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BRISBANE NORTH

An Australian Government Initiative

Quality Improvement Toolkit for General Practice

Domestic and family violence

Contents

How to use this toolkit

There are checklists included below that will guide you and your practice.

- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support

Primary Care Liaison Officer

(PCLO) 07 3630 7300

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including Brisbane South PHN; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout. While the Australian Government Department of Health and Department of Justice and Attorney-General has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Department of Health and Queensland Government and is not advice that is provided, or information that is endorsed, by the Department of Health and Queensland Government. The Department of Health or Queensland Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein. The information in this toolkit does not constitute medical advice and Brisbane North PHN accept no responsibility for the way in which the information in this toolkit is interpreted or used.

Domestic and family violence

Domestic and family violence (DFV) occurs when one person in an intimate personal, family or carer relationship uses **violence or abuse** to maintain **power and control** over the other person. DFV does not always involve physical violence and is usually an **ongoing pattern of behaviour** aimed at controlling a partner or children.[1]

Physical violence always co-occurs with psychological and emotional abuse but psychological and emotional abuse can occur without any threat of physical violence. People of any race, age, gender, sexuality, religion, education level, or economic status can be a victim — or perpetrator — of domestic violence. DFV impacts the whole family and has a lifelong impact on health.

Estimates are that every week, a full-time general practitioner (GP) sees up to five women who have been abused by their partners, of which the GP may not be aware. One in 10 women attending general practice have been afraid of their partners in the previous 12 months, and one in three women have experienced fear of a partner over their lifetime.[2]

Types of violence can include:

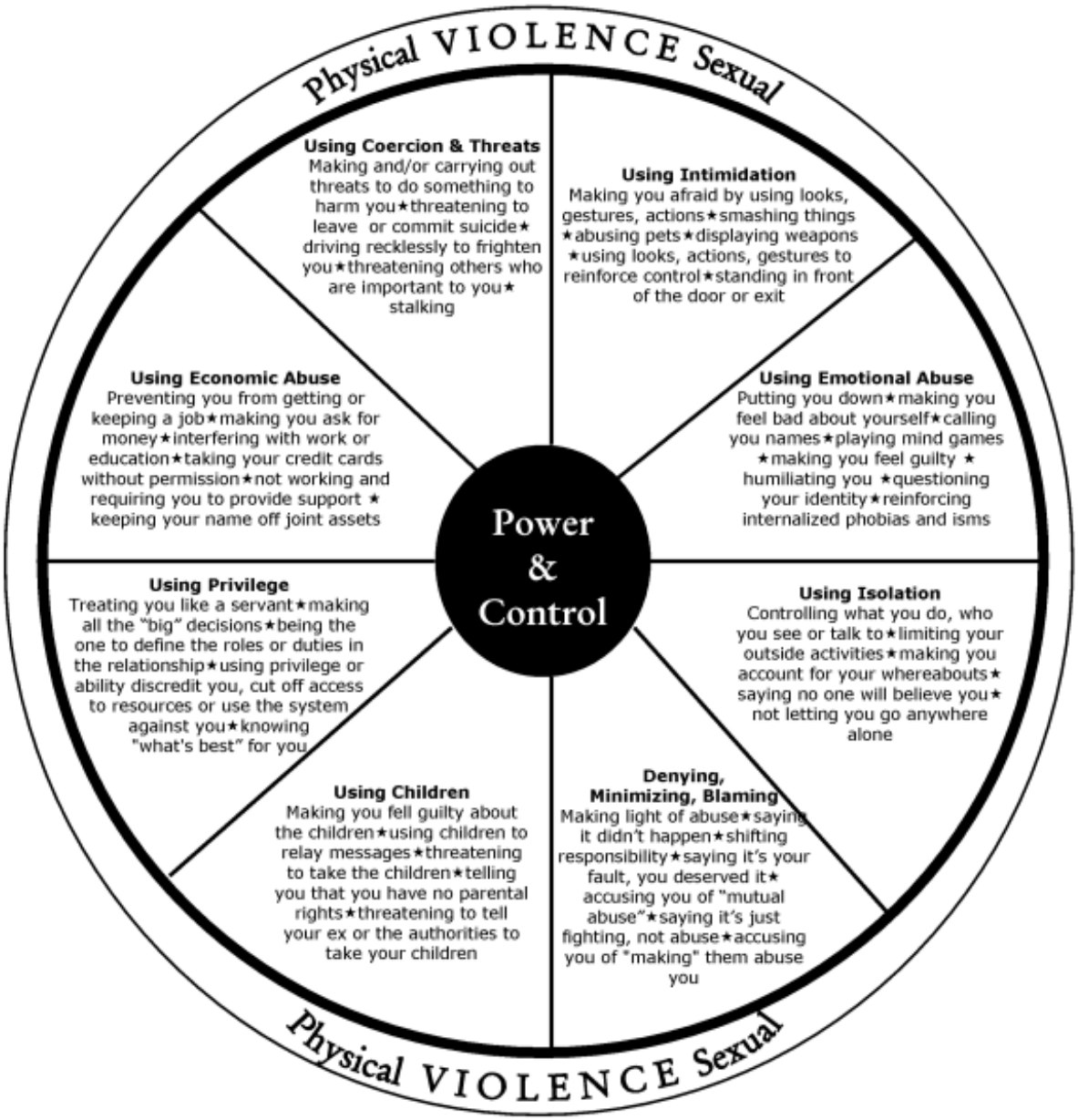
Emotional abuse	Financial abuse	Verbal abuse	Psychological abuse
Physical abuse	Social isolation	Technology-based abuse	Spiritual abuse
Sexual abuse	Identity based abuse	Coercive control	Reproductive Abuse

1 https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/domestic-family-violence/what-is-domestic-and-family-violence/what-is-domestic-violence/about-domestic-and-family-violence

2 Kelsey Hegarty, et al, 'Identifying and reporting to men who use violence in their intimate relationships' (2016) 45.4 Australian Family Physician 176

Power and Control Wheel

The Power and Control Wheel is a tool utilised in the domestic and family violence field to understand the tactics people using violence use to gain power and control over their victims. [3]



Education and training

This toolkit is to be used to support and reinforce education sessions and online training.

Education modules for primary care workers can be found at:

- RACGP – professional development program on family abuse and violence.
- WorkUp Queensland – resource hub.
- DV-alert – domestic and family violence for frontline workers

[3] Adapted and Copyright by the Domestic Abuse Intervention Project

ACTIVITY 1 – GENERAL PRACTICE ROLE IN DFV

General practice roles in identifying DFV

Primary care providers, including general practitioners (GPs), practice managers, practice nurses and administration staff, all play an important role in often being the first point of contact for people who are experiencing DFV.[4] It is important to know your role in relation to DFV is to work within your scope of practice to recognise, respond and refer

Importance of working as a team when managing DFV

It is important to collaborate and work with other team members involved in caring for and managing adults and children involved in DFV. There are a variety of roles that support a health service; both clinical and non-clinical. Every member of the team is valuable.

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.

General practice staff:

- play an important role in providing continuity of care
- are trusted and valued by patients
- have been supporting patients experiencing DFV for a long time
- offer whole person care that integrates physical, social and emotional wellbeing
- have a goal of healing and support
- provide frontline care and assistance
- are exposed to vicarious trauma
- care about their patient's wellbeing
- utilise specialist referral pathways every day
- provide frontline care and assistance
- are part of that community response.

