CLINICAL RESPONSE TO
DOMESTIC AND FAMILY
VIOLENCE

Train-the-trainer facilitator guide
Clinical response to domestic and family violence

Train-the-trainer facilitator guide
Published by the State of Queensland (Queensland Health), December 2017

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Acknowledgements
The development of the train-the-trainer program was guided by members of the Domestic and Family Violence Expert Advisory Group (DFV EAG). The Department of Health are appreciative of the time and expertise provided by members of the DFV EAG.

Cultural acknowledgement
We acknowledge Aboriginal and Torres Strait Islander people as the traditional custodians of this country, and their connection to land, wind, water and community. We pay our respects to their cultures and to Elders past, present and future.

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The National Plan to Reduce Violence against Women and their Children 2010–2022 (the National Plan), is supported by all jurisdictions and aims to achieve a significant and sustained reduction in violence against women and their children. The National Plan focuses on stopping violence before it happens, supporting women who have experienced violence, preventing men from committing violence, and building an evidence base so we learn more about what works in reducing domestic and family violence and sexual assault.

The National Plan aims to achieve six national outcomes:

1. Communities are safe and free from violence
2. Relationships are respectful
3. Indigenous communities are strengthened
4. Services meet the needs of women and their children experiencing violence
5. Justice responses are effective
6. Perpetrators stop their violence and are held to account.

Policy context – why are we delivering this training?
Queensland

The Taskforce on Domestic and Family Violence in Queensland was established to examine Queensland’s domestic and family violence support systems and make recommendations to the Premier on how the system could be improved and future incidents of domestic violence could be prevented. In February 2015, the ‘Not Now Not Ever: Putting an End to Domestic and Family Violence in Queensland’ report (NNNE report) was delivered to the Premier. In August 2015, the Queensland Government responded to the NNNE report by supporting or accepting the recommendations.

The NNNE report examines three key themes to bring about cultural and attitudinal change. These themes include:

- increasing awareness and reinforcing intolerance of domestic and family violence through education and engagement
- preventing domestic and family violence by building respectful relationships
- supporting victims/survivors of domestic and family violence by empowering the community to intervene and hold perpetrators to account.

The Domestic and Family Violence Prevention Strategy 2016–2026 and action plans outlines a shared vision and a set of principles to guide action across government and the community, including a staged 10-year plan.

Reforms, outlined in the strategy, will recognise the victim’s perspective, prioritise their safety, and reduce the onus on them to take action or leave their home. There is a focus on:

- educating frontline professionals to help them recognise and respond to domestic and family violence
- creating safe communities and workplaces that support victims
- providing effective services that efficiently wrap around the victim
- ensuring our legal system supports victims and holds perpetrators to account.
Introduction

This facilitator's guide has been developed to support the delivery of the ‘Clinical Response to Domestic and Family Violence’ train-the-trainer sessions. The length of the train-the-trainer session will be determined by the facilitator depending on the knowledge and skill of each group.

A train-the-trainer facilitator – should have knowledge and expertise on the topic domestic and family violence and in facilitating groups.

Train-the-trainer participants – may include social work leads, clinical leads, medical officers and clinical educators from a range of clinical areas such as maternity, emergency, mental health, paediatrics, child health, women’s health and sexual health, Aboriginal and Torres Strait Islander and multicultural health services, Queensland Ambulance Service as well as key staff from private hospitals.

Preparing for the train-the-trainer session

This facilitator’s guide contains suggested topics for discussion, key messages and facilitator notes, suggested activities, power point, handouts, a domestic and family violence training session plan and pre and post training evaluation tool.

- It is the role of the facilitator to guide the train-the-trainer participants through the course work, acknowledging that each group of participants will be unique.
- The facilitator should attempt to create an environment that is safe and respectful.
- Domestic and family violence is a complex and sensitive topic. It is essential the facilitator is confident in their knowledge of domestic and family violence and experienced in facilitating group sessions.
- Identify your local domestic and family violence support services and other resources available in your local community.
- Invite a member of the local domestic and family violence service team to participate in the delivery of the training session.
- Invite a person with lived experience of domestic and family violence to participate in the training session.
- Mechanisms should be available to provide support in case any participant experiences emotional or physical distress.
- Ensure all participants are aware of how to contact EAP or DVConnect in case they need additional confidential support.
- Ensure housekeeping is outlined to all participants’ e.g. toilet facilities, emergency exits.
- Ensure you have all of the resources required to deliver the activities on the day.
- Confirm with participants they have completed the ‘CEO challenge – Recognise Respond Refer Domestic and Family Violence in the workplace’ online module.
- Confirm with participants they have completed the ‘Understanding Domestic and Family Violence’ online module.
- Confirm the completion of the ‘Clinical Responses to Domestic and Family Violence’ online module.
- The scenarios and role plays used will reflect the nature of the presentations to each specific clinical area.

Aim

The aim of the train-the-trainer program is to build on the participants existing knowledge and provide them with additional expertise to assist them to deliver face to face training sessions to clinicians in relevant clinical areas. Each participant should leave the train-the-trainer session with confidence to deliver face to face training sessions on domestic and family violence.

Prerequisites

Train-the-trainer facilitators should be familiar with the content of this guide and be comfortable with discussing this topic in a group setting prior to delivering the session.

Prior to attending the train-the-trainer session participants must have completed the ‘Clinical Response to Domestic and Family Violence’ online module.
Topics, key messages and facilitator notes

1 Introduction to the day

- Welcome to the ‘Clinical Response to Domestic and Family Violence’ train-the-trainer session.
- The aim of today’s session is to:
  o develop your knowledge, skills and practice in domestic and family violence
  o increase your confidence in delivering training to clinical staff in sensitively asking questions about domestic and family violence and
  o responding to a disclosure of domestic and family violence.
- Acknowledge that some participants may have personal or professional experience with domestic and family violence and that self-care in this case is important.

