



## POLICY ON DOMESTIC AND FAMILY VIOLENCE

### 1. PURPOSE

This document is a policy of the Australasian College for Emergency Medicine (ACEM) and relates to the identification, screening, treatment and support of victims of domestic violence.

### 2. SCOPE

This policy is applicable to public and private hospital emergency departments throughout Australasia.

### 3. DEFINITIONS

Domestic violence refers to acts of violence that occur between people who currently, or have in the past, had an intimate relationship. [1] The term 'domestic violence' encompasses intimate partner violence, which more specifically refers to violence perpetrated by someone with whom the victim has or has had a close personal relationship characterised by:

- Emotional connectedness. [2]
- Regular contact. [2]
- Ongoing physical contact and/or sexual behaviour. [2]
- Identity as a couple. [2]
- Familiarity or knowledge about each other's lives. [2]

Australia's *National Plan to Reduce Violence against Women and their Children* considers the central element of domestic violence to be ongoing patterns of behaviour which are aimed at controlling a partner through fear. [1] Domestic violence therefore includes, but is not limited to:

- Abusive or threatening behaviour, in the form of physical, sexual, emotional, psychological or economic abuse or threat.
- Coercive or threatening behaviour, in the form of domination or control over a person so as to make them fear for their safety or that of another person or their property.
- Actions used to gain or maintain power and control over an intimate partner or family member.

Family violence refers to violence between family members, as well as violence between intimate partners. [1] This form of violence therefore also encompasses domestic violence, as it involves similar behaviours. According to the *National Plan to Reduce Violence against Women and their Children*, 'family violence' is the term most commonly utilised when describing the experiences of Aboriginal or Torres Strait Islander peoples, as it encompasses the spectrum of marital and kinship relationships in which violence may be present. [1]

Interpersonal violence encompasses all of the above forms of violence, including child abuse and elder abuse. [3] This form of violence can be divided into two sub-categories; family and intimate partner violence, and also community violence, which refers to violence that occurs between acquaintances or strangers, such as bullying or sexual assault. [3]

## **4. INTRODUCTION**

Domestic and family violence does not discriminate between race and culture, socio-economic status, sexual orientation, religion, age or gender. However, ACEM acknowledges that there are a number of groups who are at high risk due to social disadvantage, vulnerability, issues relating to unequal power or control, isolation, or trauma caused by discriminatory policies of the past. For example, as identified below, women, those with a disability, children, the elderly, those from culturally and linguistically diverse (CALD) communities, and Māori and Aboriginal and Torres Strait Islander peoples, are particularly vulnerable. ACEM acknowledges that experiences of domestic and family violence will differ between these communities.

### **4.1 Women**

Domestic and family violence are forms of violent behaviour that are often considered to be “gendered”, as they have an unequal impact upon women. [1] For example, in Australia, 16.9% of women have experienced violence perpetrated by a partner since the age of 15, compared to 5.3% of men. [4] In New Zealand, one in three women experience physical and/or sexual violence from a partner in their lifetime. [5]

### **4.2 People living with a disability**

In the first Australian population-based estimate of the prevalence of violence for men and women with disabilities, it was identified that the prevalence of all forms of violence including physical and sexual assault, emotional abuse and stalking and harassment, was higher among people with disabilities. [6] The same study also found that Australians with a disability are more likely to experience interpersonal violence than those without. [6]

Experiences of domestic and family violence are also gendered for those with a disability, with studies showing that women with disabilities are more likely to experience domestic and family violence, and for more extended periods of time. [6]

### **4.3 Children**

Children are highly vulnerable to the effects of domestic and family violence. Studies conducted by the Centre for Social Research and Evaluation in New Zealand have shown that the brain development of children is damaged by prolonged, severe or unpredictable stress, such as that caused by experiences of domestic and family violence in their early years. [7,8]

Children and young people who are witness to and/or victims of such violence may themselves exhibit violent behaviour and be prone to behavioural disturbances, including issues affecting concentration and their ability to learn and develop, as well as drug and alcohol addiction. [7,8]

### **4.4 Elderly**

Domestic or family violence experienced by elderly people is commonly described as “elder abuse”. Between two and five per cent of Australians over the age of 65 years have experienced abuse, predominantly perpetrated by family members. [9] Available studies from New Zealand indicate that between 3 and 10% of the New Zealand population over the age of 65 are potentially experiencing abuse or neglect. [10]

Elder abuse is often characterised by social isolation, neglect, control of finances without consent, as well as chemical or substance abuse, and can also be perpetrated by a person who is not related to the victim but is in a position of care. [9]

#### 4.5 Māori and Aboriginal and Torres Strait Islander communities

Māori and Aboriginal and Torres Strait Islander victims of domestic and family violence experience additional intersectional oppressions that impact on both the increased levels of violence experienced, as well as their ability to access the resources and care needed in such situations.

In Australia, under-reporting and a lack of culturally appropriate screening services present barriers to determining the full extent of domestic and family violence in Aboriginal and Torres Strait Islander communities. [11] However, studies and surveys have shown that more severe forms of violence are recorded in some Aboriginal and Torres Strait Islander communities, and that their experiences of violence is twice the rate of Australians who do not identify as Aboriginal or Torres Strait Islander. [11] Studies have also shown that Aboriginal and Torres Strait Islander women report higher levels of violence, and also suffer higher levels of injury and death as a result of domestic and family violence. [11]

Frameworks for understanding the causal factors of domestic and family violence in Aboriginal and Torres Strait Islander communities divide these causes into three categories:

1. Precipitating causes – specific events that precede and trigger a violent episode by the perpetrator. [11]
2. Situational factors – the social environment of the antagonist. [11]
3. Underlying factors – the historical circumstances of Aboriginal and Torres Strait Islander peoples, which make them vulnerable to enacting or being the victim of violent behaviour. [11]

The social problems caused by the physical trauma and violence inflicted upon Aboriginal and Torres Strait Islander peoples are exacerbated by high unemployment, low socioeconomic development, poor access to adequate housing, poor health, high mortality rates and a lack of support services, which are in turn a contributor to high levels of violence. [11,12]

ACEM notes that there are also limitations regarding studies into Māori experiences of domestic and family violence. [13] However, there is evidence to show that Māori are over-represented as victims of domestic and family violence, with Māori women between the ages of 15- 24 seven times more likely to be hospitalised as the result of an assault than non-Māori women. [13]

As with the causal factors of domestic and family violence within Aboriginal and Torres Strait Islander communities, causal factors of domestic and family violence for Māori are the loss of cultural identity, land, self-determination and traditional mechanisms for support caused by colonisation. [14] Social and economic disadvantage experienced by some Māori in relation to low income levels, unemployment, poor health, education and housing, are also key contributors to high rates of domestic and family violence within the Māori population. [14]

ACEM notes that the disconnect between Māori and Aboriginal and Torres Strait Islander communities, and the mainstream approaches to reducing domestic and family violence, remain an ongoing problem to resolving the domestic and family violence issues experienced by these groups. ACEM therefore considers it vital that culturally appropriate support services are provided when treating suspected victims of domestic and family violence from Māori and Aboriginal and Torres Strait Islander communities.

#### 4.6 Culturally and Linguistically Diverse (CALD) communities

Experiences of domestic and family violence in CALD communities are also typically gendered, with women from CALD backgrounds at increased risk of physical and sexual violence due to a number of systemic barriers. These barriers include a lack of support networks, socioeconomic disadvantage, community pressure and a lack of knowledge in regards to their rights as victims. [15] Furthermore, issues relating to language, existing racism and discrimination, as well as fears regarding residency status and access to income support, further exacerbate these issues. [15]

Within some CALD communities, there may also be significant diversity regarding the way in which violence is perceived and understood. For example, some refugee and migrant women may not perceive sexual violence within a marriage as a “real” crime due to beliefs and obligations, whether they be religious or traditional, to remain in the relationship. [15]

## 5. POLICY

ACEM is concerned by the rising rates of incidents of domestic and family violence that have been recorded in both Australia and New Zealand, and considers that reducing all violence in the community should be a priority of governments in both countries. ACEM considers that domestic and family violence is unacceptable and is never the fault of the victim, and therefore strongly supports international, national and jurisdictional legislation which recognises domestic violence as a violation of human rights, such as the United Nations *Declaration on the elimination of violence against women*. [16]

ACEM supports the recognition of domestic and family violence as a public health issue, and considers that a “whole-of-system approach” is required in order to address this problem. [17] This approach entails cross-agency collaboration between communities, local and national governments, justice systems, health systems and social service providers. In order for this approach to be effective, ACEM also considers it vital that the appropriate cultural support services are made available to victims of domestic and family violence from diverse backgrounds.