Tip 1.1 The steps to intervention - the 8 "Rs"

- Be **R**eady to identify and respond to intimate partner abuse
- **R**ecognise symptoms of abuse and violence, ask directly and sensitively.
- **R**espond to disclosures of violence with empathetic listening.
- Explore **R**isk and safety issues (brief risk assessment and safety plan). Document carefully what a patient says in their patient record, to ensure clear communication with others, and potentially for legal processes.
- **R**eview the patient for follow-up and support
- **R**efer patients to specialist services for advocacy to enhance safety and mental health support.
- **R**eflect on your own attitude, management and limitations to address abuse and violence.
- **R**espect your patients, your colleagues and yourself. [5]

4 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble

5 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble

More specific roles and responsibilities:

General practitioners	Practice managers	Practice nurses	Administration staff
• being aware of and complying with legislation, local clinical pathways, guidelines and procedures in DFV • 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, safety planning, 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.	• implementing quality improvement protocols for DFV • ensuring staff are trained to manage DFV	• being aware of and complying with legislation, local clinical pathways, guidelines and procedures in DFV • be aware of the non-verbal cues and signs of DFV • be aware how to respond and support referrals as required	• being alert - sharing information if the receptionist hears or sees anything while the patient is in the reception or waiting room • maintaining patient confidentiality [6] • encouraging patients to book longer appointments for complex matters • creating a climate of disclosure in the waiting room – posters and leaflets

[6] https://www.health.qld.gov.au/__data/assets/pdf_file/0025/465154/understanding-dfv-booklet.PDF

Creating a climate for disclosure

It is important for people affected by DFV to feel safe and supported when disclosing information.

Research tells us patients are more likely to disclose family violence if asked by their doctor. Other facilitators of disclosing include a positive doctor-patient relationship, and the primary care provider ensuring the environment is safe, disclosure is confidential and concerns about the consequences of disclosing are mitigated. [7]

What people impacted by DFV say they want from GPs

Before disclosure or questioning	When the issue of intimate partner abuse is raised
• understand the issue, including knowing about community services and appropriate referrals • ensure that the clinical environment is supportive, welcoming, and non-threatening • place brochures and posters in the clinical setting • try to ensure continuity of care • be alert to the signs of abuse and raise the issues • be compassionate, supportive and respectful towards people	• be non-judgemental, compassionate and caring when questioning about abuse • be confident and comfortable asking about intimate partner abuse • do not pressure people to disclose; simply raising the issue can help them • reassure the patient that when they are ready you will be there for them and believe them • consider asking about abuse at later consultations because patients may disclose at another time • ensure that the environment is private and confidential, and provide sufficient time.
Immediate response to disclosure	**Response in later interactions**
• take time to listen • respond in a non-judgemental way, with compassion, support and belief of experiences • validate their decision to disclose, their experiences, challenge assumptions and provide encouragement • acknowledge the complexity of the issue, respect the patient's unique concerns and decisions • remind the patient the abuse is not their fault and there is help available • put patient-identified needs first, making sure social and psychological needs are addressed • address safety concerns • provide information and where appropriate offer referral for more specialised help • before giving any printed information check if it is safe to take as some perpetrators go through the victim's personal belongings. • assist patients to make their own decisions.	• be patient and supportive; allow the patient to progress at their own pace • understand the chronicity of the problem and provide follow-up and continued support • respect the patient's wishes and do not pressure them into making any decisions • be non-judgemental if patients do not take up referrals immediately • informed consent for referrals is vital *unless a patient is in imminent danger.

7 Heron RL, Eisma MC. Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. Health Soc Care Community. 2021 May;29(3):612-630. doi: 10.1111/hsc.13282. Epub 2021 Jan 13. PMID: 33440034; PMCID: PMC8248429.

Recognising DFV

- Domestic and Family Violence can happen to anyone, regardless of where they live, their profession, their education, or their age.
- Some people experience barriers to accessing information, services, supports and legal protections and so are at a greater risk of experiencing DFV: Aboriginal and Torres Strait Islander women, older women, culturally and linguistically diverse groups, people with a disability, LGBTIQ+ community and people who live in rural and regional areas.

Clinical indicators of partner abuse

General

- delay in seeking treatment/inconsistent explanation of injuries
- multiple presentations to general practice
- noncompliance with treatment and attendances
- accompanying partner who is over attentive
- identifiable social isolation
- recent separation or divorce
- past history of child abuse
- age less than 40 years
- abuse of a child in the family

Physical

- obvious injuries, especially to head/neck or multiple areas
- bruises in various stages of healing
- sexual assault
- sexually transmissible infections
- chronic pelvic pain
- chronic abdominal pain
- chronic headaches
- chronic back pain
- numbness and tingling from injuries
- lethargy

Psychological

- insomnia
- depression
- suicidal ideation
- anxiety symptoms and panic disorder
- somatoform disorder
- post-traumatic stress disorder
- eating disorders
- drug and alcohol abuse. [8]

Pregnancy indicators

- miscarriages
- unwanted pregnancy, e.g., unreliable use of contraception
- antepartum haemorrhage
- lack of prenatal care
- low birth weight of infant.

Indicators in children of family violence

- aggressive behaviour and language
- anxiety, appearing nervous and withdrawn
- psychosomatic illness
- bedwetting and sleeping disorders
- difficulty adjusting to change
- restlessness
- ‘acting out’, such as cruelty to animals

Recommendations from RACGP[9]

Ask all patients who present with clinical indicators (e.g. depression and anxiety about possible experiences of IPAV.

Routinely screen for IPAV in all pregnant women attending a practice or clinic.

8 https://www.racgp.org.au/afp/2011/november/intimate-partner-violence/

9 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble

Activity 1.1 – Understanding general practice role in DFV

Complete the checklist below to review your practice's strategies for recognising and preparing the practice and the team to assist patients effected by DFV.

Description	Status	Action to be taken
Do services and settings within the practice maximise patient experiences of choice and control?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	How do you communicate to your patients about services available at the practice, availability of longer appointments, patient confidentiality? Are these included in your patient information sheet? Are all patients offered this information? Who can book or change appointment details? This can present a serious issue when partners reschedule or cancel appointments without consent. Consider the policies for new patient appointments, are they conducted individually to create an opportunity to establish safety?
Have relevant practice team members participated in training related to DFV?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to training options.
Do the practice's services and settings ensure the physical and emotional safety of patients?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Consider how services can be modified to ensure safety is effective and consistent? - *physical safety of practice setting (e.g., communication, performance management and grievance handling; discrimination, bullying and harassment, workplace aggression and violence, occupational health and safety in the workplace (injury prevention, infection control, safe handling of chemicals and waste); hazard identification and reporting systems; and crisis management and emergency incident response).* Review how you would describe the reception and waiting areas? Are they comfortable and inviting? ☐ Yes ☐ No Are the first contacts with patients welcoming, respectful and engaging?

Description	Status	Action to be taken
		□ Yes □ No
Does the practice have DFV resources available in waiting areas in the practice?	□ Yes: **see action to be taken**.	Is there a person/position responsible to ensure DFV resources are restocked? □ Yes □ No Are resources available in multiple languages and available for First Nations and LGBTQI people? □ Yes □ No
	□ No: **see action to be taken**.	Obtain resources from First Nations Health Focus and Health Translations.
Do each team member understand their roles in DFV?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Discuss team roles at the next practice meeting. Page 6 of this toolkit.
Do all relevant team members know how to contact the Primary Care team for additional support?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to information from Brisbane North PHN website.
Do all relevant team members know the signs that may identify DFV?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to information on identifying DFV.
How does your practice view their role in assisting patients effected by DFV? Are there any changes you would like to implement in the practice to help manage staff over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 2 – RESPONDING AND MANAGING DISCLOSURE OF DFV

Asking about violence

The detail of your questions will depend on how well you know the patient and what indicators you have observed.