Suggested activity
- Ask the group to generate the ground rules by contributing to a list of rules that is displayed in the room throughout the training day. See some examples:
  o participants should respect the views of the other participants
  o maintaining confidentiality within the group
  o it is okay to leave the session if you are experiencing distress.
- Be sure to enable those who wish to contribute an opportunity to do so.

2 Supporting an employee experiencing domestic and family violence

- The experience of domestic violence can have serious impacts on a person’s physical, psychological and emotional health at a personal level and therefore on their attendance and performance at work.
- Every organisation should have a policy that outlines the workplace’s commitment to supporting employees affected by domestic and family violence.
- The Department of Health has worked in partnership with the Public Service Commission to develop and implement a ‘Supporting employees affected by domestic and family violence directive’, as well as a training package and intranet web page to provide guidance for managers of victims of domestic and family violence in the workplace.
- The Department of Health Human Resources Policy ‘Support for employees affected by domestic and family violence’ outlines leave entitlements of up to 10 days per year or flexible work arrangements to assist with attendance at appointments.
- Queensland public sector employees can increase their understanding of domestic and family violence and how to support colleagues affected by domestic and family violence by completing the online Recognise, Respond, Refer program available http://qheps.health.qld.gov.au/hr/staff-health-wellbeing/domestic-family-violence/home.htm

Everyone deserves to be safe and supported in the workplace.
3 Reflective practice

Reflective practice is fundamental to professional development; it involves considering the impacts that personal experiences have on a response to certain issues. It recognises that health professionals will bring individual and professional values and beliefs and cultures to their analysis of domestic and family violence issues.2

Being thoughtful about the circumstances of others as well as self-reflection about where and how we come to hold our own values, is an extremely positive and open way of approaching professional practice.3

Seeking clinical advice from a team leader and / or domestic and family violence specialist within the health facility, such as a clinical area social worker, can assist in ensuring your response is appropriate.

4 Roles and responsibilities

It is important to know your role in relation to domestic and family violence is to work within your scope of practice to recognise, respond and refer.

- Professional competency standards, code of conduct and scope of practice were discussed in the ‘Understanding Domestic and Family Violence’ online learning module and booklet.
- It is important to know your role as a health professional is to ask about domestic and family violence in a way that facilitates disclosures, in a private discussion, in a sensitive manner and in an environment where the person feels safe.4 Offer a sensitive approach and share information on referral options so the patient can make an informed decision about their current and future options.
- Your role includes referral to professionals who have expertise in the area of domestic and family violence such as social workers, psychologists and specialist domestic and family violence services and workers who are trained to undertake assessment and therapeutic intervention. Refer to your local organisation’s procedures and referral pathway if further assessment and safety planning is required.
- If you are a health professional involved in providing care to women in the antenatal period please refer to the ‘Antenatal screening for domestic and family violence’ Guideline link to understand your responsibilities in identifying and responding to the particular needs of pregnant women at risk or experiencing domestic and family violence.
- You may have a legislative responsibility to report any reasonable suspicion of child abuse and neglect to the Department of Communities, Child Safety and Disability Services.

5 Definition

Several definitions of domestic and family violence exist.

- Domestic violence occurs when someone in an intimate relationship uses fear to control their partner on an ongoing basis; it is an abuse of power by one person over another in that relationship.\(^5\) This ongoing pattern of behaviour may include a range of tactics that may be criminal and non-criminal in nature.

- “Domestic and family violence can affect any person regardless of gender, age, socio-economic status, or cultural background. While both men and women can be victims and perpetrators of domestic and family violence, it is important to acknowledge that the rate of domestic and family violence perpetrated against women is significantly higher than it is against men.”\(^6\)

Suggested activity

- Ask the participants to break into small groups to develop their own definition of domestic and family violence. Ask each group to feedback on the definition they developed.

- Emphasise to the group that definitions should highlight the inequity in power and control that occurs in an abusive relationship.\(^7\)

- Ensure the group understands the feeling of fear experienced by the victim of domestic and family violence.

- Discuss the definitions provided.

6 Duluth Model

The Duluth model underpins our knowledge of perpetrator behaviours.

- The ‘Duluth Wheel of Power and Control’ is a helpful tool in understanding the overall pattern of abusive and violent behaviour used by perpetrators to establish and maintain control of their partner.\(^8\)

- Power and control in a relationship can be gained by exercising behaviours such as intimidation, isolation, denying and blaming and male privilege.

- Display and discuss the ‘Duluth Wheel of Power and Control’.

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5. DV Connect womenline http://www.dvconnect.org/womensline/what-is-domestic-family-violence-2/
6. NOT NOW, NOT EVER—Putting an End to Domestic and Family Violence in Queensland
Legislation

**Domestic and Family Violence Protection Act 2012.**

- Legislation has been reviewed as part of the domestic and family violence reform process.
- Section 315A of the *Criminal Code 1899* now defines non-lethal strangulation in domestic and family violence as a stand-alone criminal offence.
- Section 5A of the *Domestic and Family Violence Protection Act 2012* defines the circumstances under which agencies working with victims and perpetrators of domestic and family violence may share information without consent. Whilst seeking consent to release client information is always preferable, this new legislation allows agencies to share information in circumstances where seeking consent is either not possible or puts victims and their children at risk.

