CENTRE OF RESEARCH EXCELLENCE
Safer Families

Strengthening Response to Family and Sexual Violence in Tasmania

A primary care learning initiative

PATHWAYS TO SAFETY WORKSHOP

Participants Handbook
2026- 27

"A health professional may be the **only** *person that sees a victim who is experiencing family violence. Your response could save a life."*
Jasmine, WEAVERS lived experience group

SaferFamilies CENTRE OF RESEARCH EXCELLENCE
Safer Families Centre of Research Excellence
University of Melbourne
www.saferfamilies.org.au

THE UNIVERSITY OF MELBOURNE

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1. Program Overview

"I think it's important that doctors take the time with survivors of violence to understand the full array of all our symptoms, the impacts that they have on our lives, and on our mental health, and recognise that what they have studied in medical books is not necessarily how we experience our diagnoses, everyone is different and experiences things differently."

Cina, WEAVERS lived experience group

Acknowledgements

‘Pathways to Safety’ is an educational program developed by The University of Melbourne that has been adapted for delivery in Tasmania in a workshop format. This handbook is for those who have attended the training supported by Primary Health Tasmania.

We would like to thank the WEAVERS lived experience group of survivor advocates for their expertise about the role of primary care and health practitioners and the quotes they have supplied for this handbook.

Terminology and Definitions

The terms domestic violence and family violence are often used interchangeably. However, the scope of relationships covered by domestic and family violence legislation varies across the states and territories.

In other jurisdictions, violence perpetrated by a spouse or partner may be known as domestic violence or intimate partner violence, and family violence is a broader term that can include violence between other family members. Tasmania uses the term ‘family violence’ to acknowledge that children are impacted when violence is directed at one of their carers and, as a result, are victim-survivors in their own right.

Within this handbook and workshop series we will use the acronyms ‘FV’ to refer to family violence and ‘FSV’ to refer to family and sexual violence.

Learning Objectives

The program will enable you to reflect on your practice, read new material, test out some new tools and be involved in experiential learning. It will be most valuable to you if you are able to identify your own practice’s needs.

The training program aims to support and build upon GPs’, nurses’, and other practice staff members:

- active listening and responding skills to build trust with patients
- access to up-to-date evidence and resources in responding to FSV
- skills to assess readiness for change and non-directive goal setting
- promotion of changes in the practice to support dealing with FSV

At the end of the training all primary care staff should be able to:

1. **Respectfully** engage with patients experiencing FSV, including culturally safe ways to engage
2. **Review** current clinic protocols and resources and implement changes to enhance response
3. **Reflect** on their own attitudes which might facilitate or inhibit effective engagement with families experiencing FSV

At the end of the training all primary care clinical staff should be able to:

1. **Recognise** families presenting with symptoms and signs of FSV
2. **Risk** assess for safety of women and children experiencing FSV
3. **Respond** to disclosures using the World Health Organisation first line response of LIVES, including being able to assess readiness for patients to take action, make safety plans and enable support for survivors and their families
4. **Refer** appropriately depending on the needs of patients
5. **Record** and share information in a safe, effective manner

Learning outcomes for the clinical workshops are:

1. Identify respectful and culturally safe ways to engage with patients experiencing family and sexual violence.
2. Distinguish families presenting with symptoms and signs of family and sexual violence.
3. Assess safety risks for women and children experiencing family and sexual violence.
4. Apply appropriate clinical responses* to disclosures of family and sexual violence in Tasmanian general practices, including assessing readiness to take action, supporting safety planning, facilitating access to Tasmanian support services/referral pathways.
5. Assess current clinic protocols and resources for responding to family and sexual violence to identify areas where changes are needed to enhance response.

*Using the World Health Organisation first line response of LIVES (Listen, Inquire, Validate, Enhance safety, Support).

Learning outcomes for the non-clinical workshops are:

1. Identify types and signs of family & sexual violence and how members of the family might present in the waiting room.
2. Identify and examine barriers to disclosure and seeking support for patients experiencing family & sexual violence
3. Apply appropriate, respectful and culturally safe engagement strategies with patients experiencing family & sexual violence.
4. Assess current clinic protocols and resources for responding to family & sexual violence to identify areas where changes are needed to enhance response.

Workshop Outline

Clinical Workshop Outline		
Item	**Topic and activities**	**Duration**
1	Introductory and background discussion about family & sexual violence	20 min
2	Discussion: - How women and children experiencing family and/or sexual violence and men using violence might present	15 min
3	Barriers and facilitators/ setting the scene: - Discussion on barriers and facilitators for women to disclose, including additional barriers for diverse patient populations. - Reflection on challenges in work environment to address family and sexual violence	15 min
4	Asking about abuse, violence and safety	15 min
5	Disclosure: - What women want from health professionals and what to do when someone discloses	10 min
6	Enhancing safety: - Risk factors, risk assessment & management, safety questions & planning	10 min
7	Training video: - How to build trust to enhance change	20 min
8	Working where survivors are at: - Overview of patient's various states of ability to take action and how practitioners should respond at each stage	10 min
9	Sharing information and making a warm referral	5 min
10	Trauma and violence informed care and practice	15 min
11	Services and Summary: - Available local services overview - Reflection of impact of training to date on practice for patients seen	15 min
12	Questions	15 min

The Pathways to Safety Workshop Series Project Team

Primary Health Tasmania

Primary Health Tasmania support community-based healthcare providers to deliver the best possible care for Tasmanians, particularly those most at risk of poor health outcomes.

Primary Health Tasmania has received Australian Government funding for the Supporting the Primary Care Response to Family and Sexual Violence Pilot.

This pilot aims to strengthen responses to FSV in Tasmania with increased support to GPs and other primary care providers to assist in the early identification of family and sexual violence and child sexual abuse, and to aid early intervention. It will also help better connect the different services providing care to people affected by violence.

The Pathways to Safety Workshops were funded by Primary Health Tasmania as part of this pilot. For more information see: https://www.primaryhealthtas.com.au/for-health-professionals/programs/family-domestic-and-sexual-violence/

For any questions about this pilot, you can contact Primary Health Tasmania Provider support via: providersupport@primaryhealthtas.com.au Ph: (03) 6213 8260.

Safer Families Centre, Department of General Practice, The University of Melbourne

The Safer Families Centre coordinates a program of work aimed at transforming the health sector's response to domestic and family violence. The Centre based at The University of Melbourne oversees the day to day running of the *Pathways to Safety* educational program. Visit: www.saferfamilies.org.au

Kelsey Hegarty is a GP and Chair of Family Violence Prevention at The University of Melbourne and The Royal Women's Hospital and Director of the Safer Families Centre. Kelsey's research and teaching interests are in women's emotional well-being (domestic and family violence, depression, counselling).

Kitty Novy is an Education Officer with extensive experience in working with general practices. Kitty is responsible for the day-to-day management of the educational program and is a first point of contact for queries relating to the program.
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Rachel Komen is the Resources Manager, Special Projects and Safer Families Key Contact assisting in the day-to-day management of the educational program and is another point of contact for queries relating to the program.
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Engender Equality

Since 1987, Engender Equality has worked with, and on behalf of, individuals, families and communities affected by family and domestic violence in Tasmania.

By actively challenging gender-based oppression they aim to achieve positive and respectful relationships within healthy, inclusive structures and institutions.

A dynamic, evolving organisation, Engender Equality's philosophies, practice and resources are based around lived experience and grounded in cutting-edge research.

admin@engenderequality.org.au Ph: (03) 6278 9090

2. Tools for use in Consultations

Many of these tools are available online from the Safer Families Centre website, simply click on the title of the tool to access it. Other useful tools not available online or that have been adapted specifically for Tasmania health care providers, have been included in this section of the handbook. We encourage you to review all of the tools listed.

> *"Please seek to understand my own personal circumstances...I am not a number...and a pill isn't always the answer!"*
> **Sharon, WEAVERS lived experience group**

Identification of Family Violence

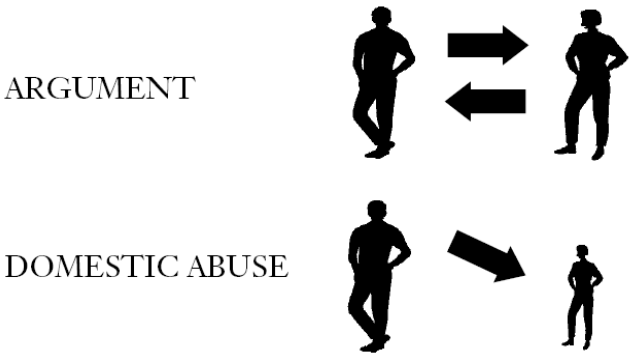
- **Healthy Relationships Tool** – Page 9
- **Power and Control Tool**
- **Power and Control Wheel for Lesbian, Gay, Bisexual and Trans Relationships**
- **The disemPOWERed & out of CONTROL wheel: A trauma-informed approach to working with Aboriginal and Torres Strait Islander men**
- **WEAVE Model**
- **Use of Telehealth** – Page 10
- **Safety and Relationship Tool**
- **Life Situation Assessment Tool** – Page 11

Healthy Relationships Tool

The health of an adult relationship encompasses a spectrum ranging from positive to negative.

Positive relationship health involves mutual trust, support, investment, commitment and honesty. It involves the exchange of words and actions in which there is shared power and open communication.

Negative relationship health involves unhealthy and abusive interactions with varying exchanges of emotional, physical and sexual violence. It involves words and actions that misuse power and authority, hurt people, and cause pain, fear or harm.



How healthy is your relationship with your current partner?

Place an X on the point on the line that most closely reflects how you feel.

Negative
Abusive

Positive
Healthy

Unhealthy

How healthy is your relationship with your ex-partner?

Place an X on the point on the line that most closely reflects how you feel

Negative
Abusive

Positive
Healthy

Unhealthy

Use of Telehealth to Identify and Respond to Family & Sexual Violence (FSV)

Telehealth consultations can be an effective way to reach some survivors of FSV. It may require additional ways of communicating to ensure safety but overall, the benefits will outweigh the harms if a safe approach is used.

The basic rule of asking about FSV is that the patient is alone in a private setting. For example, all antenatal patients are screened for FV in Victoria, but with increased telehealth consultations, the screening rate is likely to be less than before the COVID-19 pandemic.

It is almost impossible to know if patients are alone while they are on a telehealth call. Below we provide some tips on how to ask about whether a patient is alone or not during a telehealth consultation.

How to approach asking about Family Violence during a telehealth consultation

Use closed questions initially that require a yes/no answer:

- "Are you alone? Can anybody overhear? Is this a safe time to talk?"

If you hear or see somebody in the background:

- "This consultation requires by law that you are alone. Could I ask for the person in the background to leave please?"

Then once you are sure they have left:

- "I frequently ask patients how safe they are feeling at home because this can affect your health. Do you feel safe at home at the moment?"

If you are very concerned about what you hear or see in the background:

- Make an excuse for the patient to be seen face-to-face so that they are allowed to come and see you.

How to approach responding to Family Violence

Express your ability to help:

- "I can connect you with services that can help even during lockdown. Would you be interested? How can I send you the details safely?"
- "You know you can always phone the police if you feel more unsafe."
- "Do you have a friend/family member who you can contact/go to if you feel unsafe?"

Organise a follow-up visit:

- "I would also like to see you again. Can we organise a code word now so that I know it might not be a good time when I ring again for the next consultation? Can you say an ordinary word now that would not alert anybody if they heard you?"

(Simon, M.A. 2021)

Some other points to consider:

Telehealth might enhance safety, trustworthiness and transparency, collaboration and mutuality. Survivors want choice and control, action and advocacy, recognition and emotional connection, all of which can be delivered by telehealth (Tarzia, L et al, 2020).

Some survivors prefer digital health interventions via mobile devices or web-based platforms as it can be perceived as more non-judgemental, practical and convenient, and some trials have shown acceptability and feasibility of this mode of delivery for survivors of family violence (Tarzia, L et al, 2017).

During the COVID-19 pandemic, suggesting use of these digital interventions through telehealth can provide access to screening, risk assessment, safety planning and connection to support services in a safe and private way.

Patients may:

Perceive telehealth appointments as the same as face-to-face (Isautier, JM et al, 2020).

Prefer not to have to leave their home, catch public transport, wait in a room with other patients, or wear masks. Some trauma survivors may even be triggered by catching public transport.

Not be able to perceive the clinician's level of empathy when wearing masks during face-to-face consultations (Ka Man Wong, C 2013).

Find their home an emotionally safe place and, for these survivors, telehealth consultations may be a better modality to receive trauma informed care.