Asking about violence		
Broad questions	Questions links to clinical observations	More direct questions
• How are things at home? • Do you feel safe at home? • How are you and your partner relating? • How are you and your family relating? • Is there anything else happening that might be affecting your health? • Has anything changed at home? • Do you ever feel like you're walking on eggshells?	• You seem very anxious and nervous. Is everything ok at home? • When I see injuries like this I wonder if someone could have hurt you. • Is there anything else that we haven't talked about that might be contributing to this condition?	• Are there ever times when you are frightened of your partner? • Are you concerned about your safety or the safety of your children? • Does the way your partner treat you make you feel unhappy or depressed? • I think that there's a link between your (insert illness) and the way your partner treats you. What do you think?

When English is not the patient's first language, use a qualified interpreter. Do not use a partner or a child as the interpreter.[10]

Responding to disclosures by patients of violence against them

Using the World Health Organisation **LIVES** model of first-line response to IPAV.[11]

Listen - Listen to the person closely, with empathy and without judgement.

Inquire- Assess and respond to their needs and concerns - emotional, physical, social and practical

Validate the decision to disclose - 'It must have been difficult for you to talk about this.' Emphasise the unacceptability of violence - 'You do not deserve to be treated this way.'

Enhance safety: Discuss a plan for the person to protect themselves from further harm if violence occurs again.

Support: Support the person by helping them connect to information, services and social support. Be patient led in this process.

10 https://www.dvrcv.org.au/publications/books-and-reports/guide-for-general-practitioners

11 https://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf

What not to say

Avoid suggesting that the woman is responsible for the violence.

- 'Why do you stay with a person like that?'
- 'What could you have done to avoid the situation?'
- 'Why did you let them hit you?'

Helping to assess patient and any children's safety

- Speak to the person who has disclosed DFV alone.
- Do they feel safe going home after the appointment? If no, refer to DFV support services.
- Are the children safe? May need to discuss role of child safety and when mandatory reporting is required as this is a fear for people that they will have their children taken away
- Are pets safe?
- Do they need an immediate place of safety?
- Do they need to consider an alternative exit from your building?
- Ensure all team members are aware not to release any information or confirm/deny attendance of any patient at the practice
- If immediate safety is not an issue, what about their future safety? Do they have a future plan of action if they are at risk?
- Would you engage with a trusted person or police if you felt unsafe or in danger?
- Does the partner have weapons? Does the patient need to seek a Domestic Violence Protection Order?
- Does the victim have emergency telephone numbers? (police, DV support services)
- Discuss privacy. More information is available from Family and Child connect.
- Help make an emergency plan. (Where would they go if they had to leave? How would they get there? What would they take with them? Who are the people they could contact for support?) Document these plans for future reference.[12]
- Has the perpetrator made any threats in the past two weeks? If so, what are these threats?

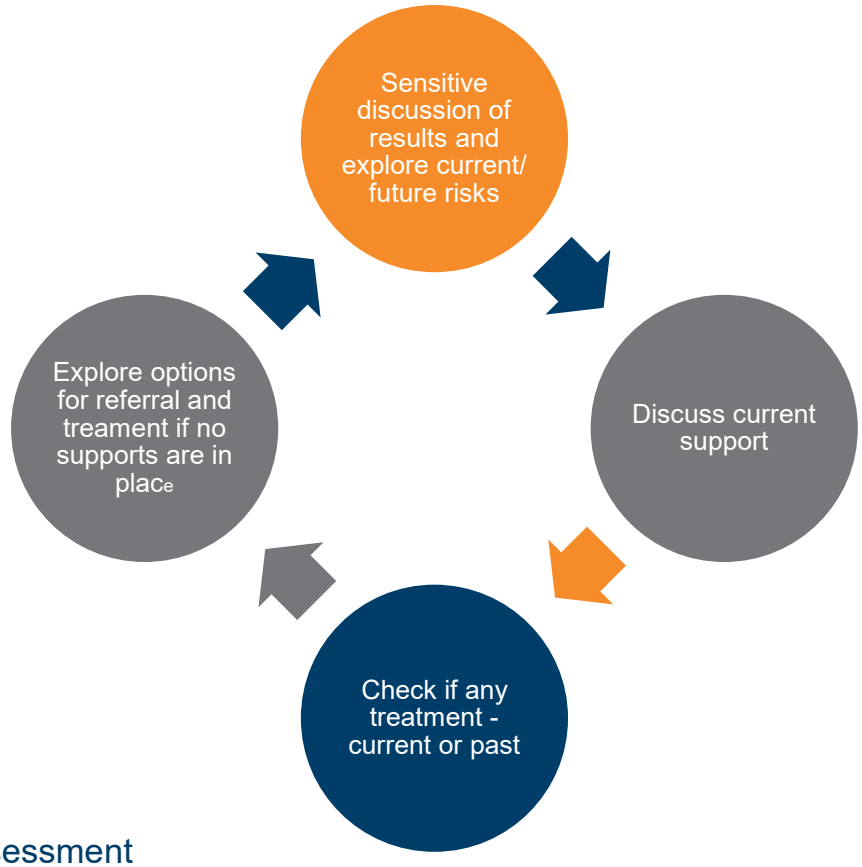
Further information on questions to ask is available from Queensland Common Risk and Safety Framework.

How to follow up and provide ongoing care

- consider your patient's safety as a paramount issue
- monitor the patient and their children's safety by asking about any escalation of violence
- empower them to take control of decision making; ask what they need and present patient with choices
- respect the knowledge and coping skills they have developed. You can help build on their emotional strengths, for example, by asking 'How have you dealt with this situation before?'
- provide emotional support
- be familiar with appropriate referral services and their processes. Patients may need your help to seek assistance
- advise all team members not to release information or confirm/deny attendance of a patient even to partner
- after separation consider delinking their files on the practice records.

12 https://www.dvrcv.org.au/publications/books-and-reports/guide-for-general-practitioners

Next steps if trauma is identified



Brief Risk assessment

Any assessment of risk to victims of intimate partner abuse must be structured and informed by:

- the patient's own assessment of their safety and risk assessment
- the presence of risk indicators outlined below
- your own professional judgement.

There are several factors consistently associated with perpetrators of intimate partner abuse. These include age, severity (for example, strangulation) and duration of previous violence, history of arrest and incarceration, violence in the family of origin, drug and alcohol abuse, hostility levels and unemployment.

Risk indicators of ongoing family violence include:

- perpetrator history of violent behaviour both within and outside of the household
- perpetrator access to lethal weapons
- perpetrator use of alcohol and drugs
- recent separation or divorce
- perpetrator stressors such as unemployment or recent loss
- perpetrator history of witnessing or being the victim of family violence as a child
- evidence of mental health problems or personality disorder in perpetrator
- perpetrator resistance to change and lack of motivation for treatment.