‘Clinical Response to Domestic and Family Violence’ online module

- Recap some of the important messages from the online module.
- As you work through the key messages check if anyone in the group needs to clarify any of the concepts in the online module.
Complexities of domestic and family violence

Everyone, regardless of their sex, religion, nationality, race, language, relationship or living arrangements, has the right to feel safe and be safe in public and at home.9

- Cultural groups – the impact of past trauma may be a contributing factor for domestic and family violence in Aboriginal and Torres Strait Islander communities. Women from culturally and linguistically diverse backgrounds (CALD) backgrounds face additional barriers to accessing services and support.
- Domestic and family violence may be condoned in some cultural groups.
- Community expectations – the attitudes, knowledge, and beliefs of individuals and communities can, and do, create a culture that justifies, excuses, perhaps trivialises or even condones or encourages domestic violence. Culture and attitudes may impact the ability of victims to report violence and seek help, and influences the willingness of the community to hold perpetrators to account.
- Family structure – All families are unique with family structure varying across communities. Consider same sex couples, people with disability and older family members who may be at risk of domestic and family violence.
- Gender inequality – domestic and family violence can be considered gendered crime which has an unequal impact on women. One in 6 Australian women has experienced physical abuse at the hands of a current or former partner.11
- The evidence demonstrates that domestic and family violence is a gendered issue. Women are significantly overrepresented as victims of violence and coercive behaviour, including higher rates of Indigenous women. Men are statistically more likely to be the perpetrators.12

Suggested activity
- Ask participants to break into small groups and identify additional issues experience by clients from vulnerable groups.

Domestic and family violence affects health

Domestic and family violence can affect an individual’s health and wellbeing in a number of ways.

The effects of living with violence include physical and psychological health impacts.
- Indicators of domestic and family violence are outlined in the ‘Understanding Domestic and Family Violence’ module and include bruises, injury to parts of the body hidden from view, rape and sexual assault, miscarriages and other pregnancy complications, mental illness, depression, panic attacks, anxiety and suicide.
- Domestic and family violence often commences or intensifies during pregnancy and is associated with increased rates of miscarriage, low birth weight, premature birth, foetal injury and foetal death. Domestic and family violence during pregnancy is regarded as a significant indicator of future harm to the woman and her child.
- Non-lethal strangulation or choking can cause serious injuries to the structures in the neck that are not visible to the eye and/or for which there may be delayed or generalised symptoms. Use the non-lethal strangulation in Domestic and Family Violence factsheet and flowchart to understand the signs, symptoms and key indicators for serious harm, and to guide health service responses.

Suggested activity
- In small groups identify what some of the health impacts might be.
Why doesn’t she leave the relationship?

Women experiencing domestic and family violence want recognition and continuing support from clinicians without pressure for a specific course of action.

- There is an increased risk of violence for a victim at the time of leaving a relationship.
- **Never ask** a victim “why don’t you leave?” and always offer referral to specialist support services.
- Clinicians should not encourage a woman to leave an abusive relationship as this may lead to an increased risk of violence. For women who are experiencing domestic and family violence the high risk for violence periods include immediately prior to, during, or immediately after separation.
- It is essential women are supported to make their own decisions.
- It is the role of the clinician to ensure the woman is well informed about support services and to offer ongoing support and information.

Suggested activity

- In small groups discuss and list some of the reasons women don’t leave a violent relationship.
- Some examples might include:
  - fear
  - stigma
  - unaware of how to get help
  - lack of family support.

Women and children

Recognising the disproportionate rate of domestic and family violence on women enables the nature of the problem to be correctly characterised and responded to including the rights of the most vulnerable victims within the family, children.

- The response to women and children is founded on their right to receive healthcare that is consistent with human rights including autonomy, privacy, confidentiality, informed consent and choice.13
- It is possible to draw a correlation between domestic and family violence and ‘social determinants’ of health for women impacting on availability of resources and ability to access healthcare.
- Women identify health care providers as the professionals they would most trust with disclosures of abuse.14

Suggested activity

- Listen to an audio tape or watch a YouTube clip.

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13. WHO clinical and policy guidelines: Responding to intimate partner violence and sexual violence against women (2013)
14. WHO clinical and policy guidelines: Responding to intimate partner violence and sexual violence against women (2013)
### 13 How domestic and family violence affects children

Children exposed to domestic and family violence may be at higher risk of physical, emotional and behavioural problems that persist into adulthood.

- Health professionals should be aware of the close link between domestic and family violence and child abuse and neglect. Health professionals involved in working with families must accept their child protection reporting responsibilities in addressing domestic and family violence within their professional practice.
- Having a child aware approach encompasses the unseen child when working within the adult hospital context of assessing both protective factors and parental risk factors such as domestic and family violence.
- Does information at hand suggest the child has suffered, is suffering or is at unacceptable risk of suffering significant harm and may not have a parent who is able and willing to protect them from the harm? If so then you are required to make a report to Child Safety Services.

### 14 High risk population groups

People from diverse and vulnerable groups are at higher risk of domestic and family violence and may require additional support.

- Aboriginal and Torres Strait Islander people in Queensland experience disproportionately high levels of violence, including domestic and family violence. This is true both for the frequency and severity of the violence, despite high levels of non-disclosure (some studies suggest that around 90 per cent of violence against Aboriginal and Torres Strait Islander women is not disclosed).\(^\text{15}\)
- Staff should engage in cultural competency training and consult with local Aboriginal and Torres Strait Islander liaison service or health worker for cultural advice.
- People from CALD backgrounds experiencing domestic and family violence are at greater risk of being marginalised and isolated socially, culturally, politically and economically. It is recommended where possible that staff engage an interpreter who is not known to the family or the local community when conducting assessment and intervention as required.
- If a client requires any form of assistance to communicate, this should be in place before the assessment commences. It is important to always engage an interpreter to communicate effectively with people from non-English speaking backgrounds.
- Do not use partners, other family members or a child as interpreters.\(^\text{16}\) Interpreters should be fully briefed before communication with the individual occurs to inform them of the likely topic of discussion; and to provide them with an opportunity to decline the engagement. This is especially important in situations of domestic and family violence and associated counselling.\(^\text{17}\)
- People with disabilities are highly vulnerable to domestic and family violence and can experience ‘disability related’ abuse such as withholding care and threats of institutionalisation.\(^\text{18}\)
- Ensure if a patient is under the adult guardian/has a health attorney, they are consulted if the person does not have capacity to consent for health care.
- Studies indicate that the perpetrators of elder abuse may be different to those who use violence against younger women, with an increase in reporting of children, grandchildren, other relatives and carers as abusers.\(^\text{19}\)
- The Queensland Elder Abuse Prevention Unit (EAPU) helpline number is 1300 651 192.

