent domestic violence. These options offer protection against many forms of domestic violence. The specific legal processes include:

- Apprehended Domestic Violence Orders
- criminal charges arising out of a domestic violence incident
- Family Law
- Victims' Compensation.

Legal action in response to domestic violence may address:

- a criminal action
- the future protection of a victim by prohibiting or restricting certain behaviours of the defendant in the form of a protection order
- compensation for the victim.

Apprehended Domestic Violence Orders (ADVOs)

In NSW, one form of protection from domestic violence is provided by an Apprehended Domestic Violence Order, which is made under part 15A of the *Crimes Act 1900*. An ADVO can be granted by the court to protect a person against acts of violence such as physical assault, non-physical abuse such as harassment or intimidation, or threatened damage to property.

An ADVO is not a criminal conviction. The purpose of an ADVO is to provide protection from future violence, harassment or molestation by placing conditions or restrictions on the offender. The victim does not have to be living with the person who abuses them to apply for an ADVO. The order itself does not give a criminal record. However, breaching an ADVO is a criminal offence.

ADVOs are designed to:

- ensure the safety and protection of all persons who experience domestic violence
- reduce and prevent violence between persons who are in a domestic relationship with each other
- enact provisions that are consistent with certain principles underlying the 'Declaration on the Elimination of Violence Against Women'.

Criminal charges

Many acts of domestic violence constitute criminal offences and are not limited to physical assault. Stalking, trespassing and malicious damage are all criminal behaviours. Police are responsible for deciding whether to proceed with an assault case. If a police officer lays charges, NSW Police or the Director of Public Prosecutions (DPP) will prosecute the offender where sufficient evidence exists. The prosecution of the charge can proceed even if the victim does not want it to. If found guilty the offender receives a criminal conviction.

Family Law

The purpose of the Family Court of Australia is to resolve or determine family disputes with as little antagonism as possible and to encourage the parties to reach their own agreements about their children, finances and property. To do this the Court provides a range of services including:

- information services
- dispute resolution services (counselling, mediation and financial conciliation)
- judges deciding matters brought through the Family Court.

Some of the areas the Family Court deals with are:

- marriage and the dissolution of marriage
- disputes between married couples about the ownership and division of property
- children and parenting within the context of marriage and divorce
- family violence.

There are several areas where the work of the Family Court directly relates to domestic violence. They include:

- the working of the Family Court
- parenting orders
- location and recovery orders
- the relationship between parenting orders and ADVOs
- injunctions for personal protection.

Victims' Compensation

The Victims Compensation Tribunal administers a scheme of compensation for victims of violent crime.

A victim of domestic violence can apply for compensation if she sustains an injury as a result of an act of violence that has occurred in NSW.

An 'act of violence' is an act that has:

- apparently occurred in the course of the commission of a criminal offence (including domestic violence offence)
- involved violent conduct (including sexual assault or domestic violence) against one or more persons
- resulted in injury to one or more persons.

There are a number of ways in which a victim who has experienced domestic violence may be eligible for compensation. The victim may be eligible as a:

- 'primary victim', that is, they can apply as someone who is a victim of an act of violence because they have sustained an injury as a direct result of the act.
- 'secondary victim', ie someone who sustained injuries as a result of witnessing the violent act against another.
- 'family victim' if they are a member of the immediate family of someone who has died as a result of an act of violence.

The classification of primary, secondary and family victim affects, among other things, the type of compensation a victim can receive. Both primary and secondary victims are entitled to compensation for the injury itself and for financial loss arising from the injury.

In order to be eligible for compensation the act of violence must be able to be proved and must have occurred in NSW. In most cases the application must be lodged within two years of the act of violence.

Compensation is not only in the form of money. The Victims Compensation Tribunal also offers at least two hours of counselling to primary, secondary and family victims, and further counselling if the Tribunal considers it appropriate. Counselling is available to victims of an act of violence even if they are not eligible for financial compensation.

Applications for compensation and counselling are made to the Victims Compensation Tribunal (Refer to Appendix 8 – Referral and resource information).

List of domestic violence offences

The *Crimes Act 1900* defines a domestic violence offence as a personal violence offence committed against:

- a. A person who is or has been married to the person who commits the offence, or
- b. A person who has had a defacto relationship, within the meaning of the *Property (Relationships) Act 1984*, with the person who commits the offence, or
- c. A person who has or has had an intimate personal relationship with the person who commits the offence, whether or not the intimate relationship involves or has involved a relationship of a sexual nature, or
- d. A person who is living or has lived in the same household or other residential facility as the person who commits the offence, or
- e. A person who has or has had a relationship involving his or her dependence on the ongoing paid or unpaid care of the person who commits the offence, or
- f. A person who is or has been a relative of the person who commits the offence.