Some researchers have developed risk assessment tools, for example, a danger assessment scale was developed for use by GPs in consultation with women to enhance women's reflection on safety and self-care.[13]

13 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/safety-and-risk-assessment

Brief Safety planning strategies for patients

Safety planning involves developing a plan for a person to follow should the violence escalate. The purpose of a safety plan is to outline escape and help-seeking strategies. It is essential to plan for the safety of both victim-survivor and children.

This safety planning list can be worked through with each patient as part of their safety plan.

During an emergency: When violence occurs	Attempt to leave the home immediately or get to a safe and secure location. Call police (000) immediately or contact another house member or neighbour to call. If in public, get to the nearest busy location or shop to ask for help calling police.
If planning to leave or high risk of violence escalating	Save phone numbers for police, DV Connect & the local DFV specialist service in a safe place or encourage to memorise. Encourage your patient to have a pre-planned escape path from home including access to keys and points of exit. Remove any weapons from house. Encourage your patient to speak with friends/family/neighbours to check in regularly or call police if needed 'Where will you go in an emergency and who will come (e.g. children)?' 'Which friends, family or neighbours can be contacted in an emergency?' Develop code words to use with loved ones if needing to ask for help quickly.
Additional safety planning strategies	Encourage patients to have a bag packed and kept in a safe location with important documents. - money - Medicare and tax file numbers - rent and utility receipts or birth certificates (or copies) for you and children - ID and/or driver's licence for you and children - bank account and insurance policy numbers - marriage certificate and valuable items like jewellery - hidden bag with extra clothing and other essential items - obtain a new phone that the perpetrator has no knowledge of, so you are untraceable. May need to be hidden with other objects. *A safe location could include a family or neighbour, or hidden place in a house. [14]

[14] **Adapted from Brisbane Domestic Violence Service – safety planning for GPs.**

Response to disclosure flowchart

Presentation to health service

RECOGNISE

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

An individual discloses domestic and family violence.

Is a language or disability interpreter service required? Would the patient like to speak to an Aboriginal and Torres Strait Islander Health Liaison Offi cer?

RESPOND

Respond sensitively:

- Cultural considerations
- Non-judgemental listening
- Communicate belief
- Validate the experience
- Affi rm that violence is unacceptable

NEVER ASK

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

Screen for safety to ensure the immediate 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
- Call DV Connect or a specialist domestic and family violence service for advice
- An Aboriginal and Torres Strait Islander clinician
- 1800RESPECT website for information and tools
- A social worker

Private health services should consult with their Child Safety Regional Intake Service.
1300 682 254
(9am - 5pm Monday to Friday)

Child Safety After Hours
1800 177135 - 24/7

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 will lessen or prevent a serious domestic and family violence threat. Refer to Domestic and Family Violence Information Sharing Guidelines.

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

REFER

You can make a referral to:

- A domestic and family violence expert in your clinical area
- A social worker
- An Aboriginal and Torres Strait Islander clinician or health liaison offi cer
- DV connect or a specialist domestic and family violence service/help line
- Legal service
- Victim Assist and victim support services
- Queensland Police Service

OR

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 offering a referral to Aboriginal and Torres Strait Islander specific services.

Ensure people from culturally and linguistically diverse backgrounds 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.

SC200007002/20

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, 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 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 clients cultural background may have an influence on decisions.
- Remain patient and supportive, allowing clients to progress at their own pace wherever possible.

[15] https://www.health.qld.gov.au/__data/assets/pdf_file/0025/635803/dv-referral-flowchart.pdf

Activity 2.1 – Review your practices systems for responding and managing disclosure of DFV

Complete the checklist below to review your practice's systems for assessing and managing disclosure of DFV.

Description	Status	Action to be taken
Do all team members (GPs, nurses and admin), know what to do if a patient discloses violence against them?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Meet as a practice team to establish a system if anyone discloses violence against them. Ensure all team members have participated in training.
Do relevant team members have access to appropriate trauma identification tools?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to more information on identification tools. How will this information be communicated to the practice team?
Are longer appointments booked for patients when a mental health treatment plan or screening assessment is required?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Discuss at next team meeting how to ensure longer appointments are booked for patients, so they don't feel rushed. This also assists the GP to not run late for subsequent patients.
Is screening done in a way that avoids over complication and unnecessary detail to minimise stress for patients?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the six principles of trauma informed care.
Does the practice have access to violence and trauma related resources to provide to patients if required? Are they aware of how to distribute these safely?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to resources.
Remind all practice team members not to release information or confirm/deny attendance of a patient event at the practice to a partner or anyone else?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to RACGP standards for general practice – criterion 6.3.
After reviewing your practice's systems for assessing and managing disclosure of violence, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

15

ACTIVITY 3 – UNDERSTANDING YOUR PRACTICE DATA

Advantages and disadvantages of labelling patients

If someone is involved in DFV, it is important that it is recorded correctly so that the treating team are aware and to allow correct treatment. Any diagnosis should be discussed with the person. Just as we would record a physical health diagnosis, DFV should be recorded. If preferred by the patient, it may be marked as confidential and/or the patient may choose not to upload it to My Health Record.

It is recommended that you meet as a practice team to discuss how your practice will identify and record DFV.

Tips for recording progress notes

- Describe physical injuries including the type, extent, age and location of any physical injuries sustained and (if possible) include the name and DOB of the alleged perpetrator. Do not refer to partner or husband, you need to include the name.
- If you suspect violence is a cause, but your patient has not confirmed this, it may be relevant to include your comments as to whether the explanation accurately explains the injuries.
- Consider taking photographs of injuries (with patient permission).
- Record what the patient has said (using quotation marks) and any relevant behaviour you have observed.[16]
- Be aware if you are recording information in a child's records, both parents will have access to the records unless there is a court order.
- If the records are requested by police, lawyers or other third parties, it is recommended the GP seeks advice from their medico-legal provider, prior to proceeding.

Activity 3.1 – Data collection from Best Practice and Medical Director

The aim of this activity is to collect data to determine the number of patients from your practice with a condition marked DFV victim.

Instructions are available from Best Practice or MedicalDirector to search for this activity. You will need to select conditions from the search screen.

	Details	Total number
1.1a	Number of patients from your practice with a condition marked as domestic violence victim	

16 https://www.dvrcv.org.au/publications/books-and-reports/guide-for-general-practitioners

Information sharing guidelines

To support practitioners in the field of domestic and family violence to appropriately share information under the new legislative provisions, Domestic and Family Violence Information Sharing Guidelines have been developed. These Guidelines provide information about what is permitted under the legislation, who is allowed to share information, what circumstances allow information sharing without consent to ensure the safety of victims and children, and what information can be shared.

What does the legislation say?

The Act (part 5A div 1 s169B) identifies the following key principles specific to information sharing:

- Adult patients experiencing DFV do **not** fall under mandatory reporting laws.
- Obtaining the patient's consent to release information is preferable where safe, possible, and practical.
- Consider if disclosing the information is likely to adversely affect the safety of the patient or another person.
- If there are concerns about a serious threat to life, health, or safety because of DFV, relevant information can be disclosed without patient consent to another prescribed entity, including police and specialist DFV service, to assess risk and manage serious threat.

Mandatory reporting for children

Exposure to domestic and family violence – children living in families where domestic and family violence occurs (any incident of threatening behaviour, violence or abuse that is psychological, physical, sexual, financial or emotional) are considered victims of child abuse. Clinicians need to ensure, where possible, that the child or children and the non-abusive parent are in a safe environment.

