Guidelines for responding to Family and Domestic Violence

Delivering a Healthy WA
## WHAT TO DO - A SUMMARY

Identifying and Responding to Family and Domestic Violence and Child Abuse and Neglect

<table>
<thead>
<tr>
<th>Step 1 COMMUNICATE &amp; CONSULT</th>
<th>Step 2 ASSESS</th>
<th>Step 3 REFER</th>
<th>Step 4 MANAGE</th>
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<td>The Health Worker will:</td>
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<td>Where there is to be ongoing contact with the client and/or the family:</td>
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<td>• Speak with the client alone and in a private area.</td>
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<td>• Validate their experience:</td>
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<td>• Reassure the client that the violence is not her/his fault, she/he has a right to feel safe, and help is available.</td>
<td>• services already involved with the family</td>
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<td>Refer for assessment</td>
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<td>FDV not disclosed but suspected or some supports are already in place:</td>
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<td><strong>GO TO STEP 2</strong></td>
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<td>• Provide written information on specialist FDV services.</td>
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<td>• Develop a Safety Plan with the client.</td>
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<td>Have relevant information and the client’s details available to pass to referral source.</td>
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Family and Domestic Violence Assessment Flowchart

Client presents at Health Service
Complete initial screening

Assess for Family and Domestic Violence
Interview client alone

- No FDV disclosed. No signs and symptoms identified. 
  - Treat presenting condition as required.

- Client discloses family and domestic violence. 
  - Acknowledge abuse and support client. Consult with specialist FDV Health Worker or Agency.

- FDV not disclosed but signs and symptoms identified. 
  - Consult with specialist FDV Health Worker or Agency.

Undertake an assessment

If Immediate Protection Required
- In consultation with the client:
  - refer to the Police
  - seek refuge/emergency accommodation
  - sexual assault - refer to SARC
  - suicide risk - refer for mental health assessment.

If High Risk
- Refer to specialist FDV Health Worker or agency.
  - Develop a Safety Plan with client.

If at Risk
- Provide written information on specialist FDV services.
  - Develop a Safety Plan.

Children at Risk
- Refer to Police and/or Department for Child Protection (after hours Crisis Care).

Document steps taken on client records

Follow-up as appropriate
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GUIDELINES FOR RESPONDING TO FAMILY AND DOMESTIC VIOLENCE

The Guidelines for Responding to Family and Domestic Violence support the development of models of care and provision of services that conform to a state-wide standard of practice.

The Guidelines have been developed to provide Health Workers with an understanding of Family and Domestic Violence (FDV), the impact it has on members of the family and the wider community and to assist Health Workers to make safe and effective interventions with victims of violence and abuse, their children and other vulnerable people in the household. It sets out principles of screening for violence and abuse and of intervention and provides standard information applicable to health professionals and clinical settings.

While it is not possible to provide a comprehensive response specific to every clinical setting, it is anticipated that individual services will formulate their own response, relevant to the particular circumstances of their community or region.

Due to the high co-occurrence of FDV and child abuse and neglect, this manual is intended to be used in conjunction with the Guidelines for Responding to Child Abuse, Neglect and the Impact of Family and Domestic Violence.

**Note:** For the purposes of these Guidelines, the terms ‘child’ and ‘children’ is used to describe a young person or persons up to the age of 18 years.

**Note:** The term ‘Health Workers’ refers to all Government of Western Australia health employees.
FACTS ABOUT FAMILY AND DOMESTIC VIOLENCE

- The Australian Bureau of Statistics (ABS) Personal Safety Survey in 2005 estimated that in the previous 12 months, 363,000 Australian women experienced physical violence and 126,100 women experienced sexual violence. The ABS further estimate that 2.56 million or 1 in 3 Australian women have experienced physical violence at some stage in their life since the age of 15 years and that 1.47 million or 1 in 5 have been exposed to sexual violence. (Note that these statistics do not necessarily relate to FDV but do highlight the significance of the issue)

- A comprehensive study by Access Economics found that for the period 2002-03, the estimated cost of FDV to the Australian community was $8.1 billion. The largest contributor is pain, suffering and premature mortality with an annual cost of $3,521m. The estimated health cost is $388m. These costs are associated with the provision of facilities, resources and services including GP consultations, accident and emergency, inpatient care, psychiatric care and alcohol and drug services.

- FDV is the leading contributor to preventable death of women in Western Australia. A 2005 report released by the Australian Institute of Criminology found that 49 per cent of female victims of homicide were killed as a result of a domestic altercation.

- Although men can be victims of violence, this is much less common. Access Economics found that 87 per cent of victims of intimate partner violence were female and 98 per cent of perpetrators of this violence were male.

- Physical and sexual violence in Aboriginal families is not usually reported for fear of community and family reaction, however, a high percentage of the FDV incidents reported to the Western Australian Police Service concern Aboriginal people.

- Pregnancy is a time of heightened risk of FDV with the abdomen being targeted more frequently and more severely. Women experiencing violence during pregnancy often obtain minimal or late antenatal care. They are at increased risk of having poor weight gain, anaemia, infection or preterm labour, of bearing a low birth weight infant and of experiencing postnatal depression.

- Women who have been abused are at higher risk of experiencing psychiatric disorders including depression, anxiety and suicidal behaviour and are more likely to misuse alcohol and drugs as a coping strategy.

- There is strong co-occurrence between FDV and child abuse and neglect. It is estimated that children living in domestic violence situations are up to 15 times more likely to be abused or neglected than children from non-violent homes.

- FDV occurs across all social, cultural, economic and religious groups. It affects families in metropolitan and country areas. In assisting people experiencing family and domestic violence, account needs to be taken of the social, cultural, economic and religious factors impacting on the individual.
PRINCIPLES AND VALUES

The following principles and values underpin these guidelines:

- Family and domestic violence is a violation of basic human rights. People are entitled to live in dignity, free from fear and harm in their own home or domestic environment. Children have the same rights ascribed to adults in respect to violence and abuse.

- The safety of victims of FDV and their children and other vulnerable people is paramount. A primary duty of care to the victim and their dependants is to focus on their immediate safety needs.

- All forms of FDV are unacceptable. There is no acceptable cultural justification for violence.

- People have a right to privacy and confidentiality. This is upheld in all areas of service delivery, within the limits of the law and where safety is not compromised.

- The perpetrator is always responsible for his/her behaviour. No blame or responsibility for the violence is attributed to the victim.

- Clients have access to written and verbal information in relation to their rights and options and are encouraged and supported to make decisions which promote their safety and the safety of their children.

- Clients who chose to remain in or return to a violent home environment are supported and their decision respected.

- People from all cultural and linguistic backgrounds and their community ties are respected and their individual needs met through culturally appropriate intervention and management of services.

- People have a right to the support of someone from their cultural background and have access to an independent interpreter where this is required.
DEFINITIONS

Family and Domestic Violence
There are many definitions of family and domestic violence, however, for the purpose of these guidelines, FDV is defined as an abuse of power within intimate relationships or relationships of trust and/or dependency which causes the victim, most often women, to live in fear of the abuser. FDV can involve physical, sexual, psychological, emotional, spiritual or cultural abuse, forced social isolation and neglect. It can involve financial or economic deprivation and exploitation and destruction of property. It can be perpetrated by male or female, an adult or child, a related or unrelated carer, a heterosexual or same sex partner.

The term ‘family violence’ is most often used to describe violence occurring across the full range of family and/or caring relationships. For many Aboriginal and Torres Strait Islander people this term is preferred as it acknowledges intimate, family and other relationships of mutual obligation and support.

Physical Abuse
Physical abuse is the use of physical force with the intent to harm or frighten. Actions include restraint of a person, punching, beating, choking, kicking, biting, shaking or any other action that results in harm. It can include the use of weapons such as guns, knives, bats, etc.

Neglect
Neglect is the failure of a caregiver to provide for the basic physical, emotional, developmental, social, medical, educational, nutrition or shelter needs of a person.

Sexual Abuse
Sexual abuse is any unwanted sexual activity or behaviour to which the victim has not consented or was not able to consent. Activities can include unwanted sexual touch, being forced to masturbate, view pornography or perform sexual acts on oneself or others and sexual penetration by penis, object or other parts of the body into vagina, anus or mouth.

Psychological/Emotional Abuse
Psychological or emotional abuse is the systemic use of threats of physical or sexual violence, intimidation, harassment or damage to property that result in anguish and fear. It can include threats to harm or kill the victim, threats with weapons, threats to abduct or harm children and hurting or killing pets. It includes acts or omission by partners or caregivers that result in serious behavioural, cognitive, emotional or mental health problems.
It can involve the perpetrator deliberately causing confusion for a partner or family member, prolonged silences, withholding important information, excluding a partner or family member from decision-making, blaming the victim for the violence and attacks on a person’s self esteem or social competence.

It includes stalking which is unpredictable, considered dangerous and can end in violence. This can occur during a relationship or after a relationship ceases, and involves harassment or threatening of another person in a way that haunts that person. It can involve intense monitoring of the victim’s activities by phone, in person, via the internet or email (cyber-stalking), monitoring phone calls or unexpectedly showing up at a place where the victim is currently attending, such as home, school or work.

Children exposed to domestic violence are at risk of psychological and emotional abuse.

Social Abuse
Social abuse involves the manipulation, isolation and/or intimidation of a person and includes having their movements and contacts monitored, being prevented from making contact with family and friends, having the use of the telephone or the family car restricted and being prevented from having a job or other interests outside of the home.

Economic Abuse/Financial Exploitation
Economic abuse is the control by one person over the finances of another, stealing from or defrauding a partner of money or assets, or taking advantage of that person for monetary gain or profit. The perpetrator can deny access to bank accounts, force the surrender of bank cards to gain control of a person’s income or social security payments, or prevent a person from seeking or maintaining employment. It can also include denying a person input into important financial decisions which directly affect them.

Note: It is important to be aware that many forms of FDV are a crime such as physical assault, aggravated assault, sexual assault and deprivation of liberty.

Victim
A person who is the target of violence and/or abuse and is subjected to excessive controlling behaviour or neglect within the context of an intimate or family relationship.

Indirect Victim
A person, usually a child, who is harmed and violated by violent or abusive behaviours directed towards another, usually a female parent.

Perpetrator
A person who inflicts the violence or abuse or causes the violence or abuse to be inflicted on the victim.
Intimate Partner
This can be a current partner, including marital or common-law partner, heterosexual, same sex partners, boyfriend or girlfriend and former marital (divorced or separated) or common-law partners.

Child Abuse
The physical, sexual or psychological/emotional abuse or neglect of a child by their parent/s, a carer or a person in a position of authority.
**WHAT TO DO – A SUMMARY**

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<td>• Where necessary, engage a trained interpreter to liaise with clients from a CaLD background or clients with a disability.</td>
<td>• high risk factors</td>
<td>• Police Service - local station or Police Communications; and/or</td>
<td>• Arrange regular scheduled meetings of health workers involved with the client. Include external agencies which are involved with the client and/or family.</td>
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<td>• Listen to and acknowledge what the client is saying</td>
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<td>• Department for Child Protection (after hours contact Crisis Care) if children are at risk.</td>
<td>• Monitor and support client and/or family.</td>
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<td>• Validate their experience:</td>
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<td>• Seek refuge/emergency accommodation.</td>
<td>At any point of intervention, if concerns for the immediate safety of the client and/or children emerge as a result of:</td>
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<td>• Reassure the client that the violence is not her/his fault,</td>
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<td>• she/he has a right to feel safe, and</td>
<td>• action required to address immediate safety.</td>
<td>• Mental health service if client is at high risk of suicide or serious self harm.</td>
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<td>• help is available.</td>
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<td><strong>High Risk</strong></td>
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Guidelines for responding to Family and Domestic Violence

Family and Domestic Violence Assessment Flowchart

Client presents at Health Service
Complete initial screening

Assess for Family and Domestic Violence
Interview client alone

- No FDV disclosed. No signs and symptoms identified.
  - Treat presenting condition as required.

- Client discloses family and domestic violence.
  - Acknowledge abuse and support client. Consult with specialist FDV Health Worker or Agency.

- FDV not disclosed but signs and symptoms identified.
  - Consult with specialist FDV Health Worker or Agency.

Undertake an assessment

If Immediate Protection Required
- In consultation with the client:
  - refer to the Police
  - seek refuge/emergency accommodation
  - sexual assault - refer to SARC
  - suicide risk - refer for mental health assessment.

If High Risk
- Refer to specialist FDV Health Worker or agency.
- Develop a Safety Plan with client.

If at Risk
- Provide written information on specialist FDV services.
- Develop a Safety Plan.

Children at Risk
- Refer to Police and/or Department for Child Protection (after hours Crisis Care).

Document steps taken on client records

Follow-up as appropriate
INDICATORS OF FAMILY AND DOMESTIC VIOLENCE

Typically the level of violence in FDV increases and becomes more damaging and severe over time and occurs more frequently. Early detection and intervention can therefore lessen the risk of more severe harm or even homicide of the client and/or children.

There are many indicators of FDV. One indicator in isolation may not necessarily indicate abuse therefore each indicator needs to be considered in the context of the client’s personal circumstances and presenting issues.

High Risk Indicators

There is no absolute indicator to determine the risk of homicide, however, the greater the number of high risk indicators, the greater the risk that a homicide may occur.

A referral to the WA Police Service with or without the client’s consent should be made when there are concerns for the client’s immediate safety or the safety of others.

Client

- has received life threatening injuries
- injuries have increased in frequency and severity over time
- is pregnant or has recently given birth
- has recently separated from or is considering separating from an abusive partner.

Note: Separation is a time of extreme danger. Separation includes the victim leaving the perpetrator or the perpetrator being removed from the home against their will as a result of a violence restraining order or police charges.

Perpetrator

- has access to weapons, particularly firearms and other lethal weapons
- has used a weapon in most recent event
- has previously tried to harm/kill the victim
- has previously threatened to harm/kill the victim
- has previously harmed or threatened to harm/kill children or other family members
- has harmed/killed pets or other animals
- has threatened to harm/kill pets
- has previously threatened or attempted suicide
- has sexually abused the victim
- misuses drugs and/or alcohol
- has or is stalking the victim
- uses obsessive/jealous/controlling behaviour towards victim
- is unemployed
- has previously had Violence Restraining Orders taken out against him/her
has previously or is in current breach of a violence restraining order
has financial difficulties
has depression or other mental health illness.

**Note:** The presence of a mental health illness needs to be carefully considered in relation to the co-occurrence of other risk factors. The victim is at high risk if, for instance, the perpetrator has paranoia whereby he/she identifies the victim as hostile.

**Physical Signs and Symptoms**

Physical signs and symptoms are not in themselves evidence of FDV, however, the indicators may raise suspicion that it is present.

Client presents with
- injuries to the head, face, neck, chest, breast, abdomen or genitals
- unexplained physical injuries
- patterns of repeated injury
- ruptured eardrums
- multiple and bilateral soft tissue injuries especially contusions and abrasions
- lacerations, bruises, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures
- bruises of various ages and multiple injuries such as bruises, burns and scars in different stages of healing
- signs of hair being pulled out
- been victim of sexual violence
- lethargy
- a history of gynaecological problems, miscarriages, chronic pelvic pain
- illnesses including
  - headaches, migraines, dizziness
  - insomnia
  - musculoskeletal complaints
  - chronic pain
  - malaise, fatigue
  - neck stiffness
  - numbness
  - chest pain, palpitations
  - gastrointestinal disorders
- hyperventilation
- ongoing complaints of acute or chronic pain (eg. chronic pain syndrome), without evidence of tissue injury
- eating disorders.
Pregnancy

Women are at increased risk of FDV commencing or increasing during pregnancy. Women abused during pregnancy are at even greater risk of violence in the postpartum period. Factors to consider include

- minimal or late attendance for antenatal care
- unintended or unwanted pregnancy
- injuries or vaginal bleeding during pregnancy
- miscarriage or other pregnancy complications
- low birth weight of infant
- seeking a termination of the pregnancy.

Psychological and Emotional Indicators

Recurring abuse can lead to other illness and emotional problems that on the surface may not appear related to FDV

Indicators include

- post traumatic stress disorder involving
  - increased psychological arousal
  - intrusive thoughts and flashbacks
  - sleeping difficulties and nightmares
  - difficulty with concentrating
  - hyper-arousal and hyper-vigilance
  - disassociation
- repeated visits to a Health Service or general practitioner for stress-related symptoms.
- emotional distress such as anxiety, indecisiveness, confusion, hostility, panic attacks
- depression
- self-harming behaviours
- suicidal thoughts and/or attempts
- unexplained somatic complaints
- drug and or alcohol abuse including dependence on tranquillisers and alcohol.

Presentation and history

The client is

- hesitant or evasive when describing injuries
- minimises injuries/pain
- distress is disproportionate to injuries, e.g. client shows extreme distress over minor injury
- explanation is inconsistent with injury, e.g. “I walked into a door”
uncomfortable or anxious in the presence of his/her partner
makes excuses for the perpetrator’s violent behaviour
withdraws from touch
substantial delay before seeking medical treatment
multiple presentations at health services for vague symptoms
partner or family member presents with the client, insists on remaining with the client and speaks on client’s behalf
record of or suspicion of previous abuse
misuses drugs and/or alcohol including prescribed drugs
insecure housing
financial problems.
COMMUNICATING WITH CLIENTS

Clients may not bring up the subject of FDV but may discuss it when asked simple, direct questions in a non-judgemental manner and in a confidential setting. It is important to gain a client’s trust through patience and support and to be open and honest as to what can or cannot be done to assist them.

Where possible, clients suspected of being victim of FDV should be given frequent opportunity to discuss the abuse. For instance, pregnancy offers an ideal opportunity for women to be screened at several intervals when they attend antenatal appointments.

Provide a Supportive Environment

Providing a supportive, safe and private environment is essential
- Conduct the interview in a private room where possible
- Do not talk to the client in the presence of the suspected perpetrator
- Interview the client alone, unless a specific request is made for another person, such as an advocate to be present
- Be firm about excluding others whose presence could interfere with or influence the assessment. The presence of a third party can result in the client withholding information or being coerced to disclose information they would prefer not to reveal
- Be aware that young children who are present during the interview may relay information back to the perpetrator
- Provide same-sex staff where possible and when requested by the client.

Communicating with the Client

Disclosing FDV is a big step and carries an element of risk for the person. They cannot be sure of how the disclosure will be received or what the consequences will be. Conveying a genuine attitude that is gentle, welcoming, caring, non-judgemental, non-blaming, respectful and reassuring will help the client develop a sense of trust in the Health Worker.

- Do not rush the client but allow them time to think about and respond to questions in their own time
- Be sensitive to the emotional distress or fear the client might be experiencing
- Listen to what the client is saying
  - Acknowledge what they have told you “That must have been frightening for you.” “You are a strong person to have survived that…”
  - Affirm that the client has made an important step by talking about the abuse
- Validate the client’s experience
  - Reassure the client that their reaction to the abuse is normal ... (e.g. physical, emotional, behavioural reactions)
  - Reinforce with the client that the violence is not their fault, that there is no excuse for violence and that the responsibility lies with the perpetrator.
  - Let them know that violence is a crime
  - Inform the client she/he has a right to feel safe and live free from abuse or violence.

Screening for Family and Domestic Violence

Due to the high prevalence of FDV, particularly amongst females of child bearing age, it is preferable that Health Workers ask a series of screening questions to identify whether FDV or child abuse and neglect are present. These questions should be asked of mature minors and young people (both male and female) as well as adult women.

All women attending antenatal appointments should routinely be screened.

An explanatory statement can be made to set the context such as “I am concerned about you because of ... (list indicators that are present) and would like to ask you some questions about how things are at home. Is that OK with you?” or “People are routinely asked these questions when they come in to see me because violence is common in people’s lives.” Or “When I see injuries like this I wonder if someone could have hurt you.”

The following are useful screening questions
- Are you afraid of someone close to you (e.g. friend, partner, family member)?
- Has someone close to you hit, slapped, punched, kicked or otherwise physically hurt you?
- Has someone close to you put you down, humiliated or embarrassed you?
- Has someone close to you tried to control what you can do or say?
- Has someone close to you threatened you?
- Have you been hurt or threatened by someone in your family or household?
- Have you been forced into any sexual activities you did not want to do?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who makes you feel unsafe now?
- Would you like help with any of this now?

(Refer to Resources - Screening and Referral for Family and Domestic Violence template)

It is useful to determine when the last incident of violence or abuse occurred.

If FDV is disclosed, the person should be asked about any children or other people in the home, who may also be at risk.
Questions to consider include

- Are you worried about your children (or someone else in your family or household)?
- How is this affecting your children?
- Has ... (the perpetrator) threatened to hurt your child?
- Has ... (the perpetrator) hurt you in front of your child?
- Has ... (the child) overheard the yelling/violence?
- Has ... (the child) tried to protect you/try to stop the violence?
- Has ... (the child) been injured by ... (perpetrator) or injured while trying to protect you?
- Is ... (the child) afraid to leave you alone?

Many people chose to remain in an abusive situation in the belief that keeping the family together is in the best interests of the children. It is helpful for clients to be made aware of the impact of violence on children and to be encouraged to discuss this with a professional who works with children or to seek counselling for the children. The following questions can guide a client towards a greater understanding of the impact

- How do you think ... (child) would describe life at home?
- What changes do you think ... (child) would like to happen?
- What is the reaction of ... (child) when ... (perpetrator) has been violent to you?

(Refer to Special Groups - Children section)

Where there are concerns about the parent’s ability to protect the child due to an intellectual disability, a mental health illness, their substance misuse or poor parenting ability, consideration will need to be given to referring the family to the Department for Child Protection.

If FDV is suspected but the client does not acknowledge that it is a problem

- Provide written information and telephone numbers for specialist family and domestic violence services
- Discuss a safety plan.

(Refer to Assessment – Safety Planning section)

It is important for an assessment to be undertaken when

- concerns for the safety and wellbeing of children are identified
- a person discloses FDV or there are sufficient indicators that FDV is present.

Where possible, this assessment should be undertaken by a staff member with FDV experience, such as a social worker.

(Refer to Assessment section)
Communicating with Children

Age appropriate questions can be asked of children. Similar to working with adults, a supportive style should be used with children. Children will also need reassurance that they are not responsible for the abuse occurring in the family.

Examples of questions can include
- Tell me about the good things at home
- Are there things at home you wish you could change
- What don’t you like about home
- Who makes the rules at home
- What happens when you break the rules
- What happens when your parents are angry with you
- What happens in your house when people have an argument
- What do you do when mum and dad are fighting
- Do you get frightened
- Do you have someone you can talk to such as an older sister/brother.

For more information on responding to disclosures of abuse by children, refer to the Guidelines for Responding to Child Abuse, Neglect and the Impact of Family and Domestic Violence.
ASSESSMENT

It is important that an assessment of clients who have disclosed or who are suspected of or have been identified as victims of FDV be undertaken, in order to determine their immediate safety needs and the most appropriate referral options for them.

Where a health service has a social work department this support should be enlisted.

Health Workers are not required to undertake an investigation into the violence. This is the responsibility of the WA Police Service or the Department for Child Protection (where children are at risk).

Prior to commencing an assessment, where it is believed that the perpetrator poses a risk to client and staff, safety arrangements in keeping with the health service’s policy need to be actioned. This may involve knowing the current whereabouts of the perpetrator and undertaking the assessment in a safe place away from that person, or arranging for security staff to be close by.

A General Guide to Assessment

Assessment is a process that involves the Health Worker and the client working together to ascertain the level of immediate risk to the client and that of her/his children and other dependant people in the household, after the client leaves the health service. It is also important for the Health Worker to take into consideration the co-occurrence of victim and perpetrator characteristics or indicators from which the likelihood and severity of further violence can be determined.

Prior to commencing the assessment, ensure that the client
- has had their immediate medical needs addressed
- feels and is psychologically safe enough to talk about the violence
- has had urgent issues addressed, such as childcare arrangements
- is able to communicate effectively so they will be understood, for instance an Auslan interpreter may be required for someone who has a hearing disability
- is engaged in a culturally sensitive manner
- understands the role of the Health Worker/s undertaking the assessment
- feels comfortable with the Health Worker/s.

The assessment should address the following
- details of the most recent incident of violence or abuse
- a history of the violence or abuse
- identifying the presence of high risk indicators such as the perpetrator having access to firearms or other lethal weapons (refer to Indicators of Family and Domestic Violence section)
- identifying whether a crime has been committed, for instance, a sexual assault, in which case involving the police should be discussed
identifying whether the client is at immediate risk of suicide or serious self harm
identifying what action is required to address immediate safety, such as arranging safe accommodation or involving the police
identifying existing protective factors, for example client has a current violence restraining order or a supportive social network
identifying what services are currently involved with the family, such as a social worker from an external agency
Identifying whether there are children or other family members who are at risk.

It is important to encourage the client to tell her/his story and define the problem. Questions to open the discussion can include
- can you tell me what has been happening for you at home?
- can you tell me about your relationship with ... (perpetrator).

Once the client has provided some level of detail about their circumstances, questions can be more specific
- Can you tell me what ... (perpetrator) did to hurt you?
- How long has this ... (violence) been happening?

Refer to Indicators of Family and Domestic Violence section and use the indicators as a guide for asking appropriate questions or for identifying risk factors which will assist in collecting all the information required for this assessment.

Note that a client’s own assessment of their level of fear or risk is usually accurate, however, in some cases, victims cannot accurately describe their level of fear or assess their level of safety because of mental health problems or because they have been desensitised to the violence as a result of their history. Caution must therefore be taken when interpreting their response.

A useful way to assess the level of risk to a client or their level of fear is by using ‘scaling’ questions. For example “On a scale of 1 to 10 with 1 being safe and 10 being very unsafe, where would you put yourself?”

Where the need for immediate protection is identified, then immediate action is required. For instance, if the perpetrator has threatened or attempted to injure or kill the client and/or his/her children, an immediate referral to the Police is essential. Similarly, where immediate risk to children is identified, a referral must be made to the Department for Child Protection.

If a client is threatening suicide or is assessed to be at immediate risk of suicide or serious self harm, an urgent referral for a psychiatric assessment is necessary.

Note: While it is preferable that the above referrals are made with the client’s consent, this is overridden by the Health Worker’s duty of care to ensure the immediate safety of the client and others.
Where **high risk** as a result of FDV is identified, however the client is choosing to return home, a referral needs to be made to the Social Work Department or to a specialist FDV service. A Safety Plan must also be developed with the client prior to them leaving the health service. (Refer to **Safety Planning** below).

Where a client is **at risk**, for instance some FDV risk indicators are identified and supports are already in place or the client does not disclose FDV although it is suspected, provide the client with verbal and written information about appropriate support agencies, discuss a Safety Plan with them and offer the option of returning for another appointment.

(Refer to Resource section for an example of an FDV Assessment Outcome Recording Template)

**Note:** It is important to document the process taken and the outcome of the assessment on the client’s records. If an FDV Assessment Outcome Record form is used, this is to be included on the client’s records.

**Note:** Written consent from the client must be obtained in order to pass on information to another service such as the social work department or a specialist FDV agency

**Mental Health Assessment**

Where a client has a diagnosed mental health illness or is suspected of being mentally unwell, it is important to determine if they are currently or have previously been on medication or have been hospitalised.

Where the client has a history of suicide attempts, has stated a wish to die, self harms or is depressed, the following questions can be asked

- You sound really depressed. Have you ever thought about killing or hurting yourself?
- Have you hurt yourself before?
- What would you do to hurt yourself now?
- Have you a plan?

**Physical Examination**

Where necessary, arrange for the client to have a complete physical examination including a neurological examination. If appropriate, x-rays should be taken to determine whether old and new fractures are present.

**Safety Planning**

Safety planning occurs in discussion with the client. Areas to cover include

- Safe accommodation. Identify options with the client, for example a trusted friend or family member or a refuge. Contact Crisis Care for information about refuge availability on 9323 1111 or free call 1800 199 008. In the absence of these options, consider an overnight social admission to hospital.
Guidelines for responding to Family and Domestic Violence

- Referral to an FDV service. Support on an emotional and practical level can be provided by women’s refuges, specialist domestic violence services, women’s health centres, the social work department of a hospital and counselling services. Check the Department for Communities website for FDV services in the region.

- Providing written information and pamphlets on FDV services available in the region.

Many women choose to return to a violent home environment. There are many reasons for this including fear of the perpetrator who may have threatened to kill the victim/children if they leave, or fear that she will not be able to manage on her own. This decision must be respected, however safety planning should always be discussed to promote some level of safety.

Refer to Resource section for pro-forma Safety Plans on

- Increasing Safety in the Relationship
- Preparing to Leave the Relationship
- Living Safely after Separation

These can be developed with the client and taken away with them where it is considered safe to do so.

Self Care

Responding to family and domestic violence and child abuse and neglect can be stressful and overwhelming. It is recommended that Health Workers debrief with their direct line manager or supervisor, a colleague or Employee Assistance Provider if they feel distressed after working with a client.

Safety of Health Workers

Any threats or violence towards Health Workers must be reported to management and documented. A ‘risk management strategy’ should be developed within the health service to deal with individual situations.
CONSULTATION

Consultation with Health Worker Colleagues

Where possible, Health Workers should consult with a staff member who has FDV experience or an appropriate senior staff member about the outcome of the assessment. This support should be sought by telephone if necessary.

Issues to be discussed include
- the specific safety and risk indicators identified and how these should be addressed within the health service
- what has been discussed with the client
- whether a referral should be made to an external agency
- what external agency is the most appropriate one to use
- whether a referral should be made to the police or the police consulted
- whether a referral should be made to Department for Child Protection or whether they should be consulted.

Consult with an Aboriginal Liaison Officer/staff member if the client is Aboriginal.
Consult with a Cultural Consultant if the client has a CaLD background.

Supervision

Supervision enhances good practice and provides an opportunity for extending and challenging the Health Worker’s understanding and approach. Supervision is to be undertaken with a senior staff member and should incorporate the following
- overview of the case and the development of case plans
- overview of perceived level of risk to the client and children
- protective measures and practices that maximise the safety of clients, their children and workers
- overview of the role of external agencies
- that the health service’s policies and procedures are understood and being followed
- to alert management to contentious and at risk cases/situations
- to access debriefing for critical or traumatic incidents
- to be referred to an employee assistance program if requested or identified as appropriate.
Consultation with Other Agencies

**WA Police Service**
The police can be consulted where FDV is identified or suspected.

- Contact the police on 131 444, or the local police station during office hours. Each of the fourteen police districts has a dedicated Child Protection and Family Violence Officer. These officers can be contacted through the local police district office or through the State Co-ordinator for Family Protection on 9492 5485.
- For urgent assistance ring 000. (Note that 000 cannot be called from mobile telephones).

**Sexual Assault Resource Centre**
The Sexual Assault Resource Centre (SARC) is available for statewide consultation on sexual violence.

SARC provides a free 24 hour metropolitan based crisis medical, forensic and counselling service to females and males aged 13 years and over, who have been sexually assaulted within the previous 14 days.

Calls are taken by the SARC Duty Counsellor. Health professionals will be asked for details of the client and the incident and transferred to the SARC Duty Doctor. The SARC Duty Counsellor will also ask to speak with the client to give them information about SARC and obtain their consent for SARC services.

Clients initiating the call will be assessed by the SARC Duty Counsellor to determine whether they can safely be seen at SARC or need to go to a hospital emergency department.

Clients who are pregnant, have a serious medical condition, are psychotic, are seriously affected by drugs and/or alcohol or suffered injury and require medical attention cannot be safely managed at SARC. A forensic examination cannot be undertaken until medical issues have been addressed or the client is fully cognisant and able to consent.

When a client is referred to an emergency department, the SARC Duty Doctor will be contacted after the client has been medically assessed. The SARC Duty Doctor and Counsellor will see the client at the hospital if necessary.

A SARC Doctor is available 24 hours a day to provide guidance to rural Health Workers on forensic examinations.

SARC can be contacted on 9340 1828 or Freecall 1800 188 999.
Department for Child Protection (DCP)
The DCP can assist with

- Accommodation - referring clients to refuges or other appropriate accommodation
- Transport - to enable the client to travel safety to a refuge or safe-house
- Material assistance - this may include loans for furniture removal, food vouchers and telephone connection
- Information on how to access other types of assistance including legal advice, counselling and support services, police assistance and income support.

After hours contact Crisis Care on 9223 1111 or Freecall 1800 199 008. Crisis Care can also be consulted when FDV and child protection matters are identified or suspected.

Department for Communities
Refer to the domestic violence on-line resource guide www.community.wa.gov.au/onlineresourceguide/ to identify appropriate agencies or services in the health service area.

Domestic Violence Legal Unit (Legal Aid Western Australia)
The Domestic Violence Legal Unit provides legal advice to women. They will also

- Liaise with the police to ensure that appropriate criminal charges are laid against the perpetrator
- Advise and assist in obtaining restraining orders against the perpetrator/s
- Provide initial counselling on legal rights and options
- Represent women in court for Restraining Order hearings where legal aid has been granted
- Provide initial advice and referral to victims trying to escape FDV. This includes family and property law matters and criminal injury compensation.
- Provide information and referral on non-legal matters such as emergency and safe housing, Centrelink benefits, counselling and medical matters.

A Duty Lawyer is available at Central Law Courts between 9.00am and 11.00am daily.

The Unit can be contacted on 9261 6254 during business hours.
DOCUMENTATION

Client Records

Client records and case notes must be clear, accurate, concise and objective.

The following information is to be relayed to clients in relation to their records

- All contacts the client has with a health service are documented
- Records are confidential and kept in a secure place
- Confidentiality is subject to constraint and is overridden where the record is later subpoenaed for court
- Clients have a right to access their personal health records under the Freedom of Information Act 1992.

The following information is to be documented

- the date and time of contact with the client
- the date and time the entry was made on the file
- the name and signature of the Health Worker
- the history provided by the client and relevant to the service they are receiving
- all indicators of FDV, high risk factors and the outcome of assessment
- all relevant medical history
- the injuries suffered and the medical treatment provided. Note that injuries can be recorded on body maps which are included in the file
- stated or suspected cause of injuries or abnormalities and when these allegedly occurred
- how the injuries were inflicted, including if a weapon was used
- if known, the alleged perpetrator’s name and relationship to the client
- all communication with the family
- the client’s behaviour and reactions towards other family members and partner
- the outcome of consultation with staff members or external agencies
- whether photographs were taken
- if police are involved, the name and contact details of the police officer
- intervention plans discussed with the client
- details of other family members, adults and children, in the home.

Client records should be

- factual - accurate and objective recording of issues, information, action and observations. This includes the use of body maps. Note that opinions or judgements of clients, their actions or the truth of their statements should not be recorded either in words or by using exclamation marks. Be aware that records can be subpoenaed to court.
- Where professional opinion is recorded, this should be limited to the Health Worker’s area of expertise.

Documentation of Physical Examination

Record a description or make a detailed drawing of physical injury using a Body Map. (Refer Resources - Body Maps section).

Medical Photography

As the person taking photographs is required to swear in court that they took the photographs, it is appropriate that that person also complete the body map diagrams.

Photographs are highly recommended. Non-digital 35 mm cameras are preferred as digital images can be altered.

- Commence roll of photographs by photographing an identity plate which shows the name of the Health Worker, the name of person taking the forensic photographs if this differs, name of the client, date and time
- Do not use a distracting background. Use a plain coloured sheet under the part of the body to be photographed
- Take an overview shot of the injured limb or part of the body to identify the part of the body where the injury is located
- Take 2 close up photographs of each injury at right angles to the injury
- Take one photograph with a scale or ruler next to the injury
- Take one photograph without the scale or ruler (to show the scale or ruler is not obscuring an underlying injury)
- Sign and record staff position, place of work and date and time the photograph was taken on each photograph.

Note: Medical photography is to be accompanied by a written description of the injury and body maps.

Note: The police are able to take forensic photographs if a camera is not available in the health service.
WORKING COLLABORATIVELY

Due to its complex nature, FDV intervention is increasingly undertaken within a multidisciplinary and an interagency framework because no agency acting in isolation can expect to provide the required diversity of support services a victim of FDV, or the perpetrator, may need. Referral agencies can include the WA Police, Department for Child Protection, Department for Corrective Services, as well as community based organisation, such as refuges and FDV advice and referral services. Referral plans should be initiated prior to the client being discharged from or leaving the health service.

Making a Referral

- Outline the client’s options to them and provide them with verbal and written information on appropriate referral agencies
- Encourage and support the client’s decision-making about the services available to them
- Support the client to self refer. This should be done prior to them leaving the health service
- If the client is not willing or not able to self refer, obtain the client’s consent and refer on their behalf, ideally prior to them leaving the health service
- Provide information to the referral agency on the client, their history of FDV and significant issues, for instance that a Violence Restraining Order is in effect
- Provide information on other services involved with the family
- Provide information on safety of the client from self or others
- Alert referral agency to any likely risk to staff by perpetrator or others
- Provide information on services provided to the client and/or family by the health service.

Case Management

Clients who are victim of FDV and who have ongoing or regular contact with a health service can benefit from a case management model.

Case management can be facilitated by
- A meeting of the Health Workers involved with the client
- Deciding on the Health Worker who will have case management responsibility within the health service
- Identifying the specific role each person has with the client and/or family
- Organising regular, scheduled, minuted meetings to discuss and record action plans.
Content of meetings can include

- An update by each Health Worker on the outcome of previous action plans and the progress of the client
- Referral to and involvement of other support agencies. This can include inviting external agency representatives to participate in meetings.

Role of the Case Manager

- To coordinate and chair case discussions
- Liaise with the client and/or family about the outcome of meetings
- Work with client on an ongoing Safety Plan
- Link any children into counselling services
- Liaise with agencies involved with the client, the perpetrator and/or family and feedback information to case management meetings
- Consider strategies to prevent access to client by perpetrator during admission.
PERPETRATORS OF FAMILY AND DOMESTIC VIOLENCE

There are a number of theories and commonly held beliefs as to why people perpetrate FDV. These include that it is a symptom of learned behaviour so that a person growing up in an abusive environment learns that violence is a legitimate way to resolve problems, or that violence within the family is a response to traditional concepts of male privilege. In Aboriginal communities oppression, dispossession, loss of identity, culture and continued racism are believed to be factors contributing to a sense of powerlessness which can lead to violence.

The Cycle of Violence

FDV involves a cycle of violence. The cycle varies in the length of time in which it is completed and may skip some stages. The resulting feeling is of ‘being on a merry-go-round’. This is common to almost all abusive relationships.

Phases include

- **Build up phase** - the tension is building. There is disagreement without resolution. There is a feeling something is about to happen, so the victim is ‘walking on eggshells’
- **Standover phase** - the perpetrator maintains control through anger, threats, jealousy, resulting in fear for the victim and compliance in an endeavour to maintain harmony
- **Explosion** - this can involve any type of violence - physical, sexual, emotional/psychological, verbal, financial, social
- **Remorse phase** - many perpetrators feel remorse but do not admit it. They justify and minimise their behaviours. Victims often want to believe in the remorse and will deny or minimise the violence because of guilt, shame or the hope that things will change
- **Withdrawal phase** - sometimes one party will withdraw from the other and may leave or sulk or give the ‘silent treatment’. This is often the phase when people seek help
- **Pursuit/buyback phase** - Initially, this can be pursuit with promises and pressure, including apologies and gifts followed by helplessness “I can’t live without you” followed by threats to hurt the victim, themself or children
- **Honeymoon phase** - enmeshment by mutual dependence on the relationship. This can be good for a while and the couple can often believe that “this time it will be different”.

Adapted from Ian MacDonald (Dec 1986)

Victims will describe their partners as capable of being charming and caring but also capable of abuse and violence. Many love their partners and want to continue the relationship, but they want the violence to stop.
Guidelines for responding to Family and Domestic Violence

Communicating with Perpetrators

When meeting with perpetrators, it is important to be aware that

- Personal safety should always be put first. A senior staff member, security staff or colleagues should be notified prior to the Health Worker meeting with a perpetrator to discuss the violence.
- The perpetrator may be polite and seductive or intimidating, threatening and violent towards the Health Worker.
- It is appropriate to offer support when a perpetrator has identified the violence as a problem.

Responses to Perpetrators

Due to the complex dependency and care arrangements that a family may need to maintain, referring the perpetrator for help is essential.

Intervention with perpetrators is an area of expert practice and it is preferable this be left with people experienced in this area, however in situations where the violence is discussed with the perpetrator, consider the following

- The abused client should not be present when meeting with the perpetrator
- Written information about the abused client should be stored safely where it cannot be accessed by the perpetrator
- Use a direct and calm approach
- Frame the discussion about the FDV as a health care issue, for example “There appears to be a lot happening in your life right now.”
- Advise the perpetrator that FDV is a crime. This is particularly important for men from a CaLD background who may not be aware of the law in Western Australia
- Advise the perpetrator there are services which can assist when he/she is ready
- Provide written information about support services in the region or of appropriate websites.

Should the perpetrator display anger or resist or reject the discussion, bring the subject to a close and move back to the presenting issue. For example, “Your use of force against your partner and/or child is of concern and I will gladly assist with a referral whenever you want it”.

Support and information for perpetrators is provided by

- Men’s Domestic Violence Helpline on 9223 1199 or Freecall 1800 000 599
- WA Police Service
- Breathing Space 9439 5707
Counselling for perpetrators is provided by
- Centrecare on 9325 6644
- Relationships Australia (Western Australia) Inc on 1300 364 277
- Kinway Relationship Counselling on 9263 2087 or Freecall 1800 812 511.
SPECIAL GROUPS

Children

Children, even very young children, witnessing FDV or being abused by the perpetrator can experience life-long psychological and emotional damage, physical and psychosomatic disorders, behavioural problems and post-traumatic stress disorder. They can have poor educational achievements and experience difficulties with relationships in later life. Statistics indicate that approximately 20% will become victims or perpetrators of violence as adults.

The impact on children living in a home where there is FDV can involve

- Being denied a safe and supportive environment in which to grow and develop
- Witnessing the non-abusing parent being abused
- Hearing ongoing verbal and/or emotional abuse and witnessing the degradation and isolation of the non-abusing parent
- Being physically, verbally or emotionally abused when they attempt to intervene in the violence
- Being denied extended family, peer and broader social support and connection as a result of social isolation imposed on them by the perpetrator
- Being denied the physical care and emotional support necessary for their wellbeing when the non-abusing parent is neither physically nor emotionally able to care for them
- Assuming a parental role over younger siblings when the non-abusing parent is neither physically nor emotionally able to care for them
- Protecting siblings from harm during explosive outbursts
- Feeling responsible for the violence or blaming siblings or the non-abusing parent
- Being pressured to maintain the family secret
- Being subjected to death threats towards themselves, their siblings or the non-abusing parent.

Children can experience

- high levels of anxiety and fear about their own and/or the non-abusing parent’s safety
- feelings of shame, guilt, self blame, anger about what is happening in the family
- behaviours of withdrawal and hostility towards parents or others for the ongoing violence
- a sense of loss and grief in losing the family or their father/mother at separation
- learning difficulties, high levels of compliance, verbal and physical aggression due to hopelessness and despair that the violence will not end.

(Refer to Communications section for interview questions with children.)
Where appropriate and dependant upon the age of the children they should be told what is happening, for example that their mother is leaving the home, and be involved in decision-making that affects them.

Aboriginal People and Families

Aboriginal communities, while sharing much in common, are not a homogenous group. They instead comprise distinct groups with rich and diverse cultural practices. FDV therefore impacts on communities or individuals in different ways. Intervention with Aboriginal clients needs to take into account and not diminish or threaten their cultural rights, expectations or practices.

FDV is endemic amongst Aboriginal people with statistics indicating they involve the highest rate of reported incidents to WA Police, yet a high proportion of sexual and physical violence is unreported for fear of community and family reaction. Victims are more likely to suffer serious injury than the rest of the population and have higher rates of hospitalisation. There is a high link between FDV, self-harm and suicide in Aboriginal communities.

Ideally and in order to achieve the best outcome, a long term involvement with the client and/or family is recommended.

What to consider

- Consult with an Aboriginal staff member where available
- Provide same-sex staff to assess and treat the client
- Always look at the ‘big picture’ when working with Aboriginal clients. Be aware that FDV may not be the client’s primary problem, but part of an underlying bigger problem.
- Consider historical impacts on Aboriginal society. Identify and take into account other forms of abuse which have previously been experienced by the client/family/community
- Be aware that Aboriginal clients will feel ‘shame’ about the violence
- Be aware that Aboriginal clients will feel ‘shame’ and have difficulty talking about sexual interaction or sexuality as these are taboo subjects, particularly when liaising with someone of the opposite sex. They may not disclose physical injury to the private parts of their bodies
- Identify the client’s community and assess if it is safe for the client or their family to return to their community
- Aboriginal people can experience difficulty leaving their community because of the violence or because of their community/family ties
- Be aware that for some Aboriginal people, English is their second language and may be limited
- Aboriginal women may leave a health service before they are medically well, because of fear of reprisal or because of concern for their children
Leaving a violent relationship or going to the police may result in reprisal for the Aboriginal woman by extended family members.

Keep a list of services for referral of Aboriginal clients. However, be aware that Aboriginal people may not want to access Aboriginal services or workers for reasons of confidentiality. Offer both options and respect their choice.

Using legal services is especially problematic for Aboriginal people, not only because they fear reprisal but because they often do not understand their legal rights or the legal system.

Aboriginal people can question the effectiveness of the police and the mainstream legal system to protect victims or respond to domestic violence.

Women and Pregnancy

Violence often begins or increases during pregnancy, however it is during pregnancy that chronically abused women are likely to, or be permitted to have regular contact with a health service. This provides a unique opportunity for women to ask for help and for routine screening for FDV and intervention to take place over an extended period.

Be aware that chronically abused women:
- often obtain minimal or late antenatal care
- often seek terminations, especially younger women with unintended pregnancies
- are less likely to have planned a pregnancy or to want a pregnancy
- are likely to develop coping strategies such as alcohol or drug misuse. This compounds the risk to the pregnancy and the woman’s capacity to manage her health, the pregnancy and delivery and can lead to poor birth outcomes for the baby.
- are at increased risk of poor weight gain, anaemia, infections, preterm labour, of bearing a low birth weight infant and of experiencing postnatal depression.

Examples of questions to use include:
- How do you feel about the pregnancy?
- Was the pregnancy intended?
- How does your partner feel about the pregnancy?
- How would you describe your relationship with your partner?
- What do you think your relationship will be like after the birth?
- Do you think you will have any concerns about your baby once it is born?

Counselling prior to labour can be valuable. The following can also reduce the incidence of problems for the woman:
- Fewer vaginal exams
- Offering pain relief of choice to the woman
- Reducing the number of people present at the birth.
Discharge planning is very important, particularly for younger women, as they are less likely to stay in hospital for the recommended period and might be at risk of little or no support or of homelessness after discharge.

Young People

Young people both male and female can experience dating violence, however they are often not aware that this behaviour is unacceptable and a crime. As with adult domestic violence, teen dating violence crosses all social and economic classes, races, cultures, genders, and sexual orientations. The abuse of young women in particular can lead to homelessness, pregnancy, serious long-term emotional problems and can be a key factor in young women developing eating disorders and drug and alcohol dependencies.

Young women who are pregnant can experience a higher rate of abuse and increased severity of abuse as well as significantly higher rates of desertion (by the father), social isolation, homelessness and major psychosocial disorders.

Young women often do not feel confident about accessing support or assistance. They should be provided with written information about services and be offered the opportunity to return to the health service at a later stage.

Older People

Elder abuse is defined as “any act which causes harm to an older person and occurs within an informal relationship of trust, such as family or friends”. Acts can include financial or material, psychological or emotional abuse, physical, sexual, social abuse and neglect. (APEA:WA, 2006)

Elder abuse can remain hidden due to the victim’s feelings of shame and guilt, lack of self worth, feelings of powerlessness and fear of retribution and the resultant loss of support from their caregiver. It is difficult for an older person to stand up for their own rights and complex to disclose and deal with abuse by relatives and friends because of the emotional bond and social ties associated with these relationships.

Conversely, people may not be able to report because of age-related illness such as dementia and general frailty/disability.

Risk factors associated with elder abuse can include carer stress, increased dependency, family conflict, isolation and addictive behaviours.

Older people from a CaLD background are at increased risk of abuse as a result of language barriers, lack of traditional extended family support and the widening gap between generations.
What to consider

- Abuse and neglect can sometimes be detected from the behaviour of the older person as well as from the more obvious physical signs and symptoms.
- Be aware of sudden and unusual behaviour patterns, such as fear of others, changed sleep patterns, thoughts of suicide, worry or anxiety for no apparent reason.
- The older person’s wish for an independent advocate of their choice should be respected.

Culturally and Linguistically Diverse (CaLD) People

The needs of people from a CaLD background differ as a result of cultural and religious beliefs, levels of education, length of residence in Australia, circumstances under which they came to Australia, fluency in English, family and social networks and economic circumstances.

- Violence can escalate as a result of the stresses of migration and because of forced cultural change as gender roles shift with, for example, unemployment or a downward shift in employment status for men, or paid employment for women. Further, traditional hierarchies of age and gender can be eroded as the younger generation assimilate into the broader Australian culture.
- The risk of homicide of CaLD women is increasing.
- CaLD women are less likely to leave violent relationships. There is pressure to remain in a marriage because of their
  - fear of bringing shame and dishonour to the family
  - fear that their family in their home country will experience repercussions
  - dependency on their spouse for their residency status
  - fear of isolation and lack of extended family support
  - religious belief that marriage is a sacred vow and cannot be broken
  - fear of being deported
  - fear of a loss of anonymity
  - fear of losing their children - women cannot take their children out of the country unless the husband gives permission
- The perpetrator’s extended family can collude in the violence.
- CaLD women may not understand their rights relating to violence and abuse under Australian law.
- They may lack knowledge of the services available or how to access these services.
- Fear of government authority figures for example, police or government workers, can be experienced by people coming from repressive regimes.
Some migrant groups are not eligible for Centrelink benefits because of their visa status. Those escaping a violent relationship will not have access to an independent source of income. This in turn impacts upon their ability to access refuge accommodation.

Be aware that suggesting the man leave the room in order to speak to the woman alone can result in further violence against the woman.

Respect the woman’s strength - be aware she may have survived terrible atrocities in her country of origin.

Religion and culture is no justification for violence.

**Using Interpreters**

- Always use a trained interpreter. It is not appropriate to use partners or the client’s children to interpret. A member of the victim’s community may also be inappropriate because of confidentiality.
- Use an interstate telephone interpreter if the client is concerned about confidentiality within his/her community group.
- Use short sentences and focus on one point at a time. Talk directly to the client, not the interpreter.

Provide information on culturally specific services. Support for CaLD women is available through:

- Muslim Women’s Support Centre
- Migrant Resource Centre
- Catholic Migrant Centre (Centrecare)
- ISHAR
- Crisis Care Unit.

The Multicultural Women’s Advocacy Service (tele 9328 1200) provides specialist FDV services to CaLD women.

**People with Mental Health Problems**

FDV is often not identified in people with mental health problems and this can result in deterioration in client health and well-being and a lack of appropriate intervention. The link between a person’s emotional distress and the violence and abuse they are experiencing cannot be ignored. A person may appear to be mentally unwell but this may be their response and way of coping with living in a constant state of fear. This makes the perpetrator’s role in the mental health problem invisible and places the victim at increased risk of more serious abuse and mental illness.

Appropriate assessment of the injuries and client circumstances is essential. Where the risk of suicide or serious self-harm is identified, the client should be referred for assessment by a mental health service.
What to consider:

- Take a thorough history of clients presenting with signs of FDV
- Undertake an assessment of the safety and wellbeing of any children involved
- Listen to the client’s story of abuse. Do not automatically consider disclosures are delusional
- Women in domestic violence relationships are more likely to be diagnosed with anxiety or depression. The anxiety or depression may be a direct result of the violence.
- It is important the client be treated for their victimisation, with, for instance, referrals to FDV services, and not put on medication unnecessarily
- Supportive networks are one of the most effective cushions for managing depression
- Increased suicidal ideation and self harming behaviours can result from the sense of entrapment experienced in violent relationships
- Coping strategies can include increased drug and/or alcohol use which can exacerbate the mental health problem
- People with mental health problems require adequate time to disclose their experience. Pushing them to speak about the abuse is detrimental. Work at the client’s pace and assist them to feel in control of the process
- People may prefer to be referred to a mental health service in the non-government sector. Assess if this is an appropriate and safe option
- Discharge planning needs to take into consideration a person’s safety if they are returning home
- If a VRO against the abusive partner is in place, holding a meeting with the couple could be a breach of the court order.

Note: Getting assistance for the perpetrator is recommended due to the often complex dependency and care arrangements that a family where there are mental health problems may need to maintain. The perpetrator can be referred to the Men’s Domestic Violence Helpline on 9223 1199 or Freecall 1800 000 599.

People with a Disability

The term ‘disability’ is wide-ranging and encompasses physical disability; chronic disease such as rheumatoid arthritis; congenital conditions such as cerebral palsy, sensory impairment to sight and hearing; mental and cognitive impairment and psychiatric disability.

People with a disability are at increased risk of FDV as a result of the disability, their isolation and their dependence on others. There are also forms of abuse which are unique to them because they may be dependant on others to meet their basic health or social needs which if ignored, result in neglect. Or they can be subject to threats such as being sent to an institution or withdrawing services of care.
People with a disability can reside in ‘domestic’ environments which have a broader context than the traditional understanding of domestic, such as group homes, residential institutions or boarding houses, where they can be at risk of violence from other residents, carers or service providers. (Cockram, 2003:11)

What to consider:
- The disability may involve a reduced capacity for self-care/management, mobility or communication. Check a person’s capabilities and limitations when making a safety plan or providing them with written information. A person with an intellectual or cognitive disability for instance, may have difficulty in accessing help, or may not be able to use the telephone or read pamphlets.
- Be aware of the person’s domestic situation and make provision to ensure their ongoing safety.
- When referring a person to another service, first check with the service that it is able to meet the needs of the person.

For further information, consult the Disability Services Commission on 9426 9200.

If there are concerns about a person’s decision making capacity, consult the Public Advocate on 9278 7300 or Freecall 1800 807 437.

If a person has a hearing disability, contact Crisis Care on 9223 1111 for access to a TTY service.

Diverse Sexuality and Gender Relationships

FDV occurs in diverse sexuality and gender relationships. This includes same-sex, transgender, bi-sexual, trans-sexual and intersex relationships and as with heterosexual relationships, involves issues of power and control.

Additional to usual forms of emotional violence, it may also involve homophobic control with threats of ‘outing’ or revealing their sexual identity made by the perpetrator. This can result in the victim fearing the loss of significant relationships and fearing discrimination in, for instance, the workplace.

What to consider:
- Community isolation may be experienced by people in diverse sexuality and gender relationships
- There are limited support services and legal protection available for these people
- The focus of intervention should be on enhancing the safety for the client.

Further information is available from:
- The Gay and Lesbian Community Services of WA (Inc) 9420 7201 or Freecall 1800 184 527.
- Same Sex Domestic Abuse Group (SSDAG) www.ssdag.org.au
Rural and Remote Areas

People in rural and remote areas face particular issues of geographical isolation, a lack of privacy in the community and limited service availability. They can also hold different value systems to those in metropolitan areas.

Professional roles can be complicated by the social or interpersonal relationship the Health Worker may have with a person who presents as either a victim or perpetrator of FDV. The client in response can feel embarrassed or humiliated.

What to consider:
- Careful safety planning, which may need to involve the police
- Be aware that guns are more accessible. Contact the police if a perpetrator has ready access to a gun
- High levels of alcohol and/or drug use are common and may exacerbate violent outbursts
- A person’s sense of isolation can increase the risk of self-harming behaviours
- Economic isolation is a common feature which can result from conservative values, traditional gender roles or male control of family finances.
- Poor roads, limited access to private vehicles and often non-existent public transport can complicate the means of escape from a violent relationship and lead to a greater sense of powerlessness for the victim
- Inadequate access to telecommunications increases vulnerability
- Legal responses are not as accessible or as useful. For instance, in some areas there may not be a police presence or courts sit on a monthly basis, hence making it difficult to obtain an urgent Violence Restraining Order
- Aboriginal and CaLD people can experience additional isolation as a result of language and cultural difference
- Limited police presence, the need to wait for backup and long delays in travelling to remote areas puts victims further at risk.

Refer to www.womenscouncil.com.au for information on rural and remote refuges or www.domesticviolence.wa.gov.au for information on services in the health service area.

Note: Health workers may need support to deal with safety and personal issues arising from managing an FDV case. It is important to have a personal safety plan in place and to build on personal support networks, for example with other professionals in the area.
Staff Conduct

Health Workers are subject to their professional Codes of Conduct and area health service policies and practice guidelines.

Where there are concerns about the conduct of a Health Worker with a client:
- Immediately discuss concerns with a senior staff member
- If the concern relates to a senior colleague, a person in a more senior position needs to be notified
- In an emergency situation (i.e. where the Health Worker in question has current responsibility for the client), the WA Police or Department for Child Protection should be contacted
- Document all actions undertaken.

It is recommended each health service develop protocols to manage concerns or allegations of abuse by Health Workers. These protocols must promote the safety of clients and the best interests of children.
LEGAL INFORMATION

DISCLAIMER

The information contained in this section provides a summary and general overview on legal topics relevant to the operation of the Guidelines. It is limited to the laws applicable within Western Australia only.

The law is dynamic and while we attempt to ensure the content is accurate, complete and up-to-date, it cannot be guaranteed.

The information contained in this section is not intended to be comprehensive. Similarly, it is not intended to be, nor should it be relied upon as a substitute for legal or other professional advice.

If you have a legal problem you should seek legal advice tailored to your circumstance from the Legal and Legislative Directorate at the Department of Health (or from the State Solicitor’s Office in the case of teaching hospitals only) before acting or relying on any of the content of this section.

CLIENT CONFIDENTIALITY AND INFORMATION SHARING

Health Workers are under a duty of confidence in relation to all information that comes to them in the course of their health care relationship with clients. This duty of confidence applies to all persons who come into contact with information as part of the health care process, including administrative staff.

The duty of confidence can arise by statute, under the common law and in equity.

The unauthorised disclosure of confidential information by a Health Worker to third parties (including the police and the Department for Child Protection (DCP)) will generally involve a breach of the duty of confidence.

A breach of the duty of confidence may lead to a civil action for damages against the individual who made the unauthorised disclosure and their employer. It may also be a matter for disciplinary proceedings by the employer of the individual who made the unauthorised disclosure and review by the relevant professional registration body, such as the Nurses Board.

There are a number of exceptions to the duty of confidence where otherwise confidential information may be disclosed to third parties. The relevant exceptions are discussed below.
Disclosure by Consent

Consent of Client or Client’s Legal Guardian

In general, if a mentally competent adult client consents to the disclosure of confidential information, then the Health Worker(s) to whom consent has been given may disclose the information. The Health Worker may only lawfully disclose the information falling within the scope of the consent and only to those individuals or institutions in respect of which consent has been given.

Where the patient is a minor, the appropriate person to provide consent to the release of information relating to that minor will ordinarily be the patient’s parent or other legally appointed guardian.

However, a minor is capable of giving informed consent to the release of confidential information on her/his own behalf where she/he has sufficient understanding and intelligence to enable her/him to understand fully what is proposed and the possible consequences (see mature minor information below).

Other Health Care Professionals

People who have a legitimate therapeutic interest in the care of the client may have access to confidential information concerning the client relevant to the care being provided. Consent to disclosure of confidential information in such circumstances will generally be implied.

If a Health Worker wants advice, or simply wishes to talk over the patient’s treatment with a colleague who is not involved with the patient’s care but the patient has not expressly consented, then identifying information should not be given.

Disclosure by Operation of the Law

Statutory Disclosure

Where confidential information is disclosed pursuant to a statutory obligation or in accordance with statutory authority, there will be no breach of confidence. However, the information disclosed should be limited to that necessary to comply with the statutory obligation or to that permissible under the relevant statutory provision.

An example of this is at s 276 of the Health Act 1911, which requires a medical practitioner or nurse practitioner who forms the opinion that a patient of the practitioner has an infectious disease, to notify the Executive Director, Public Health.

In Western Australia, there is no specific statutory requirement for the reporting of actual or suspected child abuse to the police, the Department for Child Protection or any other authority or person.
Child Safety and Wellbeing

It is permissible under s 129 of the Children and Community Services Act 2004 for an individual to give information in good faith to the Chief Executive Officer or another officer of the DCP about any aspect of a child’s wellbeing. Section 23(3), (4) and (5) of the Children and Community Services Act 2004 also permit the disclosure of such information in good faith in compliance with a request from the Chief Executive Officer or an authorised officer of the DCP. A person is generally considered to be acting in good faith where he or she acts honestly and without improper motive.

Health Workers and other confidants who have concerns or information relevant to the wellbeing of a child may report their suspicions to DCP by contacting DCP’s Crisis Care Unit or its local district office.

A child need not be at imminent, likely and serious risk of harm or neglect before a report to DCP is justified. Any decision to provide information to DCP in relation to the wellbeing of a child should be well documented and include the reasoning that led to the decision to notify DCP.

In Western Australia, there is currently no specific statutory requirement for Health Workers to report actual or suspected child abuse to the police, DCP or any other authority or person.

Firearms or Ammunition

It is permissible under s 23B of the Firearms Act 1973 for a “health professional” (defined to mean “medical practitioner”, “psychologist”, “registered nurse”, “prescribed class of social worker” or “prescribed class of professional counsellor”) to inform the Commissioner of Police of their opinion that:

(a) because of the patient’s physical, mental or emotional condition, it is not in the person’s interest or not in the public interest that the person possess any firearm or ammunition to which the patient is believed to have access; or

(b) a person is seeking or has sought medical assistance for an injury in the infliction of which a firearm or ammunition is believed to have been involved.

Subpoena

A Health Worker may be required by subpoena to produce documents to a court and/or attend court to give oral evidence. Where a Health Worker divulges confidential client information to the court in response to a valid subpoena, they will not be in breach of their duty of confidence. Failure to comply with a subpoena (or similar court order) can amount to a contempt of court resulting in a prison sentence or fine.
Public interest disclosure
The “public interest” exception to the duty of confidence recognises that there may on occasion be a need to breach confidentiality because of an overriding public interest favouring disclosure of the information to a third party. In such circumstances, the disclosure of the information to a responsible authority may be justified.

The law in the area of what constitutes a “public interest” is complex. The decision to disclose otherwise confidential information should be made at a senior level within the relevant public health authority’s administration. Wherever practicable, it is recommended that there be consultation with the treating medical practitioner. The factors taken into account in reaching a decision to disclose confidential information in the public interest should be well documented. It is recommended that advice be sought before disclosure is made in the “public interest”.

DUTY OF CARE
Health Workers have a duty to take all reasonable care for the welfare of their clients. Generally, the duty of care will arise when a person presents to the health service for medical attention and that health service expressly or impliedly accepts responsibility for the treatment of that person. The Health Worker also owes a duty to third parties where it is reasonably foreseeable that a person under their control may harm the third party.

A Health Worker may be liable for negligence where they fail to take steps that a reasonable person would to prevent a reasonably foreseeable risk of harm to a person to whom they owe a duty of care. It is arguable that a Health Worker’s duty extends to taking reasonable care by predicting whether a child client is at risk of harm from abuse if discharged into the custody of the parent/carers.

The court will consider all the circumstances of the case when deciding whether a Health Worker has acted reasonably, including the nature and extent of the risk of harm and the resources available to deal with the risk. The Health Worker will only be liable for a breach of the duty of care where they have not acted reasonably, the breach has caused injury or loss to the person to whom the duty is owed and that injury or loss is not considered too remote.

CLIENT CONSENT TO TREATMENT AND DISCLOSURE OF MATERIAL RISKS
Duty to Obtain Consent
Except in an emergency situation, a Health Worker has a legal obligation to obtain the patient’s voluntary consent before any physical examination, test, procedure or other treatment is provided.

Informed Consent
A Health Worker has a duty to inform the client in broad terms about the general nature of the proposed treatment, including any material risks inherent in the treatment, so that the client understands what they consenting to.
A Health Worker may be liable for negligence where a client has been informed of the type of treatment to be undertaken but has not been told of the material risks involved.

Before providing any treatment, the Health Worker providing the treatment should provide the following information to the client in terms that they will understand:
- an explanation of the client’s condition
- the reasons for the proposed treatment or care
- the risks involved, including any significant long-term physical, emotional, psychological, social, sexual or other risks
- the expected benefits (noting that the results of treatment can never be guaranteed)
- alternative treatment options, including the likely result of ‘no treatment’
- whether the treatment is irreversible
- the time involved in the treatment
- the likely recovery period
- any follow-up care that may be required.

Matters that have been discussed should be accurately documented in the client’s medical file, including any questions asked by the client and the answers to those questions.

Legal Capacity to Consent
A client must have legal capacity to consent to the treatment to be performed. A client will have capacity to consent where they are able to understand in broad terms the nature and consequences, including the risks, of the proposed treatment.

In the case of medical treatment to children (persons under 18 years of age), the appropriate person to consent to the treatment of that child will ordinarily be the child’s parent or other legally appointed guardian.

However, a child is considered to be a ‘mature minor’ where the child is capable of giving informed consent to treatment and where that child has sufficient understanding and intelligence to enable her or him to understand fully what is proposed and the consequences of it. The assessment of a child client as a ‘mature minor’ involves the Health Worker making a judgment about the client based upon the circumstances of the individual case.

Any assessment of a child client as a ‘mature minor’ and that child’s consent to treatment should be clearly documented in that client’s medical file.

Duration of a Client’s Consent
A Health Worker’s duty to disclose material risks and obtain a client’s consent for treatment is a continuing obligation and should occur as close as is reasonably practical to the commencement of the treatment. The Health Worker should also be mindful of any changed circumstances, which may require further discussion.
FEMALE GENITAL MUTILATION

In Western Australia, s 306 of the *Criminal Code* provides that a person who performs “female genital mutilation” on another is guilty of a crime and is liable to imprisonment for 20 years. The fact that the person or their parent or guardian consented to the “female genital mutilation” is no defence.

Section 306 also provides that a person who takes a child from Western Australia or arranges for a child to be taken from Western Australia, with the intention of having the child subjected to female genital mutilation is guilty of a crime and is liable to imprisonment for 10 years.

Where it is suspected a person has been subjected to female genital mutilation Legal and Legislative Services are to be contacted for advice.

RESTRAINING ORDERS

A court may make a violence restraining order under s 11A of the *Restraining Orders Act 1997* if it is satisfied that:

(a) the respondent has committed an act of abuse against a person seeking to be protected and the respondent is likely again to commit such an act against that person; or

(b) a person seeking to be protected, or a person who has applied for the order on behalf of that person, reasonably fears that the respondent will commit an act of abuse against the person seeking to be protected,

and that making a violence restraining order is appropriate in the circumstances.

An “act of abuse” means an “act of family and domestic violence” or “act of personal violence”. The terms “act of family and domestic violence” and “act of personal violence” are defined in s 6 of the *Restraining Orders Act 1997*. The acts that comprise an “act of family and domestic violence” involve conduct that occurs in a family and domestic relationship. The acts that comprise an “act of personal violence” involve conduct that does not occur in a family and domestic relationship.

A court may, if it is satisfied of certain matters, make a violence restraining order for the benefit of a child under s 11B of the *Restraining Orders Act 1997*.

A police officer may, under s 30A of the *Restraining Orders Act 1997*, make a police order in certain circumstances if the officer reasonably believes that:

(a) it would not be practical for an application for a violence restraining order to be made in person because of

(i) the time when, or the location at which, the behaviour complained of occurred, is occurring or is likely to occur; or

(ii) the urgency with which the order is required,
(b) there is some other factor that justifies making a violence restraining order as a matter of urgency and without requiring the applicant to appear in person before a court, and the making of the order is necessary to ensure the safety of a person.

A police order is to be either a 24 hour police order or a 72 hour police order. The duration of a police order cannot be extended or renewed and another police order cannot be made in relation to the same facts.

On client request, the social work section of the Health Service may be able to assist a client in obtaining a violence restraining order. Health Workers may also call the Legal Aid Domestic Violence Unit or the WA Police for information and assistance in relation to restraining orders.

OTHER INFORMATION

If children are attending court, court preparation and support is available from the Child Witness Service of the Department of the Attorney General.
RESOURCES

USEFUL TELEPHONE NUMBERS

COUNSELLING SERVICES

Centrecare
9325 6644 (Perth)
9091 1833 (Goldfields)
9721 5177 (Bunbury)

Domestic Violence Children’s Counselling
9328 1888

Incest Survivors Association
9227 8745

Relationships Australia
1300 364 277

Sexual Assault Resource Centre
9340 1828 or Freecall 1800 199 888

Victim Support Service
9425 2850 or Freecall 1800 818 988

Yorgum Aboriginal Counselling Service
9218 9477

CRISIS SERVICES

Crisis Care
9223 1111 or Freecall 1800 199 008
Guidelines for responding to Family and Domestic Violence

WA POLICE SERVICE 131 444

Child Protection Squad
9492 5444

Domestic Violence Unit
9250 3948

Family Protection Unit
9492 5485

LEGAL INFORMATION

Domestic Violence Advocacy Support Central (DVAS)
Police support with VRO applications
9226 2370

Domestic Violence Legal Unit (Legal Aid Western Australia)
9261 6254

Legal Services Branch
Department of Health
9222 4038

Women’s Law Centre
9272 8800 or Freecall 1800 625 122

MENTAL HEALTH SERVICES

Mental Health Emergency Response Line (previously PET)
1300 555 788 or Freecall 1800 676 822

Aboriginal Activity Centre (Graylands Hospital inpatient service only)
9347 6868

WA Transcultural Mental Health Centre
9224 1760

Princess Margaret Hospital (Psychological Medicine Unit)
9340 8373

Youth Link
1300 362 569 or Freecall 1800 803 356
PRINCESS MARGARET HOSPITAL 9340 8222

Child Protection Unit
9340 8646 (Fax 9340 8822)

Social Work Department
9340 8920

Emergency Department
9340 8222 (After hours)

24 HOUR HELP LINES

Alcohol and Drug Information Service
9442 5000 or Freecall 1800 198 024

Family Help Line
9223 1100 or Freecall 1800 643 000

Kid’s Help Line
Freecall 1800 55 1800

Life Line
131 114

Men’s Domestic Violence Help Line
9223 1199 or Freecall 1800 000 599

Parenting Line
9272 1466 or Freecall 1800 654 432

Salvo Care Line
9442 5777

Women’s Domestic Violence Helpline
9223 1188 or Freecall 1800 007 339

FINANCIAL INFORMATION

Centrelink
131 021 for appointment with a social worker
INTERPRETER SERVICES

Telephone Interpreter Service
131 450 (All hours)

National Relay Service - TTY-voice-modem
133 677

Deaf Society of WA
9441 2655 (TTY)
0410 017 540 (Emergency Service)

CaLD SERVICES

Multicultural Women’s Advocacy Service
9328 1200

Women’s Information Service
6217 8230 or Freecall 1800 199 174

ON LINE RESOURCES

Department for Communities website
www.community.wa.gov.au/onlineresourceguide/
Body Maps

Indicate findings on body diagrams

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<td>Fracture Open</td>
<td>S</td>
<td>Swelling</td>
</tr>
<tr>
<td>L</td>
<td>Laceration</td>
<td>T</td>
<td>Tenderness</td>
</tr>
</tbody>
</table>

Specify Other _______________________

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Guidelines for responding to Family and Domestic Violence

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Local Service Information:

<table>
<thead>
<tr>
<th>Hospital Service</th>
<th>Hospital:</th>
<th>Telephone:</th>
<th>Social Worker:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Station:</td>
<td>Contact:</td>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Department for Child Protection - District Office</td>
<td>Contact:</td>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Crisis Accommodation</td>
<td>Refuge:</td>
<td>Contact:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Legal Service</td>
<td>Name:</td>
<td>Contact:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>Name:</td>
<td>Contact:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Name:</td>
<td>Contact:</td>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Family and Domestic Violence Services</td>
<td>Name:</td>
<td>Contact:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Name:</td>
<td>Contact:</td>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Counselling Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact:</td>
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<td></td>
<td></td>
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<tr>
<td>Telephone:</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perpetrator Programs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Contact:</td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
</tbody>
</table>
SCREENING AND REFERRAL FOR FAMILY AND DOMESTIC VIOLENCE

Points for the use of this tool:
- Ask the woman when she is alone
- Ask the woman if it is safe to give her written information about family and domestic violence to take home
- Women experiencing domestic violence may not report it until after they have been asked a number of times
- File this record in the hospital medical record.

Before assessing the woman, the health worker should use her own words to explain that:
- In this health service we are concerned about the health and safety of all women, therefore we ask everyone the same question about violence in the home
- This is because violence to women can occur at anytime, especially during pregnancy (perhaps 20% of women) and we want to improve our response to families experiencing violence
- If the woman answers “Yes” to any of the questions below explain that a referral to social work will occur so that information and support can be offered. Emphasise that this will be discrete.
- If domestic violence has been identified and a social work referral has been completed, there is no need to screen again. For women who answer “No” to all questions screening should be repeated.

Ask the Woman - Record answers as ‘Yes’ or ‘No’

<table>
<thead>
<tr>
<th>Pre-admission</th>
<th>Admission/EC</th>
<th>Prior to Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been afraid of someone close to you (e.g., friend, partner, family member)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone close to you ever hit, kicked, punched or otherwise hurt you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone close to you ever put you down, humiliated or embarrassed you or tried to control what you can do or say?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone close to you ever threatened you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessment

- No screening done because
  - Partner present
  - Family/friends present
  - Interpreter not available
  - Woman declined

FDV not identified
FDV identified, referral accepted
FDV identified, referral declined

Action Taken

- Nil action required
- Social Work department referral arranged and Details provided
- Contact number for FDV provided to woman

Other (please state):

Signature

Date

Designation
## FDV ASSESSMENT OUTCOME RECORDING

<table>
<thead>
<tr>
<th>Surname:</th>
<th>URN:</th>
<th>Health Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given Names:</td>
<td></td>
<td>Health Worker:</td>
</tr>
<tr>
<td>Sex:</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tel:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability (circle one):</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Aboriginal or TSI (circle one):</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
<td>Country of birth:</td>
</tr>
</tbody>
</table>

### Marital Status and Perpetrator Relationship

<table>
<thead>
<tr>
<th>(circle)</th>
<th>Married</th>
<th>Defacto</th>
<th>Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perpetrator’s relationship to client (circle):</td>
<td>Partner</td>
<td>Daughter</td>
<td>Ex-Partner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(circle)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Perpetrator in the Health Service (circle one):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the Perpetrator likely to come to the Health Service (circle one):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the Perpetrator know client’s whereabouts (circle one):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Perpetrator Details

<table>
<thead>
<tr>
<th>Perpetrator’s name:</th>
<th>Age</th>
<th>Sex</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity:</td>
<td></td>
<td>Country of birth:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Nature of Abuse

<table>
<thead>
<tr>
<th>(circle)</th>
<th>Physical</th>
<th>Psychological</th>
<th>Neglect</th>
<th>Threats</th>
<th>Social Isolation</th>
<th>Financial</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### History of Abuse

<table>
<thead>
<tr>
<th>When did abuse start</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the triggers (circle)</td>
<td>Alcohol</td>
</tr>
<tr>
<td></td>
<td>Work Stress</td>
</tr>
</tbody>
</table>

### High Risk Factors

<table>
<thead>
<tr>
<th>Is the client pregnant/just given birth</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the client depressed/has a mental health illness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is the client suicidal or seriously self harming</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has the perpetrator ever used a weapon</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was a weapon used in most recent event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, what type of weapon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the perpetrator ever threatened to kill client</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has the perpetrator ever threatened to kill children/other family</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has the perpetrator killed/threatened to kill a pet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the perpetrator have access to a gun</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has the perpetrator destroyed property</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has the perpetrator broken a VRO</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If separated, when did separation occur</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

66
### Guidelines for responding to Family and Domestic Violence

#### Children

<table>
<thead>
<tr>
<th>Children at home?</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessing abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being abused</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Police Involvement

<table>
<thead>
<tr>
<th>Did the police attend the home:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have charges been laid against the perpetrator</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does client want the police notified</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Outcome

<table>
<thead>
<tr>
<th>Discharged to</th>
<th>Home</th>
<th>Family/Friend</th>
<th>Refuge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to ward</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Transferred to</td>
<td>Perth</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

#### Consent to refer to a support agency (circle one)

<table>
<thead>
<tr>
<th>Police</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Social Worker</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Specialist FDV Service</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sexual Assault Service</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Counselling service</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>DCP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Women’s Refuge</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Referral made to

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Contact Person</th>
<th>Date referral made</th>
</tr>
</thead>
</table>

#### Protective factors

<table>
<thead>
<tr>
<th>If client returning home, was a safety plan developed with client</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does client have a current VRO</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are other agencies already involved with family</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Name of agency

<table>
<thead>
<tr>
<th>Purpose of involvement</th>
</tr>
</thead>
</table>

#### Physical Examination


#### Client’s assessment of their safety


#### Health worker’s assessment of client’s safety


<table>
<thead>
<tr>
<th>Client’s Signature</th>
<th>Health Worker’s Signature</th>
</tr>
</thead>
</table>
**Safety Plan - Client Resource**

**INCREASING SAFETY IN THE RELATIONSHIP**

### Steps you can take

<table>
<thead>
<tr>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Believe the violence is not your fault</td>
</tr>
<tr>
<td>Keep a diary of events</td>
</tr>
<tr>
<td>Talk to someone you trust</td>
</tr>
<tr>
<td>Seek support and counselling</td>
</tr>
<tr>
<td>Have any injuries documented by your doctor</td>
</tr>
<tr>
<td>Notify the police</td>
</tr>
<tr>
<td>Seek legal advice</td>
</tr>
<tr>
<td>Apply for a Violence Restraining Order or Family Court Order</td>
</tr>
</tbody>
</table>

### Safety at Home

**Plan to do what you can to avoid serious injury**

<table>
<thead>
<tr>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave if you can. Know the easiest escape route including windows and doors and obstacles to avoid in a speedy exit</td>
</tr>
<tr>
<td>Identify a safe place to go and how to get there in an emergency. This includes your nearest 24 hour police station, refuge, friend or family member</td>
</tr>
<tr>
<td>Identify supportive friends and family willing to provide assistance</td>
</tr>
<tr>
<td>Rehearse an escape plan with someone you trust</td>
</tr>
<tr>
<td>Keep a spare key to the car in a safe, easily accessible place</td>
</tr>
<tr>
<td>Keep a list of emergency telephone numbers, e.g. police, friends, refuge, FDV hotline</td>
</tr>
<tr>
<td>Program the telephone number for the police and other emergency telephone numbers into the telephone</td>
</tr>
<tr>
<td>Keep some money, medication, clothing and important documents in a safe and easily accessible place or with someone you trust in case you need to leave in a hurry</td>
</tr>
<tr>
<td>Tell a neighbour or someone you trust about the situation and arrange a signal if in danger</td>
</tr>
<tr>
<td>If your partner has firearms tell the police</td>
</tr>
<tr>
<td>Talk to the children about getting help. Depending on the age and ability of the children this could include</td>
</tr>
<tr>
<td>Running to a neighbour and asking them to call the police</td>
</tr>
<tr>
<td>Calling 000</td>
</tr>
<tr>
<td>Identifying a safe place outside the house where the children can hide</td>
</tr>
</tbody>
</table>
Safety Plan - Client Resource

**PREPARING TO LEAVE THE RELATIONSHIP**

In certain circumstances, you may think the only way to feel safe is to leave the home yourself. Many people have found that violence increases at the time of separation. Your ex-partner may feel a loss of control over you because you are making your own choices.

**Make a safety plan**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gather information about the support that is available to you.</td>
<td>Find out about specialist family violence services and what they can offer</td>
</tr>
<tr>
<td>Seek legal advice</td>
<td>you. Contact as many of these organisations as you need to until the abuse</td>
</tr>
<tr>
<td>Apply for a Violence Restraining Order or Family Court Order</td>
<td>stops or you feel safe</td>
</tr>
<tr>
<td>Save some money. A small amount of money can be useful for emergency</td>
<td>transportation and afterwards. Contact Centrelink to find out about your</td>
</tr>
<tr>
<td>entitlements and what emergency assistance is available</td>
<td>entitlements and what emergency assistance is available</td>
</tr>
<tr>
<td>Arrange transport in advance and know where you will go</td>
<td></td>
</tr>
<tr>
<td>Tell one or two trusted friends or a refuge worker about your plans</td>
<td>Tell one or two trusted friends or a refuge worker about your plans and</td>
</tr>
<tr>
<td>and rehearse the details together</td>
<td>rehearse the details together</td>
</tr>
<tr>
<td>Consider purchasing a phone card - long distance calls are</td>
<td>Consider purchasing a phone card - long distance calls are itemised on</td>
</tr>
<tr>
<td>itemised on telephone bills.</td>
<td>telephone bills.</td>
</tr>
<tr>
<td>Make arrangements for pets</td>
<td>Make arrangements for pets</td>
</tr>
<tr>
<td>Make a list of the important documents you will need and collect</td>
<td>Make a list of the important documents you will need and collect them</td>
</tr>
<tr>
<td>them together</td>
<td>together</td>
</tr>
<tr>
<td>Pack irreplaceable personal items, family and photograph albums</td>
<td>Pack irreplaceable personal items, family and photograph albums</td>
</tr>
<tr>
<td>Open a new bank account and arrange a new address for statements</td>
<td>Open a new bank account and arrange a new address for statements</td>
</tr>
<tr>
<td>Remove your name from telephone, electricity and gas accounts and</td>
<td>Remove your name from telephone, electricity and gas accounts and house</td>
</tr>
<tr>
<td>house leases</td>
<td>leases</td>
</tr>
</tbody>
</table>
What to take

- **Important documents:** marriage certificates, birth certificates for yourself and children, Medicare and concession cards, passport, citizenship papers, school reports, medical records, prescriptions, driver’s licence, vehicle registration papers, insurance policies, bank cards, credit cards, address books, rental agreement or deed to house, your will
- **Keys:** house, car, office
- **Clothing and personal needs**
- **Phone card** and address and phone numbers
- **Children’s essential needs:** favourite toy or comforter
- **Photograph of your partner** so that people protecting you know what he looks like

Playing it safe

- **Keep spare copies of documents** and essentials such as medication with a trusted friend
- **Try not to react** to your partner in a way that might make him suspicious about your plans
- **Tell children what they need to know only when they need to know** so that they don’t worry about keeping a difficult secret
Safety Plan - Client Resource

LIVING SAFELY AFTER SEPARATION

Some people remain in their family home after separation. Consider the following to ensure safety for yourself and your children.

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply for a Violence Restraining Order or Family Court Order</td>
</tr>
<tr>
<td>Change the locks, install security doors, a security system, smoke detectors, and an external security lighting system</td>
</tr>
<tr>
<td>Inform trusted people/neighbours that your partner no longer lives with you and ask that they call the police if that person is observed near your home or the children</td>
</tr>
<tr>
<td>Liaise with the school principal and child care centres and advise them of the names of people who have your permission to collect the children</td>
</tr>
<tr>
<td>Ask your employer for your phone calls to be screened</td>
</tr>
<tr>
<td>Avoid shops, banks, etc that you used when residing with your partner</td>
</tr>
<tr>
<td>Attend an educational program or counselling to strengthen your confidence, freedom and support to deal with your ex-partner</td>
</tr>
<tr>
<td>Identify a support person you can call when you feel down and want to return to the potentially abusive situation</td>
</tr>
</tbody>
</table>

For some people, it is safer to hide their whereabouts from their ex-partner. In addition to the above, also consider the following

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change your name</td>
</tr>
<tr>
<td>Obtain a silent telephone number</td>
</tr>
<tr>
<td>Change your mobile number and email address</td>
</tr>
<tr>
<td>Have your name removed from the electoral role</td>
</tr>
<tr>
<td>Obtain a new Tax File number, Medicare and Centrelink number</td>
</tr>
<tr>
<td>Obtain a post box address and redirect mail to it</td>
</tr>
<tr>
<td>Change your vehicle registration</td>
</tr>
<tr>
<td>Change the children’s name</td>
</tr>
<tr>
<td>Remove details of inter-school transfers from school records</td>
</tr>
</tbody>
</table>
REFERENCES:


Access Economics, The Cost of Domestic Violence to the Australian Economy, Part 2, Office for the Status of Women, 2004


Unless they’re asked: Routine Screening for Domestic Violence in NSW Health, An evaluation report of the pilot project, NSW Health Department 2001

Laing, L: Routine Screening for Domestic Violence in Health Services, Australian Domestic and Family Violence Clearinghouse, 2003


Western Australian Family and Domestic Violence State Strategic Plan 2004-2008, Department for Community Development [Family and Domestic Violence Unit]

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