When she talks to you about the violence

A toolkit for GPs in NSW

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

You may be the only person she will tell.

Your skills and sensitivity are essential.

This resource has been developed to assist you in identifying and responding to your patients and their children who have been victims (also known as survivors) affected by domestic violence (also known as 'family violence' or 'intimate partner violence'.)

> ***Estimates are that every week, a general practitioner (GP) sees up to five women who have been abused by their partners, of which the GP may not be aware. One in 10 women attending general practice have been afraid of their partners in the previous 12 months, and one in three women have experienced fear of a partner over their lifetime.***[2]

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

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

Responding effectively to domestic violence requires knowledge of the physical and emotional consequences of the violence, an understanding of how to respond appropriately, and having networks which assist you to refer for ongoing specialised support.

> ***After family and friends, health professionals are the most common first-line response for women, accounting for approximately one-quarter of women seeking help in relation to the abuse...***[4]

Contents

1. What is domestic violence?

Domestic violence is **an abuse of power** within a **domestic relationship**, or after separation. It involves one person dominating or controlling another, causing **intimidation or fear, or both**. Domestic violence is **often experienced as a pattern of abuse** that escalates over time.

Domestic violence is a gendered crime. 95% of all victims of violence (men and women) experience violence from a male perpetrator. LGBTIQ and gender diverse people are also identified as being particularly vulnerable to domestic, family and sexual violence.

Most victims of domestic violence are women.

Women are at greater risk of violence from their partners during pregnancy, or after separation. The 2016 Personal Safety Survey found that nearly half of women who had experienced violence by a previous partner and who were pregnant during that relationship, experienced violence from their partner while pregnant.[5]

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

- sexual abuse, also known as intimate partner sexual violence (IPSV) (discussed in greater detail below)
- emotional or psychological abuse
- verbal abuse
- spiritual abuse
- stalking and intimidation, including using technology
- social and geographic isolation
- financial abuse
- cruelty to pets
- damage to property.

IPSV is the intentional perpetration of sexual acts without consent in intimate relationships and is a common tactic of domestic violence.[6] It includes sexual assault obtained by force or psychological coercion; unwanted, painful or humiliating sexual acts; tactics to control decisions around reproduction; image-based abuse; or forced watching of pornography.[7]

According to the *Crimes (Domestic and Personal Violence) Act 2007*, a person has a **domestic relationship** with another person if they are/were:

- married, in a de facto or intimate relationship whether or not it is of a sexual nature
- living together in the same house
- living together in a residential facility
- relatives by birth, marriage or adoption
- in the case of an Aboriginal or Torres Strait Islander, part of the same extended family or kinship group
- in a relationship involving his or her dependence on the ongoing paid or unpaid care of the other person
- married to, or in a de facto or intimate relationship with the same person, eg. a woman's ex-partner and current partner are in a domestic relationship with each other even if they have never met.

2. Indicators

'When assessing your patient… remember that most presentations of family violence are probably hidden and not the obvious black eye.'[8]

The following are indicators associated with victims of domestic violence. Please note that none or all of these might be present and be indicators of other issues. This is where using these indicators as a guide can complement the practice of asking directly.

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

Figure 1: Indicators associated with victims of domestic violence

Strangulation, suffocation and choking in the context of domestic violence

Strangulation is a common and serious form of domestic violence. Recognising the subtleties of presentation remains imperative as strangulation is a strong predictor for future severe domestic violence and subsequent homicide. According to NSW Police Standard Operating Procedures, police are now required to advise a victim who discloses strangulation to seek urgent medical attention.

Assessing a patient who reports strangulation

Ask about:

Details of assault:

- Mechanism of strangulation (hands, ligature), length of time (if able to estimate), multiple episodes of strangulation.

Symptoms at time of assault:

- Incontinence (urinary or faecal), loss of consciousness (or lapses in memory), isolated weakness or numbness to part of body, vision changes.

Symptoms post assault:

- Headaches, seizures, syncope, agitation and confusion
- Palpitations
- Respiratory distress, stridor, cough
- Sore throat, difficulty swallowing, drooling
- Neck or jaw pain
- Nausea or vomiting.

On examination:

- Musculoskeletal – neck pain, cervical spine tenderness
- Respiratory – shortness of breath, sore throat, voice changes (hoarse or raspy voice)
- Facial – petechiae eyes, palate, ears, Ptosis, swelling of mouth and lips, bruising or redness to neck.

Delayed symptoms from strangulation are often subtle and in 50% of cases there is little or no visible evidence of injury after an incident of strangulation (Queensland Health, 2017). Patients experiencing strangulation should be monitored for up to 48 hours post assault.

How to accurately document and why it's important

- Accurate and thorough documentation is important in providing continuity of support and may be relied upon in criminal proceedings or claims for victims support.
- All history and examination findings must be clearly documented and include the exact mechanism of the assault and any previous assaults to date. History should be documented verbatim where possible.
- Examination should include both positive and negative findings with particular reference to location and size of injury, patterned bruises (eg fingertip bruising).
- Investigations and management provided including referral and investigations should be documented.

Source: The *onthewards.org* podcast.[9]

3. How to ask your patient

In any situation that you suspect underlying psychosocial problems you can ask indirectly and then directly about partner abuse.[10]

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

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

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

It is important to realise that women who have been abused want to be asked about domestic violence and are more likely to disclose if asked.[11]

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

- 'Are there ever times when you are frightened of your partner?'
- 'Are you concerned about your safety or the safety of your children?'
- 'Does the way your partner treats you make you feel unhappy or depressed?'
- 'Has your partner ever physically threatened or hurt you?'
- 'Has your partner forced you to have sex when you didn't want it?'
- 'Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.'[12]

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

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

If your patient's fluency in English is a barrier to discussing these issues, you should work with a qualified interpreter. Don't use your patient's partner, other family members or a child as an interpreter. It could compromise her safety, or make her uncomfortable to talk with you about her situation. **The Doctors' Priority Line, phone 1300 575 847**, is a 24/7 free telephone interpreting service to assist GPs to communicate with patients from non-English speaking backgrounds.

4. Responding to a disclosure

Your immediate response and attitude when your patient discloses domestic violence can make a difference.

Women require an initial response to disclosure, where they are listened to, validated and their own and their children's safety is assessed. They also need to be assisted on a pathway to safety.[13]

Listen

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

Communicate belief

'That must have been frightening for you.'

Validate the decision to disclose

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

Emphasise the unacceptability of violence

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

Be clear that she is not to blame

Avoid suggesting that your patient is responsible for the violence or that they are able to control the violence by changing their behaviour.

Do not ask

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

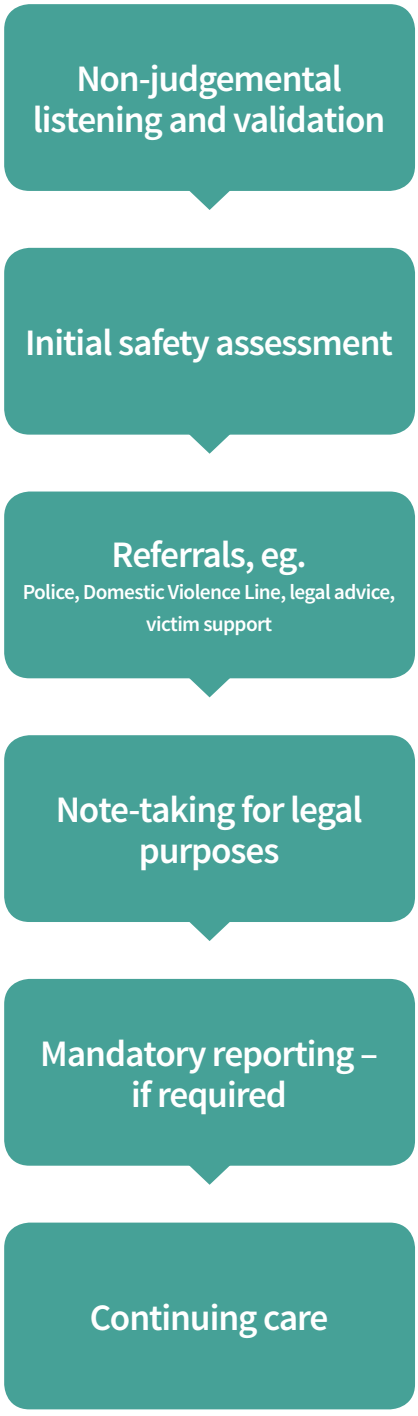

Figure 2: Key steps after a disclosure of domestic violence

5. Initial safety planning

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

The strongest indicator of future risk/violence is current and past behaviours of the perpetrator.[14]

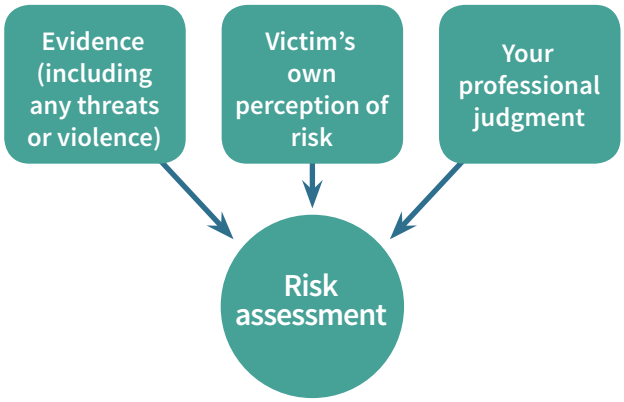

Figure 3: Aspects of best-practice risk assessment

It is also essential that you engage the person in a conversation about their perceptions of risk and how they have managed their safety in the past.

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

- Speak to the your patient alone
- Check for immediate concerns
  - Do they feel safe going home after the appointment?
  - Are their children safe?
  - Do they need an immediate place of safety?
  - Do they need to consider an alternative exit from your building?
- If immediate safety is not an issue, check your patient's future safety
  - Has the perpetrator's behaviour changed/ escalated recently?
  - Does the perpetrator have access to weapons?
  - Does your patient need a referral to police or a legal service to apply for an Apprehended Violence Order?
  - Do they have emergency telephone numbers?
- NSW Police: **000** or **106 (TTY)**
  - Domestic Violence Line (24/7 emergency, referral and counselling line for people experiencing domestic violence. Can explain basic information about AVOs and assist with risk assessment): **1800 656 463** or **1800 671 442 (TTY)**
  - Does your patient need a referral to a domestic violence service to help make an emergency plan:
  - Where would they go if they had to leave?
  - How would they get there?
  - What would they take with them?
  - Who could they contact for support?
- Document any plans made, for future reference.

Risk assessment is an ongoing process. You may need to check in on your patient to follow up on this initial safety plan. See section 13 (Continuing care).

It is important to remember that the true goal… is to prevent violence, not predict it.[15]

6. Domestic violence and renting

Victims of domestic violence can end their tenancy immediately, without penalty, if they, or their dependent child are in circumstances of domestic violence. You can help your patient end her tenancy immediately by completing a **Medical Practitioner Declaration Form**[16] or a **Medical Practitioner Declaration Form – Dependent Child**.[17]

The declaration is one of four permitted types of evidence your patient can use to attach to their **Domestic Violence Termination Notice**. The reason medical practitioners can provide this evidence is so that victims of domestic violence who are too fearful to report the violence to police are supported to end their tenancy. By signing a declaration, you are providing evidence, that based on your professional assessment, your patient or their dependent child is a victim of domestic violence perpetrated by a person with whom they are in a '**domestic relationship**' (see page 2). You do not have to prove that an incident of domestic violence has taken place nor do you need other evidence of domestic violence, such as a police report or an Apprehended Violence Order, to complete the declaration.

For more information, and to access the forms, visit **www.fairtrading.nsw.gov.au**

7. Victims support scheme

If your patient has experienced domestic violence in NSW, they may be entitled to free counselling and financial support through the victims support scheme, administered by Victims Services NSW. Financial assistance may be awarded to pay for immediate needs (such as relocation expenses, or emergency medical or dental expenses.) Further financial assistance for economic loss can be applied for to cover ongoing costs, such as loss of earnings. Some victims may also be granted a recognition payment depending on the nature of violence that occurred.

In most cases, applicants for financial support need evidence they suffered an injury as a direct result of an act of violence. Making accurate and detailed notes of domestic violence related injuries might help your patients obtain financial support.

There are strict time limits in making an application for financial assistance. Refer your patient to **www.victimsservices.justice.nsw.gov.au** for more information.

8. Centrelink crisis payment

If your patient has experienced domestic violence, they may be entitled to a crisis payment. An application must be made within 7 days of their 'crisis'. If your patient is in receipt of a government payment and experiencing domestic violence, they may be exempted from certain mutual obligation requirements. They may require a medical report to assist in applying for an exemption from these requirements.

9. Note-taking for legal purposes

You can support the Police investigation and future legal proceedings by making detailed notes.

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

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

10. Subpoenas

You may be served with a subpoena relating to a patient. It is important to treat subpoenas with caution, especially when the person seeking the information is not your patient but, for example, their ex-partner. First, check that the subpoena is valid. It must have a court stamp, been served on you before the stated deadline and conduct money must be provided.

You must ***respond*** to a valid subpoena – either to obey the orders, or to object. There are various grounds for objecting to a subpoena, for example, the request is too onerous, or the information is 'privileged' (protected by law).

Always contact your patient to let them know that you have been served with a subpoena, and to ask them how she would like you to respond. A person who has experienced sexual assault may be able to claim the Sexual Assault Communications Privilege to maintain the confidentiality of your records if subpoenaed. You may be legally required to go against their wishes.

Subpoenas requesting documents will have a schedule of what material is being sought. ***Never hand over more*** than what is listed in this schedule.

In some cases, you or your patient may need legal advice. You could seek guidance from the AMA, the RACGP, your insurer, or a private lawyer. Your patient could get legal advice from her own lawyer, a community legal centre, or – if appropriate – the Sexual Assault Communication Privilege Service at Legal Aid.

11. Mandatory reporting

As a mandatory reporter, if a patient talks about experiencing or perpetrating violence, and you believe you have reasonable grounds to suspect that a child is at risk of significant harm, you may need report this to Community Services. You are not obliged to report violence experienced by adults. Reporting violence experienced by adults without their consent could put them at greater risk of harm.

Exposing children to domestic violence can have a serious psychological impact on children. In some cases you may feel there is risk of significant harm to a child even though it seems unlikely that the violent person in their home would physically hurt them. Use your professional judgment about the individual circumstances and the nature of the violence.

The Child Story Mandatory Reporters Guide will assist you in assessing child protection concerns and provide a directive on how to proceed. See: reporter.childstory.nsw.gov.au/s/mrg

12. Immigration family violence provisions

If your patient is on a partner or spouse visa, a report or statutory declaration from you detailing physical injuries and/or treatment for mental health issues that are consistent with domestic violence can help your patient apply for permanent residency.

You can refer your patient to the **Immigration Advice & Rights Centre** on **(02) 9279 4300** or **LawAccess** on **1300 888 529** for advice about how you can help them.

13. Continuing care

- Consider your patient's safety as a paramount issue. The person experiencing the violence is the best judge of their own safety. You can help to monitor the safety by asking about any escalation of violence.
- Empower your patient to take control of decision-making. Ask what they need and present choices of actions she may take and services available.
- Respect the knowledge and coping skills they have developed. You can help build on your patient's emotional strengths, for example, by asking 'How have you dealt with this situation before?'
- Provide emotional support.
- Ensure confidentiality. Your patient may suffer additional abuse if their partner suspects they have disclosed the abuse.
- Be familiar with appropriate referral services and their processes. Your patient may need your help to seek assistance. Have information available for the patient to take with them if appropriate.

'I dropped some hints to test the water. [The GP] was supportive without being interfering and because of this I made the decision to tell her. She was fantastic and told me about the [Domestic Violence Line] who I called and put me into contact with a women's refuge. I am rebuilding my life, and looking forward to a happy future'.[18]

14. When your patient is the perpetrator

Consider the safety of your patient and their children as the highest priority. Note that perpetrators of violence tend to minimise the violence, or shift blame.

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

- 'How are things at home?'

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

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

Acknowledge the existence of violence by statements such as:

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

15. When both partners are your patients

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

If you have seen your patient who has disclosed domestic violence and their children, your primary duty is to them. If the perpetrator is also your patient, you should refer them to another practitioner or another practice.

If both partners remain within your practice, you will need to take extra caution, for example:[19]

- Establish staff protocols that ensure confidentiality of records.
- There should be no discussion about suspected or confirmed abuse with the violent partner unless the woman consents to it.
- If a your patient agrees that you can talk with her partner about the violence, it is important that a safety plan is in place and consider referring the perpetrator to the **Men's Referral Service on 1300 766 491**.

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

WOMEN'S LEGAL SERVICE NSW
PO Box 206, Lidcombe NSW 1825
Administration (02) 8745 6900 | Fax (02) 9749 4433
Email: reception@wlsnsw.org.au | Website: www.wlsnsw.org.au

16. Referrals

Here are some key contacts for patients.

- **Domestic Violence Line**
  P: 1800 65 64 63
  www.facs.nsw.gov.au/domestic-violence/helpline
  24/7 emergency, referral and counselling line. Can explain basic information about AVOs and assist with risk assessment.
- **NSW Rape Crisis Centre**
  P: 1800 424 017
  www.nswrapecrisis.com.au
  24/7 telephone and online counselling service for anyone in Australia affected by sexual, family or domestic violence.
- **MensLine Australia**
  P: 1300 78 99 78
  www.mensline.org.au
  24/7 support, information and referral service, helping men deal with relationship problems.
- **LawAccess**
  P: 1300 888 529
  www.lawaccess.nsw.gov.au
  Free legal information, referrals and in some cases, advice for people who have a legal problem in NSW.
- **Victims Services NSW**
  P: 1800 633 063
  www.victimsservices.justice.nsw.gov.au
  Support, referrals and information for victims of crime in NSW. Support coordinators help victims apply for assistance under the NSW victims support scheme.
- **Legal Aid NSW – Sexual Assault Communication Privilege Service**
  email: sacps@legalaid.nsw.gov.au
  www.legalaid.nsw.gov.au/what-we-do/civil-law/sexual-assault-communications-privilege-service
  Free legal advice for victims of sexual assault if their records are the subject of a subpoena in criminal proceedings.
- **Centrelink Emergency Line**
  P: 132 850
  For help applying for a crisis payment.

See www.facs.nsw.gov.au/domestic-violence for more extensive referrals.

18. Training & resources

- **RACGP** – Abuse and violence: Working with our patients in general practice (white book)
  www.racgp.org.au/your-practice/guidelines/whitebook
- **AFP** – Intimate partner violence: Identification and response in general practice
  www.racgp.org.au/afp/2011/november/intimate-partner-violence/
- **NSW Health** – The Education Centre Against Violence
  www.ecav.health.nsw.gov.au/
- **Australia's National Research Organisation for Women's Safety Limited** (ANROWS)
  www.anrows.org.au

WOMEN'S LEGAL SERVICE NSW

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