Safe and Healthy

A PRIMARY CARE DOMESTIC AND FAMILY AND SEXUAL VIOLENCE INITIATIVE

DFSV Primary Care Action Plan Guide

Last updated March 2023

THEPHN.COM.AU/DFV

Hunter New England and Central Coast (HNECC) PHN acknowledges the traditional custodians of the lands we walk, reside and work upon. We pay our respects to First Nations people and value the continued connection to culture, country, waterways and contributions made to the life of our vast region.

FIRST NATIONS HEALTH

This document was developed by the Hunter New England and Central Coast Primary Health Network, with support from Nepean Blue Mountains and Central Eastern Sydney Primary Health Networks', to provide a guide to the General Practice Domestic & Family Sexual Violence (DFSV) Action Plan.

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Watch the following video to see the Action Plan applied in Practice:

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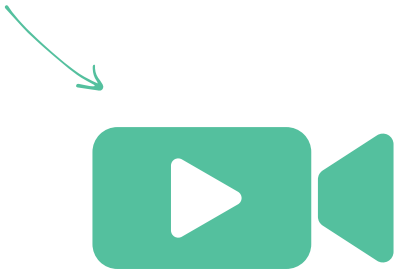

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INTRODUCTION

Purpose

The DFSV Action Plans primary focus is to provide a tool to guide General Practice in patient risk assessment, escalation, safety planning and development of a patient plan to reduce risk of harm, provide patients supports and to structure ongoing follow-up, so that patients can live free from abuse and violence.

Guiding Principles

Providing support to patients affected by Domestic and Family Violence/Abuse can be overwhelming for both patient and practitioner. However, the following guiding principles will assist in establishing best practice throughout the process.

- VALIDATE AND BELIEVE

Believe the patient, validation is an intervention in and of itself. Patients affected by DFV often experience a wide range of negative support responses, such as blame or humiliation and can lead to poor outcomes. It is important to be mindful patients may have received negative responses previously, and when discussing the violence believing, validated, and acknowledging these experiences will lead to positive outcomes.

- PRIORITISE RISK AND SAFETY

The safety of patients and their children is the first priority. When assessing risk of patients, also evaluate the wellbeing and safety of any children or other family members. Screening for risk and safety is an ongoing process. Recognising change to risk over time allows for an appropriate response to changing circumstances, in turn ensuring harm from the abuser is abated.

- WHOLE OF PRACTICE RESPONSE

If safety is not acute, complete the plan over a number of sessions. Practice Nurses are well placed to complete the Action Plan. Other staff will observe behaviours outside of the consultation room that are important to communicate discreetly to the primary clinician. This may include presenting behaviour between the person using DFSV and the victim-survivor.

- CONFIDENTIALITY AND SAFE DISCLOSURE

Ensure the Action Plan with the patient is conducted in a safe space where the person choosing to use abuse is not present or within proximity to overhear. Be mindful of communication with other practice staff in regard to Domestic and Family Abuse/Violence is done covertly. Please see "Covert coding and Patient Discretion" in this guide.

- COORDINATION AND COLLABORATION

Coordination between health care and social care is paramount and plays an important part in determining the health of the patient. As patient circumstances can change over time, ongoing follow-up with either the patient and/or the LCP/Local Link is encouraged so the cross-sector response remains relevant in ensuring the patient and their children's safety are appropriately being addressed.

Domestic and Family Abuse/ Violence Definition

The NSW Government has defined domestic and family abuse/violence as:

Domestic and family violence includes behaviours that control or dominate a person, causing them to fear for their own (or someone else's) safety. It includes behaviour that controls, intimidates, terrifies, or coerces a person. It includes physical, sexual, verbal, psychological, mental, and emotional abuse; stalking; harassment; financial abuse and manipulation; denial of freedom and choice; and control of access to family and friends.

IT STOPS HERE. Standing Together to end domestic and family violence in NSW. The NSW Domestic and Family Violence Framework for Reform (2012-2017) p5

Other Terminology

Descriptors such as 'domestic violence', 'domestic and family violence', 'family violence', violence may be used interchangeably. Domestic Violence is a term used historically and throughout literature. Family Violence is the term preferred by First Nations people and is unambiguous in that there are a broad range of relationship dynamics that can be abusive. This term is further inclusive to the impacts on children. However, to be in line with the term used primarily in legislation and whilst also to encapsulate all dynamics of abuse presented, the term 'domestic & family violence/abuse' (DFSV) is frequently used through the action plan and its relevant resources.

Due to this document and relevant Action Plan being used over various regions, some terms are used interchangeably in this document as relevant to specific regions. Local Coordination Point and DFV Local Link are often used in this document and where one is used over the other can be assumed to be referring to the structure for your specific region.

WHAT IS THE DFSV ACTION PLAN?

The Domestic and Family Violence/Abuse (DFSV) Action Plan should be used following identification or disclosure of DFSV risk in General Practice.

Once DFSV has been identified, the Action Plan will assist in guiding clinicians to:

- assess risk levels
- safety plan with patients
- record for safety
- plan
- link for specialist support

The DFSV Action Plan has three components:

1. Patient details and contact safety

Identifies all parties involved including children and the appropriate safe methods for all services to contact the patient. All details are paramount to providing to referred DFSV services to minimise risk in contact and ensure the safety is considered for all those affected by DFSV. At minimum, when time capacity is limited, this page can also be solely sent as a referral form for sending to your LCP or DFSV Linker. When possible, it is recommended to send all 3 pages of the Action Plan to enhance ongoing safety of patients through a systemic collection of risk between services.

2. Risk Assessment, Safety Planning and Follow-up

Divided into three parts (A, B and C), are conducted alongside the patient in the risk assessment consultation to ensure risk factors of DFSV are identified, responded to through referrals and by safety planning directly with the patient. This also includes through ongoing follow-up appointments to identify changes in risk factors and ensure current safety responses are appropriate.

- Part A) risk assessment is a series of questions to be asked to the patient to ensure DFSV risks are identified, and appropriate escalation is undertaken. These questions are valuable for referred DFSV services to know to ensure appropriate safety measures can be undertaken to protect those at risk of harm.
- Part B) safety planning helps patients make decisions that will keep them safe when dealing with an abusive situation. Patients are more knowledgeable than anyone else on how and what will keep them safe. Safety Planning is essential to ensure patients are prepared for escalating abuse and ensuring their children and themselves are safe.
- Part C) prompts that review and follow up appointments must be made a priority to provide ongoing safety assessment and support. When a follow up appointment is not feasible with a patient, a follow up with the DFV Local Link is recommended.

3. Patient Plan and Referral

Completed with the patient to provide treatment and support through referrals corresponding to any identified patient needs or goals. Additionally, this page includes the recording of patient consent for referrals, as well as patient review for ongoing follow-up.

To Learn more about how to use the DFSV Action Plan, please see the Online Toolkit or watch the video the Action Plan Applied in Practice.

HOW WILL THE DFSV ACTION PLAN HELP MY PATIENTS & PRACTICE?

The Action Plan will help patients experiencing DFSV and your practice by:

- Enhancing the physical and emotional safety of patients in relation to their partners, family members, friendships and other significant relationships.
- Promoting safety for all individuals when family members are in conflict, distressed and experience abuse and violence.
- Providing opportunities for practitioners supporting DFSV victim/survivors to work together in relation to family abuse and violence cases.
- Creating opportunities for practitioners to receive support with their patients.

WHEN SHOULD I COMPLETE THE DFSV ACTION PLAN?

Practitioners should complete the DFSV Action Plan when they first become aware that a victim is experiencing DFSV. It is common with DFSV for risk to fluctuate or escalate rapidly. Practitioners should complete a new Action Plan if they become aware of a change in circumstances that may impact on safety. When completing a new Action Plan, review the existing action plan and make changes where necessary. It is important to not to make the victim-survivor re-tell their story unnecessarily.

Practitioners are encouraged to use their professional judgement when revision of an existing Action Plan should take place. Circumstances where it may be appropriate to review and/or complete a new Action Plan may include:

- Change in living circumstances and/or separation.
- The Patient is in a new relationship.
- The Patient is pregnant or gives birth.
- The Patient has ceased engaging with support services.
- Local and/or Family Court matters have commenced or finalised.
- Local and/or Family Court orders have been made (inclusive of ADVO changes).
- The Person choosing DFSV has been released from Custody and/or ADVO has expired.
- The Person choosing DFSV has returned to the Patients residence.
- The Person choosing DFSV has become aware of the patient has engaged in support services.
- The Person choosing DFSV substance abuse has escalated.
- The Person choosing DFSV has increased mental health symptoms.
- Negative risk factors have been identified as increasing in severity.

