Policy Document

Intimate Partner Violence and Abuse (2018)

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's medical students. AMSA believes that all communities have the right to the best attainable health. Accordingly, AMSA advocates on issues that may impact health outcomes.

Intimate partner violence and abuse (IPVA) refers to abusive and violent behaviours enacted against an individual with whom the perpetrator has been, or is currently, in an intimate relationship. These behaviours can be physical, sexual, or psychological nature, and the word abuse is included to highlight a spectrum of controlling behaviours that exert harm towards a woman without being explicitly violent (Figure 1) (7). Whilst the full impact of IPVA is unknown given high rates of under-reporting, IPVA is an issue that transcends demographics (1). One in six women have experienced sexual and/or emotional abuse from a current or existing partner, compared to 1 in 16 men, with IPVA being the greatest health risk in women aged 25-44 (1). The effects of IPVA on those in same-sex relationships, ethnic and cultural minorities, men, children and elder abuse are important areas of consideration but beyond the scope of this policy. Impacts of IPVA vary enormously and survivors may require years of mental and physical support (2).

Figure 1: Forms of intimate partner violence and overlaps with sexual violence

The most profound outcome of IPVA is death. One woman is killed in Australia each week by a current or former partner. IPVA is the leading contributor to death, disability and illness for Victorian women aged 15-44 years (5). 80% of victims of intimate partner homicide are female and 42% of national murders were related to IPVA (3). In addition to mortality, there is significant morbidity associated with IVPA. Women exposed to violence have poorer physical health and higher rates of stress, anxiety, depression, post-traumatic stress disorder, suicidal ideation, syndromes related to pain, phobias, and somatic and medical symptoms (4). Women subject to IPVA are more likely to engage in risk taking behaviours such as substance abuse and report difficulties accessing health services (4). The significant effects of violence on women's health and wellbeing can affect their ability to work; for example, women fleeing IPVA are more likely
to become homeless (6). As such, Australia’s economic burden of IPVA is comprised of both the burden of disease on the medical system and the loss of working capacity, and has been projected to cost $9.9 billion in 2021-22 (5).

ROLE OF HEALTHCARE PROFESSIONALS

Doctors and other healthcare professionals have unique opportunities to identify and support people experiencing IPVA (7), particularly in general practice, sexual and reproductive health clinics, obstetric and gynaecological care, emergency departments, addiction services, paediatric medicine and mental health services (8, 9). Women experiencing IPVA seek medical care more often than other women and trust healthcare staff to receive disclosures about IPVA (7, 8). Healthcare staff can provide confidential assistance, follow up, and access to other support services (7, 8). As will be discussed, well-trained doctors with institutional support will be best positioned to use these opportunities to intervene (8, 9). Given that women working in the healthcare setting are equally as or more likely to experience IPVA than the general population, female healthcare staff risk re-traumatisation when caring for patients subject to IPVA (10). This underscores the importance of institutional support, including paid IPVA leave, for healthcare staff in policies and protocols (8, 10).

BARRIERS TO REPORTING

Fear of reprisal, not being believed, and an internalised belief that violence within a relationship is acceptable prevent women from disclosing IPVA, in particular those at acute risk of harm (11). Whilst fear is a significant barrier to reporting, studies have shown that a practitioner’s communication skills are critical in creating a comfortable environment to engender safety and trust for women to disclose IPVA (12, 2). These skills include making the patient feel at ease, devoting appropriate time, respect for patient autonomy, and a non-judgemental and supportive manner (12). Confirmation that violence is unacceptable, challenging false assumptions about violence, respectful and shared decision-making, and allowing women to progress at their own pace without pressure to disclose, leave their relationship or press charges, are also important (12). Disclosures are more likely if the health professional raises the topic rather than the patient (4, 12). Several studies have indicated that healthcare providers feel inadequately prepared by their training to ask about and respond to disclosures of IPVA (35, 36). Healthcare providers who are under-prepared to respond appropriately risk reinforcing women’s feelings of powerlessness and violation. In rural communities, fear of community response and lack of confidentiality, coupled with a lack of specialist support services available to victims, also drives a lack of reporting (13). This effect may be compounded by social isolation, lack of culturally diverse safe support services and financial concerns (13).

CURRENT POLICIES, STRATEGIES AND GUIDELINES

Commonwealth, State and Territory Governments have worked collaboratively to create a 12-year National Plan to Reduce Violence against Women and their Children (14). As of 2018, this features 36 practical actions that span six National Priority Areas, including Aboriginal and Torres Strait Islander women and their children, sexual violence, and prevention and early intervention (14). Progress reviews highlight the importance of monitoring and evaluation to ensure outcomes are aligned to goals for change (14).

