

Clinical response to Domestic and Family Violence

Training facilitator guide





Clinical response to Domestic and Family Violence, Training facilitator guide

Published by the State of Queensland (Queensland Health),
June 2022



This document is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit:
[Creative Commons — Attribution 3.0 Australia — CC BY 3.0 AU](https://creativecommons.org/licenses/by/3.0/au/)

© State of Queensland (Queensland Health) 2022

You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland (Queensland Health).

For more information contact

Social Policy, Legislation and Statutory Agencies Branch

Department of Health, Queensland Government
Level 9, 33 Charlotte Street, Brisbane QLD 4000

Disclaimer

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

Acknowledgment

The development of the training program was guided by members of the Domestic and Family Violence Expert Advisory Group in 2016, and revisions to the program were guided by an Evaluation Reference Group in 2019. The Department of Health acknowledges members' commitment to the development of a health workforce in Queensland that responds safely and appropriately to suspicions and disclosures of domestic and family violence and extends its appreciation for the time and expertise provided.

Cultural acknowledgement

We acknowledge Aboriginal and Torres Strait Islander people as the Traditional Custodians of this country, and their continuing connection to land, wind, water and community. We pay our respects to their cultures and to elders past, present and future of Queensland.

Warning

Aboriginal and Torres Strait Islander viewers are warned that the following information may link to or contain images and voices of deceased persons.

Contents

Policy context—why are we delivering this training?	1
Queensland	2
Introduction	3
Aim	3
Prerequisites	3
Preparing for the training session	3
Topics, key messages and facilitator notes	4–15
Clinical scenarios	16–20
Maternity	16
Emergency	16
Non-lethal strangulation in DFV	17
Ante-natal screening for DFV	17
Mental health	18
Alcohol and other drugs	18
Aboriginal and Torres Strait Islander health	19
Multicultural health	19
Primary health care setting	20
<i>Clinical Response to Domestic and Family Violence</i> training session plan	22
Pre and post training evaluation questionnaire	24





Policy context —why are we delivering this training?

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 DFV 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.



Queensland

The Taskforce on Domestic and Family Violence in Queensland was established to examine Queensland's DFV support systems and make recommendations to government 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 was delivered to the Premier. The Queensland Government responded to the *Not Now Not Ever* report by supporting or accepting all recommendations and in October 2019 all of these recommendations had been implemented.

The Queensland Government maintains a firm commitment to ending DFV. The [Domestic and Family Violence Prevention Strategy 2016–2026](#) (the Strategy) and action plans outline a shared vision and approach to furthering change across government and the community. Reform work outlined in the Strategy and its action plans incorporate a range of activities that build on *Not Now Not Ever* recommendations.

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.

The Strategy focuses on:

- educating frontline professionals to help them recognise and respond to DFV
- 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* training sessions. The length of the training session will be determined by the facilitator depending on the knowledge and skill of each group.

A **training facilitator** should have knowledge and expertise on the topic of DFV, and in facilitating groups.

Training participants may include social workers, nurses, midwives, medical officers, clinical educators and clinicians from a range of clinical areas including maternity, emergency, mental health, paediatrics, child health, women's health, sexual health, Aboriginal and Torres Strait Islander and multicultural health services across the public, private and primary health sectors.

Aim

The aim of the *Clinical response to Domestic and Family Violence* training program is to build on participants' existing knowledge and skills so as to increase their confidence in responding safely and appropriately to suspicions and disclosures of DFV in healthcare settings.

The aim of this Facilitator's Guide is to provide training materials to support facilitators to design and deliver DFV training and information sessions for clinicians in their hospitals and health services.

Prerequisites

Training 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 facilitating a DFV training session, facilitators must have completed both eLearning modules [Understanding Domestic and Family Violence](#) and [Clinical Response to Domestic and Family Violence](#).