A **personal violence offence** includes a range of offences and attempted offences including but not restricted to the following:

- assault
- maliciously destroying property
- breaching an AVO
- sexual assault
- murder
- manslaughter
- wounding with intent to do bodily harm
- discharging loaded firearms with intent
- malicious wounding or infliction or grievous bodily harm
- stalking.

Source: NSW Attorney General's Department,
NSW Domestic Violence Interagency Guideline 2003

NSW Health has endorsed the NSW Charter of Victims' Rights (*Victims Rights Act 1996*), which provides a framework for high quality service delivery.

The NSW Charter of Victims' Rights

- **Courtesy, compassion and respect**

A victim should be treated with courtesy, compassion, and respect for the victim's rights and dignity.

- **Information about services and remedies**

A victim should be informed at the earliest practical opportunity, by relevant agencies and officials, of the services and remedies available to the victim.

- **Access to services**

A victim should have access where necessary to available welfare, health, counselling and legal assistance responsive to the victim's needs.

- **Information about investigation of the crime**

A victim should, on request, be informed of the progress of the investigation of the crime, unless the disclosure might jeopardise the investigation. In that case, the victim should be informed accordingly.

- **Information about prosecution of accused**
A victim should, on request, be informed of the following:

- a. The charges laid against the accused or the reasons for not laying charges.
- b. Any decision of the prosecution to modify or not to proceed with charges laid against the accused, including any decision for the accused to accept a plea of guilty to a less serious charge in return for a full discharge with respect to the other charges.
- c. The date and place of hearing of any charge laid against the accused.
- d. The outcome of the criminal proceedings against the accused (including proceedings on appeal) and the sentence (if any) imposed.

- **Information about trial process and role as witness**

A victim who is a witness in the trial for the crime should be informed about the trial process and the role of the victim as a witness in the prosecution of the accused.

- **Protection from contact with accused**

A victim should be protected from unnecessary contact with the accused and the defence witnesses during the course of court proceedings.

- **Protection of identity of victim**

A victim's residential address and telephone number should not be disclosed unless a court otherwise directs.

- **Attendance at preliminary hearings**

A victim should be relieved from appearing at preliminary hearings or committal hearings unless the court otherwise directs.

- **Return of property of victim held by State**

If any property of a victim is held by the State for the purpose of investigation or evidence, the inconvenience to the victim should be minimised and the property returned promptly.

- **Protection from accused**

A victim's need or perceived need for protection should be put before a bail authority by the prosecutor in any bail application by the accused.

Information about special bail conditions

A victim should be informed about any special bail conditions imposed on the accused that are designed to protect the victim or the victim's family.

- **Information about outcome of bail application**

A victim should be informed of the outcome of a bail application if the accused has been charged with sexual assault or other serious personal violence.

- **Victim impact statement**

A relevant victim should have access to information and assistance for the preparation of any victim impact statement authorised by law to ensure that the full effect of the crime on the victim is placed before the court.

- **Information about impending release, escape or eligibility for absence from custody**

A victim should, on request, be kept informed of the offender's impending release or escape from custody or of any change in security classification those results in the offender being eligible for unescorted absence from custody.

- **Submissions on parole and eligibility for absence from custody of serious offenders**

A victim should, on request, be provided with the opportunity to make submissions concerning the granting of parole to a serious offender or any change in security classification that would result in a serious offender being eligible for unescorted absence from custody.

- **Compensation for victims of personal violence**

A victim of a crime involving sexual or other serious personal violence should be entitled to make a claim under a statutory scheme for victims' compensation.

