



Australasian College
for Emergency Medicine

Identifying and responding to family and domestic violence and abuse in the emergency department

P39 (V5)

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acem.org.au

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01	July 2005	Original version approved by Council
02	Mar 2012	- Change to content under 'Purpose and Scope' - Slight change to some of the content under 'Procedure and Actions'
03	July 2016	- Definitions' and 'Introduction' added - Policy expanded in order to discuss approaches and tools that can be applied by emergency physicians - Procedures and Actions expanded to include skills and resources required
04	July 2020	Substantial revision throughout, and application of new document style
05	Aug 2025	Whole of document revision

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1. Purpose and Scope

This document is a policy of the Australasian College for Emergency Medicine (ACEM; the College) and is applicable to all emergency departments (EDs) in Australia and Aotearoa New Zealand.

P39 Identifying and responding to family and domestic violence and abuse in the emergency department has been developed in recognition of the critical role EDs play as a first, and sometimes only, opportunity to intervene. The policy provides overarching guidance, refers to relevant local resources and outlines the roles of hospitals, EDs and clinicians in identifying, responding to, and safeguarding victim-survivors of family and domestic violence and abuse (FDVA), including their whānau, family and children.

2. Acknowledgement

ACEM acknowledges that the legacy of colonialism and continuing systemic racism and cultural bias contributes to the disparity and disproportionate rates of FDVA experienced by the Aboriginal and Torres Strait women and children in Australia and wāhine Māori (Māori women) and tamariki (Māori children) in Aotearoa New Zealand.

ACEM acknowledges that one of the biggest barriers to disclosing FDVA for Indigenous women is the fear of losing their children or isolation from family and community.^{1,2} This underscores the need for early identification of signs of violence and referral to wrap-around support services that meet the victim-survivors' specific cultural needs.

3. Terminology

The below section outlines key terminology used in this document; however it is acknowledged that there is significant variation across a vast range of resources produced by non-government organisations, government reports and in local legislation regarding preferred terminology.

Please access the following resources for further examples of terminology commonly used:

- National Plan to End Violence against Women and Children 2022-2032³
- Te Puna Aonui⁴

Family and Domestic Violence and Abuse

ACEM uses the combined term 'family and domestic violence and abuse' (FDVA) to refer to violence and abuse that occurs between people who have any family or domestic relationship. This includes physical, sexual, emotional or psychological abuse, which includes a range of controlling behaviours, such as the use of verbal threats, enforced isolation from family and friends, restrictions on finances and public or private humiliation.

Family violence is the preferred term for family and domestic violence within Aboriginal and Torres Strait Islander communities due to its broader application that encompasses family, kinship networks and community relationships in which violence occurs.⁵

Intimate Partner Violence

Intimate partner violence (IPV) refers to abusive behaviours within an intimate relationship that cause psychological, physical, sexual and financial harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Perpetrator

Refers to any individual who uses behaviour that meets common definitions of family violence, intimate partner violence and sexual violence.⁶

Victim-survivor

Victim-survivor refers to a person or people who have experienced family violence, domestic violence and/or sexual violence.

4. Related ACEM Documents

- *P35 – Policy on Child at Risk*
- *P51 – Policy on the Care of Older Persons in the Emergency Department*
- *P936 – Policy on the Care of LGBTIQ+ISB People in Emergency Departments*
- *P56 – Policy on Public Health*
- *P37 – Policy on Forensic Testing and Examination in Emergency Departments*
- *S738 – Statement on Gender Equity*
- *S52 – Position Statement on Health Equity for Aboriginal and Torres Strait Islander Peoples*
- *S913 – Position Statement on Health Equity for Māori*
- *S881 – Position Statement on Health and Human Rights*

5. Background

5.1 Overview

Family and Domestic Violence and Abuse is a Gendered Issue

FDVA affects people of all genders, ethnicities, sexual orientations and socio-economic backgrounds, but the majority of violence is perpetrated against women by a former or current intimate male partner, demonstrating that FDVA is a gendered issue.^{5,6} Data shows that most victim-survivors are women and children, and that overwhelmingly, violence against women and children is perpetrated by men. Women are more likely to experience severe and repeated violence and be subjected to coercive and controlling behaviours.⁵

The prevalence of FDVA in Australia and Aotearoa is unacceptably high. Over 23 per cent of Australian and Aotearoa New Zealand women and about 5 per cent of men have experienced abuse from a current or previous partner, and 13 per cent of Australian children have witnessed this type of violence. On average, one Australian woman is killed every 11 days by an intimate partner.⁷

The cost of FDVA is estimated at \$26 billion a year in Australia, while in Aotearoa New Zealand there is limited data available, with the most recent estimates regarding the impact of child abuse and IPV believed to be between \$4.1 to \$7 billion per year.^{1,8}

Aboriginal and Torres Strait Islander Women

FDVA significantly affects Aboriginal and Torres Strait Islander peoples, who face rates of assault-related hospitalisation far beyond those of non-Indigenous Australians. These realities are shaped by the legacies of colonisation, intergenerational trauma, forced child removals and ongoing structural inequality.⁹

Wāhine Māori

Māori experience family and domestic violence and abuse (FDVA) at more than twice the rate of Pākehā (non-Māori New Zealander). This disparity is shaped by the enduring effects of colonisation, which continue through structural inequities and institutional racism.²

Older Persons

Elder abuse affects a significant proportion of the older population, with psychological, financial and physical abuses being prevalent. Family members and close acquaintances are frequently the perpetrators, exploiting trust and dependency. Challenges such as social isolation, cognitive impairments and cultural norms can hinder reporting.⁹

Intersectionality

Women from culturally and linguistically diverse communities, women experiencing deprivation, or living with disability or mental illness, or in regional, rural and remote communities, and LGBTIQ+ISB people experience partner violence at disproportionately higher rates and face additional barriers getting help.⁹⁻¹¹

52 The Role of Emergency Departments

EDs can be the first, and sometimes the only, opportunity to intervene. Victim-survivors seek ED care for a range of health problems, including chronic health issues and psychological symptoms of FDVA, and less often with obvious signs of physical abuse, requiring health providers to be alert to signs that something is not right.¹² Despite FDVA prevalence being higher in EDs than most other health settings, only about 5-10 per cent of adults presenting to Australian EDs are screened for FDVA, while enquiry rates among women 16+ years range from 0 per cent to 56 per cent across all Aotearoa New Zealand EDs.^{13,14}

Health professionals are in a unique position to identify and respond to FDVA. Many people who experience FDVA will not contemplate engaging with a specialist service but will interact with health professionals at times of heightened risk or seek treatment for injuries or medical conditions arising from violence perpetrated against them. Failing to identify signs, or minimising disclosures by victim-survivors can have a profound impact and deter them from seeking help in the future.¹⁵

6. ACEM Policy

6.1 Hospital responsibilities

- 6.11 Advocate for and participate in interdisciplinary approaches to FDVA that include protocols and policies for identifying, assessment, reporting, trauma-informed care and intervention. Hospitals must recognise FDVA as a complex, multi-faceted issue, requiring coordinated support for victim-survivors including their whānau, family and children.
- 6.12 Ensure that staff are trained to recognise the indicators of FDVA, including coercive control and that all staff are aware of the legal requirements (including mandatory reporting requirements) in their jurisdiction, including what constitutes 'reasonable grounds' for reporting a concern. A clear, legally compliant referral and notification pathway must be established for FDVA concerns, that is integrated with local Child Protection, Police and FDVA specialist services.
- 6.13 Ensure that established policies, procedures and processes are in place to support all clinical and non-clinical staff across the hospital to identify, respond to and safeguard victim-survivors of FDVA.
- 6.14 Set and maintain documentation standards for clinicians.
- 6.15 Provide staff with appropriate access to advice on difficult situations involving consent, confidentiality and sharing of medical information, to cover ethical and legal matters appropriate to the ED environment and jurisdictional laws to maximise victim-survivor safety.
- 6.16 Ensure quality improvement processes are in place to identify opportunities for learning and improvement.

