

# COVID-19: Domestic and Family Violence

## FACTSHEET

### How does COVID-19 affect the occurrence of domestic and family violence?

For many people, including victims/survivors of domestic and family violence (DFV), being at home is not always a safe place. We know that the incidence of DFV has increased during the COVID-19 pandemic period. Measures introduced to reduce the spread of COVID-19 such as social restrictions, home schooling, self-isolation and quarantine requirements, as well as the stress caused by the economic impacts such as unemployment, have increased the risk of DFV.

As many support services change their model of care, health services may become the most accessible service during the COVID-19 pandemic. When treating and/or discharging patients, it is imperative that health professionals assess patient's safety at home and provide safe, appropriate and timely responses to presentations of DFV.

### How can COVID-19 be used to perpetrate violence?

A person may use COVID-19 measures to perpetrate DFV. Tactics may include:

- Withholding necessary items such as food, medicine, hand sanitizer or disinfectants
- Misinforming victims/survivors about the pandemic to control or frighten
- Using the pandemic as an excuse to gain total or increased control of the family's finances
- Threatening or preventing the victim/survivor and children from seeking appropriate medical attention if they have symptoms and/or hiding their Medicare card
- Increasing their monitoring and criticism of parenting such as blaming the victim/survivor if children 'misbehave' or are upset
- Further isolating the victim/survivor (and children) in the home by restricting movements in the house, forcing the victim/survivor (and children) into specific spaces in the house
- Increased monitoring of personal communication devices, such as mobile phones, house phones, emails and online messaging and/or preventing communication methods to those outside the home
- An ex-partner may use COVID-19 in their attempt to reconcile or enter/live in the victim/survivor's home. One way is to emotionally manipulate the victim/survivor to allow them to stay so they can 'help' care for the children.

All health service employees are responsible for working within their scope of practice. If you are not confident in responding to DFV, please consult with a DFV expert in your clinical area, such as a social worker, or call DV Connect or a specialist DFV service for advice.

## How can you ensure the safety of vulnerable women and children?

**RECOGNISE** - If you have any concerns that a patient may be experiencing DFV, ensure that conversations are conducted alone and in private, away from the perpetrator. You may ask questions such as:

- Are you okay?
- How are you all coping at home together?
- If the patient is a parent or carer - How are the kids? (even if the children are not present)
- Do you have any worries about your safety or someone else's at home?
- Do you have any contact with people outside your home?

### **RESPOND sensitively**

It takes a lot of courage to disclose an experience of DFV. It is important to respond sensitively and in ways that support the needs of the person impacted, including:

- Cultural considerations – is a language or disability interpreter service required? Would the patient like to speak to an Aboriginal and Torres Strait Islander Health Liaison Officer?
- Non-judgemental and careful listening – this can be empowering for a person experiencing DFV
- Communicate belief – *'that must have been frightening for you'*
- Validate the experience of abuse – *'it must have been difficult for you to talk about this'*
- Affirm that violence is unacceptable behaviour – *'violence is unacceptable; you don't deserve to be treated this way'*

### **REFER for risk assessment and safety planning/management**

When discussing referral options, you should:

- Ensure immediate safety
- Listen carefully to determine the patient's needs
- Use language that is easily understood – arrange qualified interpreters if necessary
- Present the patient with a range of options and services available, including the referral process and any known changes to service delivery.

### **CONSULT** - You may consult with:

- A DFV expert in your clinical area, such as a social worker
- DV Connect or a specialist DFV service for advice
- An Aboriginal and Torres Strait Islander clinician or Health Liaison Officer

If you have concerns for the safety of a child, consult with a Child Protection Liaison Office or Child Protection Advisor. If after hours, consult with the After-Hours Child Safety Service Centre.

### **REFER**- Where a patient consents to a referral to a specialist service:

- Patients may be referred to a DFV expert within your clinical area, such as a social worker, a specialist DFV service or helpline such as DVConnect (1800 811 811) or Mensline (1800 600 638).
- If a patient declines a referral it is important to provide them with ongoing support and appropriate information and undertake safety planning to increase their safety on discharge. Please see the **Safety Planning Checklist** below for further information.

For more information about the referral process, please see the quick reference [DFV Referral Flowchart](#).

### **DOCUMENT**

Document your concerns, referral details and details of any information shared with other agencies in the clinical record.