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15. NOT NOW, NOT EVER–Putting an End to Domestic and Family Violence in Queensland
19. NOT NOW, NOT EVER–Putting an End to Domestic and Family Violence in Queensland
Perpetrator risk factors and clinical response

Perpetrators of domestic and family violence come from all socio-economic, cultural and social groups.

- Perpetrators who have access to weapons, particularly guns, are much more likely to seriously injure or kill a victim than perpetrators without access to weapons.
- Threats by the perpetrator to hurt or cause actual harm to family members can be a way of controlling the victim through fear.
- The use of non-lethal strangulation/choking by male perpetrators is an indicator for a dangerous escalation in violence, and a key risk factor for domestic homicide.
- Stalkers are more likely to be violent if they have had an intimate relationship with the victim. Stalking, when coupled with physical assault, is strongly connected to murder or attempted murder. Stalking behaviour and obsessive thinking are highly related behaviours.
- Obsessive and/or excessive jealous behaviour is often related to controlling behaviours and has been linked with violent attacks.
- In some cases, perpetrators may self-disclose domestic and family violence behaviour because they do not believe what they are doing is wrong e.g. “She pulled a knife on me after I pushed her, that’s how I got cut.”
- If a perpetrator discloses domestic and family violence:
  - Acknowledge their courage and reinforce that violence is not acceptable;
  - Provide ongoing support; and
  - Offer referral to a specialist clinician or specialist service to continue with assessment and intervention.

Principles of sensitive practice

Sensitive practice is an approach to engaging with clients in a way that increases their feelings of safety, respect and control.

- Discuss the principles of sensitive practice.
- Remind participants that these principles can be applied to all clinical practice and across all disciplines.
- A supportive response from a well-trained professional can act as a turning point on the pathway to safety and healing.

- Respect – experiences of abuse may undermine a client’s personal worth and may be sensitive to not being listened to or believed. Listening to and validating belief in a client’s experiences will help them feel respected.
- Taking time – feeling that a clinician is taking time to listen to them and feeling genuinely heard is a contributing factor to healing and in some cases may be the best intervention a clinician can offer.
- Rapport – building rapport with a client will increase their sense of safety and assists to encourage both communication and cooperation.
- Sharing information – this is a process whereby information is exchanged and both parties feel heard and understood.
- Supportive – being supportive means accepting a client as an individual with unique beliefs, values, needs and history.
- Respectful – seek permission from your client to ask questions of an intimate nature or before performing an examination.
- Create a sense of control – sharing control of actions and discussion in the clinician client relationship enables clients to participate in their own care.

Suggested activity

- As a larger group consider a brainstorming exercise, asking participants about how they would feel sharing personal matters e.g. relationship problems, how they would want this approached in a health setting. What would be important for them if they were the client?
- As a group identify what they could consider as possible barriers for the client around disclosure (e.g. social, isolation, fear etc.).

Six steps to ‘sensitive inquiry’

This sensitive inquiry model provides guidance for clinicians on how to identify and respond to domestic and family violence.

1. Identification
2. Supportive response
3. Consider safety and manage risk
4. Actions for safety
5. Referral support
6. Documentation

• Health professionals can reduce the barriers for victims/survivors through receiving appropriate training and education in sensitive inquiry and appropriately responding to domestic and family violence.

Step 1 – Identification

Domestic and family violence can be identified through client disclosure, recognising indicators, recognising risk factors or routine screening for domestic and family violence.

• Identification of domestic and family violence through recognising high risk groups, risk factors and health indicators is key to initiating conversation about domestic and family violence with a client.
• If a clinician suspects domestic and family violence conversations with the client should take place alone and in private.
• Ensure the client is comfortable and consenting to discussion.

Clients may be reluctant to disclose domestic and family violence due to a range of factors including:
• pressure from families, friends or abusers to remain silent
• fear of a negative response
• the sense that health professionals do not have the time to listen or seem unaware of the potential long term impacts
• clients who have experienced domestic and family violence generally want to be asked about their experiences, and are more likely to make a disclosure.

Suggested activity
• In small groups to identify risk factors and indicators of domestic and family violence.
• Review with the group the list of risk factors or indicators of domestic and family violence.
Step 2 – Supportive response

An initial supportive response will assist in building rapport between the health professional and the client and provide a supportive environment for clients to share information.

- A supportive and professional response from health professionals can reinforce to a client that they are entitled to a healthy relationship and a life free from violence.
- Focusing on the needs of the client can be achieved through displaying empathy, a non-judgemental attitude and offering privacy and confidentiality.
- Opening statements using words that affirm the client is not being targeted or judged are a way of introducing the subject of domestic and family violence:
  - “Domestic and family violence is a health issue that we ask about routinely”
  - “As we know domestic and family violence affects your health and we are routinely asking clients about it”.
- Clinicians can ask questions that are broad questions:
  - How are things at home?
  - Is there anything else happening which might be affecting your health?
- Clinicians can ask direct questions:
  - Are there ever times when you are frightened of your partner?
  - Has your partner ever physically threatened or hurt you?
- Clinicians can ask specific questions:
  - When I see injuries like this I wonder if someone could have hurt you?
  - Is there anything else we haven’t talked about that might be contributing to your condition?
- Clinicians responding to a disclosure of domestic and family violence should use the following steps:
  - non-judgemental and careful listening
  - communicate belief
  - validate the experience of abuse
  - affirm that violence is unacceptable behaviour
  - show support towards the victim
  - make an initial safety assessment
  - respond to any concern about safety.