The Queensland Child Protection Guide (CPG) is a tool to assist professionals in their decision-making if concerns arise about a child who appears:

- to have experienced, or is likely to experience significant harm AND
- may not have a parent willing and able to protect them from harm.

The CPG will help professionals decide whether to report to the Department of Child Safety, Youth and Women (Child Safety) or refer to other service providers, to help families receive appropriate support and services in a timely manner.

The Child Protection Act 1999 requires doctors and nurses, to make a report to Child Safety, if they form a reasonable suspicion that a child has suffered, is suffering or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse, and may not have a parent able and willing to protect them. New laws have been released in relation to failing to protect children from sexual offences.

Activity 3.2 – Understanding your practice data and reporting for DFV

The aim of this activity is to increase your understanding of the systems in your practice to assist patients

Description	Status	Action to be taken
Are relevant team members aware of how to enter DFV in the practice's clinical software?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to instructions for Best Practice or MedicalDirector.
Are relevant team members aware of how to mark a condition as confidential, not included in summaries and not uploaded to my health record?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to instructions for Best Practice or MedicalDirector.
Do relevant team members know how to enter an appointment reminder to ensure patients experiencing DFV have a long appointment booked at each visit?	☐ Yes: continue with activity**.** ☐ No: **see action to be taken**.	Refer to instructions for Best Practice (record in appointment notes) or Pracsoft.
After completing **activity 3.1** are there any unexpected findings with the number of people who have DFV recorded?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: *(e.g., our records indicated we did not have any patients with DFV, but we know this is not accurate).* How will this information be communicated to the practice team?
Have all relevant team members participated in technology facilitated abuse training?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to training.
Are relevant team members (doctors and nurses) aware of who to contact in relation to mandatory reporting for children?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Information on how to report child abuse can be found from Department of Children, Youth Justice and Multicultural Affairs.
After reviewing the systems in your practice, are there any changes you would like to implement in the practice, to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 4 – REFERRAL PATHWAYS

If anyone, including practice staff, is in immediate danger, call 000.

Domestic and family violence HealthPathways

HealthPathways has comprehensive pathways for domestic and family violence, including abuse and neglect.

HealthPathways provides clinicians in the greater Brisbane north catchment with web-based information outlining the assessment, management and referral to other clinicians. It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

Important DFV HealthPathway

Domestic and Family Violence
- Managing Perpetrators of DFV
- Assistance for Victims of Crime
- Domestic and Family Violence Support Services

Assault or Abuse
- Assault or Abuse Intervention Requests
- Child Protection Reporting

Elder Abuse and Neglect
- Elder Abuse Support Services

DFV SUPPORT SERVICES

DVConnect
1800 811 811 (24/7)
DVConnect helps Queenslanders escape domestic, family and sexual violence by providing crisis helplines, as well as emergency transport and accommodation away from violence.

1800RESPECT
1800 737 732 (24/7)
National sexual assault, family and domestic violence counselling service for anyone in Australia who has experienced, or is at risk of, family and domestic violence or sexual assault.

Brisbane Domestic Violence Service (BDVS)
(07) 3217 2544
BDVS provides support to any adult (regardless of gender), young person or child to reach a stage where they are safe and free from fear of DFV in the Brisbane Local Government Area. BDVS provide a range of services including information and referral, crisis support, practical assistance, advocacy and counselling and emotional support.

Centre Against Domestic Abuse (CADA) - Caboolture, Redcliffe, Strathpine
(07) 5498 9533
CADA provides a range of services including, crisis support, court-based services, information and referral, practical assistance, advocacy, emotional support and counselling to individuals (inclusive of all genders) who have experienced domestic and family violence. CADA operates across the Moreton Bay region.
- Caboolture (07) 5498 9533
- Redcliffe (07) 3283 6930
- Pine Rivers (07) 3205 5457

LEGAL SUPPORT

Family Violence Law Help
1800 737 732
Provides information about family and domestic violence and the law in Australia, and links to helpful references and support services.

Women's Legal Service Queensland
1800 957 957
Brisbane, the Gold Coast and Caboolture
A Specialist Domestic Violence Unit (DVU) and Health Justice Partnership organisation, Women's Legal Service provide tailored legal assistance and other holistic support to women and children experiencing domestic violence. Includes assisting clients to access services such as:
- financial counselling
- tenancy assistance
- trauma counselling
- emergency accommodation, and
- employment services.

Lawyers work at hospitals and health centres to ensure women can access legal assistance in a safe location. They also train health professionals to recognise when women have legal problems related to domestic violence.

Family Advocacy and Support Service Queensland
1300 267 762
FASS combines free legal advice and support at court for people affected by domestic and family violence. Lawyers can assist with:
- arrangements for children
- domestic violence orders
- property after separation
- divorce
- child support
- child protection
- applying for legal aid / some urgent court matters

Community Legal Centres Queensland
07 3392 0092
Community Legal Centres are independent, not-for-profit community organisations that provide legal services to the public.

Legal Aid Queensland
1300 65 11 88
Legal Aid provides legal assistance to socially and economically disadvantaged Australians.

Aboriginal and Torres Strait Islander Legal Service Queensland
1800 012 255 (24/7)
A community-based organisation established to provide professional and culturally competent legal services for Aboriginal and Torres Strait Islander people across Queensland.

Police

Domestic Violence Liaison Officers *may be available*

- Albany Creek 3264 0599
- Boondall 3865 5622
- Brisbane City 3258 2582
- Carseldine 3863 5111
- Ferny Grove 3872 1555
- Fortitude Valley Police Beat 3131 1200
- Fortitude Valley 3737 5757
- Hendra 3632 2333
- Indooroopilly 3377 9444
- North Lakes/Mango Hill 3482 1444
- Petrie 3897 7222
- Sandgate 3631 7000
- Stafford 3364 1800
- The Gap 3510 1111

Helplines

Lifeline
13 11 44 (24/7)
Statewide service providing crisis support and suicide prevention services.

Sexual Assault Helpline
1800 010 120 (7.30am to 11.30pm, 7 days)
Statewide helpline providing telephone support and counselling to anyone who has been sexually assaulted or abused, and for anyone who is concerned or suspects someone they care about might have been assaulted or abused.

Kids Helpline
1800 551 800 (24/7)
Statewide counselling service for children and young people aged 5 to 25 years.

Women's Infolink
1800 177 577
Statewide confidential information and referral service on issues affecting women's wellbeing across a broad range of topics, including health, employment, legal services and domestic violence.

Counselling and related services

Women's Wellbeing Hub (part of the Centre Against Domestic Abuse)
(07) 5407 0217
- Offers counselling, support, groups, advocacy information and referrals to women who have experienced trauma from gender based violence

Women's Health QLD (WHQ)
1800 017 676
- DFV specialist counsellors provide trauma-informed and healing centred counselling. Support groups available.

Victim Assist Queensland (VAQ)
1300 546 587
- Access to support services and financial assistance to help victims of violent crime – including DFV – to recover.

Sandbag Community Centres – Bracken Ridge
07 3269 0277
- Offers specialised counselling for women and children (5+years) who have been affected by Domestic and Family violence.

Family and Relationships Services - Fortitude Valley
07 3251 5000
- Provides information and domestic violence counselling to adult victims.

Relationships Australia - Family Violence Prevention Program – Spring Hill
1300 364 277
- Provides domestic violence counselling to adult victims and intervention programs for men who use violence in their intimate relationships.

Specific Populations

Culturally and linguistically diverse

Immigrant Women's Support Service (IWSS)
(07) 3846 3490
Practical and emotional support to immigrant and refugee women from non-English speaking backgrounds who have experienced domestic and/or sexual violence

Aboriginal and Torres Strait Islander people

Kurbingui Development Association - Numula Domestic & Family Violence Safety Response
(07) 3265-3260

Provides culturally responsive support service and links to services for Aboriginal & Torres Strait Islander individuals and families impacted by domestic and family violence.

Gallang Place Counselling Services
(07) 3844-2283.
Provide a range of counselling, advocacy and support services.

ATSICH Brisbane
(07) 3240-8903.
Provides health and social support services, with a variety of family and child programs.

Differently abled

WWILD
(07) 3262 9877
Supports people with intellectual or learning disabilities who have experienced sexual abuse or have been victims of crime.

Men

MensLine Australia
1300 789 978 (24/7)
MensLine Australia is a telephone and online counselling service for men with emotional health and relationship concerns, including issues of violence.

Men's Referral Service
1300 766 491
(M to F: 8am to 9pm, Sat/Sun: 9am to 5pm)
The Men's Referral Service is a men's family violence telephone counselling, information and referral service for men using or at risk of using violent or controlling behaviour.

Men's Information and Support Association Inc.
(MISA)
(07) 3889 7312
Men's information and support services

LGBTIQ

Q Life
1800 184 527
Counselling and referrals focussed on the well-being of LGBTIQ people

Perinatal

Perinatal Wellbeing Support
(Monday to Friday: 8:00am to 4:30pm).
Perinatal Team Member Contacts

- Team Leader - 0438 682 967
- 0408 151 138
- 0413 482 684
- 0417 819 949
- 0417 851 452

Email referral:
perinatal-mental-health@health.qld.gov.au
Fax: 3146 2587

Hospital Services

Social workers undertake risk assessment, safety planning and referral to specialist support services.

RBWH - There is 24/7 Social Work coverage in the Emergency and Trauma Centre (ETC) at RBWH. Social workers respond jointly with medical and nursing staff to patients presenting for health care in relation to domestic and family violence. The ETC social workers are also available 24/7 to primary care staff for consultations and advice on 3647 4619.

TPCH – Social work hours 6:30am-11pm, 7-days a week. Services include crisis counselling and domestic and family violence support (safety planning and referral to mental health and/or DFV services, including QPS).

SART 24/7 Acute Response (RBWH Emergency Department)	**SART Post-Acute Counselling & Support Service (RBWH Monday to Friday 8:00am-4:30pm)**
• Based in the RBWH Emergency and Trauma Centre (ETC) • Provide crisis intervention, information and reporting options including QPS complaint and 'Just In Case' pathways (forensic medical examination); and QPS Alternative Reporting Option. • 24/7 on-site Forensic Medical Officer/ Forensic Medical Nurses. • Psychosocial, risk and safety assessment, discharge planning and post-acute follow up referrals. • Referral to QPS, support during initial QPS interview and forensic medical exam, post-acute follow up.	• Post-acute follow up and sexual assault counselling based at RBWH. • Statewide 'Just in Case' follow up @ 3,6, and 11 months post forensic medical examination. • Responding to referrals from QPS. • Service coordination. • Professional training. • Community based education.

What to do if someone does not want to be referred

- consider your patient's safety as a paramount issue
- monitor the woman and her children's safety by asking about any escalation of violence
- empower them to take control of decision making; ask what they need and present them with choices
- respect the knowledge and coping skills they have developed. You can help build on their emotional strengths, for example, by asking 'How have you dealt with this situation before?'
- provide emotional support and offer a mental health care plan referral instead of a DFV referral.
- reassure the patient that the referral to the service will be confidential and supportive
- encourage your patient to book appointments with you regularly.

Activity 4.1 – Referral Pathways

Complete the checklist below in relation to referral pathways.

This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Description	Status	Action to be taken
Do all GPs and nurses have login details for HealthPathways?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Information on accessing HealthPathways
Do all relevant team members know where to refer a patient for DFV support?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to information from Brisbane North PHN website or Queensland Health for more support.
Do all relevant team members know where to obtain information about reporting child safety concerns?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to the Queensland Child Protection Guide.
After reviewing your practice's referral pathways, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 5 – WORKING WITH PEOPLE USING VIOLENCE AND COERCIVE CONTROL

While it is important to focus on the survivors of abuse and violence, it is equally important to acknowledge the entire family when considering care. General Practice, unlike other health services, may come into contact with the victim, the perpetrator and/or the children. Intimate partner abuse affects all members of the family.

- Perpetrators are not a homogenous group; they come from all socioeconomic, cultural and social groups.
- It is not recommended for one health practitioner to counsel both the victim and the perpetrator.[17]
- If a health practitioner is providing consultations to both the victim and the perpetrator, it is recommended they contact their medical defence organisation to discuss in detail.

> ***Perpetrators of intimate partner abuse tend to minimise responsibility for their use of violence, blame the victim or other issues and greatly under-report their use of violence.***

Perpetrators use physical, sexual, emotional, social, financial and other forms of violence to maintain their power and control in the relationship. This is rather hard to do on occasions.

Factors identifying a perpetrator

Perpetrators are more likely to come from families where intimate partner abuse occurred, where they experienced child abuse or an absent or rejecting father. Other factors include:

- Mental disorders
- Substance abuse
- Poverty
- Unemployment
- Associating with delinquent peers in the community

It is extremely important to understand that while some of the factors outlined above may be risk factors for intimate partner abuse, they are not causal. It cannot be assumed that perpetrators are mentally ill and/or substance abusers.[18]

Responding to disclosures by people that are violent towards family members

If violence is suspected and further information is needed, start with broad questions such as:

'How are things at home?'

Then, if there is a disclosure of violence, ask more specific questions such as:

'Some people who are stressed like you are, hurt the people they love. Is this how you are feeling? Is this happening to you? Did you know that there are services from which you can get assistance?'

Assist the person to contact a counselling service for behaviour change.

If you believe the perpetrator's behaviour poses as immediate risk of harm to the victim, their family or themselves, and urgent assistance is required, call the police on 000.

For further information, go to Health Pathways.

17 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/dealing-with-perpetrators-in-clinical-practice

18 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/dealing-with-perpetrators-in-clinical-practice

Activity 5.1 – Understanding the role of general practice with people using violence

Complete the checklist below in relation to people using violence.

This activity is designed to raise your awareness of local referral options available for people using violence.

Description	Status	Action to be taken
Are relevant team members aware that perpetrators can come from any socioeconomic, cultural and social groups?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to the RACGP's White Book 5th Edition – released 2021 for further information.
Are team members aware of counselling programs and services to assist perpetrators of DFV?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to HealthPathways for Managing Perpetrators of DFV
Does the practice have a plan on how to safely arrange different GPs for both victim and perpetrators of DFV?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	It is recommended the GP discuss this with their medico-legal representative.
Has the practice manager discussed specific referral information and opportunities to connect with the local specialised DFV service?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Find your local service provider on HealthPathways or contact Brisbane North PHN at practicesupport@brisbanenorthphn.org.au to be connected.
After reviewing your practice's understanding of managing someone using violence, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 6 – DEBRIEFING PRACTICE STAFF AND SUPPORT FOR VICARIOUS TRAUMA

Working with those who are experiencing or have experienced trauma can be emotionally challenging and result in the experience of vicarious trauma.