Preparing for the training session

This Facilitator's Guide contains suggested topics for discussion, key messages and facilitator notes, suggested activities, a PowerPoint, handouts, a DFV training session plan and pre and post training evaluation tool.

- It is the role of the facilitator to guide the training 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.
- DFV is a complex and sensitive topic. It is essential the facilitator is confident in their knowledge of DFV and experienced in facilitating group sessions.
- Identify your local DFV support services and other resources available in your local community.
- Invite a member of the local DFV service team to participate in the delivery of the training session.
- Invite a person with lived experience of DFV 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 their employee assistance program (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.
- Ask if 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 Response to Domestic and Family Violence online module](#).
- The scenarios and role plays used will reflect the nature of the presentations to different clinical areas.

Topics, key messages and facilitator notes

1. Introduction to the day

Establishing the ground rules.

- Welcome to the *Clinical Response to Domestic and Family Violence* training session.
- The aim of today's session is to:
 - Develop your knowledge, skills and practice in DFV, including responding safely and appropriately to suspicions and disclosures of DFV.
 - Increase your confidence in delivering training to clinical staff in sensitively asking questions about DFV.
- Acknowledge that some participants will have personal or professional experience with DFV and that self-care in this case is important.



2. Supporting an employee experiencing DFV

Everyone deserves to be safe and supported in the workplace.

- 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 DFV.
- All Queensland Government public service employees affected by DFV can access support options, including a minimum of 10 days paid leave, counselling from EAP, flexible work arrangements, and workplace and role adjustments where appropriate.
- Queensland public sector employees can increase their understanding of DFV and how to support colleagues affected by DFV by completing the online Recognise, Respond, Refer program. For Queensland Health employees this training is available on [Training | Domestic and family violence | Human Resources | Department of Health](#).
- The Department of Health also provides training to all departmental managers to guide their approach to supporting employees who have experienced DFV.
- Private health sector employees can increase their understanding of DFV and how to support colleagues affected by DFV by completing the online Recognise, Respond, Refer program available at [Workplace Learning Solutions—Challenge DV](#).



3. Reflective practice

Responding appropriately and effectively in diverse contexts often means addressing one's own attitudes, knowledge and actions as a learning process.

- 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, beliefs and cultures to their analysis of DFV issues.¹
- 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.²
- Seeking clinical advice from a team leader and/or DFV specialist within the health facility, such as a clinical area social worker, can assist in ensuring your response is appropriate.

1. [Strengthening Hospital Responses to Family Violence \(SHRFV\) Tool Kit | The Royal Women's Hospital \(thewomens.org.au\)](#)

2. [Strengthening Hospital Responses to Family Violence \(SHRFV\) Tool Kit | The Royal Women's Hospital \(thewomens.org.au\)](#)

3. [Strengthening Hospital Responses to Family Violence \(SHRFV\) Tool Kit | The Royal Women's Hospital \(thewomens.org.au\)](#)

4. Roles and responsibilities

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

- Professional competency standards, code of conduct and scope of practice are discussed in the Understanding Domestic and Family Violence online learning module and booklet.
- It is important to know that your role as a health professional is to ask about DFV in a way that facilitates disclosures, in a private discussion, in a sensitive manner and in an environment where the person feels safe.³ 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 DFV such as social workers, psychologists, specialist DFV services and workers who are trained to undertake risk assessments 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](#) to understand your responsibilities in identifying and responding to the particular needs of pregnant women at risk or experiencing DFV.
- You may have a responsibility to report reasonable suspicions of child abuse and neglect to Child Safety Services. For more information and guidance regarding health workers' child protection responsibilities, contact the Child Protection Unit in your hospital or go to [Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People \(health.qld.gov.au\)](#)

Topics, key messages and facilitator notes

5. Definition

Several definitions of DFV 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.⁴ This ongoing pattern of behaviour may include a range of tactics that may be criminal and non-criminal in nature.
- “DFV 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 DFV, it is important to acknowledge that the rate of DFV perpetrated against women is significantly higher than it is against men.”⁵

Suggested activity:

- Ask the participants to break into small groups to develop their own definition of DFV. Ask each group to share the definition they developed.
- Emphasise to the group that definitions should highlight the inequity in power and control that occurs in an abusive relationship.⁶
- Ensure the group understands the feeling of fear experienced by the victim of DFV.
- Discuss the definitions provided.

6. Legislation

- The [Domestic and Family Violence Protection Act 2012](#) (the Act) defines DFV as behaviour that is physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive or aimed at controlling or dominating another person through fear. The Act says that DFV occurs when one person in an intimate, family or informal care relationship uses these forms of violence, power and control over the other person.
- Section 315A of the [Criminal Code 1899](#) defines non-lethal strangulation in DFV 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 DFV may share information without consent. Whilst seeking consent to release client information is always preferable, Section 5A of the Act enables some agencies to share information without consent for the purpose of assessment or management of a serious DFV threat.

7. 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.⁷
- 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](#).

8. Clinical Response to DFV online module

Recap of key messages.

- 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.

4. DVConnect womensline [What is Domestic Violence for women—DVConnect](#)

5. NOT NOW, NOT EVER—Putting an End to Domestic and Family Violence in Queensland

6. Baird, K. Price, S. Salmon, D. (2005), Bristol Pregnancy and Domestic Violence Programme Training Pack, University of the West of England.

7. Baird, K. Price, S. Salmon, D. (2005), Bristol Pregnancy and Domestic Violence Programme Training Pack, University of the West of England.

9. Complexities of DFV

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.

- People with disability experience more violence in intimate, family, informal and formal caring relationships than any other population group. Where there are relationships of dependency, people with disability can experience unique kinds of DFV e.g. withholding food, stimulation or medication or damage to mobility devices. People with disabilities also experience unique forms of discrimination. Regardless of their cognitive function, people with disability report being less likely to be asked about their experiences, less likely to be believed when they disclose abuse, that their choices are less likely to be respected and their needs less likely to be understood.
- First Nations people and communities experience disproportionately high levels of family violence. These elevated levels of violence are known to be one part of the interdependent impacts of colonisation which can include intergenerational trauma, grief and loss, poverty, and subsequent mental health issues and drug and alcohol use.
- Because of a history of unjust policies, First Nations people may be distrustful of mainstream services and systems. Alternatively, they may also have confidentiality concerns when accessing Aboriginal and Torres Strait Islander-specific services. For those living in regional and remote areas there may be limited services and family members may not wish to move away from country and/or community to escape violence.
- In making sense of higher rates of violence in some First Nations communities, Aboriginal and Torres Strait Islander scholars have highlighted the concept of lateral violence. Lateral violence refers to the ways in which people and communities who are in positions of powerlessness direct their feelings of frustration, anger and fear inwardly to each other and themselves, and onto those less powerful.⁸ Family violence may be a manifestation of lateral violence within and beyond First Nations communities.

- Women from culturally and linguistically diverse (CALD) backgrounds are particularly vulnerable to DFV. This can be a result of social isolation, language barriers, a lack of knowledge regarding the service system and community stigma related to family breakdown. People from CALD backgrounds may avoid sharing their experiences for fear that it will impact their immigration status. Regardless of a person's cultural beliefs and practices, DFV is never okay.
- Research shows that same-sex attracted people suffer violence in their intimate relationships at around the same rates as those in heterosexual relationships. Lesbian, gay, bisexual, trans, intersex and queer people may have experienced homophobia, transphobia and heterosexism when accessing mainstream services, and may have genuine concerns that their experiences of DFV will be seen as less valid and that their experiences and support needs will not be understood.

Suggested activity:

Ask participants to break into small group and identify how inequality impacts people's vulnerability to and experience of DFV.