Suggested activity

- In pairs ask participants to practice through role play how they would sensitively inquire about domestic and family violence. It is important to practice asking the question about domestic and family violence so you feel comfortable with the questions. In pairs take turns to play the part of the clinician and the client:
  - ask a client about their experience of domestic and family violence
  - respond to a positive disclosure
  - what would be their key messages
  - consider verbal and non-verbal communication.

Reflect on:

- communication skills including body language
- interactions between pairs conducting the role play.

Step 3 – Consider safety and manage risk

Consideration of safety is an important step in determining how to respond.

- In assessing a client’s safety the health professional will use a combination of:
  - knowledge of evidence based risk factors
  - the victim’s own perception of safety and risk
  - professional judgement
- A social worker or specialist domestic and family violence service can assist through performing a comprehensive risk assessment and provision of ongoing care and intervention.

- Assessment of risk is important to identify dangers associated with victims including risk of homicide, suicide or self-harm and risk to their children.
- Risk assessment should be conducted by trained and experienced clinicians as part of an ongoing process of assessment. Risk should be monitored regularly and necessary steps should be taken where immediate safety concerns are identified.
- In some facilities or at certain times there may not be access to a social worker or specialist domestic and family violence service in this case you should refer to domestic and family violence expert within your clinical area or telephone advice from a specialist domestic and family violence service e.g. DVConnect (1800 811 811)
- Recent updates of the Domestic and Family Violence Prevention Act 2012 have changed how Queensland Health and other agencies can share relevant information with one another in order to assess risk in situations of domestic and family violence and to manage serious domestic and family violence threats. Refer to the Domestic and Family Violence Information Sharing Guidelines and use the Information Sharing in Domestic and Family Violence factsheet and flowchart as quick-reference guides for use in busy clinical environments for sharing information in a safe and appropriate way.

Suggested activity

- Provide the group with a scenario from the attached suite of scenario’s and ask them to work through to the assessment phase recording their feedback on butcher’s paper.
- Feedback to the larger group.
### 21 Step 4 – Actions for safety

**Plan for safety in partnership with the client.**

- Following medical and clinical assessment and during engagement with your client immediate safety should be given first priority.
- If immediate safety is not a concern the health professional should consider the client’s future safety and ongoing care.

- An emergency plan is the development of a plan by health professionals in consultation with victims to achieve and maintain their safety. It may include:
  - Compiling a list of emergency numbers
  - Helping to identify a safe place for the woman to go to and how she will get there
  - Identifying family and friends who can provide support
  - Ensuring cash is available
  - Providing a safe place to store valuables and important documents.

**Suggested activity**

- Ask the group to develop an emergency plan.
- Role play working through an emergency.
  - Give examples of what questions you would ask to determine immediate safety?
  - Give examples of questions to determine future safety?
  - What does an emergency plan look like for your client?
  - Would you be concerned if you became aware of attempts to choke, strangle or suffocate your client?

### 22 Step 5 – Referral support

**With the consent of the client offer referral options.**

- Introduce the referral model.
- Hand out a copy of the referral model and flowchart.
- Review of domestic and family violence specialist services and contact arrangements DVConnect, the local/regional domestic and family violence service and police contacts both in and after hours.

### 23 Step 6 – Documentation

**Documentation of relevant information especially about physical injuries important for ongoing care and for legal purposes.**

- It is important to document a disclosure and/or any signs/symptoms of non-lethal strangulation as this is a standalone criminal offence and records may be subpoenaed to support a conviction.
- If you have shared client information with other agencies for the purpose of risk assessment or threat reduction it is essential that a detailed record is kept of the reason/s why information was shared, what information was shared and with whom it was shared.
- Use your local facility policy and guidelines to guide your documentation of your response to a disclosure of domestic and family violence including an assessment or safety plan.

**Suggested activity**

- Ask the participants how they would document a disclosure, risk assessment and safety plan in the hospital records.
- Provide the participants with examples of a good and not so good case note to demonstrate what key information would be needed following local procedures around record keeping.
Clinical scenarios

Maternity

Scenario 1
Birthing suite
Sonia is a gravida 4 para 2. Her children are aged 3 and 5. Although not married she has been living with her partner for 5 years. She is presently 32 weeks pregnant. Sonia arrives on birthing suite via her GP with unexplained abdominal pain. Upon palpation she is small for dates. Medical notes show that Sonia has had several admissions to the maternity unit with similar symptoms. She also has a history of recurrent urinary tract infections. She seems unsure of herself and is unkempt and thin. She offers a vague history of symptoms. She is admitted to the ward overnight and as on previous occasions insists on going home because of child care problems.

Scenario 2
Maternity ward
Maggie is a solicitor. Her husband is also a solicitor. She has a two year old daughter. Maggie has been admitted to the ward at 15 weeks of pregnancy with vaginal bleeding. She is very tearful and upset and worried about a possible miscarriage. Her medical records show that she has had three previous miscarriages in the past 18 months. On examination you notice bruising on her abdomen and thighs.
Emergency

Scenario 1
Emergency department

Jacqui, a 27 year old female presented to emergency department post alleged assault by her partner. She presents with facial injuries, bruising to her arms and chest and rectal bleeding. Jacqui reports that her partner had used IV drugs prior to the alleged assault. She also reported that a verbal altercation commenced following her confronting her partner about his intravenous drug use (IVDU).

Jacqui indicates that she recently moved from Melbourne with her partner of four years and has limited supports in Brisbane. She is listed on a 12 month lease with her partner and is fearful of returning to the home. She is employed as a manager at a local café and works full time and reports that she has two children aged 5 and 10 years.

Scenario 2
Critical care

Maria, a 74 year old female, was admitted to the Critical Care Unit following a cardiac episode. Whilst admitted she reports a longstanding history of physical, psychological and sexual abuse by her husband which she is fearful will continue following her discharge from hospital.

She has two adult sons who are aware of the history of abuse but not the current situation. Maria is reluctant to speak to her sons as she doesn’t want them to “yell and cause a scene”.

Maria’s cultural background is Italian, and she is very concerned about the community perception of “staying while things are good and he can work and leaving him now that he’s old”.

Non-lethal strangulation in DFV

Scenario 1
(Non-lethal strangulation/Primary care)

Penny is a 40 year old woman who regularly sees a visiting GP in a community health centre in a regional area of western Queensland. She lives with her husband on a remote farming property. Penny presents with a deep and raspy voice and her doctor suspects she isn’t telling the truth when she denies being a smoker. Penny attended a recent visit with slurred speech and her doctor wonders about other lifestyle issues such as drug and/or alcohol abuse. Penny is now presenting with a range of general health complaints, including headaches, memory loss and difficulty swallowing. Penny and her husband do not have any children, and Penny works with her husband on the farm. The doctor considers offering Penny a referral to an alcohol and drug service before noticing petechiae on Penny’s face.

Scenario 2
(non-lethal strangulation/Emergency department)

Ruth, a middle-aged Papua New Guinean woman, has been brought to a hospital emergency department following a police callout. Ruth was found staggering around outside an inner city apartment block, confused and unable to tell officers where she resided. Suspecting mental health issues, the police brought her to the emergency department for assessment. There is no record of previous mental health diagnoses or treatment, however it is Ruth’s second late night admittance to the emergency department in 6 months. On the previous visit she had been treated for cuts and bruises to her face, and she reported that her husband had got very drunk and throttled her. During this first visit she stated that she had been frightened he might kill her. At that first admission she had refused a referral to a social worker, reporting at discharge that she was not scared to go home as her husband was generally a quiet and reserved man, and would now be sober.
Scenario 1

Natalie is a 33-year-old woman who is attending her first antenatal appointment at 14 weeks gestation. She does not identify or disclose any issues or concerns when responding to questions in the psychosocial screening tool. However you have suspicions that there is something wrong/you recognize domestic and family violence indicators. At Natalie’s 28-week antenatal appointment, she again does not identify issues when responding to psychosocial screening. As your rapport develops through the consultation, she hesitantly discloses that her husband has a long history of mental health issues; and that she has experienced past sexual assault and some physical violence in the relationship, some physical violence, usually related to her partner’s alcohol consumption. Natalie is concerned as the frequency and intensity of the violence is increasing. Natalie reports limited support from family and friends and informs you that she wishes to leave the relationship, but feels she is not ready to do so until after the baby is born.

Scenario 2

Ashley is a 35-year-old woman who is presenting for antenatal care at 28 weeks. She has three children currently in her care. She discloses a history of domestic violence from a previous partner, the father of her children. Her current partner is the father of her unborn baby and she reports that he has also been domestically violent in the past, and currently has had a DVO against him. Ashley discloses that one of the children has a significant disability with behavioural issues and her partner finds this difficult to manage becoming angry when dealing with the child. Her partner is currently unemployed and consequently they are experiencing financial difficulties. She has a supportive mother who assists her with the children. Close to the end of her appointment Ashley advises that her partner is outside the hospital and she is afraid to leave but is also concerned about her children who are at school.

Scenario 3

Jenny is a 29-year-old woman who presents quite late in pregnancy for care. She is accompanied by her partner. He will not leave her side, and answers all of the questions you ask Jenny. When you talk about Jenny’s recommended maternity care plan you sense she is uncomfortable and the partner becomes increasingly agitated.

Scenario 1

Mental health

Sophie is a 26 year old female with a history of Bipolar Affective Disorder; her treatment is managed privately in the community. She is brought in to the emergency department by Queensland Ambulance Services and her intake form states that her neighbours contacted the police following loud yelling heard from inside the house.

You meet Sophie in the mental health waiting area where she is waiting with her husband. She presents as tearful, anxious, yet polite and cooperative.

Her husband demands an admission for his “out of control crazy wife". Sophie does not make eye contact with you and her husband continues to answer questions on Sophie's behalf in a manner that is condescending and belittling towards his wife.

Scenario 2

Mental health

Jane is a 49 year old female who has been an inpatient in the local mental health unit for three weeks following a serious suicide attempt by overdose. Jane has made some progress while on the ward, and during an interview, discloses some family ‘issues’ and concerns about returning home to live with her partner.

She asks whether alternative accommodation could be explored by her treatment team. You offer to raise this for discussion at the family meeting scheduled for tomorrow. Suddenly Jane becomes overwhelmed and tells you she is just being ‘stupid’ and it won’t be necessary to discuss this especially with her husband present.
Alcohol and other drugs

Scenario 1
Courtney is a 26 year old female, attending the Alcohol and Drug Service for support in regards to recent relapse to daily dependant methamphetamine use. During her counselling session she reports that she had returned to “using” since her partner was released from prison about three months ago. In exploring more about their relationship, she stated that they have been fighting more and more when they are “coming down” due to his increased levels of paranoia. Courtney reports that he has stopped her from having other male friends, checks her mobile phone when she is out of the room and has been calling her names such as “whore and slut” and recently there have been incidents of kicking and biting when they have been arguing. When this was further discussed with Courtney – she stated “Oh, it’s nothing to worry about though, because I give it back just as much as I get.”