- It is important to maintain an environment, both individually and in practice, where there is adequate protection from burnout or the vicarious trauma that may come from hearing the stories of patients involved in abuse and violence.
- Health practitioners cannot give to others if they are experiencing compassion fatigue, so it is advised that self-care and a whole of practice approach be addressed for patients to receive the best possible care. Refer to and encourage all health practitioners to complete the self and organisation care checklist.
- Working as a team within the practice by using a system that provides peer support and the ability to discuss distressing cases may help protect against stress. [19]

Example of awareness, balance and connection strategies		
	Personal	**Organisational**
Awareness	• Proactively instigate self-care strategies. • Understand and improve your awareness of when you are stressed, tired, overwhelmed.	• Ensure your practice has a mentor or supervisor to support your professional development. • Consider using debriefing strategies (formal or informal) in your practice. Working with those who are experiencing or have experienced trauma can be emotionally challenging and result in the experience of vicarious trauma. • Cultivate open and supportive dialogue with your practice team. • Ensure organisational boundaries are known and understood by patients (e.g., home visits, consultation length).
Balance	• Review your lifestyle and consider healthy options. • Seek balance in all spheres of your life: physical, psychological and social.	• Review workload regularly to ensure that all members of the practice team are adequately supported. • Take care in scheduling complex care needs patients.
Connection	• Consider joining a social action group where you have a passion for change. • Talk to others about work, debrief safely, ensuring confidentiality is always maintained. • Nurture positive relationships with family and friends.	• Join a peer support or Balint group or informal network. • Undertake regular continuing professional development with your colleagues.

19 https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book

Activity 6.1 – Reviewing your practice's strategies for self-care for your practice team

Complete the checklist below to review your practice's strategies for self-care for your practice team.

Description	Status	Action to be taken
Have relevant team members completed the sense of safety self-care audit?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide team members with a copy of the audit to complete and self-reflect.
Are GPs and medical students aware of the DRS4DRS support line?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the DRS4DRS website for more information.
Do relevant team members have mentors or supervisors who they can talk to about stressful situations?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider developing a buddy system in the practice. Assist GPs to identify supervisors/mentors.
Do practice team members take adequate leave during the year?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Create leave calendar and ensure all team members are given adequate leave each year. Ensure all team members are taking leave on a regular basis.
Does the practice ensure practice team members are provided with physical security and a safe, confidential workplace?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to tips and tools from the RACGP general practice – a safe place guidelines.
Are relevant team members supported to complete continuing education?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to RACGP QI&CPD planning learning and need information.
After reviewing your practice's strategies for self-care for your practice team, are there any changes you would like to implement in the practice to help manage staff over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 7 – ONGOING CARE CO-ORDINATION

Follow up and continuity of care for victims

At least one follow-up appointment (or referral) with a health care provider or social worker should be offered after disclosure of current or past abuse.

At every follow up visit with patients currently in abusive relationships:

- review the medical record and ask about current and past episodes of DFV
- communicate concern and assess both safety and coping or survival strategies:
  - "I am still concerned for your health and safety"
  - "Have you sought counselling, a support group or other assistance?"
  - "Has there been any escalation in the severity or frequency of the abuse?"
  - "Have you developed or used a safety plan?"
  - "Told any family or friends about the abuse?"
  - "Have you talked with your children about the abuse and what to do to stay safe?"
- Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.)[20]

Activity 7.1 – Reviewing your practices ongoing care co-ordination

The aim of this activity is to review your practices care co-ordination and continuity of care for patients with DFV.

Description	Status	Action to be taken
Can patients at your practice request their preferred practitioner?	☐ Yes, how is this done? ☐ No, **see action to be taken.**	Please explain: Have processes so patients can see their preferred practitioner when possible and when appropriate, considering the medical urgency of the issue.
Does the practice have a system to ensure patients return for follow-up appointments?	☐ Yes, what is the system? ☐ No, **see action to be taken.**	Please explain: Consider holding a team meeting to discuss how you ensure patients return for follow-up appointments. Is this via reminder system? Is it via action list? Need to make sure this is done safely.
Are all team members aware of maintaining patient confidentiality? This is being mindful not to discuss patient information even with partners.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to RACGP standards for general practice – criterion 6.3.
After reviewing your practice's ongoing care coordination, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

20 NCG_final.pdf (ipvhealthpartners.org)

ACTIVITY 8 – EDUCATION, TRAINING & RESOURCES

Resources for health professionals

- RACGP - Abuse and violence: working with our patients in general practice, 5th edition, (the White book)
- RACGP and Emerging Minds Child Mental Health Series covering adverse childhood experiences (ACEs), trauma-informed care, social and emotional development, and relationships and attachment
- RACGP - GP e-learning and face-to-face
- Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery – Blue Knot Foundation
- Project ECHO (Children's Health Qld) Video link - Interactive on-line multidisciplinary education and case presentations to improve knowledge and capability of GPs and health professionals. Offered for free throughout the year at certain times/dates.
- Emerging Minds – National Workforce Centre for Child Mental Health
- Mental Health Professionals Network
- RACGP - Webinar discussion - Stress, burnout and vicarious trauma: looking after yourself
- RACGP - Webinar: overview of the role of GPs in identifying and responding to men who use violence in their relationships
- RACGP - Webinar: how elder abuse can present in general practice, ways to effectively recognise and respond to risk factors and signs
- RACGP - Webinar: Aboriginal family violence and the impact on women and children in this cycle of violence and abuse
- Queensland Health - Dream Big, Act Big for Kids
- ANROWS Australian National Research Organisation for Women's Safety – publication and news updates
- Our Watch – tools and resources.

Training for health professionals

- RACGP – professional development program on family abuse and violence
- WorkUp Queensland – resource hub.

Aboriginal and Torres Strait Islander & CALD community information

- Safer Healthcare for Australia's First Peoples – free 6-hour self-paced online course for health professionals, Griffith University
- RACGP guides on Aboriginal and Torres Strait Islander Health
- Healing Foundation
- Evolve Therapeutic Services

General information on the child protection system

- Department of Child Safety, Youth and Women
- Family and child connect
- Medical decision-making guide for health professionals
- Information sharing guidelines
- Regional child safety offices may be able to arrange in-services.

Tenancy Information for patients

- Domestic and Family Violence tenancy forms -to be completed and signed by an authorised professional can be provided as a type of relevant evidence to support that a tenant/resident is/has been experiencing domestic and family violence.
- Domestic and Family Violence tenancy toolkit by TenantsQLD

Activity 8.1 – Identifying health professionals with a special interest DFV

Complete this checklist to identify relevant team members who have a special interest in DFV.

Description	Status	Action to be taken
Do you have any GPs or admin leads in your practice who have a special interest or have done extra training in managing people effected by DFV?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	List a clinical lead and admin staff member who have a special interest in DFV in your practice: _____ _____ _____ _____
Do you have any GPs in your practice who are interested in pursuing further training or professional development in this area?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Contact the PHN to discuss available training options.
After reviewing your practice's interest in managing DFV, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

ACTIVITY 9 - POLICY AND PROCEDURES

It is important the practice reviews its policy and procedure manual, to ensure relevant documentation is in place and up to date. It is recommended the practice reviews their policy and procedure manual for inclusion and accuracy.

Activity 9.1 – Policies and Procedures

*Complete the below table to gather information on your **current** policies and procedures relating to domestic and family violence.*

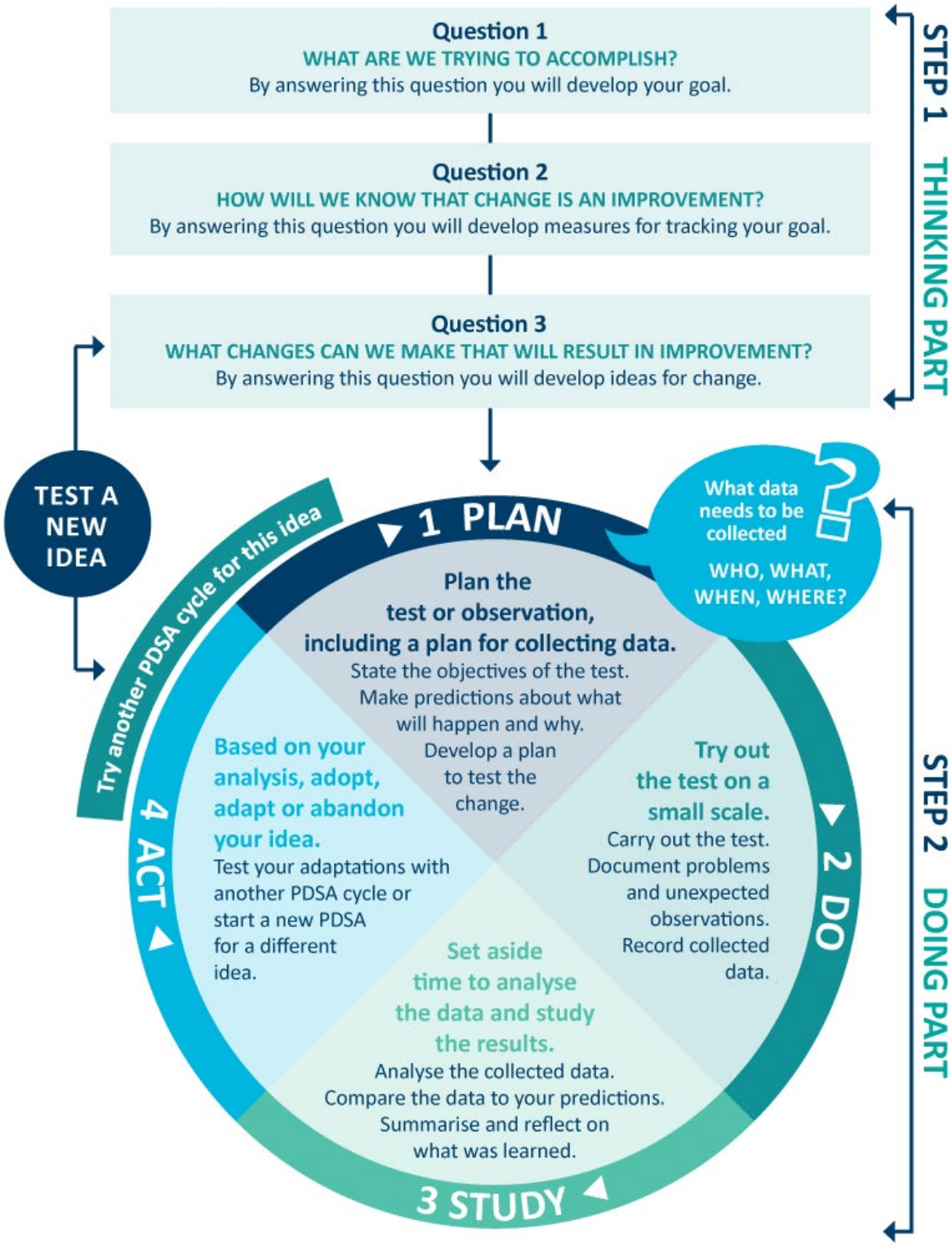
Activity 9.1 – Review Policy & Procedures				
Does the practice have a policy and procedure for the following?	**Policy up to date ***	**Policy needs reviewing**	**Who will develop, review or update?**	**Date completed**
Domestic and family violence workplace policy	☐	☐		
Trauma informed care	☐	☐		
GP self-care (Doctor's Health in Queensland)	☐	☐		
Transfer of patient care	☐	☐		
Patients' rights and responsibilities	☐	☐		
Patient confidentiality	☐	☐		
Mental health first aid	☐	☐		
Availability and use of interpreter services	☐	☐		
Stress management	☐	☐		
Continuing professional development and ongoing training	☐	☐		
Mentoring and supervision	☐	☐		
Working with service providers				

Activity 9.2 – Policies and procedures review

The aim of this activity is to complete a PDSA if any policy and procedures need updating in your practice.

Description	Status	Action to be taken
After reviewing your relevant policy and procedures, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken** to help set your goals. ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

Step 1: The thinking part - The 3 fundamental questions

Practice name:	Date:
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.

Record this as a S.M.A.R.T. goal (Specific, Measurable, Achievable, Relevant, Time bound).

Our goal is to:
Ensure all practice team members complete DFV training.
This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.

So, for this example, a better goal statement would be:

Increase the number of practice team members who have participated in DFV by 25% by 20th December.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g., CAT4 reports, patient surveys etc). Record and track your baseline measurement to allow for later comparison.

We will:

A) Review all the teams completed education during the past 24 months.
B) Identify individuals who have not completed DFV training.

BASELINE MEASUREMENT: 25% of our team members have completed DFV training DATE:

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.MA.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming to develop this list of change ideas.

IDEA: Identify training opportunities that are available including face-to-face, webinars, in house upskilling etc.

IDEA: Manager to meet with each staff member to identify training requirements.

IDEA: Create an ongoing system to ensure staff members participate in training regularly.

IDEA: Management meet to discuss and finalise process for applying for training (will there be a template for applying, will practice pay for training etc). Ensure this is documented in the policy & procedure and employment manuals.

IDEA: Practice team decides on the best way to communicate upcoming education opportunities (is it via email, invitations place on pinboard etc).

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing

Which idea are you going to test? *(Refer to Q3, step 1 above)*

Practice manager will meet with each team member individually to identify training requirements.

PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.

WHAT:

Sally will develop a staff training template and meet with all team members to discuss training needs. Sally will also identify current training opportunities. Sally is going to create a folder on her computer called staff training and then have sub folders for each team member. All training certificates will then be scanned and saved electronically. Each team member will have a meeting with Sally to review completed and future training opportunities.

WHO/WHEN/WHERE:

Who: Practice manager When: Begin 1st September Where: Practice manager office.

DATA TO BE COLLECTED: Number of team members who have participated in DFV education.

PREDICTION: 50% of the practice team will have participated in DFV education.

DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).

Done – completed 20th December – Sally developed a staff training template and met with all team members to discuss training needs. Sally also identified current training opportunities. Sally created a folder on her computer called staff training and then sub folders for each team member. All training certificates were scanned and saved electronically. A spreadsheet was created to easily be able to identify the number of training sessions each person has completed. Each team member had a meeting with Sally to review completed and future training opportunities.

Most staff reported that they felt because of COVID restrictions that they would not be able to participate in face-to-face training, but Sally was able to provide staff with options for webinars and online sessions.

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.

After focussing on increasing the number of team members who have participated in DFV training, 50% of the practice team had completed the training.

Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT: Sally felt this was a great opportunity to review training requirements for team members. However, this will be done as part of the annual performance review.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea