

Understanding Domestic and Family Violence





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Cultural acknowledgment

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.

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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 (DFV).

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 DFV.
- **Clinical response to Domestic and Family Violence**—designed to assist clinicians working in key clinical areas to identify DFV 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 DFV affects individuals across all socio-economic, social and cultural groups. Therefore, it is recognised that health service employees may also experience DFV in their own lives, which may impact on their 'safety, wellbeing, attendance and performance at work'.¹

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 DFV in the workplace.

Accessible to public health employees through [Training | Domestic and family violence | Human Resources | Department of Health](#).

Accessible to private health employees through registering with [Australia's CEO Challenge](#).

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 DFV for health service employees
- provide information on how to recognise DFV and respond to a disclosure of DFV in a way that is culturally sensitive and that ensures people’s safety.

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 specialist service.

Roles and responsibilities

There are a number of key services who may respond to a DFV 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 DFV 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 DFV.

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 DFV
- responding safely and appropriately to disclosures of DFV
- comprehensively and accurately documenting all issues considered and discussed in association with a disclosure of DFV 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 DFV 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 DFV are more likely to disclose an experience of DFV to a health professional. The way in which they respond to the disclosure is critical to the victim’s safety and support.

The [Domestic and Family Violence Prevention Strategy 2016–2026](#) (the Strategy) and action plans outline a shared vision and set of principles to guide action across government and the community. Reform work outlined in the Strategy incorporate a range of activities that build on recommendations made by the Special Taskforce into DFV in Queensland in 2015. The Strategy focuses on four key areas including:

- 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.

Definition of domestic and family violence and other terms

There is no single national or internationally agreed definition of family or domestic violence.²

As explained in the [Queensland Domestic and Family Violence Protection Act 2012](#) (the Act), 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.³

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. DFV against women is a violation of human rights and is unacceptable in any form.⁴

The Act says that DFV occurs in a range of intimate and family relationships including between people in dating, marriage and de facto relationships, currently or in the past. The Act includes violence toward parents and adult children, siblings and extended blood relatives, and violence perpetrated by an informal carer towards the person they are looking after.

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

2. [January 2015: Domestic Violence | Relationships Australia](#)

3. [View - Queensland Legislation - Queensland Government](#)

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

Additional definitions

Victim	noun: a person harmed, injured, or killed as a result of a crime, accident, or other event or action.
Survivor	noun: a person who survives, especially a person remaining alive after an event in which others have died.
Perpetrator	noun: a person who carries out a harmful, illegal or immoral act.
Disclosure	any occasion when an adult or child who has experienced or perpetrated DFV informs a health employee or any other third party.
Relevant relationships	<p>Includes intimate personal relationships, family relationships and informal care relationships.⁵</p> <p>Intimate partner relationships</p> <p>Intimate partner relationships 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 and carers of the elderly and people with disability.</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>Family relationships</p> <p>Family relationships exist between two people who are related by either blood or marriage, including:</p> <ul style="list-style-type: none">• a spouse• a child• a parent• a sibling• a grandparent• an aunt or uncle• a cousin• a step-relative• half-relatives• in-laws. <p>Children under the age of 18 cannot access protection in these categories of relationships. For some cultural groups, for example First Nations 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>Informal care relationships</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>

5. [View - Queensland Legislation - Queensland Government](#)

Prevalence and statistics

DFV is a social issue that has health implications. DFV affects the mental health and physical health of men, women and children.⁶

DFV has serious impacts on women's health. These impacts can include injuries, homicide, poor mental health and reproductive health problems. In Australia DFV is the leading preventable contributor to death and illness for women aged 18–44.⁷

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.

Statistics collected from a number of sources provide an overview of the prevalence of DFV in Australia and Queensland. While the rate of violence overall has decreased over time, rates of partner violence have remained steady over the last decade.

Since the age of 15:

- 1 in 6 Australian women, and 1 in 16 Australian men, have experienced physical or sexual violence from a current or former partner.
- 1 in 5 Australian women and 1 in 20 Australian men have experienced sexual violence
- 1 in 4 Australian women, and 1 in 6 Australian men, has experienced emotional abuse from a current or former partner.⁸

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

7. ANROWS - A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions (2016)

8. AIHW – Family, Domestic and Sexual Violence in Australia (2018)

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

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

11. [Family, domestic and sexual violence in Australia: continuing the national story 2019. Summary - Australian Institute of Health and Welfare \(aihw.gov.au\)](#)

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



Women are at greater risk of violence from intimate partners during pregnancy, or after separation. In 2015–16 the total economic cost of violence against women and children in Australia was \$22 billion.