Appendix 8

Referral and resource information

<p>NSW Police</p> <p>In case of an emergency Tel. 000</p> <p>In non-emergency situations contact local police stations listed in the <i>White Pages</i> under Police NSW.</p>	<p>Wirringa Baiya Aboriginal Women's Legal Centre</p> <p>Tel. 1800 686 587</p> <p>The legal centre provides legal advice and support to Aboriginal and Torres Strait Islander women.</p>
<p>Translating and Interpreting Service</p> <p>Tel. 131 450</p> <p>This service is available 24 hours, 7 days a week.</p>	<p>Women's Information and Referral Service</p> <p>Tel. 1800 817 227</p> <p>TTY. 1800 673 304 (for people using a TTY machine)</p> <p>This telephone service provides free and confidential information about Court Support Schemes, Family Support services and other useful contacts.</p>
<p>Department of Community Services (DoCS) – Domestic Violence Line (DV Line)</p> <p>Tel. 1800 65 64 63</p> <p>TTY. 1800 67 14 42 (for people using a TTY machine)</p> <p>The DV Line is an information and referral service of DoCS which is open 24 hours, 7 days a week. It provides telephone counselling, information and referrals to women's refuges, Women's Domestic Violence Court Assistance Programs, local services and legal services.</p>	<p>Immigrant Women's Speakout</p> <p>Tel. (02) 9635 8022</p> <p>This service provides information and advocacy to women from non-English speaking backgrounds experiencing domestic violence. It also assists workers with information in relation to these issues.</p>
<p>Domestic Violence Advocacy Service (DVAS)</p> <p>Tel. 1800 810 784 or (02) 9637 3741</p> <p>TTY. 1800 626 267 (for people using a TTY machine)</p> <p>The DVAS is a non-government organisation, which offers legal advice and support to women experiencing domestic violence. It is open Monday, Tuesday, Thursday and Friday from 9.30am – 12.30pm and from 1.30pm – 4.30pm.</p>	<p>Immigration Advice and Rights Centre</p> <p>Tel. (02) 9281 8355</p> <p>The service provides advice, information and advocacy in relation to immigration matters.</p> <p>Advice Line opens 2pm – 4pm on Tuesday and Thursday only.</p>
<p>Women's Legal Resource Centre (Indigenous Women's Contact Line)</p> <p>Tel. 1800 639 784</p> <p>TTY. 1800 674 333</p> <p>The Legal Resource Centre provides legal advice and support to Aboriginal and Torres Strait Islander women experiencing domestic or family violence.</p> <p>It is open Monday, Tuesday, Thursday and Friday from 9.30am – 12.30pm and 1.30pm – 4.30pm.</p>	<p>NSW Victims Compensation Tribunal</p> <p>Tel. (02) 9374 3111 or 1800 069 054 (toll free)</p> <p>This service provides compensation and counselling to victims of crime.</p> <p>Victims of Crime Approved Counselling Scheme</p> <p>Tel. (02) 9374 3000 or 1800 633 063 (toll free)</p> <p>TTY. (02) 9374 3175 (for people using a TTY machine)</p> <p>This scheme provides free face to face counselling to victims of violent crimes that have occurred in NSW. The counsellors with the scheme are social workers, psychologists or psychiatrists who have proven experience of working with victims of crime. Counsellors are available in most rural and regional areas in NSW.</p>

<p>Victim Support Line</p> <p>Tel. (02) 9374 3000 or 1800 633 063 (toll free)</p> <p>TTY. 9374 3175 (for people using a TTY machine)</p> <p>If the person needs to talk to someone or would like to know about other options for their recovery, they can contact the Victim Support Line 24 hours a day 7 days a week. The lines provides support, information and referral to victims of crime in NSW. The service is provided by the Victim of Crime Bureau in conjunction with Mission Australia.</p>	<p>Mensline Australia</p> <p>Tel. 1300 78 99 78</p> <p>This national service provides information, support and referral for men who want to talk about their family and relationship concerns. This service is open 24 hours a day and can be called from anywhere in Australia for the cost of a local call.</p>
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Useful web and intranet addresses

<p>Web sites</p> <p>NSW Department of Health</p> <p>www.health.nsw.gov.au</p>	<p>NSW Attorney General's Department</p> <p>www.lawlink.nsw.gov.au</p>
<p>Education Centre Against Violence (ECAV)</p> <p>ECAV is a statewide, specialist organisation committed to producing training and resources for NSW Health and interagency professionals in working with children and adults who have experienced sexual assault, domestic violence, and/or physical and emotional abuse and neglect. For more courses in domestic violence, sexual assault and child protection you can visit the website.</p> <p>www.ecav.health.nsw.gov.au</p>	<p>NSW Victims of Crime Bureau</p> <p>www.lawlink.nsw.gov.au/vcb</p>
<p>Australian Domestic and Family Violence Clearinghouse</p> <p>www.austdvclearinghouse.unsw.edu.au</p>	<p>Mensline Australia</p> <p>www.menslineaus.org.au</p> <p>Intranet sites</p> <p>NSW Health Intranet – Domestic Violence</p> <p>This site provides information and resources in relation to NSW Health policies and staff development and training on domestic violence. This site also provides resources in different languages.</p> <p>www.internal.health.nsw.gov.au/policy/hsp/domesticviolence</p>

Appendix 9

Related policies, legislation and reports

NSW Health policy documents

Circular 1993/53, *Minimisation and Management of Aggression in NSW Health Care Facilities*, NSW Health.

Circular 1997/99 – *Critical Incident Manual: Policy and Guidelines*.

Circular 1998/29, *Subpoenas*, NSW Health.

Circular 1998/31, *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Facilities*, NSW Health.

Circular 1999/18, *Health Information Privacy Code of Practice*, NSW Health.

Circular 2001/22, *Workplace Health and Safety: A Better Practice Guide*, NSW Health.

Circular 2002/19 – *Effective Incident Response: A Framework for Prevention and Management in the Health Workplace*.

Circular 2002/22, *Charges for Health Records and Medical Records* (updated annually), NSW Health.

Circular 2003/16, *Protecting Children and Young People*, NSW Health.

NSW Health Department (1995), *Victims of Crime Policy*, Sydney.

NSW Health Department (1995), *NSW Aboriginal Health Strategy*, Sydney.

NSW Health Department (1997), *Child Sexual Assault Procedure Manual*, Sydney.

NSW Health Department (1997), *Physical Abuse and Neglect of Children: Procedure Manual for Health Workers Providing Secondary Specialised Response*, Sydney.

NSW Health Department (1998) *Safety and Security Manual*, Sydney.

NSW Health Department (1998), *Safety and Security Manual: Minimum Standards for Health Care Facilities*, Sydney.

NSW Health Department (2000), *Frontline Procedures for the Protection of Children and Young People*, Sydney.

NSW Health Department (2000), *Gender Equity Statement*, Sydney.

Legislation

Bail Act 1978 (NSW)

Children and Young Persons (Care and Protection) Act 1998 (NSW)

Crimes Act 1900, Part 15A (NSW)

Crimes (Domestic Violence) Amendment Act 1993 (NSW)

Evidence Act 1995 (NSW)

Family Law Act 1995 (Commonwealth)

Firearms Act 1996 (NSW)

Firearms (General) Regulation 1997 (NSW)

Property (Relationships) Act 1984 (NSW)

Victims Rights Act 1996, including Charter of Victims Rights (NSW)

Victims Support and Rehabilitation Act 1996 (NSW)

Weapons Prohibition Act 1998 (NSW)

Government reports and publications

Australian Institute of Criminology (August, 1999), 'Femicide: An Overview of Major Findings', *Trends And Issues In Crime And Criminal Justice*, Canberra.

Ethnic Affairs Commission of NSW (August, 1999), *Use of Interpreters in Domestic Violence and Sexual Assault Cases*, Sydney.

Judicial Commission of NSW (August, 1999), *Apprehended Violence Orders: A Survey of Magistrates*, Monograph Series No. 20, Sydney.

A Report to the NSW Legal Aid Commission, Sydney (1998), *Evaluation of the NSW Women's Domestic Violence Court Assistance Program*.

NSW Advisory Committee on Abuse of Older People (1995), *Abuse of Older People: Inter-Agency Protocol*, Sydney.

NSW Bureau of Crime Statistics and Research (1996), *Evaluation of the NSW Apprehended Violence Order Scheme*, Sydney.

NSW Bureau of Crime Statistics and Research (July, 1999), *Predicting Violence Against Women: The 1996 Women's Safety Survey*, Sydney.

NSW Council on Violence Against Women (1999), *Principles for the Implementation of Perpetrator Programs*, Sydney.

NSW Attorney General's Department (2003), *NSW Interagency Guidelines for Domestic Violence*, Violence Against Women Unit, Sydney.

NSW Interagency Guidelines for Child Protection Intervention (2000), Sydney.

Office of the Director of Public Prosecutions (1998), *Prosecution Policy and Guidelines*, Sydney.

Partnerships Against Domestic Violence (August, 1998), *Against the Odds: How Women Survive Domestic Violence*, for the Cabinet of the Status of Women and the Department of Prime Minister and Cabinet, Canberra.

Glossary

Aboriginal Community Liaison Officers (ACLOs)	The NSW Police Service has an ACLO located in each region. ACLOs provide advice, information, referral sources and support to police dealing with issues relating to the Aboriginal community.
AVO	<p>An apprehended violence order (AVO) is a court order which prohibits a person from behaviour such as harassing or intimidating another person. The order itself does not give a criminal record. However, the breach of an AVO is a criminal offence and the police may arrest and charge a person who breaches an order.</p> <p>The purpose of an AVO is to protect a person against acts of violence such as physical assault, non-physical abuse such as harassment or intimidation, or damage or threatened damage to property. The victim does not have to be living with the person who abuses them. There are two types of AVOs, domestic and personal.</p>
ADVOs	Apprehended Domestic Violence Orders (ADVO) are made when a domestic relationship exists between the victim (complainant) and the abuser (defendant).
APVOs (defendant)	Apprehended Personal Violence Orders are made to protect a person from an abuser when there is no domestic relationship which links the two people, for example neighbours or work colleagues.
Assault	Any act done intentionally or recklessly which causes another person to apprehend immediate and unlawful violence, as commonly used assault includes battery (however an assault may occur without battery). The act must be a hostile one. An assault can be reckless with foresight of the likelihood of inflicting injury. Battery is the intentional or reckless application of force.
Carer	A person who, while not a parent of the child, has actual custody of the child. A carer may provide the care with or without fee or reward and can include relatives, friends or acquaintances of a parent, residential care workers, childcare workers, youth workers, nursing staff and foster parents.
Chamber magistrate	A person who is available at the Local Court to give free legal information and assistance in completing documents and forms.
Charge	The crime or allegation that a person is accused of committing
Child	Any person under 16 years of age, except where otherwise stated, as defined by the <i>Children and Young Persons (Care and Protection) Act 1998</i> .
Class of children or young persons	More than one child or young person who may be at risk of harm because of association with a person or a situation causing risk of harm from abuse and neglect.
Complainant	The person who is complaining to the court, ie the person who takes out the ADVO (the victim or the police).
DVLO	Domestic Violence Liaison Officers (DVLOs) support the work of the NSW Police Local Area Command (LAC) by providing link with community issues, and intelligence, while forming partnerships for victim support and follow-up. In addition, DVLOs provide consultancy to other police officers.
Employee Assistance services Program (EAP)	This service provides professional and confidential counselling for employees of NSW Health in order to assist them to identify and resolve professional, personal, health or work-related issues. All Area Health Services are required to offer employee assistance programs, which must adhere to the NSW Health Policy Framework and best practice guidelines (Circular 2000/42 – <i>Policy Framework and Better Practice Guidelines for the Development of Employee Assistance Programs</i>).

Ethnic Community Liaison Officers (ECLOs)	NSW Police has an ECLO located within each region. ECLOs provide advice, information, referral sources and support to police dealing with issues relating to a range of ethnic communities.
<i>Family Law Act (1995)</i>	<p>The <i>Family Law Act</i> covers divorce, property division and spouse maintenance for married people. It also deals with all issues concerning where children will live and who has responsibility for the continued care, welfare and development if the parents are separated.</p> <p>The <i>Family Law Act</i> covers parents who are or were married, in a de facto relationship, gay and lesbian couples and parents who had no relationship. Children's maintenance is dealt with by the family court but only in limited circumstances.</p>
Gay and Lesbian Liaison Officers (GLLOs)	The NSW Police has GLLOs located in various Local Area Commands within each Region. GLLOs provide advice, information, referral sources and support to police dealing with issues relating to the gay and lesbian community.
Gender	This term refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of biological differences. It refers therefore to certain roles, characteristics, responsibilities and expectations that our society ascribes to being female or male.
Interim order	An order for an ADVO that is temporary. It still tells the perpetrator what they are not to do. If they break the order after they have been served with it before going to court, they still receive the same penalty as if it were a final order.
Interpreter	Accredited language or sign interpreters and persons experienced in the use of facilitated communication techniques for people with disabilities.
Magistrate	The person who makes decisions in the Local Court.
Mandatory reporting	The act of a person mandated under Section 27 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> reporting that they suspect a child is at risk of harm.
Mental Health Outcomes and Assessment Tools (MH-OAT)	MH-OAT is a statewide project to strengthen the mental health assessment skills of clinical staff in mental health. The project coordinates the implementation of mental health assessment training, uniform assessment protocols and outcomes and casemix measures throughout NSW.
Parent	Any person having parental responsibility for a child or young person.
Parental responsibility	All the duties, powers, responsibility and authority, which, by law, parents have in relation to their children.
Part 15A of the <i>Crimes Act 1900</i>	The law regarding Apprehended Violence Orders (AVOs) is contained in Part 15A of the <i>Crimes Act 1900</i> (NSW).
Perpetrator	A perpetrator of domestic violence is an adult who carries out violent, abusive or intimidating behaviour against a partner or ex-partner to control and dominate that person.
Reasonable grounds	Reasonable grounds are those which would cause a reasonable person to form a judgement of risk of harm, having regard to the circumstances of the individual case including the nature and seriousness of the allegations made, the age and physical condition of the child, any corroborative evidence which exists, and other relevant information.
Report	Information in accordance with sections 23, 25 or 27 of the <i>Child and Young Persons (Care and Protection) Act 1998</i> provided to the Department of Community Services by a person who forms the belief on reasonable grounds that there are current concerns for a child, young person or a class of children or young people due to a risk of harm from abuse or neglect. 'Report' has replaced the term 'notify'.

Reporting	The act of making a report to the Department of Community Services.
Risk assessment	An assessment of the likelihood of further risk of harm to a child from abuse or neglect, based on the seriousness and circumstances of past and current risk of harm, the capacity of adults to protect the child or young person and the age and vulnerability of the child or young person.
Risk of harm	Risk of harm refers to the likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (physical, sexual or psychological abuse) or not done (neglect) by another person, often an adult responsible for their care. Risk of harm can also refer to young people who may suffer physical, psychological, sexual or emotional harm as a result of environmental factors (for example homelessness) or self-harming behaviours. Agencies and practitioners are required to make judgements about risk of harm to a child or young person from child abuse or neglect. This requires a consideration of the likely degree of harm taking into account the age and vulnerability of the child or young person.
Subpoena	A court order to make a witness come to court to give evidence or to request access to documents.
Victim	<p>Victim refers to a person whose partner uses behaviours such as psychological, emotional or verbal abuse, physical assault, sexual assault, social or economic abuse, to gain and maintain control over them. The overwhelmingly majority of domestic violence victims are heterosexual females, and as a result this policy usually refers to victims as female and perpetrators as male.</p> <p>The term victim identifies and reinforces that the woman is blameless and has experienced what is, in many instances, a crime. Victim is used deliberately in the context of this document, rather than survivor or women who have experienced domestic violence, to reflect the fact that the women whom this document aims to assist are primarily those who are still living within a domestic violence situation and who present to NSW Health services for assistance in escaping the violence.</p>
Victim Impact Statement	This is a report prepared by the victim, a counsellor or psychiatrist about the impact of a crime on the victim.
Young person	Any person who is aged 16 years or above but who is under 18 years, as defined by the <i>Children and Young Persons (Care and Protection) Act 1998</i> .

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Endnotes

- 1 Because of the gendered nature of domestic violence and for simplicity of language, the terms 'victim' and 'woman' will be used interchangeably to refer to persons who have experienced domestic violence as primary victims.
- 2 This definition is consistent with the current definitions adopted by the *NSW Interagency Guidelines for Child Protection Intervention 2000*, NSW Department of Community Services, and the Partnerships Against Domestic Violence Statement of Principles, agreed by the Australian Heads of Government at the 1997 National Domestic Violence Summit.
- 3 An analysis of power and control in intimate relationships is important because many perpetrators blame anger, alcohol, stress or other factors for their behaviour. Understanding that these individuals almost always successfully manage these issues when dealing with other people, makes it clear that domination of a partner is a behaviour of choice.
- 4 These perpetrator programs should be operated in a manner that is consistent with the seven principles identified in NSW Council on Violence Against Women's *Position Paper on Programs for Perpetrators of Domestic Violence* and outlined in the *NSW Health Policy for Identifying and Responding to Domestic Violence Policy, 2003*.
- 5 'Family violence' is the term used in the current *NSW Aboriginal Family Health Strategy 1995*. The Strategy emphasises the importance of 'family' to Aboriginal communities and that solutions need to include strategies for men, women and children. The strategy also highlights the need for perpetrators of violence to accept responsibility for their actions.
- 6 This information has been reproduced from the *NSW Domestic Violence Interagency Guidelines 2003*.

Notes
