

**Submission on Mandatory Reporting of Domestic Violence  
By Health Professionals**

Response to Discussion Paper

From: Northern Territory Domestic and Family Violence Advisory  
Council

March 2008

## **Introduction:**

The Domestic and Family Violence Advisory Council members were appointed in March 2006. The Council has seven members, including the Chairperson. They are Jane Lloyd (Chair), Phynea Clarke, Des Rogers, Angela Dowling, Lawrence Costa, Melanie Little and Dr Lesley Barclay. The members are both Indigenous and non-Indigenous with a depth of experience in Family and Domestic Violence and related areas across a broad range of sectors and communities.

The Council's Terms of Reference are to provide advice to Government on:

1. Implementation of the Domestic and Family Violence Strategies in a Territory-wide context.
2. Improving cross-agency and community partnerships and alliances.
3. Designing, implementing and reviewing family violence programs and agreements between the NT and the Australian Governments, as well as making a contribution to schedules in overarching agreements.
4. Implementation of the revised Strategic Framework to manage resource shifts and improve reporting on domestic and family violence programs.
5. Problems at the local level and how to get early warning of these issues.
6. Strengths, weaknesses, opportunities and threats relating to strategies and local program delivery.
7. Building better systems at the community and government level.

The Council member's views on the issue of mandatory reporting of domestic violence for health professionals reflect the diverse backgrounds and experiences of the members. While we are unable to put forth a definitive unanimous position on this issue, our submission highlights a number of key points that strongly support a consideration of mandatory reporting of domestic violence for health professionals. The majority of key points put forth in this submission were discussed with Ms Sarah Wilkie from the NT Department of Justice when she attended the Advisory Council's meeting in Darwin in February 2008.

## **Discussion Paper: Key Points**

1. **The Discussion Paper:** There appeared to be only limited informal consultations in the preparation of the discussion paper and a short time frame to put in a response. The council felt that the discussion of this issue was restricted by the general outline and description and definition of domestic violence (Page 3) in the discussion paper. This does not describe the particular aspects of the violence in the NT that has initiated a call for mandatory reporting obligations to be considered. The aspects that need to be stressed are;

- **The very violent nature of the violence and the high incidence in the NT**
- **The social and cultural context of the violence. Remote location of many women, kinship conflicts and or lack of family support, inability of victims to**

- do their own reporting because of the fear and threat of further violence, pressure by family against reporting**
- **the lack of access to services in many communities**
- **challenges in recruiting and retaining suitably skilled staffed.**

The discussion paper does not give enough attention to the safety needs of domestic violence victims who are subject to continuing and escalating violence in their relationships. Generally the discussion paper places more focus on reasons against mandatory reporting and the safety needs of the health professionals rather than the safety needs of victims of domestic violence and how they and their children can best be protected.

There is no evidence to date to suggest that strengthening the current health system, and a well resourced government and non-government sectors alone will provide the most effective interventions and responses to domestic violence that focus on the safety of the victim and prevention of further violence. There is evidence to suggest that domestic and family violence policies and strategies are not fully implemented and health professionals are still exercising their professional and personal discretion as to whether they should report or not. Other information we have indicates that even when there is an information sharing agreement in place for health professionals to report domestic violence, this is not regularly and consistently being adhered to. Training and education of health professionals does not guarantee an appropriate and effective response.

Many of us have observed how the acceptance and tolerance of the brutality and high incidence of domestic and family violence has been reinforced by the attitudes and responses of government and non-government agencies. Against this background we strongly support the careful consideration of mandatory reporting to complement a well resourced government and non-government sector that gives priority to the safety and protection of those most at risk of domestic and family violence.

### **Improving the response system: early intervention**

2. There appears to be a major systemic break down in the response system to domestic and family violence. We base this on the number of women repeatedly presenting to health professionals with assault or family violence related injuries that would fall within the Criminal Code definition of “harm” (as outlined in Item 3.1 of the Discussion Paper p6) with relatively few referrals to Police (and the criminal justice system) and or other intervention type services. This has been highlighted by the Coronial Inquiry into the domestic violence fatality of Ms Palipuaminni and the Alice Springs Hospital project. This reported in November 2006 on the high frequency of Aboriginal women repeatedly presenting to the Alice Springs hospital with assault related injuries. The Coronial Inquiry and the Hospital report revealed that the health system did not report or refer those victims to police and or other specialist victim support services. The Council is aware of other cases where a victim of a domestic violence fatality had presented to the health system on numerous occasions with assault related injuries that increased in severity with the repeat presentations.

3. Mandatory reporting was seen by some members as a mechanism to make agencies accountable and responsible in doing something about violence and limiting the number of deaths that were occurring. The mechanism could ensure that early intervention systems were operating. Members are aware that the majority of domestic violence fatalities that they know of were all preventable if there had been more **vigilant** and responsive systems of intervention in place. Mandatory reporting for child abuse and neglect has increased the awareness and responsibility of those services and sectors who deal with children but has not necessarily resulted with this being better dealt with by health or social welfare systems. Mandatory reporting of domestic and family violence could bring similar increased awareness into health systems and could also introduce solutions or remediation if sufficiently well resourced and supported.

4. Mandatory reporting would provide a valuable source of data to contribute to the picture of the nature and extent of Domestic and Family Violence in the NT. That data is required to assist in developing and shaping policies and programs that are targeted at the prevention, intervention, crisis and recovery responses. The available data is limited as it largely relies on police data of reported incidents of violence.

