IMPRODOVA

Factsheet
Domestic violence in the Health Sector

Definition of domestic violence

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

It is not necessarily physical and can include:

- Sexual abuse
- Emotional or psychological abuse
- Verbal abuse
- Spiritual abuse
- Stalking and intimidation, including using technology
- Social and geographic isolation
- Financial abuse
- Cruelty to pets
- Damage to property

Power and Control Wheel

The Power and Control Wheel illustrates the most common abusive behaviours and tactics.

Detailed information on the forms and dynamics of domestic violence is provided in module 1.

Indicators

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

Physical Indicators:

- Unexplained bruising and other injuries (especially head, neck and facial injuries, bruises of various ages, injuries sustained do not fit the history given, bite marks, unusual burns, injuries on parts of the body hidden from view (including breasts, abdomen and/or genitals; especially if pregnant)
- Miscarriages and other pregnancy complications
- Chronic conditions including headaches, pain and aches in muscles, joints and back
- Sexually transmitted infections and other gynaecological problems

Psychological Indicators:

- Emotional distress, e.g. anxiety, indecisiveness, confusion and hostility
- Sleeping and eating disorders
- Anxiety / depression / pre-natal depression
- Psychosomatic complaints

- Self-harm or suicide attempts
- Evasive or ashamed about injuries
- Multiple presentations at the emergency room / client appears after hours
- Partner or other family member does most of the talking and insists on remaining with the patient
- Seeming anxious in the presence of their partner or other family member
- Reluctance to follow advice
- Social isolation / no access to transport
- Frequent absences from work or studies
- Submissive behaviour / low self-esteem
- Alcohol or drug abuse

Indicators of domestic violence are dealt with in more detail in module 2.

Stages of effective response

1. Non-judgemental listening and validation
2. Initial risk assessment
3. Referrals (e.g. Police, Domestic Violence Line, legal advice, victim support)
4. Note-taking for legal purposes
5. Mandatory reporting – if required
6. Continuing care

How to talk to a patient about domestic violence

In any situation when presence of DV is suspected one can ask indirectly and then directly about domestic violence. If there are concerns that a patient is experiencing domestic violence, one should ask to speak with them alone, separately from their partner or any other family members. It is important to understand that very often the victim blames herself/himself or tries to protect the perpetrator. At the beginning of a situation that makes one suspicious, broad questions should be asked about whether the patient's relationships are affecting their health and wellbeing. It is important to listen to patients non-judgmental.

For example:

'How are things at home?'

'How are you and your partner getting on?'

'How do you argue when you are at home?'/'Can you disagree with your partner?'

'Is anything else happening which might be affecting your health?'

It is important to be aware that some victims want to be asked about domestic violence, give hints, but they are more likely to disclose if they are being asked in a safe environment. If appropriate, you can ask direct questions about any violence.

For example:

'Are you afraid when you are at home?'/'Are there ever times when you are frightened of your partner?'

'Are you concerned about your safety or the safety of your children?'

'Does the way your partner treats you make you feel unhappy or depressed?'

'Has your partner ever verbally intimidated or hurt you?'

'Has your partner ever physically threatened or hurt you?'

'Has your partner forced you to have sex when you didn't want to?'

'Domestic violence is very common. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.'

In case specific clinical symptoms are seen and one is sure about their suspicion, one can ask specific questions about these (e.g. bruising). These could include:

'You seem very anxious and nervous. Is everything alright at home?'

'When I see injuries like this, I wonder if someone could have hurt you?'

'Is there anything else that we haven't talked about that might be contributing to this condition?'

If the patient's fluency in English is a barrier to discussing these issues, one should work with a qualified interpreter. Don't use a patient's partner, other family members or a child as an interpreter. It could compromise their safety or make them uncomfortable to talk with you about their situation.

How to talk to victims of domestic violence is the subject of module 3. For more information, please visit this module.

Responding to a disclosure

The immediate response and attitude when a patient discloses domestic violence can make a difference. Victims require an initial response to disclosure, where they are listened to, validated and their own and their children's safety is assessed. They also need to be assisted on a pathway to safety.

- One should listen
- One should communicate belief
- One should validate the decision to disclose
- One should emphasize the unacceptability of violence but do not judge the perpetrator
- One should be clear that the victim is not to blame
- One should not ask questions that might raise victims' stress and sense of powerlessness

Aspects that should be considered after the disclosure of domestic violence such as medical assessment and securing of evidence are addressed in module 4.

Initial risk assessment

A patient should be assisted to evaluate their immediate and future safety, and that of their children. Best-practice risk assessment involves seeking relevant facts about their particular situation, asking them about their own perception of risk, and using professional judgment. A patient may need to be referred to a specialized domestic violence service. The strongest indicator of future risk/violence is current and past behaviours of the perpetrator. Therefore, the patient may need to be advised to go to the police.

It is essential that the victim should be engaged in a conversation about their perceptions of risk and how they have managed their safety in the past. Any plans made should be documented for future reference!

For initial risk assessment, one will at least need to:

Speak to the victim in private setting

Check for immediate concerns:

- Does the patient feel safe going home after the appointment?
- Are his or her children safe?
- Does he or she need an immediate place of safety?
- Does he or she need to be assisted to do the next steps for their safety?
- Does he or she need to consider an alternative exit from your building?

If immediate safety is not an issue, the patient's future safety should be checked

- Has the perpetrator caused physical harm before (e.g. by beating)?
- Has the perpetrator's behaviour changed/ escalated recently?
- Does the perpetrator have access to weapons or any other objects to cause serious physical harm?
- Does your patient need an assistance to make a referral to police or a legal service?
- Does your patient have emergency telephone numbers?
- Does your patient need a referral to a domestic violence service to help make an emergency plan?
- Where would your patient go if he or she had to leave?
- How would your patient get there?
- What would your patient take with him or her?
- Who could your patient contact for support?

Risk assessment is an ongoing process. It may be necessary to check in on the victim to follow up on this initial risk assessment.

Find more information on risk assessment and safety planning in module 5.

Note-taking for legal purposes

- The Police investigation and future legal proceedings can be supported by making detailed notes.
- The physical injuries, including the type, extent, age and location need to be described. If violence as cause is suspected, but a patient has not confirmed this, it should be documented whether their explanation accurately explains the injury. If there is an official form or template for documenting DV injuries, it should be used.
- What the patient said (using quotation marks) should be recorded.
- Any relevant behaviour observed needs to be recorded, detailed and factual rather than stating a general opinion, e.g. rather than 'the patient was distressed', 'the patient cried throughout the appointment, shook visibly and had to stop several times to collect herself before answering a question' should be written.
- Photographs of injuries need to be taken, or photographs taken of the injuries presented at the time of consultation should be certified. The file notes must include the date and time and clearly identify the client. One must clearly identify oneself as the author and sign the file note. Generalisations or unsubstantiated opinions should not be included. One should correct and initial any errors, set out the report sequentially, and use only approved symbols and abbreviations.

International standards and legal frameworks in Europe are discussed in more detail in module 6.

Mandatory reporting

In case a victim talks about experiencing or perpetrating violence, and one believes to have reasonable grounds to suspect that a child is at risk of significant harm, it is mandatory to report this to Community Services or the Youth Welfare Centre. One is not obliged to report violence experienced by adults as long as their life is not endangered. Reporting violence experienced by adults without their consent could put them at greater risk of harm.

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

Continuing care

The victim's safety needs to be considered as a paramount issue. One can help to monitor the safety by asking about any previous escalation of violence or physical harm.

One should be familiar with appropriate referral services and their processes. The victim may need help to seek assistance. Information should be available for the patient to take with them if appropriate.

In module 7 you will find more information on inter-organisational cooperation and risk assessment in cases of domestic violence in multi-professional teams.

Sources

Women's Legal Service NSW (2019): When she talks to you about the violence – A toolkit for GPs in NSW: https://www.wlsnsw.org.au/wp-content/uploads/GP-toolkit-updated-Oct2019.pdf

Hegarty (2011): Intimate partner violence – Identification and response in general practice: https://www.racgp.org.au/download/documents/AFP/2011/November/201111hegarty.pdf