

FACTS

An innovative Primary care program Advancing Competency
To Support family violence survivors



STUDY GUIDE

June 2016

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INTRODUCTION

WELCOME

Welcome to the PACTS program – An innovative **P**rimary care program **A**dvancing **C**ompetency **T**o **S**upport family violence survivors.

PACTS is a learning resource for use among pre-vocational primary health care students. The resource teaches students background information on family violence (including its extent and impacts on individuals and the community), the skills needed to identify survivors of family violence, and the skills required for working in a health care team in this context.

The resource also seeks to equip primary health care graduates with the skills to intervene and improve patient/client access to services and resources.

PACTS has been developed as an online resource and is available via an open access website: www.pactsproject.org.

This ‘Study Guide’ provides hard copy details of the material presented online.

RATIONALE AND PURPOSE

Family violence is a serious and significant problem within our society. Family violence can be defined as any violent, threatening, or controlling behaviour that coerces a family member (current or past), or causes that family member to feel fearful.^{1;2} It includes violence between intimate partners, child abuse, violence by adolescents toward parents, elder abuse, carer abuse, and sibling abuse; it can take many forms including physical, sexual, emotional, psychological, social, economic, verbal and spiritual.³

Family violence against women is the most common form, with women representing the majority of family violence victims (usually perpetrated by a current or former intimate male partner and/or male relatives). Statistics tell us that one in three Australian women have experienced physical violence since the age of 15 years, while one in five have experienced sexual violence. Children are also at significant risk of experiencing family violence. About 50% of Australian women who have experienced family violence during their lives were caring for their children during the relationship.⁴

Family violence is a leading public health concern for Australia and countries across the world. The health impacts of family violence can take a huge toll on individuals and the community alike. In Victoria, intimate partner violence against women is a bigger contributor to ill-health and premature death in women aged 15 to 44 years than any other risk factor including high blood pressure, obesity and smoking.⁵ Family violence is also associated with reproductive health problems, mental health problems, and risk behaviours (such as substance abuse and self-harm). Childhood violence, including witnessing family violence as a child, can lead to poor health, emotional and behavioural problems, learning difficulties and mental health problems later in life. The annual cost of family violence to our economy is huge. It is estimated that in 2009 violence against women and their children cost the Australian economy \$13.6 billion. Unless appropriate action is taken it is predicted to reach \$15.6 billion by 2021-22.⁶

Evidence suggests that primary health care professionals feel they would benefit from further training about family violence.⁷ A recent survey of primary care practitioners in Victoria found that between 57 and 82 per cent of practitioners felt further training around how to ask questions about family violence and support survivors would be beneficial.⁷ Primary health care professionals who lack training in responding to family violence and recognising its indicators find it difficult to approach the subject, worry that they are about to open a 'Pandora's box', and do not feel equipped to respond to disclosures of violence.⁸⁻¹⁰ As a result, survivors may face difficulties in accessing early intervention and other services, and can suffer poorer physical and mental health throughout their lives.

Given the extent of family violence, its impacts on health, and the difficulties expressed by primary health care professionals about how to respond to family violence, the PACTS program aims to prepare students with the necessary knowledge and skills in diagnosing, preventing, responding to and working with patients/clients to manage family violence.

PACTS: UNIT OUTLINE

The PACTS unit (resource) is divided into six modules each taking approximately one hour to complete online.

Module 1: Defining 'Family Violence'

Module 2: Identifying and recognising family violence

Module 3: Assessing and responding to risk

Module 4: Responding well

Module 5: Management and referral pathways

Module 6: Safety, reflection and self-care

The online learning activities include mini lectures, readings, self-reflection questions, quizzes, and videos.

THE PILOTING OF PACTS

During 2014-2015 the PACTS resource was piloted at Monash University and each of the PACTS partner universities – The Australian National University, The University of Melbourne and The University of Newcastle.

NOTE TO STUDENTS

Family violence is a sensitive topic and it is a normal response to find some of the material contained in this course upsetting. Take a break if you feel distressed - you can stop at any time. If you are upset, if your distress persists, or if you are triggered by any of the material, please consider contacting/accessing one of the following:

- your course coordinator/teacher
- student services at your university/organisation:
- your general practitioner
- 1800RESPECT in Australia
- Online resources:

⇒ [Vicarious Trauma Institute](#)

⇒ [The Compassion Fatigue Awareness Project](#)

This 'Study Guide' provides links to videos of survivor stories – remember that these are filmed with actors, and while the stories told are based on real experiences, the videos are simulated.

MODULE 1: DEFINING ‘FAMILY VIOLENCE’

SYNOPSIS

This module provides an overview of background knowledge and information about the issue of family violence within our community. It defines ‘family violence’ and discusses the types of violence and abuse encompassed within this definition. The content in this module also provides an outline of the extent and prevalence of family violence in Australia, along with its associations with health and wellbeing – namely physical health, emotional and psychological wellbeing, and economic and social impacts.

LEARNING OBJECTIVES

On completion of this module, you, the learner should be able to:

1. Define ‘family violence’ and recognise the different types of violence;
2. Recognise the extent of family violence across Australia and internationally;
3. Describe key theories of cause and frameworks for prevention of violence;
4. Recognise family violence as a health and social issue, and understand the health, social, and economic impacts of violence on individuals and our community;
5. Describe the role that primary health care professionals can play in situations of family violence.

WHAT IS FAMILY VIOLENCE?

There is **no single definition** of family violence. What is accepted in the community as family violence may differ based on the types of relationships, settings where violence occurs, and the nature of this behaviour. Definitions can also vary based on legal, social and health interpretations of family violence. Furthermore, these understandings of what constitutes family violence may be different to community attitudes, or the perspectives of victims or perpetrators.

Some of the difficulties in defining family violence occur because of the various names used to describe violent and controlling behaviour by family member(s) toward family member(s) or partners – such as domestic violence and intimate partner violence.

Family violence typically refers to **any violent, threatening or controlling behaviour** that coerces a family member (current or past), or causes that family member to feel fearful.^{1; 2} Violence between intimate partners, child abuse, violence by adolescents toward parents, elder abuse, carer abuse, and sibling abuse are all forms of family violence.

Whatever definition is used to explain family violence, a central feature is that it involves a person **exercising power and control** over another by, for example, using threats of violence which can create a climate of fear and coercion.³ Definitions also typically recognise that the violence is not often a ‘one off’ incident, but a **continuum of violent behaviour** that can last years.¹¹

Dimensions and dynamics of family violence

Family violence can take many forms. It can be physical, sexual, emotional, psychological, social, economic, verbal, and spiritual in nature.³

Physical violence

Physical violence refers to the use of physical force that can, or is intended to, cause harm and/or pain. This can include punching, slapping, kicking, choking, pushing, the use of weapons, assault of children, and sleep and food deprivation.³

Sexual violence

Sexual violence refers to any form of unwanted sexual act(s) or sexual degradation. This can include: sexual activity without consent, coercive sex without protection against pregnancy or sexually transmitted disease, making someone perform sexual acts unwillingly, and using sexually degrading insults.³

Emotional abuse

Emotional abuse refers to a course of conduct that is likely to have the effect of being unreasonably controlling or intimidating, or causing mental harm, apprehension or

fear.¹² This can include blaming someone for all of their problems and/or problems within the relationship, stalking, emotional blackmail, criticising the individual(s) self-worth, and withdrawing engagement (for example, periods of silence).

Psychological abuse

Psychological abuse refers to behaviours and actions that are likely to, whether intended or not, cause feelings of susceptibility to danger, loss of power and control, and entrapment.¹³ This can include making threats regarding custody of children, harming pets in front of family members, destroying property, driving dangerously, and threatening that the police and justice system will not help or believe them.³

Note: the terms ‘emotional abuse’ and ‘psychological abuse’ are often used interchangeably.

Social abuse

Social abuse refers to a pattern of systematic isolation from family, friends and social networks. This can include the abuser initiating and controlling a move to a residential location where the abused individual(s) has/have no social circles, and denying and/or physically preventing the abused from going out, socialising and meeting people.³

Economic abuse

Economic abuse refers to behaviours and actions that negatively affect a person financially, and undermines their efforts to become economically independent.¹⁴ This can include control of money and resources, forbidding access to bank accounts, appropriating wages and other resources, providing an inadequate ‘allowance’, forbidding the individual(s) to seek employment, and/or expecting them to use all of their wages on household expenses.³

Verbal abuse

Verbal abuse refers to the use of overt or subtle verbal taunts that can, whether intentional or not, ridicule, denigrate and/or belittle another. This can include constant private and/or public humiliation, swearing and aggressive and/or threatening language, and attacks on the person’s intelligence, sexuality, body, and capacity as a parent or spouse.³

Spiritual abuse

Spiritual abuse refers to the denial or misuse of religious or spiritual beliefs or traditions to justify violence.³ This can include citing scripture to justify abusive behaviour, forcing partners to violate religious beliefs, and belittling a family member for their religious practices.

Violent family relationships tend to be characterised by a combination of these forms, which create a pattern of behaviour that can result in fear, control, coercion, and domination.

PREVALENCE AND EXTENT OF FAMILY VIOLENCE

It is difficult to measure the prevalence of family violence because of the private nature of the relationships and settings within which the violence occurs. Furthermore, statistics suggest that family violence is significantly underreported – for example, it is estimated that **less than 20% of women** who have experienced violence **report it to authorities**.¹⁵ This underreporting adds to the difficulties in knowing the true extent of violence in our community. What we do know, however, is that family violence is a **common and serious problem** in Australia and internationally.

Family violence cuts across **all social, economic and racial backgrounds**, although, women with a disability, Indigenous women, women from culturally and linguistically diverse backgrounds, and young women are most at risk of family violence. This will be discussed in greater detail in Module 2.

Violence against women

Most family violence victims/survivors are **women**. Most of this violence toward women is perpetrated by current or former intimate male partners (known as intimate partner violence), as well as male relatives. Women who experience violence are most likely to experience it in the home, from a male partner, or from a male family member.⁴

Globally, almost a third of women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner.¹⁶

In Australia, of all **women** who reported being **physically assaulted** in the past 12 months, 38% were assaulted by current or previous partners, and 34% by other male family members or friends.⁴ Of all **women** who reported having been **sexually assaulted** in the past 12

months, perpetrators include previous partners (21%), current partners (8%), and family members or friends (32%).⁴ Furthermore, 40% of women reported experiencing **controlling behaviour(s)** with a relationship.¹⁷

Women are also **more likely to be killed** by their male partner than by anyone else. In Australia between the period 2008 and 2010, 73% of the 122 victims killed in intimate partner homicides were women.¹⁸ Globally, 38% of all murders of women are committed by intimate partners.¹⁶

Violence toward men

The Australian Bureau of Statistics tells us that overall, men are more likely to experience violence. In fact, after the age of 15 years, men experience 10% more violence than women; however, the majority of this violence (65%) is perpetrated by a male stranger.⁴ Nevertheless, men are also victims of family violence.

The evidence available on the nature and extent of family violence experienced by men is limited. But, what we do know is that the dynamics of family violence among men is likely to be quite different than violence toward women. Consider the following.

- Men are more likely to be physically assaulted by a male family member or friend than a current and/or previous partner. Of all **Australian men** who have been **physically assaulted** in the past 12 months, 4.4% were assaulted by a current and/or previous partner, while 11% were assaulted by male family and friends.⁴
- When men experience violence from an intimate (female) partner it is more likely to be emotional, psychological and verbal in nature, while women are more likely to experience more severe forms of violence and controlling behaviour than men over time.¹⁹
- When subjected to intimate partner violence, men are less likely to be injured during assaults than women, less likely to receive medical attention than women, and less likely to fear for their lives than women.²⁰
- Women who do use violence are more likely to do so as self-defence against violence already perpetrated by male partners.²⁰

Violence in same sex relationships

Research on the prevalence of violence in same sex relationships is limited; however, the available literature tells us the following.

- In a Victorian study of 390 gay, lesbian, bisexual, transgender, and intersex respondents, 31% reported being in a same sex relationship where they were subject to abuse by their partner, with lesbians more likely than gay men to report such abuse (41% versus 29% respectively).²¹
- In the United States, research indicates that between 22% and 46% of lesbians have been in a physically violent partner relationship.²²
- The percentage of women who experience intimate partner violence in their lifetime appears to be higher for lesbian women than for heterosexual women. Research has found that lesbian women are more likely to have experienced violence at the hands of female and male partners, as many women have had intimate relationships with men before a same sex relationship.²³
- Physical victimisation perpetrated by partners is higher among homosexual men compared with heterosexual men.²³

As with heterosexual relationships, violence in same sex relationships ranges from physical and sexual violence to psychological, emotional and financial abuse. It also forms a pattern of abuse in which one partner maintains power and control over the other. However, there are important differences in the nature of violence in same sex relationships that relate specifically to sexuality and gender such as:^{24(p3)}

- ⇒ ‘outing’ or threatening to out their partner to friends, family, police, church or employer;
- ⇒ telling their partner that s/he will lose custody of the children as a result of being ‘outed’;
- ⇒ telling a partner that the police or the justice system will not assist because the legal justice system is homophobic;
- ⇒ telling a partner that the abusive behaviour is normal within gay relationships and convincing the abused partner that s/he does not

understand lesbian or gay relationships and sexual practices because of heterosexism.

Violence toward children

Statistics also show that violence toward children is prevalent and widespread. Children can experience family violence by being **exposed to or witnessing violence** including hearing violence between parents or other family members, being forced to watch or participate in assaults, being told they are to blame for the violence, being used as a hostage, defending a parent or family member against violence, or intervening to stop violence.²⁵ Children are often present when there is family violence perpetrated in the home or between family members.

- Almost 50% people who experienced violence from a current partner had **children in their care at some point during the relationship**, while more than 25% of these reported that the children had **witnessed the violence**.⁴
- Over 50% of Australian women who experience family violence during their lives are caring for their children during the relationship.⁴
- Up to **25% of young people** (aged 12 to 20 years) have **witnessed violence** against their mother or step-mother.²⁶

Children also experience violence in the form of directly being abused themselves – this is referred to as **child abuse**.

- In Australia during 2012-13, there were **53,666 substantiated cases of child abuse and neglect**. Emotional abuse (38%) and neglect (28%) were the most common forms; while physical (20%) and sexual (13%) violence were also experienced at significant levels.²⁷

Research also tells us that **family violence and child abuse** tend to **co-occur**. Between 30% and 60% of children whose mothers are subjected to violence are also experiencing violence.²⁸ This is often because the same person is violent toward family member(s) as well as the child, the child may be injured when ‘caught’ in incidents of family violence, children may be neglected as a result of the impact of violence on the person’s health, or the child may be victimised by the person who is also experiencing violence from another family member.²⁵

MAIN THEORIES OF CAUSE AND PREVENTION

Many different theories have sought to explain why violence occurs. No single factor can explain violence, or why some groups in our community may be more at risk of violence – either as a victim or perpetrator – than others. Explanations of causation can focus on macro (societal) level factors, micro (individual and/or relationship) level factors, or a combination of both. Key theories that have been used to explain family violence include:²⁹

- Ecological approach;
- Feminist theory;
- Culture of violence theory;
- Social learning theories;
- Exchange/social control theory.

Different theories of violence are important to acknowledge as they often imply different strategies or practical outcomes for addressing violence. For example, if family violence is explained as an individual issue, practical strategies are likely to focus on addressing interpersonal communication, which might involve managing emotions and anger. On the other hand, if family violence is seen as a socially created issue, the practical strategies may involve, for example, advocacy for victims and holding perpetrators accountable for their violent behaviour.³⁰ Here we see how theory can contribute to, and provide a context for, practical outcomes.

Ecological approach

An **ecological approach** identifies a range of determinants and factors to understanding violence. The factors that contribute to violence are encompassed within four levels:^{31; 32}

1. Individual,
2. Relationship,
3. Community,
4. Societal.

1. Individual

This level identifies the personal factors that can contribute to the risk of becoming a victim and/or a perpetrator of violence. This includes factors such as age, education, income, substance abuse, and history of violence.^{31; 32}

2. Relationship

The second level looks at the close relationships that may increase the likelihood of experiencing violence, either as a victim or perpetrator. An individual's peers, social network or circles, and family members can influence their behaviours and their experiences. For example, having violent peers may influence whether an individual engages in violence and/or becomes a victim.^{31; 32}

3. Community

The third level considers how settings, such as schools, workplaces and neighbourhoods, and their characteristics contribute to, and are associated with, becoming a victim or a perpetrator. These can include factors such as level of employment, and population density.^{31; 32}

4. Societal

The final level looks at broader social factors that can create an environment in which violence is encouraged and accepted. These can include social and cultural norms, as well as health, economic, educational and social policies that can maintain social inequalities and disadvantage in our society.^{31; 32}

Feminist understandings

Feminist understandings focus on the **gendered nature of family violence** to explain the predominance of women as victims and of men as perpetrators. A feminist understanding explores how sexist norms, values and institutions within our society contribute to family violence. Institutions such as the family and marriage are understood as maintaining the dominance of men in our society – men are seen to use violence against women and children in the family and home to maintain this position and inequality.³³

Culture of violence theory

The culture of violence theory focuses on the acceptance of violence in our society. This theory explains that violence is accepted in our society as a way of settling disputes, which becomes the foundation for family violence in the home. In other words, the approval of the use of violence in broader society legitimates it as a means of also resolving conflict within the family.³⁴

Social learning theories

Social learning theories take the view that violence is learned through our life experiences and our environment. Therefore, people are not born with the tendency to be violent – instead, this theory explains violence as behaviour that is learned through our communication and interactions with others. The nature, frequency and duration of violence in our environment influence our learning experience and impact the motives, attitudes and thoughts we hold about violence.³⁴

Exchange/social control theory

The exchange/social control theory is based on the idea that individuals act according to a system of rewards or punishments. In explaining family violence, this theory argues that individuals use violence within the family unit, and towards family members, to pursue rewards and obtain goals, which may outweigh perceived possible costs or punishments. Given the privacy of the family unit, along with the relatively low risk of intervention and disclosure, family violence is therefore viewed as low cost, allowing it to occur.²⁹

LEVELS OF PREVENTION

Explanations of violence are important in devising approaches to addressing violence. Violence prevention follows three levels: primary, secondary and tertiary.