HOW DO I COMPLETE THE DFSV ACTION PLAN?

The DFSV Action Plan will assist in spotting the signs, starting the conversation, recording for safety, and link for support.

Watch the following video to see the Action Plan applied in Practice:

https://vimeo.com/722788562

Practitioners should complete the DFSV Action Plan during discussion with the patient, however it is important to ask the risk assessment questions rather than have the patient complete the questions on their own. Answering the questions on the Action Plan may be confronting or upsetting for the patient. It is therefore important to complete the DFSV Action Plan through a narrative and empathetic conversation with the patient.

It is highly encouraged that the patient is informed of confidentiality and its limitations in the context of Domestic & Family Abuse/Violence. The exceptions to confidentiality can be seen further below under the heading "Reporting - Risk of Significant Harm".

When starting the conversation introduce the Action Plan in a way that feels comfortable to you and the patient and obtain the patient details outlined on page 1.

"We have a document that I would like us to go through together that looks at how we can best keep you and your family safe."

When moving on to the DFSV Risk Assessment on page 2, transition the conversation in a empathic and inclusive manner to ensure the patient is involved and not overwhelmed.

"We have a checklist that I would like to go through with you that looks at what sorts of behaviours you have experienced from your partner during your relationship, including your children. Please answer what you are comfortable to answer."

A) DFSV Risk Assessment

Risk screening and assessment aims to ensure that safety risks are identified early. An important reason for screening and risk assessment is to identify serious risk of harm or lethality. Risk assessment focuses on potency of abuse, pattern of abuse, currency of abuse, type of abuse, and the effects on children and other family members.

Risk assessment questions should be gone through with the patient using a narrative approach. Additional information outside of the 13 questions can be entered in additional information at the end of Part A as well as further in the patient plan professional judgement section on page 3. For further information on each Risk Assessment question please see subheading "Risk Assessment Indicators & Significance" further below.

B) Safety Planning

Safety planning is focused on assisting the patient in identifying and planning how they can stay safe, and what actions they can take to maintain their safety. This can be inclusive of being prepared to leave home, safety in their home for themselves and their children, safety at work, using technology safely and safety when separated for themselves and children.

A Safety Plan will support patients to protect themselves when under threat of violence or abuse. A safety plan helps patients make decisions that will keep them safe when dealing with an abusive situation. It may be a plan to escape or leave a violent situation, or a plan for what to do during a violent incident. It is important to remember each individual situation is unique, so when discussing their safety plan, use the patient's best judgement to determine what is safest, what is realistic and what is feasible for them.

C) Review & Follow-up

Review is important as risk indicators are likely to change over time. Increasing risk indicators are an important indicator that client safety is in decline and escalation to ensure safety is needed. Clients' answers to the risk assessment may differ over time depending on several factors. Different responses do not necessarily indicate decreased risk or unreliable reporting by clients, however increased threat indicates a need for action. Consult with your LCP or DFSV Linker for notification of changes to risk and for further advice.

Follow-up is essential to identify changes in circumstances for patients as risks may be increasing and only identified on a follow-up appointment. If a follow-up appointment is not feasible with the patient, please consider organising an appointment with the practice nurse. Alternatively, follow up can be conducted with the DFSV services referred to on first appointment that has maintained contact with the patient.

The Patient Plan on page 3 provides guidance to practitioners as they support the patient on an ongoing basis towards safety and freedom from abuse. It is encouraged to complete this alongside the patient as the patient will be the expert of their own experiences and is a first step to regaining freedom and empowerment over their own life.

RECORDING IN CLINICAL SYSTEM & PATIENT DISCRETION (DSWB)

The code DSWB (Domestic Safety & Wellbeing) is a covert code for clinical software, appointments, notes, and future relevant bookings when patients present with DFSV. This is in place to protect the patient's confidentiality and safety, as an unrecognisable indicator to external parties, inclusive of the person choosing to use DFSV. DSWB should be used at every presentation related to DFV.

Benefits to using DSWB include:

- Ensures other parties inclusive of person choosing to use DFSV will remain unaware that DFSV has been disclosed or identified to the practice.
- Allowing to track the number of presentations of DFSV in your practice discretely.
- Advises colleagues about the presence of DFSV when seeing an unfamiliar patient.
- Ensures non-clinical staff are aware of additional safety and privacy needs of patients.
- Easily locate DFSV related information if needed for legal purposes.