Aboriginal and Torres Strait Islander service settings

Scenario 1
A 35 year old indigenous woman lives with her 16 year old son and three younger children. He is unemployed and has recently been expelled from school and is now smoking marijuana on a daily basis. His mother is worried about his health and takes him to visit their local Indigenous medical service. He reports that he is hearing voices to the nurse who also is his mother’s friend. He advises the nurse that the voices are telling him to hurt his mum and then kill himself. The nurse is concerned for the safety of the boy, his mother and siblings. On a previous occasion the boy had punched his mother while she was holding her youngest child.

Scenario 2
Michelle, a 20 year old pregnant Indigenous woman rings DVConnect wanting assistance to flee her community. The Indigenous woman wants to go to a domestic violence shelter but is requesting a shelter with Indigenous workers. DVConnect advises the woman that there are currently no Indigenous workers working at any domestic violence shelters in the state. Michelle refuses to go to a mainstream shelter, however, has disclosed to the worker that her partner physically and sexually assaulted her last night and his sister is threatening to further assault her if she goes to the police.

Multicultural (CALD)

Scenario 1
Esther is a 25 year old woman who came to Australia under the Humanitarian program three years ago. She originally settled in Victoria and has recently moved to Queensland. She is married with three small children. Esther presents to the ward for admission for persistent genito-urinary symptoms. She is very focused on her length of stay as she is concerned about who will look after her children as her husband is normally away from home during the day. The next day Esther’s husband arrives in the ward, they argue in their own language, Acholi, and he leaves two of the children with Esther for her to look after. Esther decides to discharge herself as she is concerned about the other child. Esther has no money, no phone and no transport to make the journey home. You offer to call her husband from the ward phone but Esther is too scared. She declines a nursing home visit as she said her husband wouldn’t be happy with her if someone came to the house.

Scenario 2
You have met a West African mother who has recently arrived to Queensland, having come from interstate where she lived for 4 years. She attends the refugee health clinic for assistance with an infectious disease. Her affect is flat and despite an interpreter she is a poor historian. You elicit that she is not happy but she is unable to disclose more due to cultural reasons. You plan weekly appointments for the next four weeks to build rapport and discuss the diagnosis and treatment options. On her return two weeks later, she states her husband leaves home in the morning and returns after dark. She does not get any financial support from him but he expects her to support him. She says she is always hungry because she doesn’t have enough food in the house for herself or the children. Her affect remains flat, difficult to engage and she will not disclose any more information about her home situation. When you try to use probing questions she is silent. The interpreter advises you that she cannot answer due to cultural reasons.
Primary health care setting

Scenario 1
GP practice

Helena a 67 year old woman of Croatian background presented to her GP with a forearm fracture which she attributed to a fall from a ladder at work. She still works in the family painting business and had multiple presentations with bruises on her limbs, for which she blamed dogs jumping up or a simple trip. Her husband, who is a heavy drinker, was noted to be very argumentative during the presentation.

Helena subsequently presented with loss of consciousness and body bruising after hitting her head on a cupboard as she fell in the kitchen. The GP asked her about domestic and family violence but she denied any domestic and family violence claiming it was just her mistake to slip on a wet kitchen floor. After a short time Helena disclosed that her husband had beaten and kicked her as she lay semi-conscious on the kitchen floor. Her adult son arrived home and transported her to the surgery.

After admitting to years of physical abuse Helena took out a restraining order against her husband. Her husband moved away for a while and became quite suicidal with ongoing significant binge drinking. Eventually she let him back home as he is less physically capable of harming her due to physical impairments associated with severe degenerative arthritis.

Scenario 2
Community health home visit

Jim is an 80 year old male who lives alone in a small home in Brisbane. He has two adult children a daughter who lives in Brisbane and a son who lives in Cairns. Jim had been admitted to the local hospital three months ago after sustaining skin trauma and burns to his arms.

You have been visiting Jim over a period of time to provide wound dressings to his burns. Over the period of time visiting you have noticed Jim has poor oral and general hygiene, soiled clothing and is showing signs of malnourishment. When you ask Jim about who helps him with cleaning and shopping he is reluctant to answer and avoids eye contact. Jim has indicated in previous conversations that his daughter looks after his money and he has been told there is not enough money for food after the bills have been paid and that his daughter gets angry and aggressive if he questions her about it.
Following completion of the train-the-trainer program participants will be confident to deliver ‘Clinical Response to Domestic and Family Violence’ face to face training sessions to clinicians working in a range of clinical areas.

The ‘Clinical Response to Domestic and Family Violence’ face to face training session is designed to support the introduction of a sensitive practice framework and six step sensitive inquiry model for clinicians who work in areas where they are more likely to identify clients who have experienced domestic and family violence.

This face to face session will assist clinicians to build competence and confidence in identifying, enquiring, assessing, responding to, and documenting domestic and family violence. The identification of clients experiencing or at risk of experiencing domestic and family violence is often dependent on the clinician’s awareness of signs and symptoms that are indicative of domestic and family violence, as well as their level of confidence to sensitively inquire.

Learning outcomes

Through delivery of the domestic and family violence training participants will:

- identify clients experiencing the effects of domestic and family violence through a demonstrated understanding of high risk groups, risk factors and indicators of domestic and family violence
- gain knowledge and confidence in their ability to ask questions of and respond appropriately and safely to clients experiencing domestic and family violence
- increase their knowledge and skills in assisting clients to seek help through a referral model outlining pathways for referral to specialist clinicians and specialist domestic and family violence services.
Prerequisite

The prerequisite for attending the face to face training is completion of the 'Clinical Response to Domestic and Family Violence' online learning module available at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence

Target audience

Clinicians working in the following clinical areas:
- maternity services
- emergency department
- mental health and alcohol and other drugs services
- acute paediatrics and community child health
- women's health and sexual health clinics
- Aboriginal and Torres Strait Islander health and multicultural health clinics
- Queensland Ambulance Service
- nominated domestic and family violence champions in private hospitals
- primary health care providers.

