Policy Directive

Domestic Violence Routine Screening

Summary This Policy Directive outlines requirements and procedures, supports safe implementation of domestic violence routine screening and response to disclosures of domestic violence. The application of domestic violence routine screening is mandatory with all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health, and alcohol and other drug services.

Document type Policy Directive

Document number PD2023_009

Publication date 03 April 2023

Author branch Government Relations

Branch contact (02) 9424 5751

Review date 03 April 2028

Policy manual Privacy Manual for Health Information

File number DG23/265

Status Active

Functional group Clinical/Patient Services - Baby and Child, Governance and Service Delivery, Maternity, Mental Health
Corporate Administration - Governance, Information and Data
Personnel/Workforce - Learning and Development, Workforce planning

Applies to Ministry of Health, Local Health Districts, Specialty Network Governed Statutory Health Corporations, NSW Health Pathology, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Private Hospitals and Day Procedure Centres

Audience Mental health services;Alcohol and Other Drug Services;Maternity Services;Child and Family Services;NSW Health services implementing domestic violence routine screening;Workforce Development Teams (including Learning Management System Administrators)

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

NSW Health
POLICY DIRECTIVE

Domestic Violence Routine Screening

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning. All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2023_009 April-2023	Deputy Secretary, Health System Strategy and Planning	New policy directive

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1. BACKGROUND

Domestic violence is a significant public health issue that has significant negative health consequences for women, children and their families. It is causally linked to depression and anxiety disorders, early pregnancy loss, homicide and physical injuries, suicide and self-harm, and issues related to alcohol use[1]. A range of other negative health outcomes is outlined in further detail in the Integrated Violence, Abuse and Neglect Statistics Research Project[2].

Domestic violence can be experienced by people who are (or have been) in an intimate partnership, whether of the same or different gender. An intimate partnership may or may not involve a sexual relationship and includes people who are:

- married, or engaged to be married
- separated or divorced
- de-facto partners
- couples promised to each other under cultural or religious tradition
- dating/ in a relationship but not living together.

A woman can experience domestic violence regardless of her current relationship status, including after an intimate relationship has ended.

Gender is the biggest risk factor for domestic violence. Women and children are most at risk of domestic violence from male perpetrators, predominantly their current or former partners[1]. Research indicates domestic violence experienced by women is more severe and frequent than domestic violence experienced by men in heterosexual relationships and that women are more likely to be seriously injured or die at the hands of a male partner[2].

There is also a range of intersecting identity and situational factors and experiences of discrimination that can heighten the likelihood, impact or severity of domestic violence for some specific population groups. For example, evidence suggests that women living with disability are 40 per cent more likely to experience domestic and family violence than other women[2].

As domestic violence often remains hidden, active efforts are required to enable women to identify and talk about their experiences and connect with support services. A health service may be the only service a woman experiencing domestic violence can access without the perpetrator being present. Domestic violence routine screening can provide an important opportunity to support disclosure of domestic violence in a safe environment.

The Domestic Violence Routine Screening Program is an early identification and intervention strategy to promote awareness of the health impacts of domestic violence, ask questions about patients' safety in relationships and the safety of their children, and to provide information on relevant health services for victims.

Domestic violence routine screening has many benefits and can help to:

- reduce the severity and impacts of domestic violence through early identification and intervention

- address barriers to help-seeking behaviour and help stop the violence from escalating
- inform women about the nature of domestic violence and available support, even when they are not ready to disclose
- provide women with a health service response more tailored to their specific circumstances and needs
- assess the needs of, and provide appropriate support to, children and young people experiencing domestic violence
- improve health workers' knowledge and responses to domestic violence.

Routine screening by skilled workers has little or no adverse effect on women. It is supported by most women who have experienced violence and participated in screening and can improve the longer-term safety and wellbeing of the woman, particularly when associated with a referral to further support[3].

Domestic violence routine screening gives all women who are screened the clear message that:

- domestic violence is not a victim's fault
- there is support available
- domestic violence is a serious public health problem that negatively impacts women and children's health and wellbeing.

It also demonstrates that health workers care about women experiencing domestic violence and can offer support to them and their children, and that health services are a safe place to seek support if required in the future.

1.1. About this document

This Policy outlines the minimum standards for both mandated and non-mandated NSW Health services implementing domestic violence routine screening. This Policy and NSW Health screening tool, support participating health services to screen all eligible women using their service and provide appropriate responses to women's answers.

Domestic violence routine screening is conducted through five phases:

1. Delivering the domestic violence routine screening preamble
2. Asking the screening questions
3. Taking appropriate actions in response to the woman's answers
4. Explaining and offering the domestic violence Z-card; and
5. Documenting screening and outcomes in clinical records.

1.1.1. NSW Health responses to domestic and family violence broadly

Regardless of whether domestic violence routine screening is being undertaken, a health worker who suspects any client (regardless of gender) is experiencing domestic and family violence must ask direct questions about the violence and respond to disclosures, consistent

with the NSW Health Policy Directive *Domestic Violence – Identifying and Responding* (PD2006_084).

1.2. Key definitions

Aboriginal Family Wellbeing and Violence Prevention workforce	Aboriginal-identified positions providing individual and family support activities, including initial crisis support, advocacy, and referral, that specifically address family violence, sexual assault, and child abuse. Their work also comprises broader community development and education strategies, with a focus on prevention and early intervention.
Aboriginal Health Practitioner	These positions provide direct clinical services to local Aboriginal communities. Aboriginal Health Practitioners are required to hold a Certificate IV Aboriginal Primary Health Care Practice and be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia supported by the Australian Health Practitioner Regulation Agency (AHPRA).
Aboriginal Health Workers	Includes the roles of Aboriginal Community Health Workers, Aboriginal Hospital Liaison Officer and Aboriginal Liaison Officer. These roles are non-clinical and provide a variety of services in a community and/or hospital setting. These services include advocacy, support, liaison and health promotion.
Cultural safety	Cultural safety is a concept that aims to recognise, respect and nurture the unique cultural identity of a person in order to create safety for them and meet their needs, expectations and rights. It means centring the perspective of the other person rather than our own.
Domestic violence (often used interchangeably with intimate partner violence)	A pattern of sustained coercive and controlling behaviours in intimate partner relationships and after separation. It may involve physical and sexual assault, emotional abuse or financial exploitation. 'Domestic violence' is used throughout this Policy as the domestic violence routine screening questions relate to violence in intimate relationships (current or former).

Domestic and family violence	The NSW Government's shared definition as set out in the NSW Department of Communities and Justice *Domestic and Family Violence Plan 2022 2027*. 'Family violence' is used in this Policy when referring to the identification and response to violence experienced in a family relationship and not an intimate relationship. 'Domestic and family violence' is used in this Policy when referring to NSW Health and other service system responses to domestic and family violence beyond domestic violence routine screening.
Domestic Violence Safety Assessment Tool (DVSAT)	The Domestic Violence Safety Assessment Tool is a NSW Government tool developed to support risk assessment and safety planning. NSW Health has not prescribed this particular risk assessment tool, as it recognises health workers are using a variety of different domestic violence risk assessment tools.
Education Centre Against Violence (ECAV)	The NSW Health Education Centre Against Violence is a state-wide unit responsible for workforce development in the specialist areas of prevention and response to violence.
NSW Health Domestic Violence Routine Screening Tool	The tool was initially developed in 2001. It includes eight questions in total. The initial two questions support identification of domestic violence. The other questions seek to follow up when domestic violence is disclosed and include questions regarding the presence of children and their safety needs.
NSW Health Safer Pathway coordinator	The staff member within a NSW Health Local Health District's or Speciality Health Network's violence, abuse and neglect services who coordinate NSW Health's engagement in Safety Action Meetings.
Priority populations	Gender and intersecting identity or situational factors and experiences of discrimination can heighten the likelihood, impact or severity of domestic violence for some priority populations. Priority populations identified in the *NSW Health Strategy for Preventing and Responding to Domestic and Family Violence* include: women; Aboriginal women; women with mental illness; women in pregnancy and early motherhood; women with disabilities; LGBTQI people; migrants, refugees and people who are culturally and linguistically diverse; people who have experienced child abuse; older women; women in regional, rural and remote areas; women experiencing sexual violence; and young women and adolescents.