Life Situation Assessment Tool

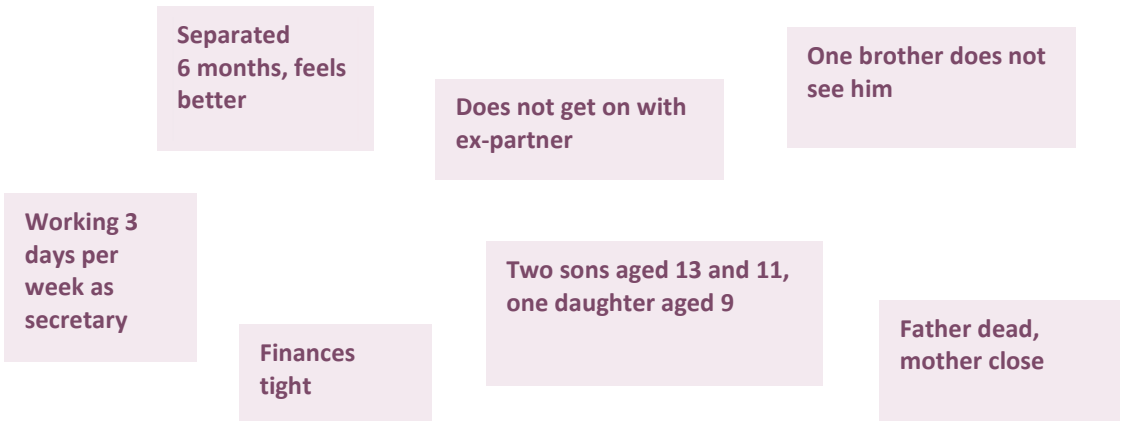
Even though you may know the patient quite well, it is worthwhile taking a history of their patient's current life situation using a life biopsy approach. In this method you do not delve in depth into any of the areas your patient raises but rather attempt to draw a picture or a 'mind map' of the people and things that are in your patients' life (both positive and negative). Sometimes it is good to then focus on how this map would have looked in the past at a time when your patients' emotional health was better or worse. The questions from the WEAVE model might assist you. The trick is to not stick to one area but assure your patient they want to hear about all areas and that you can come back to the ones they want to talk about in depth later. Below is an example.

Remind me again ……

Who is in your life? or

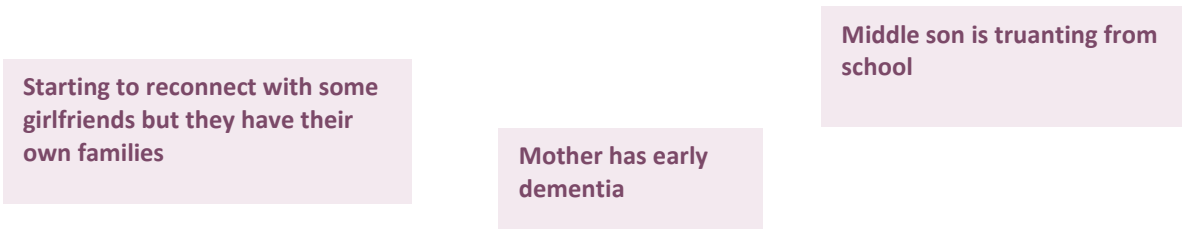
What is happening in your life? or

Tell me about how life is for you at present….



What else is going on? or

Tell me more about your current situation…



Lead into discussion about impact of fear of partner or ex-partner and healthy relationships, using the Safety and Relationships Too

First Line Response to Disclosure

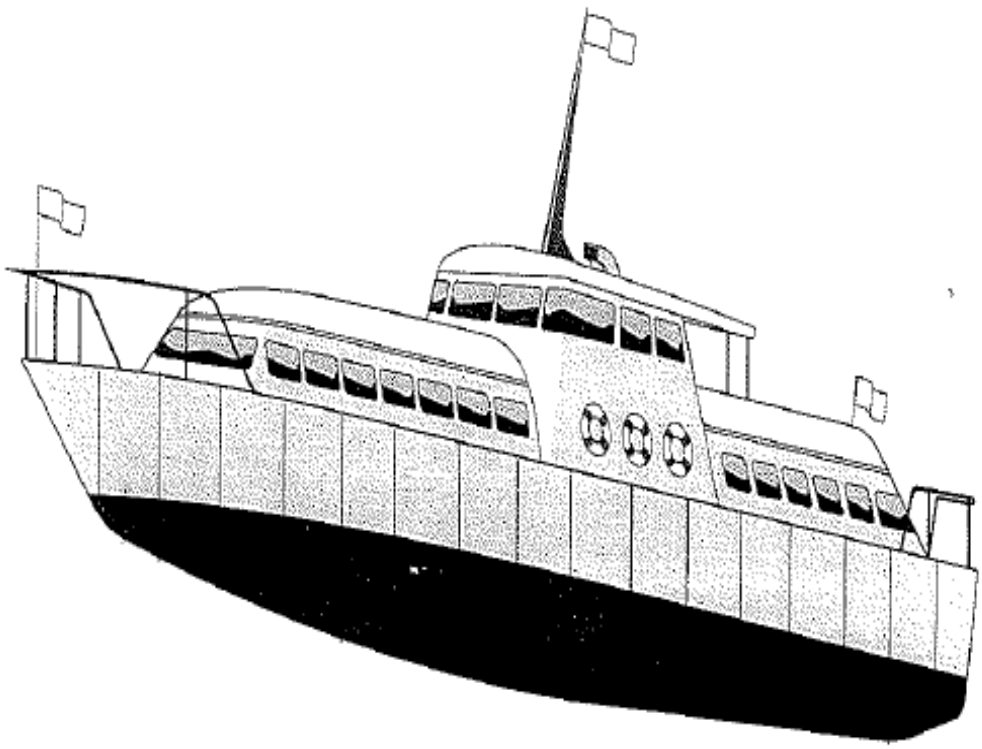
- **LIVES Model**
- **CARE Model**
- **Support Assessment Tool** – page 12
- **Support Wheel** – Page 13
- **Confidentiality Tool**

Support Assessment Tool

There are many ways to assess support.

One way is, when you are doing the life situation assessment, you also get an assessment of how connected the patient is to the people in the mind map. This can be represented by drawing lines to indicate the strength of connection or support. For example, "Who is in your life? How supported do you feel by ….?" Draw the patients' network of support.

Another way to do it visually is to ask the patient to imagine they are on a ship with compartments below water that keep them afloat. Ask them to fill in people/things that keep them afloat now and in the past.



Support Needs Wheel

This wheel can assist patients to identify their needs. Ask them to think about apart from their physical health what the priority is today or in the next month for them in the different areas on the wheel.

What is your greatest need at the moment?

Hegarty, K. (2009)

Safety and Risk Assessment and Management

"Please don't forget I am more than just a 10min timeslot…Please look at me and remember I am a person with a story…"
Emily, WEAVERS lived experience group

Safety and Risk Assessment

Any assessment of risk for FSV must be structured and informed by the patient's own assessment of their safety, the presence of risk indicators, any information that has been shared with the you from other professionals and your own structured professional judgment.

(Family Violence Multi-Agency Risk Assessment and Management Framework)

Assessing safety of women experiencing family violence

- Does the patient feel safe to go home today?
- What do they need in order to feel safe?
- How safe do they feel?
- How safe are their children?

Patients at any time might be feeling unsafe to go home and may need urgent crisis referral and an urgent safety plan. Most patients however feel safe to go home after the visit that day. For these patients, further discussion of risk assessment and safety planning can often be delayed until the next visit. Many clinicians feel very concerned about their patients' welfare and want to stop patients returning to an abusive environment. In addition, it is vital that GPs and nurses assess the level of fear and safety of children and at some stage they need to inform women that the greatest risk to their life is at the time they are leaving or thinking about leaving.

However, **patients are the best judge of whether it is safe to go home**, and a series of questions based on high-risk evidence-based factors listed below can assist both the patient and the GP or nurse reflect on her risk.

Clinicians should work out whether people are at immediate risk (not safe to go home) or elevated risk (says yes to one of the questions above). It may be necessary to share information with other professionals working with the family.

Risk Indicators

Some questions that may help you determine the level of risk are included in the safety and relationship tool as a brief risk assessment:

- Has any physical violence increased in severity or frequency in the last year?
- Has the person being violent to you recently?
    - been obsessively jealous or possessive of you?
    - assaulted you when you were pregnant?
    - threatened or used a weapon against you?
    - tried to choke or strangle you?
    - forced you to have sex or participate in sexual acts when you did not wish to?
    - threatened to kill you?
- Do you believe they are capable of killing or seriously harming you?
- Do you believe they are capable of killing or seriously harming children or other family members?
- Have they ever threatened to harm the children?
- Have they ever harmed your children?
- Have you recently separated from your partner? (family violence only)

(Family Violence Multi-Agency Risk Assessment and Management Framework)

If any of the above questions are answered positively then that patient is at higher risk and you should be sensitively referring them to a specialist service. The flow chart on the following page might help you with this.

Traumatic brain injury and strangulation

Patients who have experienced head trauma and/or non-fatal strangulation can be at risk of traumatic brain injury (TBI). It is important to assess this risk with victim survivors who have experienced physical violence. Strangulation is also an important indicator of increased homicide risk. For more information on this please see: Abuse and violence: Working with our patients in general practice.

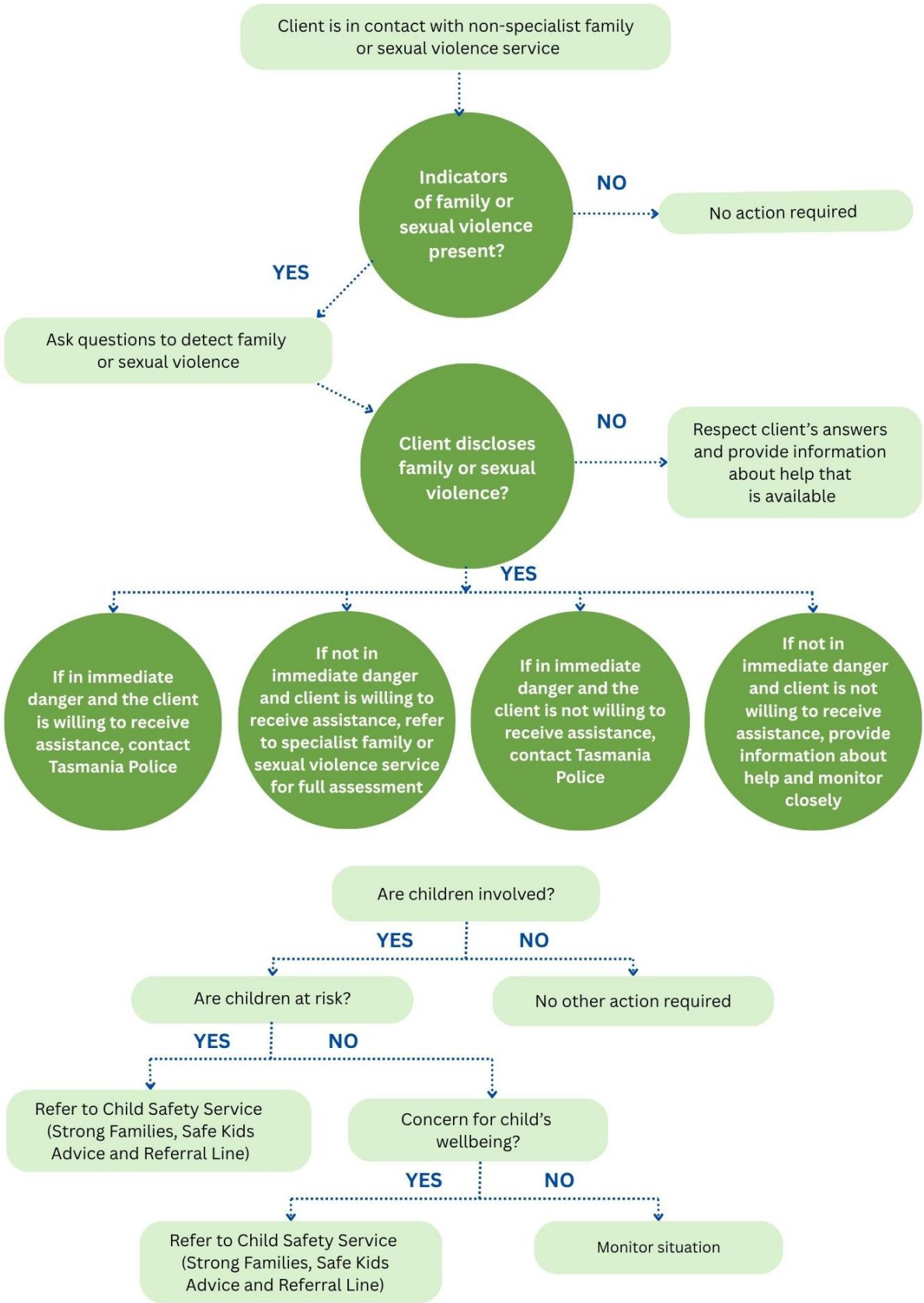
Tasmanian law has made strangulation a crime in itself and has a maximum sentence of 21 years in jail. While it is titled 'strangulation', this law equally applies to choking and suffocation as well. Find out more from Tasmania Legal Aid and Women's Health Tasmania.

Bendigo Community Health Services, in Victoria, has released a training video to assist practitioners in how to talk to victim survivors and what to look for during examinations. View this video here.

Women's Health NSW have developed a video the looks at the important role that general practitioner's (GPs) play in addressing women's experiences of non-fatal strangulation and acquired brain injury. View the video here.

Survivor Risk Assessment Flow Chart

Response options following Identification and Screening of Family and/or Sexual Violence Risk: Referring clients impacted by family and/or sexual violence



Safe Homes Families Communities RESPONDING TO FAMILY AND SEXUAL VIOLENCE - A guide for service providers and practitioners in Tasmania, 2021

Safety and Risk Assessment for Diverse Population Groups

The following set of questions might be helpful for when you are seeing people with diverse backgrounds and identities as they may face additional risks and barriers.

Aboriginal and Torres Strait Islander peoples

- Are you concerned that other people in the community or other family members will find out what is occurring?
- Are you able to get support from your family and community?
- Have you ever been forced to go or stay somewhere you didn't want to be?

Migrant and refugee patients

- If you are not a citizen or permanent resident, are you on a dependent visa?
- If you were thinking about separating from your partner would your family or friends be supportive?
- Have you or your family been subject to any financial coercion (e.g., about dowry)?
- Are you dependent on them for financial needs? (consider ineligibility for Centrelink or work rights in Australia, access to own bank account)
- Are you restricted from having contact with your family, friends and community in Australia or overseas?
- Did you have a choice about being married?

People identifying as LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning)

- Have they outed you or threatened to do so?
- Have they undermined or refused to accept your identity, including in public and with other family members?
- If affirming your gender, have they stopped you from accessing medication or surgery?

Disability

- Are you dependent on the person abusing you to meet your daily needs?
- Are you fearful they will stop giving you support?
- Do you have access to community support from services or other people with disabilities?
- Have they or any other family member stopped you from accessing therapy, mobility or communication aids, equipment, medication, or surgery (if relevant)?

People over the age of 65

- Are you dependent on carers to meet your daily needs or your financial needs?
- Have they threatened to relocate you or make you stay somewhere you did not want to go?
- Are you socially isolated?

Living in Rural/isolated areas

- Do you have mobile reception where you live?
- Do you have people close to you to help should you need practical assistance?

Assessing safety of children (children over 8 years if appropriate)

- Are you scared of either of your parents/caregivers or any other adult in the home?
- Have you ever been physically hurt by either of your parents/caregivers?
- Have you ever tried to stop your parents/caregivers from fighting?
- Has your parent said bad things to you about your other parent?
- Have you ever had to protect or be protected by a sibling or other child in the home?

Information Sharing and consent

GPs are able to share information, where permitted to do so under permissions, such as in accordance with Commonwealth privacy laws which permit the disclosure of information with consent and without consent in other circumstances such as to lessen or prevent a serious threat to the life, health, safety or welfare of a person. These permissions can be used to facilitate referrals, provide information to other services assisting the patient or notifying appropriate services about information that is pertinent to preventing serious risk.

In Tasmania, the permission to share information is provided by the client, unless in certain circumstances provided for by the Personal Information Protection Act 2004, being that there are immediate safety and risk concerns for the individual or others. The information sharing provisions under the Child and Youth Safe Organisations Act 2023, however, override other laws that prohibit information sharing, such as the Personal Information Protection Act 2004. Consent to share information is an ongoing process. For more information, also see Family Violence Act 2004.

Here is an example of the Tasmanian Government Child and Family Wellbeing Assessment Tool Consent to Share Information Form

Consent to Share Information

Name: …… D.O.B: ……/……/……

Address: ……

1. Personal information will be collected from you for the purpose of identifying the services you may need and providing you / your family with support services such as health care services; accommodation services; family support services; mental health, alcohol and drug services; and employment services.
2. If you do not provide consent this information will not be shared with other service providers unless required by law. This may limit our ability to identify other services that could offer support.
3. Under the *Personal Information Protection Act 2004 (Tas)* the Department of …… …… is a personal information custodian and must comply with this Act when collecting, using and disclosing your personal information.
4. This information may be used by the Department of …… to determine appropriate strategies for addressing any risks that are identified for you or your family.
5. Information may also be shared with other professionals helping with wellbeing and risk assessments (e.g. schools, child and family centres and the Advice and Referral Line). It may also have to be disclosed to a relevant authority, if required by law.
6. The information received from you will not be made public and will only be used for the purposes for which it was collected.
7. You can ask your Key Worker to assist you to understand the sort of personal information that is held about you, why they hold that information and how they each collect, hold, use and disclose the information.
8. If you have any questions or concerns, or if you need to update any of the personal information you have provided, please contact your Key Worker on the number provided on the following page of this form.

I ……, acknowledge that this has been explained to me and consent to the use of my information for the purposes outlined above.

Client's Signature

Signature_____Name_____Date_____

Authorised Person's Signature *(if client does not have capacity to consent – legal or informal)*

Signature_____Name_____Date_____

Relationship to Client _____

Key Worker's Signature

Signature_____Name_____Date_____

Position _____

Unit_____ Contact Number_____

Once signed, a photocopy of this form should be offered to the client. The original should be retained and attached to the client's record.

Ongoing responses

- **Readiness to Change - Motivational Interviewing Tool**
- **Non-directive Problem-solving Goal-setting Tool** – Page 21
- **Whole of Practice Checklist** – Page 23

Non-Directive Problem-Solving Goal-Setting Tool

(Gath DH, Mynors-Wallis LM, 1997)

Goal-setting and non-directive problem solving (see the Background Resources section for more detail) assist individuals to use their own skills and resources to function better. For patients who have decided that the abuse is damaging to their health and wellbeing, but whose intentions are not translated into action due to perceived external barriers, then problem-solving techniques may be helpful. Remembering, of course, that as GPs and nurses we should not problem-solve for the patient.

Goal setting occurs in the following stages:

- Clarification and definition of problems,
- Choice of achievable goals,
- Generation of solutions,
- Implementation of preferred solutions,
- Evaluation.

When used by health professionals, this technique engages the patient as an active partner in their care. It creates a framework for individuals to re-focus on practical approaches to perceived problems and learn new cognitive skills.

Whether the solution chosen by the patient is successful is not as important as what the patient learns during the process to apply in other situations. A written example of how a structured approach to problem solving can be applied with an individual is detailed on the next page

Example of written plan for goal setting

Non-directive problem-solving aims to help you to

- recognise the difficulties that contribute to you feeling overwhelmed
- become aware of the support you have, your personal strengths and how you coped with similar problems in the past
- learn an approach to deal with current difficulties and feel more in control
- deal more effectively with problems in the future

You are asked to:

Step 1 Identify the issues/problems that are worrying or distressing you

Step 2 Work out what options are available to deal with the problem

Step 3 List the advantages and disadvantages of each option, taking into account the resources available to you

Problem	Options	Advantages	Disadvantages
1.	1. 2. 3.		
2.	1. 2. 3.		

Step 4 Identify the best option(s) to deal with the problem

Step 5 List the steps required for this option(s) to be carried out

Step 6 Carry out the best option and check its effectiveness

Best option _____

What steps are required to do this?

1. _____
2. _____
3. _____

Whole of Practice Checklist

The whole of practice checklist objectives are:

1. To examine current practices and systems within the practice.

2. To identify areas for change within the practice.

3. To consider supports for staff experiencing Family and/or Sexual Violence

Checklist		Describe
The waiting room/website and other communal areas or general access points		
Are there messaging or posters saying the practice supports those who are experiencing family and sexual violence?	☐	
Do you have messaging or posters that reinforce respectful communication where the client will be listened to and treated respectfully?	☐	
Are resources appropriate to the health literacy and cultural needs of your patients available?	☐	
Are there factsheets and resources available on family and sexual violence?	☐	
• In multiple languages?	☐	
• Specifically for Aboriginal and Torres Strait Islander peoples?	☐	
• For LGBTIQA+ Family Violence specific service?	☐	
Is information about local and national family and sexual violence support services clearly displayed?	☐	
Is there the facility for patients to speak privately to any member of the practice staff so they cannot be overheard?	☐	
Has the practice engaged in cultural sensitivity training in the last 2 years?	☐	
Do you have an acknowledgement that you are on Aboriginal land?	☐	
Does the practice acknowledge NAIDOC week?	☐	
Do interpreters used by your health services receive family and sexual violence training?	☐	
Do staff know how to use the interpreter service and regularly reminded of it?	☐	
Practice staff		
Does the practice have policies and procedures for staff who have been affected by family violence and sexual violence?	☐	
Is support available to staff who may experience vicarious trauma?	☐	

Checklist		Describe
Practice procedures		
Has the practice established access to regular and contemporary training in responding to family and sexual violence for clinical and administrative staff?	☐	
Are all clinical and non-clinical staff trained in recognising and responding to family and sexual violence? • Are they trained to recognise the warning signs of family and sexual violence? • Are they aware of privacy protocols and reporting requirements? • Are all GPs and nurses specialising in antenatal care trained to screen for family and sexual violence? • Have staff reflected on their own assumptions and bias regarding family and sexual violence?	☐ ☐ ☐ ☐ ☐	
Are staff aware of and use Medicare item numbers appropriately? e.g., • Health assessment and chronic disease plans? • Pregnancy numbers for screening and responding to psychosocial issues? • Family violence inquiry to Mental Health Care Plan templates?	☐ ☐ ☐	
Has the practice established a referral pathway to specialist family and sexual violence agencies? Including: • Patients who have disclosed family and/or sexual violence • Perpetrators of family and/or sexual violence • Children affected by family and/or sexual violence	☐ ☐ ☐	
Is there a procedure in place to ensure patients who may be experiencing family and sexual violence can be seen on their own?	☐	
Is there a procedure in place for requests for sharing information?	☐	
Do all staff know, or have access to, information about local specialist family and sexual violence services, their policies & procedures in relation to family and sexual violence?	☐	
Does the practice have a family and sexual violence champion to oversee and regularly monitor practice protocols and act as a secondary consult?	☐	

3. Background Resources

"I am a DV survivor, but trauma does not define me. I am much more than that"
Sanda, WEAVERS lived experience group

Nature of Family Violence, Prevalence, Health Impact and Help-seeking

Trauma and Violence Informed Care and Practice

Asking About Violence and Initial Validation

Cultural and Linguistic Diverse Populations

Aboriginal and Torres Strait Islander Populations

LGBTQIA+ Family Violence Considerations

Information Sharing

Safety of Children and Mandatory Reporting

Legal Issues

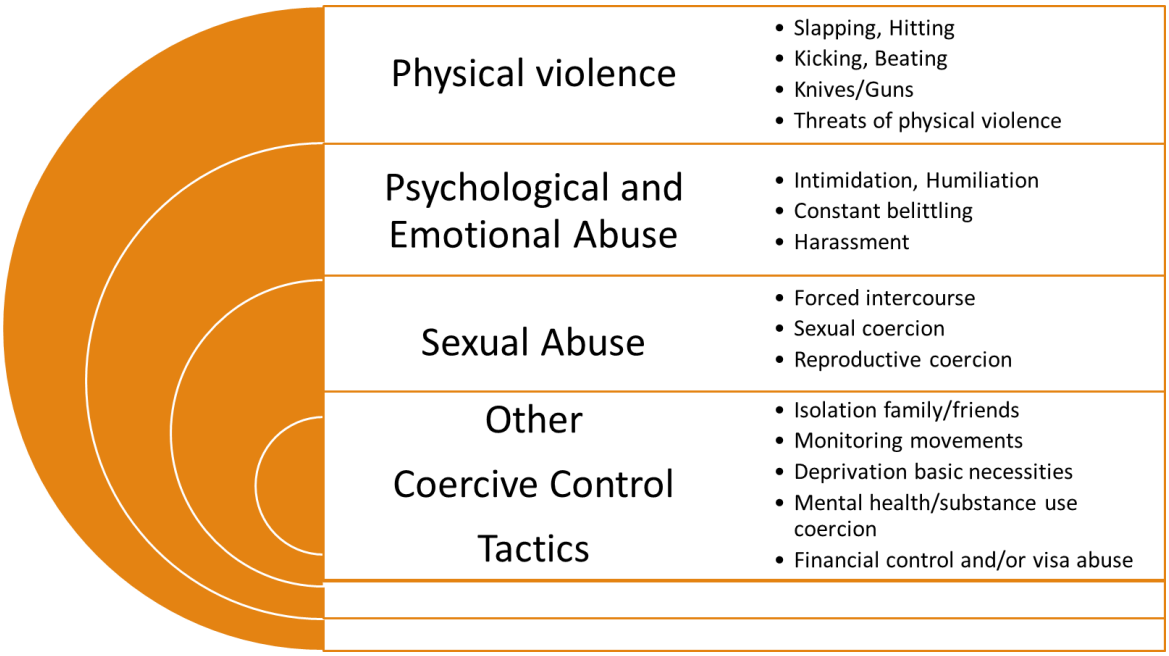
Understanding Change for Patients

Motivational Interviewing & Problem-Solving Techniques

Men Who Use Violence in their Intimate Relationships

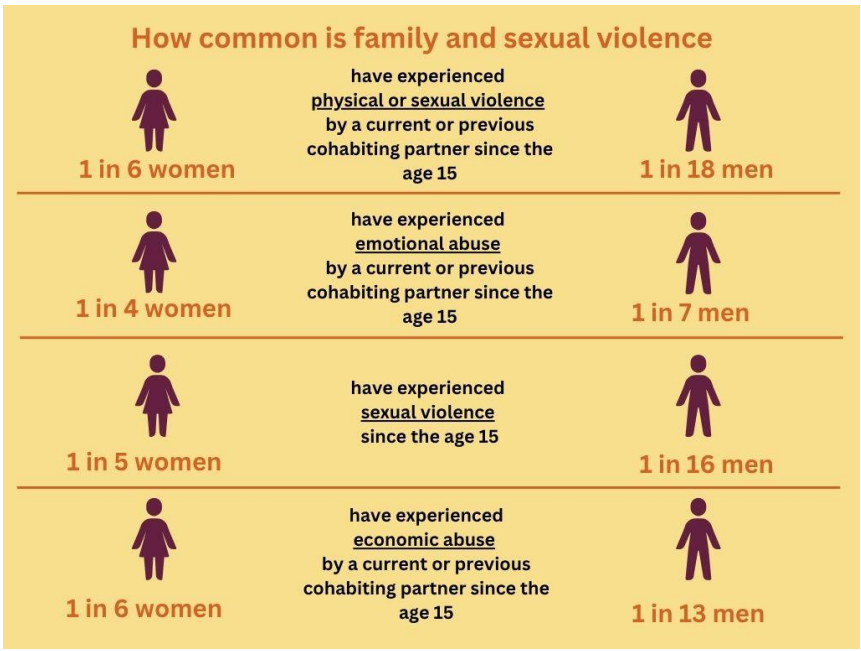
Nature of Family and Sexual Violence, Prevalence, Health Impact and Help-seeking

In Tasmania, under the Family Violence Act (2004), family violence occurs where violent conduct is committed directly or indirectly against a person's spouse, partner or ex-partner and includes a range of violent behaviours. Family violence is more than physical and includes psychological and emotional abuse, sexual abuse and other coercive and controlling tactics, including isolation, monitoring, financial abuse and visa abuse, or an attempt to do any of those things. It can be done face to face or through technological mechanisms.



WHO 2013

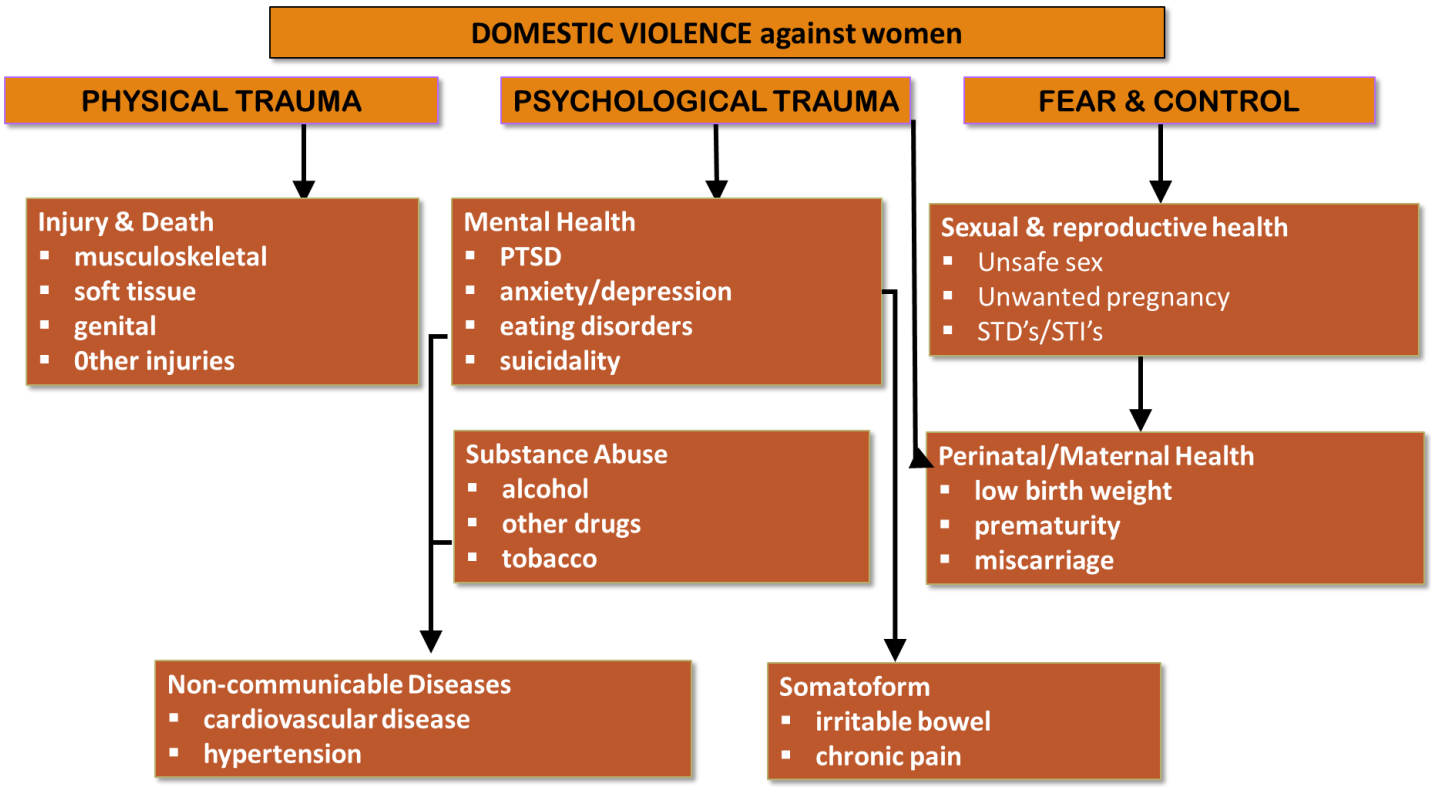
Family and sexual violence is common in the Australian community.



AIHW 2021-22

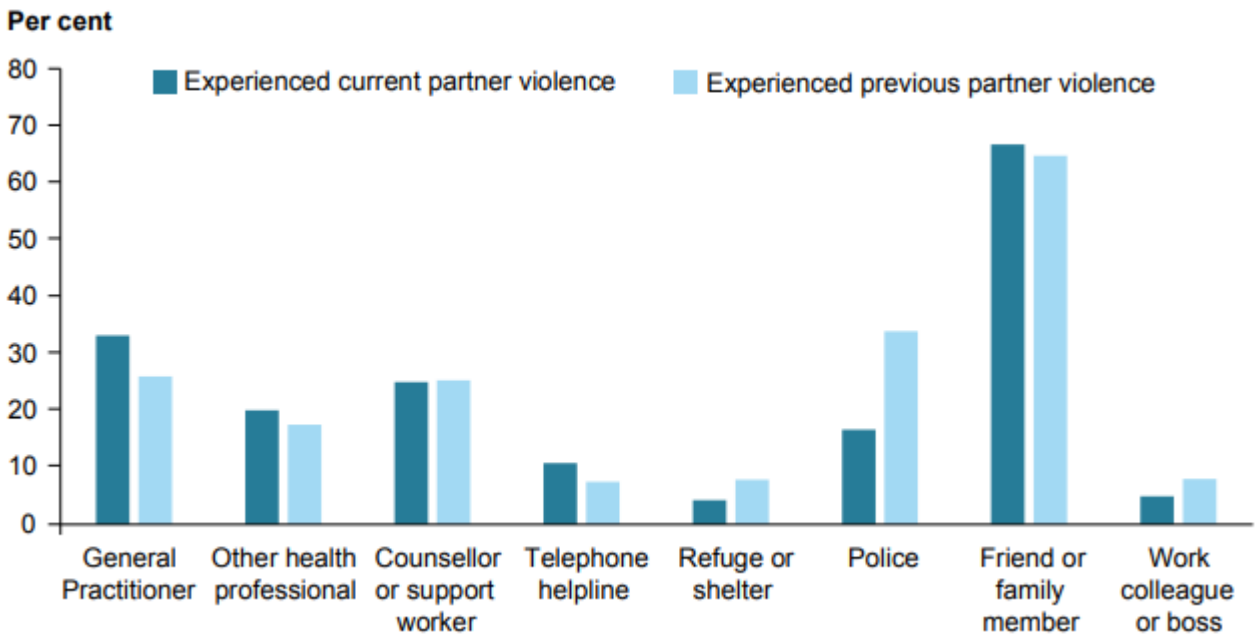
These figures from a national survey in Australia clearly shows women are more likely to be victims, particularly of sexual violence. Women are also more likely to be injured and killed more than male victims.

From a World Health Organization systematic review, we know that there is evidence that family and sexual violence has widespread interrelating effects on people's health. It is also not healthy for men to use violence, and they can present with mental health, substance abuse or chronic pain issues.



WHO 2013

Sources of advice and support sought by women who experienced intimate partner violence



AIHW 2018

General practitioners are the highest group told about family violence in Australia after family and friends and police.

Trauma and Violence Informed Care and Practice

Trauma and Violence Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations
This article outlines how Trauma- and violence-informed care (TVIC) seeks to create safety for patients by understanding trauma and its impact on health and behaviour. It is not only about treating people's trauma histories but about creating safe spaces that limit potential for further harm for all. TVIC expands the concept to account for a person's experiences of past and current violence so that problems are not seen as residing only in their psychological state but also in social circumstances. Responses to trauma, including substance use and mental health problems, are seen as expected or predictable consequences of highly threatening events such as family and sexual violence. Staff knowledge and skill are key to addressing the traumatic effects of harmful institutional practices, including all forms of discrimination. Organisational leadership to support such staff is essential.

Principles of TVIC

1. Understand trauma, violence and its impacts on people's lives and behaviour.

Organisational:

- Develop structures, policies, processes (e.g., hiring practices) to build culture based on understanding of trauma and violence.
- Staff training on health effects of violence/trauma, and vicarious trauma.

Provider:

- Be mindful of potential histories and effects ('red flags').
- Handle disclosures appropriately.

2. Create emotionally and physically safe environments for all clients and providers.

Organisational:

- Create a welcoming space and intake procedures; emphasize confidentiality and client/patient priorities.
- Seek client input about safe and inclusive strategies.
- Support staff at-risk of vicarious trauma (e.g., peer support, check-ins, self-care programs).

Provider:

- Take a non-judgemental approach (make people feel accepted and deserving).
- Foster connection and trust.
- Provide clear information and predictable expectations about roles and services.

3. Foster opportunities for choice, collaboration and connection.

Organisational:

- Have policies and processes that allow for flexibility and encourage shared decision making and participation.
- Involve staff and clients in identifying ways to implement services.

Provider:

- Provide appropriate and meaningful options/real choices for treatment/care.
- Consider choices collaboratively.
- Actively listen and privilege the person's voice.

4. Use a strengths-based and capacity-building approach to support clients.

Organisational:

- Allow sufficient time for meaningful engagement.
- Service options that can be tailored to people's needs, strengths and contexts.

Provider:

- Help people identify strengths,
- Acknowledge the effects of historical and structural conditions, and
- Teach skills for recognizing triggers, calming, centering (developmentally appropriate).

(Adapted from Ponic, P., Varcoe, C., Smutylo, T. 2016)

Using trauma and violence informed care approaches

A whole of systems approach also applies to embedding principles of trauma and violence informed care. Approaches in care that recognise the connections between violence, trauma, negative health outcomes and behaviours will work to enhance safety, control and resilience, and minimize the potential for harm and re-traumatization for people seeking support for family and sexual violence. There have however, been very few evaluations of such approaches.

The following are a set of principles to embed in all aspects and levels of practice and service delivery to help adopt a trauma and violence-informed approach.

Guiding Principles of Trauma-Informed Care

Principles	Description
Safety	• Staff and clients feel physically, psychologically, emotionally, spiritually, and culturally safe • Compassion, empathy, affirmation and validation is employed to establish and maintain safety and trust • Self-care and safety plans are established for both workers and clients • Staff have responsibility to challenge issues of unsafety • Recognition and prevention of retraumatization
Trustworthiness & Transparency	• Operations and decisions within the organisation are conducted with transparency • Building and maintaining trust amongst staff, clients, and families is valued • Client expectations about how the service, treatment and care is clarified at the outset, including sensitivity regarding unintentional re-enactment of trauma, and managing this
Peer Support & mutual self-help	• Those with lived experiences of trauma and their family members referred to as 'survivors' or 'experts by experience', provide peer support for establishing safety, building trust, enhancing collaboration, promoting healing and recovery, fostering hope, connection and empowerment
Collaboration & mutuality	• True partnering between staff, clients and their families/carers with meaningful and equal sharing of power and decision-making • Workers make decisions with (not for) clients ensuring there are no 'us and them' dynamics • There is awareness of and communication about each other's trauma triggers and safety needs and recognition of the need for tailored support
Empowerment, voice & choice	• The organisation ensures that the individual strengths of their staff and clients are recognized, built upon and validated • The organisation recognises that each client requires a person-centred approach and that the experience of trauma may be a unifying aspect for staff and clients • Decision making and goal setting is shared, and self-advocacy skills cultivated. Staff are seen as facilitators, not controllers of recovery • Re-traumatisation is actively resisted by fostering empowerment, choice (providing options) and ensuring voices are heard in a supportive way
Respect for diversity and inclusiveness	• The organisation actively works to prevent stereotypes and biases based on gender, race, age, ethnicity, sexual orientation, ability or geography • The organisation promotes and acknowledges the healing value of traditional cultural connections, recognises ongoing and historical trauma and identifies and responds appropriately to complex and intergenerational traumas • Communication and care are accessible for peoples with disabilities, and there is an understanding that trauma can impact brain development and cognitive functioning
Strengths based and skill building approach	• The organisation promotes resiliency and coping skills for managing triggers and fostering empowerment • Working with a strengths-based approach helps to ensure continuity of supports following a client's involvement with a service, see Orygen's What is trauma-informed care and how is it implemented in youth healthcare settings resource. • For more information and tools on TVIC, also see:https://equiphealthcare.ca/resources/trauma-and-violence-informed-care/

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach 2014

Effective Communication

Fundamental to trauma and violence informed care is actively listening to the voice of the patient. With active listening, the listener uses verbal and non-verbal techniques to communicate that they have heard and understood the message. Active listening is central to the use of the following core skill communication.

Attending skills include an attentive, open posture and facial expression; looking directly at the speaker; appropriate body movement and eye contact; establishing a non-distracting environment.

Effective questioning skills include:

- **Open-ended questions** e.g. How are things at home?
- **Focused Questions** e.g. "Can you tell me about your visit to the doctor?
- **Closed Questions** e.g. "How long have you been experiencing that trouble sleeping?"
- **Leading Questions** e.g. "You agree that getting some professional help is the only way you're going to start feeling better, don't you?"
- **Compound Questions** e.g., "Tell me, have you decided on the model of care you want and whether you want to breastfeed?"

Open-ended, focused and closed questions are **appropriate** questions and leading and compound questions should be avoided as they usually elicit insufficient information. The choice of the type of question to be used will be influenced by the person to whom you are speaking. For example, with a very talkative speaker, your questions will need to be more focused and direct.

Responses that may be useful in trauma-informed care include:

- **Clarifying** e.g. "I'm having trouble understanding exactly what you are saying.", "Do you mean….", "Sounds to me like you're saying…".
- **Confirmation** e.g., Speaker: "I don't know if I can talk to anyone about the problems I'm having with in my relationship …" Listener: "It can be very hard to talk about these things, but such problems are not uncommon and talking about them sometimes helps."
- **Probing** e.g., "Tell me more…", "Let's talk about that", "I'm wondering about….", rather than how, what, when, where, or who questions.
- **Confronting** e.g. "You say this doesn't bother you, yet you looked upset when we were talking about it."
- **Paraphrasing** e.g., Speaker: "I've tried everything to make him happy and nothing ever seems right. I just feel like giving up!" Listener: "You're feeling really frustrated by trying all these different strategies."
- **Restatement** e.g., Speaker: "It's only since becoming pregnant that we've started to realise we have very different approaches to managing things." Listener: "different approaches?"
- **Summarising** e.g., Listener: "So, you've been feeling really worn out these last few weeks since your back started troubling you. And that means it requires a huge effort just to get out of the house."
- **Reflecting feelings** (empathic responses) e.g., Speaker: "I've just been feeling so tired lately. I can't seem to get my work and the housework done and I'm always dashing off to kinder with the baby not even out of her pyjamas; sometimes not even changed. "Listener. "It sounds as though all this is really getting you down."

The listener receives a great deal of information about the speaker's emotions from a door opener. A door opener typically includes the following four elements:

a) An acknowledgement of the speaker's body language e.g. *"You look as though you're upset about something…."*

b) An invitation to talk or continue talking, e.g. *"Do you want to talk about it?"*

c) Silence – giving time to decide whether they want to talk and what to say.

d) Attending behaviour – eye contact and posture of involvement that demonstrates the listener's interest in and concern for the speaker.

Attentive silence

This is one of the hardest skills, as people often feel uncomfortable and feel the compulsion to jump in and fill the silence. However, there are times when silence is the most appropriate response. These include the following examples:

- When the speaker is thinking and searching for a response. If the listener comes in too quickly, it will prevent the speaker finding his/her own response.
- When the speaker is emotionally distressed, silence allows him/her to experience the distress, regain composure and continue communicating.
- A minimal encourager followed by silence indicates to the speaker that you would like him/her to continue talking.

Further Resources:

- Safer Families Providing Trauma and Violence Informed Care in Primary Care eLearning module
- RACGP The White Book Trauma-informed care in general practice, Chapter 7

> *"I would like GPs and health professionals to recognise the long-term impacts of the trauma on my physical health, chronic infections, and living with complex medical conditions. I feel the violence and living as a torture survivor is the root cause of my physical health issues but most practitioners fail to see the links or how they're related at all."*
> **Cina, WEAVERS lived experience group**

Asking about Violence and Initial Validation

When the issues of family and sexual violence are raised, patients want a non-judgmental and compassionate response and they do not want to be pressured to disclose. Simply raising the issue can help patients. Ask generally about patient's relationship before asking directly. Ask about abuse on several occasions because patients may decide to disclose at a later date. Ensure that the environment is private and confidential. Allowing time is essential. According to women themselves, women are most encouraged to disclose to GPs and nurses when they perceive that the GP or nurse will:

- Listen to all their problems and concerns,
- Believe them,
- Be sympathetic and not blame them, and
- Not tell anyone.

If you ask sensitively, it is extremely unlikely that you will offend patients by asking about this area of their life. Abused patients are relieved that someone has finally shown an interest in their problems and non-abused patients realise that this is an issue for patients and needs to be addressed. Your initial objective is to encourage the patient experiencing family and/or sexual violence to tell their story and define the problem in their own words. Broad prompting questions can be used to begin the conversation, for example:

- What has brought you here today?
- Can you tell me what has been happening for you lately?
- Tell me about your home life/relationship with X/what is worrying you?
- Is there someone you are afraid of?
- How is your relationship? or How much tension is there in your relationship?
- What happens when you argue? What happens when he gets angry?

Other open questions to ask

Once the person experiencing family and/or sexual violence has had the opportunity to provide some details about their circumstances, you can ask more specific questions, such as:

- Could you tell me more about the last time you were hurt?
- What happens that hurts /scares /controls you or your children?
- What does he do that gets in the way of your relationship with your children /the way you parent?
- Sometimes partners use physical force. Is this happening to you?
- Have you felt humiliated by your partner?
- Has your partner ever physically threatened or hurt you?
- Have you been hit or otherwise physically hurt by your partner?
- What is the worst thing that has happened in your relationship?
- When was the first time that violence happened in your relationship?
- Have you been forced to have any kind of sexual activity by your partner?

Initial response to patients who disclose abuse

You should affirm that violence is unacceptable behaviour and express support before any other response. Even if a patient does not choose to pursue other interventions or engage with other agencies, your validation of their experience and the offer of support is an act that may in the long run contribute to the patient being able to change their situation. In addition to offering support, the clinician needs to make an initial assessment of their safety. This may be as simple as checking with the patient if it safe for them (and their children) to return home. A more detailed risk assessment will include questions about escalation of abuse, the content of threats, direct and indirect abuse to the children.

Possible validation statements if a patient discloses intimate partner violence

- Everybody deserves to feel safe at home.
- You deserve to feel safe at home.
- You don't deserve to be hit or hurt. It is not your fault.
- I am concerned about your safety and well-being.
- You are not alone. I will be with you through this, whatever you decide. Help is available.
- You are not to blame. Abuse is common and happens in all kinds of relationships. It tends to continue.
- Abuse can affect your health and that of your children in many ways. I am interested in assisting you.

"As you know, GPs can be such a key player in assisting women to leave- in fact, my GP many moons ago, in cahoots with my children's school, was the one who told me I was in an abusive relationship- and she guided me to help me leave and referred me to the many people who assisted. Just that first conversation, and someone acknowledging what I was too afraid to say out loud, changed my life. In a world where I honestly thought it was all my fault, and I had been well trained that 'no one would believe me' to have someone who did was transformational."
Carol, mother of 2

Cultural and Linguistic Diverse Populations

Barriers and challenges to working with migrant women experiencing violence:

Knowing what is violence

- Some cultures may normalise gender inequality and reinforce male supremacy through various traditions and customs. Some cultures may not differentiate between "abuse" and "discipline" making it okay to use violence for disciplinary actions. Women from certain cultural and linguistic diverse (CALD) backgrounds might consider abuse as a common form of discipline from the partner
- Witnessing various forms of violence, including sexual and gender-based violence, in their home country or transition country could make CALD women (especially refugees and asylum seekers) more tolerant and resilient
- People from CALD backgrounds may not recognise some forms of abuse e.g., verbal, emotional, social, financial, sexual, isolation, threat and intimidation.

Awareness of systems

- Lack of awareness of victim's rights and legal system, support systems available
- Lack awareness about the role of police in Australia and that police *must respond* to family and sexual violence reports and *take action*, regardless of who made the report or how it was made and whether the affected family member makes a verbal complaint or written statement.

Language

- The questions that should be asked: What languages does the client speak, other than English? How comfortable are they with communicating in English? Does the client's comfort level change with the length, complexity and sensitivity of the communication? What is the client's cultural background? What culture does the client identify with?
- Consider different ways to communicate your message such as provide written materials/pictures
- Availability of interpreters, especially in newly arrived & small communities

Social isolation

- Women might be in total isolation and may not have family and community support
- Taking action can result in isolation or ostracism from their families and their communities.

Visa dependency issues

- Women on dependent spouse visa are especially at risk and there is fear that reporting family and sexual violence will compromise their future residency in Australia
- Partner Visa issues that can arise include perpetrator uses threat of "deportation" to control the victim or until Permanent Residency is approved, limited access to financial/housing support, vulnerability associated with no income & dependants to care for.
- Non-Partner Visa issues that can arise include victim-survivor has no long-term rights in Australia or financial/housing support is extremely limited and not always accessible or no recognition of relationship.

Migration experience

- Pre-migration history and prior issues of torture and trauma might impact on their taking action
- Loss and grief issues and the migration journey and experience
- Women hold themselves accountable to maintain the family structure and often blame themselves if failing to do so.

Fear of authority

- Fear of authority such as police and courts because of experiences in their home country and this fear may be reinforced by eroded relationships between authority and minority communities in this country
- Mediation through family members, faith and community leaders might often be the first and preferred step to get support.

Resettlement experience

- For a lot of refugee, migrants and asylum seekers, moving to a new country can be a very stressful time as they face new challenges such as lack of language, social disconnection, no family support, financial limitations, lack of education or non-recognition of qualifications and unaffordable housing
- Role reversal and the impact on familial relationships (e.g., the wife being the breadwinner)
- Loss and grief of family and friends back home which with pre-migration history and traumatic journeys may compound barriers to support
- Experience in detention centres or having survived the refugee experience.

Complex family dynamics

- Strong cultural beliefs may not allow couple to separate or divorce as this may bring shame to the family both in Australia and in their home country
- Fear of consequences for family back home
- There may be multiple perpetrators of violence (e.g., the in-laws, brother etc).

Access to resources and support

- Culture differences, language barriers, isolation and limited support networks make it difficult for the victim to seek support and to take action to seek safety.

Risk assessment of women experiencing violence

There are a number of barriers to assessing risk for women from CALD backgrounds experiencing violence. These are:

- Denial and Minimization are powerful and at times unconscious coping strategies when living with excessive control and violence on a daily basis.
- Suicidal or homicidal ideation is not always observable.
- Terminologies such as 'abuse', 'domestic violence', family violence', threat', may be too loaded because many victim/survivors may not share the same understanding of such words.
- In short term interventions there may not be enough rapport or trust established for women from refugee/migrant backgrounds to answer intensive questions as they appear in some risk assessment tools.
- While women want the violence to end, a victim/survivor may not want to see their husband harmed, publicly shamed, or damaged financially.
- The victim/survivor may be concerned about the impact of police or court intervention and risks to partner's social and employment status.

So, when assessing CALD women for risk of family and/or sexual violence, include the following:

1. understanding of family and sexual violence and its forms within your local context,
2. understanding of systems family law, what an intervention order is, child protection etc.,
3. interpreter suitability (community language and female),
4. any links to community and determine whether it is protective or adds more risk,
5. their visa – ensure she has the right information available to make informed decisions,
6. their level of confidence in police response,
7. their familiarity with Australian systems, ATM, Centrelink etc,
8. family dynamics to determine multiple perpetrators.

Additional considerations include threats of harm to family overseas, deportation threats, any potential slavery/trafficking offences, and threats to children.

Culturally and Linguistic Diverse Population Resources

- ANROWS: Best practice for working with culturally and linguistically diverse communities in addressing violence against women resource.
- Safer Families Recognising and responding to DFSV experienced by ethnic/racial minority women eLearning module.
- RACGP White Book Chapter 17, Working with migrant and refugee communities.

> *"Victim/survivors of DV and trauma come from diverse cultural backgrounds. So if you don't know, please ask someone else of that background. Get a fuller picture. By you being better informed, it helps victims/survivors to open up and to give themselves better control over their reactions."*
> **Shelly, WEAVERS lived experience group**

Aboriginal and Torres Strait Islander Populations

Family and sexual violence in Aboriginal and Torres Strait Islander communities across Australia is disproportionately high in comparison to the non-Indigenous Australian population. Aboriginal and Torres Strait Islander women are more likely to experience serious forms of violence such as physical assault and have higher rates of hospitalisation.

It is important to recognise that family and sexual violence is not part of Aboriginal and Torres Strait Islander culture. Although all family and sexual violence survivors have reasons for avoiding help-seeking, Aboriginal and Torres Strait Islander peoples have additional reasons than those not of Indigenous descent.

Barriers specific to Australia's Indigenous peoples include shame, fear and culturally inappropriate service provision. Health care providers such as GPs and practice nurses need to understand that the removal of children and many subsequent policies have created mistrust of governments, policy makers and the health care profession. Recent evidence suggests that Indigenous peoples (globally) report poor experiences with health care providers when accessing care for family and/or sexual violence. A lack of cultural awareness, problems with communication, mistrust and perceiving the environment to be unsafe contribute to the poor experiences and expectations reported.

Colonisation, kinship disruption, disconnection from land and culture and ongoing racism contributes to the higher incidence of family and sexual violence seen in Aboriginal and Torres Strait Islander communities. All practitioners are encouraged to increase their understanding about the influence colonisation continues to have on generating mistrust in health care practitioners and organisations. Doing so creates an opportunity to provide culturally appropriate and safe care.

In attempting to provide appropriate and culturally safe care, the practitioner needs to examine their own personal biases and demonstrate a willingness to invest in the relationship, have a yarn and display deep listening.

Aboriginal and Torres Strait Islanders prioritise keeping the family together and they also recognise that family and sexual violence has an impact on the whole family. Therefore, it is essential that a whole of family response is included in care provision, and that all family members are encouraged to begin a healing journey from their experiences with family and sexual violence.

To facilitate this journey, the practice team can work in partnership with Aboriginal and Torres Strait Islander health workers and practitioners to improve the likelihood that cultural connection is a used as a strength for healing.

Concepts of health

When working with Aboriginal and Torres Strait Islander people, the issues of family and sexual violence and abuse are important because their view of health is holistic; it is inclusive of the body and the mind, as well as cultural, spiritual, country (land), environmental and community connection and wellness. All these factors, in turn, can impact a person's health outcomes and, more immediately, impinge on their presentations in primary care settings. Three Indigenous-identified expectations for practitioners include:

- Demonstrate cultural awareness,
- Work to establish a trusting relationship, and
- Provide strength though safety.

(Downing R et al 2011)

Indigenous Healthcare Model for Peoples Experiencing Family Violence

Fiolet, R et al 2020

Working with Aboriginal and Torres Strait Islander Peoples

(Abuse and violence: Working with our patients in general practice, Specific populations, Aboriginal and Torres Strait Islander Communities, 5th edn. RACGP, 2022)

Health care workers and non-clinical team members can benefit from incorporating the following elements into their practice when responding to Aboriginal and Torres Strait Islander patients experiencing family and sexual violence.

- Demonstrate cultural awareness through an understanding of the history of the Aboriginal Country you practice on and familiarise yourself with their values, beliefs and traditions.
- Establish a rapport with individuals and their families. Work on gaining trust through having a “yarn” and getting to know the individual. It is acceptable to let Aboriginal and Torres Strait Islander people know that you have limited knowledge about their cultures but are willing to learn.
- Establish a safe space for the individual to slowly learn to trust you. Reassure the client that their needs will be prioritised and that you intend on taking an approach that values their connection to family, culture, and country.
- Engage in deep listening (which some Aboriginal people call ‘Dadirri’) in an attempt to build the relationship and enhance feelings of trust. Aboriginal and Torres Strait Islanders often prefer to be heard than to see that a health care practitioner is taking notes.
- Ask about fears or barriers to help-seeking that may deter the individual from pursuing support.
- As with any other client, allow the individual to determine their own needs to demonstrate person-centred care. Encourage self-determination by encouraging the individual to contemplate their priorities for the future.

- Following the establishment of trust, when working with women during antenatal period, it is important to ask all patients about FAV because of the elevated risk during this time.
- Link and liaise with Aboriginal Health Workers, Aboriginal Health Organisations and specialist FAV services where the client permits you to do so.
- Encourage healing by working with the individual to identify their strengths, their preferences for healing, and to determine who could help them in their healing journey.
- Advocate for resources for Aboriginal and Torres Strait Islander patients and investments in developing the Aboriginal Health Workforce.

Aboriginal and Torres Strait Islander Resources

- Improving Aboriginal Cultural Respect Across Tasmania's Health System Action Plan 2020-2026
- WELLMOB: healing our way Online resources made by and for Aboriginal peoples with a focus on social and emotional wellbeing.
- NATSILS National peak body for Aboriginal and Torres Strait Islander Legal Services.
- HealthInfoNet Provides an evidence base to inform practice and policy in Aboriginal and Torres Strait Islander health, as well as undertaking research and providing specific training.
- RACGP White Book Chapter 16, Aboriginal and Torres Strait Islander communities.

Further reading

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LGBTIQA+ Family & Sexual Violence Considerations

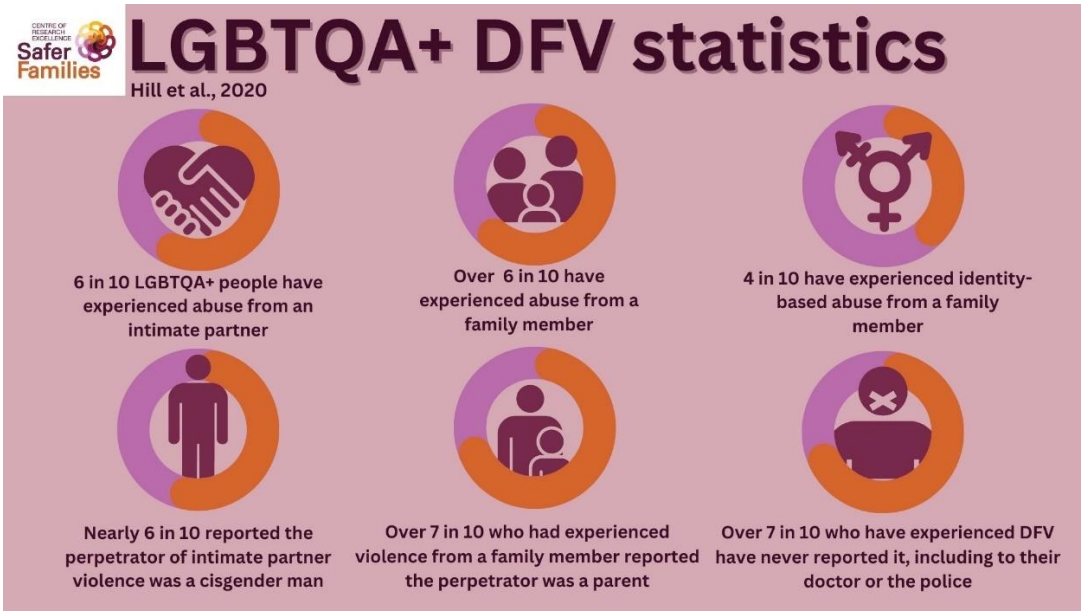
Acronyms

SOGIESC: Sexual orientation, gender identity, gender expression and/or sex characteristics.

LGBTIQQAA/SB+ Lesbian, Gay, Bisexual, Bi+, Pansexual, Sistergirl, Brotherboy, Transgender, Gender Diverse, Non-Binary, Intersex, Queer, Questioning, Asexual, Aromantic.

	Definitions
Sexual Orientation	a person's romantic and/or sexual attraction to others
Gender Identity	is part of how you understand who you are and how you interact with other people. Transgender, gender diverse, non-binary and cisgender are examples of some gender identities
Gender Expression	external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behaviour, voice, and/ or body characteristics.
Sex Characteristics	are physical features relating to sex, including chromosomes, genitals, gonads, hormones, and other reproductive anatomy, and secondary features that emerge from puberty. For example, intersex people have innate sex characteristics that don't fit medical and social norms for 'female' or 'male' bodies
Lesbian	a lesbian woman is romantically and/or sexually attracted to other women. This definition includes cis women, sistergirls, trans women and femme identifying peoples
Gay	a gay person is romantically and/or sexually attracted to the same sex and/or gender as themselves. This definition is often used to describe men who are attracted to other men, some women and gender diverse people may also describe themselves as gay. This definition includes cis men, trans men and masc identifying peoples
Bisexual	a bisexual person is romantically and/or sexually attracted to people of their own gender and other genders inclusive of non-binary peoples
Pansexual	a pansexual person is romantically and/or sexually attracted to all genders or lack thereof for those who are genderless
Transgender, gender diverse and/or non-binary	umbrella terms to describe a person's gender identity not aligned with their gender assigned at birth.
Sistergirls and Brotherboys	culturally specific terms used by Aboriginal and/or Torres Strait Islanders to describe a kinship system outside of white settle perspectives.
Intersex	people born with physical or biological sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that are more diverse than stereotypical definitions for 'female' or 'male' bodies
Queer	a term used to describe a range of sexual orientations and gender identities under a singular definition. This term is considered offensive for some mature aged rainbow peoples who have lived experience and/or have survived this term being used against them as a slur.
Asexual	an asexual person does not experience sexual attraction however may experience romantic attraction towards others.
Aromantic	a person who has no interest in or desire for romantic relationships

LGBTQA+ Family & Sexual Violence Statistics



Hill et al., 2020

LGBTIQA+ Considerations

Similarities to cisgender/heterosexual family/intimate partner violence:

- Finding love and happiness in relationships
- Wish to have loving family and, for some, children
- Wanting a secure home and income
- Desire to be safe in the world, at work, at home
- Relationship problems and breakups
- Abusive or violent relationships due to human dynamics of power and control

Intersectional considerations surrounding LGBTIQA+ specificities:

- Less bound by gendered roles and traditional heterosexual relationship expectations (e.g., monogamy, sex)
- History of non-recognition of relationships, socially and in law
- More isolated from traditional supports (e.g., family, workmates)
- More likely to rely on their chosen families for support
- More likely to conceal relationships at work, in public, from family of origin, in social/sporting contexts
- Partner/friends less likely to recognise/understand IPV when it occurs
- Some dynamics of abuse partner's control can be LGBTIQA+ specific (e.g., threat to out them; shame; misgendering)
- Pros and cons of LGBTIQA+ community connection

Further Resources:

- Engender Equality's LGBTIQA+ Family Violence Practice Guidelines (Tasmanian)
- LGBTIQ+ Power and Control Wheel and Frameworks for Understanding Violence
- How to Support Someone Who Shares Their Experience of Violence with you
- Referral points for LGBTIQ+ People Who Have Experienced Violence
- Safer Families Recognising and responding to LGBTQA+ people impacted by DFV eLearning module
- RACGP White Book LGBTIQA+ Family abuse and violence, Chapter 19

Safety of Children and Mandatory Reporting

Children are particularly vulnerable to the impact of Family Violence, and their well-being and safety is of paramount importance. **Following policy and procedure and state law, all doctors and nurses need to report any disclosure of child abuse from your patient to local authorities.** You need to know Tasmania's mandatory reporting laws, and document whom you notified of the suspected abuse.

In Tasmania, it is mandatory for medical practitioners to report if they have a belief, suspicion, or knowledge on reasonable grounds, formed in carrying out official duties or in the course of their work (whether paid or voluntary) that:

- a child has been or is being 'abused' or 'neglected' or a child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence, or
- there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides
- while a woman is pregnant, that there is reasonable likelihood that after the birth of the child: the child will suffer abuse or neglect, or may be killed by a person with whom the child is likely to reside; or that the child will require medical treatment or other intervention as a result of the behaviour of the woman or another person with whom the woman resides or is likely to reside, before the birth of the child.

Child 'abuse' or 'neglect' is defined as:

- sexual abuse or
- physical or emotional injury or other abuse, or neglect, to the extent that
    - the injured, abused, or neglected person has suffered, or is likely to suffer, physical or psychological harm detrimental to the person's wellbeing or
    - the injured, abused, or neglected person's physical or psychological development is in jeopardy.

This also includes exposure to family violence.

Child well-being response

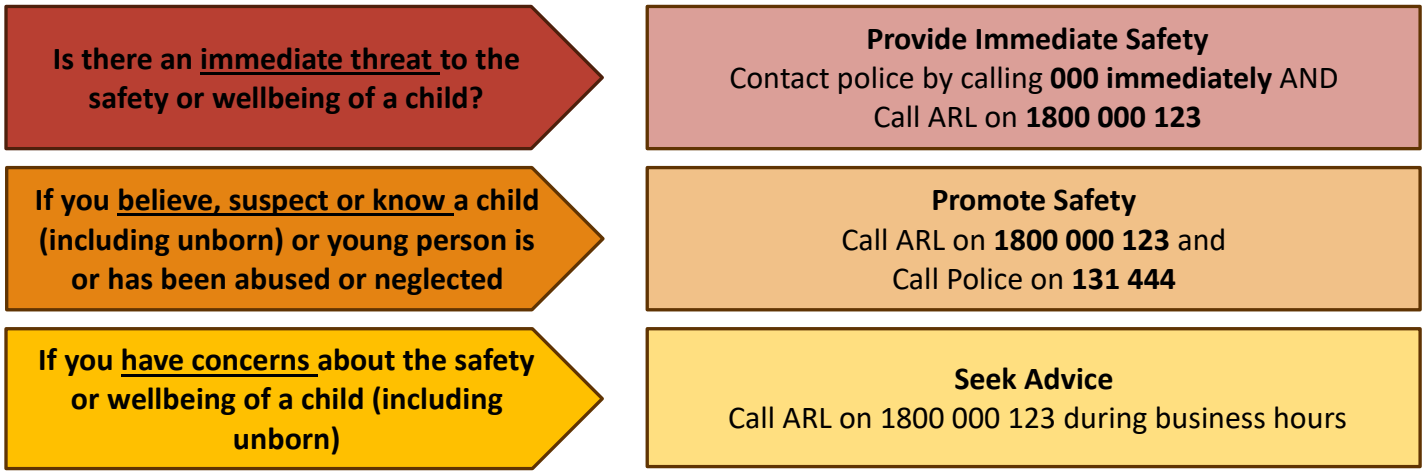
Where a child experiences any of the following factors that may impact upon a their safety, stability or development, contacting the Strong Families, Safe Kids advice and referral line is the best way of connecting children, young people and their families to the services they need:

- Sees violence happening between family members
- Is abused or neglected
- Is threatened by someone at home
- Is unsupervised or uncontrolled
- Is missing school
- Is at risk of physical or psychological harm.

All serious concerns should be reported by phone, rather than online or via email, during business hours or, in urgent or emergency situations, after hours. Serious concerns include when you suspect a child or young person is in imminent or immediate danger of serious harm, serious injury or chronic neglect.

If there is an immediate threat to the child's wellbeing or safety, **contact 000 immediately**.

This figure provides a clear guide on who to call and when.



Child Safety response

When you call the Strong Families, Safe Kids advice and referral line, you will speak to a trained staff member who will talk to you about the situation, answer any questions you have, and record your concerns.

Child Safety may then gather more information so that a recommendation can be made about what needs to be done. The case may be referred to a more appropriate service for response, referred to police for joint investigation or classified and prioritised for a risk and/or needs assessment by Child Protection.

If Child Safety think that the child is not safe based on the information for the notification, they will use any other information they have (such as from Police reports or other notifications). They will use all this information to consider whether they need to make an investigation.

Child Safety may contact parents, guardians and other people who know things about the situation and they will protect a child who is not safe.

People who call the Advice and Referral Line have a legal right to confidentiality. The staff member will record your details but won't disclose your identity without your consent unless they need to consult with another person acting in the course of official duties such as a Child Safety Officer; or if they have been ordered by a court.

Further Resources:

- Strong Families Safe Kids Child and Family Wellbeing Assessment tool
- Australian Institute of Family Studies Mandatory reporting and child abuse and neglect
- RACGP The White Book Child abuse and neglect, Chapter 9.
- National Institute for Health and Care Excellence (NICE) guidelines on recognising child abuse and neglect
- VEGA Family Violence evidence-based guidance and education Resources to assist healthcare and social service providers in recognizing and responding safely to family violence.
- We also encourage you to review the National Centre for Action on Child Sexual Abuse's practice tool: Strengthening General Practitioner responses to child sexual abuse in primary health care.
- Safer Families Identifying and Responding to Child Abuse and Neglect eLearning module

Legal Issues

Health practitioners need to understand what options patients can take when they have experienced abuse and violence. These include taking out a family violence order, contacting the police, and contacting community legal services for specific legal advice.

The law can address family violence in two ways: family violence orders that are legislated under civil law, and criminal charges. The term 'family violence order' is a generic term for those orders specifically for family violence ('intervention orders', 'protection orders' or 'restraining orders'). These orders are made by the court and, in some emergency cases the police. The orders attempt to restrict or prohibit certain behaviours by the perpetrator (e.g., prohibiting a person from harassing or threatening the survivor and/or approaching the victim's home or place of employment or that the perpetrator be excluded from the family home).

GPs and nurses should encourage and assist their patients to approach the police directly and report an assault. Once having reported to the police, patients will be able to activate or withdraw from criminal proceedings at a later stage. This is important as they can reinstate the complaint in the future when they feel more confident and able to cope with the situation. It can remain simply as a 'statement'. This can help to empower patients by giving them back some sense of control. Further to this, a number of counselling services can be made available to a victim of assault via victim of crime support agencies. It is important to respect the patient's wishes and not pressure them into making any decisions.

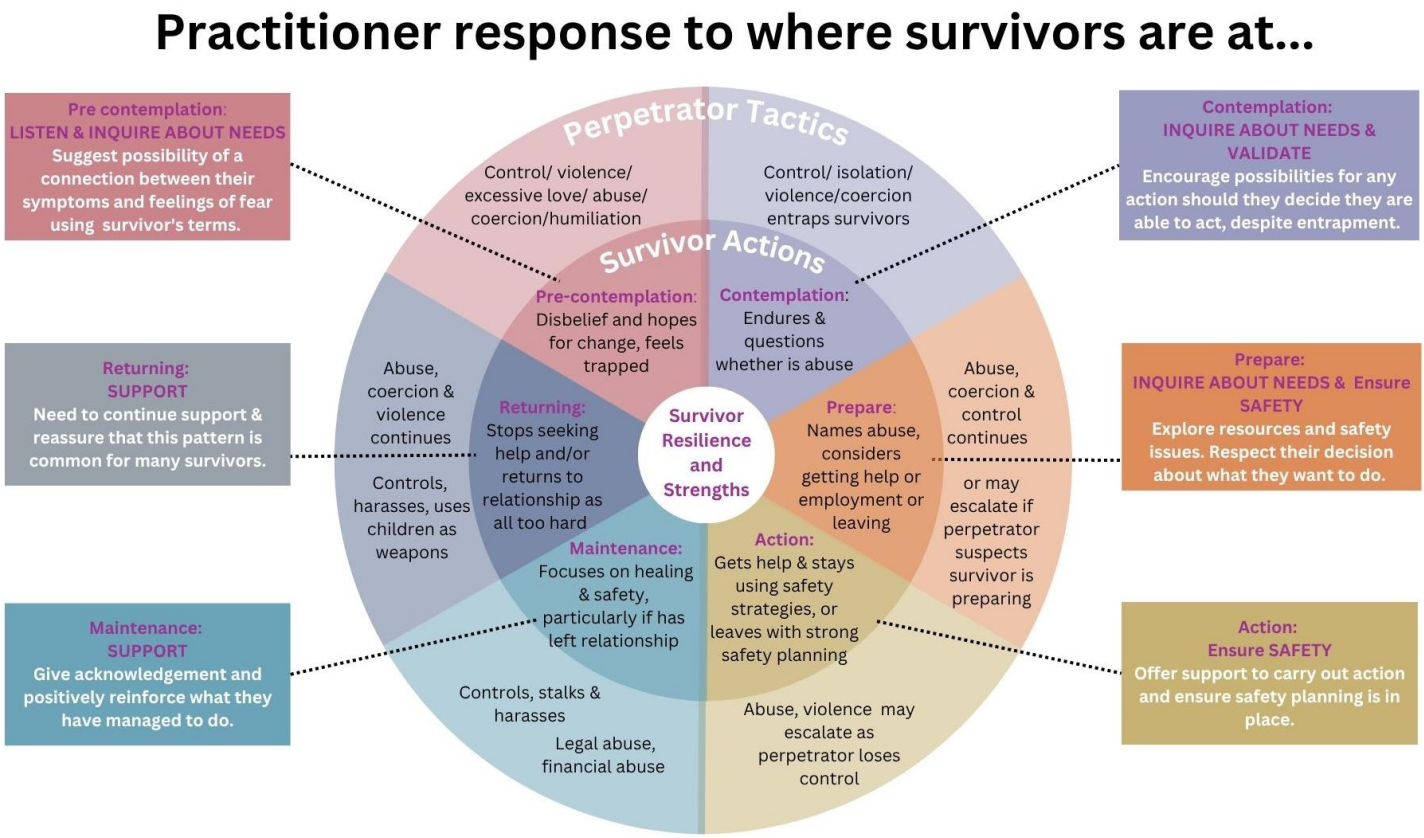
More information can be found at the websites below:

- Violence and the law **- RACGP**
- Violence and the law **- 1800RESPECT**
- Court and Legal Services **– Safe at Home (Tasmania)**

Understanding Change for Patients

The readiness to change concept can be applied to any area of behaviour change. In relation to Family Violence, patients are often at various stages in a cycle from 'pre-contemplation' to 'action' with regard to the abuse (see figure and table below). Clinicians should tailor responses to the stage a patient is at. Some patients who are pre-contemplative need brief messages and that they may be experiencing abuse. Others who are contemplative need encouragement to explore possibilities of changing the life they are experiencing with the clinician's help. At the decision stage, resources and support need to be explored further; whilst at the action stage, some patients need to have their injuries documented or a referral to a counsellor. Maintaining readiness for action will require clinician's support even if they do not follow through with some particular action. Our aim should be to facilitate the patient's identification that a problem exists and of the best course of action, followed by supporting their implementation and review of that action.

Readiness to take action



Stages of change applied to patients' experience of Family violence

(Abuse and violence: Working with our patients in general practice, 5th edn. RACGP, 2022)

Stage	Description	Health provider response
Pre-contemplation	Patient is not aware that they have a problem or holds a strong belief that it is their fault.	Suggest possibility of a connection between symptoms, feelings of fear and problems at home. Try to use terms the patient says when referring to their problems.
Contemplation	Patient has identified a problem but remains ambivalent about whether or not they want to or are able to make any changes.	Encourage the possibilities for change should they decide to do anything. Point out that you are available to help and support them on the journey.

Stage	Description	Health provider response
Preparation/decision	Some catalyst for change has arisen (e.g., concern for children, realisation that partner will not change, getting a new job).	Explore resources within the patient's network and the local community. Respect their decision about what they want to change (e.g., talking to family/ friends or counsellor, leaving the relationship, taking out a restraining order, reporting to the police).
Action	Plan devised in the previous stage is put into action.	Offer support to carry out plan and ensure safety planning is in place.
Maintenance	Commitment to above is firm.	Praise whatever they have done, support decision.
Returning/relapsing	The patient may feel compelled to reverse the above action. Reasons include finding life without the partner too stressful, lack of access to children or resources.	Need to support them whether they do or do not return to the relationship, see a counsellor or report abuse. Reassure that this pattern of behaviour is common for many patients.

Responding to patients in different stages of change

As outlined above, patients presenting to you will be positioned at different points along the spectrum of readiness for change from having never disclosed to having acknowledged the problem already and left their partners. Indeed, some patients may be somewhere in between - considering, for the first time, that what is happening to them is abuse, or taking action to leave the partner for the first time (or trying again). In this section we outline **motivational interviewing** and **non-directive problem-solving therapy**, which refer to two techniques that can be used in counselling patients at different stages of change. The table below summarises the appropriate timing of these techniques. Though motivational interviewing could be beneficial to eliciting change at any point along the spectrum of readiness, relying on problem-solving therapy during the early stages of problem recognition could be deleterious to a patient's progress by inducing additional resistance to change.

Stage of change	Description	Typical statements from women	Motivational interviewing	Non-directive Problem solving
Pre-contemplation	Not aware of issue(s) and/or not considering response	"It is not so bad; my friend gets worse" "It is only emotional things, not abuse"	✓	
Contemplation	Considering action possibilities and whether to take action or not	"I am concerned that if I do something it will make him worse" "I can't afford to risk ending up with nothing – think of the kids" "I am sure he will change"	✓	
Preparation	Decision to act taken, no action as yet	"I know this must stop; I am not sure how best to do it" "I will leave him, but now is not the time; anyway he has been drinking less recently"	✓	✓
Action	Action in response to issues has started	"The help has been really good, but do I need to do more to really change the situation"	✓	✓

Stage of change	Description	Typical statements from women	Motivational interviewing	Non-directive Problem solving
Maintenance	Action in response to issues established as routine	"He has changed but what can I do if he starts back to his old ways again" "I am glad that the violence in my life has stopped but some days I also think of what I have lost"	✓	✓

Motivational Interviewing & Problem-Solving Techniques

An approach to behaviour change known as motivational interviewing (MI) (Rollnick, S., & Miller, W. R. 1995) is a patient-centred, directive method which aims to enhance intrinsic motivation to change by exploring and resolving ambivalence. The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the client/patient. Here we are interested in its capacity to inspire action with respect to how patients think about fear of their partner and implications for their lives. It has to be acknowledged that it is not the victim's behaviour but rather the person using violence that needs to change, however promoting self-reflection and ambivalence to take action can be helpful. While MI can be useful across the stages of change, it is best used with patients who are in the pre-contemplation and contemplation stages. It is unlikely that over the course of time you will support a patient who starts in the early stages to shift to a point of taking action. However, don't be disheartened! To see concrete changes in behaviour, much cognitive processing has to occur first. Linking how they might be feeling (physically and emotionally) with their relationship or acknowledging that there may be relationship issues are considered strong bases for future change. A useful tool for applying MI is available on the Safer Families website.

Key features of Motivational Interviewing

(Abuse and violence: Working with our patients in general practice, 5th edn. RACGP, 2022)

Key features	Stage of Change
Demonstrate support and empathy	• Attempts to accurately and genuinely communicate understanding of the patient's perspective • Facilitates behaviour change by removing defences • Reflective listening
Develop discrepancy	• Highlights the difference between the patient's goals and their current behaviour, beliefs and attitudes • Asks patients to list the positive and less positive aspects of their current situation • Encourages patients to recognise discrepancies
Avoid argumentation	• Refrain from persuading patient to change their current management strategies • Argumentation encourages the patient to defend their current behaviour • When strong resistance is encountered, divert attention to topics that are more likely to elicit self-motivational statements
Roll with resistance	• Restate the patient's words in a way that demonstrates an understanding of patient's ambivalence • The patient often responds by favouring the positive change • Acknowledge the possibility of the truth of the patient's resistant statement • Emphasise patient choice • Highlight possibility of future behaviour change • "Things do change. Can we agree to leave the door open on this one?"
Build self-efficacy	• Eliciting self-statement that enhances the patient's confidence and belief that change is achievable • Where has there been successful behaviour change in the past? • The patient is more likely to accept and act on that which they verbalise

Non-directive problem-solving techniques

(Mynors-Wallis L 2001)

Problem-solving treatment or techniques (PST) is a brief, structured psychological intervention which involves active collaboration between patient and practitioner, with the patient taking an increasingly active role in the planning of treatment and the implementing of activities between sessions.

Goals

- For patients to understand the link between their symptoms and problems
- To define the patient's current problems
- To teach a problem-solving technique that attempts to resolve problems in a structured way
- To provide patients with a positive experience of problem-solving

Seven stages of problem-solving therapy

- Stage 1 – explanation of treatment and its rationale; formulation of problem list
- Stage 2 – clarification and definition of problem
- Stage 3 – setting achievable goals
- Stage 4 – generating solutions
- Stage 5 – choice of preferred solution
- Stage 6 – implementation of the preferred solution
- Stage 7 – evaluation

Application of PST

PST is only likely to benefit patients who have acknowledged that they are experiencing partner abuse (or at least that their partner is causing them to feel afraid) and that their partner's behaviour is unacceptable to them. It is likely to be most beneficial for a patient who identifies as barriers to change factors that are largely distinct from the emotions they feel towards their partner (e.g., financial issues, housing, employment, education and instrumental support). A patient for whom PST might be effective is one who has acknowledged that they can (emotionally) live independent of their partner. Then you can assist them to identify the barriers to change (problems) and collaboratively develop some solutions. Here again a good understanding of the available services and resources in your locality would be beneficial.

Eliciting self-statements from patients based around the attainment of goals set in earlier sessions (e.g., start a night course; do a job search; attend a work interview) to address original problems (e.g., "I'm concerned about how we'll fare financially without him") enhance self-efficacy. This, in turn, leads to more change which altogether can help buffer against future challenges. Should you choose to adopt a PST approach, there is a tool available in this handbook.

Men who use Violence in their Intimate Relationships

GPs have a role in the identification, management and referral of men who use violence in their relationships. Such men may present to general practice with relationship problems, mental health issues or substance abuse. Great care needs to be taken when GPs are seeing the whole family, to ensure the safety of women and children.

GPs need to be aware that men tend to minimise responsibility for their violence, blame the victim or other external factors, and greatly under-report their use of violence. They will generally have developed ways of convincing themselves and others that they are not responsible for their violence and can invite GPs to collude with their attitudes and beliefs.

More information on the main roles of the GP in intervening early with men who use violence in their relationships can be found in this article.

We also urge you to read the RACGP White Book chapter 5 'Working with men who use intimate partner abuse and violence'.

> *"(I now realise) I have seen perpetrators who have dropped hints that I have not picked up at the time."*
> **GP, Pathways to Safety training participant**

4. What Next?

Referral Resources

Practice Systems and Sustaining Change

Support for Yourself

Self-paced e-learning Modules

Other Training Resources Available

Pathways to Safety Workshop Series Project Team

Referral Resources

Community HealthPathways Tasmania has a large list of national, state-wide and local services available for your patients. We recommend you review the different services and resources available. Learn more about Tasmanian HealthPathways.

Practice Systems and Sustaining Change

Thinking about sustaining change

We are interested in encouraging you to think about how the changes that come about as a result of your in this program might be sustained. Change here is relevant at the level of the patients, the GP /nurse and the practice. Much of the 'change talk' has been about the GPs or nurses and the patients only. Yet the practice plays a key role in sustaining positive change also.

You can play a role in propagating positive change in your practice through building awareness, sharing knowledge, and reviewing processes with the practice administrative and clinical teams. For example, we could provide you with a handout that you could give to colleagues who are interested in the area but could not participate in the educational programs or you could share your experiences of the educational programs at practice meetings. In the role of 'champion for change' you can look at ways of developing support mechanisms for the whole practice responding to Family Violence and suggest points for future intervention and issues that need to be addressed to initiate and maintain change.

Consider the following questions:

- What can you do to continue supporting patients?
- How are you going about achieving any changes?
- What sorts of barriers to change might you encounter, and how might you address these?
- What can you do to sustain changes to your attitudes, skills, behaviours?
- Have you reflected on how you might apply your new skills with patients in the future?
- Have you experienced any unintended positive or negative outcomes?
- What can the practice do to stimulate change among administrative and clinical staff?
- How might you reinforce change that has occurred?
- How would you know that you have sustained any changes you have made?

Further Reading

Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers (World Health Organisation).

Identifying and responding to domestic abuse and family violence: Implications for the health sector - Safer Families Centre Evidence Brief

The National Centre for Action on Child Sexual Abuse (National Centre) have developed resources for General Practitioners and the Primary Care Workforce as part of the Strengthening Primary Health Care Responses to Sexual Violence and Child Sexual Abuse project. Links to these resources can be found below.

- Strengthening General Practitioner responses to sexual violence in primary health care (practice tool)
- Strengthening General Practitioner responses to child sexual abuse in primary health care (practice tool)
- Working with victims and survivors of Child Sexual Abuse and Sexual Violence (Video)

Support for Yourself

It is possible that participating in the program has brought to light sensitive issues in your own personal life. We urge you to always prioritise your own well-being and seek assistance where appropriate

Contact your own GP

1800RESPECT (1800 737 73)
National Sexual Assault, Domestic Family Violence Counselling Service 24-hour, 7-day helpline, information and support)

Nurse Midwife Health Program Australia (1800 001 060)
Peer support counselling for nurses, midwives and students of the professions

Bush Support Line (1800 805 391)
Offer free 24/7, 365-day telephone counselling support line for the rural and remote health workforce and their families.

RACGP GP Support Program (Call Optum 1300361008)
A free service available to all Australian RACGP members who are registered medical practitioners. Provides access to professional advice to help cope with life's stressors which may include personal and work-related issues that can impact on wellbeing, work performance, safety, workplace morale and psychological health.

DRS4DRS (1300 Dr4Drs - 1300 374 377)
Confidential and qualified advice available 24/7 to any doctor in Australia. For crisis support call

Doctors' Health Line (1800 006 888)
Available 24/7, you'll speak with another doctor who understands the pressures of the job and can provide a listening ear, support, and guidance through any challenges.

AMA Peer Support Service (8am-11pm 365 days a year) TAS Ph: 1300 853 338

Self-paced e-learning Modules

This suite of e-learning modules has been specifically designed for primary care to strengthen skills in responding to domestic and family violence. Each module takes between 60-90 minutes to complete and accredited for CPD hours through the RACGP and ACRRM.

The 'Identifying and Responding to DFV' is currently free for primary care staff in Tasmania and can be access from www.tasp.hn/FDSV

The other modules are available to from www.saferfamilies.org.au/readiness-elearn

	Identifying and Responding to Domestic and Family Violence Learn about the nature, prevalence, and impact of DFV and how to enquire sensitively and assess the level of risk and safety of patients experiencing DFV. Learn practical ways to strengthen your skills in responding to DFV including addressing the needs of patients, developing brief safety planning and options for support and referrals.
	Identifying People who have used Domestic and Family Violence Learn to identify and respond to people who have used or are at risk of using DFV and how to establish a safe and collaborative environment in order to ask a patient about their use of violence. This module will outline how to conduct basic risk assessments, manage risk, and motivate a patient towards referrals that will support behaviour and attitude change.
	Identifying and Responding to Child Abuse and Neglect This module outlines how to respond safely and appropriately to children and their families and determine when reporting is mandated. It will illustrate key challenges in responding to child abuse and neglect within the practice environment and explain how to select methods and resources for seeking support for yourself.
	Providing Trauma and Violence Informed Care in Primary Care Strengthen your skills in implementing principles of TVIC and learn how these principles benefit facilitating disclosure, conducting safety assessments and providing early support. This module will outline how prevalence and systemic factors impact on patient experiences of DFV, disclosure and help-seeking & how your knowledge, attitudes and behaviours can impact on the delivery of TVIC.
	Addressing Family Violence: Aboriginal and Torres Strait Islander Peoples Learn how to how to respond safely and appropriately to Aboriginal and Torres Strait Islander people and their families who are at risk of or are presenting with FV. This module outlines the barriers Aboriginal and/or Torres Strait Islander people experience when seeking support for FV and will strengthen your skills in identifying and safely responding to FV.
	Six Steps to Support you to Assess and Respond to Elder Abuse Learn practical ways to strengthen your skills in identifying and responding safely and appropriately to older persons experiencing or at risk of violence or abuse using a six-step framework. You will learn how to recognise the risk factors, types and signs of the abuse of older people and understand the barriers and enablers for the older person to seek help.
	Recognising and responding to LGBTQA+ people impacted by DFV Learn practical ways to strengthen your skills in identifying & responding to lesbian, gay, bisexual, trans, queer/questioning, asexual/aromantic and other people of diverse genders & sexualities (LGBTQA+) who are impacted by domestic & family violence (DFV).
	Recognising and responding to domestic, family and sexual violence experienced by ethnic and racial minority women Learn how to build a culturally safe primary care environment for ethnic and racial minority women who are impacted by DFSV. This module outlines the barriers these women face when seeking support and the skills and whole of practice collaboration required to support these patients.
Coming Soon	NEW 'Sexual Violence in Adulthood' e-learning module (available in 2026)
Coming Soon	NEW 'Child Sexual Abuse' e-learning module (available in 2026)

Other Training Resources Available

Safer Families Centre Intimate Partner Violence (IPV): Identification and Initial Response Clinical Audit Activity (Measuring Outcomes CPD)

The Safer Families Centre has developed a clinical audit CPD activity for GPs on Intimate Partner Violence Identification (IPV) and Initial Response. The activity aims to provide a better understanding of IPV and how to identify and ask patients about it. GPs will also strengthen their capacity to identify barriers to asking about IPV and how to overcome those barriers.

The clinical audit has been designed to be easy to use and navigate and is fully accredited by the RACGP and ACRRM as a CPD audit activity.

There are two versions of the audit available. A mini audit that is comprised of 3 steps (approximately 7 hours to complete) and attracts **7 hours RACGP CPD hours including 5 Measuring Outcomes (MO), 1 Educational Activity (EA) & 1 Reviewing Performance (RP)**, and **7 ACRRM CPD hours including 6 MO & 1 EA.**

A full audit that is comprised of 4 steps (approximately 13 hours to complete) and attracts **13 RACGP and ACRRM CPD hours including 10 MO, 1 EA & 2 RP.**

The Full Clinical Audit is designed to give GPs an opportunity to implement learnings from their initial data analysis and review if those changes have been effective, and to identify any additional barriers that may present even with those changes.

For more information on this Audit activity, or to download the Audit template, visit:
https://www.saferfamilies.org.au/cpd-audit

Safer Families Toolkit

The Safer Families have also developed a toolkit which contains a set of tools to use in clinical practice or other health service settings and are designed to help you identify and respond to those experiencing Family Violence.

All the tools are available to download as a PDF from the Safer Families website. Visit:
https://www.saferfamilies.org.au/toolkit

Monash University Recognizing and Responding to Sexual Violence in Adults

Monash University's Department of Forensic Medicine and the Victorian Institute of Forensic Medicine (VIFM) have developed a three-unit course in recognising and responding to sexual violence in adults. They are seeking expressions of interest from general practitioners, nurses, midwives and healthcare practitioners who provide primary health care services to undertake this training at no cost. You can enrol in single or multiple Units. This course is fully accredited training. For more information visit:
https://www.monash.edu/medicine/sphpm/study/professional-education/responding-to-sexual-violence