ACEM acknowledges that victims of domestic or family violence may regularly attend the ED as a result of injury or an associated condition, or in place of other health care services due to the level of anonymity provided. [18] ACEM therefore considers that ED staff must maintain a high index of awareness and be knowledgeable of their legal obligations in regards to treating patients who are suspected victims of domestic or family violence. ED staff must also be skilled in understanding the cultural complexities of how to respond to presentations from diverse communities.

There are a number of resources available to ED staff located in all jurisdictions in Australia, and in New Zealand, that can be utilised when treating those who are suspected victims of domestic and family violence. These resources include guidelines or manuals that are specific to particular groups who are disproportionately affected by domestic or family violence, but also resources such as screening tools and risk assessment guidelines which provide a broad approach to identifying and treating all victims of domestic and family violence.

### 4.1.1 The New Zealand Ministry of Health (MoH) *Family Violence Assessment and Intervention Guideline*

The MoH [\*Family Violence Assessment and Intervention Guideline\*](#) has been endorsed by ACEM’s New Zealand Faculty. [16] The Guideline acknowledges domestic and family violence as a public health issue requiring a whole-of-system approach. [17]

ACEM considers the Guideline as a vital resource for New Zealand EDs, as it provides specific guidance on routine enquiries that can be conducted with female patients who are suspected victims of domestic or family violence, as well as securing safety for victims and health care workers in situations of imminent threat, or extremely high risk.

### 4.1.2 The Family Violence Risk Assessment and Risk Management Framework

The [\*Family Violence Risk Assessment and Risk Management Framework\*](#), developed by the Victorian Department of Human Services, aims to provide a consistent approach for assessing and managing family violence. [19]

The Framework offers six components to be utilised in order to identify and respond to victims of family violence and is accompanied by three practice guides detailing how to:

1. Identify family violence. [19]
2. Conduct a preliminary assessment to determine the risk and safety for the victim. [19]

### 3. Conduct a comprehensive assessment to determine the risk and safety for the victim. [19]

ACEM considers that the Framework offers an approach that could be utilised by emergency physicians across Australia when treating suspected victims of domestic or family violence, but acknowledges that each State and Territory has its own approach. Importantly, the Framework also highlights the importance of ensuring that, when conducting risk assessments and undertaking risk management, culturally sensitive and knowledgeable services are offered to Aboriginal and Torres Strait Islander people, or women from CALD communities. [19]

#### 4.1.3 Screening Tools

ACEM notes that screening tools such as the Domestic Violence Identification Tool (DVIT), have in the past been used as the basis of a screening program to identify and refer women who have experienced domestic and family violence. [20] However, ACEM considers that other validated tools, such as the Hurt-Insulted-Threatened-Screamed (HITS), could be used by ED staff in the identification and referral of all victims of domestic and family violence, with the appropriate modifications where necessary.

#### 4.1.4 The Domestic Violence Identification Tool

The DVIT uses three questions eliciting a “yes/no” response in relation to whether a woman’s partner has behaved violently toward her. [20] These questions are:

“Has a partner or significant other person ever done any of the following:

- Made you feel afraid?
- Hurt you physically or thrown objects?
- Constantly humiliated or put you down?”

ACEM strongly considers that screening for violence can send the message to the victim that domestic and family violence is wrong, and that health services that can provide support to them are available. As a form of primary prevention (and if adequate services are in place, secondary prevention), ACEM considers that screening tools such as the DVIT could be adapted for use in situations where ED staff believe that a patient is a victim of domestic or family violence. Such tools could be utilised whether the patient is male, female, Aboriginal or Torres Strait Islander, Māori, from a CALD community, elderly or disabled, and with the presence of an appropriately skilled social worker where necessary. [20]

##### 4.1.4.1 The Hurt-Insulted-Threatened-Screamed Screening Tool

The HITS tool utilises four items to assess current physical and psychological abuse, using face-to-face interviews. [21] The tool was developed in order to provide a simple and brief instrument to identify victims of domestic violence, and was created for use in clinical settings. [21]

The HITS tool consists of the following four questions:

“Over the last 12 months, how often did your partner:

- Physically hurt you?
- Insult you or talk down to you?
- Threaten you with physical harm?
- Scream or curse at you?”