#### **Who should report?**

5. All health professionals need to have the same requirements and responsibilities. That is mandatory reporting obligations need to apply to independent health services across the NT in addition to the NT Department of Health professionals. This would ensure that mandatory reporting had maximum impact. Further, it would ensure that all those who were subjected to family violence were treated the same way (and not differently based on, e.g. income, residence). This would include many remote clinics and nurses where the clinic is one of the only services where victims can seek help. It must be noted that despite mandatory reporting for children many nurses do not know how to act in relation to this. Also, particularly in these circumstances, they are reluctant to report because of fear of retribution from community members and or their employers.

#### **What must be reported?**

6. It was also noted that if you were trying to prevent repeat presentations you should not wait for serious harm to be the result of family violence – intervention needs to occur before this stage. The Council identified the escalation in brutality and incidence of violence as typical in family violence situations. Early intervention is to be encouraged and the definition of what it to be reported is broadened to include injuries which fall within the Criminal Code definition of “harm”.

7. The Council wanted to emphasise that the focus should be directed to improving managing the safety of those most at risk of violence. The discussion paper raises important issues around the capacity of the response system across the government and non-government agencies to effectively respond to domestic violence. Whilst concerns were expressed that the current system was not in a position to deal with mandatory reporting obligations, it was noted that the legislation could have a deferred commencement date to ensure that systems were developed and put in place. Careful consideration would need to be made and systems put in place to manage the

reporting but the **focus must remain on the safety and protection of victims of domestic and family violence.**

### **Impact on health seeking behaviour**

**8.** In the view of most Advisory Council members there appeared to be little evidence to suggest that victims stop presenting to a clinic to obtain help after a domestic violence incident. The nature of domestic violence is that many victims are prevented from seeking medical treatment or accessing health systems. This is about the nature of the violence, the controlling behaviour of the offender not the victim's fear to have a third party make a report. Current profile of people being injured was that they were looking for intervention and outside help to receive that intervention. However it was also noted that an effective response to domestic violence required a number of agencies and services to work collaboratively and that there was a real danger when the response was left to the discretion of one agency or service. The Chair cited two examples from Central Australia where health professionals were aware that their patient was experiencing domestic violence but chose not report or notify police and or the local victim advocacy agency. In both cases the young women were murdered by their partners in the community. The Council will soon be considering whether deaths from Family Violence should be the subject of a coronial type investigation as a matter of course.

**9.** Other issues expressed by members included that any reporting mechanism needed to be mindful that it did not intrude on the relationship between health professional and patient and it could be demonstrated that the process can prevent and reduce violence.

**10.** The point made in 5.9 (p11) that "victims of domestic violence may use different health care services to avoid detection or injuries or a series of injuries caused by domestic violence" needs to be put into context as the inference is that victims don't want any help or protection. We suggest that the reasons may be the nature of the violent relationship and fear of further violence.

**11.** "Screening at Royal Darwin Hospital" (p12). It would have been helpful if the paper had given statistics for Alice Springs Hospital as well.

### **What is required to make Mandatory Reporting work?**

**12.** It was acknowledged that **information-sharing** was a critical issue and necessary mechanism to underpin and manage a mandatory reporting system. Members are aware that there are currently very few information sharing arrangements in place for the benefit of protecting victims of domestic violence. Members are also aware that information sharing has not been effectively managed for mandatory reporting of child abuse and neglect. Information sharing is a complex concept that involves the internal and external management of information and relationships. In many instances it requires information to be managed and shared within agencies, across government agencies, between government and non-government agencies and across jurisdictions.

**13.** There is an information sharing agreement in place between Police and Alice Springs Hospital involving the Emergency Department that is aimed at providing

better intervention and protection to high risk victims of domestic violence who present with assault related injuries to the hospital. A core aspect of this arrangement is health professionals reporting to the police within a clear and carefully drafted set of protocols. This arrangement has only been in place since the end of last year and it is probably too early to evaluate. Anecdotal evidence suggests that despite the agreement being in place the hospital has not been fulfilling its' part of the agreement. Members are aware of one or two other arrangements in place between a victim advocacy service and the police within the NT and neighbouring jurisdictions that work well. Any information sharing arrangement and agreement requires continuing relationship building and management within and across agencies.

#### **Autonomy versus safety and protection:**

**14.** A member expressed the view that they would not be comfortable in **not** advocating for mandatory reporting. Their view was that by doing nothing it legitimises the issue that it is just a "domestic", a private matter between a husband and his wife. Whereas the reality is that it is currently devastating Aboriginal society and families. Another member advised that they agreed with the comment in the discussion paper that "mandatory reporting obligation denies a victim's autonomy in dealing with the issue themselves, particularly in a way that maximises their own safety." It was felt the reporting mechanism would disempower victims and that support services and advocates needed to get stronger and work harder. Concern was expressed about the 'one-size fits all' approach.

Other members did not agree with the argument that mandatory reporting "denies a victim's autonomy in dealing with the issues themselves" as it ignores the reality that many victims, particularly young Aboriginal women are unable to exercise any autonomy in many of the important and basic aspects of their lives, specifically relating to their safety and wellbeing. Some Council members felt strongly that safety and protection should not be compromised by arguments about "autonomy".

The challenges faced in this difficult area are reflected by our divergence of opinion. However not to act was and is not tenable. How to act however needs careful thought and better systems in place than we have managed so far for our work in relation to children.