WHAT TO DO ONCE THE DFSV ACTION PLAN IS COMPLETED?

If a patient is identified as at risk, practitioners should provide appropriate support to the patient either directly and/or through referrals. Where available, practitioners should consider referring the patient to their Local Coordination Point or DFSV Linker for support. This is especially important for patients who identify as to risk indicators on the DFSV Risk Assessment.

The DFSV Risk Assessment on page 2 outlines the most appropriate action to take based on answers provided by the patient. However, please consider your own professional judgement and escalate to further supports if you disagree with the recommended outcome response.

Patient who are referred to a Local Coordination Point and are assessed as being at medium to high risk may have their safety considered at a Safety Action Meeting where further risk reduction and service collaboration can support the patient and their family towards freedom from abuse and violence. For more information about Safety Action Meetings, refer to the Safety Action Meeting manual.

Referrals to supports are essential in building a safety framework around the patient and their family. It is best practice to seek consent before sharing a patient's information with other service providers. When seeking consent, service providers should advise their patient of why and with whom their information will be shared.

Referral Accepted by Patient

If a referral is accepted by the patient, practitioners can then phone, email or refer with MO to the Local Coordination Point or DFSV Linker for further service delivery. Assure the patient that this information is confidential and centered around their needs, wishes, and informed consent, and a referral is completed.

Referral not accepted by patient

In limited circumstances information may be shared about a patient without their consent when themselves, others or their children are at significant risk of harm if it is necessary to prevent or lessen this significant risk of harm.

It is highly encouraged to explain to the patient why and to whom you will be referring to ensure risk to damaging trust and rapport with the patient is at a minimum.

"I'm so glad you told me, if you don't want me to do anything I understand. But I would still like to see you again in a few days/weeks to check in.""I understand that you don't want me to share this information, but I am very concerned for your safety because of (a, b, and c) and I have a duty of care. "

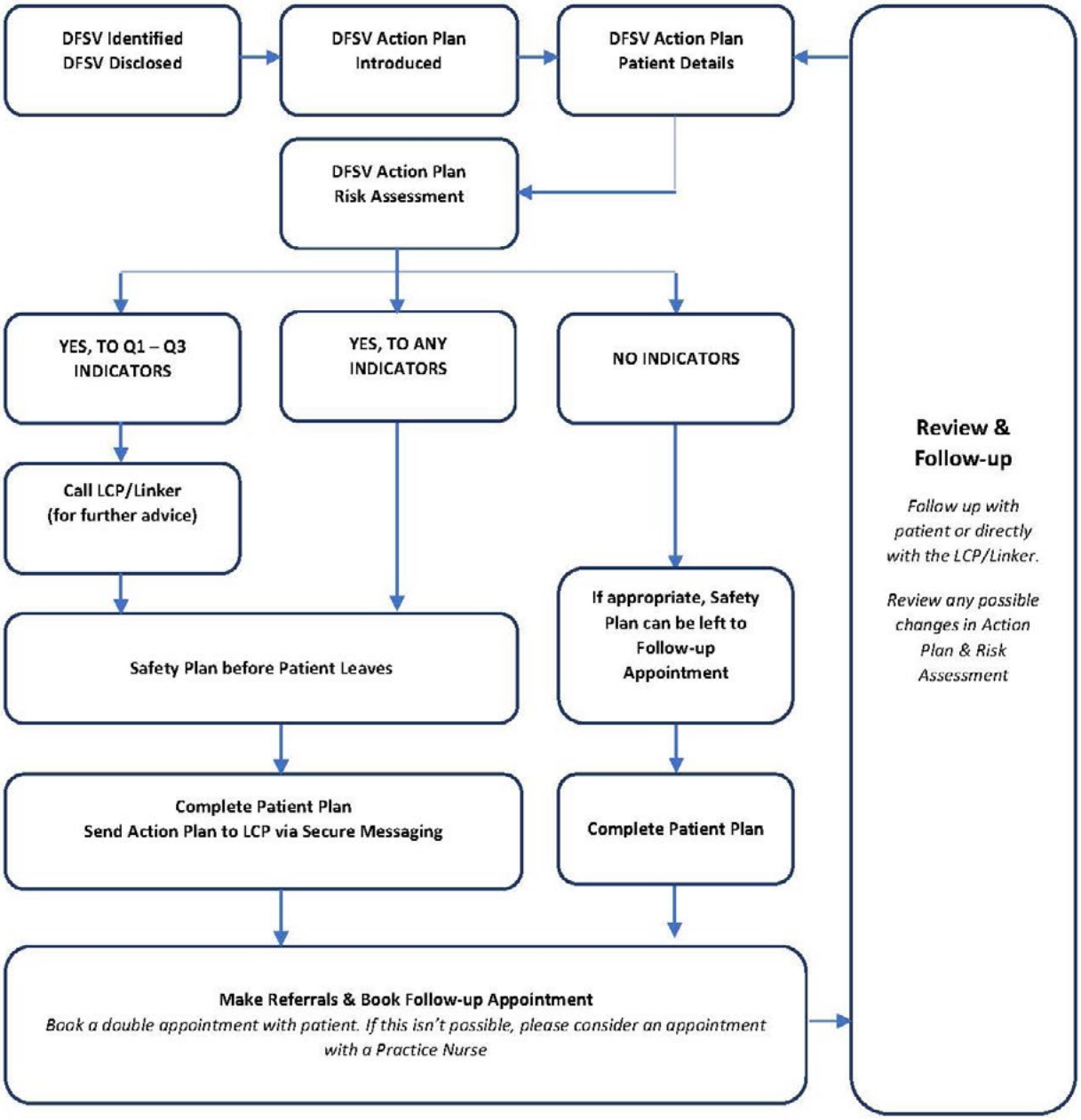
Please see "Reporting – Risk of Significant Harm heading and content further below.

DFSV Action Plan Process Flowchart

The below flowchart demonstrates how to use the Action Plan once a patient has disclosed DFSV ensuring a continuous re-evaluation and appropriate response to risk through regular follow-up with either the patient, the Local Coordination Point or DFV Local Link.

DFSV ONLINE TOOLKIT

For further information on how to Spot the Signs, Start the Conversation, Record for Safety and Link for Support, as well as additional resources and service listings, including the Local Coordination Point contact details, please view the DFSV Online Toolkit.



REPORTING - RISK OF SIGNIFICANT HARM?

If there are reasonable grounds to suspect a child or young person is at risk of significant harm and there are current concerns about the safety, welfare or wellbeing of the child or young person mandatory reporters must, and any person may, make a report to the Child Protection Helpline.

The threshold for reporting was changed from 'risk of harm' to 'risk of significant harm'. This is so that only those children and young people who are likely to need the protection powers of the State under the *Children and Young Persons (Care and Protection) Act 1998* are subject to it being exercised. This means that the needs of children and young people are more likely to be addressed by the services that are most appropriate for them.

Mandatory reporters

Mandatory reporters are defined under section 27 of the Act. All mandatory reporters are encouraged to use the Mandatory Reporter Guide to assist them in their decision making. See the Department of Family and Community Services website for more information.

Domestic and Family Abuse/Violence Information Sharing Protocol

The Domestic Violence Information Sharing Protocol explains information sharing allowed under Part 13A of the Crimes (Domestic and Personal Violence) Act 2007. It sets out the procedures for service providers to share information, including consent and referral practices, and outlines their information management obligations. It also outlines procedures for access and amendment, the management of complaints, and a compliance framework.

Information exchange

Chapter 16A of the Act gives legal authority for better interagency information exchange in the interests of children and young people.

These government and non-government agencies (known as "prescribed bodies") may volunteer information, but if requested must supply information (subject to some specified exceptions set out in section 245D(4)) to other prescribed bodies where the information relates to a child or young person's safety, welfare or wellbeing, whether or not the child or young person is known to Community Services.

As per section 245G, a person who provides information in good faith in accordance with Chapter 16A, will not be liable for providing this information.

Chapter 16A applies to information being supplied between prescribed bodies. It does not limit the pre-existing powers to request information from or to respond to a direction to supply information to Community Services, as set out in section 24.

RISK ASSESSMENT EVIDENCE-BASED INDICATORS

The following are a list of the risk indicators outlined in the Action Plan, inclusive of the reasoning behind asking the question to patients affected by DFV, as well as the evidence behind it for further understanding of what each indicator means.

Evidence-based risk factors and the below descriptors were adapted from various sources (See in table references) including the Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework, accessible here and the National Risk Assessment Principles for Domestic and Family violence NRAP, found here.

1. Do you feel unsafe to go home after this visit?

Patients are often good predictors of their own safety and risk factors, including potential risk to further abuse. However, the person choosing to use abuse may impact on the victim-survivors self-evaluation through creating fear, uncertainty, and denial, that may lead to a victim-survivor minimising their level of risk and safety. Clinicians are encouraged to consider their patient's self-assessment, whilst applying their own professional judgement when supporting patients through barriers to taking steps to be free from violence and abuse.

State of Victoria, Australia. Family Safety Victoria. (2021) MARAM practice guides: Foundation knowledge guide. https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide.

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners (ANROWS Insights 10/2018). Sydney, NSW: ANROWS.

2. Are the abusive behaviour/s getting worse or happening more often?

When abusive behaviours are increasing in severity and frequency, the likelihood of lethal outcomes increases significantly. Clinicians are encouraged to be mindful risk may increase significantly in a short period of time. Separation,

changes in ADVO's and Family Court matters outside of the patient's control may greatly influence the current level of risk.

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners (ANROWS Insights 10/2018). Sydney, NSW: ANROWS.

3. Has anyone ever put any pressure on your neck and tried to stop you breathing? Have you been put in a chock hold or a head lock? If so, did you lose consciousness or have altered consciousness. Did you lose bladder or bowel control where you needed to get changed?

Linked to an increased risk of lethality, strangulation is one of the most lethal forms of abuse used by perpetrators to kill victims-survivors. When a victim is strangled, they may lose consciousness within seconds and die within minutes. Loss of consciousness is linked to increased risk of lethality at the time of assault as well as the following time thereafter. Strangulation may also lead to hospitalisations and acquired brain injury. Those who survive a strangulation are up to seven times more likely to go on to die at the hands of the abuser. Clinicians should be mindful that the evidence of strangulation is not always apparent with many with very minor marks, and few having observable marks to be photographed.

Strack, G, B., McClane, G. E, Hawley, D. The Journal of Emergency Medicine, Vol. 21, No. 3, pp. 303–309, 2001

Stapczynski, strangulation injuries, emergency medicine reports, 2010

4. Are they jealous or controlling of you, including following/tracking where you are going or isolating you from others?

Coercive control includes repeated acts of violence, abuse, and control to gain compliance and dependence from victim-survivors. Coercive and controlling behaviours are a highlighted pattern and precursor to intimate partner homicide and include a variety of behaviours, such as:

- verbal and financial abuse
- psychologically controlling acts, including telling them how to dress, and
- social isolation through who they can and cannot socialise with, such as cultural and community connections as well as family and friends.

Stalking behaviours (repeated, persistent, and unwanted) including technology-facilitated surveillance, GPS tracking, interferences with property, persistent phoning/texting and contact against court order conditions, increases risk of homicide.

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners (ANROWS Insights 10/2018). Sydney, NSW: ANROWS.

5. Do you rely on them to care for you, and do they use this position to control or hurt you?

For some with disabilities a reliance on or fear of losing a family member from whom they receive disability support may be a factor. People of all genders with disabilities are also at higher risk of experiencing family violence. The intersection of gender and disability increases the risk of violence against women and girls with disabilities. International and Australian evidence shows that women with a disability experience violence more intensely and frequently than other women.

Women with disabilities Victoria, 2014, Position Statement: Violence Against women with disabilities.

6. Have they ever threatened to kill you, pets, or your children?

Abusers who threaten to kill their partner or former partner, themselves or others including their children, are particularly dangerous. Threats of this nature are psychologically abusive.

Cruelty and harm directed to pets and other animals can indicate risk of future or more severe violence and are often used as a control tactic by perpetrators. Additionally, having to leave pets behind is a barrier to victim-survivors leaving the abusive relationship.

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners (ANROWS Insights 10/2018). Sydney, NSW: ANROWS.

7. Have they ever threatened or hurt you or your children inclusive of weapons or other objects?

Use of a weapon (any tool used by the abuser that could injure, kill or destroy property) indicates high risk, particularly if used in the most recent violent incident, as past behaviour strongly predicts future behaviour. It was found by Campbell et al. (2003) that women are 20 times more likely than others to be killed when weapons and other objects are involved, as the severity of fatal harm is significantly heightened.

Campbell et al (n 3), cited in Backhouse and Toivonen (n 1) 43

8. Have they ever pressured you to do anything sexually that you did not want to do?

Often underreported and not disclosed, victim-survivors who are sexually abused are at greatly higher risk of being killed, particularly if they are also being physically assaulted. Furthermore, it is further harmful due to the invasive assault on victim-survivors' bodies, as well as the severity of mental and physical harm it can cause. Perpetrators who sexually assault victim-survivors are more likely to use other forms of violence against them.

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners (ANROWS Insights 10/2018). Sydney, NSW: ANROWS.

State of Victoria, Australia. Family Safety Victoria. (2021) MARAM practice guides: Foundation knowledge guide. https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide

9. Have they ever threatened or physically hurt you while you were pregnant or made you do something that you didn't want to do while you were pregnant to hurt the baby?

Abuse often intensifies during pregnancy, leading to an increased risk of miscarriage, low birth weight, premature birth, foetal injury and foetal death. Violence perpetrated against pregnant women is also a significant indicator of future harm to the woman and child. Women with a disability, women aged 18-24 years and Indigenous women are at particularly significant risk of experiencing severe violence from their partner during pregnancy.

Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners (ANROWS Insights 10/2018). Sydney, NSW: ANROWS.

State of Victoria, Australia. Family Safety Victoria. (2021) MARAM practice guides: Foundation knowledge guide. https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide

10. Does the person using abuse have access to guns?

There is a significant relationship between abuser possession of a gun or firearm licence and risk of future assault/s, as found by Millsteed and Coghlan's study of the predictive validity of Victoria Police's risk assessment form. Access to firearms and knives in particular presents a much more likely chance to seriously injure or kill a victim or victims than perpetrators without access to weapons.

Melanie Millsteed and Sarah Coghlan, Predictors of recidivism amongst police recorded family violence perpetrators (Report No 4, May 2016) cited in Backhouse and Toivonen (n 1) 25.

State of Victoria, Australia. Family Safety Victoria. (2021) MARAM practice guides: Foundation knowledge guide. https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide

11. Has the person using abuse ever breached an AVO, even if this was not reported to police?

Breaching an intervention order, or any other order with family violence protection conditions, indicates the accused is not willing to abide by the orders of a court. It also indicates a disregard for the law and authority. Such behaviour is a serious indicator of increased risk of future violence.

Offenders with a history of domestic violence—particularly more frequent offending—and of breaching violence orders were more likely to reoffend. The risk of reoffending was cumulative, increasing with each subsequent incident.

Anthony Morgan, Hayley Boxall and Rick Brown, 'Targeting repeat domestic violence: Assessing short term risk of reoffending. Trends & issues in crime and criminal justice' (Research Paper No 552, Australian Institute of Criminology, June 2018) 1.

12. Does the person using abuse have any known mental illness or a history of drug or alcohol misuse?

Although Alcohol or other drug (AOD) abuse are not a direct cause of DFSV, they can be a significant contributing factor. AOD and abuse can exacerbate the severity of abuser negative risk behaviours and future abusive behaviours.

Although, mental health is not a direct cause of DFSV, it can be a contributing factor to negative risk behaviours due to fluxes in their mental state potentially increasing likelihood of abuse frequency, escalation, and severity. Behaviours can also be further exacerbated when the abuser is not actively engaging in AOD treatment, recovery, or rehabilitation.

AOD alongside mental illness can further exacerbate negative risk behaviours and should be considered together and separately when assessing risk. Furthermore, AOD and mental illness can both be a significant barrier towards a person choosing to use violence engaging in interventions such as behaviour change.

State of Victoria, Australia. Family Safety Victoria. (2021) MARAM practice guides: Foundation knowledge guide. https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide

13. In the last 12 months, have you separated, changed your living arrangement, or are you thinking about doing this?

Victims of DFSV are most at risk of being killed or seriously harmed when planning to leave as well as during and/or immediately after separation. Patients being most aware of their circumstances, may choose to stay with the abuser because they are accurately anticipating the risks associated with them leaving. Safety planning is essential in mitigating these risks, as well as a systemic cross-sector response from DFSV services.

State of Victoria, Australia. Family Safety Victoria. (2021) MARAM practice guides: Foundation knowledge guide. https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide.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