8. Cripps & Adams, 2014.

Topics, key messages and facilitator notes

10. DFV affects health

DFV 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 DFV 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.
- DFV often commences or intensifies during pregnancy and is associated with increased rates of miscarriage, low birth weight, premature birth, foetal injury and foetal death. DFV 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?

11. Some people wonder “Why doesn’t she leave the relationship?”

Women experiencing DFV 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 push a woman to leave an abusive relationship as this may lead to an increased risk of violence. For women who are experiencing DFV 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 identify and discuss the many issues impacting women’s ability to leave abusive relationships.
- Some examples might include:
 - fear
 - stigma
 - unaware of how to get help
 - lack of family support.



12. Power, vulnerability and DFV

Recognising the disproportionate rates of DFV against women, First Nations people, people with disability and women from CALD backgrounds enables health professionals to correctly characterise the problem as one that relates to a lack of power to access appropriate information, support and services.

- Children are among the least powerful and the most vulnerable to the impacts of DFV.
- Health services may be one of the few service systems regularly accessed by people experiencing DFV and women identified health care providers as the professionals that they would most trust with a disclosure of abuse.
- This means that health services are a critical part of the DFV service system, and knowledgeable and skilled clinicians and workers are essential.

Suggested activity:

Watch a relevant online video or select from the following:

- [CALD Women's Club \(with captions\)—YouTube](#)
- Seven short films for disability workers: [Responding to Abuse—National Disability Services \(nds.org.au\)](#)
- [Children as victims of domestic violence —YouTube](#)

13. How DFV affects children

Children exposed to DFV 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 DFV and child abuse and neglect. Health professionals involved in working with families must accept their child protection reporting responsibilities in addressing DFV 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 DFV.
- 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.
- For more information and guidance regarding health workers' child protection responsibilities contact the Child Protection Unit in your hospital or go to [Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People \(health.qld.gov.au\)](#)

Topics, key messages and facilitator notes

14. Responding to diversity and complexity

Many people face barriers to accessing information, services and legal protections and these barriers put them at a greater risk of experiencing DFV. They may require different or additional support.

- First Nations people may be distrustful of mainstream services and systems. Providing a safe cultural space in which to share their experiences is key. A consultation room/office is often not a welcoming or safe environment, but it may be the only place where First Nations people feel they can talk confidentially and free from harm from the perpetrator. Spaces can be made more culturally welcoming through the use of artwork, flags, culturally identifiable uniforms and other culturally appropriate resources.
- Consider consulting with an Aboriginal and Torres Strait Islander Health Liaison Officer or another cultural capability champion in your Hospital and Health Service who has knowledge about local cultural protocols and practices and whose knowledge will support you to respond in a culturally safe and appropriate manner. Be mindful that communities are often small and there may be confidentiality concerns, so do not share the client's details unless they have provided consent.
- Ask the client if they would prefer to talk to an Aboriginal and Torres Strait Islander clinician, health worker or service and respect the client's wishes.
- All Hospital and Health Services provide training for staff as part of their Aboriginal and Torres Strait Islander Cultural Practice Program. Queensland Health staff will find a range of relevant cultural capability contacts and resources though searching 'cultural capability resources' on QHEPS (QH intranet).
- People with disability experience high levels of violence from family members and carers, that may not be immediately noticeable such as withholding mobility aids, food, medication or stimulation. Health clinicians should be mindful of how people with disability's unique experiences of DFV intersect with their experiences of marginalisation and discrimination.
- If you suspect violence or abuse against a client with disability, ask the client directly and/or refer them to a social worker or a DFV specialist worker to ensure their needs are fully assessed. If a person with disability has particularly complex needs, contact your Hospital and Health Service allied health department and/or refer the client to a nurse navigator. Follow up may be required.
- Rather than rely on carers to facilitate communication with people requiring communication support, prepare yourself in advance by contacting your Hospital and Health Interpreter Service Coordinator to find out how to access disability interpreting services.
- Women from CALD backgrounds are more likely than other women to experience marginalisation, social isolation and a lack of access to services, making them more vulnerable to DFV.
- If language assistance is required always use professional interpreters, never rely on family members or children for interpreting when discussing issues relating to DFV.
- Do not assume that a client will want an interpreter. Victims may have concerns regarding confidentiality and their safety and may wish to share their experiences without an interpreter.
- If an interpreter is necessary or requested, engage an interpreter who is not known to the family or the community. Cultural communities can be small even in urban environments so the use of a telephone interpreter from elsewhere in Australia is recommended. Prepare yourself in advance by contacting your Hospital and Health Interpreter Service Coordinator to find out how to access language interpreting services.

15. Perpetrator risk factors and clinical response

Perpetrators of DFV 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.
- **The safety of victims and their children is paramount** and health clinicians should be careful not to engage with perpetrators in ways that increase the risk of DFV.
 - Never breach the confidentiality of victims and their children to the perpetrator.
 - Only engage with a perpetrator about his behaviour if he discloses his DFV, or if you have an ongoing relationship or trust.
 - Do not confront perpetrators in an accusatory manner or in a way that will shame or anger them.
 - Do not collude with the perpetrator in attempts to minimise, excuse or justify the violence, or blame the victim.
- Maintain the focus on perpetrator behaviour and on how violent behaviour impacts on family members.⁹
- Refer to services that will support positive behaviour change and that will increase victim safety. With consent, you can refer to one of a number of perpetrator programs available in Queensland. These can be accessed via the Queensland Government's DFV portal.

16. Trauma-sensitive care in tertiary healthcare settings

Trauma-sensitive care involves engaging with clients in a way that directly contradicts experiences of violence i.e. in ways that increase their feelings of safety, respect and control.

Suggested activity:

- Discuss some of the practices of trauma-sensitive care.
- Remind participants that these practice approaches can be applied to all clinical settings and contexts.
- A supportive, trauma-sensitive 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.¹⁰
- Taking time—feeling that 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.¹¹
- 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.¹²

Suggested activity:

- As a larger group consider a brain storming exercise, asking participants about how they would feel sharing personal matters e.g. relationship problems. How would they 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.).

9. Safe and Equal: [Safe and Equal | Standing strong against family violence](#)

10. [Strengthening Hospital Responses to Family Violence \(SHRFV\) Tool Kit | The Royal Women's Hospital \(thewomens.org.au\)](#)

11. [Strengthening Hospital Responses to Family Violence \(SHRFV\) Tool Kit | The Royal Women's Hospital \(thewomens.org.au\)](#)

12. [Strengthening Hospital Responses to Family Violence \(SHRFV\) Tool Kit | The Royal Women's Hospital \(thewomens.org.au\)](#)



Topics, key messages and facilitator notes

17. Six steps to ‘sensitive inquiry’

This sensitive inquiry model provides guidance for clinicians on how to identify and respond to DFV.

- Health professionals can reduce the barriers for victims/survivors through receiving appropriate training and education in sensitive inquiry and appropriately responding to DFV.
1. Identification.
 2. Supportive response.
 3. Consider risk and safety.
 4. Actions for safety.
 5. Referral support.
 6. Documentation.

18. Step 1—Identification

DFV can be identified through client disclosure, recognising indicators, recognising risk factors or routine screening for DFV.

- Identification of DFV through recognising high risk groups, risk factors and health indicators is key to initiating conversation about DFV with a client.
- If a clinician suspects DFV, 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 DFV 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 DFV generally want to be asked about their experiences, and are more likely to make a disclosure.

Suggested activity:

- In small groups identify risk factors and indicators of DFV.
- Review with the group the list of risk factors or indicators of DFV.

19. 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 DFV:
 - “DFV is a health issue that we ask about routinely”
 - “As we know, DFV 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 DFV 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 DFV. It is important to practice asking the questions about DFV so you feel comfortable asking clients these questions. In pairs take turns to play the part of the clinician and the client:
 - Ask a client about their experience of DFV.
 - 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.

Topics, key messages and facilitator notes

20. Step 3—Consider risks and safety

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

- When screening for 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 DFV service can assist through performing a comprehensive risk assessment and provision of ongoing care and intervention.
- Risk screening is important to identify immediate risk including risk of homicide, suicide or self-harm and risk to their children.
- Risk assessments should be conducted by people with specialist training (e.g. social workers and specialist DFV workers) 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 DFV service. In this case you should refer to a DFV expert within your clinical area or telephone advice from a specialist DFV service e.g. DVConnect (1800 811 811).
- The [Domestic and Family Violence Protection Act 2012](#) allows for some client information to be shared without consent between some agencies if it will support assessment and management of a serious DFV threat. For an overview of the circumstances under which health workers and clinicians may share information, see the [Information Sharing for Domestic and Family Violence Factsheet](#) and [Flowchart](#).

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.
- Share their feedback with 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 victim to go to and how they 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 DFV specialist services and contact arrangements for DVConnect, the local/regional DFV service and police contacts both in and after hours.

23. Step 6—Documentation

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

- What should health professionals include when documenting an awareness or disclosure of DFV?
- 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 a 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 DFV, 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 young mother. Her children are aged three and five. Although not married, she has been living with her partner for five years. She is presently 32 weeks pregnant. Sonia arrives on birthing suite via her GP with unexplained abdominal pain. 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. 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 five 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 long standing 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.

Ante-natal screening for DFV

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 DFV 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, 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 a domestic violence order 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.

Clinical scenarios

Mental health

Scenario 1

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 teary, 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

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 health

Scenario 1

A 35-year-old woman lives with her 16-year-old son and three younger children. Her son 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 Aboriginal and Torres Strait Islander medical service. He reports to the nurse that he is hearing voices and advises the nurse that the voices are telling him to hurt his mum and then kill himself.

The nurse is a friend of his mother and 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 Aboriginal woman rings DVConnect wanting assistance to go to a domestic violence shelter but is requesting a shelter with Aboriginal and Torres Strait Islander workers.

DVConnect advises the woman that there are currently no vacancies in Aboriginal and Torres Strait Islander shelters. Michelle does not wish to go to a mainstream shelter.

Michelle has disclosed to the worker that her partner physically and sexually assaulted her last night and that his sister is threatening to further assault her if she goes to the police.

Multicultural health

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 nurse 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 in Queensland, having come from interstate where she lived for four 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.

Clinical scenarios

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 DFV 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.







***Clinical Response to Domestic and Family Violence* training session plan**

Following completion of the training program, participants may be confident to deliver all or parts of the *Clinical Response to Domestic and Family Violence* face to face training session to clinicians working in their clinical area.

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 DFV.

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

Learning outcomes

Through delivery of the DFV training, participants will:

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

Prerequisite

The prerequisite for attending the face-to-face training is completion of the [Clinical Response to Domestic and Family Violence online training module](#).

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 DFV 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 [Understanding Domestic and Family Violence](#) and [Clinical Response to Domestic and Family Violence](#) online learning modules, and the face-to-face *Clinical Response to Domestic and Family Violence* training session.
- The face to face training is conducted in partnership with the local specialist DFV service.
- The DFV training will be supported by PowerPoint 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.
- DFV is a complex and sensitive topic, therefore it is essential the trainer is confident in their knowledge of DFV and experienced in facilitating group sessions.
- Identify your local DFV support services and other resources available in your local community.
- Invite a member of the local DFV 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 their 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 used, and the role plays will reflect the nature of the presentations to each specific clinical area.

Pre and post training evaluation questionnaire

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 (DFV) 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 DFV?

- ☐ No
- ☐ Yes

If yes, please list the training below:

How frequently do you interact with victims, survivors or perpetrators of DFV in your day to day activities?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Regularly
- ☐ Every day

