When she talks to you about the violence

A toolkit for GPs in WA

Over 1 in 5 Women make their first disclosure of domestic violence to their GP[1].

You may be the only person she will tell.

Your skills and sensitivity are essential

This resource has been developed to assist you in identifying and responding to women and children who have experienced or are experiencing family violence (also known as 'domestic violence' or 'intimate partner violence'.)

'It has been estimated that full time GPs are seeing up to five women per week who have experienced some form of intimate partner abuse (physical, emotional or sexual) in the past 12 months.'[2]

The toolkit contains guidelines for patient care, from a range of sources, as well as some legal information relevant to your role as her GP.

'The Medical Profession has key roles to play in early detection, intervention and provision of specialized treatment of those who suffer the consequences of domestic violence, whether it be physical, sexual or emotional.'[3]

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

After family and friends, victims are most likely to tell health professionals about violence.[4]

Contents

This toolkit was originally developed by Women's Legal Services NSW. "When she talks to you about the violence- A toolkit for GPs in NSW" was published in October 2013 with the financial assistance of the Law and Justice Foundation of NSW.

It has been adapted, with permission, by the Women's Law Centre of WA to suit general practitioners in the WA context.

This publication was funded by Aurizon through the Aurizon Community Giving Fund. The Aurizon Community Giving Fund program was established to provide relevant and sustainable support to communities in the areas of Health & Wellbeing, Community Safety, Environment and Education.

Proudly supported by

Published in October 2014.

1. What is family violence?

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

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

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

Often the terms 'family violence' and 'domestic violence' are used interchangeably. 'Family violence' is sometimes thought of as the broader term, covering intimate, family and other relationships of mutual obligation and support.

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

Most domestic violence is perpetrated by men, against women and children.[5] However, women can also be perpetrators of violence, and domestic violence also happens in same-sex relationships.

Women are at greater risk of violence from intimate partners during pregnancy, or after separation. A safety survey conducted by the Australian Bureau of Statistics in 2005 found that 17% of women who had experienced violence from a partner during a relationship, experienced it for the first time during pregnancy.

2. Indicators

'When assessing your patient... remember that most presentations of family violence are probably hidden and not the obvious black eye.'[6]

The following are indicators associated with victims of family violence.

Indicators in adults	Indicators in children
Physical ➢ Unexplained bruising and other injuries ➢ Bruises of various ages ➢ Head, neck and facial injuries ➢ Injuries on parts of the body hidden from view (including breasts, abdomen and/or genitals), especially if pregnant ➢ 'Accidents' occurring during pregnancy ➢ Miscarriages and other pregnancy complications ➢ Injuries to bone or soft tissues ➢ Injuries sustained do not fit the history given ➢ Bite marks, unusual burns ➢ Chronic conditions including headaches, pain and aches in muscles, joints and back ➢ Ulcers ➢ Dizziness ➢ Sexually transmitted disease ➢ Other gynaecological problems **Psychological / behavioural** ➢ Emotional distress, eg, anxiety, indecisiveness, confusion, and hostility ➢ Sleeping and eating disorders ➢ Anxiety/depression/pre-natal depression ➢ Psychosomatic and emotional complaints ➢ Drug abuse ➢ Self-harm or suicide attempts ➢ Evasive or ashamed about injuries ➢ Multiple presentations at the surgery ➢ Partner does most of the talking and insists on remaining with the patient ➢ Seemingly anxious in the presence of the partner ➢ Reluctance to follow advice ➢ Social isolation/no access to transport ➢ Frequent absences from work or studies ➢ Submissive behaviour/low self esteem ➢ Alcohol or drug abuse	**Physical** ➢ Difficulty eating / sleeping ➢ Slow weight gain (in infants) ➢ Physical complaints ➢ Eating disorders **Psychological / behavioural** ➢ Aggressive behaviour and language ➢ Depression, anxiety and/or suicide attempts ➢ Appearing nervous and withdrawn ➢ Difficulty adjusting to change ➢ Regressive behaviour in toddlers ➢ Delays or problems with language development ➢ Psychosomatic illness ➢ Restlessness and problems with concentration ➢ Dependent, sad or secretive behaviours ➢ Bedwetting ➢ 'Acting out', for example cruelty to animals ➢ Noticeable decline in school performance ➢ Fighting with peers ➢ Over protective or afraid to leave mother ➢ Stealing and social isolation ➢ Abuse of siblings or parents ➢ Alcohol and other drug use ➢ Psychosomatic and emotional complaints ➢ Exhibiting sexually abusive behaviour ➢ Feelings of worthlessness ➢ Transience (decreasing accessibility of memory over time) ***Remember: Most bruises are invisible!***

Figure 1: Indicators associated with victims of family violence.

'Frequently there are no visible signs of assault or rape in domestic violence presentations. This does not mean that the emotional or psychological effects of the assault are any less devastating to the victim.'[7]

3. How to ask your patient

'In any situation that you suspect underlying psycho-social problems you can ask indirectly and then directly about partner abuse.'[8]

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

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

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

'It is important to realize that women who have been abused want to be asked about domestic violence and are more likely to disclose if asked'.[9]

If appropriate, you can ask **direct questions** about any violence. For example:[10]

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

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

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

If your patient's fluency in English is a barrier to discussing these issues, you should work with a qualified interpreter. Don't use her partner, other family members or a child as an interpreter. It could compromise her safety, or make her uncomfortable to talk with you about her situation. The Australian Government provides free telephone interpreting services to assist GPs to communicate with patients from non-English speaking backgrounds:

- The Translating and Interpreting Service (TIS)
- Doctors Priority Line (available 24 hours a day, seven days a week)
- On site interpreting service (subject to interpreter availability).

Information on these services and a medical practitioners free interpreting registration form are available at www.immi.gov.au/tis or by calling 131 450.

4. Responding to a disclosure

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

'Patients... value emotional support from healthcare professionals, careful and non-judgmental listening, and reassurance that the abuse is not their fault and that negative feelings are understandable.'[11]

Listen

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

Communicate belief

'That must have been frightening for you.'

Validate the decision to disclose

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

Emphasise the unacceptability of violence

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

Be clear that she is not to blame

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

Do not ask

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

Figure 2: Key steps after a disclosure of family violence

5. Initial safety planning

Assist your patient to evaluate her immediate and future safety, and that of her children. Best-practice risk assessment involves seeking relevant facts about her particular situation, asking her about her own perception of risk, and using professional judgment. You may need to refer your patient to a specialised domestic violence service such as the Domestic Violence Help Line, Crisis Care or a Family Violence Service at the metro courts. See 'Abuse and violence: Working with our patients in general practice' (white book) for detailed guidance on your role as a GP.

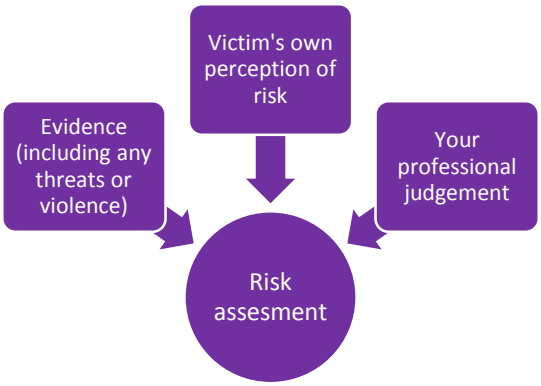

Figure 3: Aspects of best practice risk assessment

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

- Speak to the woman alone
- Check for immediate concerns
- Does she feel safe going home after the appointment?
- Are her children safe?
- Does she need an immediate place of safety?
- Does she need to consider an alternative exit from your building?
- If immediate safety is not an issue, check her **future safety**
- Does he have weapons?
- Does she need a referral to police or a legal service to apply for a Restraining Order?
- Does she have emergency telephone numbers?
- Police: 000 or 106 (TTY)
- Women's Domestic Violence Help Line or 1 800 RESPECT (24/7) emergency, referral and counselling lines for people experiencing domestic violence.
- Does she need a referral to a domestic violence service to help make an **emergency plan**:
- Where would she go if she had to leave?
- How would she get there?
- What would she take with her?
- Who are the people she could contact for support?
- Document any plans made, for future reference.

Risk assessment is an ongoing process. You may need to check in on your patient to follow up on this initial safety plan. See Section 10 (Continuing care).

> *'It is important to remember that the true goal is to prevent violence, not to predict it.'*[12]

6. Referrals and Support Services

If your client has been subjected to family and domestic violence, she may require some support. For example, your client may need/benefit from legal advice, financial counselling or assistance, counselling, reporting to police, accommodation support, etc.

It is important for you to be informed about available referral options for your client. Below is link to a list of some key contact points for patients that may need assistance. Each service has their own brochures and resources available that can be ordered and placed in bathrooms, reception or patient waiting areas.

For a comprehensive list of referral services, visit: http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/FDV%20Referral%20Guide%20April%202013.pdf

7. Note-taking for legal purposes

Your notes may be required as evidence, if charges are laid against the perpetrator.

If family violence is a concern, you should keep detailed notes that:

- **Describe physical injuries** (including the type, extent, age and location). If you suspect violence is a cause, but your patient has not confirmed this, include your comment as to whether her explanation accurately explains the injury.
- Record what the patient said (using quotation marks)
- **Record any relevant behaviour observed**, being detailed and factual rather than stating a general opinion, eg, rather than 'the patient was distressed', write 'the patient cried throughout the appointment, shook visibly and had to stop several times to collect herself before answering a question'.

Consider taking photographs of injuries, or certifying photographs taken of the injuries presented at the time of consultation.

To be good evidence in court, file notes must include date and time, and clearly identify the client. You must clearly identify yourself as the author, and sign the file note. Do not include generalisations or unsubstantiated opinions. Correct and initial any errors, set out your report sequentially, and use only approved symbols and abbreviations.

8. Mandatory reporting

Family & Domestic Violence

If a patient talks about experiencing or perpetrating family and domestic violence, or you have a reasonable belief a child has experienced or is at risk of family and domestic violence, you may need to report this to the Department for Child Protection and Family Support (DCPFS). It is well known that exposing children to family and domestic violence can have a serious psychological impact on children. Use your professional judgment about the individual circumstances and the nature of the violence.

Anyone who is concerned that a child is suffering any form of abuse, should report their concerns through a local District Office of DCPFS. A list of DCPFS District Offices in WA is available on the DCPFS website http://www.mandatoryreporting.dcp.wa.gov.au/Pages/DCP_District_Offices.aspx

You can also encourage the patient to seek assistance from support services.

Child Sexual abuse

If a patient talks about experiencing or perpetrating child sexual abuse, or you have a reasonable belief a child has experienced or is at risk of child sexual abuse, there is a legal requirement in Western Australia that all Doctors, Nurses, Midwives, Teachers and Police Officers must report this to the DCPFS. The Mandatory Report Service is available 24 hours, 7 days per week as follows: -

Free call: 1800 708 404 Fax: 1800 610 614

Written Mandatory reports can be lodged online at http://www.mandatoryreporting.dcp.wa.gov.au/Pages/Home.aspx

A verbal report should be followed by a written report within 24 hours. Remember, the earlier a report is received, the faster action can be taken to protect a child.

The DCPFS website and Health WA website both have online resources for mandatory reporters at http://www.mandatoryreporting.dcp.wa.gov.au/Pages/Home.aspx and http://www.health.wa.gov.au/mandatoryreport/home/

There are also great publications and other resources for children and young people that can be ordered from the DCPFS website that are perfect for patient waiting rooms, bathrooms, reception areas etc. http://www.dcp.wa.gov.au/Resources/Pages/Publications.aspx

9. Immigration family violence provisions

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

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

If your patient has concerns about her visa to stay in Australia, you may wish to refer her for legal advice.

10. Continuing care

Consider your patient's safety as a paramount issue. A woman is usually a good judge of her own safety. You can help to monitor the safety of her and her children by asking about any escalation of violence.

- Empower her to take control of decision-making; ask what she needs and present choices of actions she may take and services available.
- Respect the knowledge and coping skills she has developed. You can help build on her emotional strengths, for example, by asking 'How have you dealt with this situation before?'
- Provide emotional support.
- Ensure confidentiality – the woman may suffer additional abuse if her partner suspects she has disclosed the abuse.
- Be familiar with appropriate referral services and their processes. Patients may need your help to seek assistance. Have information available for the patient to take with her if appropriate.

'I dropped some hints to test the water. [The GP] was supportive without being interfering and because of this I made the decision to tell her. She was fantastic and told me about the [Domestic Violence Line] who I called and put me into contact with a women's refuge. I am rebuilding my life, and looking forward to a happy future.'[13]

11. When your patient is the perpetrator

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

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

- 'How are things at home?'

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

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

Acknowledge the existence of violence by statements such as:

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

12. When both partners are your patients

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

If you have seen the victim or her children, your primary duty is to them. If the perpetrator is also your patient, it may be appropriate to refer them to another practitioner or another practice, but you must be careful how you do this, as you could potentially put the victim at risk if her abuser suspects she has disclosed information to you.

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

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

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

13. Summons & Subpoenas

As a GP, you could be summonsed or subpoenaed by a court (at the request of a relevant party) to produce documents, provide oral evidence as a witness, or both in relation to a patient.

If you have been served with a summons or subpoena, always read the document carefully. The document will provide you with important information about your rights and obligations. Always check that the summons or subpoena is valid. For example, has a court stamp, has conduct money and has been properly served on you before the stated deadline. You may wish to contact the relevant court to verify. The contact details of the relevant court should be stated on the document.

You must respond to a valid summons or subpoena – either to obey the orders, to object or to ask the court to set it aside. There are penalties for failing to comply with a summons or subpoena including arrest, fine or imprisonment. The different courts and civil/criminal proceedings have different grounds for objecting or asking for a summons or subpoena to be set aside. You or your patient may need legal advice. You could seek guidance from the Australian Medical Association, the Royal Australian College of General Practitioners, your insurer, or a private lawyer. Your patient can get legal advice from a community legal centre, Legal Aid WA or her own private lawyer.

14. Training & resources

- Abuse and violence: Working with our patients in general practice (white book)
  www.racgp.org.au/your-practice/guidelines/abuse-and-violence
- Intimate partner violence: Identification and response in general practice
  www.racgp.org.au/afp/2011/november/intimate-partner-violence
- Avert Family Violence: multidisciplinary online training resource
  http://www.avertfamilyviolence.com.au/
- 1 800 RESPECT- National counselling helpline, information and support 24/7 (online training and resources for professionals)
  https://www.1800respect.org.au/workers/
- Sexual Assault Resource Centre: emergency sexual assault (rape crisis) service (online training and resources available)
  http://www.kemh.health.wa.gov.au/services/sarc/
- WA Health: Guideline for responding to family and domestic violence 2014
  http://www.health.wa.gov.au/publications/documents/Gudielines_for_responding_to_Family_and_Domestic_Violence.pdf
- WA Health: Reference manual for health professionals- Responding to family and domestic violence
  http://www.kemh.health.wa.gov.au/services/womens_health_policy_and_projects/documents/FDVReferenceManual.pdf
- Women and Newborn Health Services A-Z (free training opportunities for health professionals)
  http://www.kemh.health.wa.gov.au/services/womens_health_policy_and_projects/training.php
- Department for Child Protection and Family Support, Family and Domestic Violence webpage (information and resources relating to FDV policy and practice in WA)
  http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/FamilyandDomesticViolence.aspx

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