Australasian College
for Emergency Medicine

# Family and domestic violence and abuse

Policy P39

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## Document Review

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| Timeframe for review: | Every three years, or earlier if required |
| Document authorisation: | Council of Advocacy, Practice and Partnerships |
| Document implementation: | Council of Advocacy, Practice and Partnerships |
| Document maintenance: | Department of Policy and Strategic Partnerships |

## Revision History

| Version | Date | Pages revised / Brief Explanation of Revision |
|---|---|---|
| 01 | Jul-05 | Approved by Council |
| 02 | March-12 | Approved by Council<br>Template updated. Change to content under 'Purpose and Scope'. Slight change to some of the content under 'Procedure and Actions' |
| 03 | July-16 | Approved by CAPP<br>'Definitions' added. 'Introduction' added<br>'Policy' expanded in order to discuss approaches and tools that can be applied by emergency physicians when treating those experiencing FDVA<br>'Procedure and Actions' expanded to include skills and resources required |
| 04 | July-20 | Substantial revision throughout<br>Application of new document style<br>Limitation of policy to Australian EDs |

# 1. Purpose and scope

This document is a policy of the Australasian College for Emergency Medicine (ACEM) and relates to the identification, screening, treatment and support of patients who present to the emergency department (ED) and are experiencing family and domestic violence and abuse (FDVA). It recognises that ED staff who assess, treat and counsel patients experiencing FDVA can be vulnerable, also requiring specific organisational support. The policy includes a recommendation that hospitals in Australia are resourced to implement a whole-of-hospital model for responding to FDVA, drawing on evaluated approaches.

As Aotearoa New Zealand has a national policy on FDVA, this Policy is applicable to EDs in Australia.

## 1.1 Policy for Aotearoa New Zealand

The general principles documented in this Policy are also relevant to New Zealand EDs. However, for comprehensive national policy specific to New Zealand, ACEM has endorsed the New Zealand Ministry of Health's Family Violence Assessment and Intervention Guideline [1] which is incorporated into training provided through the Violence Intervention Programme.

That guideline acknowledges FDVA as a public health issue requiring a whole-of-system approach. ACEM considers the document a vital resource, as it provides specific guidance on routine enquiries that can be conducted with patients when FDVA is suspected in the ED. It also provides context with respect to the violence and abuse disproportionately experienced by Māori, and guidance on responding in a culturally safe way to such violence and abuse.

Furthermore, screening for FDVA already occurs under national policy in New Zealand. In 2015, 23% of women presenting to EDs were asked about abuse [2], a rate which has steadily increased since the introduction of the policy.

# 2. Definitions

## 2.1 Family and Domestic Violence and Abuse

There is no definition of 'family violence' or 'domestic violence' that is consistent across all jurisdictions. These terms are used interchangeably across the relevant laws in each State and Territory. This document uses the combined term 'family and domestic violence and abuse' (FDVA) to refer to violence and abuse that occurs between people who have any family or domestic relationship. The term 'abuse' encompasses any form of coercion or control and is included here to extend the definition beyond physical and sexual violence.

## 2.2 Family or Domestic Relationship

The relationship between offenders and those who they harm is described variously within jurisdictional FDVA legislation as either 'family' (based on interpersonal relationships) and/or 'domestic' (relationships based on current or past living arrangements). 'Family' may include:

- Relatives and family members, as connected by blood or marriage, including current and past spousal and de facto relationships ('intimate partner relationships').
- Relationships through kinship, cultural or religious grounds.
- Situations where people's lives have become enmeshed through the passage of time, trust and commitment; a level of intimacy, whether sexual or not; frequency of contact; or a level of dependency, such as in informal care arrangements between people with disabilities and their caregivers.

'Domestic' relationships generally include those situations where two or more people live together or who have lived together. They may be living or have lived together as a couple, or in a partnership on a domestic basis such as through a family or parent-child relationship, or as friends, housemates, or other cohabitants.