Training strategy

- The 'Clinical Response to Domestic and Family Violence' face to face training session will be delivered by a clinician who has completed the 'Clinical Response to Domestic and Family Violence' train-the-trainer session.
- This domestic and family violence training will be delivered in a face to face session.
- The face to face training is conducted in partnership with the local specialist domestic and family violence service.
- The domestic and family violence training will be supported by power point slides containing key messages for discussion.
- Scenario based role play and group activities will be used to facilitate skills development.
- Pre and post training evaluation will be conducted.

Training session

- It is the role of the trainer to guide the participants attending the session through the coursework acknowledging that each group of participants will be unique.
- The trainer should attempt to create an environment that is safe and respectful.
- Domestic and family violence is a complex and sensitive topic therefore it is essential the trainer is confident in their knowledge of domestic and family violence and experienced in facilitating group sessions.
- Identify your local domestic and family violence support services and other resources available in your local community.
- Invite a member of the local domestic and family violence service team to participate in the delivery of the training session.
- Invite a person with lived experience to participate in the training session.
- Mechanisms should be available to provide support in case any participant experiences emotional or physical distress.
- Ensure all participants are aware of how to contact EAP or DVConnect in case they need additional confidential support.
- Ensure housekeeping is outlined to all participants e.g. toilet facilities, emergency exits.
- Ensure you have all of the resources required to deliver the activities on the day.
- Confirm with participants they have completed the ‘CEO challenge – Recognise Respond Refer Domestic and Family Violence in the Workplace’ online module.
- Confirm with participants they have completed the ‘Understanding Domestic and Family Violence’ online module.
- Confirm the completion of the ‘Clinical responses to Domestic and Family Violence’ online module by requesting the certificate of completion.
- The scenarios used and the role plays will reflect the nature of the presentations to each specific clinical area.
Thank you for attending the ‘Clinical Response to Domestic and Family Violence’ face to face training session. Please complete the following questions for the evaluation of this training.

What happens to the results of this survey?
Your answers will remain confidential and will be collated with feedback from other staff to inform an evaluation of the domestic and family violence training session.

The following questions will take around 10 minutes to complete. Your answers will remain confidential.

Section 1: About you
What is the name of the hospital or organisation where you are employed?

In which area/s do you usually work? (please tick all relevant boxes):

- Maternity services
- Emergency department
- Mental health and alcohol and other drugs
- Acute paediatrics
- Community child health
- Women’s health
- Sexual health
- Aboriginal and Torres Strait Islander health
- Multicultural health
- Queensland Ambulance Service
- Private health sector
- Primary health care provider
- Other (please specify)

Which profession best describes your role? (please tick one box)

- Nursing
- Social Work
- Allied Health
- Midwifery
- Medical Officer
- Aboriginal and Torres Strait Islander health worker/hospital liaison officer
- Other (please specify)

How long have you worked in your profession?

- <1 year
- 1-5 years
- 6-10 years
- 10 years plus

Your gender

- Male
- Female
- Other (please specify)

Prior to attending this training, had you completed the Australia’s CEO Challenge e-learning program Recognise, Respond, Refer: Domestic Violence and the Workplace?

- No
- Yes

Have you participated in any other training on domestic and family violence?

- No
- Yes

If yes, please list the training below:

How frequently do you interact with victims, survivors or perpetrators of domestic and family violence in your day to day activities?

- Never
- Rarely
- Occasionally
- Regularly
- Every day
Section 2: Knowledge and confidence prior to training

Prior to completing the ‘Clinical Response to Domestic and Family Violence’ module and face to face training session, have you ever recognised indicators of domestic and family violence in your day to day activities but were unsure how to provide support and referral?

☐ No
☐ Yes

Prior to completing the ‘Clinical Response to Domestic and Family Violence’ module and face to face training session, rate your knowledge or confidence in the following area?

Identifying clinical risk indicators of domestic and family violence in adults?

☐ Low
☐ Medium
☐ High

Identifying clinical risk indicators of domestic and family violence in children?

☐ Low
☐ Medium
☐ High

Making a sensitive inquiry about domestic and family violence?

☐ Low
☐ Medium
☐ High

Responding to client disclosure of domestic and family violence?

☐ Low
☐ Medium
☐ High

Offering an appropriate intervention or referral to a client experiencing domestic and family violence?

☐ Low
☐ Medium
☐ High

Documenting a client’s experience of domestic and family violence?

☐ Low
☐ Medium
☐ High

Section 3: Knowledge and confidence following training

How relevant was this session to your role in your organisation?

☐ Not relevant at all
☐ Low relevance
☐ Medium relevance
☐ Highly relevant
☐ Extremely relevant

Following the completion of the ‘Clinical Response to Domestic and Family Violence’ module and face to face training session rate your knowledge or confidence in the following areas?

Identifying clinical risk indicators of domestic and family violence in adults?

☐ Low
☐ Medium
☐ High

Identifying clinical risk indicators of domestic and family violence in children?

☐ Low
☐ Medium
☐ High

Making a sensitive inquiry about domestic and family violence?

☐ Low
☐ Medium
☐ High

Responding to client disclosure of domestic and family violence?

☐ Low
☐ Medium
☐ High

Offering an appropriate intervention or referral to a client experiencing domestic and family violence?

☐ Low
☐ Medium
☐ High

Documenting a client’s experience of domestic and family violence?

☐ Low
☐ Medium
☐ High

Understanding a tailored responses for specific population groups

☐ Low
☐ Medium
☐ High

Thinking about your experience of the session, please rate your impressions in regards to the following statements:

The session today was time well spent

☐ Disagree
☐ Agree

I would recommend this session to other staff

☐ Disagree
☐ Agree

Additional comments

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Thank you in advance for taking the time to complete this.
We appreciate your feedback!