Psychosocial	In this Policy, the term psychosocial refers to services and interventions focusing on people's mental, emotional, social and spiritual health and wellbeing that are provided by health staff trained in disciplines such as, but not limited to, counselling, psychology and social work.
Safer Pathway	Safer Pathway is the NSW whole-of-government response designed to provide accessible and effective domestic violence support services to victims. Key components of Safer Pathway include: a common risk assessment tool (Domestic Violence Safety Assessment Tool); a network of local coordination points providing case coordination and support for victims; and sharing key information and working together to provide victims 'at serious threat' with a targeted, priority response through Safety Action Meetings.
Safety Action Meetings	An element of Safer Pathway consisting of fortnightly meetings attended by government agencies and local service providers to coordinate service responses for victims assessed as being at serious threat and who are aged 16 years or older.
Serious threat	'At serious threat' means there is evidence of a serious threat to a victim's life, health or safety due to domestic violence, and urgent action is necessary to prevent or lessen this threat[4]. A threat does not have to be imminent to be considered serious.
Structured professional judgement approach (to risk assessment)	The combination of a structured risk assessment tool (such as the Domestic Violence Safety Assessment Tool), professional judgement and the victim's own assessment of risk.
Vicarious trauma	The experience of symptoms similar to those who have experienced trauma directly. This is a result of indirect exposure via close contact with survivors or exposure to traumatic materials.
Violence, abuse and neglect (VAN) services	Specialist NSW Health services that have a principal responsibility for responding to violence, abuse and neglect generally or a specific form (such as sexual assault). Responses to violence, abuse and neglect are also be provided by other health services, including screening services, but this is not their principal responsibility.

Victim/ woman/ client	The terms *victim, woman and client* are sometimes used interchangeably throughout this Policy. *Victim* is used mainly when referring to women **and** other family members (including children) who might also be victims of domestic violence as identified through the screening process. *Victim* is also used in reference to other programs and service system responses to people who have experienced violence where the target group is broader than women. *Woman* is used primarily when referring to women, including trans women and women not assigned or presumed female at birth, who will be, or have been screened through the program. This includes women who have disclosed experiencing domestic violence during or prior to the screening process. The term *client* is used to refer to health service users.
Z-card	The Z-card is a discrete wallet sized card that folds out to an A4 page. The content provides basic information on domestic violence and key referral pathways. The Z-card is offered to all women as part of the domestic violence routine screening process.

1.3. Legal and legislative framework

1.3.1. Legislation

- *Children and Young Persons (Care and Protection) Act 1998* (NSW)
- *Crimes Act 1900* (NSW)
- *Crimes (Domestic and Personal Violence) Act 2007* (NSW)
- *Health Records and Information Privacy Act 2002* (NSW)
- *Victims Rights and Support Act 2013* (NSW)

1.3.2. Related NSW Health strategy, policy and procedures

Document	Title
GL2010_004	*SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants*
IB2016_056	*Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form*
IB2018_018	*Definition of an Aboriginal Health Worker*
PD2006_084	*Domestic Violence — Identifying and Responding*
PD2010_016	*NSW Health Safe Start Strategic Policy*
PD2010_017	*Maternal & Child Health Primary Health Care Policy*

Document	Title
PD2011_022	*Your Health Rights and Responsibilities*
PD2013_007	*Child Wellbeing and Child Protection Policies and Procedures for NSW Health*
PD2016_045	*Employee Assistance Programs*
PD2017_044	*Interpreters — Standard Procedures for Working with Health Care Interpreters*
PD2019_008	*The First 2000 Days Framework*
PD2019_041	*Integrated Prevention and Response to Violence, Abuse and Neglect Framework*
PD2020_001	*Identifying and responding to abuse of older people*
PD2020_006	*Responding to Sexual Assault (adult and child) Policy and Procedures*
Privacy Manual	*NSW Health Privacy Manual for Health Information*
NSW Health Strategy	*NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026*

2. IMPLEMENTATION IN HEALTH SERVICE SETTINGS

2.1. Mandated settings

Domestic violence routine screening is mandated in the following NSW Health service settings:

- maternity
- child and family health
- mental health
- alcohol and other drugs.

2.2. Opt-in local health settings

Domestic violence routine screening (DVRS) may be implemented in local health settings outside of the mandated settings. These include, but are not limited to dental clinics, women's health services, gynaecology services, sexual health services and paediatric wards.

However, if a Local Health District or Specialty Health Network is planning to establish domestic violence routine screening outside the mandated services, they must seek approval from the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit within the NSW Ministry of Health, which will confirm the service suitability for implementation and associated staff targeting to Domestic Violence Routine Screening Training. This process supports both the implementation and monitoring of domestic violence routine screening and related training at a state-wide level.

When seeking PARVAN approval, health services must complete the Domestic Violence Routine Screening Implementation and Practice Checklist (available on the NSW Health intranet website *Domestic Violence Routine Screening*) and the DVRS Training Local Targeting Proforma.

Table 1. Key considerations regarding the implementation of screening

Principle	Consideration
Suitability of the service delivery context	Consider the health care setting/s, service target group/s, and composition of the workforce that would be undertaking screening. When considering suitability, the strength of evidence supporting domestic violence routine screening varies across different health settings[5].
Training requirements and other workforce development needs	The NSW Health Mandatory Training Standing Committee has endorsed a locally determined mandatory (red flag) dependent on specific role for staff implementing domestic violence routine screening (see section 2.6.2). Additional training options exist, including those offered by Education Centre Against Violence or training provided by districts or networks that support staff capacity to respond to domestic violence.
Outcomes of self-assessment	Services need to consider how domestic violence routine screening is to be incorporated into existing service-specific policies, procedures and practise to support adherence to this policy.

2.3. Domestic Violence Routine Screening in Emergency Department pilots

This Policy does not extend to the 2021-2022 NSW Health Domestic Violence Routine Screening in Emergency Department (DVRS in ED) pilots that were funded by the Commonwealth Government Health Innovation Fund. The Domestic Violence Routine Screening in Emergency Department pilot uses a different screening tool (the HITS tool: hurt, insulted, threatened with harm and screamed/ swears) and is supported by separate and specific guidance, training, and information, communication and technology initiatives.

Staff within mandated screening settings listed in section 2.1 working within the context of the emergency department are to use the NSW Health Domestic Violence Routine Screening Tool (see sections 5 and 8).

2.4. Establishing consultation and referral pathways

Health services are to establish, maintain and promote the use of consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health. These pathways will assist in facilitating ongoing risk assessment, safety planning and support where domestic violence and other forms of violence, abuse and neglect are identified.

For further information on referral pathways, refer to the NSW Health intranet website *Domestic Violence Routine Screening*.

2.5. Supporting client-centered screening practice for all women

Health services are to promote screening practices that are accessible, trauma-informed, culturally safe and competent and respectful to all women by:

- establishing and maintaining processes that support continuity of care and an opportunity to build rapport prior to screening

- promoting workforce development opportunities and resources to increase health workers' understanding of the specific barriers faced by women from different priority populations, and enhancing knowledge and skills around proactively engaging with women through the screening process
- implementing referral and intake processes that facilitate identification and responsiveness to the accessibility and communication needs of all women accessing the service
- supporting health workers to use clear and concise communication throughout the screening process and in responding to any disclosures
- ensuring people from priority populations can access targeted information, for example, Z-cards in community languages for culturally and linguistically diverse communities and easy read resources on domestic violence for people with intellectual disability or cognitive impairment
- promoting access to accredited interpreters (in community languages and Auslan), who are trained and adhere to standards of confidentiality and impartiality.

NSW Health recognises that particular priority populations experience multiple challenges that can heighten the likelihood, impact or severity of violence, abuse and neglect. For domestic violence routine screening, the priority populations of particular note are Aboriginal and Torres Strait Islander women and women with a disability.

2.5.1. Women with disability

Health services are to support identification and response to domestic violence experienced by women with a disability by:

- building understanding of the dynamics of domestic violence for people with a disability. This includes recognising behavioural or physical indicators of domestic violence, and circumstances in which the perpetrator may be exploiting the woman's disability to perpetrate this violence (such as the woman's reliance on her partner for daily and other care needs)
- building the workforce capacity to assess communication needs and facilitate access to tools that support communication with women with an intellectual or sensory impairment
- enabling adjustments for women with disability, including intellectual disability or cognitive impairment, such as more time for appointments. The Agency for Clinical Innovation's *Building capability in NSW health services for people with intellectual disability: the Essentials* supports this work.

2.5.2. Aboriginal women and domestic violence routine screening

Understanding the loss, grief and intergenerational trauma experienced by Aboriginal people that has accompanied the ongoing processes of European colonisation and striving to eliminate interpersonal and institutional racism within health services are critical factors in improving social and health outcomes for Aboriginal women[6].

In addition to identifying confidential, safe spaces to conduct screening, health services are to address the need for culturally safe spaces for Aboriginal women and be guided by the expertise of Aboriginal Health practitioners and workers within their service.

Such an approach acknowledges that health facilities are institutions that have implemented past policies and contemporary practices of racism and colonisation against Aboriginal communities. For many Aboriginal people, entering the premises of their local health service may be a trigger of trauma from these systems abuses.