### 2.3 Violence and Abuse

FDVA is about control, and comes in many more forms than physical assault alone. The Australian Medical Association defines FDVA as 'physical, sexual, financial, emotional or psychological abuse which includes a range of controlling behaviours, such as the use of verbal threats, enforced isolation from family and friends, restrictions on finances and public or private humiliation. [3] Forms of such violence and abuse can include any coercive behaviours that are aimed at the control of or restriction of another person. The behaviours are typically categorised as:

- Physical abuse causing pain and injury.
- Sexual abuse including sexual assault or sexual abuse of children.
- Psychological or emotional abuse involving manipulative behaviour intended to lower self-worth.
- Verbal abuse designed to humiliate, degrade, demean, intimidate, or subjugate.
- Social abuse such as through forced isolation from family or friends.
- Economic abuse including deprivation of basic necessities.
- Harassment or stalking such as constant phone calls to a workplace or home. [3]

## 3. People most at risk

ACEM recognises that experiences of FDVA will differ between groups and communities. While various situations can amplify FDVA, the underlying cause is always the choice of the perpetrator to express themselves through violence. Circumstances such as social disadvantage, vulnerability relating to unequal power (including gender inequality), social isolation, and/or prior experience of trauma, put people at increased risk of ongoing FDVA. These circumstances can prevent someone from seeking help, considering an alternative, or even realising the violence is wrong. Other 'situational' factors, such as pregnancy, recent separation and periods of financial stress, are recognised as times of increased risk of abusive and violent behaviour. Alcohol and drug misuse can also lead to higher levels of aggression by perpetrators. [4]

For information on people most at risk of FDVA in New Zealand please refer to the New Zealand Family Violence Clearing House.

### 3.1 Women

The most common manifestation of FDVA is intimate partner violence and abuse committed by men against their current or former female partners. The Australian Bureau of Statistics estimated in 2016 that, in Australia, one in six women (aged 15 or above) — equating to 1.6 million women — had experienced physical or sexual violence by a current or former partner in their lifetime. Three in four (75%) experiencing FDVA reported the perpetrator as male. Young women aged 18–34 were 2.7 times as likely as those aged 35 and over to have experienced intimate partner violence in the previous 12 months. [5]

Domestic violence is the leading contributor to ill health and premature death in Australian women aged 18 to 44 years. [6] Healthcare data, while revealing, cannot truly measure the prevalence of FDVA, and therefore should be treated with caution. National data is based on hospitalisations, not ED presentations. Patients presenting to EDs may not report episodes of violence and abuse, even on direct questioning, while many people experiencing FDVA will not seek medical attention.

In Australia, for females, the rate of hospitalisation due to assault where the perpetrator was reported as a spouse or domestic partner, has risen at an average of 2.8% per year between 2002–03 and 2016–17, from 27 to 38 hospitalisations per 100,000 population. This represents a 40% increase over the 14 year period. [5] Studies from the US show that women experiencing FDVA are four times more likely to present to an ED than non-abused women, with an average of 3.7 visits over a 12-month period. [7]

### 3.2 People Identifying as LGBTI

ACEM acknowledges that Lesbian, Gay, Bisexual, Transgender and Gender Diverse, Intersex (LGBTI) is a blanket term that describes several distinct but sometimes overlapping groups, each with their own particular histories, experiences and needs.

A 2017 report commissioned by the Victorian State Government [8] found that, in addition to well-documented types of physical, sexual, psychological, financial and other types of FDVA that are relevant to all, further abuse-tactics have been identified as specific to LGBTI people. These may include threats to disclose a person's sexuality or trans identity without consent, leveraging societal stigma as a form of control and specific threats targeting a person's sexuality, gender or sex. The report also notes that violence against LGBTI people does not occur in a vacuum, but in the context of broader and deeply entrenched heterosexist discrimination and abuse. Perpetrators of FDVA against LGBTI people may include parents, carers, siblings, children (including adult offspring) as well as current and former intimate partners.

The report highlights national and international evidence indicating that LGBTI people experience intimate partner violence at a similar, if not higher rate to heterosexual, cisgendered women, and that trans and gender diverse people experience higher rates of violence from an intimate partner in comparison to cisgendered people.

