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THE SILENT ENEMY: CURRENT PRACTICES FOR HEALTHCARE PROFESSIONALS IN THE IDENTIFICATION AND REPORTING OF PSYCHOLOGICAL HARM IN CASES OF DOMESTIC VIOLENCE

MATTHEW RAJ* & ELLIE MCKAY**

Awareness and recognition of domestic violence in Australia is increasing. In 2014, the Victorian Government appointed Fiona Richardson as the first Minister for the Prevention of Family Violence and Australian domestic violence campaigner Rosie Batty, whose 11-year-old son Luke was killed by her husband, was named 2015 Australian of the Year. Also, a Special Taskforce chaired by Former Governor-General Quentin Bryce has been formed to conduct an extensive review of domestic violence in Queensland and legislative reforms have been implemented that adopt a broader concept and definition of domestic violence which include psychological harm. Despite these developments, the ability of healthcare professionals to detect domestic violence – a prerequisite to the proper functioning of these laws in practice – is limited in various ways. This article provides an overview of existing legislation that proscribes domestic violence and explores current methods used by practitioners to detect domestic violence. It then examines the duty of HCPs to report instances of domestic violence and explores the methodology behind early warning detection for victims experiencing acute or chronic psychological harm. Finally, the article explores the implications of recent legislative amendments and difficulties faced by HCPs. It then discusses adaptive methods to assist HCPs in practice to ultimately prevent domestic violence.

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I INTRODUCTION

Violence against women is a significant issue facing the Australian community. It knows no bounds and is indiscriminate to geographical location, social class, age, religious, or cultural background.¹ In Australia, the life-time prevalence of experiencing physical violence for women is one in three, and almost one in five women experience sexual violence.² Psychological abuse is experienced by approximately 40 per cent of women in their lifetime.³ Former Governor-General Dame Quentin Bryce has described recent statistics relating to domestic violence as ‘deeply disturbing’⁴ and has referred to the offence as ‘the most grave human rights issue in the world’.⁵ With such an increase in awareness concerning the rise of domestic violence, it is important to identify adaptive methods to prevent instances of abuse, specifically, early detection and intervention. Healthcare professionals (‘HCPs’) are at the front line, capable of identifying and

¹ The National Council to Reduce Violence against Women and their Children, ‘Time for Action: The National Council’s Plan for Australia to Reduce Violence against Women and their Children 2009-2021’ (Background Paper, The National Council to Reduce Violence against Women and their Children, 2009) 9.

² Ibid.

³ Jenny Mouzos and Toni Makkai, Australian Institute of Criminology, *Women’s Experiences of Male Violence – Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)*, Research and Public Policy Series No 56 (2004).

⁴ Dan Conifer, ‘Domestic Violence: “Deeply Disturbing” Statistics a Concern for all Society, Dame Quentin Bryce Says’, *ABC News* (online), 6 April 2015 <<http://www.abc.net.au/news/2015-04-06/domestic-violence-deeply-disturbing-statistics-dame-quentin-bryc/6372814>>.

⁵ Editorial, ‘Making Real Change on Domestic Violence’, *The Age* (online), 7 December 2014 <<http://www.theage.com.au/comment/the-age-editorial/making-real-change-on-domestic-violence-20141207-1226k1.html>>.

managing those experiencing family violence.⁶ The prevalence of intimate partner abuse among women seeking healthcare is higher than in the general population.⁷ In Australia, approximately eight per cent of patients attending primary care have experienced partner violence in the past 12 months.⁸ 'Victims'⁹ of partner violence frequently present to health services for a variety of related health concerns and are more likely to be admitted to hospital than non-abused women.¹⁰ Between 2002 and 2003, the cost to the Australian community for this healthcare was \$8.1 billion, namely for pain, suffering, and premature mortality.¹¹

The following outlines existing methods deployed by HCPs to detect domestic violence among victims seeking healthcare and examines the impact that legislative reforms have caused. It also explores the current legislative duties of HCPs to report instances of domestic violence, in addition to policy implications of broad methods to detect, such as mandatory screening. The object of this paper is to create a lens through which the reader can appreciate the importance of including psychological and/or emotional harm in the definition of domestic violence. It also highlights the significance of HCPs faced with an opportunity to assist victims despite limited training and awareness as to how to effectively screen, manage, advise, and/or report an instance of domestic violence.

⁶ For the purposes of this article, 'healthcare professionals' refers to medical practitioners, nursing, and midwifery staff involved in patient care. In particular, those who work in general practice, the emergency department, and antenatal or psychiatry services. The terms 'healthcare worker', 'healthcare professional', and 'medical practitioner', are used interchangeably.

⁷ See Jean Ramsay et al, 'Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychological Well-being of Women Who Experience Intimate Partner Abuse (Review)' (2009) 3 *Cochrane Database of Systematic Reviews* 1.

⁸ Kelsey Hegarty and Robert Bush, 'Prevalence and Associations of Partner Abuse in Women Attending General Practice: a Cross-Sectional Survey' (2002) 26 *Australian and New Zealand Journal of Public Health* 437, 440.

⁹ For the purpose of this article, where the word 'victim' appears, this term does not imply passivity nor, unless otherwise stated, acceptance of one's circumstances, as a casualty. It is recognised that the term 'survivor' is often preferred as it is distinct from 'victim', and the former identifies and displays an individual's resilience and resourcefulness. The word 'victim' is used here to represent those who are currently experiencing and/or have experienced harm, injury or any other detriment as a result of another person's actions, and includes 'survivors'. Also, despite frequent mention to women in this paper due to existing research, it is accepted that both men and women can be victims of domestic abuse.

¹⁰ Ramsay et al, above n 7, 4.

¹¹ *Ibid.*

II THE SILENT ENEMY

It is reported that intimate partner violence is responsible for more ill health and premature death in women under the age of 45 than other well-known risk factors including smoking, obesity, high blood pressure, and high cholesterol.¹² Victims of domestic violence attending as healthcare patients may or may not present with an obvious acute injury (for example, suspicious bruising or unexplained physical injury). As a result of protracted victimisation, they may present to primary care with chronic sequelae of health issues. The ongoing psychological stress of intimate partner violence may manifest in non-specific chronic pain syndromes, psychiatric symptomatology, gastrointestinal disturbance, gynaecological disorders, and central nervous system complaints.¹³ The most prevalent mental health implications of domestic abuse are depression and post-traumatic stress disorder.¹⁴ Other signs include anxiety, insomnia, self-harm, para-suicide, and social dysfunction.¹⁵ These are common presentations, particularly to general practice, but are three times more likely in abused women.¹⁶ Further, domestic violence is a direct cause of subsequent alcohol and drug abuse.¹⁷

Alarming, it is reported that 30 per cent of intimate partner violence occurs for the first time in pregnancy.¹⁸ Existing violence will often escalate in pregnancy, posing extreme health risks to the mother and the unborn child.¹⁹ Miscarriages and stillbirth are common in women experiencing domestic violence and these women are also over-represented in those seeking termination of pregnancy.²⁰ The complex and non-specific symptoms can result in significant over-investigation. Healthcare professionals may

¹² Victorian Health Promotion Foundation, 'The Health Cost of Violence: Measuring the Burden of Disease Caused by Intimate Partner Violence' (Summary of Findings, 2004) 8.

¹³ Ramsay et al, above n 7, 6.

¹⁴ Ibid 4.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ See Gwyneth Lewis and James Drife, *Why Mothers Die: Report from the Confidential Enquiries into Maternal Deaths in the UK 1997-1999* (RCOG Press, 2001); Lewis, Gwyneth (ed), the Confidential Enquiry into Maternal and Child Health (CEMACH), 'Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer – 2003-2005' (Research Report No 7, CEMACH, December 2007).

¹⁹ Joanna Cook and Susan Bewley, 'Acknowledging a Persistent Truth: Domestic Violence in Pregnancy' (2008) 101 *Journal of the Royal Society of Medicine* 358, 359.

²⁰ See TT Wokoma et al, 'A Comparative Study of the Prevalence of Domestic Violence in Women Requesting a Termination of Pregnancy and Those Attending the Antenatal Clinic' (2014) 121 *British Journal of Obstetrics and Gynaecology* 627; Angela Taft, 'Violence in Pregnancy and After Childbirth: Current Knowledge and Issues in Health Care Responses' (Issue Paper No 6, Australian Domestic and Family Violence Clearing House 2002) 6.

misdiagnose these complaints and instigate inappropriate anxiolytic, antidepressant, or potent analgesic medication without being aware of the root cause of symptoms.²¹

A Domestic Violence and the Law

A significant area of law reform has been concerned with the definition of domestic violence. A 2010 report by the Australian Law Reform Commission ('ALRC') provided a core definition of family violence to include state, territory, and federal legislation.²² As a broad concept, family violence is 'violent or threatening behaviour, or any other form of behaviour, that coerces or controls a family member or causes a family member to be fearful'.²³

As defined by the ALRC, such behaviour incorporates traditional concepts of family violence, including physical violence, sexual assault, stalking, damage to property, and kidnapping or deprivation of liberty.²⁴ However, the recent addition of economic abuse and emotional or psychological abuse has widened the traditional concept of family violence. Amendments to the *Family Law Act* and territory legislation now incorporate this broad definition.²⁵

The ALRC's definition of family violence is a welcomed advancement to understand and identify the endless manifestations of controlling and coercive behaviour inflicted upon victims. It removes the veil of gendered power imbalances within relationships and the notion that a person is permitted to control and discipline their partner. However, the concept of psychological abuse, which has not been comprehensively defined, adds complexity to the detection of harm by HCPs and the ability to manage the health effects in a clinically useful way. When broad detection tools are used to assess the presence of

²¹ National Institute for Health and Care Excellence (UK), *Domestic Violence and Abuse: How Health Services, Social Care and the Organisations They Work with can Respond Effectively: Public Health Guidance No 50* (February 2014) 35 <<https://www.nice.org.uk/guidance/ph50>>.

²² Australian Law Reform Commission, *Family Violence—A National Legal Response, Final Report*, Report No 114 (2010).

²³ *Ibid*, 17.

²⁴ *Ibid*.

²⁵ Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011 (Cth); *Family Law Act 1975* (Cth) s 4AB; *Domestic Violence and Protection Orders Act 2008* (ACT) s 13; *Crimes (Domestic And Personal Violence) Act 2007* (NSW) s 7; *Domestic and Family Violence Act 2007* (NT), ss 5-6; *Domestic and Family Violence Protection Act 2012* (Qld) s 8; *Intervention Orders (Prevention of Abuse) Act 2009* (SA) s 8; *Family Violence Act 2004* (Tas) s 7; *Family Violence Protection Act 2008* (Vic) s 5; *Restraining Orders Act 1997* (WA) s 6.

intimate partner violence, emotional abuse is most commonly reported.²⁶ However, emotional abuse may be least recognised by practitioners and victims themselves. There has been little scrutiny on the types of behaviour that could involve emotional or psychological and economic abuse. The ALRC has recommended that state and territory legislation be amended to include specific examples of emotional and psychological abuse but that the list should remain non-exhaustive.²⁷ Some guidance comes from the Background Paper to the National Council to Reduce Violence against Women and their Children 2009-2021 Time for Action Report.²⁸ Examples of behaviour include, but are not limited to:

- blaming the victim for all problems in the relationship;
- undermining the victim's self-esteem and self-worth through comparisons with others;
- withdrawing interest and engagement;
- swearing and humiliation in private or public;
- verbal abuse focusing on intelligence, sexuality, body image, or capacity as a parent or spouse;
- controlling money or providing an inadequate "allowance";
- controlling relocation to a place where the victim has no circle of friends or family; and
- denial or misuse of religious beliefs to force the victim into a subordinate role.

Some Australian states have chosen to expressly provide for psychological harm (Queensland, South Australia, and Victoria) and/or emotional harm (Queensland, South Australia, Tasmania, Victoria, and Western Australia) within their respective legislative provisions that proscribe domestic violence. The salient fact is that, broadly, every Australian state and territory presently includes psychological and emotional harm within the confines of their definition of domestic or family violence.

²⁶ Deborah Loxton et al, 'The Community Composite Abuse Scale: Reliability and Validity of a Measure of Intimate Partner Violence in a Community Survey from the ALSWH' (2013) 2(4) *Journal of Women's Health, Issue & Care* 1.

²⁷ Australian Law Reform Commission, above n 22, 216.

²⁸ The National Council to Reduce Violence against Women and their Children, above n 1.

III CURRENT PRACTICES TO DETECT DOMESTIC VIOLENCE

The potential to detect and engage victims of domestic abuse exists across a wide range of medical settings including general practice, the emergency department, perinatal and gynaecological clinics, and psychiatric services. However, the detection of domestic violence in these settings has traditionally been underwhelming and the profession has been criticised for allowing victims to 'fall through the cracks'.²⁹ Professional barriers include personal discomfort, time constraints, lack of knowledge, and limited referral resources.³⁰ Victims may have their own barriers to seeking professional help. Indeed, many victims presenting with somatic symptoms are unaware that these are the effect of the psychological stress of domestic violence.³¹ They may be in denial of their abusive relationship or believe that only physical harm requires professional involvement and may not seek support for psychological abuse.³²

Research from Victoria indicates that although women may be the least comfortable to discuss fear of their partner with their doctor compared with other health and lifestyle issues, they do find it acceptable to be asked.³³ Indeed, some abused women are unlikely to spontaneously disclose their experiences unless directly questioned.³⁴ How acceptable an abused woman finds enquiry into domestic abuse may be influenced by several factors. For example, women who have suffered recent abuse (within the past 12 months) are more likely to find enquiry unacceptable, whereas women who have experienced abuse at some point in their life find enquiry equally acceptable as non-abused women.³⁵

²⁹ Sheila Sprague et al, 'Barriers to Screening for Intimate Partner Violence' (2012) 52(6) *Women & Health* 587, 589.

³⁰ See Sheila Sprague et al, 'Barriers to Screening for Intimate Partner Violence' (2012) 52(6) *Women & Health* 587; The Royal Australian College of General Practitioners (RACGP), *Abuse and Violence: Working with our Patients in General Practice (4th ed): RACGP clinical guidelines* (June 2014) <<http://www.racgp.org.au/download/Documents/Guidelines/Whitebook/whitebook-4thedn.pdf>>.

³¹ Gert-Jan Prosmans et al, 'Why Abused Women Do Not Seek Professional Help: A Qualitative Study' (2014) 28 *Scandinavian Journal of Caring Science* 3, 9.

³² *Ibid.*

³³ Kelsey Hegarty et al, 'Identifying Intimate Partner Violence when Screening for Health and Lifestyle Issues among Women Attending General Practice' (2012) 18(4) *Australian Journal of Primary Health* 327.

³⁴ Loraine Bacchus et al, 'Women's Perceptions and Experiences of Routine Enquiry for Domestic Violence in a Maternity Service' (2002) 109 *BJOG: an International Journal of Obstetrics and Gynaecology* 9.

³⁵ Adrian Boyle and Peter Jones, 'the Acceptability of Routine Inquiry about Domestic Violence towards Women: a Survey in Three Healthcare Settings' (2006) 56 *British Journal of General Practice* 258, 260.

The first challenge for HCPs is recognising emotional abuse, this requires a clear understanding of what it may constitute. Current legislation and policy papers provide broad definitions,³⁶ and some stipulate behavioural examples.³⁷ It has previously been stated that the key components to distinguish emotionally abusive relationships may be 'isolation from friends, family, and outside resources and demands for subservience'.³⁸ Given the indeterminate nature of abuse, regard should be had as to whether there ought to be a threshold for behaviour or acts that are serious enough to constitute cruelty. Disagreements exist in most relationships and the odd hurtful comment or emotional distance can occur without any malice or coercion. There is, perhaps notionally at best, however, a point at which actions can generate a destructive power imbalance and fear and become patently abusive.

The authors hypothesise three approaches to determine a threshold of emotional abuse. The first is to assess the frequency of abusive actions. Current research indicates that the frequency of exposure to these acts corresponds with the degree of psychological distress.³⁹ This initial approach, however, ignores the impact of solitary episodes and the point in time that emotional abuse causes psychological harm remains unclear. An approach that seeks to establish a pattern of pervasive behaviour could serve to undermine the protracted impact on a victim's psychological and physical health. A second approach is to define abuse by an objective set of behaviours. If present, these perpetuating actions would constitute abuse irrespective of the frequency, severity, or effect on the victim. Evidently, this approach is inadequate, as is any attempt to exhaustively list a set of human behaviours. Acts that may appear trivial, objectively, can cause significant distress to an individual. A constellation of ostensibly minor actions on the part of an aggressor is capable of constituting emotional abuse.

³⁶ See, eg, *Family Law Act 1975* (Cth) s 4AB.

³⁷ See The National Council to Reduce Violence against Women and their Children, 'Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children 2009-2021' (Background Paper, The National Council to Reduce Violence against Women and their Children, 2009); Jenny Mouzos and Toni Makkai, 'Women's Experiences of Male Violence – Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)' (Research and Public Policy Series No 56, Australian Institute of Criminology, 2004).

³⁸ Richard Tolman, 'The Development of a Measure of Psychological Maltreatment of Women by Their Male Partners' (1989) 4(3) *Violence and Victims* 159 in Kelsey Hegarty et al, 'The Composite Abuse Scale: Further Development and Assessment of Reliability and Validity of a Multidimensional Partner Abuse Measure in Clinical Settings' (2005) 20 *Violence and Victims* 529.

³⁹ See Kelsey Hegarty et al, 'The Composite Abuse Scale: Further Development and Assessment of Reliability and Validity of a Multidimensional Partner Abuse Measure in Clinical Settings' (2005) 20 *Violence and Victims* 529.

Alternatively, an approach that emphasises the subjective experiences of the victim may be considered. This approach does not factor the severity or type of acts, but is concerned with the way that the victim feels. If they feel powerless, emotionally distressed, or controlled, then the perpetrating acts are deemed abusive. This is the approach favoured by professionals working with victims of sexual assault.⁴⁰ It may also be in keeping with the ALRC recommendations that definitions of domestic violence 'should not require a person to prove emotional or psychological harm in respect of conduct against the person which, by its nature, could be pursued criminally'.⁴¹ The authors do not renounce a correct methodology as this is for policy makers. Indeed, assessments should involve a combination of relevant considerations. It is clear that a challenge exists in defining psychological abuse in a way that encompasses varying degrees of behaviour and victimisation.

Current debate exists as to whether methods to detect domestic violence should involve a universal screening process, targeted screening, or alternatively, investigation on an index of suspicion basis. This debate has focused mostly on more severe physical abuse, and there exists a current void in research on the utility of screening methods for emotional abuse. A recent Cochrane review analysed 11 randomised controlled trials on the screening of women for domestic abuse in health care settings.⁴² In summary, it reported that current evidence does not show an improvement in the health or quality of life for abused women through universal screening.⁴³ There are various reasons for this conclusion including inadequate downstream referral and intervention pathways.⁴⁴

The World Health Organisation ('WHO') clinical guidelines recommend targeted screening only for women at high risk of domestic violence.⁴⁵ By way of a comparative

⁴⁰ For example, The Centre Against Sexual Assault (CASA House) in Victoria define sexual assault as '...any sexual behavior that makes a person feel uncomfortable, frightened, or threatened'. See CASA House, *About Sexual Assault: Definitions* (2010) <http://www.casahouse.com.au/index.php?page_id=156>.

⁴¹ Australian Law Reform Commission, above n 22, 17.

⁴² Lorna O'Doherty et al, 'Screening Women for Intimate Partner Violence in Healthcare Settings: Abridged Cochrane Systematic Review and Meta-Analysis' (2014) 348 *British Medical Journal* 1.

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ World Health Organization, *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines* (2013) <<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>>; Gene Feder et

analysis, in 2013, the United States Preventative Services Task Force ('USPSTF') recommended universal screening of all women attending health care services.⁴⁶ In Australia, there is no policy for universal screening of all women, however, following the WHO approach, NSW Health currently recommends routine screening of high-risk women including women attending antenatal clinics, drug, alcohol, or mental health services.⁴⁷ Indeed, there is some compelling research to support the screening of targeted population groups, in particular women attending antenatal appointments. Evidence demonstrates that women in this setting find enquiry into domestic violence more acceptable than in other clinical environments.⁴⁸ Further, anecdotal accounts suggest that routine questioning of all pregnant women can actually normalise the enquiry process and remove the stigma associated with experiences of domestic violence.⁴⁹ Red flags to consider enquiry on an index of suspicion basis may include alcohol and drug use, numerous adverse reproductive outcomes, and the chronic unexplained health complaints discussed previously.⁵⁰

If HCPs were to screen for domestic violence, it is submitted that there would need to be a robust tool available to do this effectively. A 2009 systematic review of 33 studies focused on various existing, developed, and tested domestic violence screening tools.⁵¹ These included the Hurt, Insult, Threaten and Scream ('HITS') tool,⁵² the Woman Abuse Screening Tool ('WAST'),⁵³ the Partner Violence Screen ('PVS'),⁵⁴ and the Abuse

al, 'An Evidence-Based Response to Intimate Partner Violence: WHO Guidelines' (2013) 310(5) *The Journal of the American Medical Association* 479.

⁴⁶ US Preventative Services Task Force, *Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening* (2013)

<<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening#consider>>.

⁴⁷ Department of Health (NSW), *Policy Directive: Domestic Violence – Identifying and Responding* (2006).

⁴⁸ Boyle and Jones, above n 35.

⁴⁹ Bacchus et al, above n 34.

⁵⁰ World Health Organization, *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (2013)

<<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>>.

⁵¹ Rebecca Rabin et al, 'Intimate Partner Violence Screening Tools: A Systematic Review' (2009) 36 *American Journal of Preventive Medicine* 439.

⁵² Kevin Sherin et al, 'HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting' (1998) 30 *Family Medicine*, 508.

⁵³ Judith Brown et al, 'Development of the Woman Abuse Screening Tool for use in Family Practice' (1996) 28(6) *Family Medicine* 422.

⁵⁴ Kim Feldhaus et al, 'Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department' (1997) 277(17) *The Journal of the American Medical Association* 1357.

Assessment Screen ('AAS').⁵⁵ The review concluded that these tools had only been validated in small populations and not widespread clinical practice. These existing tools purport to detect present and/or past physical or sexual abuse in addition to a woman's fear of her partner or safety. However, these tools may not be powered to detect less obvious emotional abuse. Some items attempt to address psychological abuse, for example, the WAST tool and the Conflict Tactics Scale⁵⁶ include items to measure tension and arguments in relationships. This method of measuring tension, however, has been criticised for its focus on conflict and lack of emphasis on the coercive tactics that underpin emotional abuse.⁵⁷ Researchers in Australia have identified these limitations and have developed the Composite Abuse Scale designed to classify women according to the type and severity of abuse and it includes several examples of emotional abuse.⁵⁸ The investigators acknowledge that this tool is useful for research purposes, but that it has not been validated for clinical practice.⁵⁹

More research is needed not only to validate screening tools aimed to detect physical and sexual violence, but also to develop and determine the validity of tools to detect less obvious emotional abuse. In any event, screening tools may prove to be inadequate and the detection of emotional and psychological forms of abuse may require a detailed psychosocial history involving discussion of current and past relationships, home dynamics, financial issues, and more intimate matters. Developing a psychosocial history as part of a discussion is evidently more intrusive and may cause discomfort for practitioners with limited training. It is also time consuming which poses a significant practical challenge to busy clinics. Methods that cause discomfort on the part of a practitioner or create a burden on managing time and staff for a clinic may be viewed as collateral to the charge on combatting the prevalence of domestic violence, however, practical considerations are important. Effective methods to identify and address

⁵⁵ Steve Weiss et al, 'Development of a Screen for Intimate Partner Violence' (2003) 18(2) *Violence and Victims* 131; LN Moonesinghe et al, 'Development of a Screening Instrument to Detect Physical Abuse and its Use in a Cohort of Pregnancy Women in Sri Lanka' (2004) 16(2) *Asia-Pacific Journal of Public Health* 138.

⁵⁶ Murray Straus, 'The Conflict Tactics Scale and its Critics: An Evaluation and New Data on Validity and Reliability' in Murray Straus and Richard Gelles (ed), *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families* (New Brunswick NJ: Transaction Publishers, 1990) 49.

⁵⁷ Hegarty et al, above n 39.

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

emotional abuse caused by domestic violence must be sought and models that may be put in place should be adaptive long-term.

If detection methods are successful, and domestic violence is reported to a HCP, what can they do? Many professionals are reluctant to ask about domestic violence in the first place in fear of causing more psychological distress for the victim if confronted on the topic.⁶⁰ This is particularly the case where the HCPs are not equipped with the knowledge and tools to appropriately manage these cases. Existing skill-sets empower most professionals to conduct a basic risk assessment of the threat of immediate harm to the victim.⁶¹ Where this risk is high, the practitioner may feel more confident to encourage the victim to contact the police, engage in safety planning and specialised domestic violence services, or seek refuge at a shelter. Psychological or emotional harm, however, is a grey area that may challenge professionals in their assessment of threat and safety. The patient may not be at imminent risk of physical injury, yet they may disclose emotional suffering, feelings of being controlled and, by definition, are experiencing domestic abuse. Such situations are precarious and are at the greatest risk of being overlooked.

Recognising that the perpetrating acts are abusive is difficult. In addition, there is a paucity of evidence on the effectiveness of interventions to combat physical and sexual violence and even more limited guidance on appropriate interventions for emotional abuse. A 2009 Cochrane review reported that current global literature provides only equivocal evidence that intense advocacy for victims of domestic violence results in benefits to their physical and psychological wellbeing.⁶² Four studies addressed in this review assess emotional abuse, but overall, it was found that advocacy interventions did not significantly reduce the occurrence of this abuse. Similarly, a subsequent randomised controlled trial in Australia found no improvement in a woman's quality of life, safety planning behaviour, or global mental health following brief motivational

⁶⁰ The Royal Australian College of General Practitioners (RACGP), *Abuse and Violence: Working with Our Patients in General Practice (4th ed): RACGP Clinical Guidelines* (June 2014) <<http://www.racgp.org.au/download/Documents/Guidelines/Whitebook/whitebook-4thedn.pdf>>.

⁶¹ Ibid.

⁶² Ramsay et al, above n 7.

interviewing by family doctors.⁶³ Promisingly, this study did report improvement in depressive symptoms.

The complexities of domestic violence across various social and cultural groups also pose additional challenges. HCPs may not feel empowered to comment on or change cultural practices, particularly when a victim believes the behaviour to be “normal”. Those suffering domestic violence may not consistently view their experience as deviant or criminal. Practitioners in rural and remote communities may feel particularly powerless to intrude into their patients’ wider culture and attitudes towards their partners. Like any medical concern, it is negligent to assume that all victims experience abuse in the same way and will therefore need, and respond to, the same services. Further research is required to examine the longitudinal health effects of emotional abuse and what interventions are most effective to exert agency over their ongoing victimisation.⁶⁴

A The Duty to Report

The communications between HCPs and patients are subject to confidentiality and privacy principles which are protected by legislation⁶⁵ and the common law.⁶⁶ The ethical duty for a doctor to respect their patients’ privacy originates from the Hippocratic Oath,⁶⁷ and the current code of ethical practice endorsed by the Australian Medical Association (AMA) advises doctors to:

⁶³ Kelsey Hegarty et al, ‘Screening and Counselling in the Primary Care Setting for Women who have Experienced Intimate Partner Violence (WEAVE): a Cluster Randomized Controlled Trial’ (2013) 382 *The Lancet* 249.

⁶⁴ Hegarty et al, above n 39.

⁶⁵ See, eg, *Privacy Act 1988* (Cth); *Health Records (Privacy and Access) Act 1997* (ACT) s 6; *Health Administration Act 1982* (NSW) s 22; *Medical Practice Act 1992* (NSW) s 190; *Health Records and Information Privacy Act 2002* (NSW); *Health Act 1937* (Qld) s 100E; *Health Services Act 1991* (Qld) s 62A; *South Australia Health Commission Act 1976* (SA) s 64; *Health Services Act 1988* (Vic) ss 126, 141; *Health Records Act 2001* (Vic).

⁶⁶ It has been recognised that the duty of confidentiality exists in contract, see, eg, *Breen v Williams* (1996) 186 CLR 71 Gaudron and McHugh JJ at 102; *Hunter v Mann* [1974] 1 QB 767 Boreham J at 772. In equity, see, eg, *Breen v Williams* (1996) 186 CLR 71, and in the law of negligence, see, eg, *Furness v Fichett* [1958] NZLR 396 at 405.

⁶⁷ In relation to confidentiality, the Hippocratic Oath required physicians to swear, ‘All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal’; See Kim Forrester and Debra Griffiths, ‘Privacy and confidentiality of patient information’ in Kim Forrester and Debra Griffiths (eds), *Essentials of Law for Medical Practitioners* (Elsevier, 2011) 65, 66.

Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests.⁶⁸

In certain situations, the law requires medical practitioners to breach confidentiality and imposes a duty to report some events to the necessary authorities.⁶⁹ Throughout Australia, with the exception of the Northern Territory,⁷⁰ there is no duty for a medical practitioner to report domestic abuse to law enforcement (ie police service). Reporting it is recommended, but not mandated, for incidences of physical violence resulting in serious injury, including broken bones, gunshot wounds, or lacerations.⁷¹ Ideally, this would be done collaboratively with the consent of the patient.⁷² However, where there is an imminent threat, and the patient is unable to consent due to either disability or intimidation, the medical practitioner's duty to protect the person from harm would transcend their duty of confidentiality.⁷³

There is less of an argument for reporting pure psychological abuse and whether a patient's risk of ongoing emotional injury would justify violation of confidentiality principles. Interestingly, the Northern Territory requires mandatory reporting of domestic violence but only for serious instances of harm that threaten the life or safety of the victim. Furthermore, it does not require the reporting of forms of emotional abuse.⁷⁴ Arguably, strong adherence to patient confidentiality is important to ensure women feel secure to disclose their abuse and engage support services. There is, however, a legal requirement that child abuse or concern for child safety are reported.⁷⁵

⁶⁸ Australian Medical Association (AMA), *Code of Ethics* (2004).

⁶⁹ For example, reporting the presence of alcohol or other illegal substances in the blood of a person after a motor vehicle accident, see, eg, *Road Safety Act 1986* (Vic); *Road Transport (Safety and Traffic Management) Act 1999* (NSW), reporting a person suspected of committing a serious indictable offence, see, eg, *Crimes Act 1900* (NSW) s 316, notification of certain infectious diseases to the relevant department of health, see, eg, *Public Health and Wellbeing Act 2008* (Vic) pt 8 div 3.

⁷⁰ *Domestic and Family Violence Act 2014* (NT) s 124A establishes a legal duty for all adults to report incidences of domestic violence.

⁷¹ Department of Health (NSW), *Domestic Violence – Identifying and Responding* (2006).

⁷² The Royal Australian College of General Practitioners, above n 60.

⁷³ *Ibid.*

⁷⁴ *Domestic and Family Violence Act 2014* (NT) s 124A.

⁷⁵ *Children and Young People Act 2008* (ACT) s 56(1); *Children and Young Persons (Care and Protection Act) 1998* (NSW) s 27(2); *Care and Protection of Children Act 2007* (NT) s 26(a); *Child Protection Act 1999* (Qld) s 13E(2); *Children's Protection Act 1993* (SA) s 11(1)(a); *Children, Young Persons And Their Families Act*

Most state and territory legislation mandate that medical professionals report to the relevant authorities where, in the course of their work, they have a reasonable belief or suspicion that a child is at risk of harm or in need of protection.⁷⁶ Also of note, Western Australia only mandates reporting child sexual abuse and not necessarily other forms of abuse or neglect.⁷⁷

There is increasing evidence reporting the negative impact of exposure to family violence, as a child, to brain and psychosocial development.⁷⁸ The child's brain is primed with a heightened vulnerability to stress, pre-disposition to other mental health disorders, and future perpetration or victimisation of domestic violence.⁷⁹ Qualified bodies now advise medical professionals that exposure to domestic violence (directly or indirectly) constitutes child abuse and that practitioners should seriously consider their legal obligations to report abuse in these contexts.⁸⁰ Indeed, legislation in Northern Territory, Australian Capital Territory, and New South Wales specifically reference that exposure of a child to family violence constitutes significant harm or abuse.⁸¹ Under New South Wales and Northern Territory laws, professionals may be obliged to report these instances.

There is less guidance from legislation regarding a child's exposure to the pure emotional or psychological abuse of a family member. Recent research has demonstrated that exposure to parental psychological distress in the context of domestic violence (independent of physical violence) is associated with the failure of at least one developmental milestone during the first 72 months of a child's life.⁸² Of note,

1997 (Tas) s 4(2); *Children, Youth and Families Act 2005* (Vic) s 184(1); *Children and Community Services Act 2004* (WA) s 124(B).

⁷⁶ *Children and Young People Act 2008* (ACT) s 356(1); *Children and Young Persons (Care and Protection Act) 1998* (NSW) s 27(2); *Care and Protection of Children Act 2007* (NT) s 26(a); *Child Protection Act 1999* (Qld) s 13E(2); *Children's Protection Act 1993* (SA) s 11(1)(a); *Children, Young Persons And Their Families Act 1997* (Tas) s 4(2); *Children, Youth and Families Act 2005* (Vic) s 184(1); *Children and Community Services Act 2004* (WA) s 124(B).

⁷⁷ *Children and Community Services Act 2004* (WA) s 124(B).

⁷⁸ The Royal Australian College of General Practitioners, above n 60.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Children and Young People Act 2008* (ACT) s 342(d); *Children and Young Persons (Care and Protection Act) 1998* (NSW) s 23(1)(d); *Care and Protection of Children Act 2007* (NT) s 15(2)(c).

⁸² Amy Gilbert et al, 'Child Exposure to Parental Violence and Psychological Distress Associated with Delayed Milestones' (2013) 132 *Pediatrics* 1577, 1577.

the *Children and Young People Act 2008* (ACT) defines child abuse to include emotional abuse in the setting of witnessing or being at risk of witnessing the psychological abuse of a family member, where this has or could cause significant harm to their wellbeing or development.⁸³ However, the Australian Capital Territory only requires the reporting of child sexual abuse or non-accidental physical injury. Other states include emotional and psychological harm in their definition of abuse, if it is detrimental to their wellbeing or physical or psychological development.⁸⁴ Exposure to familial psychological abuse may constitute such harm, but this is not explicitly stated in the legislation.⁸⁵

IV POLICY IMPLICATIONS AND THE FUTURE OF DOMESTIC VIOLENCE DETECTION

Recent domestic violence awareness campaigns across Australia have been encouraging. Their success can never truly be measured and the hope that victims are provoked to report crime is a fundamental design of such initiatives. To be sure, this may be the reason why there has been a statistical increase in offending across Australia.⁸⁶ Greater steps need to be taken to forensically examine the opportunity for HCPs to manage and assist victims of domestic violence. This is largely due to HCPs rich exposure to the general public set among a health focused and patient caring environment. A financial strain may already exist on medical health departments due to reporting and perhaps future budgets should accurately provide for this increasing responsibility. Mandatory screening and/or reporting may have a deleterious effect on staffed services in addition to wider government departments. Such policies, however, may serve to effectively prevent victimisation and improve the quality of many Australian family homes — a worthwhile pursuit. One supervening consideration to mandatory screening and/or reporting is the erosion of patient-doctor confidence and trust. A patient that is acutely aware of positive duties to report may avoid health professionals or engage in deceptive conduct which would be counterproductive to aiding and supporting victims of domestic violence overcome their experiences.

⁸³ *Children and Young People Act 2008* (ACT) s 342(d).

⁸⁴ *Child Protection Act 1999* (Qld) s 9; *Children's Protection Act 1993* (SA) s 6(1)(b); *Children, Young Persons And Their Families Act 1997* (Tas) s 3(1)(b); *Children, Youth and Families Act 2005* (Vic) s 162(1)(e)-(f); *Children and Community Services Act 2004* (WA) s 28(1).

⁸⁵ *Child Protection Act 1999* (Qld) s 9; *Children's Protection Act 1993* (SA) s 6; *Children, Young Persons And Their Families Act 1997* (Tas) s 3; *Children, Youth and Families Act 2005* (Vic) s 162; *Children and Community Services Act 2004* (WA), s 28(1).

⁸⁶ Conifer, above n 4.

Further and improved research is needed to investigate how to effectively detect emotional, psychological, and financial abuse among victims. Owing to their nature and role, HCPs are in a prime position to inform our understanding of domestic abuse in our society. However, there remains a dearth of expert education and training services dedicated to assist detection. Certainly, robust and evaluated training programmes that would promote and enhance HCP confidence and proficiency in the routine enquiry and screening of domestic violence are desirable. Current advances in models to detect domestic abuse and educate medical professionals are focused on past and present violent or sexual perpetrating acts. Existing scales designed to measure and address threat and risk do not adequately screen for emotional, psychological, or financial abuse.

V CONCLUSION

This paper has explored how recent legislative changes have altered the landscape of domestic violence and inevitably placed a responsibility, although perhaps an inadvertent one, on front line HCPs. If psychological and emotional abuse are to be taken seriously there needs to be clear direction on a policy level to guide referral pathways, interventions, and management of psychological abuse. Currently, this does not exist.

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