Primary prevention: Before the problem starts

Primary prevention strategies are designed to prevent violence from occurring, remove the causes of violence, prevent risk factors developing, and enhance protective factors.

Example

The *Adults and Children Together (ACT) Against Violence Parents Raising Safe Kids program* is a primary prevention program designed to educate parents and families to create safe environments that protect children from violence. Ultimately, the goal of the program is to prevent child maltreatment by focussing on early childhood, and recognising the significant role of parents and caregivers in shaping a child's early development and their experiences.

The program is based on the idea that lack of knowledge about child development,

inadequate parenting skills, and lack of problem-solving skills to deal with conflict are key contributors to child maltreatment. For example, abusive parents often hold inappropriate expectations about their child's behaviour and can react inappropriately – as a result, they are more likely to use harsh physical disciplines and verbal aggression. Parents in the ACT program are taught about childhood development, how to manage anger, conflict resolution techniques, and modelling appropriate behaviour.

Evaluation outcomes: The ACT program achieved positive results in a number of key areas, including a reduction in parents' use of harsh verbal and physical discipline, and a significant increase in nurturing behaviour. These were observed at the end of the program as well as at a three-month follow up.³⁵

Focus groups conducted with parents who participated in the program also indicated that they perceived numerous benefits of the program – such as assistance controlling their anger, learning about and applying better parenting and discipline strategies, and recognising when their child's behaviour is developmentally appropriate.³⁵

For more information see: <http://actagainstviolence.apa.org/> or <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=311>.

Secondary prevention: Once the problem has begun or occurred

Secondary prevention strategies are immediate responses to a violent episode in order to manage the immediate consequences of violence, identify those at risk of becoming a victim or perpetrator, and reduce their likelihood of further violence.

Example

The **Taking Responsibility Program** is a behaviour change program delivered by Relationships Australia (New South Wales) for men who use violence in their intimate relationships. It is designed to stop violence and make families safer by engaging men in educational and therapeutic sessions with a counsellor in which changes are monitored and arising issues are discussed.

The program aims to make a positive impact on men’s attitudes and behaviours – in particular, it seeks to make a change to levels of distress, self-control, self-esteem, and beliefs about gender equity. All of these factors have been associated with positive behaviour change for men who use violence.

Evaluation outcomes: In-depth interviews with 20 male clients were conducted over a 12 month period to determine the effectiveness of the Taking Responsibility Program. The evaluation found that:^{36; 37}

- ⇒ at program completion, respondents’ levels of distress had decreased and were significantly lower than at intake;
- ⇒ respondents’ levels’ of self-control and self-esteem had increased and were significantly higher than at intake;
- ⇒ beliefs about gender equity did not alter significantly between intake and completion. The program aims to focus more in future on addressing attitudes around gender roles and equity.

For more information see:

<http://nsw.relationships.com.au/resources/research/Taking%20Responsibility%20Program%20Evaluation.aspx>

Tertiary prevention: Responding after violence

Tertiary prevention strategies are long-term approaches to demonstrated and/or repeated violence, to treat the impacts of violence and prevent future violence.³⁸

Example

The **Women Recovering from Abuse Program (WRAP)** is an outpatient, day-hospital program involving group therapy and individual counselling for women who have experienced childhood abuse and suffer from mental health problems.³⁹

Evaluation outcomes: A qualitative study into the effects and impacts on WRAP indicates that following program participation:⁴⁰

- ⇒ Clients reported more positive regard, re-evaluated

assumptions about the world as a 'dangerous place', improved affect regulation, and increased ability to set and maintain boundaries in relationships;

⇒ Clients reported greater connectedness to others, and an increased self-awareness;

⇒ Clients reported changes in their beliefs about responsibility for the abuse, and realised more fully they were not to blame.

Example

The **Women's Experience of Abuse and Violence Care in General Practice (WEAVE)** project involves a large study examining the effect of brief counselling by GPs for women who had experienced fear of a partner or ex-partner.⁴¹

Of the almost 6,000 women (attending 55 clinics) who responded to a screening survey as part of this study, approximately 13% indicated that they were fearful of their partner, or ex-partner, in the last 12 months. Some of these women then participated in a randomised trial in which half of the GPs were trained to provide supportive counselling and their participating patients were asked to attend counselling. The remaining GPs received basic resources, and provided usual care to participating patients.

The women who participated in the study completed a survey about their relationships, health and wellbeing before the study and at 6 months, 12 months and 24 months after the study began.

Evaluation outcomes: The study found that trained GPs enquired more about the safety of women and their children. Measures were taken for "depression", "mental health" and "general quality of life". Outcomes were better for women who attended the GP counselling.⁴¹ The results suggest that GPs should be trained to ask about domestic and the safety of women and children, and to provide supportive counselling for women.⁴¹

For more information see:

<https://www.beyondblue.org.au/resources/research/research-projects/research-projects/womens-experience-of-abuse-and-violence-care-in-general-practice-a-consumer-evaluation-of-guidelines-weave>

ASSOCIATIONS WITH HEALTH AND WELLBEING

According to the World Health Organisation, family violence is a violation of basic human rights and is a leading international public health concern.⁴² It has serious impacts on health and wellbeing, including physical injuries, mental illness, reproductive problems, and substance abuse and death. In addition, there are significant economic costs for our community.

Physical health impacts

Family violence can have serious physical impacts on health in the immediate, short-term and long-term. Intimate partner violence perpetrated by male partners is the most common cause of injury to women. In Victoria, intimate partner violence against women is the biggest contributor to ill-health and premature death in women aged 15 to 44 years; it is a greater risk than high blood pressure, obesity and smoking.⁵ Common physical injuries include cuts, bruising, lacerations, and fractures as well as injuries to the eyes, ears, head, neck, breasts, and abdomen.⁵

Family violence can have long-term consequences for the physical health of patient/client – even after violence has ended. For example, there are links between intimate partner violence and physical and intellectual disability (such as acquired or traumatic brain injury),⁴³ as well as chronic pain disorders.

Childhood violence can disrupt neurodevelopment and alter life-long brain structure and function.⁴⁴ Children may also experience permanent disability as a result of violence during their mothers' pregnancy or violence during childhood.⁴³

Reproductive health impacts

The effects on women's reproductive health range from bruising and lacerations to the vaginal area, sexually transmitted diseases, urinary tract infections, unwanted pregnancy, to miscarriage or complications with pregnancy.⁵

Worldwide, women who have been physically and/or sexually abused by their partner are 16% more likely to have a low-weight baby, more than twice as likely to have an abortion, and, in some regions, are 1.5 times more likely to get HIV compared to women who have not experienced intimate partner violence.¹⁶

Mental health impacts

Research also points to the negative mental health impacts of family violence. These can range from short term effects, such as shock and fear, to longer term, more persistent mental health problems:⁴⁵

- Women who have experienced violence are more likely to experience anxiety and depression – one study reports a five-fold increase in the risk of depression.⁴⁶
- Women who report experiencing intimate partner violence are more likely to use medication for depression and anxiety.⁵
- Phobias, somatisation and dissociative disorders are reportedly more common among women reporting intimate partner violence.⁴⁷

Women who have eating disorders are more likely to have experienced family violence,⁴⁸ which is often co-morbid with depression and anxiety.

There are also significant impacts on the mental and psychological health of children experiencing and/or exposed to violence including depression, anxiety, trauma symptoms, aggression, anti-social behaviour, low self-esteem, fear, mood problems, and peer conflict.⁴⁹

Among both young women and men, direct victimisation and witnessing violence are associated with more eating disorder symptoms.⁵⁰

Risk behaviours

Family violence is also associated with an increase in engaging in risk behaviours for victims and perpetrators.

Women who have experienced intimate partner violence are more likely to have alcohol problems, to smoke, and use non-prescription drugs than women who are not victimised.⁵¹

Alcohol has also been associated with being a victim or perpetrator of violence. Research suggests that the level of harm of violence seriously heightens, and injuries are more severe, when alcohol is involved.⁵²

Children who have experienced violence are also more likely to take part in high risk behaviours (such as smoking or substance abuse) later in life.⁴⁴

Research also shows that victims of family violence have much greater risks of self-harm (such as poisoning or mutilation) compared with other Emergency Department patients;⁵³ and that family violence represents a key factor in suicide, with increased incidences of suicidal behaviours among people who have experienced child abuse, and, in particular, sexual abuse.⁵⁴

Economic impacts

Individuals who have experienced family violence can face significant long-term financial disadvantage as a result, especially if they were subjected to financial abuse.⁵⁵

Family violence is a major driver of homelessness, and the principle cause of homelessness among women. Women escaping family violence are frequent users of specialist homelessness services. In 2009-2010 almost 50% of women with children who sought assistance from specialist homelessness services cited family violence as the main reason for seeking help.⁵⁶

Family violence also has significant financial costs for our community as whole. In 2002-2003, the annual cost of family violence to our economy was estimated to be \$8.1 billion.¹¹

THE ROLE OF PRIMARY HEALTH CARE PROFESSIONALS

People experiencing violence often turn to their primary healthcare providers as the first source of professional advice and support.⁵⁷ Many people who have experienced violence are seen in healthcare settings – often repeatedly. This means that healthcare professionals can play a key role in offering assistance.

Individuals who have experienced family violence can come into contact and engage with primary healthcare professionals in a variety of ways. Consider the following.

- **Paramedics** are frequently the first point of contact for victims of violence, often in the context of ‘post-incident’.⁵⁸ They are generally the first healthcare professional to respond to a woman after violence has occurred, and are often required to defuse situations, treat injuries and provide emotional support, reassurance and advice. They are also in the unique position to be able to gather additional information from the home environment which is important in the overall management of the patient by the healthcare team.

- **General practitioners** are the major healthcare professional group that women experiencing family violence turn to talk to after family and friends.^{9; 59} A full time GP is likely to see one to two female patients each week who have experienced family violence.⁶⁰ **General practitioners** are also important in assisting the process of leaving or escaping family violence. A study by Patton (2003) found that 13% of the sample group of women who had experienced intimate partner violence reported general practitioners as a pathway assisting them to leave and/or establish a new life. Thirty six percent 36% indicated that a general practitioner was important at some point in this process.⁶¹
- **Nurses** confront family violence across all areas of their practice, particularly in areas such as the emergency department or when seeing women with gynaecology issues.
- **Midwives** also encounter issues relating to family violence, for example during antenatal care, in the labour room, or in the postnatal care of women commencing breastfeeding.
- **Maternal and Child Health Nurses** are a key health professional who come into contact with those who have experienced violence. Maternal and Child Health Nurses provide home visits within one week of birth – this potentially places them in a position to identify individuals at risk, provide a source of support and assist in providing referrals, which is particularly important when considering the risks of violence during and shortly after pregnancy (discussed in more detail in Module 3).⁶²
- **Social workers can** play a significant role in preventing and intervening before family violence occurs. They do this through supporting parenting, educating young people, and influencing other social determinants of violence.⁶³ Social workers regularly come into contact with victims of family violence in various health and social settings in which they work (including in hospitals, mental health agencies, and substance abuse treatment centres).⁶⁴
- **Occupational therapists** and **physiotherapists** play a significant role in responding to family violence. They do this by supporting children and families through rehabilitation, and have an important role with those who have ongoing

mental health issues or physical disabilities. Their ongoing therapeutic relationship with patients/clients, and the trust that is built over time, makes the role of these two professional groups particularly important for women and children at high risk – examples include those who have been physically injured by violence and those with disabilities.

MODULE 2: IDENTIFYING AND RECOGNISING FAMILY VIOLENCE

SYNOPSIS

Module 2 encourages students to think about their own attitudes towards family violence, and how these attitudes could create barriers to the way in which they respond professionally to family violence and abuse. Further, it asks students to consider how the issue of family violence may influence their future practice as a healthcare professional and reflect on patient/client encounters with the healthcare system. The module then outlines possible indicators of family violence in adults and children. It describes groups at particular risk of family violence, and outlines the particular times a person can be at increased risk of family violence. Finally, this module outlines possible indicators of family violence in adults and children.

LEARNING OBJECTIVES

On completion of this module, you, the learner, should be able to:

1. Describe your own thoughts and attitudes to family violence;
2. Reflect on how your attitudes may enable or create barriers to the ways in which you professionally respond to those who have experienced family violence;
3. Examine and reflect on encounters with the healthcare system described by those who have experienced family violence;
4. Describe and identify possible indicators of family violence in adults and children;
5. Describe groups at risk of family violence and at risk of adverse impacts as a result of violence;
6. Identify pregnancy, separation and natural disasters as times of risk for family violence;
7. Recognise common presentations of family violence in primary healthcare.

YOUR THOUGHTS AND REFLECTIONS

Reflection

- ❖ How do you see and hear about violence in everyday life?
- ❖ What does ‘family violence’ mean to you?
- ❖ Do you think this is the same for patients/clients who experience family violence?
- ❖ How do you think people who have experienced family violence may present to different primary health care professionals – that is general practitioners, midwives, nurses, occupational therapists, paramedics and social workers?

PATIENT/CLIENT EXPERIENCES

The following videos/clips feature stories from patients/clients who have experienced family violence; they speak about their experiences of violence as well as their encounters with the healthcare system.

Go to www.pactsproject.org and click on the ‘Videos’ tab.

After you have viewed the patient/client stories, reflect on the following.

Reflection

- ❖ What is it like to experience violence?
- ❖ What kind of encounters do patients/clients have with the healthcare system?
- ❖ What did patients/clients want?
- ❖ Should different professional groups respond differently? How could your professional group best respond?
- ❖ What happens when healthcare professionals don’t respond or respond inappropriately?
- ❖ What is it like when no-one believes you?

COMMON PRESENTATIONS OF FAMILY VIOLENCE

The following videos/clips feature primary healthcare professionals speaking about the importance of the issue of family violence to their practice.

Go to www.pactsproject.org and click on the 'Videos' tab.

After you have viewed these videos/clips, reflect on the following:

Reflection

- ❖ Under what types of circumstances did primary healthcare professionals recognise family violence as important to their work?
- ❖ In what ways has this changed their practice as a healthcare professional?

POSSIBLE INDICATORS OF FAMILY VIOLENCE

It can be difficult to identify whether a patient/client is experiencing family violence. However, there are a number of **signs, clues or cues** to which practitioners need to pay attention.

It is important to remember that not *all* patients/clients who experience family violence, either in the past or present, will present with *every* sign or symptom. Sometimes the symptoms or signs are not always obvious. Sometimes patients/clients may present few indicators; others may present with many of them.

It is also important to remember that these indicators *do not* by themselves indicate family violence. Some of the symptoms may be attributable to other causes – it is important to ask rather than to jump to conclusions. However, if there is a history or pattern of these indicators, there may be a history of violence. Primary health professionals should include this information in their assessments of patients/clients.⁶⁵ Healthcare professionals are more likely to ignore cues and miss family violence than to recognise it.

Indicators of family violence in adults

A patient/client who has experienced family violence might:⁶⁶

- appear nervous, ashamed or evasive;
- describe their partner as controlling or prone to anger;
- seem uncomfortable or anxious in the presence of their partner;
- be accompanied by their partner who does most of the talking;
- give an unconvincing explanation of injuries that they, or their children, have sustained;
- be reluctant to follow advice;
- suffer anxiety, panic attacks, stress, and/or depression;
- have a stress-related illness;
- have a substance abuse problem;
- have chronic headaches, asthma, or aches and pains;
- have abdominal pain and/or chronic diarrhoea;
- report sexual dysfunction;
- have attempted suicide and/or have a psychiatric illness;
- have physical signs of violence such as bruising on the chest, multiple injuries, minor cuts, injuries during pregnancy, and/or ruptured eardrums;
- have delayed seeking medical attention;
- present with patterns of repeated injury or signs of neglect.

Indicators of family violence in children and young people

Indicators of family violence in children and young people can be categorised as either physical or behavioural, and can include:⁶⁶

- bruises, burns, sprains, dislocations, bites, and cuts;
- fractured bones – especially in an infant where a fracture is unlikely to have occurred accidentally;
- poisoning;
- internal injuries;
- wariness and distrust of adults;
- wearing long-sleeved clothing on hot days to cover bruises or other injuries;
- fear of parents and of going home;
- becoming fearful when other children cry or shout;
- being excessively friendly to strangers;
- being unexpectedly passive and/or compliant.

Indicators of sexual violence in children and young people

A child or young person who is a victim of sexual violence might:⁶⁶

- tell someone sexual violence has occurred;
- complain of headaches or stomach pains;
- experience problems with schoolwork;
- display sexual behaviour or knowledge unusual for the child's age;
- display maladaptive behaviour such as frequent rocking, sucking and biting;
- experience difficulties in sleeping;
- have difficulties relating to adults and peers.

Indicators of emotional abuse in children and young people

Indicators of possible emotional abuse of a child or young person can include:⁶⁶

- displaying low self-esteem;
- being withdrawn, passive and/or tearful;
- being highly anxious;
- showing delayed speech;
- acting like a much younger child (for example, soiling or wetting pants);
- difficulties relating to adults and peers.

Reflection

- ❖ What kinds of indicators did the patient/client present with in the 'Patient/Client Stories' and 'Common Presentations' videos?
- ❖ How did the healthcare professional(s) identify and recognise these?

GROUPS AT RISK OF FAMILY VIOLENCE

Family violence occurs across all social, cultural, racial, and economic backgrounds. However, some groups of people are more vulnerable to becoming victims of family violence, while some groups of people experience greater, or more significant, adverse health impacts as a consequence of violence and/or face greater difficulties in leaving family violence and seeking help. These include:

- children;
- young women;
- people living in Indigenous communities;
- women living in rural and remote areas;
- women with a disability;
- women from culturally and linguistically diverse (CALD) backgrounds.

Children

Children face great risk of violence – in particular, **younger children are at greater risk** than older children. Very young children (under one year) are most likely to be the subject of substantiated abuse and neglect; in 2011-2012, children aged under one year had the highest rates of substantiation (13.2 per 1000 children) compared with children aged 15-17 years (3.2 per 1000 children).²⁷

The risk of family violence for children is significantly increased when coupled with violence in the home, often perpetrated by their father toward mother. Research indicates that there is a significant overlap (between 45% and 70%) between child physical abuse and family violence (amongst parents), making family violence a key risk factor for physical violence toward children.⁶⁷

Young women

Younger women face a **greater risk of violence** than older women – particularly from an intimate partner.⁶⁸ Twelve percent of women aged 18 to 23 years report that they have been in a violent relationship with a partner or spouse.⁶⁹

Young women also experience a significant risk of being **physically injured and scared** by the violence they are subjected to. For example, of young people aged 12 to 20 years who had been in a dating relationship, 25% of girls had been frightened by the physical aggression they experienced; while 24% of girls had been both frightened and hurt.⁷⁰

Indigenous communities

Knowledge about the extent of family violence in Indigenous communities is limited. This is due to a lack of reporting and disclosure of violence to authorities because of:⁷¹

- fear of consequences – particularly in small, interconnected and isolated communities;
- fear and distrust of police, the justice system, and government agencies;
- feelings of shame and responsibility for maintaining families;
- lack of awareness or access to support services.

From the available data, we know that Indigenous people – **men, women and children** - are **more likely to experience family violence**, compared with non-Indigenous people. Indigenous people experience violence at rates that are **typically double** than those experienced by non-Indigenous people.⁷²

In particular, Indigenous women are more likely to experience violence than non-Indigenous women.⁷³⁻⁷⁵ Statistics tell us that the rate of domestic assault reported to police is **more than six times higher** for Indigenous than for non-Indigenous women.⁷⁶ When Indigenous women experience violence, it is also far more likely to be **severe and injurious**. In fact, Indigenous women are **38 times more likely to require hospitalisation** for domestic partner inflicted assaults than non-Indigenous women.⁷⁷

Indigenous children are more likely to be the subject of substantiated abuse and neglect than non-Indigenous children. During 2011-2012, Indigenous children had almost 8 times the substantiation rates of child abuse and neglect compared with non-Indigenous children (41.9 and 5.4 per 1000 children).²⁷

Indigenous men are also more likely than non-Indigenous men to be victims of family violence – at a rate **almost four times higher**.⁷⁶

Women living in rural and remote areas

The evidence about the prevalence of family violence in rural and remote communities is unclear due to ideas of self-reliance, pride and privacy underpinning rural cultures; these thoughts foster a lack of reporting of violence to authorities.⁷⁸ Research does, however, indicate that women living in rural communities experience **greater levels of family violence** than women living in suburban and urban areas.^{79; 80} A study by Peek-Asa et al (2011) shows that women in rural and isolated areas reported the highest prevalence of intimate partner violence (22.5% and 17.9%) compared with 15.5% for urban women. Rural women also reported significantly higher severity of physical violence than women living in urban areas.⁸⁰

The experience of family violence for those living in rural and remote areas is influenced by a range of factors that can make leaving violence, and/or seeking help, particularly difficult. These include:⁸¹

- geographic isolation;
- lack of public transport;
- lack of telecommunication technology and infrastructure;
- lack of crisis accommodation;
- lack of financial support;
- the prevalence of weapons and therefore increased lethality;
- lack of understanding of the nature and dynamics of family violence (a perception that violence must be physical);
- a significant culture of mateship and masculinity reinforcing, minimising and condoning the use of violence;
- fears of breaches of confidentiality if family violence is disclosed;
- the often complicated financial, business and property arrangements in farming families, and a reluctance to leave the farming lifestyle or animals.

Women with a disability

Women with a disability are at **greater risk of family violence** than non-disabled women.⁸²⁻
⁸⁵ Although the rates of violence experienced by women with a disability are unclear, it is clear that disabled women are more vulnerable to violence due to increased dependency and

relative likelihood of social disadvantage. Because of their increased dependency, perpetrators often use a person's disability as a way of perpetrating violence – for example, destroying assistive equipment, and withholding food and medication – which can make the violence visible to others.⁸⁶⁻⁸⁸ The available evidence tells us that women with a disability:

- experience violence at significantly higher rates and more frequently – for example, a Canadian study found that women with disabilities were 40% more likely to experience partner violence, and were vulnerable to more severe forms of violence, than non-disabled women;⁸²
- tend to experience violence over longer periods of time;⁸⁸
- have fewer pathways to safety;⁸⁸
- experience violence that is more diverse in nature, and by a greater number of perpetrators than women without disabilities.⁸⁸

The most common perpetrators of violence against women with a disability are male partners. Male partners account for 43% of perpetrators of violence; a further 11% experienced violence from a female partner.⁸⁹ Other perpetrators can include family members, carers, healthcare providers, or service providers.

Women from culturally and linguistically diverse (CALD) backgrounds

Women from culturally and linguistically diverse (CALD) backgrounds have a wide range of backgrounds and experiences, and should not be treated as a homogenous group. However, we do know that many women from CALD backgrounds – including immigrant and refugee women, and women from non-English speaking backgrounds – are particularly vulnerable to the effects of violence, and may face additional difficulties seeking assistance or disclosing violence if they:⁸¹

- have a limited understanding of English;
- lack extended family and community support – a particular concern for women from small and emerging communities;
- encounter difficulties in accessing legal and support services owing to language and cultural differences;

- are unaware of their rights and of laws prohibiting family violence in Australia relating to immigration;
- lack knowledge of housing, income and support services;
- fear that reporting violence will compromise their future residency in Australia or their entitlement to programs and services – a particular concern for women on temporary or spouse visas;
- have limited access to resources such as employment skills, education, income, and assets which may enable them to exercise choice when subject to violence – a particular concern for the recently arrived;
- fear that their confidentiality will be breached by service providers;
- originate from societies where there is reason to be mistrustful of authorities and/or government institutions;
- originate from societies in which there are strong cultural prohibitions against separation.

Perpetrators may also use these factors as a means of perpetuating violence toward their partner and/or family member(s)⁹⁰ – for example, a lack of knowledge of the legal system may leave a CALD women open to threats of being removed from Australia, or deportation, as a way of perpetrating violence.⁹¹

TIMES OF RISK FOR FAMILY VIOLENCE

Family violence is also more commonly associated with specific points in people's lives. Pregnancy, marriage, relationship separation, and natural disasters have been identified as times in which women and children face a greater risk of violence and of significant health impacts.

Pregnancy

Research tells us that women are at **an increased risk of violence during pregnancy**. The Australian Bureau of Statistics' *Personal Safety Survey* (conducted in 2005) found that almost 60% of women who had experienced violence perpetrated by a former partner were pregnant at some time during the relationship; 36% of these women experienced violence during their pregnancy and 17% experienced violence for the **first time when they were pregnant**.⁴

The **frequency and severity** of violence is also **greater among pregnant women**, and the onset of pregnancy has been found to **increase the rate of psychological abuse** among those women who had reported experiencing violence.^{92; 93}

Among women who have previously experienced violence, violence during pregnancy has been identified as specific **risk factor for lethal violence**.

- Studies show that women who are subjected to violence during pregnancy are at **nearly 3 times the risk for serious injury and homicide** than those women who report a cessation of violence during pregnancy.⁹⁴
- Amongst a sample of 494 women (from 11 cities in the United States) who were killed or almost killed by their husband, boyfriend or ex-partner, nearly 26% had experienced violence during pregnancy.⁹⁵
- Research shows that the risk of homicide is at its greatest in the **first three months of pregnancy**.⁹⁶

The increased risk of violence in the period shortly after birth has been associated with the additional stress placed on the relationship at this time, and the mental health, wellbeing and lifestyle of partners.⁹⁷

Women who experience violence during pregnancy are more likely to smoke, use drugs and anti-depressants, and have a poor diet. As a group they also experience poorer levels of support, and higher rates of miscarriage and physical injuries than those who do not experience violence during pregnancy. All of these effects can further impact a woman's health during pregnancy, as well as the birth outcome and the health of her baby. For example, studies suggest that violence can induce preterm births and affect babies' birth weight. Violence could even be associated with asthma and epilepsy in children.⁹⁸

Separation

Separation is associated with a **high risk** of intimate partner violence against women.⁹⁹⁻¹⁰¹

Research shows the following.

- In one Canadian study, prevalence of violence amongst separated women was found to be nine times greater than married women.¹⁰⁰

- In Australia, a quarter of women who had experienced partner violence, and have separated from their partner, continued to experience violence during separation.⁴
- In Victoria, 30% of the 886 family violence incidents recorded over a two week period in 2007 and 2008 occurred after separation.¹⁰²

Women are at the greatest risk of violence in the period shortly following separation – in particular, in the twelve months after separating, when violence often escalates and becomes more prominent.^{99; 103-105} This can include physical violence and harassment,^{103; 105-107} and sexual violence¹⁰⁸⁻¹¹¹ during and after separation.

Women are at **significantly greater risk of being killed** by their intimate male partner in the context of separation.¹¹² Research shows the following:

- Separation is a significant factor in intimate partner homicides – in an Australian study around a quarter of intimate partner homicide offenders were separated from their partner at the time of the incident.¹¹³
- In the intimate partner homicides which occurred over a two year period in Chicago, United States, over half of the women killed by a male partner were killed as they were trying to leave.¹¹⁴

Children's risk of violence during separation

Children are also at risk of experiencing violence perpetrated by their fathers after their parents separate. This can include physical violence or threats of violence from their fathers, witnessing violence against their mothers or new partners, and manipulation (such as degrading or 'putting down' their mothers).^{102; 115}

Children are also at serious risk of being killed by their fathers after parental separation. Australian and international data shows that, where fathers kill their children after separation, they typically use their children to seek revenge on and/or to harm their former partners.^{102; 116; 117}

Natural disasters

The period following a natural disaster (such as a flood, earthquake, bushfire, tsunami and cyclone) represents a time in which women's vulnerability to, and risk of violence, can increase.¹¹⁸ Both international and Australian research indicates an increase in family violence – in particular, intimate partner violence – in the aftermath of natural disasters.

In the United States Anastario et al (2009) found a four-fold increase in intimate partner violence after Hurricane Katrina.¹¹⁹ Other studies indicate a 98% increase in the physical victimisation of women after Hurricane Katrina.¹²⁰

A New Zealand study conducted by Houghton (2010) found that police reported a 53% increase in callouts to domestic violence incidents over the weekend of the Canterbury earthquakes in 2010.¹²¹

In an Australian study involving interviews with 29 women affected by the Black Saturday bushfires in Victoria (2009), Parkinson and Zara (2012) found that violence increased after the bushfires.^{122; 123}

It is difficult to determine why the post-disaster period is associated with an increased risk of family violence. However, possible explanations offered include:¹²⁴

- increased stress, such as financial stress;
- perpetrators' loss of control over aspects of their life (such as housing, employment, food, shelter, communication, and social support) – this motivates them to seek more control over family;
- increase in reported rates of violence may, in some cases, reflect an increase in new help-seekers, rather than an increase in new experiences of violence.

The post-disaster impacts on individuals and communities can be devastating, ranging from homelessness, unemployment, mental and physical health problems, loss of social support networks, and loss of material items. There are additional adverse impacts unique to women who experience family violence following natural disasters. The issue of housing after a natural disaster is more complex for those experiencing violence. Being displaced or relocated after a natural disaster may result in moving away from family, friends and neighbours, reducing the capacity to support women experiencing violence at this time. The

lack of financial resources is also associated with heightened risk of violence for women as they may decide to return to a violent relationship due to shortage of funds.¹²⁴

MODULE 3: ASSESSING AND RESPONDING TO RISK

SYNOPSIS

Module 3 builds on the information about possible indicators of family violence examined in Module 2. It introduces students to some different ways in which they can respond to patients or clients once they have identified possible indicators. The module encourages students to think about the kinds of questions they may ask clients or patients about their health, and about the possibility of experiencing family violence. Finally, the module looks at the processes involved in undertaking a basic risk assessment.

LEARNING OBJECTIVES

On completion of this module, you, the learner, should be able to:

1. Recognise and respond to common presentations of family violence in primary healthcare;
2. Identify appropriate questions to ask in circumstances where you identify possible indicators of family violence;
3. Undertake a risk assessment appropriate to the discipline being studied.

WHAT IF I SUSPECT FAMILY VIOLENCE IS OCCURRING?

Asking the 'right' questions

If you suspect your patient/client is experiencing family violence, or if you are not sure, there a number of questions you can ask about possible violence in the family and home. The types of questions asked will depend on how well you know the patient/client, the kinds of indicators you have observed, and any other relevant factors (such as age, ethnicity, and disability).¹²⁵ Be mindful of these variables when engaging a patient/client about possible violence in the home or family.

Generally, these questions can be categorised as (i) **broad questions** about the patient/client's relationship(s) or home, (ii) **specific questions** relating to your observations

about, for example, the patient/client's physical or mental condition; and (iii) **direct questions** about possible violence such as whether the patient/client feels safe.¹²⁵

Broad questions

Asking **broad questions** can be an effective starting point in gauging whether violence has occurred, or if indicators or signs are attributable to violence. These kind of questions are useful if you suspect family violence has occurred but you are not completely sure; they do not imply violence has occurred, nor do they 'probe' into the personal feelings of the patient/client (for example in regards to feelings of safety).

Broad questions may include:¹²⁵

“How are things at home?”

“How are you and your partner relating?”

“Is there anything happening that might be affecting your health?”

“Have you ever been frightened at home?”

Specific questions

If the patient/client indicates a willingness to talk, you can ask more **specific questions**. These questions must begin with an explanation of why they are being asked, which can be placed in the context of the patient/client's health. For example, a clinician may explain to the patient/client that he/she is concerned about patient's/client's health and would like to ask some questions about home and family. For example:^{66(p58)}

“I am a little concerned about you because [list family violence indicators that are present]. I would like to ask you some questions about how things are at home. Is that okay with you?”

Other approaches include:¹²⁵

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

“You seem very anxious and nervous. Is everything all right at home?”

Direct questions

If the patient/client further indicates a willingness to talk, you can ask more **direct or probing questions** that relate to feelings of safety or threats of violence. For example:^{66(p58);}

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“Are you ever afraid of someone in your family or household? If so, who?”

“Has someone in your family or household ever threatened to hurt you?”

“Are you concerned about your safety or the safety of your children?”

“I think that there’s a link between your [illness/condition] and the way your partner treats you. What do you think?”

Questions for children who might be experiencing violence

It is important to remember that the questions asked about observed indicators are appropriate based on age and developmental stage. The kinds of questions asked of adults are unlikely to be suitable for children or young people, and could even create distress for them.

Some questions FOR children to ask them about possible violence include:^{66(p58)}

“Tell me about the good things at home.”

“What don’t you like about home?”

“Tell me about the ways mum/dad look after you.”

“Do you worry about your mum/dad or brothers/sisters for any reason?”

Questions for older children could include:¹²⁶

“How are the good days? What makes them so good?”

“How are the bad days? What makes them so bad?”

Questions for younger children:¹²⁶

“Sometimes children are good at keeping secrets. What type of secrets do you think children are good at keeping?”