### 3.3 People Living with a Disability

An Australian population-based study on the prevalence of violence and abuse for men and women with disabilities estimated that all forms of violence and abuse, including physical and sexual assault, emotional abuse and stalking and harassment, was considerably higher for people living with a disability. [9] The same study also found that Australians living with a disability are more likely to experience interpersonal violence and abuse. Experiences of FDVA are also gendered for those living with a disability, with studies showing that women living with disabilities are more likely to experience FDVA, and for more extended periods of time. [9]

### 3.4 Children

Protection for children is provided under specific legislation relating to the abuse of children, as well as coverage under FDVA legislation. Child abuse and neglect often occurs within complex FDVA scenarios and can range from direct violence and abuse and maltreatment of a child, through to witnessing family violence and abuse in the home or between relatives. The cumulative effects of trauma in children is becoming better understood, with complex trauma resulting from sustained experiences of harm. [10]

Evidence indicates that there is substantial overlap between the occurrence of child abuse and intimate partner violence and abuse in families. In 2017, 418,000 women and 92,200 men in Australia who had experienced violence and abuse from a previous partner said the children in their care had witnessed this violence and abuse. [3] In 2016–17, In Australia, there were 288 recorded hospitalisations of children for abuse injuries perpetrated by a parent (217 hospitalisations) or other family member (71 hospitalisations). In 2017–18, 22% (26,500) of those needing specialist homelessness services as a result of FDVA were aged 0–9. [3]

ACEM has a specific Policy on Child at Risk [11].

### 3.5 Older Persons

Older persons are extremely vulnerable to FDVA, due to factors including physical limitations, diminished capacity, and legal loss of control. The Australian Network for the Prevention of Elder Abuse specifies that elder abuse is 'any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect'. [12] In 2017–18, more than 10,900 calls were made to elder abuse helplines across Australia. [5] Females experiencing abuse outnumbered males and the proportion generally rose with age. Emotional and financial abuse were the most common types of elder abuse reported. [5]

According to a 2017 EMA article [12], elder abuse is 'common, under-recognised and simultaneously serious and complex' with many older persons suffering multiple types of abuse. Such abuse is associated with as much as a threefold higher mortality, as well as higher rates of ED visits, unplanned hospitalisation, depression and nursing home placement. [13] Those suffering abuse often live in social and medical isolation, receiving healthcare only when they present to the ED. Around 50% of perpetrators are found to be children of those experiencing abuse, and 14% their spouse. [13]

### 3.6 Aboriginal and Torres Strait Islander Peoples

Aboriginal and Torres Strait Islander people in Australia disproportionally experience FDVA. To understand the context of this increased incidence, it is essential to grasp the complex and ongoing impacts of colonisation on Aboriginal and Torres Strait Islander communities. Many of the direct outcomes of colonisation such as unemployment, financial stressors, difficulty in accessing adequate housing, high levels of chronic disease with increased rates of disability, are the circumstances that will amplify FDVA within any community [15,16]. Dispossession, cultural disruption, family destruction from the Stolen Generations and ongoing removal of children perpetuates significant intergenerational trauma, making Aboriginal and Torres Strait Islander families particularly vulnerable to manifestations of violence / abuse. [14]

Government statistics estimate that Aboriginal and Torres Strait Islander women are 32 times as likely, and men 23 times as likely, to be hospitalised due to FDVA as non-Indigenous women and men respectively. Indigenous children are estimated to be around seven times as likely as non-Indigenous children to experience substantiated cases of child abuse or neglect. [5] Additional barriers to finding help also include health and support services that are not culturally safe, and a lack of trust in mainstream services that may perpetuate the previous traumas experienced by Aboriginal and Torres Strait Islander families.

### 3.7 Culturally and Linguistically Diverse (CALD) Communities

The term 'CALD' is defined here as people born overseas in countries other than the main English-speaking countries. There is no uncontested national data available on the prevalence of violence and abuse against women from CALD backgrounds in Australia. However, anecdote suggests that CALD women may be less likely to report violence and abuse, can experience more barriers in accessing support services, and may be less able to leave an FDVA situation than other Australian women. [17]

CALD women share with many other Australian women the practical difficulties of escaping violence and abuse and gaining independence. However, this may be exacerbated by some particular pressures and barriers. [16] These may include language factors, a lack of an independent rental or credit history, lower employment rates, lack of transport, less familiarity with rights under FDVA legislation, cultural norms in relation to family life, sexuality and gender roles, and fewer close contacts in Australia who can provide support. [17]

There are also some specific forms of family violence and abuse experienced by women in some CALD communities — for example, domestic seclusion, forced marriage, female genital mutilation, and dowry-related violence and abuse.

### 3.8 People in Rural and Remote Australia

Isolation from services makes it harder for people experiencing FDVA to obtain support or information about support, and to feel confident that they have options for dealing with their circumstances. Isolation also means that harm is less noticed by others, limiting opportunities for early intervention. People living outside major cities are 1.4 times as likely to have experienced partner violence and abuse since the age of 15 as people living in major cities. People in remote and very remote areas are 24 times as likely to be hospitalised for FDVA as people in major cities. [5]

# 4. ED screening and assessment of FDVA

## 4.1 Recognition of FDVA

Health professionals are in a unique position to identify and respond to FDVA. Many people who experience family violence and abuse will not contemplate engaging with a specialist family violence service but will interact with health professionals at times of heightened risk, or seek treatment for injuries or medical conditions arising from violence and abuse they have experienced. Failing to identify signs of FDVA or minimising disclosures by patients can have a profound impact on those experiencing FDVA, and deter them from seeking help in the future. [18]

A 2019 literature review found that FDVA is generally under-identified in EDs, with one study finding that 72% of women who attended an ED after an incident failed to be identified as experiencing abuse. [19] Aside from logistic and resourcing limitations, a key barrier to identifying FDVA in the ED has been found to be professional uncertainty and discomfort, both in terms of 'causing offence' or being unsure exactly how to sensitively broach the issue with presenting patients. Discomfort may also be associated with staff being able to manage their own feelings—especially those who have personally experienced FDVA. [20]

FDVA thrives on silence. Initiatives to address low rates of recognition are clearly required. One element of this may be through training in the use of screening tools that provide a trusted and proven format of dialogue, and are organisationally mandated, resourced and supported.

## 4.2 Screening (or Assessment) for FDVA

Higher identification of FDVA occurs as a result of screening. [19] Screening of FDVA in the ED involves simple, targeted questions that will ideally identify most patients who are experiencing abuse. European guidance for EDs advises that, while outcome data regarding the efficacy of routine screening is still lacking, and even the most common tools have been evaluated in only a small number of studies and populations, 'performing a screening itself is more important than its content'. [21]

Formal screening programs are resource intensive and require specific and adequate resourcing. A 2018 feasibility study [18] conducted by NSW Health on FDVA screening and response in NSW EDs used the Hurt, Insulted, Threatened with Harm and Screamed (HITS) tool to selectively screen (in three EDs, two rural, one metro) women aged between 16 and 45 years. The HITS tool was used because it had been recommended by studies as having the most diagnostic accuracy, concurrent validity and reliability [22], and because it is a simple and brief instrument designed for use in busy clinical settings. The study [19] found that use of the HITS tool with one-hour follow-up by social work, as an intervention for women in the 16-45 age group experiencing current FDVA, was supported by staff and should be retained in future rollout or testing.

ACEM recognises that there are a variety of screening tools that could be used when screening for suspected FDVA. As it has been tested in an ED setting (including in Australia), ACEM encourages the use of the HITS tool in Australian EDs for the identification and referral of intimate partner violence and abuse (with modification as necessary). It must be accompanied by the necessary resourcing, staffing and safeguards identified further on in this document. It should be noted that HITS is designed primarily for screening for current intimate partner violence and abuse and there may be more appropriate screening tools for other manifestations of FDVA.

# 5. Policy

ACEM supports the following statements.

### *Human Rights*

FDVA is a crime. Everyone has the right to be free of violence and abuse, or the fear of violence and abuse, and to feel safe and respected in their family and relationships. Ongoing, one-sided coercion and control as a form of domination is harmful. The responsibility for FDVA always lies with the perpetrator and is never the fault of those suffering at their hands. Relevant international, national and jurisdictional legislation should recognise FDVA as a violation of human rights, as articulated in the United Nations Declaration on the Elimination of Violence against Women. [23] ACEM does not regard those who disclose FDVA to ED staff as 'victims', but as courageous and successful survivors with a capacity to flourish.

### *ACEM Advocacy*

ACEM advocates strongly for the establishment and resourcing of support services that can reach all those experiencing FDVA, with particular reference to regional and remote environments where there may be few essential and specialist services, and where leaving a relationship may involve moving away from all other supportive networks.

### *Whole-of-System*

FDVA a public health issue. A whole-of-system approach is required in order to address this problem, from prevention, early-intervention through to treatment. This should entail a shared understanding of the prescribed responsibilities of different services/sectors, recommended best practice, and agreed referral pathways required for the optimum assessment and management of FDVA risk. This approach should span communities, local/national governments, justice, health and social service providers. An example of a whole-of-system approach is the Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework.

### *Whole-of-Hospital*

The Royal Commission into Family Violence (VIC) recommendation that 'public hospitals are resourced to implement a whole-of-hospital model for responding to family violence, drawing on evaluated approaches' [18] should be the standard for all hospitals in Australia.

### *Role of EDs*

Those experiencing FDVA regularly attend the ED as a result of injury or other conditions. FDVA can also be a factor when a chronic condition, or treatment compliance, deteriorates due to self-neglect. People may present because the ED provides more 'anonymity' than other health care services, or simply represents a safe haven. EDs therefore play an important role in the recognition and treatment of FDVA. EDs need to provide a caring and safe environment for patients presenting under such circumstances, including referral to specialist support services undertaken in line with patient wishes or mandatory reporting requirements. The role of the ED can be strengthened and expanded when formal relationships are developed with external agencies and support programs.

### *Role of Emergency Physicians*

As part of their health advocacy role, emergency physicians should have a proactive approach to identifying and supporting those experiencing all forms of FDVA. The ACEM Curriculum Framework, which guides the training and practice of emergency physicians in Australia and New Zealand, requires that doctors will be able to screen patients presenting with common illnesses/injuries for recognised risk factors, including abuse, neglect and violence. For patients who are identified as being at risk, ED doctors will be trained to adapt management plans to account for the presence of vulnerability factors in patients of any age, including discharge to a place of safety and integration with appropriate support services.

### *Screening and Assessment*

There is scope to expand targeted screening for FDVA in Australian hospital EDs based on systematic identification of risk factors. In doing so, best practice and lessons learnt from international experience, ranging from prevention to early intervention, should be considered in an Australian context. Roll out of a screening program should:

- be organisationally mandated and supported;
- incorporate training for frontline staff on screening methods;
- include key performance indicators which reflect the additional work for EDs;
- support facilitated and structured recording in clinical records;
- be adequately resourced, both internally and externally, so as to enable the results of the screening to be appropriately acted upon, including brief interventions performed by social workers, and culturally safe patient referral and follow-up in the community.

### *Supportive Workplaces*

Supportive workplaces improve staff understanding and identification of FDVA, reduce organisational stigma around FDVA, inspire appropriate treatment of patients, provide a cultural environment in which staff feel it that is safe to disclose their own experiences of violence and abuse, and offer confidential counselling opportunities for staff who choose to access them.

### *Aboriginal and Torres Strait Islander People*

Care and support, including screening tools, for Aboriginal and Torres Strait Islander people experiencing DFVA must be culturally safe and tailored to the specific needs of the local community. Health services must ensure that all frontline staff have received cultural safety training, and frontline staff should be supported by Indigenous Health Liaison Services (IHLO). Access to an IHLO does not replace the needs for social work support, rather the liaison service will complement the social work intervention.

In-hospital services and referral pathways must be developed in partnership with Aboriginal and Torres Strait Islander people, communities and organisations to provide seamless and trusted transition of culturally safe care. Review and analysis of programs and services should include the community's experience and expectations.

### *Accurate Data*

There should be an immediate review on the adequacy of the evidence base around the prevalence of FDVA, with recommendations on how to overcome limitations in the collection of nationally consistent and timely data. Noting that the National Non-admitted Patient Emergency Department Care Database cannot be currently used to identify assault injuries due to family, domestic and sexual violence and abuse [5], ACEM will provide any required advice to the AIHW on ways to improve the national collection of ED presentations related to FDVA.

# 6. Competencies and resources

## 6.1 Key competencies for ED personnel in addressing FDVA, besides medical assessment and the management of injuries, include:

### *Identification*

The skills to identify FDVA experienced by patients in all its forms, including that experienced by children, intimate partners, older persons, and others. Familiarity with the often subtle emotional, psychological and physical signs and symptoms of violence and abuse, which may manifest in people who have presented for a different reason. This includes observations of a patient's interpersonal interactions with an attending support person(s).

### *Link between IPV and Child Abuse*

An understanding that there is substantial overlap between child abuse and intimate partner violence and abuse in families, and the ability to facilitate communication which may identify this risk.

### *Risk Assessment and Education*

The ability to engage with the patient and assess for FDVA risks, especially in the absence of a formal departmental screening tool, and provide opportunities for patients to safely disclose violence and abuse. The ability to educate patients on the 'cycle of violence', recognised patterns of increasing frequency and severity of FDVA over time, and the escalating risk for patients who are reluctant to disclose or report at that point in time.

### *Compassion and Choice*

The ability to treat patients who disclose FDVA in a way which is non-judgmental, compassionate, respectful and culturally safe. An awareness of patient autonomy, which acknowledges that the choice to report FDVA entirely rests with the patient unless there are mandatory requirements, significant life-threatening injuries, a risk to children, or associated mental health symptoms, such as suicidality precluding consent.

### *High Risk Factors*

Awareness that some circumstances/behaviours, such as new pregnancy, recent or planned separation, non-fatal strangulation, harm to pets, threats to kill and access to weapons, constitute high risk (increased likelihood of death), and can qualify patients for more intensive community support. ED personnel should be aware of specific high risk factors and how to refer such patients for additional support according to local arrangements.

Recognition that other conditions increase the risk of FDVA, including prolonged times spent at home with perpetrators, for example due to restrictions associated with pandemic illness, loss of jobs, and other social stressors.

### *Keeping Perpetrators Away*

Awareness of hospital protocols for keeping perpetrators away from patients who are at significant risk, combined with an understanding of what services are available to patients if they do not wish to stay. Consideration of factors including the potential dangers of patients leaving with printed cards/brochures about FDVA and associated support services, that the abuser might discover.

### *Legal Requirements*

The maintenance of knowledge specific to the treatment and care of patients experiencing FDVA, as outlined in the jurisdictional and national legislative frameworks with respect to mandatory reporting requirements and orders of restraint.

## 6.2 Resources that ACEM considers should be made available to ED staff in treating patients in cases where FDVA is suspected

### *Guidelines*

ED protocols and guidelines for suspected FDVA.

### *Training*

Appropriate education and training in the recognition, management, screening and reporting of FDVA, tailored for local communities and inclusive of referral services. Such training should support ED staff to ask about FDVA in a way that makes it easier for people to disclose, and also emphasise to ED staff the significant increased physical and emotional risks for the person following disclosure.

### *Patient Support Services*

Timely access to support services (ideally social workers and translators) seven days a week for patient referrals. Where formal screening is in place, a dedicated social work position in the ED to support such FDVA screening. Social work services should be adequately supported by an Indigenous Health Liaison Officer (IHLO) team or by professionals working with CALD communities.

### *Safe and Therapeutic Design*

Private and quiet spaces where ED personnel can speak with the patient on a one-to-one basis in an environment where the patient feels safe, and any potential perpetrator cannot overhear or interfere in the conversation.

### *Referral Pathways*

Formal referral pathways to specialist social or legal support services for those experiencing FDVA. Local action plans developed in collaboration with multidisciplinary health care teams, legal services, and law enforcement. Safe accommodation and other community resources for those experiencing FDVA and their families are also vital elements of this integrated service response.

### *Support for Screening*

Screening to be introduced contingent upon sufficient departmental resourcing, staff training in the screening tool, confidential support services for staff use if required, and the availability of culturally safe support and referral services with adequate local capacity.

### *Staff Welfare*

Provisions for staff support when screening for FDVA. When staff use these tools to screen patients, they may identify that they are themselves at risk of or are experiencing FDVA within their own relationships. ACEM therefore recommends that, if screening is formally introduced into EDs, appropriate provision is made for this scenario.

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**Australasian College for Emergency Medicine**
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
policy@acem.org.au

**acem.org.au**