## How is safety planning different in the context of COVID-19?

COVID-19 containment measures may require victims/survivors to stay home where possible and have limited social contact. Safety planning should be a personalised practical plan that includes ways to remain safe while in the relationship, planning to leave, or after the victim/survivor leaves the relationship. Safety planning should be conducted prior to discharge.

If a patient has an existing safety plan, the plan should be reviewed to ensure that it is practical within the context of self-isolation or quarantine requirements. Please see the **Safety Planning checklist** for further information.

## Can I share information?

Obtaining client consent to release information is preferable where safe, possible and practical.

Health professionals may share information without consent:

- to support an assessment of DFV risk, or to lessen or prevent a serious DFV threat.
- to avert a serious risk to the life, health or safety of the client or another person or to public safety.

Disclosure in these situations can be made by a designated person with the written authority of the Hospital and Health Service Chief Executive or delegate. Staff should be aware of which positions have this delegation within their local service.

For more information refer to the Queensland Health quick reference [DFV Information Sharing Flowchart](#).

## What if there are concerns for the safety of a child/children?

- All health employees are able to report a reasonable suspicion of child abuse and neglect under Section 13A of the *Child Protection Act 1999*. This includes an unborn child.
- Doctors and registered nurses are mandatory reporters of physical and sexual abuse under Section 13E (1) of the *Child Protection Act 1999*.
- All reports of suspected child harm should be made in writing to the Department Child Safety, Youth Justice and Multicultural Affairs (Child Safety) using their online report form available at: <https://gheps.health.qld.gov.au/csu/reportingforms>

If concerns do not reach the threshold for a report to Child Safety, seek consent from the family to be referred to a support service, including Family and Child Connect, Intensive Family Support or a DFV specialist service. Further information is available at: <https://gheps.health.qld.gov.au/csu/referralfoms>

## Domestic and Family Violence resources for health professionals

The revised DFV Toolkit of Resources is now available to all Queensland health professionals at: <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence/healthcare-workers>

## Safety Planning Checklist

Safety planning should be flexible enough to enable victims/survivors to implement contingency plans if the original plan becomes unfeasible. When engaging a victim/survivor in safety planning, consider the following:

- In an emergency, call the police on triple zero (000).
- Remind the victim/survivor that hospitals are open 24 hours, 7 days a week and that they can present to any hospital to seek support and safety.
- Is there a 'lower risk space' in the house they can move to if they sense increased risk of violence, such as a room with two exits, or with fewer items that could be used as weapons or a room where they may be seen or heard from the outside.
- Kitchens, bathrooms and garages are often more dangerous than living rooms, dining rooms or bedrooms. Explore how victims/survivors (and their children) can position themselves between 'trouble and the door'. Victims/survivors may talk to their children about how they may do this when 'trouble' arises.
- Where possible have a charged phone and a back-up plan in case the victim/survivor is separated from their phone, for example have a hidden second phone.
- Create signals that will let neighbours/family members know they need to create a supportive or defusing presence, or call 000. For example, a turned-on porch light, drawn shade, or an "I wish I could go out today" phone call.
- Develop an escape plan and back-up. Rehearse getting out in the dark and with the children. Keep spare keys and important documents where they are easily accessible. Where possible, have some money stashed away for emergencies.
- Discuss useful items that should be included in an 'escape bag' such as clothes, money, keys, important documents, a phone and charger, ID, Medicare and concession cards, prescriptions and medications.
- Where possible prepare the car to leave – such as making a habit of backing the car into the driveway and keeping it fuelled and any car seats installed so that if the victim/survivor needs to flee they can do so easily.
- Consider how travel restrictions may impact on a victim/survivor escape or safety plan – it may not be safe to use public transportation, or interstate flights may be cancelled and/or difficult to access.
- Identify strategies that the victim/survivor may use to buy time and/or space, to defuse the situation, or to protect themselves and their children.
- Explore the types of essential services the victim/survivor may come into contact with during the COVID-19 restrictions (such as school, GP and other healthcare services, post office, supermarkets, etc.) and how they can use them as part of their safety plan.
- Ensure that the victim/survivor has accurate and current information about COVID-19, including hygiene requirements, physical distancing requirements and support available in the community.
- Does the victim/survivor have access to safe accommodation outside the home they could access? It is important to ensure that the perpetrator is not aware of the address.

When responding to vulnerable groups such as children, women with disability, First Nations people, people from culturally and linguistically diverse backgrounds, homosexuals, bisexual, trans, intersex and/or queer people, undertake planning in your work group and in consultation with your local DFV sector to ensure that safety planning is age appropriate and culturally safe.