Although numbers of reported incidents of DFV have been increasing in Queensland, it must be acknowledged that the data does not come close to representing the true extent of the problem.⁹

Many incidents of DFV 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.¹⁰

Incidence is significantly higher for First Nations women who are 32 times more likely to be hospitalised for family violence assaults than other Queenslanders.¹¹

First Nations women are five times more likely to be victims of homicide than other Australian women. Fifty-five per cent of these homicides are related to family violence.¹²



Common myths and attitudes

Attitudes of the community may reinforce and excuse DFV. 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 perpetrator's 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.¹³

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 DFV.

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 or socio-economic status, is a determinant of DFV. While some social factors do contribute to the risk of experiencing DFV, it is important to remember that DFV does not discriminate—**it occurs across all areas of the community.**

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

Recognising

DFV can affect any person regardless of gender, age, socioeconomic status, or cultural background.

While both men and women can be victims and perpetrators of DFV, it is important to acknowledge that the reported rate of DFV perpetrated against women is significantly higher than it is against men. A majority of perpetrators of all forms of violence are men. About 80 per cent of all violent assaults (including sexual) are carried out by men against other men and women.¹⁴

Some people experience barriers to accessing information, services, supports and legal protections and so are at a greater risk of experiencing DFV:

- First Nations women
- Women with disabilities
- Older women
- Women from culturally and linguistically diverse (CALD) backgrounds
- Lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) people.

Risk Factors

The following factors indicate a higher risk that DFV is occurring, or that there is an elevated risk of more serious harm.¹⁵

Risk factors for victims

- Victim perceives risk
- Pregnancy/new birth
- Isolation

Relationship risk factors

- Recent or pending separation
- Court orders/proceedings
- Financial difficulties

Perpetrator risk factors

- Intimate partner sexual violence
- Non-lethal strangulation
- Increase in severity and/or frequency in violence
- Threats to seriously harm or kill
- Mental health issues particularly suicide threats and attempts
- Drug and alcohol abuse
- History of violence
- Access to weapons
- Patterns of coercive control

Types of abuse and violence

DFV 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:

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.

14. ANROWS—National Risk Assessment Principles for domestic and family violence: Companion Resource, A summary of the evidence-base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence (2018)

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

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, friends and other contacts in the community.

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, sexual or neglect.¹⁶ 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.¹⁷

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). In some circumstances a person may feel the need to 'consent' to sexual contact out of fear of antagonising further violence. Where consent is provided under threat sexual assault has none-the-less occurred.

Coercive control

Coercive control refers to one or more types of abusive behaviour that form an overall pattern of behaviour that serves to intimidate and control the lives of victims. It includes such things as online monitoring of a person's whereabouts, constant monitoring of diet and food intake, threatening self-harm if a partner were to leave the relationship and reproductive coercion. The term reproductive coercion is used to define a range of perpetrator pregnancy-controlling behaviours. These behaviours can include birth control sabotage (where contraception is deliberately thrown away or tampered with), threats and use of physical violence if a woman insists on condoms or other forms of contraception, emotional blackmail coercing a woman to have sex or to fall pregnant, or to have an abortion as a sign of her love and fidelity, as well as forced sex and rape.¹⁸

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.

16. [What is elder abuse | Seniors | Queensland Government \(www.qld.gov.au\)](http://www.qld.gov.au)

17. Domestic and Family Violence Prevention Strategy 2016–2026

18. E Miller, M Decker, H McCauley, D Tancredi, R Levenson, J Waldman, P Schoenwald, J Silverman, 'Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy' (2010) 81 Contraception 316







Indicators

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

Indicators in adults^{19 20}

Physical

- Unexplained bruising and other injuries (especially to the 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 that 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 a 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.

Indicators in children^{21 22}

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
- 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.

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

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

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

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

Responding to disclosure

- **Be non-judgemental and listen carefully**
 - this can be empowering for a patient who has experienced DFV
- **Communicate belief**
 - “That must have been frightening for you”
- **Validate the experience of abuse**
 - “It must have been difficult for you to talk about this”
- **Affirm that violence is unacceptable behaviour**
 - “Violence is unacceptable, you don’t deserve to be treated this way”
- **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 for them to return home
- **Respond to any concern about safety**
 - Offer referral to specialist support e.g. social work, DVConnect (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 a health service employee can reinforce a victim’s/survivor’s 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 explaining confidentiality and its limits.²³

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

Accessing healthcare

Individuals who are experiencing DFV 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.²⁴

Healthcare can be made more accessible by:

- clearly displaying information and posters giving supportive messages
- non-judgemental practice
- Aboriginal and Torres Strait Islander liaison staff
- outreach and community-based clinics and services
- use of interpreters and sign language.

23. WHO—Violence against women: Health-care worker intervention poster

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

Responding to perpetrators

Perpetrators of DFV will access health services, however your highest priority is to consider the safety of victims and their children.²⁵

As a health service employee you may engage with a perpetrator of DFV. Perpetrators come from all socio-economic, 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.²⁶ It is important that health workers and clinicians do not collude with perpetrators to make circumstances or victims responsible for their violent behaviour.

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.

Children and DFV

The United Nations Convention on the Rights of the Child emphasises that 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 DFV 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 reduced emotional wellbeing, cognitive ability and social capacity.

In order to get the best outcomes for children, it is important that non-violent parents and care-givers are not immediately judged or held responsible for the behaviour of the perpetrator. There may be very real and valid factors that prevent a non-offending care-giver from removing children from a harmful DFV situation. A specialist clinician will be able to explore what supports a non-offending care-giver may need to ensure that children do not have to live in a violent home.

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 a specialist.

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 Child Safety, Youth and Women 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 DFV and child protection professionals.

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

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

Consult and refer

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

Don't work alone if you recognise DFV in a client or colleague. Use your support networks to help you provide the best possible response to a disclosure of DFV. The safety of the individual and their children is paramount.

You can consult with:

- a DFV expert within your clinical area
- a social worker
- call DVConnect (1800 811 811) or a specialist DFV service for advice
- 1800RESPECT (for information and tools)
- Child Protection Liaison Officer (CPLO) or Child Safety Service
- National Disability Abuse and Neglect Hotline 1800 880 052
- call Gallang Place counselling service on (07) 3899 5041 to find culturally safe services for First Nations people in your area
- Elder Abuse Helpline 1300 651 192.

You can make a referral, with consent, to:

- a DFV expert within your clinical area
- a social worker
- DVConnect or a specialist DFV service/help line
- a 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.

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.

Amendments to the [Domestic and Family Violence Protection Act 2012](#) (the Act) change how agencies may share otherwise confidential information. The 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 DFV risk and/or to lessen or prevent a DFV 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 DFV victims and their children.

To support appropriate and safe information sharing in DFV, you may wish to access a [Factsheet](#) and [Flowchart](#) for use in busy clinical environments. Contact 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.

Information sharing

It is generally considered 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. However in cases of DFV where there is a serious risk of significant harm, information can be shared with some external agencies without consent in order to reduce harm and increase safety. Note that Section 147 of the HHB Act provides for some Queensland Health staff to share otherwise confidential information to lessen or prevent serious risk to life, health or safety.

Documentation

Maintaining an accurate, factual, considered, 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.



Understanding and responding to diversity

First Nations people and communities

The term Aboriginal and Torres Strait Islander is used as a collective descriptor for the many diverse cultural and geographic groups that make up the First Nations Peoples of Australia. First Nations people have broad definitions of family which can include people from extended family relationships and kinship networks. First Nations people also have holistic, collective understandings of health that incorporate cultural, spiritual, physical and community wellbeing. It is important to consider broader social and historical factors impacting on the health and health service needs of First Nations people and communities.²⁷

Early colonisation brought significant and widespread human rights abuses including wide spread massacres, segregation, dislocation from country, stolen generations and attempts to eradicate culture. These practices continued well into the 20th century and are in the living memory of many First Nations Queenslanders. The health impacts of these experiences are compounded by ongoing experiences of every-day racism and systemic discrimination.

All people who use violence against family members are responsible for their behaviour. Nonetheless, understanding the practices and impacts of colonisation are central to responding safely and appropriately to suspicions and disclosures of family violence. Experiences of traumatic loss, cultural dispossession and the disruption of peoples' traditional ways of safeguarding individual, community and spiritual health have created a legacy of profound grief and psychological distress.²⁸ This distress is broadly referred to as intergenerational trauma. Intergenerational trauma can manifest as mental health and alcohol and drug issues, poverty, high rates of chronic disease and 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. Family violence may be one manifestation of lateral violence.

It is also important to know that resilience, strength and connection are enduring features of First Nations culture and communities. Acknowledging and working with these qualities where possible will help to build genuine trust and to enable good quality health responses to disclosures of family violence.

People from CALD backgrounds

Queensland is a state of cultural diversity with populations including migrant, refugee, international students and travellers. People and communities from CALD backgrounds face challenges and barriers to engagement 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.**²⁹ 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 where counselling is being provided.³⁰

Experiences of racism, homophobia and other forms of discrimination in the health service system amplify the level of distress for victims of DFV and are major barriers to disclosing and seeking help.

Health workers and clinicians are ethically and legally obliged to treat all patients and clients with equal respect and dignity and this may require committing to understand the experiences and world views of a diverse range of people.

27. Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026

28. Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021 (2016)

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

30. 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, 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.³¹ 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.³²

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 DFV clinical lead to identify the appropriate agency.

People with disability

People with disability experience unique forms of DFV. They experience all of the previously mentioned forms of violence as well as such things as forced contraception, deprivation of liberty, and withholding of medication, mobility aids and stimulation. Some types of disability restrict a person's capacity to move about freely and/or to communicate easily, leaving them especially vulnerable to ongoing abuse by family members and carers who may have a role in their care and advocacy.³³

People with disability are more likely to experience abuse and violence than people without disability and may experience that violence from family members, support workers or carers. Research shows that mainstream service providers are less likely to ask people with disability about DFV and less likely to respond when a disclosure occurs. Understanding these issues can help health employees to increase the opportunities for people with disability to disclose.

It is important that health service employees respond appropriately to all suspicions and disclosures of DFV. Make an opportunity to speak to a person with disability without carers or family members present. Explain that the violence is not their fault. Work with allied health colleagues to ensure referrals to appropriate disability, advocacy and specialist services are made. Some people have complex needs and additional follow up may be required in order to ensure their safety.

LGBTIQ people

Research shows that same-sex attracted people suffer violence in their intimate relationships at the same or higher rates as those in heterosexual relationships.³⁴ LGBTIQ 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. In rural and regional areas LGBTIQ people may not wish to share experiences of domestic violence with health practitioners due to concerns about their privacy and subsequent safety in their community. Gay men and gender diverse people may have concerns regarding access to gendered DFV support services.

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

32. Domestic and Family Violence Prevention Strategy 2016–2026

33. ANROWS—Landscapes Implementing trauma-informed systems of care in health settings: The WITH study. State of Knowledge paper (2015)

34. AIHW, 2019. Family, domestic and sexual violence in Australia: continuing the national story 2019.

Further DFV 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 DFV 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 DFV.

‘Sensitive inquiry’ practice model

Evidence suggests that when a clinician suspects underlying psychosocial problems the clinician should make time to ask the client about DFV using indirect questions.³⁵

WHO recommends that clinicians, particularly first line responders, are able to identify and respond to DFV. Respectful and non-judgemental communication is key to enabling clients to share their experiences. ‘Sensitive inquiry’ is a model of routine questioning that enables health clinicians and workers to engage with people who have experienced DFV in ways that make them feel believed and supported.

Routinely asking questions about DFV 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 DFV 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, DFV clinical lead or specialist DFV service.

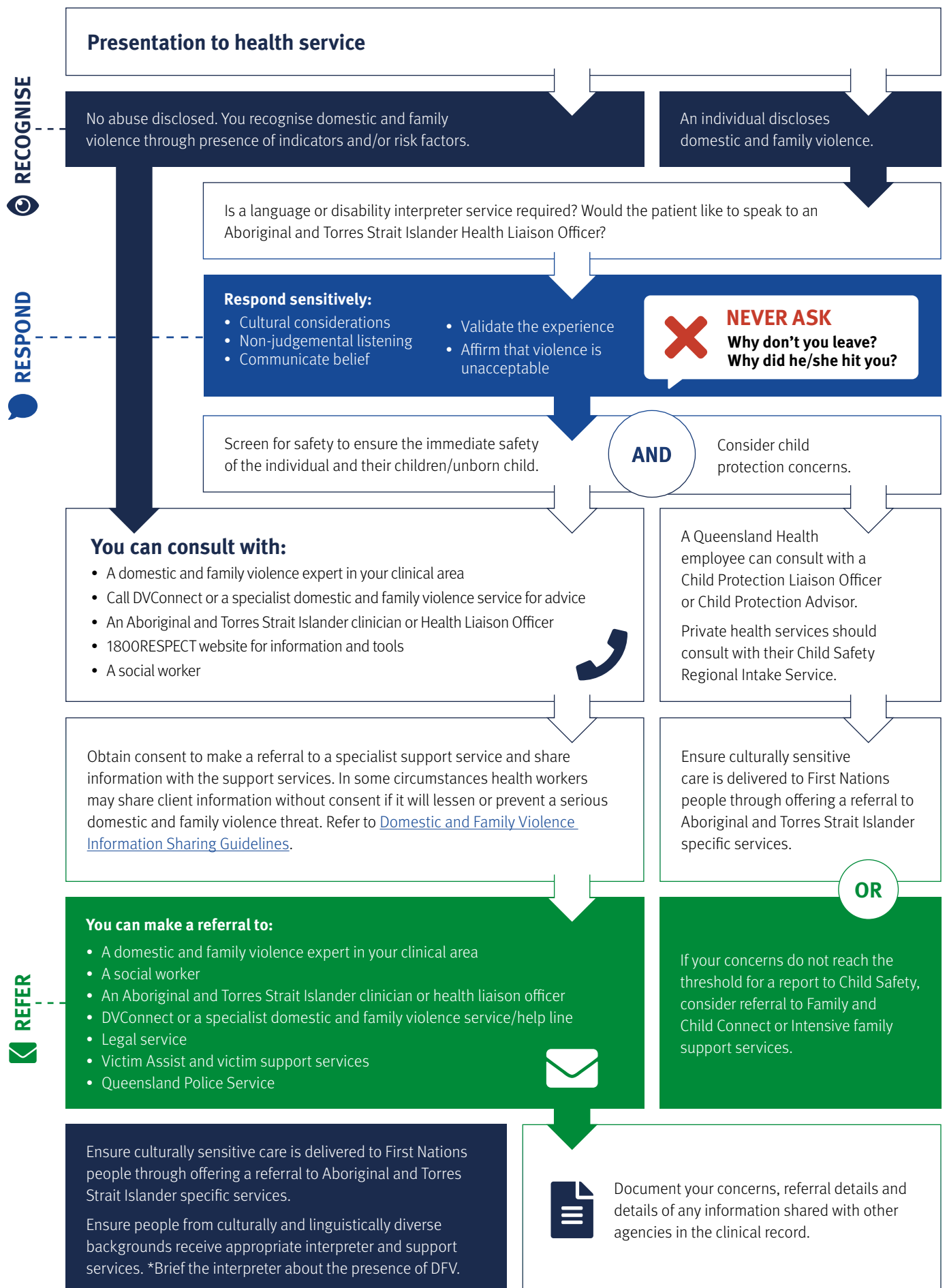
Response to disclosure flowchart

The response to disclosure flowchart outlines the steps to take to respond to a disclosure of DFV. The flowchart will assist you to respond in an appropriate, supportive and safe way.

See following page for flowchart.

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

Response to disclosure flowchart



How to make a referral

1. Provide the client with information about referral options

- Ensure immediate safety
- Ensure conversations are conducted alone and in private

- Listen carefully to determine the client's needs
- Use language that is easily understood—arrange qualified interpreters if necessary
- Present your client with the range of options and services available
- Document your concerns and actions



2. Information sharing between agencies

- It is best practice to obtain consent before you refer or share information about an individual.
- Refer to the Domestic and Family Violence Information Sharing Guidelines and/or the Factsheet and Flowchart for more information about how agencies can share relevant information safely and appropriately.

3. Explain the referral process

- Location of the service
- Mode of contact e.g. a phone call or face-to-face meeting
- Written or verbal referral

Referral in business hours

- Refer to a domestic and family violence expert within your clinical area, such as a social worker, a local specialist, domestic and family violence service or helpline such as DVConnect.
- Additional specific support and local numbers.

Referral after hours

- DVConnect **07 3156 2323**
- Womensline **1800 811 811**
- Mensline **1800 600 636**



4. Support the client throughout the referral process

- Be non-judgemental and supportive.
- Consistency of information and support is important.
- Ensure a safe and private environment for the victim/survivor or perpetrator to conduct a conversation with the support service.
- Assist the client to make telephone contact with a specialist domestic and family violence service or crisis service.
- Provide culturally safe and physically accessible spaces in which to support people with diverse needs.

- With the consent of the client, offer to speak to the service on their behalf and then support them until the call is complete.
- With the consent of the client, provide introduction and preliminary information to the referral service so the client does not have to repeat their story.
- Accept the client's choice about whether to continue with the conversation or the referral.



Respect the decisions and choices of the client

- View the client as the expert in their own life.
- Recognise and respect that the client's cultural background may have an influence on decisions.
- Remain patient and supportive, allowing clients to progress at their own pace wherever possible.