“Sometimes I see children I worry about. I saw another child who was sore like you, what do you think happened to them?”

“Some children can get scared at home, what do you think makes them scared?”

“Sometimes kids worry about lots of things, like when they have a fight with their friend, or they feel their teacher was mean to them. Kids also worry about things in their homes, maybe about mum and dad fighting or when their mum or dad was mean to them. Sometimes kids are scared and don't know what to do. Do you sometimes worry about things like that?”

Remember, **it is not your job to ‘prove’** that family violence has occurred or is occurring.

CONDUCTING A PRACTITIONER RISK ASSESSMENT

What is a risk assessment

A risk assessment is a process of evaluating individuals in order to:¹²⁷

- characterise the likelihood they will commit, or be subject to, an act of violence or relationship of abuse;
- assess the likely impact of the situation on an individual’s safety and wellbeing, with and without further incidents of violence;
- develop interventions to manage likely trajectories;
- document information.

Asking the right questions is one part of performing a risk assessment.

A risk assessment focuses on the nature, form, pattern, and degree of danger to assess the likelihood of family violence. It not only predicts the likelihood of violence, but also considers what steps can be taken to prevent violence in the future.

Risk assessment forms an **ongoing process of monitoring, review and re-assessment** (rather than a one-off event). In the context of family violence, this is important because relationships are dynamic, as are the factors associated with violence; therefore, risk assessment must be in line with the dynamic and complex nature of violent family relationships. For example, changes in perceptions of risk may occur along with the vulnerability of those involved and drug or alcohol use.¹²⁷

Why do a risk assessment

Undertaking a risk assessment is important for a number of reasons. It can assist in:¹²⁷

- preventing violence;
- providing a shared language about risk among healthcare professionals and other service providers;
- providing structure to reflect on risk factors;
- helping patients/clients understand their risk and increase confidence to seek support ;
- identifying risk to children – which can be facilitated through identifying risk to adults);
- helping healthcare professionals and patients/clients develop effective safety plans.

How to assess risk

Risk assessment in the context of family violence is a relatively new area. Some jurisdictions within Australia have developed **standardised risk assessment processes or frameworks**. In Victoria, for example, the Family Violence Common Risk Assessment and Risk Management Framework (also known as CRAF) has been developed to assist a wide range of professionals and organisations (including: mainstream services such as healthcare, mental health and education; justice services such as police and courts; and family violence services) identify family violence, and provide supportive and timely responses to individuals who have experienced family violence.¹²⁸ Similarly, the Western Australian Family Violence Common Risk Assessment and Risk Management Framework outlines a standardised approach to identifying, assessing and responding to family violence for mainstream and specialist professionals.¹²⁹

An assessment of risk to patients/clients of family violence must be structured and informed by:¹²⁸

- the patient's/client's own assessment or perception of safety and risk levels;
- a sound evidence base which identifies factors that indicate an increased risk of re-occurrence of family violence;
- the professional judgement of the person making the assessment, which takes into account the above and includes all other information known about the patient/client and their situation.

The importance of patient/client information

The information provided by a patient/client about their perception of risk and re-occurrence of family violence is critical to assessing risk. In the context of family violence, it is necessary that your work as a healthcare professional recognises and respects that patients/clients already have their own knowledge and methods to identify and assess risk. A patient/client who is experiencing family violence is often a good predictor of their own level of risk and therefore their perspectives must be considered in the process of assessing risk.¹²⁸

An evidence base of risk factors

The identification of risk factors that indicate an increased risk of family violence is important in assessing risk. Risk factors are psychological and psychosocial characteristics of perpetrators, victims and the victim-perpetrator relationship that increase the likelihood of violence being repeated or escalated. These factors include:^{127; 128}

- the perpetrator's history of violent behaviour within and outside of the home/family;
- the perpetrator's history of physical, sexual or emotional abuse toward intimate partners/family members;
- the behaviour of the perpetrator (for example, behaviours that are disruptive of normal standards of social behaviour and affiliation with peers);
- perpetrator access to lethal weapons;
- relationship instability, separation or divorce;
- presence of life stressors for perpetrator such as unemployment ;
- perpetrator history of family violence as a child;
- mental health issues or personality disorder in the perpetrator;
- perpetrator resistance to, or lack of motivation for, treatment;
- violence-supportive attitudes of the perpetrator.

Professional judgement

Assessing risk involves the professional judgement of the healthcare practitioner in determining the level of risk for the re-occurrence or escalation in family violence; it encompasses information about the patient's/client's own perception of risk, and evidence-based risk factors. Typically referred to as the **structured professional judgement**

approach, this approach involves drawing upon evidence-based frameworks and taking into account patient-/client-specific situations and contexts.¹²⁸

Engaging children in risk assessment

Assessing risk of children may involve an assessment of the following areas in relation to a child's wellbeing and experience:¹²⁷

- experience of childhood violence;
- feelings, including their emotions;
- psychological disposition including fear;
- a sense of responsibility;
- their capacity to make meaning of their experiences;
- sense of safety.

Engaging perpetrators in risk assessment

Engaging an (alleged) perpetrator in an assessment of risk to perpetrate violence can involve a consideration of their:¹²⁷

- level of stress or distress;
- employment and income;
- access to weapons;
- view of gender roles;
- mental health issues;
- dependence on the victim ;
- drug and alcohol use;
- level of acceptance of the use of violence;
- experience of childhood violence.

However, it is important to remember that a perpetrator may underestimate their level of risk, be reluctant to disclose information, be in a state of denial, and/or minimise responsibility. When a healthcare professional makes an assessment of risk, the power dynamics between the victim and the perpetrator must also be considered.¹²⁷

Safety planning

After collecting information to assess risk, the healthcare professional needs to determine whether risk is in fact present. The healthcare professional does this drawing on structured decision-making in collaboration with the patient/client.

If risk is present, then safety planning is may be required and healthcare professionals need to know how to develop a safety plan. A safety plan needs to be developed in consultation with the patient/client and usually includes:¹²⁹

- the contact numbers for a family violence service;
- other emergency contact numbers, including police and crisis services;
- security arrangements at the patient's/client's address, whether that is the family home or another location ;
- the identification of a safe place to go if in danger, and how the patient/client (and children) will get to that location;
- the identification of a relative, friend or neighbour as the emergency support person who can assist in an emergency;
- the identification of a way to contact the emergency support person and a plan to get to a safe place;
- quick access to cash and important documents.

There may be some circumstances where developing a safety plan with a patient/client is inappropriate because: (i) the healthcare professional believes the patient/client is at extreme risk but unwilling to take action and (ii) a child's safety or wellbeing is at risk. In these situations, you may be required to report to other agencies/services – this is discussed in greater detail below.

DOCUMENTATION

In assessing the risk of a patient/client, the healthcare professional must document all key information that has been gathered and used in the risk assessment. This includes the following.¹²⁸⁻¹³⁰

- **Patient/client (victim) details:** name; address; contact details; date of birth; country of birth; language spoken at home; if an interpreter is required; Aboriginal and/or Torres Strait Islander; disability; relationship to perpetrator; if the perpetrator lives with the patient/client; if children are present; income source; visa category; carer; any additional needs.
- **Perpetrator details:** name; address; contact details; date of birth; country of birth; language spoken at home; if an interpreter is required; Aboriginal and/or Torres Strait Islander; disability.
- **Child / dependent details:** name; address; contact details; date of birth; country of birth; Aboriginal and/or Torres Strait Islander; relationship to perpetrator; concerns issues for child (Child Protection Involvement, Family Court Order).
- **Presence of risk factors as related to victim:** pregnancy/new birth; mental health issues; drug or alcohol misuse; suicidal ideas or attempts to commit suicide; isolation.
- **Presence of risk factors as related to perpetrator:** use of weapons in most recent event; access to weapons; harmed or threatened to harm victim; raped or sexually assaulted victim; attempt to strangle victim; attempt to kill victim; harmed or threatened to harm or kill children; harmed or threatened to harm or kill other family members; harmed or threatened to harm or kill pets; threatened or attempted to commit suicide; stalking the victim; controlling behaviour; unemployment; mental health issue; drug or alcohol misuse; history of violence.
- **Relationship dynamics:** recent separation or divorce; increase in severity and/or frequency of violence; financial difficulties.
- **Immediate safety requirements of the patient/client, their children and/or family members**
- **Safety planning requirements**
- **Any other information:** such as requirements for accommodation; history of contact with legal system; requirements for information about emergency contacts.

Examples of how to document assessed risk can be found in the Victorian and Western Australian Family Violence Common Risk Assessment and Risk Management Frameworks.

REPORTING PROCESSES

Depending on the circumstances of the patient/client and the legal requirements of the state/territory, the healthcare professional may need to report the level of risk posed to the patient/client along with documentation to external agencies/services. For instance, in situations where a patient/client is at extreme risk, you are required to refer to Police; similarly, if a child's safety and wellbeing are at risk, you are required to refer to Child Protection. (More details about legal requirements for reporting family violence will be included in Module 5: Management and referral pathways).

MODULE 4: RESPONDING WELL

SYNOPSIS

Module 4 provides an outline of how healthcare professionals can engage in appropriate ways of responding to patients/clients who are victims of family violence. Learners will be encouraged to reflect on the barriers they may face when asking about violence, and the expectations, needs and interests of patients/clients who do disclose. The module also covers the personal, professional and organisational barriers healthcare professionals may face in responding to family violence. Lastly, learners will explore how to 'respond well' in the context of family violence by exploring the concept of trauma informed care. This will be complemented by video clips of 'best practice encounters' between a patient and professional.

LEARNING OBJECTIVES

On completion of this module, and with further reading, you, the learner, should be able to:

1. Describe key barriers patients/clients can face when disclosing violence;
2. Recognise the expectations, needs and interests of patients/clients who disclose violence to their healthcare professional(s);
3. Describe appropriate ways of responding to patients/clients as victims;
4. Identify the professional and personal barriers that can interfere in appropriately responding to disclosures of violence and reflect on how these may create challenges in your future practice as a healthcare professional;
5. Describe the importance of trauma-informed care in the context of family violence and how it applies in practice;
6. Examine best practice encounters of patients/clients with healthcare professionals.

RESPONDING TO DISCLOSURES OF VIOLENCE

Responding to disclosures of violence from patients/clients can be challenging. It can be difficult to know how to best approach the subject of violence with someone who you suspect is experiencing violence (but may be reluctant to disclose). It is also difficult to gauge how to talk with a patient/client who has disclosed violence.

Providing a safe, non-judgemental setting which is respectful and sensitive to the patient/client, their feelings and their experiences is paramount in ensuring an appropriate environment for patients/clients to disclose violence.¹²⁶

Barriers to disclosure

It is important to realise that some patients/clients may not want to disclose violence. Research suggests that there are a number of reasons why a person may not want to talk about it. As a result, they face various **barriers to disclosing violence** and seeking help. Barriers to disclosing violence can be broadly categorised as **internal** and **external barriers**¹³¹⁻¹³⁵ – see Table 1.

Table 1: Internal and external barriers to disclosing violence

<i>Internal barriers:</i> <i>The way in which individuals who are experiencing violence internalise this violence</i>	<i>External barriers:</i> <i>Expected or actual responses from informal and formal supports to disclosures of violence</i>
<ul style="list-style-type: none"> • Feelings of shame¹³⁴ 	<ul style="list-style-type: none"> • Fear of stigmatisation from others¹³⁵
<ul style="list-style-type: none"> • Self-blame¹³² 	<ul style="list-style-type: none"> • Fear that others will not believe them¹³³
<ul style="list-style-type: none"> • Feelings of responsibility¹³² 	<ul style="list-style-type: none"> • Belief that they will be judged or criticised¹³⁴
<ul style="list-style-type: none"> • Shame of marital or relationship failure¹³² 	<ul style="list-style-type: none"> • Belief that no help is available or is too difficult/confusing to use¹³¹
<ul style="list-style-type: none"> • Belief that family violence is a ‘private matter’^{131; 132} 	<ul style="list-style-type: none"> • Cultural stigmatisation of family violence in the community - judgemental, punitive and victim-blaming attitudes¹³⁵
	<ul style="list-style-type: none"> • Prevented or blocked by their partner and/or family member(s)’ violence¹³⁴
	<ul style="list-style-type: none"> • Fear of retaliatory violence¹³⁶

Respecting barriers

Barriers to disclosing violence, and limits to seeking help, are often more pronounced amongst marginalised or vulnerable communities. As discussed in Module 2, those more at risk of experiencing family violence include women with a disability, women living in rural communities, women from culturally and linguistically diverse backgrounds, individuals from Indigenous communities, young women, and children; and the circumstances and experiences of people in these particular groups can mean there are even greater difficulties in disclosing violence and seeking help.

If you suspect that a patient/client is experiencing family violence, but does not want to disclose it upon careful questioning, you **must respect** this. The patient/client might be experiencing family violence but they may not be ready to talk, feel uncomfortable talking about it, or be experiencing any number of the barriers described above. Regardless, the patient/client should be thanked for answering any questions you have asked and informed that help is available should they require it.¹²⁸

Responding to disclosures of violence

Given the challenges facing patients/clients in disclosing violence, it is important to be mindful that it must take a lot of strength and courage to tell someone about the violence and/or to seek help. It may even be the first time the patient/client has disclosed the violence and spoken about it to anyone. Therefore, taking a respectful and sensitive approach when discussing violence with a patient/client who has disclosed their experience is paramount. Listening, believing, and validating the feelings of the patient/client are key elements of such an approach.

What to do:

- **Listen**

Being listened to and provided with an opportunity to speak about their experience can be empowering for someone who has experienced family violence.¹²⁵

- **Communicate belief**

Communicating belief is important in validating the patient's/client's experience of violence. Statements such as "*That must have been very frightening for you*" communicates to the patient/client that you believe, and understand, what they have told you about their experience of violence.¹²⁵

- **Validate the decision to disclose**

As described above, there are numerous barriers a patient/client may face in making the decision to disclose violence and seek help. It is important to acknowledge the difficulties and challenges they have overcome in telling you about their experience of violence by validating their decision to disclose. Statements such as "*It must have been difficult for*

you to talk about this”, and *“I am glad you were able to tell me about this”*, are important in doing so.¹²⁵

- **Emphasise that the violence is unacceptable**

Reinforce to the patient./client that the violence they have experienced is unacceptable and is not their fault. Many people find it difficult to disclose violence because they fear judgement, criticism and blame from others. Thus it is significant to emphasise the unacceptability of violence by, for example, telling the patient/client that they do not deserve to be treated in such a way.¹²⁵

- **Offer assistance and help**

In responding to disclosures of family violence, it is important to inform patients/clients of options for help. You can inform patients/clients that there are a range of different services for people who have experienced family violence, which can be followed up by asking if they would like your help.

What not to do:

Avoid placing blame or responsibility on the individual for the violence. Likewise, avoid questioning the person’s choices or actions in light of their experience of violence. Unacceptable questions to ask someone who has disclosed violence to you include:¹²⁵

“What could you have done to avoid the situation?”

“Why did he/she hit you?”

“Why do you stay with a person like that?”

What to expect from someone who discloses family violence

A disclosure of violence from a patient/client does not always mean that they are willing to accept your offer for help and assistance. You must respect the patient’s/client’s decision. However, there are a number of things you can do if they indicate they do not want your assistance, such as:¹²⁸

- provide them with contact details for a specialist family violence service;
- consider discussing the idea of safety planning;

- try to arrange ongoing opportunities to monitor and discuss violence – perhaps through future appointments.

PATIENT/CLIENT WANTS AND NEEDS

Considering patient/client wants and needs is important in responding well to disclosures and suspected cases of, family violence. Research tells us the kinds of responses patients/clients expect and desire from their healthcare professional(s) include a number of things.

- **Safe and supportive environment**

Women who have experienced family violence emphasise the importance of the healthcare professional asking about violence in a safe and supportive atmosphere.¹³⁷

- **Strong patient/client-professional relationships built on trust**

Women emphasised that healthcare professionals need to build trust, by establishing a good patient/client-professional relationship, before asking about family violence.¹³⁷

- **Listening**

Women who have experienced family violence want healthcare professionals to have ample time to discuss violence and to listen.^{126; 137}

- **Validation**

Women who have experience family violence report that validation from a healthcare professional (indicating that they are not to blame for the violence, that the behaviour is wrong, and that they did not deserve it) is significant in providing relief and comfort. It also helps initiate the process of seeking help.¹³⁸

- **Emotional and material support regardless of disclosure**

Women who have experienced family violence expect healthcare professionals to be thorough and competent, and provide emotional and material support.¹³⁷

Understanding women's 'readiness' to disclose violence and seek help is important to the way in which healthcare professionals must respond to family violence. Women want to learn about their options, and the sources of support available to them. However, healthcare professionals must understand that this does not always mean the patient/client is ready or comfortable discussing their experience of violence.¹³⁹

- **Respecting autonomy**

Women who have experience family violence stress the importance of healthcare professionals respecting their autonomy by allowing them to make their own choices, and gain a sense of control over their life.^{137; 139} In respecting women's decisions, healthcare professionals must recognise that women's choices to seek help may be compromised by coexisting factors, concerns or issues.

The kinds of responses patients/clients receive from healthcare professionals in relation to disclosures of family violence (or suspected family violence) can have significant impacts on their willingness to discuss violence, their experiences of violence, help-seeking, and emotional wellbeing. Research tells us that, when patients/clients do not receive appropriate, expected or desired responses it can result in the following.

- **Unwillingness to disclose violence**

Women consider the lack of time afforded to them, along with disinterest from a healthcare professional, as key barriers to disclosing violence.¹³⁷ Other barriers affecting women's willingness to disclose violence to the healthcare professional(s) include a lack of trust, and the absence of a positive patient/client-professional relationship.^{126; 137}

- **Limited help-seeking and/or avenues for help**

Women allude to the fact that a lack of collaboration between healthcare professionals and community resources (i.e., poor referral systems and few options for help provided) place limits on further help-seeking and/or the pursuit of other avenues of support.¹³⁷

- **Feelings of self-blame, shame and responsibility**

Patients/clients who have experienced family violence describe inappropriate responses (for example, focusing on the physical aspects of violence, and a poor understanding of family violence) can lead to feelings of shame, isolation and guilt.¹⁴⁰

Note: the response options for patients/clients who have disclosed family violence will be discussed in Module 5: Management and referral pathways.

WORKING WITH PERPETRATORS

As a primary healthcare professional, you are likely to come across not only cases in which a patient/client has experienced family violence, but also circumstances where a patient/client is, or has been, violent toward family member(s). For example:

- a patient/client who is violent toward family member(s) may disclose this violence to you;
- you may suspect that a patient/client is perpetrating family violence;
- you may see both the perpetrator and the victim(s) as patient/clients and the victim(s) may disclose violence to you.

Responding to perpetrators

The following strategies provide an overview of how to best respond to perpetrators of family violence in these situations.

- **Information from the victim must be kept confidential**

If you are seeing both the perpetrators and the victim(s) as patients/clients and the victim discloses violence, it is important to keep this information confidential. Relaying information to the perpetrator could raise issues of safety for the victim and place him/her in danger. In circumstances where a patient/client asks you to speak with the perpetrator about his/her violence, it may be acceptable to do so; however, it is necessary to explore the consequences of doing so with the patient/client. You could discuss with the patient/client how the perpetrator will respond to his/her disclosure of violence, for example:¹⁴¹

- Is he/she in danger?
- Will he/she retaliate?
- Will he/she be safe if I discuss the topic directly with the perpetrator?

- **Discussions with the perpetrator should not be done in the presence of the victim**

When you wish to discuss violence with a perpetrator, it is important that this is done privately. Issues of privacy and confidentiality are relevant in the healthcare setting; however, you must also consider the implications of engaging in a discussion about family violence with the perpetrator in the presence of the victim(s) – namely victims’ feelings of safety and danger.

- **Validate the decision to disclose**

In responding to disclosures of violence from perpetrators, acknowledging the existence of violence, and validating their decision to disclose, is necessary. This can be achieved, for example, by stating:¹²⁵

“That was brave of you to tell me. Violent behaviour towards your partner and other family members is not acceptable. It not only affects your partner but your children as well. Did you know that there are services that may be able to assist you?”

- **Describe family violence as a healthcare issue**

Family violence is a healthcare issue not only for those experiencing it, but also for perpetrators. Therefore, when discussing violence it is important to make reference to the healthcare needs of the perpetrator.¹⁴¹

- **Focus on descriptions of the perpetrator’s behaviour**

You should use descriptions of the behaviours expressed by the perpetrators, rather than ‘family violence’. For example, using phrases such as *“When you hit your partner...”* instead of *“When you abused your partner....”*.¹⁴¹ Terms such as ‘batterer’ and ‘abuser’ should also be avoided as the patient/client may be then unwilling to further disclose violence.¹⁴¹

- **Use a calm and direct approach**

A direct, matter-of-fact, and calm approach should be used when discussing the topic of violence. Such an approach considers the implications of your responses for both the perpetrator and victim(s); for example, expressing anger about a disclosure of violence may translate to retaliation against the victim.¹⁴¹ If there is a disclosure of violence, you can ask specific questions in a calm, yet direct, manner. For example:¹²⁵

“Some men who are stressed like you are, hurt the people they love. Is this how you are feeling? Is this happening to you? Did you know that there are services from which you can get assistance?”

However, if you suspect violence is occurring, but further information is needed, ask broad questions such as:¹²⁵

“How are things at home?”

In both of these circumstances, if the perpetrator is unwilling to talk about it, it is important not to force the issue.

Response options for perpetrators

Key avenues of support for perpetrators of family violence typically include:

- (i) men's referral services: which include counseling, information and referral services for men who are violent towards family members
- (ii) behaviour change programs; which include group programs to help perpetrators understand and address their violent behaviour.

OVERCOMING BARRIERS IN RESPONDING TO VIOLENCE

At some point, as a healthcare professional you are likely to experience barriers to working with, and responding to, patients/clients who have disclosed violence. These barriers can include:¹⁴²

- time constraints;
- limited patient/client contact;
- lack of comfort;
- feeling helpless/powerless;
- distress and trauma;
- fear of offending the patient/client
- feeling angry.

All of these are likely emotions and/or practical constraints to be expected from working with patients/clients who have experienced violence or perpetrated violence. In addressing practical and personal challenges, there are various strategies to consider at an individual and professional level to improve responses to disclosures of family violence.

- Using **alternate means of providing information about support options** could alleviate some of the constraints that limited patient/client contact time pressures may place on responding to disclosures of violence. These could include having standard appointment cards with relevant services listed on the back, placing pamphlets or leaflets about family violence in the waiting room, or developing a list of emergency numbers and family violence specialist services. Within the time constraints, these

measures may be useful in providing detailed information that perhaps cannot be explored in-depth during the visit or consultation.¹²⁶

- Getting to **know as much as you can about family violence** services and the help available; yet recognising that you do not have to feel like you know everything.¹⁴³
- Reflecting on **your role as a healthcare professional**. Understanding it is not your role to ‘fix’ the issue for your patient/client; rather it is your role to provide a safe and supportive environment for your patients/clients to talk about the issue of violence should they wish, and provide appropriate avenues of support and referral.¹⁴³
- Consider **external avenues for support** to deal with traumatic and distressing feelings regarding family violence. Examples include counselling, contacting an advisory service appropriate to your area, and/or connecting with organisational support networks.¹²⁶ (This will be discussed in more detail in Module 6: Safety, reflection and self care).

TRAUMA-INFORMED CARE

Trauma refers to “an experience of real or perceived threat to life, limb and one’s sense of self”.^{144(p1)} It can occur as a result of single or repeated adverse event(s) that threaten a person’s ability to cope with their experience. In the context of family violence, trauma can be much more **damaging** – in particular, because traumatic stressors in these circumstances are interpersonal in nature, perpetrated in relationships of care, and often premeditated or planned. Therefore, domestic violence represents a **complex form of trauma**.¹⁴⁴

Trauma survivors have complex needs as trauma can result in significant impacts on health. In particular, traumatic experiences are associated with substance abuse as individuals use alcohol and/or drugs to cope with complex trauma, and psychiatric disorders.

Trauma-informed care and practice is a framework that:¹⁴⁴

- is grounded in an understanding of, and responsiveness to, the impact of trauma;
- emphasises physical, psychological and emotional safety for providers and survivors;
- creates opportunities for survivors to rebuild a sense of control and empowerment.

Providing trauma-informed care for survivors of family violence is important for a number of reasons. If they or their community have had prior negative experiences, trauma survivors can experience services as unsafe, disempowering and invalidating. In the context of family

violence, adopting a trauma-informed care approach means practice is informed by an understanding of the impact of people's experiences of violence (past and present), their reactions, and methods for coping.¹⁴⁴

Taking this approach means moving away from the question of '*What happened to you?*' to '*What might have happened to cause this person to behave this way?*'. In doing so, healthcare professionals can accommodate the needs and sensitivities of patients/clients, minimising the potential for re-traumatisation and harm as a result of encounters with the healthcare system.¹⁴⁴

Trauma-informed care is guided by the core principles of **safety, trustworthiness, choice, collaboration, and empowerment**. Guided by these principles, trauma-informed care respects individual's choices, values and culture. Remember the following:¹⁴⁴

- **Safety** is a key component of providing trauma care and practice. It involves an understanding that many trauma survivors struggle to feel safe – some may have never felt safe in their relationships and/or homes. Therefore, it is important that healthcare professionals and practitioners prioritise the patient's/client's understanding and feelings of safety.
- Recognising the impacts of violence on those who have experienced it at the hands of partners and/or family members means understanding that patients/clients may face difficulties in developing **trust** in others. In providing trauma-informed care, healthcare professionals must recognise the dynamics of power characterise violent relationships, and thus **facilitate trust** through the sharing of power, information and mutually agreed boundaries.
- Many individuals can feel out of control in the context of violent intimate and/or family relationships – relationship that are often chaotic and unpredictable. Patients/clients can present to healthcare professionals at times of great distress and vulnerability, and can be triggered by, and face difficulties managing, their emotions. Through **choice and collaboration**, patients/clients may begin to feel a sense of predictability and control which can enable them to better cope with emotions.

For those who have experienced family violence, the trauma occurred in the context of relationships, therefore, the kinds of relationships formed and encountered in the healthcare

setting are significant. Taking a trauma-informed care approach can facilitate positive relational experiences for patients/clients, which can provide opportunities for healing.¹⁴⁴

BEST PRACTICE

The following videos/clips feature best practice encounters between patients/clients who have experienced family violence and healthcare professionals.

Go to www.pactsproject.org and click on the 'Videos' tab

to find the best practice clip for your profession.

After you have viewed the best practice clips, reflect on the following.

Reflection

- ❖ What did patients/clients present with, or how did they describe their problem?
- ❖ Under what circumstances did patients/clients present to healthcare professionals?
- ❖ What types of interactions did healthcare professionals have with patients/clients?
- ❖ How did healthcare professionals respond?
- ❖ Describe how or why the response from healthcare professionals is considered 'best practice'.

MODULE 5: MANAGEMENT AND REFERRAL PATHWAYS

SYNOPSIS

Module 5 encourages students to reflect on the importance of being part of a team in responding to and managing family violence, and act as an informed and effective communicator. The module content also highlights key medical, legal and community referral pathways in discussing the healthcare professional's role as part of a multidisciplinary and coordinated team. At a community level, this module discusses the role healthcare professionals play in engaging with communities to advocate for the prevention and intervention of family violence.

LEARNING OBJECTIVES

On completion of this module, and with further reading, you, the learner, should be able to:

1. Recognise the importance of being a part of an informed primary health care team that is knowledgeable about, and aware of, family violence;
2. Identify the strategies you could employ in your future practice as a healthcare professional to effectively communicate with other healthcare professionals and patients/clients;
3. Describe and identify medical, legal and community referral options and pathways for patients/clients who have experienced family violence;
4. Describe the role primary health care professionals can play in engaging with the community to promote and advocate for improved prevention and intervention strategies for family violence.

AN INFORMED TEAM

An informed team involves awareness of all individuals at all levels at a clinic, practice or organisation about family violence. Evidence suggests low levels of knowledge, awareness and training about family violence often resulting in misperceptions and prejudicial attitudes among primary health care professionals and administrative staff.^{145; 146} Knowledge about

family violence across the healthcare professionals and staff at a clinic, practice or organisation, along with an acknowledgement of a patient's/clients personal experience of violence, can be a 'powerful intervention' that can enable the patient/client to move toward safety.¹⁴⁷

Engaging in strategies at an organisational level (such as participating in training programs about family violence) for all staff involved in primary health care can be effective in increasing awareness, while providing a foundation for improved management and referral in cases of family violence.¹⁴⁷

COMMUNICATING WITH OTHERS

Communication between patients/clients and other healthcare professionals is an important aspect of managing and responding to family violence. It is not only *what* you communicate to others (i.e., what you actually say), but also *how* you communicate with others (i.e., how information is presented and exchanged).

Communicating with other healthcare professionals

In healthcare, effective communication involves a shared understanding of a situation, and often a shared course of action. This will require the use of a wide range of skills including negotiating, listening, goal setting, and assertiveness; skills which need to be applied in a range of contexts and situations. Effective communication also requires healthcare professionals to provide, and have access to, adequate and timely information. To facilitate the 'flow' of communication between healthcare professionals, the information exchanged about patients/clients should be:¹⁴⁸

- **Complete:** The information should answer all questions asked to the satisfaction of those receiving the information.
- **Concise:** Use relevant statements and avoid unnecessary repetition.
- **Concrete:** Words and phrases used should be specific and considered. Give accurate facts and figures.
- **Clear:** Use short, familiar words to construct effective and understandable messages.
- **Appropriate:** Ensure the level of language is appropriate for the context. Avoid jargon and discriminatory or patronising expressions.

In the context of family violence, effective communication between healthcare professionals is important in facilitating access to supports and resources outside of your professional area. Given the range of health impacts associated with family violence, the sharing of information (that is appropriate, accurate and complete) with other healthcare professionals is integral in ensuring that patients/clients who have experienced family violence (and are likely to be facing a variety of issues) receive an informed, co-ordinated response from healthcare professionals.

Communicating with patients/clients who have experienced family violence

The communication strategies used by healthcare professionals when speaking with patients/clients can impact upon the information shared and the willingness to disclose family violence. A study by Rhodes et al (2007) on communication about family violence between emergency providers and female patients found:¹⁴⁹

- patient disclosure was more likely when the healthcare providers created open-ended opportunities for discussion, were generally responsive, and expressed empathy when a patient talked about a psychosocial issue (for example, stress);
- the creation of meaningful (and sensitive) discussions about family violence is important in facilitating disclosures of violence from patients/clients.

Consider the possible challenges in discussing family violence with patients/clients who may experience communication barriers. Think about, for example, how patients/clients who are culturally and linguistically diverse may experience significant challenges in discussing and disclosing violence. In this situation, patients/clients may want to disclose violence but face the barrier of language or the presence of a family member or child acting as an interpreter – these are hurdles which may make them unwilling to disclose.¹⁵⁰

MANAGEMENT AND REFERRAL OPTIONS

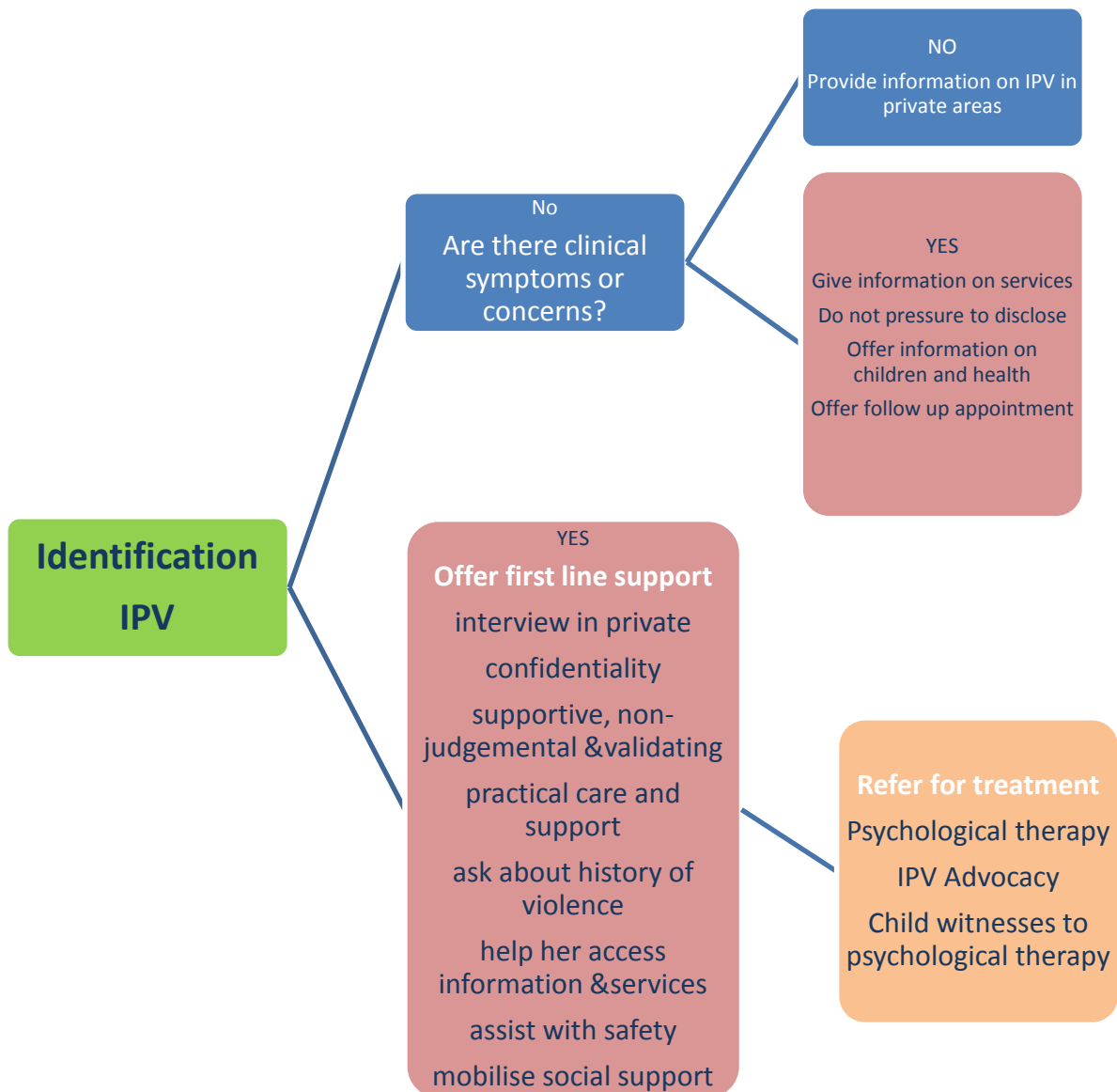
Managing family violence is largely dependent on the patient's/client's circumstances and the decisions they make. For instance, some patients/clients may disclose violence to you but might not want any further assistance; others may tell you about the violence and want your help in facilitating access to other resources and supports. It is important to respect the decisions patients/clients make when providing ongoing care in your role as a healthcare professional.

Due to the complex nature of family violence, no single professional or organisation is likely to have the capacity to provide all the support needed for the diverse issues facing a patient/client who has experienced violence. As discussed in Module 1, the impacts of family violence can be wide-ranging relating to physical health, psychological and emotional wellbeing, economic disadvantage, safety concerns, child care issues and so on.

In recognising the array of issues faced by those who have been a victim of family violence, we can begin to see how, as a healthcare professional, it is vital to identify the resources and referrals available from medical, legal and community fields that can assist in adequately meeting the needs of patients/clients. This can be achieved through **multidisciplinary collaboration** and the development and maintenance of a **network of resources and referral contacts**.

World Health Organisation Guidelines

The World Health Organisation Guidelines for Healthcare Providers responding to Intimate Partner Violence are summarised in the image below.



Adapted from: World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, Switzerland: World Health Organization.

Multidisciplinary collaboration

Working collaboratively (or as it is also known, **multidisciplinary collaboration**) in the context of responding to family violence refers to working in a team of other healthcare professionals (from your area and the healthcare system more generally), as well as with specialist family violence service providers, family violence providers, and the legal system. Initial collaboration between healthcare professionals and family violence services could be achieved in a variety of ways, such as working with a local family violence group, a family violence program or a family violence resource centre. You could also consider networking with other colleagues (within, and outside of, your clinic, practice or organisation) who are also concerned about family violence.¹⁵¹

A multidisciplinary approach to the complexity of issues patients/clients who have experienced (or perpetrated) family violence face means that we can go beyond simply addressing an individual's needs from a medical or healthcare perspective. For example, addressing the issue of substance abuse without recognising the relationship to and the impact of violence fails to provide the patient/client with appropriate resources and services. Working as part of a multidisciplinary team allows us, as healthcare professionals, to expand beyond the boundaries typically set by our disciplines and areas of speciality in responding well to family violence.

Developing a referral and resource network

As a healthcare professional, you will need to know about the resources and service options available to your patients/clients. This includes being aware of:¹⁵¹

- legal protections and options available to patient/clients, as well as what they can expect when contacting the police and from further contact with the criminal justice system;
- counselling and support groups for individuals who are victims and/or perpetrators of family violence;
- substance abuse and mental health programs;
- childcare services.

Referral options

The referrals you make for patients/clients who have disclosed family violence depend on the patient's/client's circumstances; it is important to be mindful of this when suggesting or making referrals to services. When assessing the safety of a patient/client, the referral options can be categorised into four key pathways.^{66(p60)}

Pathway 1: If the patient/client is in immediate danger and IS willing to receive assistance, you can refer to Police and/or Specialist Family Violence Service for further assessment.

Pathway 2: If the patient/client is NOT in immediate danger and IS willing to receive assistance, you can refer to a Specialist Family Violence Service for further assessment.

Pathway 3: If the patient/client is in immediate danger but is NOT willing to receive assistance, you can consider referral to Police.

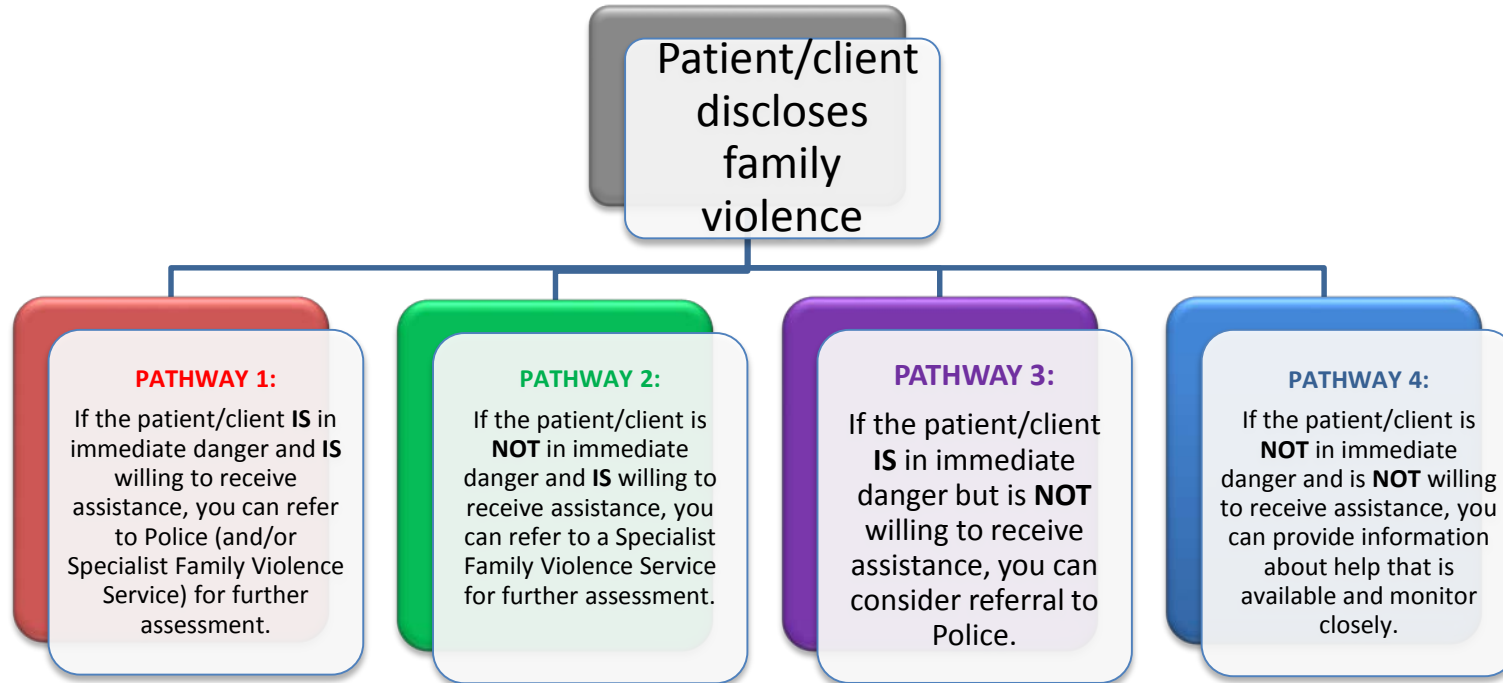
Pathway 4: If the patient/client is NOT in immediate danger, and is NOT willing to receive assistance, you can provide information about help that is available, and monitor closely.

A specialist family violence service provides a holistic response to individuals who have experienced family violence, including practical, legal, financial, and emotional support. In addition to specialist family violence services, other services that might be points of referral include:¹²⁸

- outreach family violence services;
- emergency accommodation and refuges;
- counselling programs;
- Family Relationship Centres;
- drug and alcohol services;
- mental health services.

Note: A list of resources and referral options in each Australian state can be found in Appendix A.

Response options for patients/clients experiencing family violence

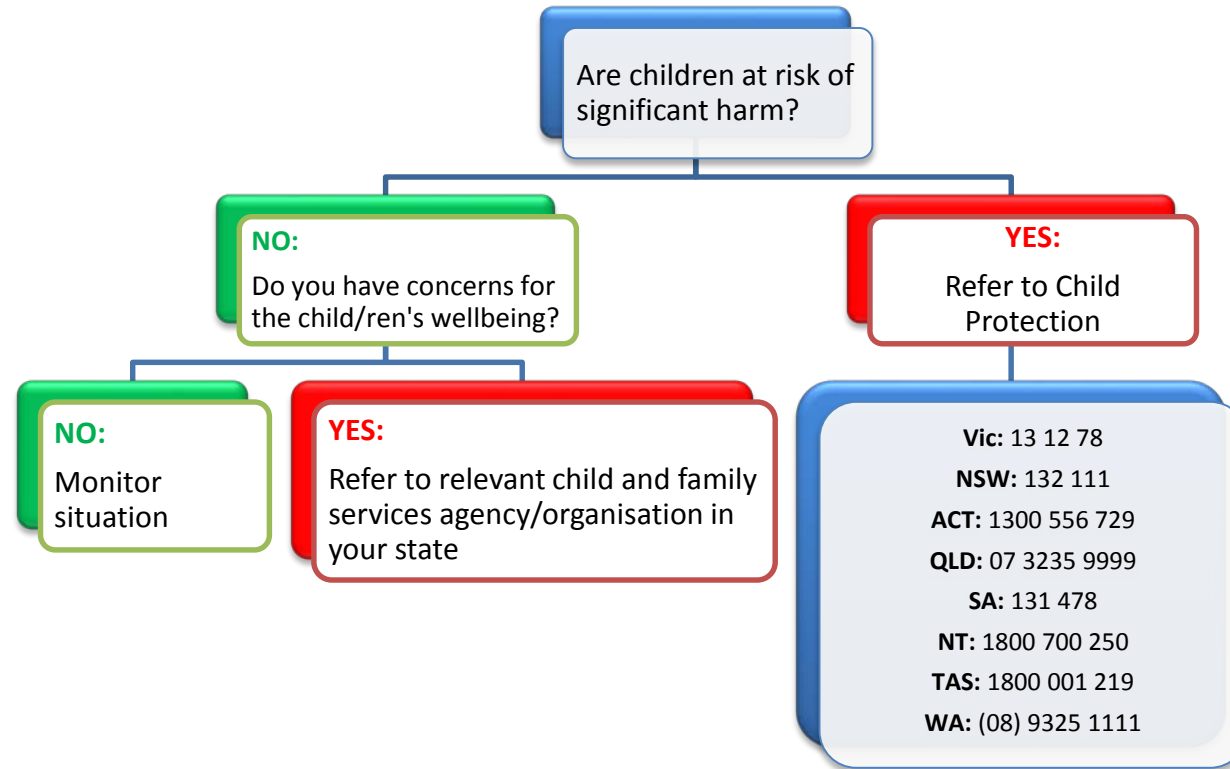


Adapted from: Department of Human Services Victoria. (2012). *Family violence: Risk assessment and risk management framework and practice guides 1-3*. Melbourne, Australia: Department of Human Services, State Government of Victoria

<p>Police and specialist family violence officers (Pathways 1 and/or 3)</p>	<p>Specialist family violence services (Pathways 1 and/or 2)</p>	<p>Other services (Pathway 4)</p>
<ul style="list-style-type: none"> •Vic: Family violence liaison officer (call local 24hr police station) or Family violence manager: Central 03 9247 5688; West 03 5223 7816; North West 03 9302 8268; North East 03 9457 4444; South East 03 9767 7621 • NSW: Call local police and ask for Domestic Violence Liaison Office (DVLO) •ACT: Victim Liaison Officer 02 6245 7441 •QLD: Call local police and ask for District Domestic Violence Co-ordinator •SA: Family Violence Investigation Teams – Eastern Adelaide 08 8172 5890; Elizabeth 08 8207 9381; Holden Hill 08 8207 6413; Western Adelaide 08 8207 6413; South Coast 08 8392 9172; Sturt 08 8207 4801 •NT: Call local police station •TAS: Family Violence Response and Referral Line 1800 633 937 •WA: Metropolitan Family Protection Units - Central Metropolitan 08 9223 3171; Sth East Metropolitan 08 9351 1400; Sth Metropolitan 08 9430 1264; Nth West Metropolitan 08 9400 0936; East Metropolitan 08 9250 0374;; Peel 08 9581 0278; West Metropolitan 08 9435 9133. 	<ul style="list-style-type: none"> •Vic: Women’s Domestic Violence Crisis Service of Victoria 03 9322-3555 (24 hours) or 1800 015 188 (country toll free) •NSW: NSW DV Line 1800 656 463 (24 hour); NSW Women’s refuges 1800 656 463 (24 hour) •ACT: DV Crisis Service ACT 02 6280 0900; Canberra Emergency Accommodation Service Crisis Line 02 6230 1486 (business hours) •QLD: DV Connect 07 3008 8294 or 1800 811 811 (24 hours) • SA: DV Crisis service 1300 782 200 (24 hours); DV Helpline 1800 800 098 (24 hours) •NT: DV Crisis Line 1800 019 116 (24 hour domestic violence counselling); DV Counselling Service 08 8945 6200 (9am-5pm weekdays) •TAS: DV Crisis Service 1800 633 937 (Mon-Fri 9am-midnight; weekends 4pm-midnight) •WA: Women’s DV Helpline 08 9223 1111 (24 hours) or 1800 199 008 (24 hours); Crisis care unit 08 9325 1111 or 1800 199 008 <p>•See appendix for full list of specialist family violence services.</p>	<ul style="list-style-type: none"> •Vic: Domestic Violence Resource Centre 03 9486 9866; Women's Information and Referral Exchange 1300 134 1300 •NSW: DV Legal Service 02 8745 6900; DV Advocacy Service 02 8745 6999 or 1800 810 784 •ACT: Women’s Information and Referral Centre 02 6205 1075; Family Relationship Centre Canberra 02 6122 7190 •QLD: Women’s Legal Service 1800 677 278; Brisbane Domestic Violence Resource Centre 07 3217 2544 •SA: Women’s Information Service of SA 08 8303 0590 or 1800 188 158; •NT: Women's Information Service (08) 8951 5174 (Alice Springs) or 1800 508 051; Domestic Violence Legal Help (Alice Springs) 08 8981 9726 •TAS: Yemaya: Women’s Support Service 03 6334 0305; Women's Legal Service 1800 682 468 or 03 6224 0974 •WA: Women’s Information Service 1800 199 174; Legal Aid WA 1300 650 579 <p>•See appendix for a range of other services.</p>

Response options for children experiencing family violence

When considering how to best respond to a patient/client who is experiencing family violence, it is also important to consider whether children are also involved. If children are involved, the following response options outline how you can respond in these circumstances.



Adapted from: Department of Human Services Victoria. (2012). *Family violence: Risk assessment and risk management framework and practice guides 1-3*. Melbourne, Australia: Department of Human Services, State Government of Victoria

Specialist children's services and referral points

- **Australia-wide:** Child Abuse Prevention Service 1800 688 009; Child Wise - National Child Abuse Prevention Helpline 1800 99 10 99
- **Vic:** ChildFIRST - For a list of ChildFIRST services in local councils: <http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/family-and-parenting-support/family-services/child-first-child-and-family-information,-referral-and-support-teams>
- **NSW:** Kidsafe 02 9845 0890; YouthLine (02) 9633 3666
- **ACT:** Australian Childhood Foundation (02) 6248 1701
- **QLD:** Bravehearts 07 5552 3000 or 1800 272 831
- **SA:** Australian Childhood Foundation 1800 176 453
- **TAS:** Australian Childhood Foundation (03) 6232 0222
- **WA:** Australian Childhood Foundation 1800 176 453

LEGAL REQUIREMENTS

One way that police may become alerted to family violence is through reports made by others, including neighbours and health professionals.¹⁵² While all Australian states and territories have provisions for mandatory reporting of child abuse and neglect, the Northern Territory is currently the only jurisdiction to have specific mandatory reporting laws for family violence.

In the Northern Territory, the Domestic and Family Violence Amendment Act 2009 states that any adult (not just those of certain professions) must report family violence if they believe on reasonable grounds that “another person has caused, or is likely to cause, harm to someone else (the victim) with whom the other person is in a domestic relationship; and/or the life or safety of another person is under serious or imminent threat because domestic violence has been, is being or is about to be committed”.¹⁵³

Harm is taken to be ‘physical harm’ that is ‘serious harm’¹⁵³. The definition of ‘physical harm’ is legislated under the Northern Territory’s Criminal Code to include “unconsciousness, pain, disfigurement, infection with a disease and any physical contact” that a person “might reasonably object to in the circumstances (whether or not the person was aware of it at the time)”.¹⁵⁴ ‘Serious harm’ is defined as “any harm (including the cumulative effect of more than one harm) that endangers, or is likely to endanger, a person’s life; or is or is likely to be significant and longstanding”.¹⁵⁴

In Tasmania, 2004 legislation proposed mandatory reporting requirements for prescribed persons to report family violence “if they believe or suspect on reasonable grounds that family violence involving the use of a weapon, sexual violence or physical violence, or where a child is affected, has occurred or is likely to occur.”¹⁵⁵ Although the legislation received Royal Assent,¹⁵² it has not actually been proclaimed or commenced.¹⁵⁵

Reporting of family violence when a child or young person is affected

Some jurisdictions (New South Wales, the Northern Territory, and Tasmania), through their child protection legislation, mandate the reporting of family violence by prescribed persons in circumstances where a child has been exposed to family violence.¹⁵⁶

In New South Wales, mandatory reporting includes circumstances where “a 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”.¹⁵⁷

In the Northern Territory, reportable harm to a child includes “exposure of the child to physical violence”, with the Care and Protection of Children Act 2007 giving the specific example of “a child witnessing violence between the child’s parents at home”.¹⁵⁸

In Tasmania, child abuse reporting includes mandatory reporting when a child is believed or suspected on reasonable grounds to be an ‘affected child’ within the meaning of the Family Violence Act 2004.¹⁵⁹ An affected child is “a child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence”.¹⁵⁵

Reporting of child abuse and neglect

In all Australian states and territories, legislation stipulates particular requirements for the reporting of child abuse and neglect. Legal obligations differ between jurisdictions according to the requirements of federal and state law.¹⁶⁰ The following table outlines the particular individuals that are legally required to report/notify authorities of child abuse and neglect.¹⁵⁶

Jurisdiction	Who is mandated to notify?
ACT	Doctors, dentists, nurses and midwives, teachers, police officers, school counsellors, child care providers, public servants relating to the health or wellbeing of children, young people or families, the public advocate, an official visitor, a person who (in the course of employment) has contact with or provides services to children, young people and their families and is prescribed by regulation.
NSW	Persons who deliver health care, welfare, education, children’s services, residential services or law enforcement wholly or partly to children. A person who holds a management position in an organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children’s services, residential services or law enforcement, wholly or partly to children.
NT	Anyone 18 years of age and older and registered health professionals.
QLD	An authorised officer, employee of the Department of Communities (Child Safety Services), person employed in a departmental care service or licensed care service under section 148 of the Child Protection Act 1999; a doctor or nurse; the Commissioner for Children and Young People.

Jurisdiction	Who is mandated to notify?
SA	Doctors, pharmacists, nurses, dentists, psychologists, police officers, community corrections officers, social workers, teachers, family day care providers, employees/volunteers in a government department, agency or instrumentality, or a local government or non-government agency that provides health, welfare, education, child care or residential services wholly or partly for children; ministers of religion (with the exception of disclosures made in the confessional); employees or volunteers in a religious or spiritual organisation.
TAS	Doctors, nurses, dentists, dental therapists or dental hygienists; registered psychologists; police officers; probation officers; principals and teachers in any educational institution; persons who provide child care or a child care service for fee or reward; persons concerned in the management of a child care service licensed under the Child Care Act 2001; any other person who is an employee of, for or in, or who is a volunteer in, a government agency that provides health, welfare, education, child care or residential services wholly or partly to children, and an organisation that receives any funding from the Crown for the provision of such services; and any other person of a class determined by the Minister by notice in the Gazette to be prescribed persons.
VIC	Police, doctors, nurses and teachers and principals of government and non-government schools.
WA	Court personnel, family counsellors, family dispute resolution practitioners, arbitrators or legal practitioners representing the child's interest; licensed providers of child care or outside school hours care services; doctors, nurses and midwives, teachers and police officers.
Adapted from: Australian Institute of Family Studies. (2014). Mandatory reporting of child abuse and neglect. Retrieved 25th July, 2015, from https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect	

The following table outlines the types of child abuse or harm legally required to be reported by those mandated to do so, and the state of mind (belief) about the occurrence of these.¹⁵⁶

Jurisdiction	State of mind	Extent of harm
ACT	Belief on reasonable grounds.	Not specified: "sexual abuse ... or non-accidental physical injury".
NSW	Suspects on reasonable grounds that a child is at risk of significant harm.	A child or young person "is at risk of significant harm if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of ... basic physical or psychological needs are not being met ... physical or sexual abuse or ill-treatment ... serious psychological harm".
NT	Belief on reasonable grounds.	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child.
QLD	Becomes aware, or reasonably suspects.	Significant detrimental effect on the child's physical, psychological or emotional wellbeing.
SA	Suspects on reasonable grounds.	Any sexual abuse; physical or psychological abuse or neglect to extent that the child "has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy".
TAS	Believes, or suspects, on reasonable grounds, or knows.	Any sexual abuse; physical or emotional injury or other abuse, or neglect, to extent that the child has suffered, or is likely to suffer, physical or psychological harm detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy.
VIC	Belief on reasonable grounds.	Child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type.
WA	Belief on reasonable grounds.	Not specified: any sexual abuse.
Australia	Suspects on reasonable grounds	Not specified: any assault or sexual assault; serious psychological harm; serious neglect.

From: Australian Institute of Family Studies. (2014). Mandatory reporting of child abuse and neglect. Retrieved 25th July, 2015, from <https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect>

LEGAL PROTECTIONS

Information in this section (pages 79-87) is current as of 30th June, 2015

Table 2: Summary of legal protections by Australian state

<i>State/Territory</i>	<i>Legal protection /order</i>
Victoria	Family Violence Safety Notice ¹⁶¹ Family Violence Intervention Order ¹⁶²
New South Wales	Apprehended Domestic Violence Order ¹⁶³
Australian Capital Territory	Domestic Violence Order ¹⁶⁴
Queensland	Domestic Violence Protection Order ¹⁶⁵
Northern Territory	Domestic Violence Order ¹⁶⁶
South Australia	Intervention Order ¹⁶⁷
Western Australia	Violence Restraining Order ¹⁶⁸
Tasmania	Restraint Order ^{169; 170}

Victoria

I. Family Violence Safety Notice¹⁶¹

A family violence safety notice aims to protect:¹⁶¹

- an affected family member to make sure they are safe from the respondent;
- a child who has heard, seen or been exposed to family violence in any way;
- the property of the affected family member.

Applying for a family violence safety notice

A police officer can apply for a family violence safety notice if they believe the respondent is an adult, and an affected family member needs protection until a family violence intervention order application can be heard in court.

A police officer can apply for a family violence safety notice by phone or fax while attending a family violence incident. A higher ranking officer must consider the application and agree that the family member needs protection before a safety notice can be issued.

A police officer can apply for a safety notice even if the affected family member does not want them to. It is made clear to the respondent that applying for a safety notice is a police decision.

Getting a family violence safety notice

Once a family violence safety notice is issued:¹⁶¹

- a police officer will serve a copy to the respondent and explain what the notice means;
- the affected family member will receive a copy;
- the notice is filed with the Magistrates' Court.

A family violence safety notice is considered:¹⁶¹

- an application by police for a family violence intervention order;
- a summons for the respondent to go to court.

How a safety notice works

A family violence safety notice has conditions to stop the respondent from using family violence. This may include a condition that the respondent must leave the family home. If these conditions are not met, the police can arrest the respondent.

II. Family Violence Intervention Order¹⁶²

A family violence intervention order is an order made under Victorian law to protect a family member from family violence. You can apply for a family violence intervention order at any Magistrates' Court in Victoria if you are over 18 years of age.

Family violence intervention orders can also protect children if they are included on your (parents') application. If they are not part of this application, an order can be applied for at the Children's Court for children aged between 14 and 18.

Applying for a family violence intervention order

The process of making an application for a family violence intervention order involves the following:¹⁶²

- **Obtaining legal advice:** Free legal advice and information about family violence can be obtained from Victoria Legal Aid.
- **Going to court:** A person must go to court and tell court staff that they want to apply for a family violence intervention order. It is a good idea to go to court with a friend or relative for support, and to take any evidence to support the need for a family violence intervention order.
- **Filling in an application form:** An application form can be obtained from the court counter or the Magistrates' Court website. It asks information about name and date of birth, information about the respondent, the relationship with the respondent, previous court orders and the respondent's behaviour.
- **Interview with a court registrar:** A court registrar will assist in making an application for a family violence intervention order and conduct an interview to gather details about what has happened. If the individual is in immediate need of protection, the court registrar can assist in getting an interim order until the final order is issued.
- **Getting a copy of the application and other court documents.**
- **Going back to court:** A date will be set for a court hearing where a magistrate listens to the application for a family violence intervention order.

New South Wales

I. Apprehended Domestic Violence Order (ADVO)¹⁶³

An Apprehended Violence Order is an order made by a court against a person who makes another person fear for their safety, to protect the person from further violence, intimidation or harassment. All Apprehended Violence Orders prohibit the person from assaulting, harassing, threatening, stalking, or intimidating you.

An ADVO is made when the people involved:¹⁶³

- are related;
- living together or in an intimate relationship; or
- have previously been in this situation.

In the case of an Aboriginal person or Torres Strait Islander, an ADVO can be made where the people involved are part of the kin or extended family of the other person.

An ADVO can also be made for people who are or have been in a dependent care arrangement with another person such as carers, or people living in a residential facility.

Applying for an ADVO

The police can make the application for an ADVO on a person's behalf. Alternatively, an application can be made at a local court. The application will tell the defendant (the person who is causing fears for your safety) the date and time they have to attend court. The application will be served on the defendant by police. An application for an ADVO may be refused if the court believes the application is frivolous or has no reasonable chance of success. The court may advise mediation.

Conditions of an ADVO

If an Order is made, three conditions will always be included which prohibit the following:¹⁶³

- assaulting, molesting, harassing, threatening or interfering with the Protected Person;
- intimidating the Protected Person; and
- stalking the Protected Person. (Anyone in a domestic relationship with the Protected Person is also protected by these conditions – this may include children.)

Other conditions that may be included prohibit:¹⁶³

- approaching the Protected Person;
- approaching or entering places where the Protected Person may live, work or go to;
- approaching the Protected Person, or places where the Protected Person may be, after drinking alcohol or taking illegal drugs;
- damaging property; and/or
- any other conditions as agreed by both parties or decided by the court.

Australian Capital Territory

I. Domestic Violence Order (DVO)¹⁶⁴

A DVO is made by the court to protect a person (the applicant) from future assaults, threats of violence, property damage, stalking, acts of indecency, harassment and offensive conduct

by another person (the respondent). A DVO orders the respondent not to engage in conduct that amounts to domestic or personal violence.

A person can apply for a DVO if they live with, are married to, are related by blood, or were in a domestic relationship with the respondent who has engaged in the following acts against the applicant:¹⁶⁴

- physical or personal injury;
- sexual assault;
- stalking or acts of indecency;
- damage to property;
- trespass or burglary;
- negligent, reckless or culpable driving;
- harassment or offensive conduct;
- violence directed at pets;
- threats of any of the above.

The order can also include the applicant's children.

Applying for a DVO

An application form for a DVO can be obtained from the Magistrates Court. Advice, information and assistance with the application can be sought from the Legal Aid Domestic Violence and Personal Protection Orders Unit located at the Court.

Queensland

I. Domestic Violence Protection Order¹⁶⁵

A person can apply for a domestic violence order if they are experiencing violence in a relationship including:¹⁶⁵

- an intimate personal relationship (married, de facto, registered relationship, engaged, couple);
- a family relationship (a parent, or former parent, of a child, or your relatives);
- an informal care relationship (where one person is dependent on the other person for help in an activity of daily living like dressing and cooking for them).

A domestic violence order places limits on the behaviour of the person who is being violent toward the respondent. Once an order has been made, it is illegal for them to breach the order and they cannot own a weapon or have a weapons licence.

Applying for a domestic violence protection order

A person can apply for a domestic violence order at a magistrate's court, or get a police officer, lawyer or someone trusted to apply. Legal advice should be sought before applying for a domestic violence order.

Northern Territory

I. Domestic Violence Order (DVO)¹⁶⁶

A DVO is made by the Magistrates Court, or in some cases the Police. The order aims to protect a person, their property and, sometimes, their children and other relatives from family violence. A DVO sets out rules and conditions that the defendant has to follow.

The type of DVO and the nature of conditions to be met will depend on the situation. Examples of conditions that may be specified in a DVO are as follows:^{166(p5)}

- The defendant must not contact or approach the applicant through text messages, email, letters, social media (e.g. Facebook), or through family members.
- The defendant must not contact or approach the applicant when he / she has been drinking alcohol or taking drugs.
- The defendant must not assault the applicant, but can still have contact.
- The defendant leaves the home. The court can order the return of personal property, or allow the defendant to attend the property for the sole purpose of collecting belongings.
- The defendant will attend counselling or rehabilitation if they agree.

Applying for a DVO

The following people can apply for a DVO:^{166(p5)}

- an adult or young person who is in a family relationship with the defendant;
- an adult acting on behalf and with the consent of another adult or a child who is in a family relationship with the defendant;
- a Police Officer.

The court or a Police Officer can only make a DVO if there are reasonable grounds to fear that the defendant will commit violence against the applicant. The application will need to explain to the court that the applicant believes the defendant will commit violence against the applicant. Examples of things the defendant has said or done will need to be provided.

South Australia

I. Intervention Order (IO)¹⁶⁷

Intervention orders can protect people from violence by restricting what the defendant (perpetrator) does, as well as by requiring the perpetrator to work towards rehabilitation. The kinds of behaviours covered by an IO are:¹⁶⁷

- physical violence;
- property damage;
- emotional or psychological harm;
- denying a person financial, social or personal independence.

The types of relationships covered can include:¹⁶⁷

- spouses or partners (including former spouses or partners);
- people in intimate relationships, and with children;
- grandchildren and grandparents;
- brothers and sisters;
- within an Aboriginal kinship group;
- a Carer and the person cared for;

Intervention orders can be issued when someone is at risk of being abused. The abuse does not need to have happened on any previous occasions.

For example, intervention orders often stop people from making contact with another person, or they can also stop someone from returning to the family home and limit how close that person can come to the protected person. An IO may require someone to surrender weapons or undertake a program dealing with substance abuse, problem gambling, anger control, or mental health.

Western Australia

I. Violence Restraining Order (VRO)¹⁶⁸

A VRO is designed to stop:¹⁶⁸

- threats;
- property damage;
- violence;
- intimidation;
- emotional abuse.

A VRO can be obtained against a person with whom the applicant in is a family or domestic relationship (for example, spouse or ex-spouse; de facto or ex-de facto; girlfriend/boyfriend or ex-girlfriend/ex-boyfriend; child, step-child or grandchild; parent, step-parent or grandparent; sibling or step-sibling; or relative or former relative).

Applying for a VRO

A person can apply for a VRO if they want protection. A guardian or police officer can apply for a person on their behalf.

An application for a VRO can be made in the following ways:¹⁶⁸

- In person to the Children's Court if the respondent is a child or young person under 18;
- In person to the Magistrates Court if both the applicant and the respondent are adults.
- In person to the Magistrates Court or the Children's Court if the person seeking to be protected is a child or young person under 18 against an adult respondent.
- In some cases during proceedings taking place in other courts, e.g. in the criminal courts.
- Through a police officer who may apply by telephone. They usually only do this where it is either not practical or the situation is urgent.

To get a VRO, the applicant must be able to show the court that the respondent is likely to:¹⁶⁸

- commit an act of abuse against them; or
- make them reasonably fear they will commit an act of abuse against them.

Conditions of a VRO

A VRO can have conditions to stop the person from doing things such as:¹⁶⁸

- being on or near the applicant's home or place of work;
- being on or near a certain place;
- coming within a certain distance of the applicant;
- contacting or trying to contact the applicant in any way, including texting, ringing, emailing or writing- even through other people;
- contacting the applicant in certain circumstances or in particular way, for example, only by texting to make arrangements for contact with children;
- behaving in certain ways;
- being in possession of firearms, ammunition or a firearms licence.

Tasmania

I. Restraint Order^{169; 170}

A Restraint Order may restrict contact between people or impose conditions on their behaviour. They are usually made where a magistrate determines that there is a risk of continued physical violence, threatening behaviour, damage to property, trespass and so on.¹⁶⁹

Applying for a restraint order

If the police have been called to a family violence incident they may, with the applicant's consent, apply for a restraint order. The applicant can also apply for a restraint order by filling in an application form and filing it with the Magistrates' Courts.¹⁷⁰

COMMUNITY ENGAGEMENT AND ADVOCACY

Responding to family violence, and managing the ongoing, continued care of patients/clients who have had experience with family violence, is not limited to your work as a healthcare professional within the confines of your clinic, practice or organisation. You can play a significant role in engaging your community in improving responses to family violence and employing strategies to effectively prevent and intervene in family violence.

Participating in community level activities around responding to and preventing family violence can improve links with the healthcare system and ultimately assist in developing a coordinated community response to family violence. Strategies you may engage in could include the following.

- Volunteering at family violence services (such as crisis or outreach services) to provide healthcare or help raise funds, or becoming a board member.
- Working with community organisations with expertise in relevant areas (for example people with disabilities, culturally and linguistically diverse women or Indigenous women) to promote activities for groups at risk of family violence.
- Work with advocacy groups to contribute to policy debates and activities to address family violence.
- Work within your own student organisations, as well as other healthcare professional organisations, to set family violence as a priority.
- Establish and enhance programs to support victims and perpetrator interventions.

MODULE 6: SAFETY, REFLECTION AND SELF CARE

SYNOPSIS

Module 6 discusses the strategies healthcare professionals can employ to ensure their own safety and wellbeing when working with victims or perpetrators of family violence. It encourages students to engage in reflective practice by outlining what this process involves and how it could be applied to their work as a healthcare professional. At personal, professional and organisational levels, strategies to enact self-care are also discussed in this module.

LEARNING OBJECTIVES

On completion of this module, and with further reading, you (the learner) should be able to:

1. Recognise the risks posed to your safety and wellbeing when working with patients or clients who have had an experience with family violence (as victims and/or perpetrators of violence), and describe the strategies you can employ to increase your safety;
2. Describe vicarious trauma and reflect on the possible impacts of trauma on your personal and professional life;
3. Describe reflective practice and the ways you can reflect on your work as a healthcare professional;
4. Identify strategies for self-care at personal, professional and organisational levels.

INTRODUCTION

Saakvitne and Pearlman (1996) developed a model in which healthcare professionals can explore their situations, and think about solutions. This includes identifying issues of Awareness, Balance and Connection (ABC) at personal, professional and organisational

levels.¹⁷¹ This model can be applied to discuss issues of safety, emotional wellbeing, stress and self-care for healthcare professionals when managing patients/clients who have experienced family violence and will be explored in this Module.

SAFETY AND WELLBEING

When working with patients/clients who have experienced family violence, or have perpetrated family violence, the safety and wellbeing of these individuals is paramount. It is also important to consider your own safety and wellbeing in these situations. The circumstances and situations under which care is provided can influence the nature of risks to safety and wellbeing posed to particular professional groups. There are a range of factors that can impact upon the safety of different healthcare professionals such as:¹⁷²

- the provision of care in secluded or private places (such as the home or other private residence);
- intervention in places where violent incidents have just occurred, or are still occurring;
- exposure to patients'/clients' families who may be aggressive, stressed and/or confused.

Think about your future practice as a healthcare professional:

⇒ Are these factors likely to be relevant to your future practice?

⇒ If so, how? What risks may be posed to your safety and wellbeing in your work?

Being mindful of the possible risks present in your work environment is important. Yet, these should not dominate your thinking, or make you feel scared or threatened – rather, reflecting on these potential risks can guide strategies that you can employ to increase your safety when working with patients/clients who have a history of family violence.

Foremost, there are several warning signs of aggression or even violent behaviour that are useful to be able to recognise in your work as a healthcare professional. These can include:¹⁷²

- nervous movement and gestures
- approaching very closely
- raised voice
- hitting themselves or items
- inappropriate laughter
- excessive sarcasm
- agitation

Being able to recognise these can then facilitate effective and **safe** measures in responding to, and managing, situations that may pose a risk to your safety and wellbeing. In these circumstances, you should consider the following:¹⁷²

- Maintain a calm attitude and use a calm, but directive, tone;
- Set limits in a calm and firm manner;
- Do not give orders;
- Do not use threats;
- Maintain distance from a patient/client (or a family member) if they become aggressive;
- Stay alert and ensure there is a safe route to escape if required.

Vicarious trauma

Vicarious trauma (also known as secondary traumatic stress) is a term used to describe the cumulative effects working with survivors of traumatic life events has on the healthcare provider. The presence of vicarious trauma has been noted in many groups of healthcare professionals who have contact with people who have experienced traumatic events such as family violence.¹⁷³ For example, Cunningham (2003) found that clinicians working with those who had experienced sexual violence experience significant vicarious traumatisation; in fact, clinicians working with victims of sexual violence were more negatively affected than those working with cancer patients.¹⁷⁴

The personal and professional impacts of vicarious trauma can be wide-ranging. Those working with patients/clients who have experienced family violence may personally experience:¹⁷⁵

- diminished concentration;
- confusion;
- decreased self-esteem;
- apathy;
- self-doubt;
- powerlessness;
- anxiety;
- guilt;
- sadness;
- impatience;
- irritability;
- use of negative coping strategies (e.g., smoking, alcohol use);
- loss of self-satisfaction;
- withdrawal;
- projection of anger or blame;
- intolerance;
- loss of self-satisfaction.

Professionally, vicarious trauma can also impact on one's ability to work, and affect one's performance at work. Vicarious trauma, as a consequence of working with patients/clients who have experienced family violence, can result in:¹⁷⁵

- low motivation;
- decrease in confidence;
- loss of interest;
- job dissatisfaction;
- withdrawal from colleagues;
- poor communication;
- staff conflicts;
- absenteeism;
- exhaustion;
- irresponsibility;
- overwork.

REFLECTION

Reflecting on your practice and your role as a healthcare professional occurs when you think about **the skills and knowledge you have and how this shapes your work**, and your **emotional responses to people, situations and events that happen**. It is more than just describing what you have done, or what has occurred – it involves considering the **effects, outcomes and implications of your practice**. Your practice is reflective when you ask questions about what you did, why you did it and how you did it.¹⁷⁶

Reflective practice can be defined as a process of reviewing an experience of practice to describe, analyse, evaluate and so inform learning about practice. Therefore, it is more than just thinking and describing an experience – it involves drawing upon these thoughts and reflecting to develop, learn and grow.

There are a number of ways you can engage in reflective practice:¹⁷⁶

- having informal discussions with work colleagues;
- keeping a personal reflective practice journal;
- participating in critical reflection practice groups;
- doing program or practice evaluations.

Personal

Reflecting on your **personal feelings**, your **reactions** toward them, and **how these affect your role** and practice as a healthcare professional are vital elements of engaging in reflective practice. In responding to family violence, it is important to consider the personal feelings you might have when someone discloses violence to you, or tells you that they have perpetrated violence. You may feel uncomfortable, concerned or angry. How do these feelings influence your response and your practice more generally – ask yourself “how did these influence what I did, how I did it, and why I did it”?

Reflection

- ❖ In your future practice as a healthcare professional, how do you think you would feel working with a patient/client who has experienced family violence?
- ❖ In your future practice as a healthcare professional, how do you think you would feel working with a patient/client who has perpetrated family violence?
- ❖ How do you feel when you are stressed? What are the signs or clues?
- ❖ How does stress impact on your ability to perform tasks?

Being mindful of signs that suggest you may be under stress, or feeling distressed, is also critical. While we can identify some common cues or signs of stress/distress, such as feeling anxious or overwhelmed, we each have personal indicators that tell us we are feeling stressed. It is important to be able to recognise these, particularly when working in challenging environments such as responding to family violence.

Professional

There are a number of professional factors that could contribute to stress when working with patients/clients who have experienced or perpetrated family violence. Maintaining confidentiality about violence in your role as a healthcare professional may be difficult. You may find it challenging, or even confronting, working with a perpetrator of violence in a professional capacity – particularly if the entire family are patients/clients at your clinic/practice.¹²⁶

Reflection

- ❖ In your future practice as a healthcare professional, how do you think these professional factors would impact on working with patients/clients who have experienced family violence?

Organisational

The environment within which you work can also contribute to the way you approach your work, and how you feel about your work. In circumstances of family violence, organisational factors such as time pressures/constraints, limited avenues for support, or personal responsibility for care of patients/clients can impact on the way in which you respond – emotionally and at a professional level – in your practice.¹²⁶ Reflecting on these is important as we can begin to see how factors at a broader level have implications on our personal and professional lives.

Reflection

- ❖ In your future practice as a healthcare professional, how do you think your work environment will impact on your practice when working with patients/clients who have experienced family violence?

SELF-CARE

Because working with patients/clients who have experienced family violence can be stressful, overwhelming and confronting, it is important that healthcare professionals consider strategies for self-care at personal, professional and organisational levels. These can include the approaches listed in Table 3.

Table 3: Strategies for self-care

<i>Personal</i>	<i>Professional</i>	<i>Organisational</i>
<ul style="list-style-type: none"> • Maintain a balance in life. • Have a positive life outlook. • Promote wellness and wellbeing through lifestyle choices – e.g., relationships, religion, and spirituality. • Create and sustain connections with social support systems. 	<ul style="list-style-type: none"> • Create clear boundaries between work and home. • Engage in further training and clinical practice. • Maintain professional development. 	<ul style="list-style-type: none"> • Have a safe and secure work environment. • Take adequate leave from work. • Engage in team work to manage patients/clients who experience violence – with those within the practice/clinic/profession, and with those outside the clinic/practice (for example police, public health nurses, other agencies). • Utilise formal supports such as counselling, supervision, debriefing, and the Employee Assistance Program.

Adapted from: The Royal Australian College of General Practitioners. (2014). *Abuse and violence: Working with our patients in general practice* (4th ed.). Melbourne, Australia: The Royal Australian College of General Practitioners.

APPENDIX A: RESOURCES AND REFERRAL OPTIONS

Resource and referral options by state

Victoria

Service/organisation	Phone	Website
Metropolitan Family Violence Outreach Service	Eastern Metro Region: Ringwood Ph. 9259-4200 Northern Metro Region: Ph.9458-5788 (10am-4pm Mon-Fri) Inner/Southern Region: St Kilda or Moorabbin Ph. 9536-7777 Mornington Peninsula Region Ph 5971-9454 South Eastern Region: Frankston Ph. 9781-4658 Dandenong Ph. 9791-6111 Narre Warren Ph. 9703-0044 Pakenham Ph 5945-3200 Western Region: Ph. 9689-9588	
Barwon South West Region Domestic Violence Outreach Service	Geelong/Barwon: Ph. 5224-2903 Warrnambool: Ph. 5561-1984 Hamilton: Ph. 5571-1778 Portland; Ph. 5521-7937	
Gippsland Domestic Violence Outreach Service	Warragul: Ph. 5622-7000 Morwell: Ph. 5120-2000 Leongatha: Ph. 5662-4502 or 1800 221 200 Bairnsdale: Ph. 5152-0052	

	Lakes Entrance: Ph. 5152-0052	
Grampians Domestic Violence Outreach Service	Horsham: Ph. 5362-1200 Ballarat: Ph. 5333-3666 Stawell: Ph. 5358-7400 Ararat: Ph. 5332-6200	
Hume Domestic Violence Outreach Service	Wodonga: Ph. 02 6022-8888 Shepparton: Ph. 5821-9458 Broadford: Ph. 5784-5555 Wangaratta: Ph. 5722-2203	
Loddon Mallee Domestic Violence Outreach Service	Mildura: Ph. 5021-2130 Bendigo: Ph. 5430-3000 or 1800 884 038 Swan Hill: Ph. 5033-1899	
Women’s Domestic Violence Crisis Service of Victoria	03 9322-3555 (24 hours) 1800 015 188 (country toll free)	http://www.wdvcs.org.au/
InTouch Multicultural Centre Against Family Violence	03 8413 6800	http://www.intouch.asn.au/
Domestic Violence Resource Centre Victoria	03 9486 9866 (Mon-Fri 9am-5pm)	http://www.dvrcv.org.au/
Elizabeth Hoffman House Aboriginal Women’s Service	1800 796 112 (24 hour line)	http://www.ehhaws.org.au
Centres Against Sexual Assault (CASA)	03 9635 3610 (Counselling and support line) 1800 806 292 (After hours crisis care)	http://www.thewomens.org.au/SexualAssault
Mens Referral Service	1300 766 491	http://mrs.org.au/
Community Legal Centres	To find your nearest Community Legal	http://www.communitylaw.org.au

	Service, call 03 9652 1500	
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#vic
Turning Point Alcohol and Drug Centre	03 8413 8413	http://www.turningpoint.org.au

New South Wales

Service/organisation	Phone	Website
NSW Domestic Violence Line	1800 656 463 (24 hour)	
NSW Women’s Refuges	1800 656 463 (24 hour)	
NSW Rape Crisis Centre	02 9819 7357 1800 424 017 (Counselling)	http://www.nswrapecrisis.com.au/
Dympna House (for survivors of sexual abuse)	1800 654 119 02 9797 6733	
Domestic Violence Advocacy Service	02 8745 6999 1800 810 784	
Immigrant Women’s Speakout Association	02 9635 8022	http://www.speakout.org.au
Domestic Violence Legal Service	02 8745 6900	http://www.womenslegalnsw.asn.au
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#nsw
Mens Referral Service	1300 766 491	http://mrs.org.au/

Australian Capital Territory

Service/organisation	Phone	Website
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Domestic Violence Crisis Service ACT	02 6280 0900	http://www.dvcs.org.au/
Canberra Emergency Accommodation Service Crisis Line0	02 6230 1486 (business hours) 02 6257 2333 (24 hours)	
Canberra Rape Crisis Centre	02 6247 2525	http://www.rapecrisis.org.au/
Women’s Information and Referral Centre	02 6205 1075	http://www.wirc.act.gov.au/
Service Assisting Male Survivors of Sexual Assault Canberra	02 6262 7377	http://www.samssa.org.au/
Family Relationship Centre Canberra	02 6122 7190	
Legal Aid Office ACT		http://www.legalaidact.org.au/

Queensland

Service/organisation	Phone	Website
DV Connect	07 3008 8294 1800 811 811 (24 hours) 1800 600 636 (Mensline – 9am-midnight)	http://www.dvconnect.org/
Brisbane Rape and Incest Survivors Support Crisis Centre	07 3391 0004 1800 242 526 (country callers)	http://www.brissc.org.au/
Brisbane Domestic Violence Resource Centre	07 3217 2544	http://www.dvrc.org.au/
Domestic Violence Prevention Centre – Gold Coast	07 5532 9000 (counselling)	
Statewide Sexual Assault Helpline	1800 010 120 (24 hours)	

Immigrant Women’s Support Service	07 3846 3490 (domestic violence) 07 3846 5400 (sexual assault)	http://www.iwss.org.au/
Women’s Legal Service	1800 677 278	
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#qld

South Australia

Service/organisation	Phone	Website
Domestic Violence Crisis Service	1300 782 200 (24 hours)	
Domestic Violence Helpline	1800 800 098 (24 hours)	
Crisis Care	131 611	
Yarrow Place Rape and Sexual Assault Service	1800 817 421 08 8226 8787 (after hours and emergency)	http://www.yarrowplace.sa.gov.au/
Women’s Information Service of South Australia	08 8303 0590 1800 188 158	
Men’s Information and Support Centre	0404 604 426	http://www.misc.com.au/
Law Society of South Australia		To find legal support, visit: http://www.lawsocietysa.asn.au/legal_portal/community_legal_support_services.asp
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#sa

Northern Territory

Service/organisation	Phone	Website
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Crisis Line	1800 019 116 (24 hour domestic violence counselling)	
Domestic Violence Counselling Service	08 8945 6200 (9am-5pm weekdays)	
Sexual Assault Referral Centre	08 8922 6472	
Dawn House (crisis accommodation for women with children escaping domestic violence)	08 8945 1388 (24 hours)	
Ruby Gaea Darwin Centre Against Rape	08 8945 0155	
Darwin Community Legal Service	08 8982 1111	http://www.dcls.org.au/
Domestic Violence Legal Help (Alice Springs)	08 8981 9726	
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#nt

Tasmania

Service/organisation	Phone	Website
Domestic Violence Crisis Service	1800 633 937 (Mon-Fri 9am-midnight; weekends 4pm-midnight)	
Sexual Assault Support Service	03 6231 1817	http://www.sass.org.au/
Yemaya: Women's Support Service	03 6334 0305	
Safe at Home Family Violence Response and Referral Line	1800 633 937	
Women's Legal Service	1800 682 468	

	03 6224 0974	
Community Legal Centres (CLC)		To find your nearest CLC, visit: http://www.naclc.org.au/cb_pages/state_associations.php#tas
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#tas

Western Australia

Service/organisation	Phone	Website
Women’s Council for Domestic and Family Violence Services	08 9420 7264	http://www.womenscouncil.com.au/
Women’s Domestic Violence Helpline	08 9223 1111 (24 hours) 1800 199 008 (24 hours)	
Sexual Assault Resource Centre	08 9340 1828 (Crisis Line 24 hours) 08 9340 1899 (Counselling Line 24 hours)	
Crisis Care Unit	08 9325 1111 1800 199 008	
Women’s Information Service	1800 199 174	
Women’s Multicultural Support and Advocacy	08 9325 7716	
Men’s Domestic Violence Helpline	08 9223 1199 1800 000 599	
Legal Aid Western Australia	1300 650 579	http://www.legalaid.wa.gov.au/
Family Relationship Centres (FRC)		To find your nearest FRC, visit: http://www.familyrelationships.gov.au/services/frc/pages/default.aspx#wa

Australia wide services

Service/organisation	Phone	Website
Australian Childhood Foundation	1800 176 453	http://www.childhood.org.au
Lifeline	13 11 14	http://www.lifeline.org.au
MensLine	1800 789 978	http://www.mensline.org.au
National Sexual Assault, Family and Domestic Violence Counselling Line	1800 737 732	http://www.1800respect.org.au
Relationships Australia	1800 364 277	http://www.relationships.org.au
WESNET (Women's Services Network)		http://www.wesnet.org.au

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