The Australian Medical Association (AMA) has released a position statement that addresses the magnitude and sociocultural context of IPVA (37). This statement acknowledges the unique role doctors can play in identifying those at risk, reducing morbidity and mortality, and advocating for societal change. It notes the need for further IPVA education, multidisciplinary approaches, and ongoing research for prevention and intervention programs. The AMA has also endorsed a resource outlining how to sensitively ask patients about IPVA, respond to disclosures, and medicolegal rights and responsibilities. Only three out of sixteen Australian Specialist Medical Colleges have publicly accessible statements or guidelines on IPVA. With the exception of the ACT, Northern Territory and Tasmania, every state/territory in Australia has policy guidelines about responding to IPVA in a healthcare setting. Some health departments also have guidelines relating to sexual assault, but not in the specific context of IPVA.

IMPROVING RESPONSES IN THE HEALTHCARE SECTOR

Healthcare professionals are the second most commonly sought source of support for women experiencing IPVA after friends and family (1, 15). The Victorian Royal Commission into Family Violence noted women experiencing violence are commonly unwilling to engage specialist family violence services, but will engage with health professionals, particularly during times of
heightened risk such as pregnancy (16). On average, eight women are hospitalised each day due to IPVA, and between 2002–03 and 2014–15 rates of hospitalisation rose at a rate of 1.7% per year (1). 30% of women experiencing IPVA seek advice from their general practitioner and 20% from other healthcare professionals (17). Yet, IPVA has historically been absent from medical curricula. A study of Australian medical schools conducted in 2015 found that the median time spent on IPVA across all years of the curriculum was only 2 hours (18). There is an urgent need for comprehensive curricula that addresses IPVA in an integrated and advocacy-based manner.

In order to improve the care of women experiencing IPVA, healthcare responses need to be standardised across hospitals and institutions. These responses must be sensitive to the complexities of IPVA and address women's priorities. Inclusion of non-health bodies such as police, sociologists, and criminologists helps create an informed and highly nuanced approach. To establish efficacy, a standardised, universal approach is required through nationwide inclusion of appropriately tailored IPVA education in university courses, and ongoing training of healthcare staff, though quality of interventions may vary across geographic or socioeconomic regions.

The World Health Organisation (WHO) recommends a non-judgemental response, safety assessment, and pathways to safety including referrals (7). Effective implementation of this approach in Australia requires education at all levels of the healthcare system. Education must include recognising IPVA, assessing risk, taking disclosures, documentation of evidence, referral services, when and how to involve police, guidelines to mandatory reporting, and cultural diversity provisions (19). Except in instances of acute risk, mandatory reporting of disclosures is not recommended, as this undermines patient autonomy and deters reporting (20). Sexual health checks, acute care of injuries, and contraception are also critical (7, 5). Acute assessment of patient risk should inform the immediate plan of action (21, 22).

The Royal Women’s Hospital in Melbourne advocates a system-wide approach to improving hospital responses to IPVA that provides facilitator training and modules that can be delivered remotely and completed within a short timeframe (9). This programme aligns with WHO recommendations for management of victims of IPVA in healthcare settings (7), and forms a reliable, evidence-based model for future education programs. Follow-up protocols can improve the long-term efficacy of interventions; for example, the Support Help Empowerment organisation in Tasmania developed a similar toolkit encompassing legal advice and documentation (23).

Women are most likely to engage with health professionals during pregnancy, and as such pregnancy provides an opportunity to address the significant risks posed by IPVA to mother and child (24). Miscarriages, low birth weights and post-natal depression are more prevalent in those experiencing abuse during pregnancy (24, 25). The Australian Department of Health recommends universal screening of women for IPVA during pregnancy, however research suggests this increases disclosures but not referrals and does not affect incidence or outcomes (26, 27). This highlights the need for a long-term, nuanced approach to IPVA in healthcare settings, with health practitioners not merely ticking a box but also having the tools, insight, and knowledge to respond effectively and assist the patient. Supportive information and referrals at the time of disclosure, follow-up health checks and ongoing counselling improve outcomes (28, 29).

Another opportunity for direct healthcare provider intervention is in the case of reproductive coercion. Reproductive coercion refers to behaviours by an intimate partner that interfere with a woman's reproductive choices; including contraceptive sabotage, pregnancy coercion, and controlling the outcome of a pregnancy (30, 31). Reproductive coercion is common; one study in Australian general practices found 10% of women had experienced reproductive coercion, despite the likelihood of widespread under-reporting (32). Effective care requires healthcare providers be aware of reproductive coercion and its effects on women. The American College of Obstetrics and Gynaecology released a Committee opinion on Reproductive and Sexual Coercion in 2013 (33), but this is absent from Australian guidelines. Including education on reproductive coercion in medical school curricula and in RACGP and RANZCOG training programs could improve understanding (30). Advising women on contraception that can be concealed from a partner and supporting women’s control and autonomy within their sexual relationships may both be useful approaches (30).