6.2 ED Responsibilities

- 6.21 Provide frequent in-house collaborative training for all clinicians to increase their capacity to identify, respond to and safeguard victim-survivors of FDVA, including their whānau, family and children.
- 6.22 Provide appropriate care for victim-survivors of FDVA based on legislation, local protocols, referral pathways and ensure appropriate educational resources are available to provide.
- 6.23 Implement systems that facilitate appropriate documentation and reporting of all suspected cases of FDVA and mechanisms to report immediate concern for harm.
- 6.24 Ensure patients and their whānau, family and/or carers are treated in a culturally appropriate and sensitive manner, seeking support from First Nations Health Officer/Aboriginal Hospital Liaison Officers / Māori Liaison Officers where possible. If language barriers exist; an interpreter must be used. Care should be taken if the interpreter is from the same community as the victim-survivor, to safeguard against privacy concerns.

6.3 Clinician responsibilities

- 6.31 Be vigilant in considering the possibility of FDVA and how it may present in the ED setting.
- 6.32 Maintain professional education and knowledge of local processes and procedures to support victim-survivors, including their whānau, family and children to access emergency care and increase their

safety.

- 633 Ensure documentation includes appropriate language and be aware that clinical notes may form part of future legal processes.
- 634 Provide trauma informed care, avoid negative stereotyping and consider the cultural and spiritual needs of victim-survivors, their whānau, family and children.

7. Identification

7.1 Vulnerabilities, Risk Factors and Indicators

FDVA affects people of all genders, ethnicities, sexual orientation, socio-economic backgrounds and circumstances, but there are identified risk factors and vulnerabilities that increase risk for experiencing FDVA.

Vulnerabilities

- Younger women
- Women with children in the home
- Older people are also at an increased risk of FDVA due to factors including physical limitations, diminished capacity, and legal loss of control
- During pending or actual separation
- Pregnancy and newborn period
- Court proceedings – protective orders and parenting proceedings
- Has sought outside intervention
- Major crises (pandemics, natural disasters)

Risk factors

- A victim's perception of risk of future FDVA is one of the strongest predictors of FDVA
- Past FDVA
- Escalation of violence
- Non-fatal strangulation
- Use of weapons and threats to kill
- Harmful alcohol and drug use by perpetrator
- Stalking
- Coercive and controlling, jealous, obsessive behaviours by the perpetrator
- Suicide threat by the perpetrator
- Past and frequent attendance to the ED
- History of traumatic brain injury (TBI) or repetitive head injuries

Indicators

Several signs and symptoms are significantly associated with FDVA (**Appendix 1**). Victim-survivors of FDVA more frequently show a number of clinical expressions, such as depression, anxiety, addiction, gynaecological infections or STIs and pain-prominent conditions, more frequently attend ED consultations and more frequently present a high number of concurrent symptoms.

7.2 Screening

ACEM advocates for routine screening for FDVA among women in the ED, and selected screening for FDVA among all other patient populations if any form of disclosure is made, or history identified, and/or if the health provider suspects FDVA because of identified vulnerabilities, risk factors and indicators of abuse and neglect.

Health providers may choose to use a validated screening instrument. Health providers are encouraged to choose one of the many validated screening instruments that are freely available (**Appendix 1**).

73 Sensitive, Safe and Respectful Enquiry

The College recognises the crucial importance of sensitive, respectful enquiry and validation and will advocate to build awareness of the need for ED leaders and health providers to:

- Create safe, private spaces in EDs that support confidential disclosure of FDVA
- Start the conversation about FDVA in the ED and ask the right questions safely and appropriately (Appendix 2)
- To always listen carefully to the persons story, acknowledge what they are saying and validate their feelings. The patient should always be believed
- Demonstrate culturally safe and responsive practice, i.e. by reflecting on own biases and attitudes and how this may affect decision-making and health outcomes for the patient. Access to cultural liaison within the ED is also vital when agreed on by the patient
- Ensure where possible that patients who face particular barriers because of their gender, age, disability, socio-economic status, sexual orientation, or gender identity are able to access appropriate care and specialised support services for FDVA. This may include language interpreters, referral to accessible refuges, etc.

8. Response

8.1 Trauma-informed Practice

Trauma informed practice considers trauma (broad psychological and neurobiological effects of an event, or series of events, that produces experiences of overwhelming fear, stress, helplessness, or horror) in all aspects of healthcare. It does not necessarily require health professionals to elicit disclosures of trauma; rather, it requires recognition of the lived experiences of individuals and awareness of triggers which can lead to re-traumatisation and that efforts are made to minimise re-traumatisation.

8.2 Medical Assessment

Appropriate treatment of all injuries associated with FDVA should include assessment for:

- **Non-fatal strangulation (NFS)**¹: Often presents without any physical signs. It is important to specifically enquire about NFS as part of an FDVA assessment due to it being a significant indicator of future serious harm and homicide.^{16,17} A woman who has experienced NFS is eight times as likely to be killed.¹⁸
- **Traumatic brain injury (TBI)**: A large proportion of victim-survivors attending EDs have suffered head injuries, with a Victorian study showing that 40 per cent of victim-survivors over a decade had suffered a brain injury.¹⁹ Victim-survivors with TBI's often experience decreased cognitive functioning and memory loss.²⁰ Impaired capacity may limit a person's ability to assess their own safety and or access support services, and needs to be considered when planning discharge.
- **Sexual assault**: see *P37 Policy on Forensic Testing and Examinations in the Emergency Department*.

8.3 Risk Assessment and Safety Planning

Where abuse has been identified, ACEM strongly recommends that ED clinical staff conduct a preliminary risk assessment to evaluate the immediate risk of further harm to the person and their children, and that the level of risk identified should inform subsequent actions. Assisting victim-survivors to access support services and legal protection options is one of the most valuable FDVA interventions that health providers can offer.

Consultation should occur with family violence specialists so that a comprehensive specialist response can be undertaken as appropriate, such as child and family protection services, social work, sexual assault, mental health, maternity etc.

ACEM recommends, in alignment with specialist family violence sector guidance, that:

- Risk is identified by: a) the victim-survivors' own view of their risk, b) evidence-based risk factors

¹ Non-fatal strangulation, choking or restriction of breath are all terms used interchangeably

and vulnerabilities, and c) the health providers professional judgement in combination with that of family violence specialists. A reliable risk assessment tool may be used to support decision making (**Appendix 2**).

- That safety planning is based on the level of risk involved. For example, an immediate threat to health and safety requires notifying the police and urgent referral to relevant care and support services. If safety is a concern, but there is no immediate danger, the provider should talk with the patient about concerns for their health and safety, encourage them to seek further help as needed, and ensure they have a safe discharge destination (more details in **Appendix 2**).

8.4 Documentation

ED patient records may be used in discharge support, criminal proceedings, obtaining a protective order, employment leave/financial support, and in serious case reviews. Therefore, it is critical that documentation is sufficiently detailed and includes:

- A description of what happened using the patient's own words
- History of abuse (type, time and place, who and how, current or previous orders on the perpetrator)
- Identifying information about the perpetrator must be clearly documented, for example, the perpetrator's name, date of birth, last known address and phone number
- Record of children in household or pregnancy
- Examination findings, documented injuries using body maps, comorbidities and degree of disability
- The results of the risk assessment, including the patient's perspective
- Agreed support agencies to contact and referrals
- Situations where patient information has been shared
- Concerns or disclosure of FDVA recorded on the records of dependent children

Records should be kept even if the provider's suspicions about FDVA have not led to a disclosure. The patient may disclose in the future. The choice of language should be trauma-informed and must reflect that the clinician believes any concerns or disclosures shared by the victim-survivor.

8.5 Information Sharing and Privacy

Effective information sharing is crucial in keeping victim survivors safe, protecting children and holding perpetrators to account.

- Emergency physicians have a legal responsibility to ensure that information must be kept private to protect victim-survivors from harm or death and only shared under certain circumstances. Information sharing requirements vary by jurisdiction, see **Appendix 3** for further information.
- It is the responsibility of hospitals and health services to establish and provide training and support to hospital staff regarding relevant information sharing and privacy obligations, and to ensure organisational processes are compliant with the most up-to-date local laws.

8.6 Working Collaboratively

The role of the ED can be strengthened and expanded when formal relationships are developed with external agencies and support programs.

ACEM strongly advocates to all levels of government in Australia and Aotearoa to address shortfalls in the availability of resources and follow up services available to victim-survivors of FDVA and calls for increased funding for the sector, to increase service capacity and strengthen the level of support provided.

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Appendix 1. Identification: Additional Information

Indicators of FDVA^{21,22}

Psychological/emotional	Behaviour/Demeanour
• Poor self esteem • Depression • Stress and anxiety • Panic attacks • PTSD • Sleeping and eating disorders • Self-harm • Suicidality • Abuse of drugs and alcohol • Addiction • Fear, shame, anger • Feelings of worthlessness and hopelessness • Feeling disassociated and emotionally numb	• Frequent ED presentations or other medical consultations, often with vague symptoms • Vague changing stories • Explanation inconsistent with injury • Hostile, nervous, evasive, flat affect • Reluctance to speak in front of partner/escort • Delay between injury to presentation • Poor control/management of chronic health issues • Heavy use of painkillers • Medicine non-adherence • Early self-discharge • Partner refusing to give partner privacy, intrusive, belittling, minimising, threatening, aggressive, and/or overattentive
General health	Brain and Nervous System
• Poor physical health • Chronic health condition • Multiple chronic health issues	• Headaches, migraines • Memory problems • Confusion • Impaired judgement • Seizures • Hearing loss • Speech difficulties • Traumatic brain injury
Somatic Symptoms	Cardiovascular System
• Chronic fatigue • Chronic pain • Fibromyalgia • Temporomandibular disorder • Somatic symptoms	• Palpitations • Angina • Cardiovascular disease • High blood pressure/hypertension • High cholesterol • Stroke
Reproductive System	Adverse Pregnancy Outcomes
• Pelvic pain • Genital injuries • Hysterectomy • Sexual dysfunction • Painful intercourse • Painful menses • Sexual problems • STIs • Vaginal bleeding • Emergency contraception use	• Delayed prenatal care • Foetal death, foetal loss (miscarriage, Spontaneous abortion) • Interference with contraception • Low birth weight • Neonatal death • Preterm delivery • Premature labour • Premature rupture of membranes • Unintended pregnancy • Increased abortion rate
Gastrointestinal System	Genitourinary System
• Constipation • Diarrhoea • Frequent indigestion • Functional gastrointestinal disorder	• Bladder/kidney infections • Genitourinary problems

• Gastric reflux • Gastrointestinal disturbances • Inflammatory bowel syndrome • Irritable bowel disorder • Spastic colon • Stomach ulcers • Stomach/gastrointestinal problems	
Musculoskeletal System	Social /financial
• Activity limitations • Injury during pregnancy • Multiple and/or recurrent injuries • Difficulty swallowing • Vocal changes • Head, neck, or facial pain and injuries • Defensive injuries • Weapon injuries or marks • Injuries to areas not prone to injury by falls • Old as well as new injuries • Bites and burns • Joint disease • Physical disability • Functional impairment	• Isolated • Housing instability/unhoused • Unemployed • Financial debt

Screening Instruments

The following instruments accurately detect FDVA primarily among adult women attending the ED:

- Abuse Assessment Screen (AAS) - five items assess physical, emotional, and sexual violence
- Hurt, Insult, Threaten, Screams or Swears (HITS) – four items assess the frequency of FDVA
- Extended–Hurt, Insult, Threaten, Scream (E-HITS) – includes an additional question to assess the frequency of sexual violence
- Ongoing Violence Assessment Tool (OVAT) – four items to assess ongoing physical and emotional FDVA
- Partner Violence Screen (PVS)- three items that assesses physical abuse in the last year and current safety
- Managing non-fatal strangulation in the emergency department: [Clinical Practice Guide](#) – NSW Agency for Clinical Innovation
- In Aotearoa NZ, recommended screening questions are available in the [Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence](#)

Enquiry

Examples of framing questions:

- “Because violence affects people’s health, I routinely ask [all] our patients about any violence they may have experienced.’
- “We know that family violence is common and affects women’s and children’s health, so we are asking [routinely] about violence in the home”

Examples of direct questions that are commonly used in health care settings:

- Is there anyone in your life who you are afraid of, or who prevents you from doing what you want?
- Have you ever been hit, kicked, punched, slapped, or choked by any partner or ex-partner in the past year, or ever?
- Is there anyone at home who makes you feel you are no good or worthless?

- Have you ever had a relationship with someone who made you feel afraid, hurt you, or made you have sex when you didn't want to or in a way you didn't want?
- Are you afraid of your partner or ex-partner?

Appendix 2. Response – additional information

Risk Assessment

Australian State/Territory and Aotearoa New Zealand guidelines on FDVA provide risk assessment guidance. Questions to assess patient risk commonly include:

- Is your partner here now?
- Are you afraid of your partner?
- Are you afraid to go or stay home?
- Does the physical violence seem to be happening more often or be getting worse?
- Have children seen or heard violence in your home?
- Has anyone physically hurt a child?
- How do you manage what happens to your children when you are stressed or being abused yourself?
- Has your partner ever tried to choke or strangle you or anyone else?
- Does your partner make threats to kill you, themselves, or anyone else?
- Do you believe your partner is capable of killing you?
- Do you or your partner abuse alcohol or other substances?
- Have you recently left your partner, or are you considering leaving?
- Is there a gun in your house?
- Are you pregnant?

Safety Planning

Conduct initial safety planning based on the level of risk identified.

Immediate danger:

- If there is an immediate threat to health and safety or they (and their children) are at high risk, notify the police and appropriate statutory agency. Patient consent is preferable but not needed in these circumstances
- Risk of (further) serious assault – inform the patient, notify police, seek urgent support/sexual assault services
- Suicide or self-harm – inform the patient and arrange urgent referral to mental health services
- Risk to children – make a referral to the statutory child protection agency and women's support services

Safety is a concern, but no immediate danger:

- Talk with the patient about concerns for their health and safety and encourage them to seek further help as needed
- Discuss if they have somewhere safe to stay e.g., women's refuge, friends and family
- Provide information about community family violence services and legal options e.g., protection orders

No pressing safety concerns:

- Discuss with the patient how FDVA can affect health and encourage the patient to seek further help as needed
- Provide information about FDVA support

Appendix 3. Local Resources

Information Sharing Guidance

The information sharing requirements and procedures differ by jurisdiction. It is important that emergency physicians are familiar with the information sharing guidelines and protocols in the jurisdictions in which they practice. Australian state and territory and Aotearoa New Zealand guidelines can be accessed through the links below.

Jurisdiction	Guidelines
ACT	*An information sharing protocol has not been published for this jurisdiction
NSW	Domestic Violence Information Sharing Protocol 2014
NT	Domestic and family Violence information sharing 2019
QLD	Domestic and Family Violence Information Sharing Guidelines 2023
SA	Information Sharing Guidelines 2018
TAS	*An information sharing protocol has not been published for this jurisdiction
VIC	Family Violence Information Sharing Scheme 2021
WA	The Western Australian Common Risk Assessment and Risk Management Framework (CRARMF) : Fact Sheet 9: Information Sharing 2024
Aotearoa New Zealand	Information Sharing Guidance for Health professionals from 1 July 2019

Local Guidelines

Every jurisdiction in Australia and Aotearoa New Zealand publishes local guidance on assessing risk, identifying, and managing domestic violence. These publications can assist emergency physicians by providing education and practical guidance and tools when working with patients who have experienced, or are at risk of, domestic violence.

Jurisdiction	Framework
ACT	ACT Domestic and Family Violence Risk Assessment Framework 2022
NSW	Domestic violence – Identifying and Responding 2006
NT	The Northern Territory Government Domestic and Family Violence Risk Assessment and Management Framework (RAMF) 2019
QLD	Domestic and family violence (DFV) resources to support health professionals
SA	Family Safety Portal
TAS	Responding to Family and Sexual Violence: A guide for service providers and practitioners in Tasmania 2021
VIC	MARAM Practice Guides: Foundation Knowledge Guide 2021
WA	The Western Australian Common Risk Assessment and Risk Management Framework (CRARMF) 2024
Aotearoa New Zealand	Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence 2016

Assistance for Clinicians

Managing and treating people experiencing family violence can be extremely distressing for health practitioners and it is important for practitioners affected to seek support early. Workplaces may have an Employment Assistance Program (EAP) for their workforce and there are a number of other support services available.

Jurisdiction	Support Service
Australia	Lifeline 13 11 14 Doctor's Health Advisory Service Drs4Drs
Aotearoa New Zealand	TBC



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