



**UNDERSTANDING**  
DOMESTIC AND FAMILY  
**VIOLENCE**

# UNDERSTANDING DOMESTIC AND FAMILY VIOLENCE



## Understanding Domestic and Family Violence

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# Introduction to the toolkit of resources

The health system is often a first point of contact for individuals who have experienced domestic and family violence. Queensland Health has developed a toolkit of resources to assist health employees to respond appropriately in their role as a healthcare provider. Resources include a series of online learning modules:

- **Understanding Domestic and Family Violence**—information for all health service employees both clinical and non-clinical in public and private health facilities to respond appropriately to disclosure of domestic and family violence.
- **Clinical Response to Domestic and Family Violence**—designed to assist clinicians working in key clinical areas to identify domestic and family violence through a sensitive inquiry model and to respond appropriately.

This booklet has been developed to support the Understanding Domestic and Family Violence online module.

It is important to understand that domestic and family violence affects individuals across all socioeconomic, social and cultural groups. Therefore, it is recognised that health service employees may also experience domestic and family violence in their own lives, which may impact on their ‘safety, wellbeing, attendance and performance at work’.<sup>1</sup>

All health service employees are encouraged to complete the Recognise Respond Refer: Domestic violence and the workplace online learning module to enable them to recognise and respond to a colleague affected by domestic and family violence in the workplace.

Accessible to public health employees through <http://qheps.health.qld.gov.au/hr/staff-health-wellbeing/domestic-family-violence/home.htm>

Accessible to private health employees through registering with Australia’s CEO Challenge <http://ceochallengeaustralia.org/>

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1. Department of Health: Human Resources Policy C73 – Support for employees affected by domestic and family violence (2016).



# ‘Understanding Domestic and Family Violence’ booklet

## Target group

The Understanding Domestic and Family Violence booklet is available to all health service employees, clinical and non-clinical, working in the public and private health sectors.

## Aim

### This booklet aims to:

- Raise awareness and understanding of domestic and family violence (DFV) for health service employees.
- Provide information on how to recognise domestic and family violence, and respond to a disclosure of domestic and family violence sensitively and in a way that ensures people's safety.<sup>2</sup>

## Self-care

It is possible that the contents of this booklet may cause some health service employees to feel uneasy and trigger personal experiences, reactions and feelings. If this is the case you should seek assistance from the Employee Assistance Program (EAP), if available, or a general practitioner, professional counsellor or applicable specialist service.

2. NICE Pathways Domestic violence and abuse overview (2016).

## Roles and responsibilities

There are a number of key services who may respond to a domestic and family violence incident in the community. The Queensland Police Service and the Queensland Ambulance Service are most likely to be first responders.

There are a variety of roles that support a health service; both clinical and non-clinical.

As a health service employee you may become aware of an incident or disclosure of domestic and family violence and you will need to know how to respond in the most appropriate way.

All clinical staff within their discipline have their own professional competency standards, codes of ethical behaviour and conduct. You should access these resources and consider the ways in which they influence and guide your professional response to domestic and family violence incidents.

### All health service employees are responsible for:

- working within their scope of practice
- being aware of and complying with legislation, local clinical pathways, guidelines and procedures in relation to domestic and family violence
- responding appropriately to disclosures of domestic and family violence
- comprehensively and accurately documenting all issues considered and discussed in association with a disclosure of domestic and family violence including:
  - » when and to whom the case has been reported
  - » decisions made and the basis for decisions
  - » actions taken including responses, referrals and any information shared with other agencies regarding the individuals affected
  - » all subsequent contact and communication with specialist domestic and family violence services/providers or the Queensland Police Service.

## Policy context

*The National Plan to Reduce Violence against Women and their Children 2010–2022* (National Plan) sets out a number of action plans of which Queensland will contribute. The National Plan indicates that victims of domestic and family violence are more likely to disclose an experience of domestic and family violence to a health professional. The way in which they respond to the disclosure is critical to the victim's safety and support.

On 28 February 2015, the Honourable Quentin Bryce AD CVO presented the Taskforce report, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* to the Premier of Queensland, the Honourable Anastacia Palaszczuk MP. The Taskforce report contains 140 recommendations for change with a focus on providing practical solutions under three themes:

- changing culture and attitudes
- implementing integrated service responses
- improving the law and justice system.

Many of the recommendations of the Taskforce report focus on the need for training of specialist and generalist staff, particularly those in frontline positions. The Government appreciates the need for quality and consistent training in recognising or identifying domestic and family violence and building capacity to respond in appropriate and safe ways.



# Definition of domestic and family violence and other terms

## **There is no single national or internationally agreed definition of family or domestic violence.<sup>3</sup>**

As explained in the *Queensland Domestic and Family Violence Protection Act 2012*, domestic violence means behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a relevant relationship that—

- is physically or sexually abusive
- is emotionally or psychologically abusive
- is economically abusive
- is threatening
- is coercive
- in any other way controls or dominates the second person and causes the second person to fear for the second person's safety or wellbeing or that of someone else.

The contemporary understanding of domestic violence is a person being subjected to an ongoing pattern of abusive behaviour by an intimate partner or family member. This behaviour is motivated by a desire to dominate, control or oppress the other person and to cause fear. It includes behaviour that is physically, sexually, emotionally, psychologically or economically abusive; threatening or coercive; or any other way controls or dominates another person causing fear.<sup>4</sup>

The World Health Organization (WHO) has provided guidance for the health sector through development of guidelines to support prevention and response to all forms of violence against women. Domestic and family violence and violence against women is a violation of human rights and is unacceptable in any form.<sup>5</sup>

Violence may occur in all kinds of families and in family relationships extending beyond intimate partners, parents, siblings and blood relatives. It includes violence perpetrated by extended family members, same sex partner, or from a carer towards the person they are looking after.<sup>6</sup>

Cultural groups may have a different interpretation of who is considered 'family'. Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) populations may have definitions of 'family' that extend to relationships within extended families, kinship networks and communities.<sup>7</sup>

In some circumstances, domestic and family violence is a crime in which the Queensland Police Service and courts will be involved. Domestic and family violence affects the whole community and the workplace.

3. <http://www.relationships.org.au/what-we-do/research/online-survey/january-2015-domestic-violence>

4. <https://www.communities.qld.gov.au/communityservices/violence-prevention/domestic-family-violence-protection-act-2012>

5. WHO clinical and policy guidelines: Responding to intimate partner violence and sexual violence against women (2013)

6. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit  
<http://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>

7. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit  
<http://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>

# Additional definitions

<b>Victim</b>	noun: a person harmed, injured, or killed as a result of a crime, accident, or other event or action.	
<b>Survivor</b>	noun: a person who survives, especially a person remaining alive after an event in which others have died.	
<b>Perpetrator</b>	noun: a person who carries out a harmful, illegal or immoral act.	
<b>Disclosure</b>	any occasion when an adult or child who has experienced or perpetrated domestic and family violence informs a health employee or any other third party.	
<b>Relevant relationships<sup>8</sup></b>	<p>Includes intimate personal relationships, family relationships and informal care relationships.</p> <p><b>Intimate partner relationships</b></p> <p>Intimate partner relationship include couples where the two people are of the opposite or same gender, people who are engaged, in a de facto relationship or who are married. They include people who are separated or divorced, who have a child together, and include people who are living together or have previously lived together as a couple. People who are or were engaged to be married including a betrothal under cultural or religious tradition are also covered. It can include people who haven't lived together in some circumstances, including people under the age of 18.</p> <p>A court will consider each relationship on a case-by-case basis to see if an intimate partner relationship exists. To assist the court to decide if such a relationship exists, it may look at how long the couple have been together, how often the couple see each other or how dependent on or committed the couple are to each other.</p>	<p><b>Family relationships</b></p> <p>Family relationships exist between two people who are related by either blood or marriage, including:</p> <ul style="list-style-type: none"><li>• a spouse</li><li>• a child</li><li>• a parent</li><li>• a sibling</li><li>• a grandparent</li><li>• an aunt or uncle</li><li>• a cousin</li><li>• a step-relative</li><li>• half-relatives</li><li>• in-laws.</li></ul> <p>Children under the age of 18 cannot access protection in these categories of relationships. For some cultural groups, for example Aboriginal and Torres Strait Islander people, a wider group of people may be considered as family and may be recognised under the <i>Domestic and Family Violence Protection Act 2012</i>.</p> <p><b>Informal care relationships</b></p> <p>Informal care relationships exist where one person is dependent on another person for help with essential daily tasks, such as dressing or grooming, meal preparation, grocery shopping or arranging medical care. This does not include help provided by a paid person but where the care is provided without payment. A person receiving a carer's payment from the government is <u>not</u> a paid carer and can be part of an informal care relationship.</p>

8. <https://www.communities.qld.gov.au/communityservices/violence-prevention/domestic-and-family-violence-protection-act-2012>



# Prevalence and statistics

Domestic and family violence is a social issue that has health implications. Domestic and family violence affects the mental health and physical health of men, women and children.<sup>9</sup>

In Australia, women with a current or previous experience of domestic and family violence more frequently attend both primary health care facilities and hospitals and are at higher risk of disability, illness and death.<sup>10</sup>

Most men are not violent however the majority of violence involves men; including male to male violence as well as male to female violence. It is unusual to see a case of severe female to male violence; when it does occur the same response should be provided to the victim/survivor.<sup>11</sup>

## Statistics collected from a number of sources provide an overview of the prevalence of domestic and family violence in Australia and Queensland:

- **Since the age of 15:**<sup>12</sup>
  - » 1 in 6 Australian women have experienced physical or sexual violence from a current or former partner, compared to 1 in 19 Australian men.
  - » 1 in 5 women have experienced sexual abuse compared to 1 in 22 Australian men.
  - » 1 in 4 Australian women has experienced emotional abuse from a current or former partner, compared to 1 in 7 Australian men.
- **Women are at greater risk of violence from intimate partners during pregnancy, or after separation.**
- **\$2.7–\$3.2 billion is the estimated annual cost of domestic and family violence to the Queensland economy.**
- **In 2013–14**<sup>13</sup>
  - » 66,016 incidents of domestic and family violence were reported to the Queensland Police Service.
  - » 17 homicides relating to domestic and family violence occurred in Queensland.
- **In 2014–15**<sup>14</sup>
  - » 71,775 incidents of domestic and family violence were reported to the Queensland Police Service.
  - » 29 homicides relating to domestic and family violence occurred in Queensland.

Although numbers of reported incidents of domestic and family violence have been increasing in Queensland, it must be acknowledged that the data does not come close to representing the true extent of the problem.<sup>15</sup>

Many incidents of domestic and family violence go unreported, largely because of the private nature of the relationships within which violence occurs. Australian women are most likely to experience physical and sexual violence in their home, at the hands of a current or ex male partner.<sup>16</sup>

Incidence is significantly higher for Indigenous women who are almost 35 times more likely to be hospitalised for spouse/ domestic partner assaults than members of the general female population.<sup>17</sup>

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9. BMJ August 2008; 337: a839 - Violence between intimate partners: working with the whole family
  10. BMJ August 2008; 337: a839 - Violence between intimate partners: working with the whole family
  11. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>
  12. Australian Bureau of Statistics (ABS), 'Actions Taken in Response to Partner Violence', Personal Safety, Australia, 2012, cat. no. 4906.0, ABS, Canberra, 2013
  13. NOT NOW, NOT EVER—Putting an End to Domestic and Family Violence in Queensland
  14. Domestic and Family Violence Prevention Strategy 2016–2026
  15. NOT NOW, NOT EVER—Putting an End to Domestic and Family Violence in Queensland
  16. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>
  17. Steering Committee for the Review of Government Service Provision: Overcoming Indigenous Disadvantage, Key Indicators 2014, Overview.

# Common myths and attitudes

Attitudes of the community may reinforce and excuse domestic and family violence. Victim blaming is common and shifts the focus from perpetrator accountability. Often the focus is on what the victim/survivor does or doesn't do rather than questioning the perpetrators violent behaviour. For example, expecting that a woman leave an abusive relationship assumes that women choose to stay and this continues to remove accountability from the perpetrator. Leaving the relationship is the most dangerous time and there are a range of psychological and practical things that need to be put in place for victims/survivors to be able to leave safely.<sup>18</sup>

Attitudes about gender roles and behaviours are often learnt and reinforced in the early years and may influence how individuals view and respond to incidents of domestic and family violence. Some commonly held attitudes, for example:

- boys don't cry
- boys will be boys
- pink for girls, blue for boys
- woman's work
- men should make decisions and take control in relationships.

There is often a misconception that a person's social status; for example, level of education, race or socio-economic status are a determinant to domestic and family violence.

**There is no discrimination with domestic and family violence it can occur across all areas of the community.**



<sup>18</sup>. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit  
<https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>



# Recognising

Domestic and family violence can affect any person regardless of gender, age, socioeconomic 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 reported rate of domestic and family violence perpetrated against women is significantly higher than it is against men. The vast majority of perpetrators of all violence are men. About 80 per cent of all violent assaults (including sexual) are carried out by men against other men and women.<sup>19</sup>

Women from particular groups in the Australian community are at higher risk from domestic and family violence and its effects, and can face barriers in accessing support and legal protection. They include:

- Aboriginal and Torres Strait Islander women
- Women with disabilities
- Older women
- Women from culturally and linguistically diverse (CALD) backgrounds
- Lesbian, gay, bisexual, transgender, intersex (LGBTI).

19. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>

## Risk factors

The following risk factors may indicate a person is at higher risk of experiencing or perpetrating domestic and family violence.

### Risk factors for victims

- Pregnancy and the postnatal period
- Mental health issues
- Substance abuse
- Isolation

### Relationship risk factors

- Recent separation or plans to separate
- Financial hardship or stress
- Escalation in severity and frequency of violence

### Perpetrator risk factors

- Threats to kill
- Use of non-lethal strangulation/choking
- Access to/use of weapons
- Substance abuse
- Stalking
- Sexual violence
- Threats or direct harm to children
- Suicidality
- Threats or harm to animals and pets
- Breach of intervention order
- Jealous, controlling behaviour
- History of violence

## Types of abuse and violence

Domestic and family violence is described as a pattern of abusive behaviour in any relationship that is used by one person to gain or maintain power and control over another intimate partner, this abuse and violence can take many forms. Violence can be severe and leave obvious injuries, but some victims may be subject to more subtle abuse that may not leave physical injuries. Abuse and violence may be any of the following.<sup>20</sup>

### Physical abuse

Injuries from physical abuse may range from minor trauma to broken bones and lacerations, head injuries and injuries to internal organs. Non-lethal strangulation can be particularly dangerous as it may indicate a dangerous escalation in violent behaviour, and can cause serious damage to the structures in the neck and throat with no/few external signs of injury. For many victims, the abuse occurs regularly. Some are threatened with weapons, such as knives, or household items such as a hot iron, cigarettes or a length of rubber hose. Physical abuse can take many forms such as smashing property, or killing or hurting family pets.

### Emotional abuse

Emotional abuse may include subtle or overt verbal abuse, humiliation, threats or any behaviour aimed at scaring or terrorising the person experiencing the abuse. The victim may lose their confidence, self-esteem or self-determination. Emotional abuse can take many forms including threats of suicide, extreme jealousy and stalking or harassment at work or through the use of technology.

### Economic abuse

Restricting access to money and essential needs, fraudulently using another's money for personal gain, or stealing from the victim; the illegal taking, misuse, or concealment of funds, property or assets is economic abuse.

### Social abuse

Isolating the victim from family and friends, and other contacts in the community.

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20. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)



## Elder abuse

Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. It can be physical, emotional, financial, and sexual or neglect.<sup>21</sup> Older people may face barriers to seeking help for elder abuse including physical disability, diminished cognitive function and lack of awareness that their experiences amount to abuse.<sup>22</sup>

## Adult sexual assault

Adult sexual assault involves any type of sexual activity to which there is no consent. This may or may not involve penetration or physical contact with the victim (for example, exposure). It is important to note that people with disability or the elderly may not have consented, or they may have lost their ability to consent (for example, those with dementia).

## Child sexual abuse

For children, sexual abuse may involve forcing or enticing them to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. The abuse may include non-contact activities such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

## Neglect

Neglect is the persistent failure to meet the basic physical and/or psychological needs of a person for whom you are caring, such as failing to protect from physical harm or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, the other person's basic emotional needs.

21. <https://www.qld.gov.au/seniors/safety-protection/what-elder-abuse/index.html>

22. Domestic and Family Violence Prevention Strategy 2016–2026

# Indicators in adults<sup>23 24</sup>

The following indicators are associated with victims/survivors of domestic and family violence and may be signs for identification during a health service presentation.

## Physical

- Unexplained bruising and other injuries (especially to head and neck)
- Bruises at various stages of healing
- Injuries on parts of the body hidden from view (including breasts, abdomen and/or genitals), especially if pregnant
- Injuries sustained do not fit the history given
- Accidents' occurring during pregnancy
- Miscarriages and other pregnancy complications
- Petechiae in the eyes and on the skin on or above the neck along with sore throat and/or difficulty breathing are some of the common signs and symptoms of non-lethal strangulation

## Psychological/behavioural

- Emotional distress e.g. anxiety, indecisiveness, confusion, and hostility
- Multiple presentations at the surgery
- Sleeping and eating disorders
- Partner does most of the talking and insists on remaining with the patient
- Anxiety/depression/pre-natal depression
- Seeming anxious in the presence of the partner
- Psychosomatic and emotional complaints
- Reluctance to follow advice
- Self-harm or suicide attempts
- Social isolation/no access to transport
- Submissive behaviour/low self esteem
- Drug and alcohol abuse

**Note: This list of indicators is not exhaustive.**

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23. Australian Medical Association: Supporting Patients Experiencing Family Violence, a resources for medical practitioners (2015)

24. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)



# Indicators in children<sup>23 24</sup>

The following indicators are associated with victims/survivors of domestic and family violence and may be signs for identification during a health service presentation.

## Physical

- Difficulty eating/sleeping
- Physical complaints
- Slow weight gain (in infants)
- Eating disorders

## Psychological/behavioural

- Aggressive behaviour and language
- Dependent, sad or secretive behaviours
- Depression, anxiety and/or suicide attempts
- Bedwetting
- Appearing nervous and withdrawn
- 'Acting out', for example cruelty to animals
- Difficulty adjusting to change
- Noticeable decline in school performance
- Regressive behaviour in toddlers
- Fighting with peers
- Delays or problems with language development
- Overprotective or afraid to leave parent
- Psychosomatic illness
- Stealing and social isolation
- Restlessness and problems with concentration
- Abuse of siblings or parents
- Exhibiting sexually abusive behaviour
- Alcohol and other drug use
- Feelings of worthlessness
- Psychosomatic and emotional complaints



**Note: This list of indicators is not exhaustive.**

25. Australian Medical Association: Supporting Patients Experiencing Family Violence, a resources for medical practitioners (2015)

26. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)

# Responding to disclosure

- **Non-judgemental and careful listening**  
—this can be empowering for a patient who has been abused
- **Communicate belief**  
—“That must have been frightening for you”
- **Validate the experience of abuse**  
—“It must have been difficult for you to talk about this”
- **Affirm that violence is unacceptable behaviour**  
—“Violence is unacceptable; you don’t deserve to be treated this way”
- **Show support toward the victim**  
—by taking time to listen and provide information about who can further assist
- **Make an initial assessment of safety**  
—by checking with the victim if it is safe to return home
- **Respond to any concern about safety**  
—Offer referral to specialist support e.g. social work, DV connect (1800 811 811)

## NEVER ASK

- **Why don’t you leave?**
- **What could you have done to avoid this situation?**
- **Why did he/she hit you?**

## Person centred care

A supportive and professional response from health service employee can reinforce a victim’s/survivor understanding that they are entitled to a healthy relationship and a life free from violence.

Focusing on the needs of the individual can be achieved through displaying empathy, a non-judgemental attitude and offering privacy and confidentiality.<sup>27</sup>

Remember your scope of practice and refer to a specialist clinician for further assessment.

## Accessing healthcare

Individuals who are experiencing domestic and family violence may find it difficult to access the healthcare system due to barriers including transport, cost, language/communication, lack of information/knowledge about local laws and fear of judgement or shame.<sup>28</sup>

### Healthcare can be made more accessible by:

- Clearly displaying information and posters giving supportive messages
- Non-judgmental practice
- Aboriginal and Torres Strait Islander liaison staff
- Outreach and community based clinics and services
- Use of interpreters and sign language.

27. WHO – Violence against women: Health-care worker intervention poster

28. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>



## Responding to perpetrators

Perpetrators of domestic and family violence will access health services however your highest priority is to consider the safety of victims and their children.<sup>29</sup>

As a health service employee you may engage with a perpetrator of domestic and family violence; perpetrators come from all socioeconomic, cultural and social groups; often perpetrators of violence will attempt to minimise their responsibility for violent behaviours and convince themselves and others that they are not responsible.<sup>30</sup>

If a perpetrator discloses 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.

## NEVER ASK

Do not ask questions of the perpetrator in the presence of a victim or of a victim in the presence of a perpetrator. Asking questions about alleged perpetrator behaviours is the role of specialist clinical staff.

29. When she talks to you about the violence: A toolkit for GPs in NSW (2013)

30. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)

## Children and domestic and family violence

The *United Nations Convention on the Rights of the Child* emphasises children have their own rights and entitlements, and because of their youth they need extra protection. In line with Australia's obligations as signatory to the Convention on the Rights of the Child it applies that all children have a right to grow up in an environment free from neglect and abuse and their best interests are paramount.

All responses to a disclosure of domestic and family violence should include consideration of the **safety of any children including an unborn child**. There are both immediate and long term impacts on children who have witnessed or are living in a violent environment. The impacts include emotional wellbeing, cognitive ability and social capacity.

## Reporting of child abuse and neglect

**All health employees** are able to report a reasonable suspicion of child abuse and neglect under Section 13A of the *Child Protection Act 1999*. This includes an unborn child.

**Doctors and registered nurses** are mandatory reporters of physical and sexual abuse under Section 13E (1) of the *Child Protection Act 1999*.

A **reportable suspicion** is defined at Section 13E(2) of the *Child Protection Act 1999* as a reasonable suspicion that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and may not have a parent able and willing to protect them from harm.

All reports of suspected child harm should be made in writing to the Department of Communities, Child Safety and Disability Services using their online report form—Report of suspected child in need of protection form:

<https://secure.communities.qld.gov.au/cbir/home/ChildSafety#>

If concerns do not reach the threshold for a report to Child Safety, but the family would benefit from a support service, a health professional should seek consent from the family to be referred to a support service directly or to Family and Child Connect (FaCC) and Intensive Family Support Services. The FaCC have access to specialist domestic and family violence and child protection professionals.

## Consult and refer

Health service employees have a vital role to play in recognising domestic and family violence, responding to disclosure and referral of victims/survivors and perpetrators to specialist support services.

Don't work alone if you recognise domestic and family violence in a client or colleague; use your support networks to help you provide the best possible response to a disclosure of domestic and family violence.

The safety of the individual and their children is paramount.

### You can consult with:

- A domestic and family violence expert within your clinical area
- A social worker
- Call DVConnect (1800 811 811) or a specialist domestic and family violence service for advice
- 1800RESPECT (for information and tools)
- Child Protection Liaison Officer (QH CPLO) or Child Safety Service (private sector).
- National Disability Abuse and Neglect Hotline 1800 880 052
- Elder Abuse Helpline 1300 651 192

### You can make a referral, with consent, to:

- A domestic and family violence expert within your clinical area
- A social worker
- DVConnect or a specialist domestic and family violence service/help line
- Legal service
- Victim Assist Queensland
- Queensland Police Service
- Family and Child Connect (FaCC)
- National Disability Abuse and Neglect Hotline 1800 880 052
- Elder Abuse Helpline 1300 651 192

You may share information without consent in some circumstances if it is relevant to assessing risk and or reducing threat. Refer to the Domestic and Family Violence Information Sharing Guidelines for more information:

<https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/info-sharing-guidelines.pdf>



## Privacy, confidentiality and consent

### Public health sector

Queensland Health is subject to privacy and confidentiality legislation which set the standards for how we handle personal and confidential information. The two primary pieces of legislation are the *Information Privacy Act 2009* (IP Act) and Part 7 of the *Hospital and Health Boards Act 2011* (HHB Act).

Queensland Health is required to comply with the privacy principles contained within the IP Act which includes the nine National Privacy Principles and provisions regarding contracted service providers and the transfer of personal information out of Australia.

Everyone who accesses Queensland public sector health services has a right to expect that information held about them will remain private. Section 142 Part 7 of the HHB Act sets out the duty of confidentiality and exceptions that permit disclosure of confidential information by 'designated persons', including Queensland Health staff.

Recent amendments to the *Domestic and Family Violence Protection Act 2012* (the Act) change how agencies may share otherwise confidential information. The new information sharing provisions in the Act operate as an exception to the duty of confidentiality stipulated in section 142 of the HHB Act, and provide guidance to health workers (and workers in a range of other agencies) in sharing client information appropriately to support the assessment of domestic and family violence risk and/or to lessen or prevent a domestic and family violence risk. The new provisions do not constitute mandatory reporting, and their intent is to better enable service providers to act to ensure the safety of at risk domestic and family violence victims and their children.

To support appropriate and safe information sharing in domestic and family violence, you may wish to access a quick-reference factsheet and flowchart for use in busy clinical environments. Contact [strategicpolicy@health.qld.gov.au](mailto:strategicpolicy@health.qld.gov.au) for more information.

### Private health sector

The *Privacy Act 1988* includes thirteen Australian Privacy Principles (APPs) which apply to some private sector organisations, as well as most Australian and Norfolk Island Government agencies.

Private sector health staff should always refer to their local area policies and procedures in relation to privacy, confidentiality and consent if they require further information.

### Consent

It is best practice to obtain consent before you refer or share information about an individual. Consistent with ethical and legal principles it is the individual's decision to agree to their health information being shared.

### Documentation

Maintaining an accurate, factual, considered, objective and up-to-date account of your concerns, consultations, contacts, actions and plans will facilitate you and your colleagues' involvement in any subsequent response or intervention. It is essential to document the details of any client information that has been shared, along with referrals that have been made. Your entries may form part of the assessment, treatment and ongoing care of the individual.





# A tailored response

## Aboriginal and Torres Strait Islander people

Responding in a culturally sensitive way will support the victim/survivor to accept assistance; it is important to establish if the victim/survivor would like to access a mainstream or Indigenous specific service. Assistance to establish the individual's wishes may be available through Aboriginal and Torres Strait Islander health worker or hospital liaison staff.

## Culturally and linguistically diverse (CALD) people

Queensland is a state of cultural diversity with populations including migrant, refugee, international students and travellers. CALD individuals and communities face challenges and barriers to engage with healthcare providers on a range of health issues. Barriers include stigma, fear, language and culture when seeking to access information and services. 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.**<sup>31</sup> 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.<sup>32</sup>

31. Australian Medical Association: Supporting Patients Experiencing Family Violence, a resources for medical practitioners (2015)

32. Department of Communities, Child Safety and Disability Services: Multicultural Affairs - Queensland Language Services Guidelines 2016



## Older people

Abuse may occur to older persons being cared for in the community by family or other community carers or in a health facility. A predisposing factor to elder abuse is dependency caused by health issues including physical and/or cognitive impairment.<sup>33</sup>

For an older person who is unable to protect themselves and is dependent on others for care, the fear of retribution may prevent them from disclosing experiences of abuse.<sup>34</sup>

If you become aware of elder abuse through disclosure it is important to ensure your response is tailored to take into account the individual's care setting and cognitive ability. Establish the individual's capacity for decision making. Identify the person legally responsible for giving consent for their healthcare. If the perpetrator of the abuse is the person with legal responsibility then a referral to an advocacy agency will be necessary. It is recommended that you consult with a social worker or domestic and family violence clinical lead to identify the appropriate agency.<sup>35</sup>

## People with disability

People with disability are a vulnerable group who are at an increased risk of experiencing abuse and violence. People with disability are at risk of physical, sexual and intimate partner violence perpetrated by family members, support workers or carers.<sup>36</sup>

Similar to older people experiencing abuse and violence, people with disability may find it difficult to disclose abuse due to their disability or dependence on carers. A level of awareness by health employees may improve the opportunity or ability for a disclosure to occur.<sup>37</sup>

A health service employee who witnesses or is notified about an incident or allegation of abuse, neglect and violence in relation to a person with disability should take action. Explain to the person what is happening and that it is not their fault. Ensure the individual is referred to the appropriate advocacy and specialist support services. It is recommended that you consult with a social worker or domestic and family violence clinical lead to identify the appropriate agency.



33. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)

34. Domestic and Family Violence Prevention Strategy 2016–2026

35. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)

36. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)

37. RACGP White Book - Abuse and violence: Working with our patients in general practice (4th Edition) (2014)

# Further domestic and family violence training

## Specific clinical areas

Some clinicians may work in areas where there may be an increased likelihood of interaction with individuals who may be experiencing domestic and family violence e.g. primary health care, emergency department, maternity services, mental health, alcohol and drug services, paediatric and child health services and Aboriginal and Torres Strait Islander health services. Additional training may be required to enable the clinician to appropriately inquire about domestic and family violence.

## ‘Sensitive inquiry’ practice model

Evidence suggests that when a clinician suspects underlying psychosocial problems the clinician should make time to ask the client about domestic and family violence using indirect questions.<sup>38</sup>

The WHO recommends clinicians; particularly first line responders, are able to identify and respond to domestic and

family violence. ‘sensitive inquiry’ through routinely asking clients of their experiences with domestic and family violence enables clinicians to work with a victim of domestic and family violence to increase their sense of safety, respect and control and reduces the risk of re-traumatisation.<sup>39</sup>

Routinely asking questions about domestic and family violence should be conducted in a safe and confidential environment by clinicians who have received additional training. For further information on accessing training on the ‘sensitive inquiry’ practice model contact your local social work department, clinical educator or specialist domestic and family violence service.

The ‘Clinical response to domestic and family violence’ online learning module and face to face training which includes the ‘sensitive inquiry’ practice model is available for specific clinical staff.

For further information on accessing this training contact your local social work department, clinical educator, domestic and family violence clinical lead or specialist domestic and family violence service.

# Response to disclosure flowchart

The response to disclosure flowchart (right) outlines the steps to take to respond to disclosure of domestic and family violence. The flowchart will assist you to respond in an appropriate, supportive and safe way.

38. BMJ August 2008; 337: a839 - Violence between intimate partners: working with the whole family

39. Strengthening Hospital Responses to Family Violence (SHRFV) Tool Kit <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>



## Presentation to health service

No abuse disclosed. You recognise domestic and family violence through presence of indicators and/or risk factors

An individual discloses domestic and family violence

Respond appropriately:

### Supportive response

- Cultural considerations
- Non-judgmental listening
- Communicate belief
- Validate the experience
- Affirm that violence is unacceptable



## NEVER ASK

**Why don't you leave?**  
**Why did he/she hit you?**

Make an initial safety assessment to ensure the safety of the individual and their children/unborn child.

**AND**

### Consider child protection concerns

### You can consult with:

- A domestic and family violence expert in your clinical area
- A social worker
- Call DV Connect or a specialist domestic and family violence service for advice
- 1800RESPECT website for information and tools



A Queensland Health employee can consult with a Child Protection Liaison Officer or Child Protection Advisor.

Private health services should consult with their Child Safety Regional Intake Service

Obtain consent to make a referral to a specialist support service and share information with the support services. In some circumstances health workers may share client information without consent if it is relevant to domestic and family violence risk assessment or will lessen or prevent a serious domestic and family violence threat. Refer to Domestic and Family Violence Information Sharing Guidelines.

Report child protection concerns to Child Safety Regional Intake Service.

**OR**

### You can make a referral to:

- A domestic and family violence expert in your clinical area
- A social worker
- DV connect or a specialist domestic and family violence service/help line
- Legal service
- Victim Assist and victim support services
- Queensland Police Service



If your concerns do not reach the threshold for a report to Child Safety consider referral to Family and Child Connect or Intensive family support services

Ensure culturally sensitive care is delivered to Aboriginal and Torres Strait Islander people through referral to Aboriginal and Torres Strait Islander specific services.

Ensure CALD people receive appropriate interpreter and support services. \*Brief the interpreter about the presence of DFV



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