Patients respond to these questions using the frequency format of “never, rarely, sometimes, fairly often, and frequently.” [21]

ACEM encourages the use of this tool, and considers it particularly valuable as it has been tested in an ED setting. [21] ACEM acknowledges that a weakness of the HITS tool is that it does not screen for sexual abuse, however, if sexual abuse is suspected, other screening tools could be utilised if necessary. [21] Furthermore, ACEM considers it a benefit that the HITS tool has been validated not only for use with female patients, but also with male patients, regardless of their partner's gender. [21]

ACEM acknowledges that there are other validated screening tools that could be used when screening suspected victims of domestic and family violence. However, ACEM also notes that there may be situations in which it is not appropriate or, due to resource constraints, not feasible to use such tools. Such situations may arise when treating victims of domestic and family violence from Māori, Aboriginal or Torres Strait Islander, or CALD backgrounds, who would require culturally appropriate and safe screening tools and referral services. ACEM therefore considers it vital that, if using such tools, the appropriate support and referral services are available to the victims of domestic or family violence, in particular those from diverse communities.

ACEM also acknowledges that when staff use these tools to screen patients, they may identify that they are themselves at risk of or are experiencing domestic or family violence within their own relationships. ACEM therefore recommends that, if introduced into EDs, consideration of this possibility is taken, and the appropriate training, resources and support are provided.

## 6. PROCEDURE AND ACTIONS

ACEM considers that the following measures should be considered when treating suspected or known victims of domestic or family violence:

- Provision of appropriate medical assessment and therapy are provided in the first instance.
- Treating patients and their families with compassion, respect and tolerance of diversity.
- Interventions should have the consent of the victim.
- Adherence to mandatory requirements.

ACEM also considers that the following resources should be made available to ED staff when treating suspected victims of domestic or family violence:

- Access to 24-hour, seven days per week social workers to which patients can be referred.
- Resources specifically allocated to allow for access to Māori or Aboriginal or Torres Strait Islander social workers.
- Local action plans in collaboration with multidisciplinary health care teams, legal services, law enforcement, and community resources that are readily accessible for health care providers, victims and their families should be developed in order to ensure an integrated service response.
- Provisions for screening for domestic and family violence in EDs in high risk areas (lower socioeconomic status suburbs, areas with high alcohol consumption) and, if appropriate, in high risk populations (Māori, Aboriginal and Torres Strait Islander, those from a CALD background, ante and prenatal women, low socioeconomic status or drug and alcohol abusers).
- Provisions for staff and patient safety and support when screening for domestic and family violence.
- Appropriate education and training in the recognition, management, screening and reporting of domestic violence, with recognition of cultural differences, as well as referral to the appropriate support services.

ACEM considers EDs as good starting points for identifying domestic or family violence, as staff in the ED can assist with appropriate referral of all groups who have presented as a result of domestic or family violence. The ED is also an avenue through which further action, intervention or counselling for domestic and family violence, and subsequent referral to the appropriate support services, can be provided.

ACEM also strongly considers that ED staff should continue to advocate for patients who are victims of domestic and family violence, as well as for increased and improved funding of support services for these victims.

## 7. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

### 7.1 Responsibilities

Document authorisation: Council of Advocacy, Practice and Partnerships  
 Document implementation: Public Health Committee  
 Document maintenance: Policy and Research Department

### 7.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
V1	Jul-05	Approved by Council
V2	Mar-12	Approved by Council Template updated. Change to content under 'Purpose and Scope'. Slight change to some of the content under 'Procedure and Actions'.
V3	Nov-16	Approved by CAPP 'Purpose and Scope' split into two sections. Original content under 'Purpose and Scope' removed. 'Definitions' added. 'Introduction' added with paragraphs on different groups included, describing the different ways in which domestic and family violence is experienced by these communities. 'Policy' expanded in order to discuss approaches and tools that can be applied by emergency physicians when treating victims of domestic and family violence. 'Procedure and Actions' expanded to include measures required when treating suspected or known victims of domestic and family violence, but also the resources that should be made available to emergency physicians treating these individuals.

## 8. REFERENCES

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