For domestic violence routine screening, cultural safety has been found to be central to Aboriginal women's decision to disclose or not disclose intimate partner violence[7]. A study exploring the conditions for disclosure identified that key components of cultural safety include:

- 'building the relationship first'
- 'come at it slowly'
- 'people like me are here'
- 'Borrowed Trust' (a term used by the research team to describe the practice of Aboriginal women using their kinship networks to determine if a service was safe)[7].

When implementing domestic violence routine screening, health services are to:

- Establish and promote consultation and referral pathways to Aboriginal health practitioners and workers and Aboriginal organisations with expertise in responding to domestic and family violence. This includes, but is not limited to, the Aboriginal Family Wellbeing and Violence Prevention workforce.
- Develop, maintain and promote service procedures that support health workers to offer Aboriginal women the choice to access Aboriginal Health practitioners and workers and services with experience in responding to family violence.
- Use Domestic Violence Routine Screening Training as an opportunity to promote consultation and referral pathways. An example would include the involvement of Aboriginal Family Wellbeing and Violence Prevention workers in delivering training.
- Prioritise the inclusion of learning and development opportunities in workplace planning that support the delivery of culturally safe responses to Aboriginal women and children experiencing domestic and family violence.
- Build the expertise of Aboriginal Health practitioners and workers within screening services to respond to domestic and family violence. NSW Health's Education Centre Against Violence (ECAV) offers a range of courses of varying length, including the nationally recognised Certificate IV in Aboriginal Family Wellbeing and Violence Prevention Work.
- Continue to build the capabilities of the broader Aboriginal Health Worker workforce to respond to domestic and family violence.

2.6. Training

2.6.1. Facilitator training

NSW Health organisations must identify and nominate appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training to deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.

NSW Health's Education Centre Against Violence (ECAV) delivers the Domestic Violence Routine Screening Facilitator Training (ECAV Course Code: DV-602), a one day train-the-trainer program where staff are trained to facilitate Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.

2.6.2. Mandatory training

All NSW Health workers who conduct domestic violence routine screening must complete mandatory Domestic Violence Routine Screening Training (My Health Learning Course Code: 420068274) before conducting screening.

The training is a four-hour face-to-face session delivered locally by NSW Health-endorsed facilitators. Beyond content related to consultation and referral pathways, local Domestic Violence Routine Screening Training facilitators must inform Education Centre Against Violence and the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit within the NSW Ministry of Health of any proposed content that is in addition to the minimum Education Centre Against Violence training content.

Local Health Districts and Specialty Health Networks must identify clinical staff and Aboriginal Health workers whose role will involve conducting domestic violence routine screening using NSW Health's Domestic Violence Routine Screening Tool and ensure they are targeted to the training in *My Health Learning*. Local Health Districts and Specialty Health Networks must promote and monitor staff completion of the training.

Table 2. Mandatory training targeting processes by service setting

Service setting	Local Health District and Specialty Health Network local targeting process
Mandatory service setting	Submit the local targeting proforma to your Local Health District or Speciality Health Network's organisational development team who will submit a consolidated proforma for all mandated services to eHealth NSW to apply targeting.
Opt-in service settings	Submit the local targeting proforma and the domestic violence routine screening implementation and practice checklist to Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit, Ministry of Health, for approval (see section 2.2). Once approved, eHealth NSW will apply the targeting.

Staff complete the training once only. Refresher training is recommended when it is identified through patient safety and quality improvement processes, through workers' performance development processes, or following updates to relevant policy and training content.

2.6.3. Additional learning and development opportunities

In addition to the mandatory training, Health services are encouraged to support training to:

- increase the capacity of trained psychosocial health workers within the service to apply a structured professional judgement approach to risk assessment and provide support to other health workers responding to domestic and family violence
- increase the capacity of health workers to identify and respond to domestic and family violence, sexual assault, and child abuse and neglect.

NSW Health's Education Centre Against Violence courses support health workers in preventing and responding to domestic and family violence. Further information is available on the NSW Health Education Centre Against Violence website.

2.7. Ensuring support for staff

Health workers can experience vicarious trauma as a result of engaging empathically with people who have experienced trauma and bearing witness to the traumatic events in their lives. Additionally, Health services must also anticipate the possibility that workers involved in domestic violence routine screening may have their own experiences of domestic violence or other forms of violence, abuse and neglect.

To help minimise vicarious trauma, NSW Health services are to promote:

- access to supervision and debriefing
- access to employee assistance programs (EAPs) within their Local Health District or Specialty Health Network
- use of self-care plans for health workers
- access to cultural supervision for Aboriginal workers
- staff awareness of NSW Health Policy Directive *Leave Matters for the NSW Health Service* (PD2022_006) provisions and other supports available to health workers who may themselves be experiencing domestic and family violence.

3. ELIGIBILITY AND CONDITIONS FOR CONDUCTING DOMESTIC VIOLENCE ROUTINE SCREENING

All clinical staff who have received Domestic Violence Routine Screening Training and who conduct routine medical history-taking or assessments can conduct screening in health services that have implemented domestic violence routine screening (see section 2.6). The health worker who will have an ongoing relationship with the woman is the most appropriate person to conduct domestic violence routine screening.

Prior to conducting domestic violence routine screening, staff are to consider the accessibility and communication needs of the woman, particularly women from priority populations (see section 3.3). Staff are not to underestimate the difficulty that discussing domestic violence may present for some women, especially if it is their first time disclosing violence. It is important for staff to provide an open, supportive and enquiring conversation. It is also

important to recognise that women may fear being judged or losing the care of their children because they disclosed.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until a successful screen is completed.

The domestic violence routine screening status (eligible; complete/ eligible; or incomplete) is to be sought and relayed when there is transfer of care between NSW Health services.

Domestic violence routine screening must not be conducted by administrative staff.

3.1. Eligibility for undertaking screening

The eligibility for domestic violence routine screening in any health setting (both mandated and in other health settings) includes all women, including trans women and women not assigned or presumed female at birth, who:

- are aged 16 years and over (except for in maternity and child and family health services, which, as noted below, will screen all women); **and**
- have not made a recent disclosure of domestic violence to the health worker or service (see section 3.4.3); **and**
- attend as new presentations to the service; **or**
- attend the same service stream in the same service setting and have not been successfully screened within the past 12 months or, if required under other NSW Health policy or procedures, within 12 months; **or**
- have experienced, or their partner has experienced, a change in circumstances that becomes known to the health practitioner or service (such as birth of a new baby, separation, new partner).

In addition to the above, additional criteria apply to mandated screening settings, which are set out below.

Table 3. Additional criteria applicable to mandated screening settings

Service	Applicability
Maternity services	Applies to all women accessing these services. This includes young women and girls.
Child and family health services	Applies to all women and girls accessing these services as a primary carer (usually a mother) of the child client and who are participating in the assessment and receiving support. This does not include other women or girls who may be present at the appointment or home visit.
Mental health services	Applies to all women aged 16 years and over accessing these services. Screening is to be conducted when the woman has moved from an inpatient mental health service to a community mental health service.
Alcohol and other drug services	Applies to all women aged 16 years and over accessing these services.

3.2. Timing of domestic violence routine screening

The domestic violence routine screening questions are to be incorporated into routine clinical assessment or initial assessment process. The timing of the screening will vary based upon other relevant NSW Health policy and procedures.

For example, for maternity and child and family health services, domestic violence routine screening questions are incorporated into the comprehensive primary health care assessment. In most cases, it would be appropriate to ask questions after initial rapport has been built with the woman.

If screening occurs at the initial appointment, then the timing of the screening is to provide an opportunity to build rapport.

3.3. Screening women from priority populations

Health workers conducting domestic violence routine screening must be aware of, and responsive to, additional types of abuse and barriers to seeking support that women from priority populations may face, including:

- outing (or threats of outing) someone's sexuality, gender identity or intersex status
- withholding medicine or withholding assistance of care needs (such as people with a disability, older women)
- threats of deportation due to residency status (such as migrants and refugees)
- increased sense of shame and stigma
- concern about the possible removal of their children (such as Aboriginal people)
- fear of health authorities due to past practices (such as Aboriginal people, migrants and refugees, people with mental illness).
- forced or coerced sterilisation (such as women with disabilities)

Health workers are to consider a woman's broader social context and be responsive to their needs, including through:

- asking Aboriginal women if they would like an Aboriginal Health worker to be present while they are screened, where available. When providing this option, it is important to recognise that not all Aboriginal women will want to be accompanied by an Aboriginal Health worker. In recognition of the range of kinship ties in Aboriginal communities, when providing this option, Aboriginal women must be informed of who the worker is to support her decision making.
- making adaptations to communication style for people with intellectual disability or cognitive impairment, such as allowing more time for appointments. It is important to ask women their communication preferences, check understanding in the woman's own words, speak slowly and allow plenty of time to respond to questions, reflect on feedback, and make adaptions to communication style[8].
- being aware of, and making referrals, to specialist support services and programs in consultation with the woman.

- facilitating ready access to accredited interpreters (in community languages and Auslan) who are trained and adhere to standards of confidentiality and impartiality.

When engaging interpreters, health workers are to request that the interpreter is a woman (where available) and allow adequate time for briefing and debriefing with the interpreter. Where an interpreter is not available for a face-to-face session, they are to be engaged via phone. Screening is not to be undertaken with the use of non-professional interpreters, such as family members or carers, as this may increase the risk to women experiencing domestic violence.

3.4. When NOT to conduct domestic violence routine screening

Screening must occur with all women who meet the eligibility criteria and who consent to answer the screening questions, unless one of the exceptions to screening listed below applies. If screening was not able to be completed, this is to be noted on the domestic violence routine screening form. Including the main reason why the screening was not carried out.

3.4.1. Presence of others

Screening is not to be conducted with anyone else present. This includes, but is not limited to, the woman's partner or ex-partner, friends, family members, and children aged two years or above.

Exceptions to this requirement exist where the presence of another health worker or an accredited interpreter supports a woman's equitable access and engagement with the health service and the screening process. This may include, for example, an Aboriginal Health practitioner or worker. When applying this exception, health workers are to ensure the person attending alongside the women has no pre-existing relationship with the patient.

Health workers are not to make any reference to the screening process in front of others. Where screening is not able to be conducted during a session due to the presence of others, services must try to safely and discreetly arrange a time to speak with the woman in a private and safe space to ask the screening questions or attempt to re-screen at later appointments.

3.4.2. Woman not well enough to answer the questions

Screening is not to be conducted when a woman is not physically or mentally well enough to understand and answer the questions coherently, for example, if she presents as distressed or thought-disordered.

Illness, including mental illness, is not a reason to not conduct screening, unless the nature of the illness prevents the woman from being able to answer or understand the questions coherently.

Health services and workers are to make reasonable adjustments to support accessible and inclusive screening process for all eligible women.

3.4.3. Disclosure of domestic violence

It is not necessary to ask a woman all the domestic violence routine screening questions in full if they have already disclosed domestic violence to the health worker or if the health

service is already aware of a recent disclosure. An example of a recent disclosure may be a disclosure during the assessment and referral process.

However, health workers may still ask some of the screening questions to support risk assessment and safety planning, including consideration of risks relating to children's safety, welfare, and wellbeing.

Disclosures of domestic violence may occur by women referring to domestic violence explicitly as a presenting problem. At other times, women may present with injuries, or in a severely distressed state. When asked about these injuries or their emotional state, they may disclose domestic violence either by explicitly referring to domestic violence or by describing behaviours that constitute domestic violence.

In these cases, it is important to have a supportive conversation that:

- acknowledges and validates the woman's experiences
- names the violence
- recognises that what is happening to the woman is not okay and it is not their fault.

Responses to these disclosures will be in line with *Phase 3B – Response when domestic violence is disclosed* (see section 6.2) and NSW Health policy directive *Domestic Violence – Identifying and Responding* (PD2006_084).

Where safe and appropriate, health workers are to offer the Z-card in line with *Phase 4 – Domestic Violence Z card* (see section 7).

3.4.4. The health service is not being delivered via face-to-face care

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space. Where services are being delivered through a mix of face-to-face and telehealth, domestic violence routine screening must be prioritised at face-to-face appointments. Conducting domestic violence routine screening in front of others may increase risks to women experiencing domestic violence. Likewise, service provision through telehealth cannot always ensure privacy and can also provide increased opportunities for perpetrators to monitor women's activities and conversations and technology-facilitated abuse.

Where services receive disclosures of domestic violence (but not through screening) they must respond. Guidance on responding to disclosures of violence, abuse and neglect via telehealth can be accessed on the NSW Health website *Violence, abuse and neglect and telehealth*.

Privacy must be achieved, regardless of whether screening is being conducted at a health service or in a home environment. It may be more difficult to ensure privacy during home visits than in a health facility. Where privacy cannot be ensured during a home visit, domestic violence routine screening is not to proceed. Instead, the health worker may encourage the woman to visit their health service or clinic for a follow-up appointment.

3.4.5. Unable to access an accredited interpreter

If a professional interpreter is required to work with the woman in relation to her health needs, then it is also appropriate to use the interpreter to conduct the domestic violence routine screening, with the consent of the woman.

3.5. Five phases of domestic violence routine screening

Domestic violence routine screening must be conducted with empathy and understanding. This includes explaining to the women the process and any further action that will be taken, as this will help her feel in control and understand what is happening. It is recommended that staff practice asking the preamble and screening questions and offering the Z-card before they first engage women with the screening tool. Positive engagement is more likely to occur if the woman feels safe with the staff member who is asking questions.

Domestic violence routine screening consists of five phases the health worker must work through:

1. delivering the domestic violence routine screening preamble
2. asking the screening questions
3. taking appropriate actions in response to the woman's answers
4. explaining and offering the domestic violence Z-card to the woman
5. documenting screening and outcomes in clinical records.

4. PHASE 1: DELIVERING THE DOMESTIC VIOLENCE ROUTINE SCREENING PREAMBLE

Health workers must read out the preamble on the Domestic Violence Routine Screening form to the woman before asking the screening questions.

The preamble explains to the woman why the screening process is being conducted, highlights that domestic violence can include a range of abusive and controlling behaviours, and explains the limits of confidentiality where there are concerns for the safety of the woman, children or others.

After reading the preamble, health workers are to check that the woman has understood what has been said, explain that using standard questions supports health workers to get the process right, and that there are no right or wrong answers to the questions.

4.1. The preamble

In this health service we ask all women the same questions about domestic violence.

This is because domestic violence is serious and can include a range of abusive and controlling behaviours. It can but does not always include physical violence.

We want women who may be experiencing this violence to know that our health service is available to provide assistance. We know that talking about experiences can be very difficult, so you don't have to answer the questions if you don't want to.

What you say will remain confidential to the health service except where you tell me something that indicates that there are serious safety concerns for you or your children. If we share information in these circumstances, we will make every effort to tell you and provide you with support.

5. PHASE 2: ASKING THE QUESTIONS

Health workers must read out the screening questions in full and as instructed on the Domestic Violence Routine Screening form. These questions have been tested to maximise their acceptability to, and comprehension by, women.

Questions within the NSW Health Domestic Violence Routine Screening Tool and additional guidance and practice considerations for workers are included below.

Table 4. Additional practitioner guidance when asking the screening questions

	DVRS Tool questions	Guidance for workers
Q1.	Within the last year, have you been hit, slapped, or hurt in other ways by your partner or ex-partner?	*'Hurt in other ways' includes non-physical forms of domestic violence. In addition to physical violence, some of the behaviours that may constitute domestic violence include but are not limited to:* • *sexual assault and other sexually abusive or coercive behaviour* • *emotional or psychological abuse including verbal abuse and threats of violence* • *economic abuse - for example, denying a person reasonable financial autonomy or financial support* • *stalking - for example, harassment, intimidation or coercion of the person or other key people in the person's life (e.g., parents, children, other family) in order to cause fear or ongoing harassment, including through the use of electronic communication or social media* • *kidnapping or deprivation of liberty, as well as unreasonably preventing the other person from making or keeping connections with her or his family or kin, friends, faith or culture* • *damage to property, irrespective of whether the victim owns the property* • *causing injury or death to an animal, with a view to cause fear, irrespective of whether the victim owns the animal.*
Q2.	Are you frightened of your partner or ex-partner?	*A central element of domestic and family violence is an ongoing pattern of behaviour aimed at controlling a partner through fear.*

If the woman answers 'no' to questions 1 <u>and</u> 2, go to Phase 3A.

If the woman answers 'yes' to either of the questions, continue to question 3.

	DVRS Tool questions	Guidance for workers
Q3.	Are you safe to go home when you leave here?	*A woman's assessment of her own risk is a key component for domestic violence risk assessment and must always be taken seriously.* *Where a woman answers 'no' to this question, risk assessment and safety planning must explore other accommodation options as well as other actions to reduce threat. Referral pathways to specialist homelessness services, including women's refuges, are available on the NSW Health Intranet DVRS page.*
Q4.	Would you like some assistance with this?	
Q5.	Are there children involved/ Do you have children?	

If there are no children involved go to Phase 3B.

If there are children involved, ask Q6, Q7 and Q8

Q6.	(If so) have they been hurt or witnessed violence?	*It is important to be mindful of working with the mother as the non-offending parent, partnering with her in a respectful manner, and asking her what she is already doing to keep herself and her children safe.* *Workers need to recognise that questions about children's safety are not only difficult to ask, but more importantly, very difficult to answer. The woman may worry what will happen if she answers 'yes'* ***or*** *'no'.* *If they answer 'yes', they may be very concerned about their children being removed. This is likely to be a heightened concern for women who are Aboriginal, women using alcohol and other drugs, or women with mental illness.*
Q7.	Who is/ are your child/ children with now? Where are they?	
Q8.	Are you worried about your child's/children's safety?	*Before you ask question 8, say: 'Our service wants to support you to continue to look after your children and keep them safe with you. This is why I want to ask you…'*

6. PHASE 3: TAKING APPROPRIATE ACTIONS

A health worker's response to the woman's answers will depend on the identification of domestic violence that occurs through screening or earlier disclosure, the answers given by the woman during the routine screening process, and further risk assessment where domestic violence is identified.

Whatever response a woman gives during domestic violence routine screening, health workers are to be respectful and empathetic and keep safety at the core of the response.

Requirements and further guidance to ensure appropriate action in response to a woman's answers during domestic violence routine screening are below.

6.1. Phase 3A: Response when domestic violence is not disclosed

If the woman does not disclose domestic violence through the screening process and the health worker has no other reason to be concerned that the woman is experiencing domestic violence, the health worker is to:

- Thank the woman for her response
- Offer the woman the Z-card and say:

  '*Here is some information that we offer to all women about domestic violence*'.

  Open up the Z-card and talk through its contents so that she is aware of what it contains. The woman is the best judge of whether to take it (see section 7)
- Document the screening process (see section 8).

In some circumstances, a woman may not disclose domestic violence through screening, but the health worker may still form an impression that the woman is experiencing domestic violence due to, for example, the presence of domestic violence indicators. Other examples:

- They appear anxious or nervous when their family situation or partner is mentioned (either in the screening process or through other conversation).
- They tell you that their partner pressures them to do things they don't want to do
- They tell you their partner or ex-partner criticises or embarrasses them in front of others
- They talk about their partner being jealous/ possessive
- They appear uncomfortable making decisions about themselves or their healthcare
- They say they don't want children to be left with their partner/ ex-partner.
- They have unexplained injuries or an inconsistent/ unlikely explanation for injuries

The presence of one or more of these indicators might not necessarily mean the woman is experiencing domestic violence. There are also many reasons why women who are experiencing domestic violence do not disclose, including, for example, fear of the perpetrator, shame, fear of losing their children, fears about being judged or disbelieved. In some cases, a woman may not even understand that what she is experiencing is domestic violence.

Any further discussion with the woman about a worker's concerns/ observations is to be handled sensitively and highlight to the woman that support is available if needed. The woman is to feel respected and believed to avoid creating further barriers to disclosure in the future. In these circumstances a worker may say things like:

> '*You seemed a bit nervous when we were talking about your partner and family. Are you okay to discuss this further? If you have any concerns about your safety, you can talk to this health service, or I can help you find another service that you may feel more safe talking to.*'

> '*The experiences you described can often be experienced by women living with domestic violence. This may not be what's happening to you but if you have any*

concerns about your safety you can talk to this health service, or I can help you find another service that you may feel more safe talking to.'

If the woman does make a disclosure of domestic violence, health workers are to respond in line with Phase 3B (see section 6.2).

In accordance with NSW Health Policy Directive *Domestic Violence – Identifying and Responding* (PD2006_084), where domestic violence is suspected but not disclosed, the health worker's reasons for suspicion must be documented (see section 8).

6.2. Phase 3B: Response when domestic violence is disclosed

All responses to disclosures of domestic violence are to be supportive and caring.

If a woman discloses domestic violence, thank her for choosing to talk about the violence and acknowledge the difficulties around doing so. While the exact nature of the response to a disclosure of domestic violence will vary depending on the nature of the disclosure, the woman's perspective on the choices offered and the significance of the risk identified, key responses and considerations are summarised in the box below and detailed in the remainder of this section.

Table 5. Key responses and considerations for a disclosure of domestic violence

Consideration	Response
Risk assessment and safety planning	Risk assessment and safety planning must occur whenever domestic violence is identified (see section 6.2.1).
Responding to serious threat and Safer Pathway	Where a woman is identified as being at serious threat, health workers must take action to reduce the threat. Depending on the circumstances and the views of the woman, this may include: • referral to a Safer Pathway Safety Action Meeting • supported referrals to specialist domestic and family violence services for ongoing risk assessment, safety planning and support (see section 6.2.2) • reporting to police.
Reporting to NSW Police	Victims have the right to report any offence to NSW Police. Any request by the woman to report to NSW Police is to be facilitated immediately. There may also be circumstances where health workers should contact NSW Police even where the woman does not consent (see section 6.2.3).
Psychosocial follow-up and referral	All women who disclose domestic violence are to be offered a referral to a counsellor, social worker or other appropriate, trained psychosocial worker within NSW Health, or relevant specialist services such as NSW Health violence, abuse and neglect services (see section 6.2.4)
Information sharing	A woman's consent should always be sought prior to sharing information; however, legislation permits information sharing without consent in some circumstances (see section 6.2.5).
Child protection and wellbeing	Where a child or young person is suspected to be at risk of significant harm due to domestic violence, health workers must respond. Responses are not to be limited to a child protection report and may include, for example, referral to Safe Start or consultation with NSW Health's Child Wellbeing Unit (see section 6.2.6).

Responding to girls under 16 years of age experiencing domestic violence

Consistent with section 3.1, girls under the age of 16 are eligible for screening through maternity and child and family services. If domestic violence is identified in these circumstances, health workers are to recognise and respond to the risk of significant harm to both the young mother and baby.

Consistent with section 6.2.6, workers must respond in line with this Policy and NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007). Workers are also encouraged to consult with the NSW Health Child Wellbeing Unit.

6.2.1. Initial risk assessment and safety planning

Where domestic and family violence is disclosed or identified, health workers are to assess and respond to risk and seek to reduce the threat to women's safety. As mandatory reporters under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), workers are also required to address safety, health and wellbeing concerns for children and young people. Where it is safe to do so, the health worker is to ask the woman about current risk levels.

Risk assessment and safety planning must occur whenever domestic violence is identified. Risk assessment using a structured professional judgement approach (risk assessment tool + professional judgement + woman's own assessment) by a trained health worker, for example a violence, abuse and neglect health worker or social worker, is preferred.

If a structured professional judgement approach cannot be applied by the health worker conducting screening (such as if the woman does not consent to further risk assessment, or an immediate referral to appropriately qualified psychosocial workers is not available), health workers must use their own professional judgement to assess risk. This is to be done by using information gathered from the woman, including her own assessment of risk and worker experience. When doing this, the health worker is to reflect on the responses provided by the woman during screening (such as does the woman feel safe to return home?) and, where possible, through further conversation. Sample questions and high risk or lethality indicators are available from appendix 12.2.

Safety planning is the process of identifying clear and specific strategies to improve safety for all victims within the family[9]. When developing safety plans, health workers are to work collaboratively with women, considering the woman's physical, social, emotional, financial, and technological safety needs, including:

- their life circumstances, resources, and protective strategies the woman already has in place
- their partner/ former partner's level of violence, control, and abusive tactics
- whether they have children
- their relationship status (including whether they remain in the relationship or in contact post separation)

Links to further resources to support safety planning discussions with women are available in appendix 12.2.

To support risk assessment and safety planning, health services are to:

- Develop and implement a plan to build the capacity of the workforce to use a structured professional judgement approach to risk assessment. The plan is to prioritise learning and development opportunities for health workers who already have psychosocial training to apply such an approach.
- Ensure all health workers conducting screening understand evidence-based domestic violence high risk and lethality (see appendix 12.2).
- Ensure that, when a domestic violence risk assessment tool is included within their processes, the risk assessment tool supports practice that is consistent with the *National Risk Assessment Principles for domestic and family violence* (NRAP)[9]. This includes ensuring that the indicators within the tool are consistent with the evidence-based risk factors set out within the *National Risk Assessment Principles for domestic and family violence*.
- Establish, maintain, and promote consultation and referral pathways to support their health workers' response to disclosures. Pathways are to include NSW Health violence, abuse and neglect services or other external services responding to domestic and family violence. This includes liaising with their Local Health District or Specialty Health Network to confirm NSW Health referral pathways into Safer Pathway for clients assessed at serious threat.

6.2.2. Responding to serious threat and Safer Pathway

Where a woman is identified as being at serious threat, workers must take action to reduce the threat. Depending on the circumstance and the views of the woman, this may include:

- referral to a Safer Pathway Safety Action Meeting
- urgent referral to specialist domestic and family violence services or NSW Health violence, abuse and neglect services for ongoing risk assessment, safety planning and support
- reporting to NSW Police (see section 6.2.3).

When taking action to reduce serious threat, health workers are to advise the woman that they have serious concerns for her safety and conduct initial safety planning with the woman to reduce threat (see 6.2.1). When taking action to reduce serious threat, health workers are to:

- always work with the woman, taking her wishes into consideration
- always seek the woman's consent to share information
- advise the woman of legal protections available (such as Apprehended Domestic Violence Orders) and support the woman to report to NSW Police
- consult with, and prioritise referrals to, NSW Health violence, abuse and neglect services and other specialist domestic and family violence services.

The health worker is to prioritise an urgent referral to a counsellor, social worker or another appropriate psychosocial-trained staff member within or outside NSW Health. The health

worker is to follow up with the woman to ensure she was able to connect with the referral, using the agreed follow-up process outlined in section 6.2.4.

Where a referral is not immediately available, the health worker is to help the woman access crisis services to support further safety planning and action to reduce the threat before the appointment ends.

Crisis services may include the NSW Domestic Violence Line (1800 65 64 63) or 1800 RESPECT (1800 737 732).

Safer Pathway

All women aged 16 years and over assessed as being at ‘serious threat’ are to be offered a referral to a Safer Pathway Safety Action Meeting via Safer Pathway Local Coordination Point.

Referrals can be made by contacting the Local Health District’s Safer Pathway coordinator, or directly by contacting a Safer Pathway Local Coordination Point. Screening services are to confirm referral pathways with their Local Health District or Specialty Health Network violence, abuse and neglect manager or safer pathway coordinator.

Safety Action Meetings must remain focused on victims who are at serious threat. Where health workers are unsure of the appropriateness of the referral, they are to confer with their supervisor or NSW Health Safer Pathway coordinators, or Safety Action Meeting coordinators within Local Coordination Points.

Seeking consent when sharing information

A woman’s consent should always be sought prior to sharing information; however, legislation permits information sharing without consent in some circumstances, including reporting to NSW Police (see sections 6.2.3 and 6.2.5).

The offer of referral to a Safer Pathway Local Coordination Point, or other agencies such as NSW Police, may not be accepted by the woman. If so, the health worker is to seek additional guidance from their supervisor, Safer Pathway coordinator within their Local Health District or Specialty Health Network or, where applicable, the NSW Health Child Wellbeing Unit, about whether information can and should be shared under Part 13A *Crimes (Domestic and Personal Violence) Act 2007* (NSW) or, where children are involved, under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Health workers are to also contact the Child Protection Helpline immediately (via telephone 132 111 or eReport) when imminent risk of significant harm for a child or young person is suspected.

Where a decision has been made to share information without the woman’s consent, workers are to:

- inform the woman of any decisions to override their refusal of consent to share information, except where this may further increase the serious threat
- document decisions to share or not share information to reduce serious threat in the woman’s file, in line with this Policy and the NSW Government’s Domestic Violence Information Sharing Protocol.

6.2.3. Reporting to NSW Police

Victims have the right to report any offence to NSW Police. Any request by a woman to report to NSW Police is to be facilitated. Reports can be made by phone or in person at a police station. It may be possible to arrange an appointment with or for the woman with a domestic violence officer (DVO) to discuss the situation and legal and safety options.

There may also be circumstances where it is appropriate for health workers to contact police where the woman does not consent. The decision to report to NSW Police or share information with other agencies as permitted under legislation (see section 6.2.5) is to be considered on a case-by-case basis and needs to consider:

- domestic and family violence risk assessment (assessed threat level)
- views of the woman, noting there are also potential risks in reporting without consent, including the potential for increased risk to victims when the perpetrator becomes aware of a report and further intervention
- seriousness of the injury or injuries and the offence
- the context of a therapeutic relationship and risk to damaging this relationship
- whether an offence has been committed on health premises or there has been a physical assault or serious threats of assault against individuals within a health workplace. All physical assaults and serious threats of assault against individuals must be reported to the police in line with the NSW Health Policy Directive *Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach* (PD2015_001).

Where a report to police is made or information is shared with other agencies without consent, NSW Health care workers are to advise the woman that this will occur, unless there is reasonable belief that providing that information will place the woman or others at increased risk.

Section 13 of the NSW Government's Domestic Violence Information Sharing Protocol outlines details about sharing information where serious threat is identified and provides guidance to support decision making where consent to share information is not provided.

Where workers want to seek legal advice prior to sharing information without consent, they should consult with their line manager.

Other considerations

Section 316 of the *Crimes Act 1900* (NSW) contains offences for concealing serious indictable offences, which is an offence that attracts a penalty of five years imprisonment or more. Examples include but are not limited to attempted murder, assault occasioning actual bodily harm, and choking, suffocation and strangulation offences. The *Crimes Act 1900* (NSW) requires a person who has information of 'material assistance' to securing the apprehension or conviction of an offender to notify police.

However, section 316 provides that there is a reasonable excuse for not reporting to police if:

- the information relates to a domestic violence offence or sexual offence against an alleged victim, and

- the alleged victim was an adult at the time the information was obtained by the person, and
- the person believes on reasonable grounds that the alleged victim does not wish the information to be reported to the police.

Legal advice is encouraged where staff consider that the offence may apply.

6.2.4. Psychosocial follow-up and referral

Where serious threat is identified, the health worker is to help the woman access crisis services to support further safety planning and action to reduce the threat before the appointment ends (refer to section 6.2.2).

All women who disclose domestic violence are to be offered a referral to a counsellor, social worker or other appropriate, trained psychosocial worker within NSW Health or relevant specialist services, including non-government domestic and family violence services. This includes discussing with the woman options for accessing specialist workers and services for women from priority population groups.

Where sexual violence is disclosed, health workers must offer a referral to a NSW Health Sexual Assault Service.

Health workers are to identify the woman's preferred and safest way to be contacted for follow-up support and referrals and ensure this is appropriately communicated with services in the referral process.

If no local referral pathways are available

The health worker is to work through the Z-card with the woman (see section 7) and encourage her to engage with a support service such as the NSW Domestic Violence Line (1800 65 64 63) or 1800 RESPECT (1800 737 732) to support further safety planning and action. The health worker can offer to assist the woman in making the call before she leaves the appointment. Information on referral pathways is available on the NSW Health intranet website *Domestic Violence Routine Screening*.

If the woman declines any referrals, let her know that health services can provide support to people experiencing domestic violence and that she can return to the service for support at a later stage if she chooses to. For Aboriginal women, the health worker is to also offer to support her to access support from Aboriginal Health practitioners and workers or services with expertise in responding to domestic and family violence, where available.

Also let the woman know that, if she feels at risk at any point in the future, she can contact NSW Police, which is available 24 hours a day, and that key support services such as the NSW Domestic Violence Line are also available 24 hours a day, as outlined in the Z-card. When contacting police, women should always call triple 0 in case of emergency; in other circumstances, NSW Police reports are to be made to the local police station.

6.2.5. Information sharing

A victim's consent is to always be sought prior to sharing information; however, legislation permits information sharing without consent in the circumstances outlined below.

Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) enables information to be shared without consent in some circumstances. It indicates that if consent is not provided by the woman, or it is unreasonable or impractical to obtain consent, health services are permitted to share information under Part 13A with Safer Pathway Local Coordination Points or other domestic violence support services, including NSW Police.

Further guidance on information sharing under Part 13A is set out within the NSW Government's Domestic Violence Information Sharing Protocol. In particular, the Information Sharing Protocol indicates that information sharing can occur when:

- There is a valid threat assessment indicating that the victim is at serious threat. Note that a valid threat assessment could include professional judgement, or completed Domestic Violence Safety Assessment Tool (DVSAT) or other risk assessment tool and where available the victim's own assessment of risk; **and**
- The service provider believes on reasonable grounds that the use or disclosure of personal and health information is necessary to prevent or lessen the threat to the victim or other people's life, health, and safety; **and**
- The serious threat is related to the commission or possible commission of a domestic violence offence.

The Information Sharing Protocol's chapter on serious threat provides more detailed guidance to support service providers' decision making on sharing information without consent.

Health services are a prescribed body under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and can also share information under Chapter 16A of that Act with other prescribed bodies, where children are victims or affected by domestic violence. The threshold for information sharing under Chapter 16A is broader than Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW). Health workers can share information related to the safety, welfare and wellbeing of a child or young person if the worker reasonably believes the information will assist in:

- making any decision, assessment, or plan, or to initiate or conduct any investigation, or to provide any service relating to the safety, welfare or wellbeing of the child or young person or class of children or young people, or
- helping prescribed bodies manage any risk posed by an employee towards a child or young person (or class of children or young persons).

Further detail on information exchange under Chapter 16A *Children and Young Persons (Care and Protection) Act 1998* (NSW) is set out in the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007) and resources on the NSW Health website *About child protection and wellbeing*. Workers may also wish to seek further assistance from relevant violence, abuse and neglect services in their Local Health District or Specialty Health Network, or the NSW Health Child Wellbeing Unit.

In addition to Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) and Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the *Health Records and Information Privacy Act 2002* (NSW) enables disclosure without consent of personal health information where there are reasonable grounds to believe this is

necessary to lessen or prevent a serious and imminent threat to the life, health, or safety of a person.

6.2.6. Child protection and wellbeing

Domestic violence impacts on children and young people's physical health and emotional wellbeing and is a form of child abuse. Health workers are to identify responses to assist women to continue to care for their children in a safer environment where possible.

Reporting a child protection concern is only one possible action and does not in itself ensure safety. Where a child protection report needs to be made and it is safe and appropriate to do so, workers are to tell the woman a report will be made.

Health workers can encourage a non-offending parent to be part of the reporting process and are to include in the report any information about the mother's strategies for keeping her children safe. This has the potential to support the mother-child bond, which is often deliberately sabotaged by a perpetrator of domestic violence.

Health workers must respond where a child or young person is suspected to be at risk of significant harm because of domestic violence or other forms of violence, abuse, and neglect. Specifically, health workers have a responsibility to:

- Identify signs of possible child abuse, neglect, domestic and family violence, prenatal harm and adult health issues that may affect parenting
- Use the online NSW Communities and Justice Mandatory Reporter Guide to inform decision making
- Contact the NSW Health Child Wellbeing Unit on 1300 480 420 for advice and support assessing risk of significant harm, or when the Mandatory Reporter Guide directs them to do so
- Contact the Child Protection Helpline (via telephone 132 111 or eReport) about suspected risk of significant harm or if the Mandatory Reporter Guide indicates the need to report
- Respond to child protection and wellbeing concerns by:
    - Providing health services and working with the family where concerns exist, consistent with NSW Health Policy Directive *Maternal & Child Health Primary Health Care Policy* (PD2010_017). This includes referral to a SAFE START Multidisciplinary Case Discussion where concerns are identified through perinatal assessments.
    - Contacting other professionals working with the child, young person or family in line with Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and information-sharing provisions detailed in section 6 of NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007).
    - Speaking to the NSW Health Child Wellbeing Unit about intervention and referral options.

- Referral, as appropriate, to relevant NSW Health violence, abuse and neglect services.

6.3. Phase 3C: Response to other forms of violence and abuse

Questions about domestic violence may prompt some women to disclose other experiences of abuse in their lives. Staff must respond to these disclosures with respect and empathy. In all cases where a woman discloses experiences of abuse and neglect, a referral to a counsellor, social worker, or other appropriately trained psychosocial staff member within or outside NSW Health as relevant is to be offered.

6.3.1. Family violence

If family violence is disclosed outside an intimate partner relationship (current or former), the health worker is to refer to *Phase 3B: Response when domestic violence is disclosed* (see section 6.2) as well as NSW Health Policy Directive *Domestic Violence – Identifying and Responding* (PD2006_084).

Where responding to family violence experienced by older women, health workers are to also refer to NSW Health Policy Directive *Identifying and responding to abuse of older people* (PD2020_001).

6.3.2. Child abuse and neglect

Where the health worker identifies any child abuse, neglect or other behaviours that may place children at risk of harm, they must plan actions aimed at preventing any further harm and addressing the trauma of past harm (see section 6.2.6).

6.3.3. Sexual assault

Anyone who discloses sexual assault, regardless of their relationship to the perpetrator or their gender is to be offered a referral to a NSW Health Sexual Assault Service (SAS). Victims of both recent and historical sexual assault may receive counselling, information and support from a NSW Health sexual assault service.

6.3.4. Historical violence or abuse

Disclosure of historical violence or abuse commonly takes place over time. An appropriate trauma-informed response to the disclosure is crucial, as this will influence how much a survivor of historic violence or abuse discloses. Being believed and validated are of utmost importance. Victims of historical violence and abuse may be eligible for counselling and other supports through the Victim Support Scheme, which helps people who are victims of violent crime in NSW.

7. PHASE 4: DOMESTIC VIOLENCE Z-CARD

All women must be offered a domestic violence Z-card, and have its contents explained, regardless of the woman’s answers to the domestic violence routine screening.

Health workers are to open the Z-card and explain its contents to the woman and check whether the woman feels safe to take the information with them. Staff may say, for example,

'We offer this information card to all women, no matter how they answered the questions. If you don't want to keep it or it is not safe to keep it, you can leave it here.'

This practice is intended to support further discussion of the card's content and provide an opportunity for women to consider whether carrying the information will place them at further risk.

Z-cards are only to be used in conjunction with the domestic violence routine screening process. They are not a generic resource and must not be used as a general resource (for example put into women's introductory packs or left in waiting rooms). Keeping the Z-card discreet and contained minimises the chances of it being seen by perpetrators, which can increase risk.

The Z-card is currently available in 18 additional community languages and can be ordered from the NSW Health website Education Centre Against Violence (ECAV).

8. PHASE 5: DOCUMENTING SCREENING AND OUTCOMES

Women's responses to screening, and the actions in response to their answers, must be documented in their medical record in line with the NSW Health Policy Directive *Health Care Records – Documentation and Management* (PD2012_069). This includes completing the Domestic Violence Routine Screening form in the electronic medical record where available.

Where participating health services and workers do not have access to the Domestic Violence Routine Screening form in the electronic medical record, paper Domestic Violence Routine Screening forms are available. Health services are to establish and implement processes that ensure the transcription of paper forms into the Domestic Violence Routine Screening electronic medical record form where available.

Records are to be accurate and include information that gives a detailed view of what is happening to the woman and, where relevant, her children.

In addition to the screening process, health workers are to document conversations with the woman, the woman's disclosure, and actions taken in response.

If screening was not possible, this is to be noted on the Domestic Violence Routine Screening form. This is to include the main reason why the screening was not possible.

For more detailed information on documenting domestic violence disclosures and response, health workers are to refer to the NSW Health Policy Directive *Domestic Violence – Identifying and Responding* (PD2006_084).

Where children are involved, workers are to refer to the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007).

8.1. Protecting personal health information

In accordance with the health privacy principles in the *Health Records and Information Privacy Act 2002* (NSW) and the *NSW Health Privacy Manual for Health Information*, health workers and services have responsibilities to safeguard against any inappropriate access, use or disclosure of medical records.

The protection of personal health information is of critical importance for victims of domestic and family violence and other forms of violence, abuse and neglect. Inappropriate access, use or disclosure of victims' information can further compromise their safety.

Where health workers identify the need for increased safeguards to protect against the inappropriate access and use of health information, they must liaise with their Local Health Districts and Specialty Health Networks Health Information Manager and implement safeguards to mitigate risk.

A clear example of this is where the alleged perpetrator is a NSW Health worker. In this example, the NSW Health service may have other responsibilities, including the management of child-related allegations, charges and convictions involving health workers. For further information, refer to the NSW Health Policy Directive *Managing Child Related Allegations, Charges and Convictions Against NSW Health Staff* (PD2020_044).

9. DATA COLLECTION AND REPORTING

NSW Health service agreements with Local Health Districts and Specialty Health Networks include a key performance indicator on the screening rate for the domestic violence routine screening program. Local Health Districts and Specialty Health Networks are to contribute to monitoring and reporting as required.

10. INTERAGENCY POLICY, GUIDELINES AND PROTOCOLS

- *Child Wellbeing and Child Protection — NSW Interagency Guidelines*
- *NSW Government's Domestic Violence Information Sharing Protocol*
- NSW Government *Safety Action Meeting Manual*
- *NSW Charter of Victims Rights*
- *National Risk Assessment Principles for Domestic and Family Violence*
- *Preventing and responding to abuse of older people (Elder Abuse) NSW Interagency Policy (June 2020)*

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12. APPENDICES

1. Domestic violence routine screening flowchart
2. Risk management, safety planning and information sharing

12.1. Appendix 1: Domestic violence routine screening flowchart

Domestic Violence Routine Screening flowchart

Screening and response and documentation must occur inline with Domestic Violence Routine Screening Policy Directive

Screening

Deliver the DVRS preamble

Ask the DVRS questions

DV identified
Thank the woman for her disclosure and respond with empathy

Nil DV identified → Offer a Domestic Violence Z-card

Response

Take action: risk assessment and safety planning *

If children are involved:
Use the online NSW Mandatory Reporter Guide (MRG) to inform initial decision making regarding child safety and child protection

Serious threat identified

Talk to the woman about your concerns when taking action to reduce serious threat, health workers should advise the woman about their serious concerns about her safety and/or the safety of others

Prioritise action to reduce serious threat. This may include:

- urgent consultation and referral to specialist VAN or DFV services for risk assessment, safety planning and support
- offer referral to Safety Action Meeting
- report to NSW Police

Seek Consent

Always try to obtain consent from the woman before sharing information and before referring to a Safety Action Meeting and/or NSW Police.

Where consent is not provided, consider whether information sharing is permitted under relevant legislation**

Let the woman know if NSW Health plans to share information without their consent, except where letting the victim-survivor know would increase the serious threat.

Threat identified

Offer referral to a counsellor, social worker or another appropriate psychosocially trained staff member within or outside NSW Health

If referrals are not accepted: Let the woman know Health services are able to provide support to people experiencing DV and she can come back to the service for support at any time

If sexual violence is disclosed: offer referral to NSW Health Sexual Assault Services

Offer a Domestic Violence Z-card

Documentation

Complete documentation

Document screening outcomes and actions in the woman's medical record

* Ongoing risk assessment and safety planning should occur when working with victim-survivors of domestic violence.

**Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 or Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998.

12.2. Appendix 2: Risk assessment, safety planning and information sharing

12.2.1. Assessing threats to safety

If domestic violence is identified, the health worker needs to assess risk and respond to threats to safety, including taking immediate actions to reduce serious threat.

A 'structured professional judgement' approach to risk assessment should be used wherever possible by health workers who have received appropriate training. This approach combines the use of a structured risk assessment tool, professional judgement and the victim's own assessment of risk[9].

If a structured professional judgement approach cannot be applied by the health worker conducting the screening, health workers must apply a professional judgment approach to assess risk. This is to be done by using information gathered from the victim, including the victim's own assessment of risk and worker experience. In doing this, the health worker is to reflect on the responses provided by the woman during screening (such as does the woman feel safe to return home?) and through further conversation if possible.

Some questions that practitioners may ask when assessing threats to safety include:

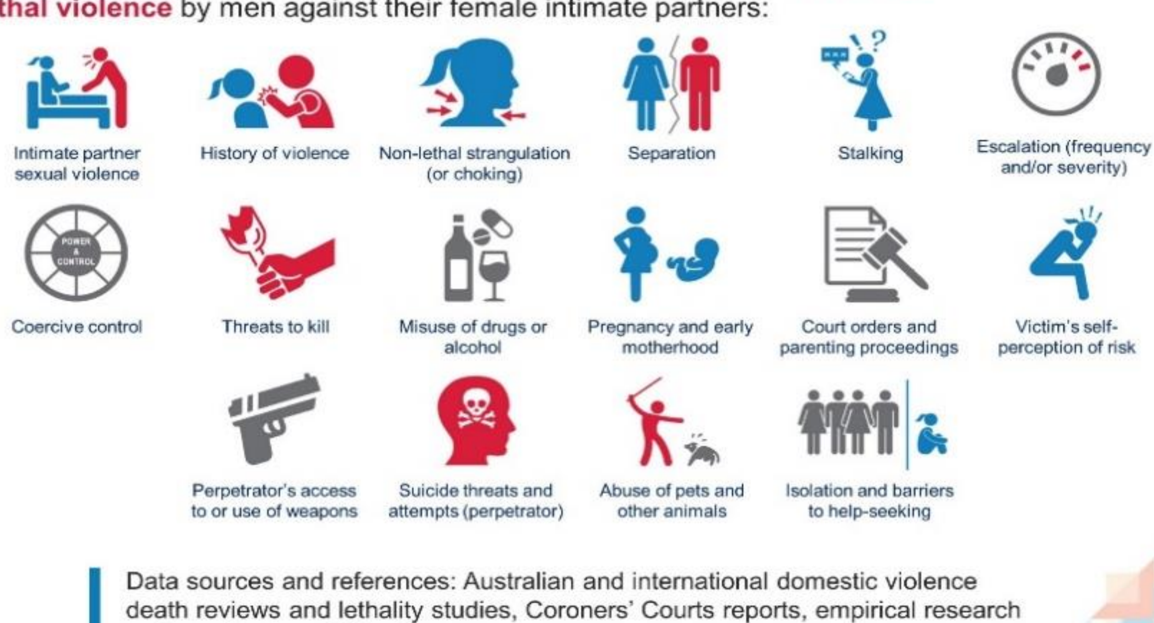
- Your safety is our priority, so I need to ask whether you have any immediate safety concerns for yourself or anyone you are caring for?
- Have they physically harmed you or anyone else in your care, such as children or elderly parents?
  - If yes, has the physical violence involved the use of a weapon?
- Have they threatened to hurt you, your children or pets?
  - If yes, have the threats to harm included threats to kill the victim or others?
- Have they ever put their hands around your neck or tried to stop you breathing in any way?
- Are they controlling your communications and activities, access to money, essential items?
- Are they currently using alcohol and/or other drugs (including medications)?
  - If yes, does their use of violence or other abusive behaviours get worse when they are drinking alcohol or taking drugs?
- Have they ever done anything, or made you do anything, sexually that you did not want to do?
- Have they threatened to harm themselves or suicide?
- Have any of these behaviours been increasing in frequency and/or severity?
- Has there been recent separation or is a separation planned?
- Where is the perpetrator now?

The above questions address some, but not all, of the evidenced based high risk and lethality indicators for domestic violence.

Many factors contribute to risk and no one factor is singularly causal. However, the presence of certain evidence-based risk factors can indicate severe or lethal violence by men against women in intimate relationships[2]. Risk assessment and management is to also consider heightened vulnerability and the specific needs of priority population groups (refer to sections 2.5 and 3.3).

High-risk factors for domestic and family violence

Many factors contribute to risk and no one factor is singularly causal. However, the presence of certain evidence-based risk factors can indicate **severe or lethal violence** by men against their female intimate partners:



Data sources and references: Australian and international domestic violence death reviews and lethality studies, Coroners' Courts reports, empirical research and practice-based literature.

Infographics: Costello & Backhouse, 2019a. Data source: Costello & Backhouse, 2019b

http://www.ecav.health.nsw.gov.au/van-statistics-and-research/

12.2.2. Risk assessment and safety planning resources

The ANROWS National Risk Assessment Principles for domestic and family violence are a useful guide for policy makers and practitioners to support the development of resources and policy. Key documents are:

- Toivonen, C. & Backhouse., C. (2018). *National risk assessment principles for family and domestic violence*.
- Backhouse, C. & Toivonen, C. (2018). *National Risk Assessment Principles for domestic and family violence: companion resource*.

NSW Government Domestic and Family Violence resources are available on the NSW Communities & Justice website *You have a right to be safe*, which include safety planning tips.

The website 1800 RESPECT includes a checklist of things women may consider for their safety plan (*Safety planning checklist*). It also provides a range of resources regarding technology-facilitated abuse and online safety plans to remain safe online (*Technology and safety*).

For resources to support online safety planning visit the eSafety Commissioner website.

12.2.3. Information-sharing resources

Information exchange for safety, welfare and wellbeing of children and young people

The Prevention and Response to Violence, Abuse and Neglect *website Information exchange for safety, welfare and wellbeing of children and young people* outlines key issues for the exchange of information related to the safety, welfare and wellbeing of children and young people.

The NSW Government Domestic Violence Information Sharing Protocol acknowledges that 'where children are victims or affected by domestic violence in the home, service providers who are prescribed bodies under the *Children and Young Persons (Care and Protection) Act 1998* must share information under Chapter 16A of that Act'.

Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) allows for the flow of information between government agencies and non-government organisations to facilitate collaboration in the provision of services to vulnerable children and their families. The NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007) outlines the legislative requirements for NSW Health staff in relation to the exchange of information with other human services and justice agencies.

NSW Government Domestic Violence Information Sharing Protocol

Service providers must adopt the provisions and standards set out in the protocol to share information under Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) and the Domestic Violence Information Sharing Protocol. The Domestic Violence Information Sharing Protocol provides precise and detailed information on the provisions of Part 13A to ensure that service providers understand their obligations.

NSW Health Privacy Manual for Health Information

Refer to section 11 of the *NSW Health Privacy Manual for Health Information* when sharing information where the threshold for information sharing for Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) or Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) has not been met.