Although there are many key areas in which healthcare providers can support people experiencing IPVA, practitioner-led interventions represent only one link in the chain of a comprehensive, community-based approach to the complex and multi-modal societal problem
of ongoing violence and abuse (26, 34). Accordingly, it may be useful to view the health practitioner as an essential point of recognition and referral to community services, rather than the solution to a woman’s exposure to violence.

**Position Statement**

AMSA believes:

1. IPVA is a serious and pervasive health issue in the Australian community;
2. Healthcare professionals, including doctors and medical students, by virtue of their position have a unique opportunity to intervene and support patients experiencing IPVA;
3. IPVA is a complex issue and doctors and medical students require ongoing training and education about IPVA to effectively intervene and support patients experiencing IPVA, particularly as it fits within the scope of ethical medical practice;
4. Doctors, medical students and healthcare workers need institutional support from government, hospitals, other healthcare providers and professional bodies to prioritise the identification and support of patients experiencing IPVA;
5. IPVA is a nuanced issue that affects a variety of communities requiring further research that prioritises women’s voices and experiences;
6. IPVA is a whole society issue and while practitioners have a role to play, they only form part of what needs to be a whole society response;
7. IPVA may also affect healthcare professionals and there should be institutional support from healthcare employers;
8. Any strategy to reduce incidence of IPVA must address barriers to reporting.

**Policy**

AMSA calls upon the Federal, State, and Territory Governments to:

1. Review the efficacy of IPVA interventions in healthcare settings.
2. Fund research into IPVA committed against all groups in society, including Aboriginal and Torres Strait Islander individuals, individuals of culturally and linguistically diverse communities, LGBTIQI+ individuals, men, individuals with a disability, children, and the elderly.
3. Increase funding for critical services accessed by victims of IPVA including refuge and housing services, counselling, sexual and reproductive health clinics, and public legal services.
4. Fund paid IPVA leave.

AMSA calls upon the Australian Medical Council to:

1. Mandate inclusion of comprehensive and standardised IPVA education within medical school curricula.

AMSA calls upon medical schools to:

1. Educate students on the socio-cultural bases of IPVA, how to recognise IPVA, and appropriate ways to respond, including mandatory reporting guidelines.
2. Liaise with clinical schools to ensure students have adequate support in dealing with IPVA amongst patients or in their own personal lives.
3. Support students who require leave from studies due to IPVA and liaise with the student to facilitate their return to study.
4. Include specific education about reproductive coercion in relevant pre-existing teaching around contraception and reproductive health.

AMSA calls upon medical training colleges to:
1. Liaise with expert bodies and organisations to develop specialised guidelines and toolkits to inform practitioners on IPVA including reproductive coercion and how to recognise and respond to it.
2. Provide training in assisting those experiencing or exposed to IPVA from all groups in society, including but not limited to Aboriginal and Torres Strait Islander individuals, individuals from culturally and linguistically diverse backgrounds, LGBTIQ, individuals with disabilities, men, children and elderly individuals.
3. Include mandatory training in IPVA within all specialty training programs and IPVA educational modules in ongoing professional development requirements.
4. Stay informed regarding research into the assessment and management of IPVA in healthcare settings and remain committed to ongoing implementation of evidence-based guidelines.

AMSA calls upon health services to:
1. Provide staff with ongoing, mandatory, evidence-based training and education in IPVA.
2. Liaise with police and legal services to develop protocols and procedures relating to assessing victims of IPVA, such as the collection of forensic evidence, documentation of injuries, and collection of DNA samples.
3. Implement proper documentation guidelines for taking IPVA disclosures.
4. Proactively offer support to victims of IPVA, including referrals to appropriate services.
5. Provide translation services for individuals from linguistically diverse backgrounds.
6. Provide support to staff members experiencing IPVA, including provision of paid leave, support to return to work and provision of counselling services.

AMSA calls upon medical students and/or practitioners to:
1. Commit to ongoing personal development, training, and education in IPVA.
2. Familiarise themselves with available avenues of support for both patients and themselves, including women's refuges, and financial, counselling and legal advice services.
3. Engage with victims of IPVA and offer acute and ongoing support, where appropriate, and within their clinical training and expertise.
4. Medical professionals to assess the acute risk to a patient and help to formulate an acute and ongoing plan of action that prioritises patient autonomy and wellbeing.

References


Policy Details

Name: Intimate Partner Violence and Abuse Policy (2018)

Category: F – Public Health in Australia

History: