FACILITATOR HANDBOOK
Online edition

HARMONY 2019-2021

STRENGTHENING THE PRIMARY CARE RESPONSE TO FAMILY VIOLENCE: Sustainable training for primary care practitioners

Culturally safe approaches for migrant and refugee women, especially South Asian patient populations.


LA TROBE
UNIVERSITY


Judith Lumley Centre
for women, children and family health research

1. Introduction

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Background

Australia is a culturally diverse nation built on the migration of people from many countries. Some people will not identify cultural issues as being important to their health care. However, for others, it may be important for the effectiveness of the doctor-patient interaction. This training program aims to deliver resources and training to general practice to improve the response of primary care to families, particularly to migrant/refugee women and children (especially South Asian) experiencing family violence. It complements the training developed by the University of Melbourne to address family violence in general practice, to add this specific focus on migrant/refugee communities.

Family violence is a common hidden problem for families attending general practice. Family violence can be more than physical violence alone, as it frequently involves controlling behaviours and often emotional, psychological, financial and sexual abuse by partners and other family members. In South Asian populations this may also include dowry, other financial and visa abuses. It has major emotional and physical consequences, and a general practitioner (GP) is often the first professional person in whom a patient confides. GPs may be also seeing male perpetrators of family violence and this program provides some information about this challenging area of how to manage both partners.

The program components have been tested through two world first randomised controlled trials responding to family violence in general practice. The IRIS study (Identification and Referral for Safety) led by Bristol University aimed to find out if linking general practice with specialised family violence services through training and ongoing support, significantly increased referral to the specialist services. The study, published in The Lancet, found that the intervention increased identification and referral of women experiencing family violence, setting them on a pathway to safety and well-being. It is now being rolled out to GP clinics all over the UK and we are learning from their experience. The WEAVE study (Women's Evaluation of Abuse and Violence Care in General Practice) led by the University of Melbourne, sought to build a better picture of how GPs and other clinic staff can provide care for women who live with fear of a partner or ex-partner. The WEAVE project incorporated an early intervention program helping GPs to deliver a brief supportive counselling intervention. This study, also published in The Lancet, found that the intervention reduced women's symptoms of depression and increased how often GPs asked about the safety of women and children.

The HARMONY study led by La Trobe University, for whom this training has been developed, combines the strengths of these two successful models. This culturally sensitive GP training model specifically addresses the needs of migrant and refugee patient populations, particularly the South Asian community. These communities include young diaspora families, whose abuse is often compounded by social isolation due to their immigrant/refugee status, language barriers and cultural distance.

The focus of this program is on promoting healthy relationships in patients' and their children's lives that feel supportive and safe, by building stronger support from their GP. We hope to enhance patients' trust in their GP by assisting them to provide a first line response aligned with World Health Organisation (WHO) guidelines, with a special focus on the needs of migrant and refugee populations. The WHO framework is based on: Listening, Inquiring about needs, Validating their experience, Enhancing safety and providing Support (LIVES-see Section 3 Tools). Further, the program provides guidance to help create clinic environments that are more sensitive to the needs of culturally diverse patients and their children. We know that a culturally sensitive, trauma- informed clinic that incorporates the principles of respect, privacy, confidentiality, and safety (see Section 3) enhances the likelihood of disclosure of abuse. We also want GPs to connect with the specialised services available in the local community (see Section 4 Referral Resources). Specifically, increasing knowledge of the range of services provided by inTouch, the state-wide Multicultural Agency Against Family Violence.

Learning Objectives

The program consists of a self-conducted audit of the participating clinics and provider clinical practice, distance learning modules for clinicians that can be done in their own time, and online training provided by skilled GP educators and the inTouch Family Violence Advocate educator. The online program will enable clinicians to reflect on their clinic and their own practices, read new material, try some new tools, and be involved in role-plays and experiential learning. It will be most valuable to clinicians if they are able to identify their own clinic needs. We have updated this manual to include consideration of working in a pandemic climate, in this case, Covid 19.

We ask that at least 75% of all staff participate in the training.

The training program aims to support and build upon GPs' and nurses' and other clinic staff's knowledge and skills in the following areas:

- Active listening and responding skills to build trust with patients
- Skills to assess readiness for change and non-directive goal setting
- Access to up-to-date evidence and resources in responding to family violence in all, but especially in South Asian communities
- Promotion of changes in the clinic to support dealing with family violence, especially in migrant/refugee communities.

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

1. **Respectfully** engage in culturally safe ways with patients experiencing family violence
2. **Review** changes to current clinic protocols and resources
3. **Reflect** on their own attitudes which might facilitate or inhibit an effective response to family violence in migrant/refugee communities

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

1. **Recognise** and inquire about family violence in culturally safe ways in families presenting with symptoms and signs of family violence
2. **Respond** to disclosures, including being able to help patients make safety plans and effectively support victims/ survivors
3. **Risk** assess for safety of women and children who are living with family violence in culturally sensitive ways
4. **Readiness** assess for culturally safe action with regard to the patient's life situation
5. **Refer** appropriately depending on the needs of patients
6. **Record** and information share in a safe, effective manner

Timetable

Components of training program to be completed over 3 months. Components denoted as compulsory must be completed to receive 40-points accreditation by RACGP.

Phase	Component	Time (approx.)
Phase 1	**Complete** pre-training survey (Compulsory)	5 minutes
Phase 2	**Complete/ review** Clinic Checklist	5 minutes
Phase 3	**Undertake** e-Learning module *Identifying and Responding to Domestic and Family Violence* (Compulsory) – *individual access code provided to GPs* **Read** section 1-2 of Handbook and chapters from RACGP White Book (see next page)	60 minutes
Phase 4	**Participate** in Training session 1: Whole of Clinic (Compulsory)	90 minutes
Phase 5	**Complete** patient audit (Compulsory, see next page)	
Phase 6	**Read** section 3-4 of Handbook and chapters for RACGP White Book (see next page) **Watch** short video	30 minutes
Phase 7	**Participate** in Training session 2: Clinical staff only (Compulsory)	90 minutes
Phase 8	**Undertake** additional online modules (see next page) **Read** chapters from RACGP White Book (see next page)	30-60 minutes
Phase 9	**Participate** in Training session 3: Clinical staff only (Compulsory)	90 minutes
Phase 10	**Complete** post-training evaluation form (Compulsory)	5 minutes
Phase 11	**Participate** in webinars (teleconferences) **Participate** in follow-up with Advocate educator	60-120 minutes

Program Outline

As part of the program, it is requested that GP participants and the clinics undertake the following:

- **Complete** a short pre-training **survey.** *This will be sent electronically to GPs prior to the first training.*
- **Complete** Clinic Checklist. *This will be sent to the clinic prior to the first training*
- **Complete** University of Melbourne Domestic Violence e-learning module, '*Identifying and Responding to Domestic and Family Violence'*
- **Read Sections 1-2** of their participant handbook.
- **Read** '*What is interpersonal abuse and violence*', *'Intimate partner abuse: identification and initial validation*' and '*Migrant and refugee communities'* from RACGP's '*Abuse and violence: Working with our patients in general practice*' (4th edition) White Book.
- **Participate** in **Session 1**, consisting of an interactive session exploring overall clinic responses to family violence in migrant and refugee community settings.
- **Perform** an **audit** of 10 consecutive migrant/refugee female patients (aged 18 to 64) with a simple clinic checklist to allow them to reflect on their current practice and systems. *This will be sent electronically to GPs prior to the first training and should be discussed in Session 1.*
- **Read** Sections **3-4** of this handbook
- **Watch** this short video Helping end family violence – the Information Sharing Schemes and MARAM.
- **Read** the following sections from the RACGP White Book and consider what additional issues should be considered in relation to migrant/refugee families:
    - *Safety and risk assessment*
    - *Intimate partner abuse: responding and counselling strategies*
    - *Dealing with perpetrators in clinical practice*
    - *Child abuse*
- **Participate** in **Session 2**, which will focus on how to ask about family violence, early identification and response strategies, including safety assessments especially in South Asian communities.
- **Undertake** RACGP's online GP-Learning module *Abuse and Violence contextual unit*, healthpathways modules on *Domestic Violence* and **read** resource, '*Overcoming Barriers: A toolkit to improve responses to CALD women and children who have experienced family violence'.*
- **Read** the following sections of the RACGP White Book:
    - *Aboriginal and Torres Strait Islander violence*
    - *The Doctor and the importance of self-care*
    - *Specific vulnerable populations: the elderly and disabled*
- **Participate** in **Session 3**, which will focus on clinical practice, building trust, showing empathy, and developing skills in motivational interviewing and goal setting and appropriate use. Be prepared to discuss any adaptions for migrant/refugee patients.
- **Complete** the online **post-training evaluation survey**.
- **Participate** in any **follow-up**, especially the webinars, where you will discuss how things are going, any cases you may be having difficulties with, including family violence in a pandemic such as Covid 19.
- Use the opportunity for further **follow-up** contact with the team as required via telephone or email to assist you with ongoing support and implementation of clinic change.

Acknowledgements

The HARMONY model is adapted from the IRIS program model. This educational program has been adapted from the WEAVE, IRIS, MOSAIC and ANEW programs. WEAVE and ANEW training were developed by Kelsey Hegarty at the University of Melbourne. IRIS training was developed by Gene Feder and team at Bristol University MOSAIC training was developed by Angela Taft and Kelsey Hegarty for La Trobe University.

Funding

The HARMONY study, of which the GP training is integral, has been funded by the National Health and Medical Research Program (NHMRC), the Commonwealth Department of Social Services, the Victorian Department of Premier and Cabinet (Division of Multicultural Affairs and Social Cohesion) and Family Safety Victoria.

The Team

Judith Lumley Centre for Mother, Infant and Family Health Research, La Trobe University

Angela Taft is a Professor and Principal Research Fellow and the Principal Investigator on the Harmony study. She has been leading interventions to prevent and reduce domestic/family violence in primary care for the past twenty years, in both general practice and maternal and child health nurse populations. She has published widely on these issues, including contributing to the RACGP White Book. Her research interests include a special focus on migrant and refugee communities.

Felicity Young is a Research Officer at the Judith Lumley Centre and the Harmony Research Manager. She has been working in the family violence sector since 2018, originally in Victorian State and Local Government. She completed her Master of International Relations in 2017, focusing on gender-based violence and the experiences of migrant and refugee women.

Molly Allen is a Research Assistant at the Judith Lumley Centre. She completed a Master of Journalism in 2016, with a special focus on the representation and depictions of refugees and asylum seekers in Australian media.

inTouch Multicultural Centre against Family Violence

Naime Cevik is the Client Services Team leader at inTouch. As a Team Leader, she has rich experience in providing crisis response, organising referrals for accommodation, ensuring safety for clients, and strong advocacy and liaison with other agencies. In the last 28 years, she has worked in various capacities in assisting women and children who have been subjected to family violence ranging from prevention projects to conducting recovery groups. Being from a Turkish background and a migrant herself, she has conducted numerous cultural awareness and community education programs to various stakeholders.

Asha Padisetti is the advocate educator and case manager for the HARMONY Study based at inTouch. Asha has a multi-disciplinary background working in counselling, psychotherapy and as an educator, working with women impacted by domestic and sexual violence. Asha specialises in supporting culturally and linguistically diverse communities and delivering workplace and community-based training.

Department of General Practice, The University of Melbourne

Kelsey Hegarty is a practising GP and Chair of Family Violence Prevention at The University of Melbourne and The Royal Women's Hospital. Her research and teaching interests are in women's

emotional well-being (domestic violence, partner abuse, depression, counselling). She led the WEAVE project and is a Chief Investigator on the Harmony Study.

Kitty Novy is an administrative officer who has expertise in recruitment and delivery of the training program and provides advice to the HARMONY team.

GP Facilitators

Jennifer Neil is a lecturer in the Department of General Practice at Monash University as well as a general practitioner at Belmore Road Medical Centre in Balwyn. Through her University work she lectures and runs tutorials for fourth year medical students around domestic violence and has worked with several domestic violence experts. In her general practice she has a strong focus on both mental health and chronic disease management and has worked with a lot of patients touched by domestic violence, both victims and perpetrators. Jennifer is an active member of the advocacy group Doctors Against Violence Against Women.

Jacinta Halloran is a GP with many years' experience in women's' health, young people's health and counselling. She has been working at Headspace Elsternwick for the past 3.5 years in both a GP and therapist role. She has a Masters in Family Therapy from the Bouverie Centre (La Trobe University).

Deepthi Iyer is a practising GP in Melbourne and a PhD candidate at the University of Melbourne. Her PhD is exploring Australian young women's perceptions of dating and dating violence.

Recruitment

Jennie Raymond and **Kitty Novy** have worked with La Trobe University to recruit clinics for the HARMONY Study in the south-east and north-west of Melbourne respectively.

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2. Clinic Training

Preparation

Zoom instructions

Aim

Participant preparation and participation

Session 1: Whole of Clinic

Session 2: Clinical Only

Session 3: Clinical Only

Preparation

There are several items to pre-arrange, which will be organised by La Trobe University. La Trobe staff will book all Zoom meetings and send links to trainers and participants.

Session 1: Whole of Clinic

*The first session is for the **Whole of Clinic - reception, practice management and clinical staff.***

Facilitators (GP educators and inTouch advocate educators) should have access to the following

- Laptop with Zoom and presentation
- Copy of facilitator handbook, **online edition**
- Notebook and pen (optional)

Please note: Participants will be provided with a pre-training survey and clinical checklist form to complete prior to the first training session. The online participant handbook will be emailed to participants prior to Session 1. Participants will be asked to review the clinic checklist and complete the pre-training survey prior to the commencement of the training. Allow time prior to the training to ask participants if they have completed the survey, if they have not completed the survey, ask them to complete in the next 5 minutes.

Session 2: Clinical Only

- Laptop with presentation and Zoom
- Copy of facilitator handbook, **online edition**
- Notebook and pen (optional)

Session 3: Clinical Only

- Laptop with presentation and Zoom
- Copy of facilitator handbook, **online edition**
- Notebook and pen (optional)
- Participants will be contacted to complete a post-training evaluation after Session 3.

Zoom Instructions (optional)

La Trobe University staff will be responsible for managing Zoom functionality throughout the online training. However, it is strongly recommended you have the following functions available on your Zoom account.

Firstly, you will need to enable the Breakout Room and Polling functions in your account. These are the instructions about how to do that for a personal account:

1. Sign into the Zoom web portal.
2. In the navigation menu, click **Account Management** then **Account Settings** (if you are an account administrator) or **Settings** (if you are an account member).
3. BREAKOUT ROOMS: Navigate to the **Breakout Room** option on the **Meeting** tab and verify that the setting is enabled.
   If the setting is disabled, click the toggle to enable it. If a verification dialog displays, choose **Turn On** to verify the change.
4. POLLS: Navigate to the **Polling** option on the **Meeting** tab and verify that the setting is enabled.
   If the setting is disabled, click the toggle to enable it. If a verification dialog displays, choose **Turn On** to verify the change.

Once you have enabled these functions, their icons will appear in the bar at the **bottom of the screen** (with chat, participant etc) when you are in a Zoom meeting.

Breakout Rooms

To initiate Breakout Rooms, click on the icon and you can either create them **automatically** (groups will be randomly assigned) or **manually** (you can assign groups). To choose the number of rooms use the up and down arrows.

Polls

Click on the Polls icon, then ‘add a question’. This will open a webpage where you can write your questions and answers in, with the options of either single or multiple choice. These can be done in advance.

Whiteboard function

1. Click on the ‘share screen’ icon at the bottom of the screen when you are in a meeting. One of the options that will appear is Whiteboard
2. Double click on the Whiteboard page option
3. Once it is open, you can write by clicking on the ‘T’ Text icon and click on where you would like to type to create a text box. You can add pages by clicking on the square in the bottom right corner.
4. To save the page click on the save button and it will download and save in your Zoom folder.

Aim

Below is a brief introduction to the purpose of these visits, which aim to provide opportunities for the whole clinic to discuss issues in an individualised way with you as GP facilitator and the advocate educator.

Session 1: Whole of Clinic

The first session is for the **Whole of Clinic.** The Whole of Clinic training allows for clinicians and staff to discuss the role of the clinic in safely responding to patients, particularly women and children and especially ethnically diverse patients who may be experiencing family violence, and how the clinic might facilitate or inhibit an effective response. This will comprise of 90 minutes. In this first session, participating staff within the clinic should discuss:

- Their views about what they would like to gain from the training, the overall benefits of the study and being involved in an educational program.
- Barriers and facilitators to providing care in cases of family violence.
- The tools and community-based resources available to clinics.
- Other resources that may be required.
- Strategies in the clinic that could contribute to sustaining change.
- The role of inTouch and the role of the FV support worker in collaborative care for patients.

Session 2: Clinical Only

Session 2 will focus on the role GPs and nurses. The use of role-plays with a simulated patient provides participating GPs and nurses with the opportunity to try out different ways of initial engagement with victims, providing supportive care and experimenting with different communication styles and techniques. In this session:

- Case scripts are linked to learning objectives.
- Role-play should be as realistic as possible.
- Simulated patients should provide feedback.
- Allow time for discussion on Covid19 context, preparation and debriefing.

Session 3: Clinical Only

This third session builds on the previous session with case studies (South Asian patients) including:

- Developing strategies to engage with women at different stages of change (motivational interviewing) with attention to cultural safety and trauma informed care.
- Offering practice in warm referrals.
- Familiarising staff with the legal and community services systems for referral, especially for migrant and refugee populations.
- Including working with male patients who abuse and addressing issues for children exposed to family violence.

Participant preparation and participation

The participants have been asked to complete readings, modules and in addition to the training sessions. See the program outline for more details.

Session 1: Whole of Clinic (90 Minutes)

Aim

This session is aimed at all staff, including clinical and administrative staff to assess the practice environment and understand how to enhance cultural safety and welcome and patients' perspectives.

Objectives

During this visit the participants should:

1. Understand how all members of the family (especially those in migrant/refugee families) might present
2. Explore the challenges and opportunities for providing safety and care in cases of family violence among ethnically diverse communities
3. Reflect on the barriers and facilitators to patients discussing abuse, especially for South Asian migrant populations
4. Discuss how the clinic may improve responses to patients and children experiencing family violence and maintain their own safety
5. Consider how change, including best practice in recording ethnicity within the clinic can be sustained

Before commencing, ask GPs if they have:

1. Completed the online pre-training survey, if not direct to complete in the next 5 minutes and;
2. Completed/ have the clinic checklist;
3. Updated their preferred name on their Zoom ID.

Task 1 Introduction: outline of the visit and discuss myths and misconceptions **15 minutes**

1. Educators and La Trobe staff introduce themselves. Outline the objectives of this visit and check they have their handbooks and whether they have looked at the eLearning module.
2. Ask participants what they think family violence is and how common it is in Australia. Use poll function and/or chat on zoom to engage participants in discussion.
3. Discuss myths about the causes and symptoms of family violence.
    a) What do you think causes family violence?
    b) What symptoms might a woman present with? What might a child present with?
    c) How might a male perpetrator present to a GP?
    d) How has COVID-19 impacted women, particularly migrant and refugee women, who are experiencing family violence?

Task 2 Setting the scene **10 minutes**

- Ask the participants to think about their working environment:
    - Identify the opportunities and challenges that impact on the care provided to patients, especially migrant and refugee patients experiencing family violence
    - Use the zoom chat and/or whiteboard function and ask participants to add their identified opportunities and challenges

Task 3 Discussing sensitive issues **15 minutes**

- Ask the participants to think of a situation in which they have felt victimised in the past, either at school, work or home.
- **They should be advised not to think of something that is too painful but rather something that was minor (e.g. neighbour played loud music in the early hours of the morning etc.).**
- Break participants up into threes using the breakroom function on zoom. Participants should spend 5 minutes telling the other about what it felt like when it was happening, while one is the observer.
- Discuss as a group, the facilitators and barriers to talking about sensitive issues and how to overcome them.
- The facilitator will discuss what women expect from you and how to respond, including a safety plan.
- The facilitator will ensure the discussion considers safety for both staff and patients.

Task 4 Introduction to inTouch, (a state-wide multicultural agency, working against family violence and the referral pathways available in the area.) **10 minutes**

- Discuss the role of inTouch.

Task 5 Selecting a process to change within the clinic **20 minutes**

- Ask participants to review the **clinic checklist** located in the participation pack.
- Break participants up using the zoom breakout rooms function into small groups (3-5) and ask them to discuss what processes already exist in the clinic and to consider how the recommended processes listed might be implemented. *Note they will need to nominate a member of the group to report back on their discussion.*
- Ask each group to report back on what they discussed.
- As a group, choose one process that you would change to improve responses to patients and children experiencing family violence, especially those from migrant /refugee backgrounds.
- Participants should then discuss how you would change this process, implement it, and sustain the change.
- Ensure the discussion considers safety for both staff and patients and challenges posed by pandemics like Covid19.

Task 6 Documentation in Best Practice or Medical Director **5 minutes**

Defer to La Trobe University staff member who will provide an overview of the importance of staff recording a patient's ethnicity in their files and GPs recording patients experiencing family violence, as it will be extracted by GrHanite. Steps are under Documentation in section 3 of the handbook.

Task 7 Summary and reflection **10 minutes**

- Ask participants what stood out for them today and what will they take away and think about more?

Preparation for Sessions 2 Clinical Only

Explain that the next session will be just for clinical staff. Ask that they bring their participant handbooks and have completed the **pre-reading and undertaken the online e-learning module and have performed the audit,** if they have not already done so.

Session 2: Clinical Only (90 Minutes)

Aim

This session is aimed at clinical staff within the general practice, for example GPs, nurses and any allied health professionals who may want to participate.

Objectives

During session 2, participants (clinical only) should:

1. Enhance their skills in listening and responding to patients, particularly women from migrant and refugee backgrounds who have experienced family violence
2. Practise assessing and responding supportively to patients' readiness to take action with regard to family violence

Before commencing, ask Participants if they have:

1. A copy of the participant handbook, as we will be referring to it throughout the training and;
2. If they have completed the patient audit.

Task 1 Introduction **5 minutes**

- Welcome the participants (clinical staff only - GPs, nurses and any allied health professionals participating)
- Note we will be drawing on the patient audits
- Explain that a simulated patient will join us during this session
- Explain that the strategy of role-play and reflection used in this visit provides an opportunity to understand a consultation from a woman's perspective

Task 2 Asking about abuse, violence and safety **15 minutes**

Ask participants to:

- Review tools in Section 3 of their handbooks;
- Discuss how they would ask about abuse, risk and safety, including safety in diverse patient populations
    - Ask participants to draw on their patient audits and think about the last contact they had with a woman (in particular, a refugee or migrant) who may have been presenting with family violence
    - Identify the top two strengths and weaknesses of their response
    - Use the zoom whiteboard function and/or chat and ask participants to add their identified strengths and weaknesses.
- Discuss limits to confidentiality and how to discuss with patients and elicit the issues for women in pandemic isolation. Refer to MARAM and discuss information sharing and breaking confidentiality. More information can be found under Section 3, safety planning MARAM and MARAM Information Sharing.

Task 3 Readiness to take action **10 minutes**

Ask participants to discuss:

- Different strategies for responding to different stages of readiness (Pre-contemplation, Contemplation, Preparation, Action, Maintenance)
- How they found the video on eLearning module of the consultation about asking about violence
- What would work and why for different scenarios?
- Specific demands of cross-cultural strategies with migrant/refugee patients

Task 4 Simulated patient: building trust to enhance change **30 minutes**

- Ensure you have read the simulated patient scenario in this handbook.
- Introduce the simulated patient/ role play exercise as a learning strategy as it may be an unfamiliar approach to participants.
- Describe the ground rules to the group.

This role-play provides the opportunity for clinical staff to try out old and new techniques and to observe different communication strategies. A simulated patient will act the role of a woman attending for care. The setting for this role-play is the GP clinic using video/tele conferencing. For 20-30 minutes, clinical staff should play the role of the GP seeing 'Bharati' (a young Indian woman with a daughter), for her first visit.

Fishbowl style: Nominate a GP to start the consultation. Ask everyone else to mute their computers and the consultation will be stopped and started by the GP Facilitator to allow feedback from the facilitator, the Advocate educator and the patient and to allow another nominate GP to 'have a turn' undertaking the consultation. Aim to have all GPs participate in patient simulation.

The simulated role-play script is on the next page.

Once completed, ask all participants to unmute their computers and return to discuss the engagement with the simulated patient.

Task 5 Role-play in pairs different case scenarios (optional, if time allows) **15 minutes**

Use the Breakout rooms function on zoom to pair participants and undertake a role play with one of two further scenarios (older Pakistani mother, Nepalese adolescent) of migrant/refugee patients and will take turns to use the patient script or be the clinician seeing them, who initiates discussion about the potential underlying issues and offers an appropriate response to a disclosure and seeks further information.

Case study 1: Older Pakistani mother

Case Study 2: Nepalese adolescent

Task 6 Discussion **10 minutes**

Clinicians share and discuss lessons learned from simulated patient and role-plays and reflect on strategies.

Task 7 Documentation of Family Violence in Best Practice or Medical Director **5 minutes**

- Defer to La Trobe University staff member who will provide a reminder from the first session about how to record family violence patients in their software, which will be extracted by GrHanite. Steps under Documentation in section 3.

Preparation for Session 3: Clinical only

Make sure you remind GP participants if they haven't already **completed the University of Melbourne e-Learning module on *'Identifying and Responding to Domestic and Family Violence',*** watch the ***MARAM*** video and **performed the audit.** The module and audit are required to be completed to receive the 40 RACGP points.

Simulated patient instructions

NAME: Bharati

AGE: 35, book keeper

SOCIAL/FAMILY STRUCTURE: Married to Rana, an engineer, for 5 years, although she has known him for 7 years. Theirs is a romantic marriage, not approved by families on either side. They have 1 child, a daughter, Anu, who is now 2 years.

PAST MEDICAL PROBLEMS: Nil

Smoker – no

FAMILY HISTORY: Nil significant in family of origin, parents live in India. Mother-in-law does not approve of daughter-in-law and offers no help with her son.

MEDICATION: Nil

OPENING STATEMENT: "My headaches are becoming more frequent"

How to play this case

You are anxious and a bit depressed but not suicidal. You are not sleeping very well, and you open up if the doctor uses good active listening skills. You are happy to come back and see them.

Relationship Background

You and Rana first met here in Australia (you are both on 457 visas – temporary sponsorship visa for skilled overseas workers) through a friend and started your relationship as friends. This steadily grew into a romance where, in the beginning, you were head over heels. However, with time, you found Rana's jealousy hard to deal with. He would complain for hours and become aggressive and nasty whenever you wanted to meet family and friends. He would claim you didn't love him. Often, he would demand to see your phone to check your messages. Once he came to pick you up from work and saw you chatting to a male colleague. When you got into the car he was furious, accusing you of cheating on him and screaming at you the entire way home. When in the house, he slapped you so hard across the face, you fell and split your lip.

Rana begged for your forgiveness the next day. He said he lost control because he loved you so much and feared losing you. You decided to give him another chance. Within a few months, he had proposed to you and you got married, despite neither family being happy with the union as it was a love marriage and not arranged.

You were working as a book keeper while married and enjoyed it. However, after a couple of years you fell pregnant with your daughter, Anu. Since Rana was earning a good income, he convinced you to leave your job and stay home to look after the baby. But when Anu was born, Rana became increasingly controlling, handling all the household finances and making you account for every single dollar you spent. He wouldn't let you invite people over to the house unless he was there and took the car keys away so you couldn't go out. He would even get angry at you for showing Anu too much attention.

He would often hit, punch and slap you, but because you hardly went out, nobody knew what was going on. Your mother-in-law witnessed what was happening to you when you were visiting her in India but explained that you must have been a disobedient wife to deserve such treatment. You have suffered like this for the past 2 years and have felt trapped, isolated and depressed. You can't understand why Rana has behaved this way toward you. You wished things could return to the way they were when you were happy and in love. You have asked Rana to get help for his behaviour, but he has refused to acknowledge any problem.

You have several underlying concerns:

1. *Whether you should tell your parents and risk bringing shame to the family*
2. *How to improve how you are feeling*
3. *There are several issues that concern you specifically about your situation:*
    a. *Will Rana change? You don't want him to get into trouble, but you also don't want his current behaviour to continue. What can you do if Rana refuses to get help?*
    b. *Are you putting your daughter in danger by staying with Rana? Rana is a 'good' father and you don't want Anu to lose this relationship by leaving.*
    c. *What will happen to your visa if you leave Rana?*
    d. *You are scared to separate from Rana as he provides for both you and Anu. Can you get financial help?*
    e. *Where can you go if you leave Rana?*

Videos are available on the RACGP website of Bharati's visit with the GP following her disclosure at a previous appointment. These videos (4 in total) will take 12-15 minutes to watch.

Case Studies

The following case studies are to be given to staff to role-play in pairs:

Case Study 1: Older Pakistani mother
NAME: Aminah
AGE: 62, widow

SOCIAL/FAMILY STRUCTURE: Was married to Ahmed for 40 years. She has 5 children and when Ahmed passed, her eldest son and his wife called Aminah to Australia to live with them.

FAMILY HISTORY: During the 40 years of marriage, Aminah was physically and sexually abused by her husband. She never said anything, as she believed her husband had the right to discipline her. Also, she was isolated from her family. When her son and daughter-in-law moved in with her, they continued abusing her both physically and mentally.

MEDICATION: Nil

OPENING STATEMENT: "My back. It hurts. Can you give me something for the pain?"

How to play this case

This is your first visit to this particular GP. You are very depressed, crying some of the time. You are anxious and have headaches and back pain. You struggle to open up as English is not your first language. Your son is very controlling and did not want you to come. You are scared of him but will open up about what happens at home when asked sensitively.

Relationship Background

You were married to your first cousin, Ahmed, at 18 years. He was almost 30 years old. You never wanted to marry Ahmed as he was too old, but you thought given time you might learn to love him. As soon as you were married, though, you learned how cruel Ahmed could be. He would beat you and shout at you, often calling you ugly and stupid. You gave birth to 5 children over a short period of time and stayed home to look after the family. You were married for 40 years when Ahmed passed away after a short illness. Your eldest son, Bilal, had already migrated to Australia and when you became a widow, he called you to live with him. It has been difficult living with Bilal. He is like his father and often shouts at you calling you names. You are very depressed. You don't eat much and have lost weight. Your back hurts from muscle spasms, and you suffer terrible

headaches most days. You stay in your room most of the time and cry.

You have several underlying concerns:

1. *Will my son get into trouble if I say something? You just want him to stop hurting you.*
2. *How to improve how you are feeling*
3. *Where would I go if I left my son's house? Who can help me?*
4. *Are there other Pakistani women I can talk to or socialise with?*

Case Study 2: Adolescent Nepali girl
NAME: Geetu
AGE: 17, high schooler

SOCIAL/FAMILY STRUCTURE: Lives with her parents and 1 sibling, a brother younger than her

PAST MEDICAL PROBLEMS: Nil

FAMILY HISTORY: Parents are migrants from Nepal who migrated for a better life for the children. However, they are forcing Geetu to get married and leave her studies.

MEDICATION: Nil

OPENING STATEMENT: "I feel sick. I feel nauseous all the time. I am irritated and lose my temper a lot."

How to play this case

You are angry. Your parents are forcing you to leave your studies to marry some man in Nepal. You love school and have dreams of becoming a doctor to help others. You feel trapped and don't know what to do. You have a boyfriend who doesn't understand what you are going through. Your friends don't either. You are irritable and lose your temper and just want to be left alone.

Relationship Background

You have just turned 17 and are dreaming about a future as a doctor. It is all you can think about. Then one evening during dinner, your parents mention that they have arranged your marriage to a man in Nepal, someone you don't know. Your engagement is in a couple of months and they have said you need to start preparing. You are not happy about this at all. Your parents don't see reason and will not cancel the engagement. A dowry has already been paid. This upsets you.

You can't sleep. The next day you try and tell your friends and your boyfriend. They don't understand your culture and traditions and think your parents are weird. You feel you can't talk to anyone about this problem. At home, your parents keep badgering you about the engagement which angers you. You start feeling nauseous and headachy. You don't sleep and are anxious about your future. You don't know what to do.

You have several underlying concerns:

1. *Who can you speak to about your problems? What are your options for getting help? Who will help you?*
2. *How can you improve how you are feeling?*
3. *Do you have to leave your home to get help? Where can you go if you must leave?*
4. *How will you support yourself if you leave? Will you be able to still have contact with your parents and extended family?*
5. *How will the Nepalese community treat you if you leave? Will this shame your whole family?*
6. *What will happen to your studies?*

Case Study 3: Young Bangladeshi wife and mother
NAME: Syeda
AGE: 28, part-time accountant

SOCIAL/FAMILY STRUCTURE: Married to Anik at age 20, Arranged marriage. Daughter Noor (12 months old)

PAST MEDICAL PROBLEMS: Attended hospital after 'falling down the stairs' during pervious pregnancy, everything was ok with the pregnancy. Had mild-moderate post-natal depression in early months of Noor's life.

FAMILY HISTORY: Nil significant medical problems. Parents live in Bangladesh, parents in-law live in Australia and often visit but don't help out with Noor much.

MEDICATION: nil

OPENING STATEMENT: "Hi doctor, I think I might be pregnant again. I wasn't expecting this as I'm still breastfeeding my daughter."

How to play this case

It took you several weeks to make this appointment as you are worried that the GP will be judgemental towards you. When you saw the doctor at the hospital in your last pregnancy after being shoved roughly onto the ground by your husband (you told the doctor that you fell down the stairs), you felt like they blamed you for your injuries. If the doctor makes you feel safe and you have built trust with them then you disclose that the last time you were pregnant, Anik's violence escalated. He shoved and pushed you on several occasions, including the time he pushed you down onto the ground. On another occasion he grabbed your arms roughly leaving bruises.

If asked, your husband is out at work and is not listening in to your conversation. He is not aware of the telehealth consult.

Relationship Background information

You have been married to Anik since you were both 20 years old. It was an arranged marriage and four years ago he got a work visa to come to Australia where he works as an engineer.

You have a 12 month old baby daughter called Noor. You thought that breastfeeding would give you adequate contraception. Your last normal menstrual period was 8 weeks ago. You have done a home urine pregnancy test which was positive when your period was late. You feel anxious about being pregnant so soon but are keen to continue with the pregnancy.

The physical violence improved after Noor was born but he has not been allowing you to have contact with your friends very often and he often checks the messages on your phone and emails to see who you have been in contact with. He has control over the finances of the household and both wages go into a joint bank account which he checks regularly.

You have been feeling exhausted since having Noor and don't want to have sex but Anik has forced you to have sex on multiple occasions. You feel afraid of Anik and feel like you are constantly walking on egg shells to avoid him getting upset with you.

Because of COVID-19 you have been working from home (as an accountant) and Noor has been recently been allowed back to childcare. You feel very isolated.

You are afraid that the physical violence will escalate again when he finds out that you are pregnant. You have been having flashbacks about being pushed to the ground in your last pregnancy and are feeling very anxious about the whole situation.

You have several underlying concerns:

1. *How can I stop Anik becoming physically violent again this pregnancy? Is there anything I can do to help the situation?*
2. *I feel very isolated. How can I get in touch with my friends and family?*
3. *If I leave Anik, how can I stay safe as I'm worried he will just get more violent?*
4. *If I leave, how can I get access to money?*
5. *Will I get post-natal depression again?*

Session 3: Clinical Only (90 Minutes)

Aim

This session is aimed at clinical staff within the general practice, for example GPs, nurses and any allied health professionals who may want to participate. Staff will be re-introduced to inTouch and now also to other community-based referral pathways and resources. Strongly encourage clinicians to consult the tools section, which has been written with cultural safety in mind.

Objectives

1. Make effective safety plans, especially for patients from South Asian communities;
2. Practise non-directive problem-solving techniques and goal setting with patients;
3. Understand how to make warm referrals; and
4. How to make changes, both individually and as a clinic to provide trauma and violence informed care.

Task 1 Feedback from Session 2 **10 minutes**

Elicit whether any clinicians have seen patients in relation to violence since they commenced training and reflect on any learnings or difficulties, they may have experienced.

- What forms of family violence do they see?
- What differing forms can family violence take in South Asian communities?
- What are the health effects they anticipate would be the most common?

Task 2 Safety planning and motivational interviewing **30 minutes**

Part 1: Briefly discuss and demonstrate safety planning, referring to safety planning tools in Section 3 of the handbook (includes MARAM).

- Discuss safety planning, tele-health and the impact of COVID-19.

Part 2: Discuss motivational interviewing and problem-solving techniques/goal setting using the written plan tools provided in Section 3 of the participants' handbook.

- Watch the recorded visit (2 minutes) with 'Bharati' and discuss points of good practice when undertaking motivational interviewing
- Fishbowl Role-Play with advocate educator as simulated patient to practice motivational interviewing. Encourage participants to look at the Readiness to Change – Motivation Interviewing Tool and Non-directive problem-solving goal setting tool.
- Provide feedback and discuss what to avoid in order to minimise harm (slide from WHO curriculum)

Task 3 Trauma and violence informed care and practice **20 minutes**

- Ask the participants to discuss how their clinic could change to become more trauma informed. See section 3, Trauma and violence informed care and practice in your

handbook. Apply these ideas to Case Study 3: Young Bangladeshi wife and mother in their handbook and then in general with their patient population.

- Ask patients to think about the patient's experiences from booking in their appointment to finishing the appointment
- Discuss how they would conduct a tele-health appointment using TVIC practice.
- Discuss what other considerations they would have with a woman from a migrant/refugee background (south Asian).

Break participant up into small groups using breakout rooms on zoom (3-5) and get them to discuss the following questions (ask they nominate one member to report back):

- How attuned are they to the possibility of trauma in the lives of all patients?
- How aligned is their clinic with core principles of safety, trustworthiness, choice, collaboration and empowerment?
- Does the clinic operate in a way that would minimise re-traumatisation for survivors?
- How does their clinic emphasise physical and emotional safety for all patients and staff?
- Do they have a strengths-based approach, providing hope and possibilities for connection?

Bring everyone back to the larger group discussion and use the whiteboard function to ask:

- What could they change to become more trauma informed?

Task 4 Making a warm referral **10 minutes**

Discuss making a warm referral, using the case studies as example and how you could refer a woman to inTouch. If there is time, break participant into pairs using the breakout room function on zoom. The GP educator and inTouch advocate educator can also demonstrate a warm referral.

Task 5 Revision - Documentation and recording **5 minutes**

Defer to La Trobe University staff member to refresh clinicians on how to document family violence in Best Practice or Medical Director, as required by GrHanite for data extraction.

Then ask the participants to:

- Ask questions and discuss how they will record family violence and ethnicity in their software.
- Review issues about how to share information safely, including issues of mandatory reporting of children: https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework

Task 6 Working with all members of the family **10 minutes**

- Remind participants about MARAM and information sharing (when do you break confidentiality?) safety planning with the MARAM Tool.
- Review the tools for seeing both partners; Confidentiality Tool and the Child Assessment Tool.
- Using the poll function on zoom, as a group**:** discuss the issues that may arise for them when seeing all members of the family.

Task 7 Summary and reflection of session 3 **5 minutes**

Discuss the ongoing role of inTouch and other support during the study and next steps with La Trobe University:

- Individually GPs can discuss/call//teleconference with Advocate Educator from inTouch, including warm referrals;
- inTouch Advocate Educator to attend staff meetings (minimum 3 in 12-month period);
- Attend webinar sessions with GP educators and inTouch Advocate educator

Post-training reminder

Please remind GPs to complete the following to receive 40 RACGP points:

- University of Melbourne e-learning module
- Patient audit to allow them to reflect on their current practice and systems.
- A post-training evaluation survey (will be sent 4-6 weeks after last training).

3. Tools and resources For family violence in clinical practice

(with special consideration of the needs of migrant and refugee families)

Introduction

Identification of Family Violence

Tools and Safety and Risk Assessment

First line and supportive responses

Trauma and Violence Informed Care

Practice Documentation

Quick Reference guide to Tools, Safety and Risk Assessment and Supportive Responses

Tools and Safety and Risk Assessment

Healthy Relationship Tool

Power and Control Wheel

Safety and Relationship Risk Assessment

Survivor Risk Assessment Tool

Child Risk Assessment Tool

Safety Planning Guide (World Health Organisation and MARAM)

Confidentiality Tool

First Line and Supportive Responses

Life Situation Assessment

Assessment of Social Support

Readiness to Change – Motivational interviewing

Non-Directive Problem Solving

Introduction

The following section introduces you to the **unique needs of migrant and refugee families experiencing violence**. It will take you through tools and resources to use at each stage of consultations with victims, their children and an abusive partner or other family member.

We begin defining these communities and outlining their potential additional needs, e.g. knowledge of our systems, isolation and layers of trauma and abuse. We follow with advice about how to incorporate trauma informed care at each stage of your consultations, and within the clinic to support best practice.

The terms MIGRANT, REFUGEE, ASYLUM SEEKER and MIGRANT OR REFUGEE are important for us to understand. There is the need for acknowledging the trauma journey & for understanding trauma informed decision making, i.e. "He is the only family I have, not just a husband…. I can't abandon/lose him"

A ***Migrant*** is someone who can choose when to leave their home country and where to go to re-settle, although sometimes these choices are extremely constrained. Most migrants can return to their country of origin if they choose to do so.[1]

According to the United Nations High Commissioner for Refugees (UNHCR) an ***Asylum Seeker*** is someone who is seeking international protection. They must apply for asylum – the right to be recognised as a refugee.[2]

The UNHCR defines a ***Refugee*** as someone who has been forced to flee their country because of persecution, war or violence. Their claims can be based on fears of persecution due to their race, religion, sexuality, gender or political affiliations. Most would be unable to return home or afraid to do so. [3]

Barriers and challenges to working with migrant and refugee women experiencing violence (seek advice from In Touch about these issues for your patients) but consider all the following:

Knowing 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. Migrant or refugee women from certain backgrounds will consider abuse as a common form of discipline from the partner, i.e. migrant or refugee perpetrators claim never to have hit/hurt women other than their own wives, as it is normal in their culture for the husband to discipline his wife and that it's not considered abuse/violence in the family.
- People from migrant or refugee backgrounds may not recognise other forms of abuse. Verbal, emotional, social, financial (e.g. dowry abuse) and sexual abuse, social isolation,

[1] http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/migrant/
[2] https://www.unhcr.org/en-au/asylum-seekers.html
[3] https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

threats and intimidation may not be recognised as violence and might have been accepted in their country of origin.

Awareness of systems

- For those who are new to a country there may be a lack of knowledge regarding family violence laws in Australia and victim rights i.e. how family violence is defined and the several types of abuse and violence (Family Violence Protection Act 2008); and that as a victim of family violence they can apply for an **intervention order** to put protection in place. Also, that if she fears for her children's safety, she can include them in her application.
- Migrant and refugee women are likely to be unfamiliar with and lack awareness of support systems available.
- There may also be a fear of authorities or a potential lack of understanding about the role of police in Australia. Police must respond to FV 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.

Visa dependency issues

- Women on dependent spouse visas are especially at risk and supports are limited.
- Those in an uncertain visa status can have trouble accessing health care; either they may not be eligible, or they may not understand the system.
- There is fear that reporting family violence will compromise their future residency in Australia.
- Partner Visa

  Issues that can arise:

  i. perpetrator uses threat of "deportation" to control the victim.
  ii. 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:

  iii. victim-survivor has no long-term rights in Australia.
  iv. financial/housing support extremely limited and not always accessible.
  v. no recognition of relationship or family violence.

Language

- Language and literacy

  The questions that should be asked:

  1. What languages does the patient speak, other than English?
  2. How comfortable are they with communicating in English?

3. Does the patient's comfort level change with the length, complexity and sensitivity of the communication?
4. What is the patient's cultural background? What culture do they identify with?

- Tips:

    - Be clear about what you want your patient to understand at the end of the communication.
    - Make the messages simple (short & clear) – 1 idea per sentence.
    - Consider different ways to communicate your message such as provide written materials/pictures in the patient's language.
    - Be mindful that a smile, nod, and yes/no answer may not mean what you expect them to mean, i.e. it may be seen as more polite than understanding the message.
    - Check availability of interpreters and their training in family violence. Ask for a female, rather than male interpreter if working with female victim.
    - Note there may be a lack of adequate interpreters especially in newly arrived community languages such as Rohingya (Burma) or Karen (Burma)
    - Fear & hesitation in smaller communities to use interpreters who might be from the same community & know the patient, might be a barrier due to confidentiality.

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.
- This is likely exacerbated by the current circumstances we are in due to COVID-19.

Migration experience

- Pre-migration history and prior experiences of torture and trauma might impact on them taking action.
- Loss and grief issues and the migration journey and experience.
- Changed gender roles might create further escalation of violence.
- 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 eroding relationships between authority and minority communities in this country.

- Abusive partners may intensify fear of authorities so as to diminish any chance that the victim may report.
- Mediation through family members, faith and community leaders might often be the first and preferred step to get support.
- Accessing protection through legal support could be the last option.

Resettlement experience

- For many refugees, migrants and asylum seekers, moving to a new country can be a very stressful time. Just some of the issues they may face include: language barriers, social isolation, lack of family support, financial limitations, lack of education or non-recognition of qualifications, uncertain visa status and unaffordable housing.
- Role reversal and the impact on familial relationships (e.g. the wife being the bread-winner).
- Grief and loss of friends and family back home, coupled with potential trauma may compound their barriers to support.
- Traumatic experiences in detention centres, refugee camps or their journey.

Complex family dynamics

- Strong cultural beliefs may not allow couples 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 for safety. This is also likely, made much more difficult with COVID-19 restrictions in place.

Racism

- Migrant and refugee patients may be experiencing or have experienced racism since arriving in Australia.
- Experiences of racism may both increase reluctance to seek help, as well as compound other issues the victim is facing in the home and exacerbate mental health issues.

Identification of Family Violence

Asking about Violence and Initial Validation

When the issue of family violence is 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 their 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
- 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 often 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 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?

The Victorian MARAM recommends the following questions for across the response system.

- We know that many people have issues with their relationships and this can affect their health, so we often ask patients a set of questions about home life and relationships.
- Answering these questions will help us understand how we can best provide care. All people deserve healthy relationships in which they are treated with respect, kindness and feel safe and supported.
- Below we ask about your recent experiences in your relationship/s with your partner or ex-partner, boyfriend or girlfriend or other family members.

Question		Yes	No	Comments (or not known)
Has anyone in your family done something that made you or your children feel unsafe or afraid?		☐	☐	
Is there more than one person in your family that is making you or your children feel unsafe or afraid? (Are there multiple perpetrators)		☐	☐	
The following risk related questions refer to the perpetrator:				
Perpetrator actions	***Have they…***			
	controlled your day-to-day activities (e.g. who you see, where you go) or put you down?*	☐	☐	
	threatened to hurt you in any way?	☐	☐	
	physically hurt you in any way (hit, slapped, kicked or otherwise physically hurt you)?	☐	☐	
Self-assessment	Do you have any immediate concerns about the safety of your children or someone else in your family?	☐	☐	
	Do you feel safe when you leave here today?	☐	☐	
	Would you engage with a trusted person or police if you felt unsafe or in danger? (Note: if lack of trust in police is identified risk management must address this)	☐	☐	

Other questions to ask

Once the person experiencing family 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 them?
- 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?

Additionally, the WEAVE model proposes the following questions for GPs:

Worries

- What is on your mind today?
- What worries, or concerns do you have about your life?
- Tell me about your recent relationships….

Efficacy

- How are you feeling within yourself?
- Are you able to control what goes on in your life?
- How confident are you that you could make changes in your life in the near future?

Afraid

- Are you afraid of your partner, ex-partner or anyone in your family?
- What is it like when it is scary? What is it like when it is safe?
- When were you most or least afraid?
- How fearful are you now? Are you safe to go home?
- What could help you feel safer?

Violence

- Unhealthy relationships can involve physical, emotional or sexual behaviours
- What is the best/worst aspect for you of your relationship?
- Are things getting better, worse or staying the same?
- How safe do you feel at home?

Expectations

- What would you like help with?
- Who could give you the most support with this issue?

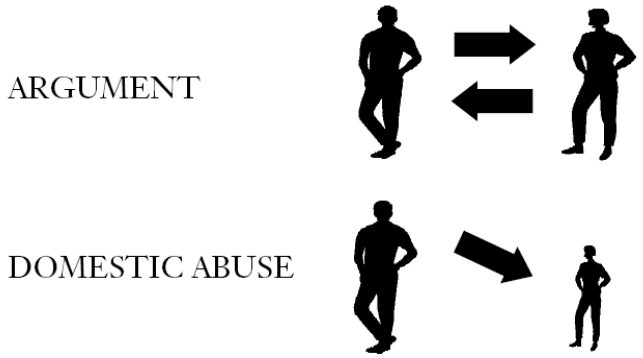
Tools and Safety and Risk Assessment

Healthy Relationships Tool

The health of an adult relationship encompasses a spectrum ranging from positive to negative. You may find this diagram useful to identify the nature of your patients relationship with her.

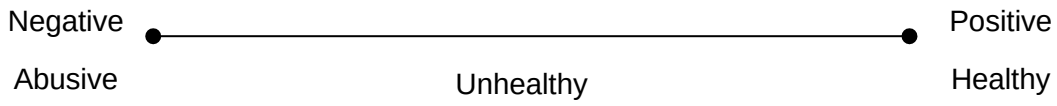
Positive relationship health involves mutual trust, support, investment, commitment and honesty. It involves the exchange of words and actions in which there is shared power and open communication.

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.



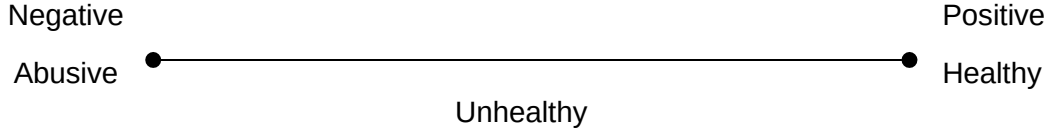
How healthy is your relationship with your current partner?

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



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



Power and Control Wheel

Below, the Power and Control Wheel has helped women to understand that there are many relationships that move in harmful cycles.

Ref: DOMESTIC ABUSE INTERVENTION PROGRAMS 202 East Superior Street Duluth, Minnesota 55802 218-722-2781 www.theduluthmodel.org

Safety and Relationship Risk Assessment[6]

The following is a written self-completion questionnaire that could be completed online or on another medium and passed on to the doctor or another trained clinician.

- We know that many people have issues with their relationships and this can affect their health, so we often ask patients a set of questions about home life and relationships.
- Answering these questions will help us understand how we can best provide care. All people deserve healthy relationships in which they are treated with respect, kindness and feel safe and supported.
- Your doctor or nurse will ask if you wish to talk about your answers.
- Below we ask about your recent experiences in your relationship/s with your partner or ex-partner, boyfriend or girlfriend or other family members.

YOUR RELATIONSHIPS

In the last year, has a partner, ex-partner or family members:

Done something that made you feel afraid?	☐ Yes	☐ No
Controlled your day to day activities (e.g. Who you see, where you go) or put you down?	☐ Yes	☐ No
Threatened to hurt you in any way?	☐ Yes	☐ No
Hit, slapped, kicked or otherwise physically hurt you?	☐ Yes	☐ No

If you answered YES to any of the above questions, please answer the below individual Safety and Needs Assessment questions

Do you feel unsafe when you leave here today?	☐ Yes	☐ No
Are you worried about the safety of your children or anybody in your family?	☐ Yes	☐ No
Would you like help with this?	☐ Yes	☐ No
Would you like to speak to someone today?	☐ Yes	☐ No

[6] Royal Women's Hospital

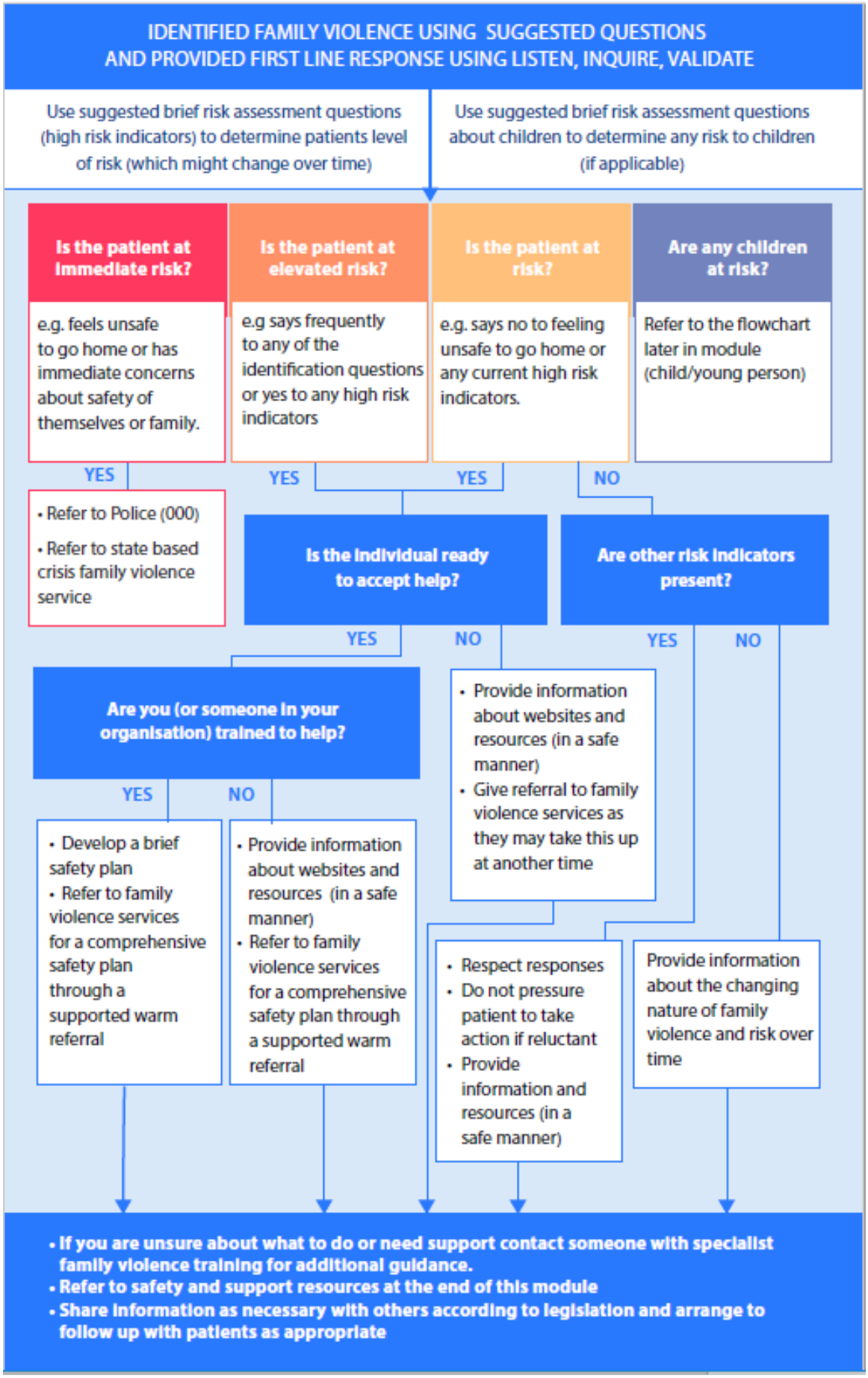
If you answered yes to any of the above, your doctor or nurse may ask you more questions about safety. You could help us further understand your safety by answering questions below.

YOUR SAFETY

Has any physical violence increased in severity or frequency in the last year?	☐ Yes	☐ No
Has your partner or ex-partner or family member recently:		
• been obsessively jealous or possessive of you?	☐ Yes	☐ No
• threatened or used a weapon against you?	☐ Yes	☐ No
• assaulted or beat you up during pregnancy?	☐ Yes	☐ No
• tried to choke or strangle you?	☐ Yes	☐ No
• forced you to have sex?	☐ Yes	☐ No
• threatened to kill you?	☐ Yes	☐ No
Do you believe it is possible they could kill or seriously harm you?	☐ Yes	☐ No
Do you believe it is possible they could kill or seriously harm children or other family members?	☐ Yes	☐ No

If any of this is happening to you, thank you for telling us. You don't deserve to be hurt, and you have the right to feel safe. A doctor or nurse can support and connect you to helpful programs

Survivor Risk Assessment Tool



Risk assessment specific to migrant/refugee women experiencing violence

There are a number of barriers to assessing the risk of women experiencing violence.

Denial and minimisation 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', 'threat', may be too loaded because many victims/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.
- Victim/survivor may fear police and court interventions and their consequences.
- Victims/survivors of refugee background may fear that they will re-traumatise their husband if they seek police or court intervention.

Important questions for 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?

When seeing migrant and refugee women at risk of domestic violence, you might consider the following or refer directly to InTouch staff for assessment:

1. Assess their understanding of family violence and its forms within the Victorian context
2. Assess their understanding of family law systems, what an intervention order is, child protection etc
3. Assess for interpreter suitability (community language and female)
4. Assess any links to community and determine whether it is protective or adds more risk

5. Assess their visa – ensure she has the right information available to make informed decisions
6. Assess their level of confidence in police response
7. Assess their familiarity with financial and welfare systems, ATM, Centrelink etc.
8. Assess family dynamics to determine whether there are multiple perpetrators

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

Safety and Risk Assessment for other diverse population groups

The following set of questions might be helpful for when you are seeing other 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?

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)?

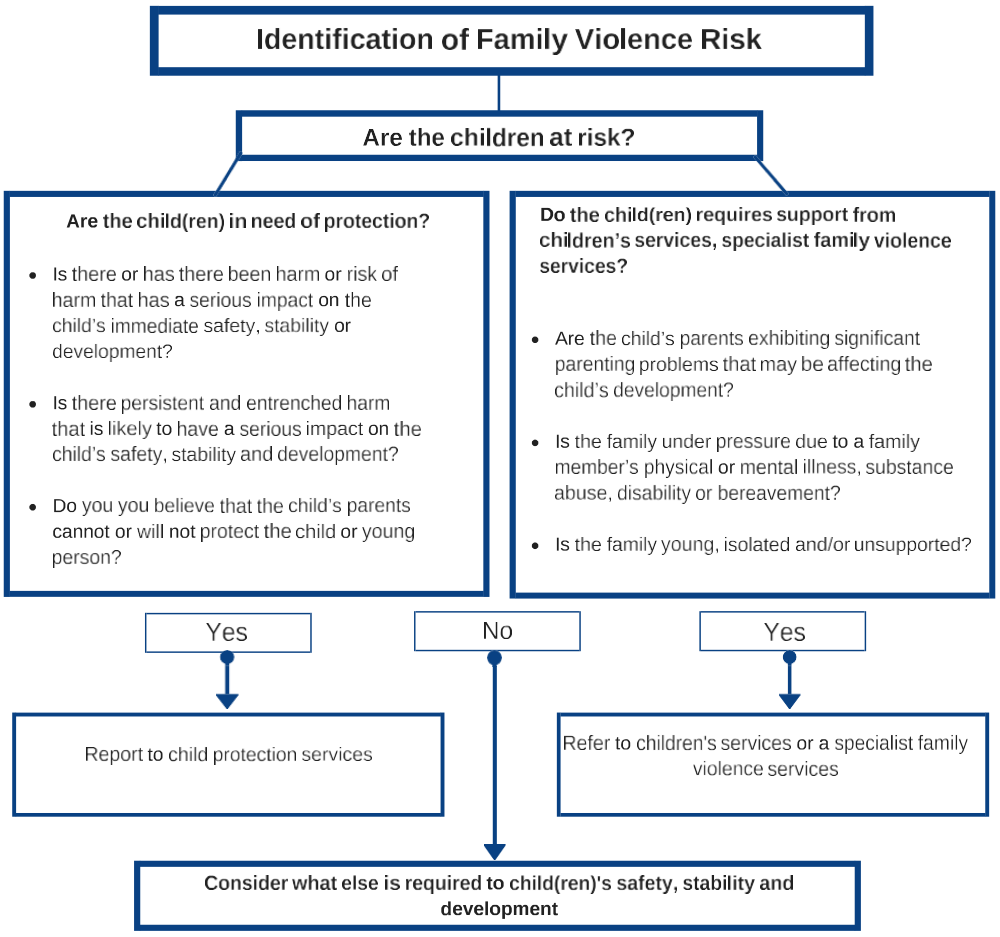
People over the age of 65

- Are you dependent on them to meet your daily needs?
- Are you dependent on them to meet 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?

Child Risk Assessment Tool



Safety Planning Guide

Safety planning is the development of a plan to achieve and maintain safety of women and their children. It includes:

- Compiling a list of emergency numbers
- Helping to identify a safe place for the patient to go to and how she will get there
- Identifying family and friends who can provide support
- Ensuring cash is available; and
- Providing a safe place to store valuables and important documents.

Devising a safety plan with her in case of an emergency can be very simple (e.g. where would she go, where to leave a packed bag, keys and money somewhere other than at home, how to be contacted, a safe place to send mail). With migrant and refugee women, ask about passports and visas, as well as other critical documents.

The World Health Organisation has provided suggestions on how to make a safety plan.

Safety Planning (World Health Organisation)	
Safe place to go	If you need to leave your home in a hurry, where would you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take all your documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

MARAM: Safety Planning guide for adults (or older children and young people, if appropriate)

The following are elements of a safety plan and questions you can ask to help the person experiencing family violence make a plan.

- Every safety plan will be unique and based on the needs of the adult or young person – you should

be guided by the victim survivor on what is important and safe for them in their safety plan.

- This guide aims to assist you to discuss what planning and actions can be undertaken safely.

Plan detail and questions to support planning	Checklist and detail
Safe place to go	
Where are you right now – are you safe? If you need to leave your home in a hurry, where could you go?	Address or name of place: Address of safe place (if different to above):
Emergency contacts	
Would you feel comfortable calling the police (000) in an emergency? (if not – How can we support you to do so?) ☐ Yes ☐ No ☐ N/A Call **000** in an emergency or Safe Steps on **1800 015 188** or local family violence service on [insert]	
Who are your personal emergency contacts?	Name, relationship, contact details
System intervention	
Where is the perpetrator right now?	(provide details)
Is an intervention order in place (and children named) or are there any other court orders or proceedings?	☐ Yes ☐ No ☐ N/A (provide details)
Support of someone close by	
Is there someone close by you can tell about the violence who can call the police?	☐ Yes ☐ No ☐ N/A
Planning for children, older people or people in your care [if applicable]	
What would you need to arrange for people in your care?	(provide details)
If you have children in your care	
How many children do you have in your care?	(provide details)
Where are they right now?	(provide details)
Safe Communication	
Do you have access to a phone or internet?	☐ Yes ☐ No ☐ N/A (provide details)
Transport	
Do you have access to a vehicle or other public transport options?	☐ Yes ☐ No ☐ N/A (provide details)
Items to take with you – escape bag	
What documents, keys, money, clothes, or other things should you take with you when you leave? What is essential?	(provide details)
Financial Access	
Do you have access to money if you need to leave? Where is it kept?	☐ Yes ☐ No ☐ N/A (provide details)

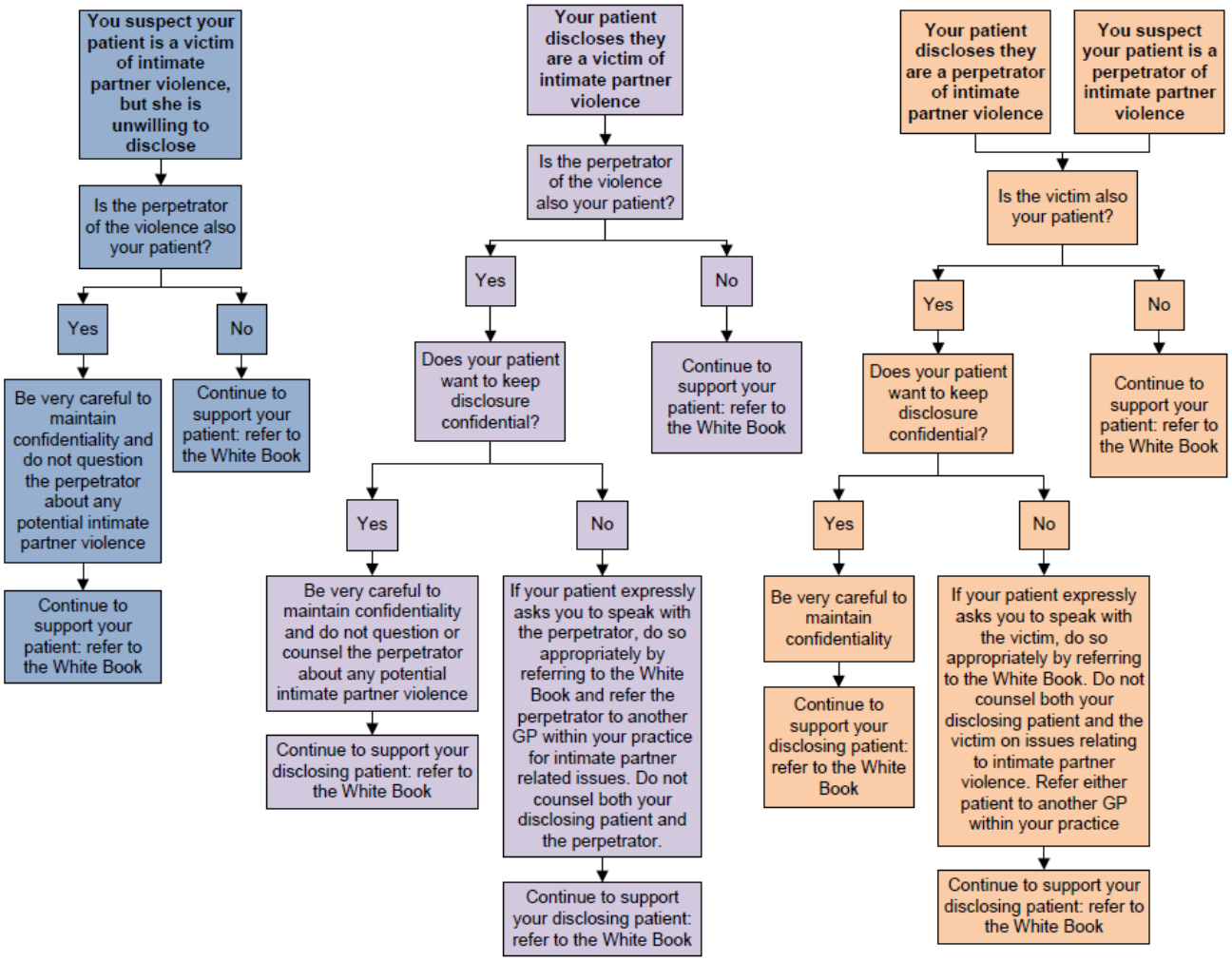
Consent to information sharing

Consent for information sharing and referral: I (name) consent to the collection, use and sharing of my personal information under Part 5A of the *Family Violence Protection Act 2008*. I understand that my information may be shared without consent if there is a serious threat to myself or another individual's life, health, safety or welfare. I also understand that my information may be shared without consent if it is relevant for assessing or managing risks to a child victim survivor of family violence, or to promote the safety or wellbeing of a child or young person. (Note where your information may be shared without your consent, we will endeavour to consult with you on your views and inform you if this occurs).	
Signature	**Date**
Name (print)	**Date**
Worker Signature	**Date**
Worker (print)	**Date**
Verbal Consent obtained 'Yes' ☐	**Date**
Please indicate your preferred contact method:	
Mail:	Email:
Phone / Text:	Would you prefer to be called from a private number? ☐ Yes ☐ No
What is the best day and time for us to call?	
A message left with an authorised/safe person for you to return the call:	
Authorised person contact details: (full name, relationship, telephone:)	

Once a woman has disclosed that she has experienced violence or abuse, the following strategies may help you to help your patient understand what is happening in her relationship.

Confidentiality Tool (when you are seeing both partners)

One of the major issues in supporting a woman experiencing violence is the maintenance of confidentiality. It is considered poor practice to see both members of a couple when there is violence, because of the risk to her safety in inadvertently breaking confidentiality. There is also little opportunity for her to be honest when she is fearful of punishment from her abuser.
We recommend this following pathway.



Ref: Hegarty, K., Forsdike-Young, K., Tarzia, L., Schweitzer, R., & Vlais, R. (2016). Identifying and responding to men who use violence in their intimate relationships. Australian Family Physician, 45, 178.

First Line and supportive responses

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 and resources to do this are included below.

Harmony supports the use of the WHO First Line Response Tool[5]

According to the WHO, there are five easy steps that can be followed when providing a first-line response to patients experiencing violence. These can be easily remembered by the following:

LIVES: Listen, Inquire, Validate, Enhance safety, Support.

LISTEN	Listen to the woman closely, with empathy, and without judging
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to her various needs and concerns-emotional, physical, social and practical (e.g. Childcare)
VALIDATE	Show her that you understand and believe her. Assure her that she is not to blame
ENHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again
SUPPORT	Support her by helping her connect to information, services and social support

Further reading:

Health care for women subjected to intimate partner violence or sexual violence: A Clinical handbook.

http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

[5] Ref: World Health Organization. (2014). Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. World Health Organization. https://apps.who.int/iris/handle/10665/136101

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

Life Situation Assessment

How can I support you through this?

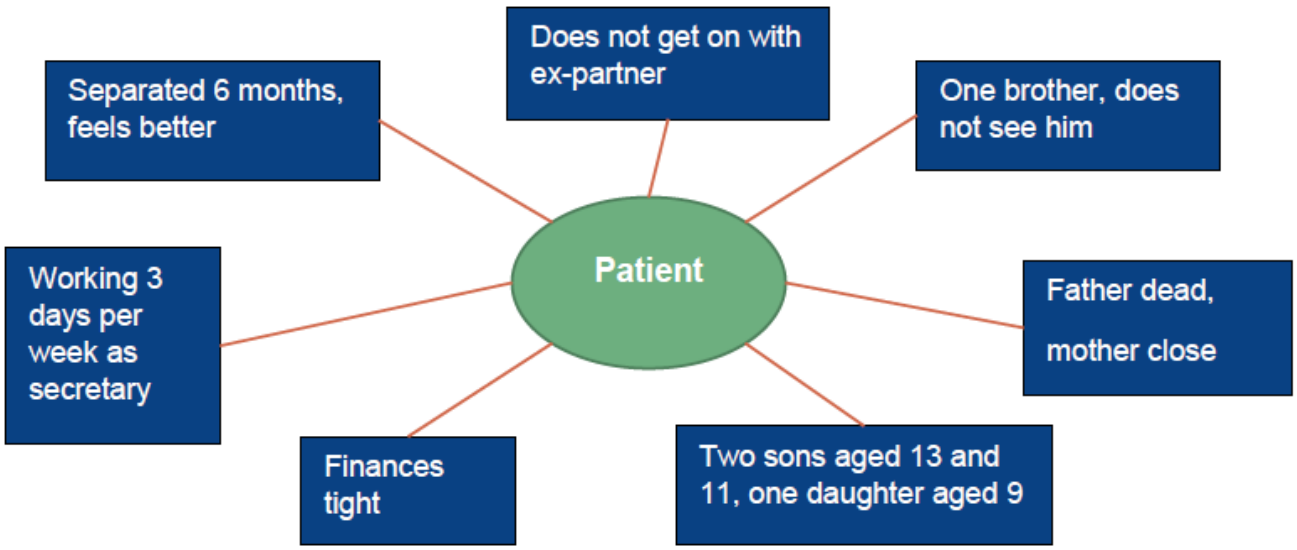
Even though you may know the patient quite well, it is worthwhile taking a history of their current life situation using a life biopsy approach. In this method you do not delve deep into any of the areas they raise but rather attempt to draw a picture or a 'mind map' of the people and things that are in their 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 their 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 to assure them you 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

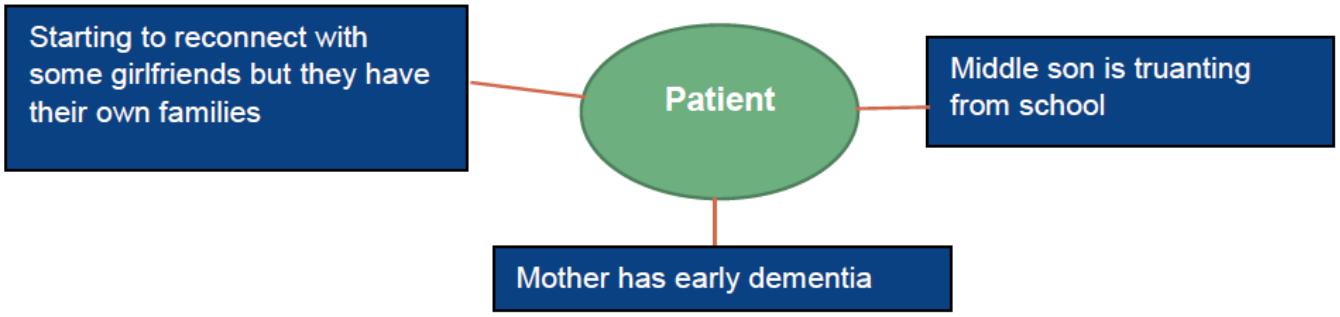
What is happening in your life? or

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



What else is going on? or

Tell me more about your current situation…

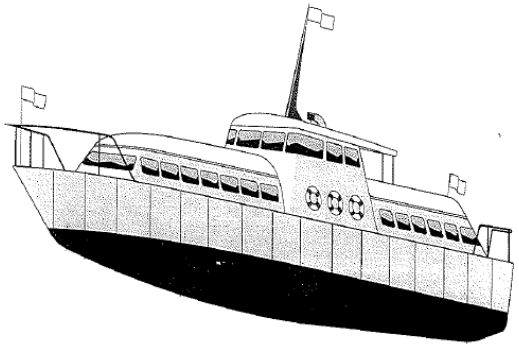


Assessment of Social Support

There are many ways to assess support, but there is good evidence that the more support available to victims, the better their mental health.

One way is when you are doing the life situation assessment, you can also assess 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 patient's 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 the people/things that keep them afloat now, and in the past.



Inquire about Needs: If a patient is not in crisis then this wheel may help you to discuss what the patient's greatest needs are.

Understanding Change for Patients

Relevance of self-efficacy

The hidden nature of family violence means that health professionals are likely to experience uncertainty about the best way to approach its identification and management and may question their skills to address the issues. Health professionals may even experience strong psychological responses to dealing with family violence if it strikes a chord with them personally. Thus, an essential part of the training is to build self-efficacy among GPs and nurses with respect to this area of practice through simple strategies such as mastery experiences and social modelling.

The approach to increasing patients' efficacy expectations might be general (e.g. encouraging them to set goals to exercise or socialise more) or specific to their relationship issues (e.g. belief that she will be able to care for her child independent of her partner). In any situation, it will be about increasing their belief that they can carry out a behaviour and that this behaviour will subsequently lead to a desired outcome. The impact of information on efficacy expectations will depend on how it is cognitively appraised. A number of contextual factors, including the social, situational and temporal circumstances under which events occur, enter into such appraisals. It is important to recognise that expectations that have served self- protective functions for years are not quickly discarded.

Readiness for change

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 table below). Clinicians should tailor responses to the

stage a patient is at. Some patients who are pre-contemplative need brief messages such as the possibility of a connection between symptoms and problems at home 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. Having recognised the problem, for many GPs and nurses the key difficulty is helping the patient to unlearn the habit of a life-time, and benignly advising the patient on what she might do. 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.

Stages of change applied to patients' experience of partner abuse[8]

Stage	Description	Health provider response
Pre-contemplation	The patient is not aware that she has a problem or holds a strong belief that it is her fault.	Suggest the possibility of a connection between symptoms, feelings of fear and problems at home. Try to use terms the patient says when referring to her problems.
Contemplation	The patient has identified a problem but remains ambivalent about whether or not she wants to or is able to make any changes.	Encourage the possibilities for change should she decide to do anything. Point out that you are available to help and support her on the journey.
Preparation	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 her decision about what she wants to change (e.g. talking to family and 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 actions is firm.	Praise whatever she has managed to do and support her 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 her whether she does or does not return to the relationship, see a counsellor or report abuse. Reassure that this pattern of behaviour is common for many patients.

[8] Abuse and violence: Working with our patients in general practice, 4th edn. Melbourne: The Royal Australian College of General Practitioners; 2014

Readiness to Change - Motivational Interviewing[9]

Patients may be at different stages in how they are processing their situation. Some may have left the relationship, with or without recognising that their partner's behaviour was abusive. Other patients may continue in relationships that are unhealthy or abusive. It is most likely that fear of their partner will have affected their emotional health, although some will not see that connection. As GPs and nurses, you will need to use different approaches at different stages. On the next page we give you an example of a written tool to use in your consultations.

You can ask:

Step 1 What do you like about your current relationship?

Step 2 What are the things you don't like about your current relationship?

Step 3 Summarise – your understanding of the patient's pros and cons

Step 4 Decide where this leaves you now

Step 5 *Ask patients who are ready to change the following question:*

What would **you** like to do to feel better about your partner/ex-partner?
They may choose a whole range of actions for this last step and we have listed some likely options below:

- Feel better about themselves e.g. do more exercise, take up yoga
- Manage finances better
- Become less isolated e.g. go to a social group activity
- Have better parenting strategies with their children
- Improve their physical health e.g. cut down on alcohol
- Leave their partner
- Get more understanding/affection from their partner
- Get their partner to go to anger management classes
- Get their partner to stop drinking/get a job/stop gambling

These last three are obviously out of the patient's control as it involves influencing their partner's behaviour. Acknowledging this difficulty is important. We have included referral options for men in this handbook.

[9] Ref: Hegarty, K., *et al*. (2013). Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): A cluster randomised controlled trial. *The Lancet*. 382, 249–258.

Example of written tool for motivational interviewing

Taking action is often challenging for people. Below is a set of steps for examining your current situation to decide on what action you might like to take and then how motivated and confident you feel at the moment about carrying out that action.

Step 1 Identify what you like about your relationship or current situation

Step 2 Identify the things you don't like about your relationship or current situation

Step 3 Summarise – doctor's understanding of pros and cons

Step 4 Decide where this leaves you now

For those patients who are ready to change to some extent:

Step 5 Decide what you would like to do to feel better about your partner/ex-partner

	Like	Dislike
Relationship		
Action (specify)		

How motivated do you feel to carry out ……...?

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

Not at all motivated ●——————————● 100% Motivated

What would have to happen for your motivation score to increase?

_____

How confident do you feel that you would succeed in carrying out…? Place an X on the point on the line that most closely reflects how you feel

Not at all confident ●——————————● 100% Confident

How can I help to increase your confidence?

_____

Motivational Interviewing & Problem-solving Techniques

Responding to patients in different stages

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	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"	✓	✓
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

'*The patient ought to or wants to change'; 'the patient's health is a prime motivator'; 'people are either motivated to change or not'* and '*I am the expert, the patient must follow my advice*' are beliefs commonly associated with more traditional styles of encouraging

behaviour change among patients. An alternative approach to behaviour change known as motivational interviewing (MI) has been developed by Rollnick and Miller.[11] It is a patient-centred, directive method which aims to enhance intrinsic motivation to change by exploring and resolving ambivalence. MI stems from stages of change theory and helps prepare patients for changing their behaviour. It appears most useful for patients in the early stages of change. It has the potential to enhance effectiveness in initiating and supporting behaviour change when incorporated into the consultation. The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the patient/patient. Though MI has benefits across a number of behaviours, here we are interested in its capacity to inspire change with respect to how patients think about fear of their partner and partner abuse and implications for their lives. The table overleaf summarises the main features of MI. A useful tool for applying MI as part of a counselling intervention is available in Section 3.

Application of motivational interviewing

While MI can be useful across the stages of change, here we are advocating it most strongly for use with patients who are in the pre-contemplation and contemplation stages. You are in a very unique situation to offer early intervention in that it is rare for patients in early stages of change (and problem recognition) to receive any support from health professionals. Rather, in this field, it is usually when abuse has escalated to severe levels that patients find themselves disclosing or seeking assistance. 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 in their relationship. 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. If you can put into practice principles of MI across your consultations, you are unlikely to elicit negative reactions. In many instances the relationship between you and the patient becomes irrevocably changed (e.g. they might decide to stop attending you or the clinic) and again it is important to consider this part of the process of change.

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

[11]Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? Behavioural and Cognitive Psychotherapy, 23, 325-334.

	• 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 Tool

Non-directive Problem-solving Goal-setting

Goal-setting and non-directive problem-solving assist individuals to use their own skills and resources to function better.[1] 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 you 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.

[1] Gath DH, Mynors-Wallis LM. Problem-solving treatment in primary care. In: Clark DM, Fairburn CG, editors. Science and practice of cognitive behaviour therapy. Oxford: Oxford University Press; 1997.

- Learn an approach to deal with current difficulties and feel more in control.
- Deal more effectively with problems in the future.

Ask the patient 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. _____

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.[2] PST has been shown to have benefits for treating a range of mental health issues in general practice and can be delivered over 4 to 6 sessions.

[2] Mynors-Wallis L: **Problem solving treatment in general psychiatric practice.** *Advances in Psychiatric Treatment* 2001, **7:**417-425..

MARAM

In Victoria, there is a Multi-Agency Risk Assessment and Management Framework (MARAM) for all professionals in contact with families with family violence (see https://www.vic.gov.au/maram-practice-guides-and-resources). General practitioners have a key role in the system of identification, first line response and referral.

Patients at any time might be feeling unsafe to go home and may need urgent crisis referral (see Section 4 for a list of services) 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.

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

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.**

The MARAM Framework outlines the elements needed for assessing risk.

Risk assessment

Any assessment of risk to victims of family violence must be structured and informed by the patient's own assessment of their safety and risk assessment the presence of risk indicators outlined below any information that has been shared with you from other professionals your own structured professional judgment.

MARAM outlines the risk indicators below:

Assessing safety of women experiencing domestic and family violence

- Does the patient feel safe to go home today?
- What does she need in order to feel safe?
- How safe does she feel?
- How safe are her children?

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) and follow the flow chart. It may be necessary to share any of this information with other professionals working with the family.

Information Sharing

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.

More information can be found at https://www.vic.gov.au/guides-templates-tools-for-information-sharing.

Assessing children about their safety

- 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 or any other adult in the home?
- 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?

Safety of children and mandatory reporting

Children are particularly vulnerable to the impact of family violence and the *Children, Youth and Family Act 2005* allows for assessments to be made in relation to a child's protection by examination of "*continuing acts, omissions or circumstances*". In the context of family violence without direct experience of violence, you may consider a referral to Child FIRST or a report to Child Protection.

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 your state's mandatory reporting laws, and document whom you notified of the suspected abuse https://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-6-child-abuse/. We provide a flow chart to a generic guideline overleaf but urge you to seek out training related to children (e.g. Children at Risk Learning Portal https://vulnerablechildren.e3learning.com.au/).

To assist you, the following information has been taken from the website of the Children, Youth and Families division of the Department of Health Services of the Victorian Government.[7]

Child FIRST response

Families that exhibit any of the following factors which may impact upon a child's safety, stability or development, a referral to Child FIRST may be the best way of connecting children, young people and their families to the services they need:

- Significant parenting problems that may be affecting the child's development
- Family conflict, including family breakdown
- Families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
- Young, isolated and/or unsupported families
- Significant social or economic disadvantage that may adversely impact on a child's care or development

A referral to Child FIRST should be considered if, after examining the available information, you believe the concerns currently have a low to moderate impact on the child, where the immediate safety of the child is not compromised, and therefore action does not need to be taken *immediately.*

On receiving a referral, the Child FIRST team will conduct further assessment of the family and may consult an experienced community-based child protection worker who is based in each Child FIRST team. This assessment may lead to the involvement of a local family services organisation. In most circumstances Child FIRST will inform you of the outcome of your referral. Where a Child

FIRST team or a registered Family Services organisation forms a view that a child or young person is in need of protection, they *must* report the matter to Child Protection.

More information can be found at https://providers.dhhs.vic.gov.au/making-referral-child-first

[6] http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people

Child Protection response

A report to Child Protection should be made in any of the following circumstances:

- Physical abuse of, or non-accidental or unexplained injury to, a child (it is mandatory for doctors and nurses to report).
- A disclosure of sexual abuse by a child or witness, or a combination of factors suggesting the likelihood of sexual abuse - the child exhibiting concerning behaviour, for example, after the child's mother takes on a new partner or where a known or suspected perpetrator has had unsupervised contact with the child (mandatory reporters must notify).
- Emotional abuse and ill treatment of a child impacting on the child's stability and healthy development.
- Persistent neglect, poor care or lack of appropriate supervision, where there is a likelihood of significant harm to the child, or the child's stability and development.
- Persistent family violence or parental substance misuse, psychiatric illness or intellectual disability - where there is a likelihood of significant harm to the child or the child's stability and development.
- Where a child's actions or behaviour may place them at risk of significant harm and the parents are unwilling or unable to protect the child.
- Where a child appears to have been abandoned, or where the child's parents are dead or incapacitated, and no other person is caring properly for the child.

Many cases will not neatly fit into these categories, and it may be harder to determine whether the level and the nature of any risk is such that the child is in need of protection. The following questions may help resolve the best course of action in such cases:

Factors for consideration

What specifically has happened to the child that has caused your concerns and what is the impact on their safety, stability, health, wellbeing and development?

- How vulnerable is the child?
- Is there a history or pattern of significant concerns with this child or other children in the family?
- Are the parents aware of the concerns, capable and willing to take action to ensure the child's safety and stability, and promote their health, wellbeing, and development?
- Are the parents able and willing to use support services to promote the child's safety, stability, wellbeing and development?

A report to Child Protection should be considered if, after consideration of the available information you are, on balance, more inclined toward a view that:

- the concerns currently have a serious impact on the child's immediate safety, stability or development, or the concerns are persistent and entrenched and likely to have a serious impact on the child's development.

Upon receipt of a report containing such factors, Child Protection will seek further information, usually from professionals who may also be involved with the child or family, to determine whether further action is required. In determining what action to take, Child Protection will also consider any previous concerns that may have been reported about the child or young person. In most circumstances Child Protection will inform you of the outcome of your report.

If you are still unsure about who to report or refer to you should contact either:

Child Protection:
http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young- people/child-protection/child-protection-contacts
or
Child FIRST
http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young- people/family-and-parenting-support/family-services/child-first-child-and-family-information,- referral-and-support-teams

Legal Information

Health practitioners need to understand what actions 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).

General practitioners and nurses should encourage and assist their patients to approach the police directly and report an assault. Upon reporting 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 a 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. These differ in each state and contact can be made via the police. 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:

RACGP. Violence and the law at https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/violence-and-the-law

Women's Legal Service Victoria at https://www.womenslegal.org.au/useful-information/family-violence.html

Women's Information and Referral Exchange (WIRE) at https://www.wire.org.au/legal/

National Sexual Assault Domestic Violence Counselling Service at https://www.1800respect.org.au/help-and-support/violence-and-the-law/

Domestic Violence Resource Centre Victoria (DVRCV) at http://www.dvrcv.org.au/community-legal-centres

Trauma and Violence Informed Care and Practice

The following section describes **strategies for Trauma and violence-informed care** especially important when working with diverse communities, including migrant and refugee, Aboriginal and Torres Strait Islander and other marginalised communities.

Trauma- and violence-informed care (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 expected or predictable consequences of highly threatening events, such as family violence. Professional knowledge and skill are critical to addressing the traumatic effects of harmful institutional practices, including all forms of discrimination. Organisational leadership to support such staff is essential.

A Canadian group of researchers and practitioners (https://projectvega.ca/) outline how trauma-informed care seeks to create safety for patients by understanding trauma and its impact on health and behaviour. They point out it is not only about treating people's trauma histories but about creating safe spaces that limit potential for further harm for all.

Further reading on this can be found at Foundation Knowledge Guide…

Principles of TVIC[4]

2. 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

3. Create emotionally and physically safe environments for all patients and providers

Organisational

- Create a welcoming space and intake procedures; emphasise confidentiality and patient/patient priorities
- Seek patient 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)

[4]Adapted by VEGA from.Ponic, P., Varcoe, C., Smutylo, T. (2016). Trauma-(and violence-) informed approaches to supporting victims of violence: policy and practice considerations. Victims of Crime Research Digest, 9. Department of Justice (DOJ); Canada. Available: http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html.

- Foster connection and trust
- Provide clear information and predictable expectations about roles and services

4. 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 patients in identifying ways to implement services

Provider

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

5. Use a strengths-based and capacity-building approach to support patients

Organisational

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

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

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 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, rambling 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. For example:

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

Documentation

Documenting your observations, your response to disclosure and the safety plan that has been negotiated is required. There are several reasons why you need to document the process, including:

- To ensure that the patient does not need to repeat all of the story.
- To provide consistency in care.
- To provide evidence of abuse in the case of a court appearance (this is not common but can be vital in establishing that the abuse has occurred)

Be sure to ask the patient's permission prior to documenting abuse, and never put unnecessary details on referrals or records that could be seen by a partner. In cases of assault it is important for the doctor or nurse to document clearly and accurately what the patient has said and a description of any injuries, as medical notes may become evidence in criminal court proceedings.

Tips for documentation

Objectively document any injuries. With the patient's permission, take photographs of all injuries known or suspected to have resulted from domestic or family violence. If that's not possible, clearly document the location, number, type, and characteristics of injuries, using an injury location chart or body map.

Use quotation marks to denote the patient's own words or use phrases such as "patient states" or "patient reports" to indicate information that came directly from the patient. When you use quotation marks, the statement must be an exact repetition of what the patient said, not paraphrased.

Identify the person who hurt the patient as stated by the patient, using quotation marks and recording the identifying information, e.g. "my husband," "my stepfather," or "my mother-in law-slapped me."

Don't write your personal conclusions about the situation, document the facts clearly and objectively and let others draw conclusions.

Don't put the term domestic violence or abbreviations such as "DV" in the diagnosis fields of a patient's medical records. These may inadvertently get seen in referral letters or by the perpetrator. Some clinics use a special code or the hidden areas of their medical software.

Record your observations of the patient's general appearance or demeanor, for example, patient crying and seems agitated

Record the time of day the patient is examined. If possible, indicate how much time has passed between the incident and the patient's visit.

Documenting Family Violence in Best Practice or Medical Director

Please make sure you document your patient's country of birth and language spoken at home OR their ethnicity, depending on the clinic software you use.

For the HARMONY study, Clinical staff are asked to document and record BOTH patient family violence AND ethnicity as per the following instructions.

NOTE: GRHANITE will extract data based on these instructions, it is extremely important that documenting your FV consults are done correctly.

Quick documenting tips for Best Practice and Medical Director

- If you have identified and/or discussed a patient's family violence situation record as **DV**;
- If you discuss safety planning, record as **DVSP**;
- If you have referred to inTouch or another service record as **DVREF**

Do NOT

- Only record in notes. Notes can be used in addition to the reason/diagnosis.
- Add to My Health Record. This could jeopardise patient safety and confidentiality of disclosure.

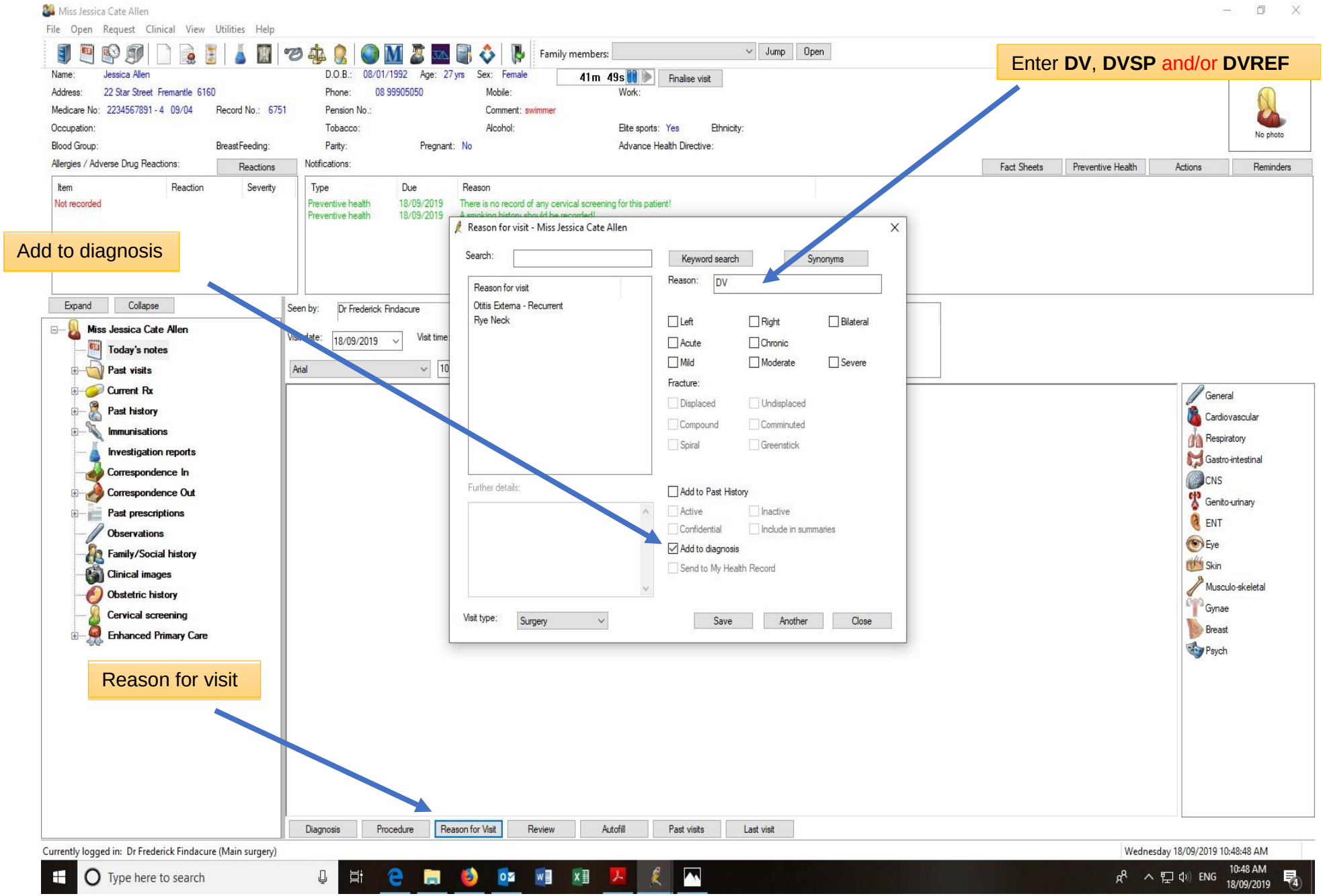
Best Practice

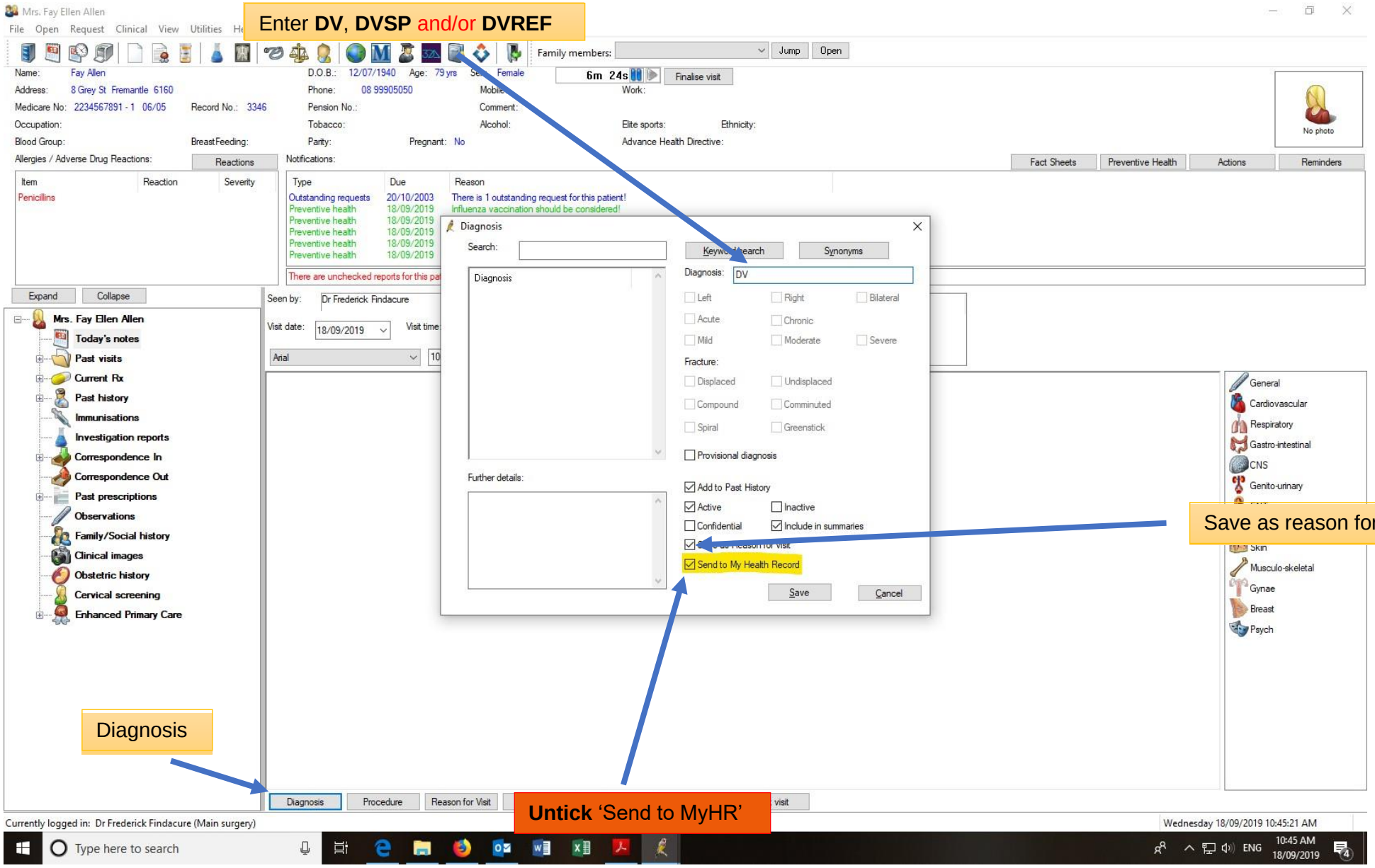
From patient menu:

1. Click '**Todays notes'**
2. Select either '**Reason for visit'** or '**Diagnosis'** at the bottom of the program
    a. For '**Reason for visit'** – enter **DV** and tick '**add to diagnosis'** box
    b. For '**Diagnosis'** – enter **DV** and tick '**save as reason for visit**' box
    *please note: when using '**diagnosis**', '**Send to My Health Record**' is automatically selected. Please **unselect** this. It is possible that the perpetrator may have access to the victim's records and will see that they have sought help, which could put the victim in further danger. Additionally, please make sure **the diagnosis does not appear on other non-domestic violence referrals**.
3. If you discuss **Safety Planning** or provide a **Referral**, follow steps 1 and 2, but record as **DVSP** or **DVREF** instead.
4. Please make notes as appropriate.
5. Don't forget to **save**!

Did you make a referral to inTouch or another family and domestic violence service?
Record in the correspondence out in the subject and/or comments which service you referred to.

Note: InTouch or other family and domestic violence services can be set up in Best Practice so that they would be available in the "To" search and you can upload the 'Clinician Referral Form – InTouch FV' that has been provided to you.


Enter DV, DVSP and/or DVREF
Add to diagnosis
Reason for visit
Reason for visit - Miss Jessica Cate Allen
Search:
Keyword search
Synonyms
Reason: DV
Reason for visit
Otitis Externa - Recurrent
Rye Neck
Left
Right
Bilateral
Acute
Chronic
Mild
Moderate
Severe
Fracture:
Displaced
Undisplaced
Compound
Comminuted
Spiral
Greenstick
Further details:
Add to Past History
Active
Inactive
Confidential
Include in summaries
Add to diagnosis
Send to My Health Record
Visit type: Surgery
Save
Another
Close
Miss Jessica Cate Allen
Today's notes
Past visits
Current Rx
Past history
Immunisations
Investigation reports
Correspondence In
Correspondence Out
Past prescriptions
Observations
Family/Social history
Clinical images
Obstetric history
Cervical screening
Enhanced Primary Care
Diagnosis
Procedure
Reason for Visit
Review
Autofill
Past visits
Last visit

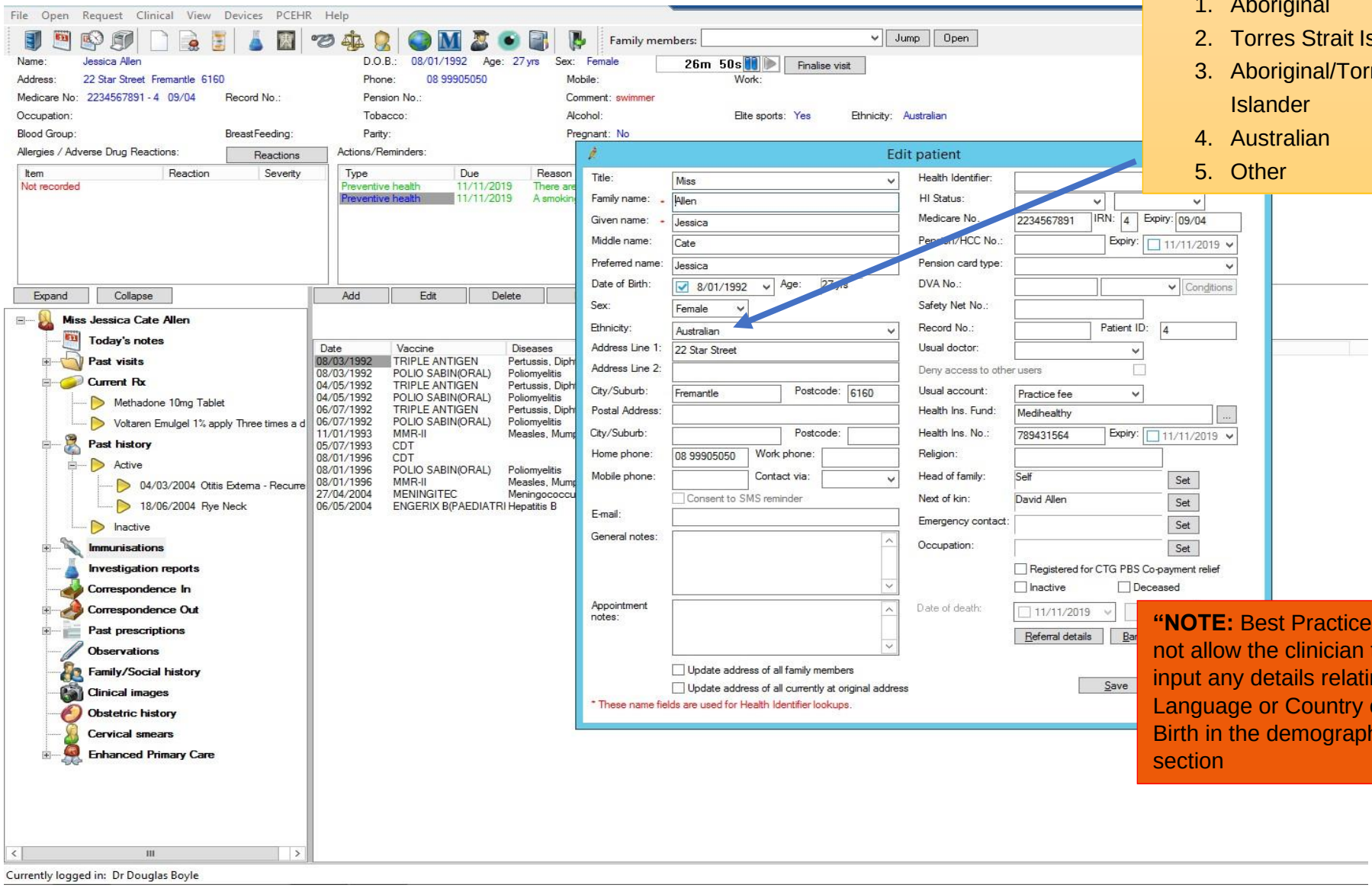

Enter **DV**, **DVSP** and/or **DVREF**
Diagnosis
Save as reason for visit
Untick 'Send to MyHR'

Selecting Ethnicity in Best Practice

To edit ethnicity for an existing patient, click on 'Open' and select 'Demographics'

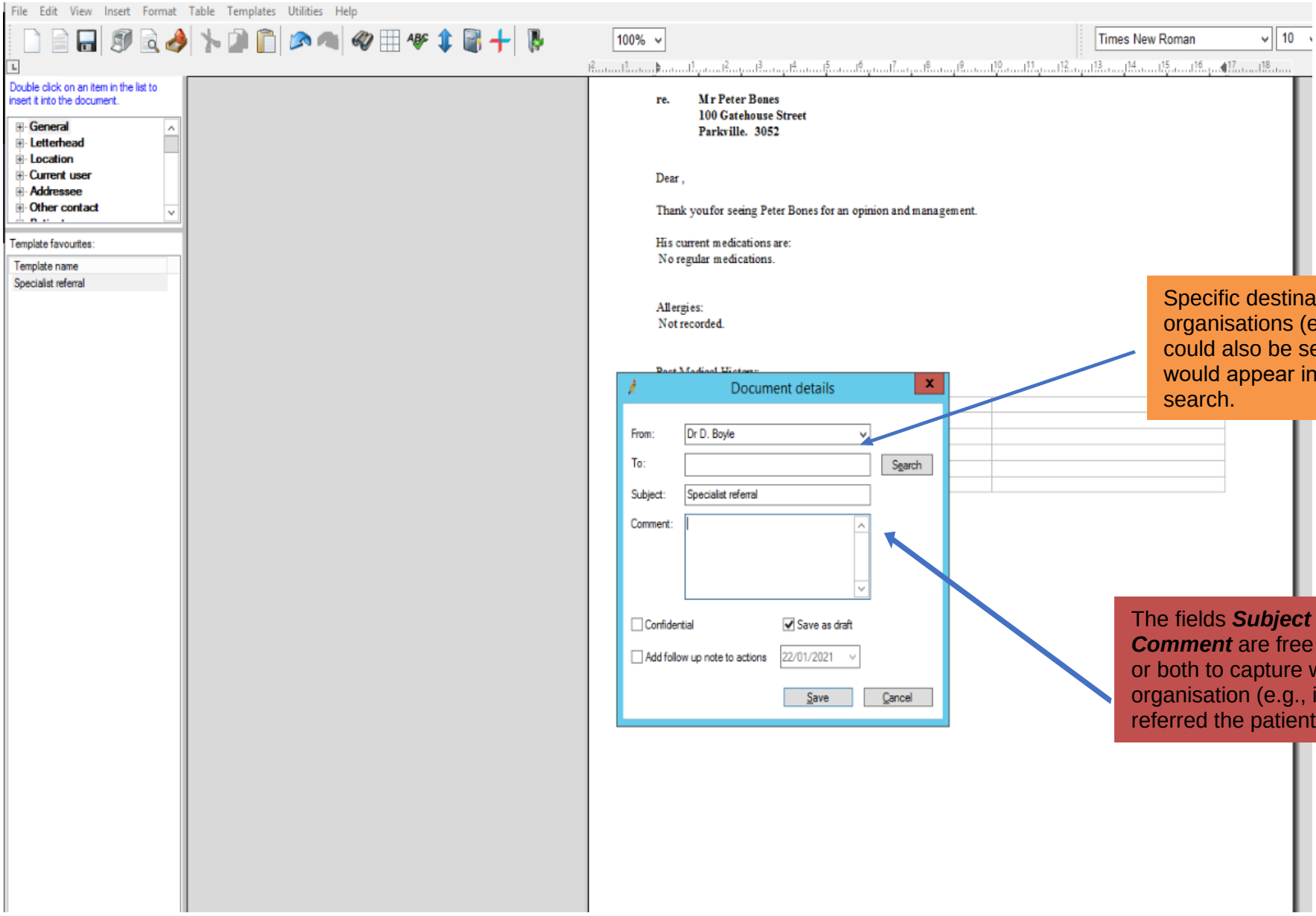
Ethnicity can be chosen from a predetermined list:

1. Aboriginal
2. Torres Strait Islander
3. Aboriginal/Torres Strait Islander
4. Australian
5. Other



"NOTE: Best Practice does not allow the clinician to input any details relating to Language or Country of Birth in the demographic section

Best Practice – Correspondence out (Referrals)



Specific destination organisations (e.g., InTouch) could also be set up so they would appear in the "**To**" search.

The fields ***Subject*** and ***Comment*** are free text. Use one or both to capture which organisation (e.g., inTouch) you referred the patient to.

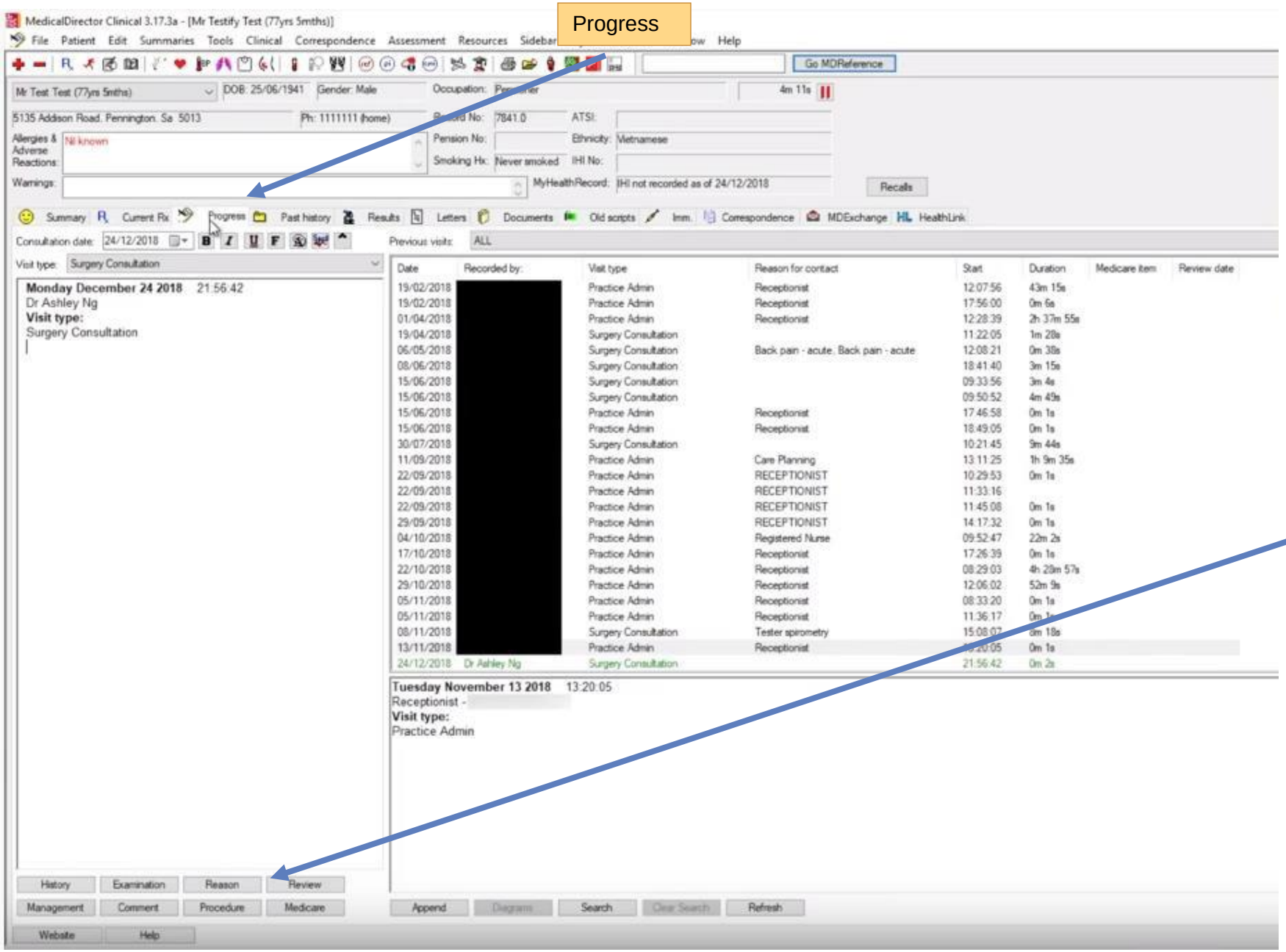
Medical Director

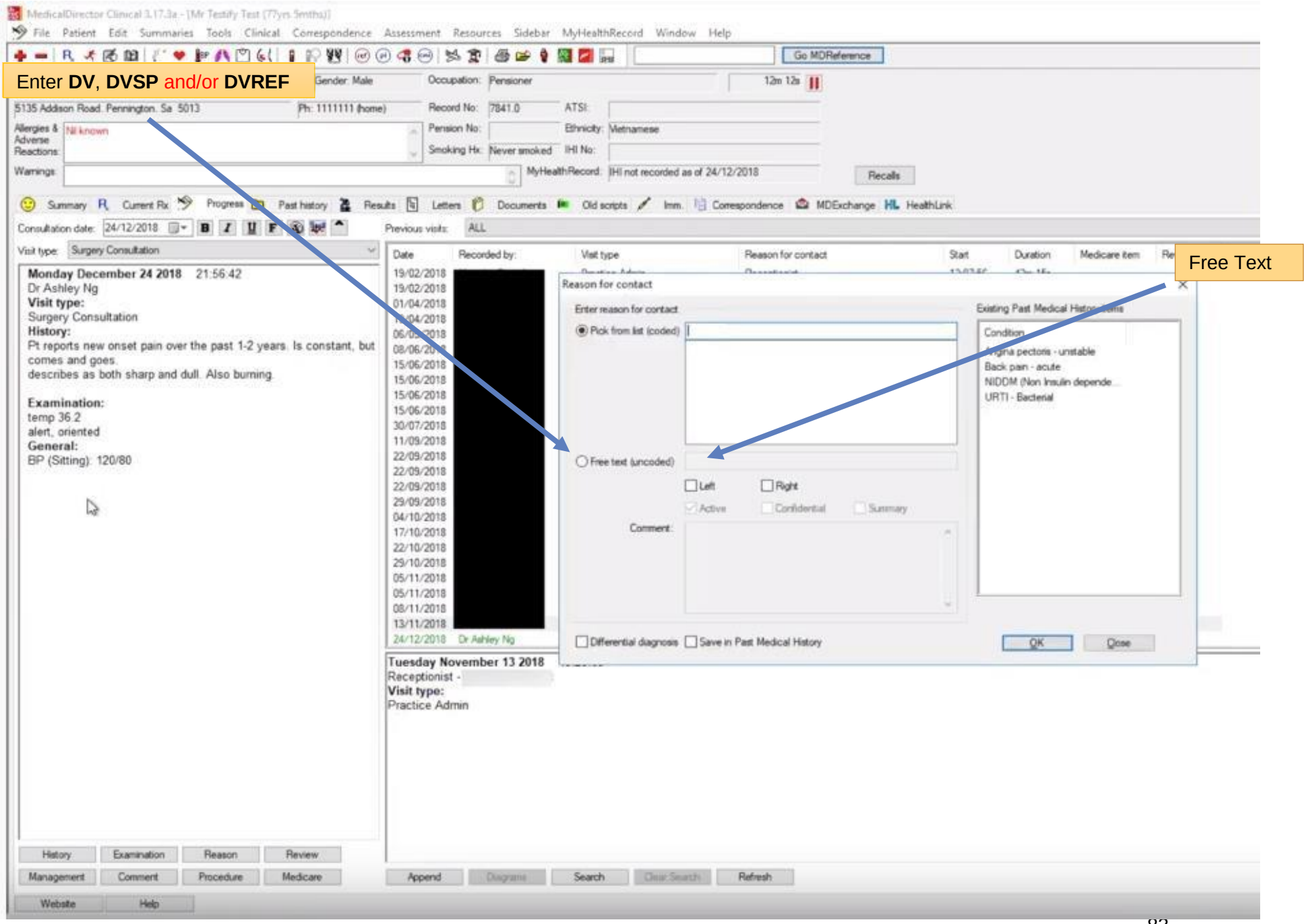
From patient menu:

1. Click **'Progress'**
2. Select '**Reason'** at the bottom of the program
3. Enter **DV** in the free text (uncoded) field or select a **'Domestic Violence…'** from coded options and tick '**differential diagnosis'** box
4. If you discuss **Safety Planning** or provide a **Referral**, follow steps 1 - 3, but record as **DVSP** or **DVREF** in the free text (uncoded) field
5. Please make notes as appropriate
6. And don't forget to **save**!

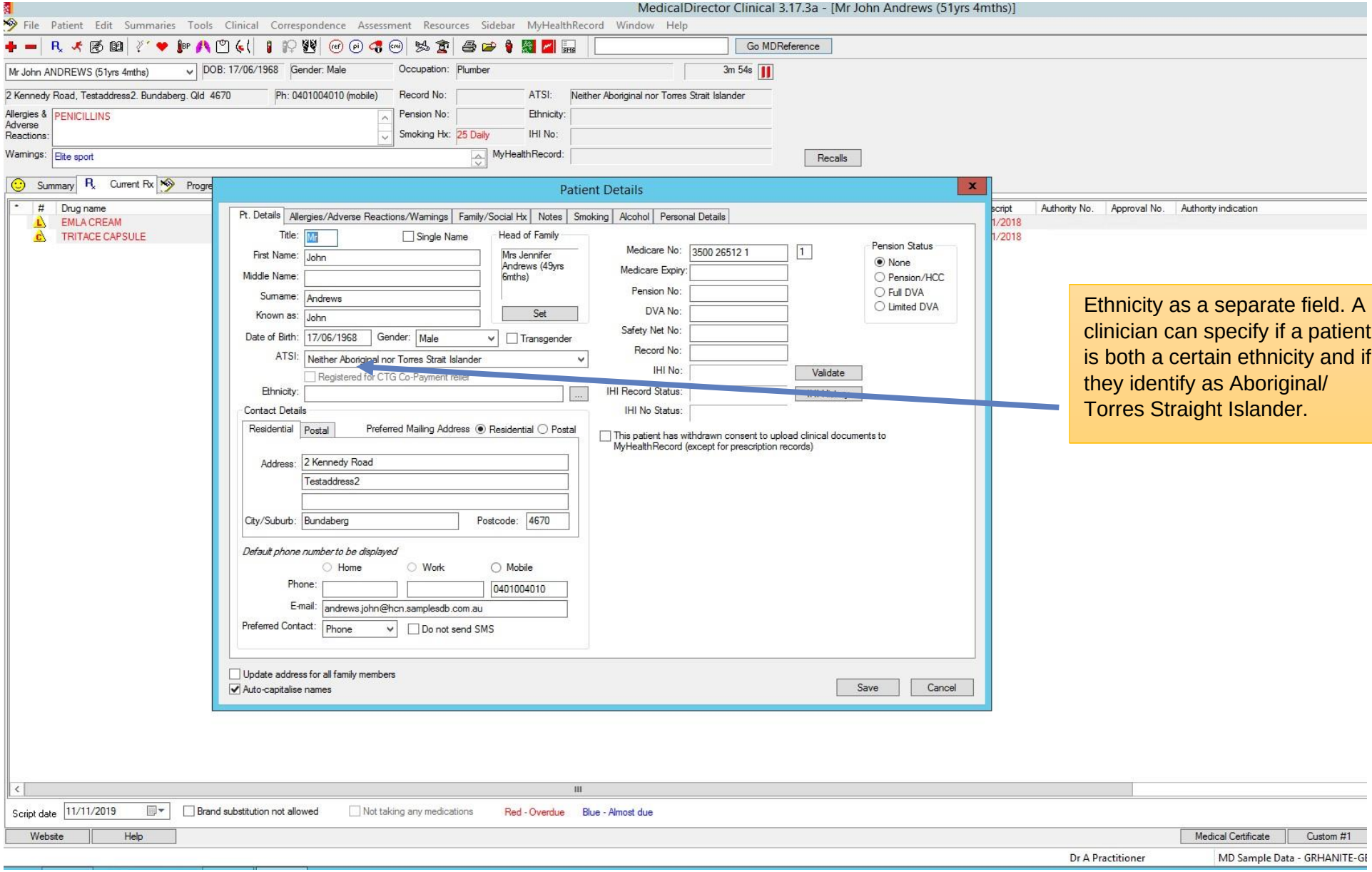
Did you make a referral to inTouch or another family and domestic violence service? Record in 'Documents' in the subject and/or description which service you referred to.

Note: InTouch or other family and domestic violence services can be set up in Medical Director so that they would be available in the "Assigned Recipient" search and you should be able to upload the 'Clinician Referral Form – InTouch FV' that has been provided to you.

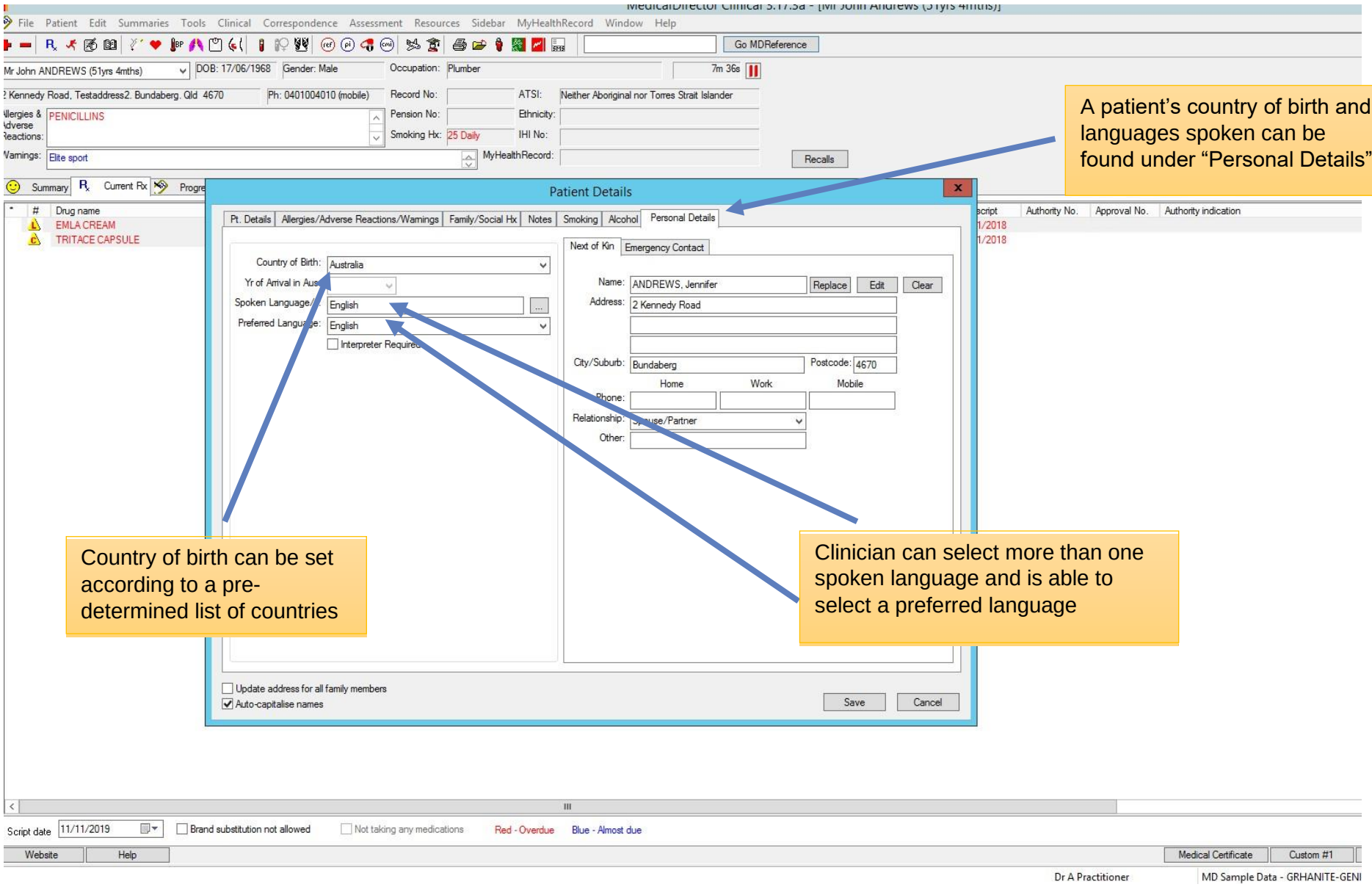

Progress
Reason
MedicalDirector Clinical 3.17.3a - [Mr Testify Test (77yrs 5mths)]
File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar Help
Go MDReference
Mr Test Test (77yrs 5mths)
DOB: 25/06/1941
Gender: Male
Occupation:
4m 11s
5135 Addison Road. Pennington. Sa 5013
Ph: 1111111 (home)
ATSI:
Allergies & Adverse Reactions:
Nil known
Pension No:
Ethnicity: Vietnamese
Smoking Hx: Never smoked
IHI No:
Warnings:
MyHealthRecord: IHI not recorded as of 24/12/2018
Recalls
Summary Current Rx Progress Past history Results Letters Documents Old scripts Imm. Correspondence MDExchange HealthLink
Consultation date: 24/12/2018
Previous visits: ALL
Visit type: Surgery Consultation
Monday December 24 2018 21:56:42
Dr Ashley Ng
Visit type:
Surgery Consultation
Date Recorded by: Visit type Reason for contact Start Duration Medicare item Review date
19/02/2018 Practice Admin Receptionist 12:07:56 43m 15s
19/02/2018 Practice Admin Receptionist 17:56:00 0m 6s
01/04/2018 Practice Admin Receptionist 12:28:39 2h 37m 55s
19/04/2018 Surgery Consultation 11:22:05 1m 28s
06/05/2018 Surgery Consultation Back pain - acute, Back pain - acute 12:08:21 0m 38s
08/06/2018 Surgery Consultation 18:41:40 3m 15s
15/06/2018 Surgery Consultation 09:33:56 3m 4s
15/06/2018 Surgery Consultation 09:50:52 4m 49s
15/06/2018 Practice Admin Receptionist 17:46:58 0m 1s
15/06/2018 Practice Admin Receptionist 18:49:05 0m 1s
30/07/2018 Surgery Consultation 10:21:45 9m 44s
11/09/2018 Practice Admin Care Planning 13:11:25 1h 9m 35s
22/09/2018 Practice Admin RECEPTIONIST 10:29:53 0m 1s
22/09/2018 Practice Admin RECEPTIONIST 11:33:16
22/09/2018 Practice Admin RECEPTIONIST 11:45:08 0m 1s
29/09/2018 Practice Admin RECEPTIONIST 14:17:32 0m 1s
04/10/2018 Practice Admin Registered Nurse 09:52:47 22m 2s
17/10/2018 Practice Admin Receptionist 17:26:39 0m 1s
22/10/2018 Practice Admin Receptionist 08:29:03 4h 29m 57s
29/10/2018 Practice Admin Receptionist 12:06:02 52m 9s
05/11/2018 Practice Admin Receptionist 08:33:20 0m 1s
05/11/2018 Practice Admin Receptionist 11:36:17 0m 1s
08/11/2018 Surgery Consultation Tester spirometry 15:08:07 0m 18s
13/11/2018 Practice Admin Receptionist 13:20:05 0m 1s
24/12/2018 Dr Ashley Ng Surgery Consultation 21:56:42 0m 2s
Tuesday November 13 2018 13:20:05
Receptionist -
Visit type:
Practice Admin
History Examination Reason Review
Management Comment Procedure Medicare
Append Diagram Search Clear Search Refresh
Website Help


Enter DV, DVSP and/or DVREF
Free Text
Reason for contact
Enter reason for contact
Pick from list (coded)
Free text (uncoded)
Existing Past Medical History
Condition
Left
Right
Active
Confidential
Summary
Comment
Differential diagnosis
Save in Past Medical History
OK
Close
Monday December 24 2018 21:56:42
Dr Ashley Ng
Visit type:
Surgery Consultation
History:
Pt reports new onset pain over the past 1-2 years. Is constant, but comes and goes.
describes as both sharp and dull. Also burning.
Examination:
temp 36.2
alert, oriented
General:
BP (Sitting): 120/80
Tuesday November 13 2018
Receptionist -
Visit type:
Practice Admin

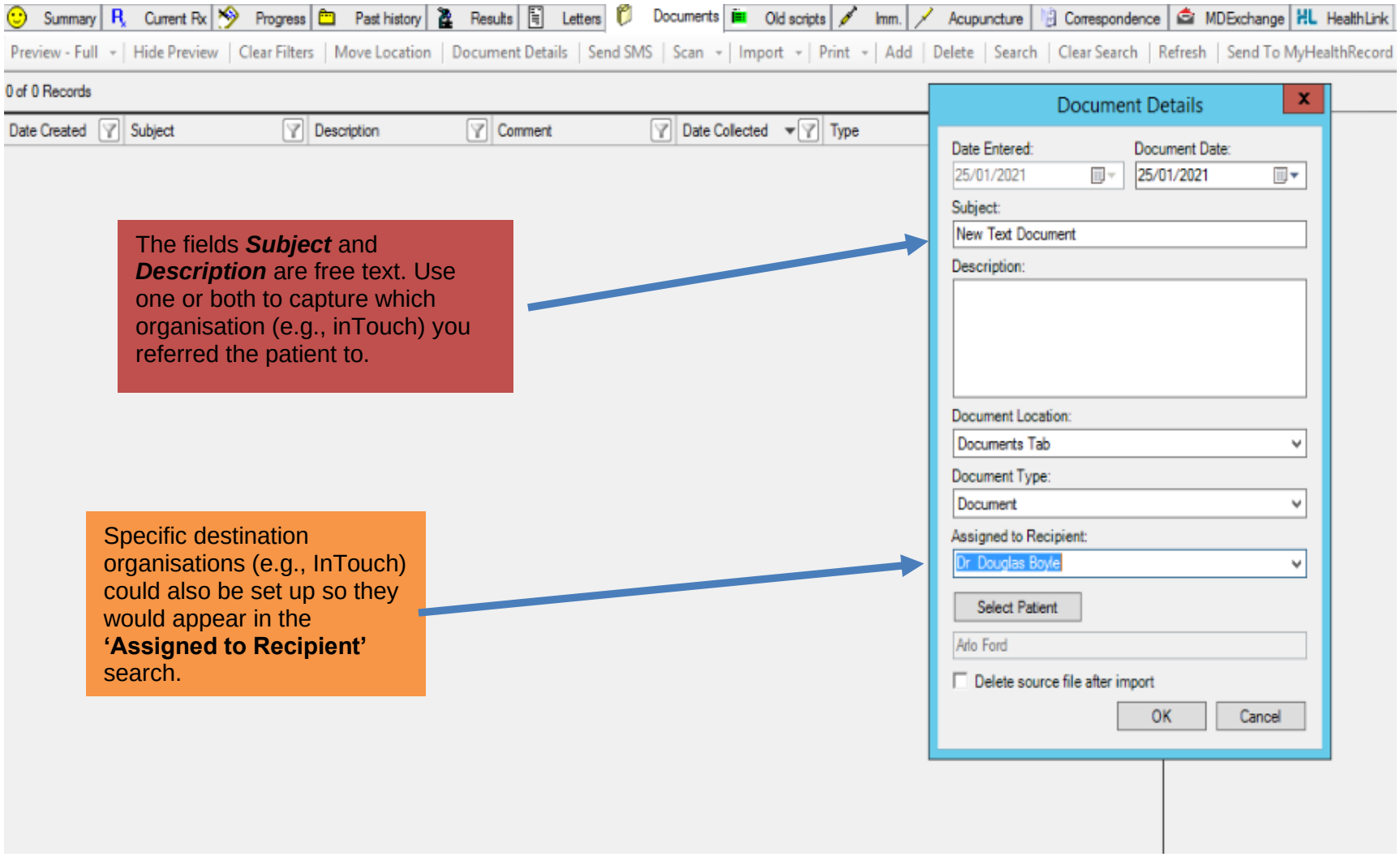
Selecting Ethnicity in Medical Director



Selecting language and country of birth in Medical Director



Medical Director – Documents (correspondence)



4. Referral Resources

Referral Resources

Help Seeking in Diverse Populations

Posters and Support Resources for the Clinic

Family Violence Support Services

Accessing the Family Violence Service System

Referral Resources

There are many community resources and referrals that you can access, although this might be more limited in rural areas. The team is happy to assist you in developing a resource book for your local area.

If a patient is in crisis the day you see them and is feeling very unsafe then you can consult the following:

- **1800RESPECT** National Sexual Assault, Domestic Family Violence Counselling Service (24-hour, 7-day helpline, information and support) 1800 737 732
- **Safe Steps Family Violence Response Centre (**24-hour, 7-day crisis line). Usually crisis counselling, referral, support and advocacy, contact point for women's refuges, referral to other short-term crisis accommodation 1800 015 188
- **Police Domestic Violence Line** (24 hours) 1800 656 463

If a patient is not in crisis then consider the following areas where the patient may need further support:

If a patient is not in crisis but would like some information and general counselling in addition to seeing you, they could contact the following:

- Domestic Violence Resource Centre Victoria (DVRCV) on 8346 5200 or at www.dvrcv.org.au
- Private counsellors and psychologists - see Australian Psychological Society www.psychology.org.au
- Women's information and Referral Exchange (WIRE) on 1300 134 130 or at www.wire.org.au

- Community health centres locally run groups on a regular basis
- General 24-hour counselling e.g. Lifeline on 131114 or www.lifeline.org.au or Relationships Australia on 1300 364 277 or at www.relationships.org.au
- Beyondblue on 1300 224 636 or at www.beyondblue.org.au
- Post and Antenatal Depression Association (PANDA) on 1300 726 306 or at www.panda.org.au
- **(North-West)** NWMPHN link to Care In Mind (mental health services) - https://nwmphn.org.au/health-systems-capacity-building/careinmind/
    - Overview of programs towards top end
    - Bottom part focuses on referral information
- **(North-West)** NWMPHN link to AOD services. The best way to access information around referral pathways regarding AOD is through HealthPathways.
    - Link to HealthPathways: Moderate to High Dependence Alcohol and Drug Treatment Assessment https://melbourne.healthpathways.org.au/526957
    - Link to HealthPathways: Low Dependence Alcohol and Drug Treatment Assessment https://melbourne.healthpathways.org.au/526955

Help seeking in diverse populations

It is important to understand that the various aspects of human lives, such as ethnicity or migrant/refugee status, First Nations People, class, race, sexual orientation, disability and gender identity do not exist separately from each other but are interwoven in often complex and multidimensional ways. A person's social situation may create additional factors for consideration in relation to help-seeking or disclosure. If the person experiencing family violence has additional factors to consider information is available from a range of sources linked below:

- **1800RESPECT:National Sexual Assault, Domestic Family Violence Counselling Service** (24-hour, 7-day helpline, information and support) on 1800 737 73 or https://www.1800respect.org.au/
- **inTouch Multicultural Centre Against Family Violence** on 9413 6500 or www.intouch.org.au
- **Djirra** (formerly Aboriginal Family Violence Legal Service) on 9244 3333 or https://djirra.org.au/
- **Women with Disabilities Victoria** (WDV) on 9286 7800 or http://www.wdv.org.au/
- **Drummond Street Services** - IHEAL – Family Violence Recovery Support for LGBTQI phone 9663 6733 or https://ds.org.au/
- **Seniors Right Victoria** (Support, including legal, for older people experiencing family violence / elder abuse) phone 1300 368 821 or https://seniorsrights.org.au/
- **Domestic Violence Resource Centre Victoria** - Information for men experiencing family violence phone 8346 5200 or http://www.dvrcv.org.au/
- **Mensline** – telephone and online counselling service phone 1300 789978 or https://mensline.org.au/

Family Violence Support Services

Key State-wide Services for family violence			
Organisation	**Who**	**Services**	**Contact**
1800Respect	All	Information, counselling and support services 24 hours	**P:** 1800 737 732 **W:** https://www.1800respect.org.au/ **Interpreter:** 13 14 50
The Lookout	All	Online directory	**W:** http://www.thelookout.org.au/
Berry Street	All	Services, programs, counselling and support	**P:** 9429 9266 (general enquiries) **W:** https://www.berrystreet.org.au/ **North:** 9450 4700; **South Eastern:** 9239 1400
Anglicare	All	Men's behaviour change provider, support, programs and services	**W:** https://www.anglicarevic.org.au/ **Preston:** 8470 999; **Lalor:** 8641 8900; **Werribee:** 9731 2500; **Bayswater:** 9721 3688; **Lilydale:** 9735 4188; **Frankston:** 9781 6700
Drummond Street Services	All	State-wide services, information, counselling, support services, LGBTIQ support	**P:** 9663 6733 **E:** enquiries@ds.org.au **W:** https://ds.org.au/
Safe Steps Family Violence Response	Women	State-wide services, Intake services, Counselling and group work 24/7 hours)	**P:** 1800 015 188 **E:** safesteps@safesteps.org.au **W:** https://www.safesteps.org.au/
inTouch Multicultural Centre Against Family Violence	Women	State-wide services, information	**P:** 9413 6500 (information & enquiries) or 1800 755 988 (support non-emergency) **W:** https://intouch.org.au/
Child First and family services (Department of Health and Human Services)	Children	Case management	**W:** https://services.dhhs.vic.gov.au/referral-and-support-teams **Brimbank, Boroondara & Melton:** 1300 138 180; **Darebin, Frankston & Whittlesea:** 1800 319 355; **Greater Dandenong:** 9705 3939; **Maribyrnong & Wyndham:** 1300 775 160;
Child Protection (Department of Health and Human Services)	Children	Case management	**W:** https://services.dhhs.vic.gov.au/child-protection-contacts **North & West**: 1300 664 977; **South:** 1300 655 795; **East:** 1300 360 391; **After Hours:** 131 278
No To Violence & Men's Referral Service	Perpetrators, Men	State-wide service, Intake services	**P:** 1300 766 491 **W:** https://www.ntv.org.au/
Relationships Australia	Men	Men's Behaviour Change	**P:** 5990 1900 **W:** www.relationships.org.au

Elizabeth Morgan House Aboriginal Women's Service	Aboriginal and Torres Strait Islanders, Women	Case management and refuge	**P:** 9482 5744 **E:** info@emhaws.org.au **W:** https://www.emhaws.org.au/
Victorian Aboriginal Child Care Agency (VACCA)	Aboriginal and Torres Strait Islanders, Women, Children	Case management and refuge	**P:** 9287 8800 (Head office - **Preston**) **W:** https://www.vacca.org/ **Dandenong:** 9108 3500; **Frankston:** 8796 0700; **Melton**: 8746 2776; **Werribee:** 9742 8300
Djirra (formerly Aboriginal Family Violence Prevention Legal Service)	Aboriginal and Torres Strait Islanders, Women	Legal Services	**P:** 9244 3333 **W:** https://djirra.org.au/
Victorian Aboriginal Legal Service (VALS)	Aboriginal and Torres Strait Islanders, Women	Legal Services	**P:** 9418 5999 **W:** https://vals.org.au/
Aboriginal Centre for Males Referral Service (VACSAL)	Aboriginal and Torres Strait Islanders, Men	Men's Group, case management	**P:** 9416 4266 (Head office) **E:** reception@vacsal.org.au
Victorian Aboriginal Health Services men's Unit (VAHS)	Aboriginal and Torres Strait Islanders, Men	Men's Group, case management	**P:** 9403 3300 **(Preston)** or 8592 3920 **(Epping)** **W:** https://www.vahs.org.au/
W/Respect	LGBTIQ	State-wide, information and support	**P:** 1800 542 847 **W:** https://www.withrespect.org.au/
Thorne Harbour Health	LGBTIQ	State-wide, information and support	**P:** 9865 6700 **E:** enquiries@thorneharbour.org **W:** https://thorneharbour.org/
Seniors Rights Victoria	Elder Abuse	Information	**P:** 1300 368 821 **E:** seniorsrights.org.au **W:** info@seniorsrights.org.au

Accessing the Family Violence Service System in the North

For the Northern region, many of the resources can be found on this online directory https://www.nifvs.org.au/find-services/

This online service directory has a full range of services available in the northern metropolitan region.

Family Violence Services

Women	• **Case Management and Refuge:** Berry Street, Georgina Martina Inc, Good Samaritan Inn, Salvation Army Crossroads, Uniting Kildonan, WISHIN • **Counselling and group work:** NIFVS Counselling and Support Alliance • **Statewide:** Safe Steps, inTouch Multicultural Centre Against Family Violence
Children	• **Case management:** Bright Futures Children's Specialist Support Service **Counselling and group work:** Restoring Childhood (Berry Street), Dolphin (Anglicare), Bright Futures, Kids First and the NIFVS Counselling and Support Alliance.
Perpetrators	• **MBC providers:** DPV Health, Sunbury Community Health, Uniting Kildonan, Anglicare • **Statewide:** No to Violence, Men's Referral Service,
LGBTIQ	**Statewide:** w/respect, Thorne Harbour Health

Aboriginal Family Violence Services

Women	• **Case Management and Refuge:** Elizabeth Morgan House Aboriginal Women's Service, Victorian Aboriginal Childcare Agency (VACCA) • **Legal Services:** Djirra (formerly Aboriginal Family Violence Prevention Legal Service), Victorian Aboriginal Legal Service (VALS)
Children	• Victorian Aboriginal Child Care Agency (VACCA) – Support for families and children, including a family violence program
Men	• **Men's Groups**: Dardi Munwurro Indigenous Men's Group, Aboriginal Centre for Males Referral Service (VACSAL), Victorian Aboriginal Health Service Men's Unit (VAHS) • **Case Management**: VACSAL, VAHS • **Legal Services:** Victorian Aboriginal Legal Service (VALS)

Northern Service Providers			
Organisation	**Who**	**Services**	**Contact**
Women's Health in the North and Northern Integrated Family Violence Services	All	Information, support, education	**P:** 9484 1666 **E:** info@whin.org.au **W:** https://www.whin.org.au/ OR **W:** https://www.nifvs.org.au
Orange Door - North Eastern Melbourne Area (NEMA)	All	Intake for specialist family violence services, children and includes aboriginal services	**P:** 1800 319 355 **E:** nema@orangedoor.vic.gov.au **A:** 56 Burgundy Street, Heidelberg, 3084
Uniting Kildonan	All	Case management and refuge, Men's behaviour Change provider	**P:** 9302 6100 (general) **P:** 9457 0500 (MBC) **E:** info@kildonan.org.au **W:** https://www.unitingkildonan.org.au/programs-and-services/
Berry Street Northern Domestic & Family Violence Service (NFDVS)	Women, children	Case management, intake services, Counselling and group work	**P:** 9450 4700 **E:** dvointake@berrystreet.org.au **W:** https://www.berrystreet.org.au/our-work/building-stronger-families/family-violence/nothern-region **A:** 677 The Boulevard, Eaglemont, 3084
Georgina Martina Inc.	Women	Case management and refuge	Georgina Martina cannot be contacted directly. Contact can be made through Safe Steps **P:** (03) 9928 9600
Good Samaritan Inn	Women	Case management and refuge	**W:** http://www.goodsamaritaninn.org.au/ **E:** info@goodsamaritaninn.org.au
Salvation Army Crossroads	Women	Case management and refuge	**P:** 9353 1011
Women's Support and Housing in the North (WISHIN)	Women	Case management	**P:** 8692 2020 **E:** admin@wishin.org.au **W:** https://www.wishin.org.au/

NIFVS Counselling and Support Alliance	Women & Children	Counselling and group work	**W:** https://www.nifvs.org.au/about/northern-metro-family-violence-sector/#counselling
Bright Futures Children's Specialist Support Services	Children	Case management, group work	**P:** 9359 5493 **E:** brightfutures@merri.org.au **W:** http://merri.org.au/site/bright-futures/
Sunbury Community Health	Perpetrators	Men's behaviour Change provider	**P:** 9744 4455 **W:** https://www.sunburychc.org.au/
Kids First - Caring Dads	Men	Group work	**P:** 1300 938 790 **E:** caringdadsintake@cps.org.au **W:** http://caringdads.org.au/
Northern Centre Against Sexual Assault	Victims of sexual assault	Counselling and group work	**P:** 9496 2369 (general enquires) OR 9496 2240 (counselling & referrals, 12.30-5pm) OR 1800 806 292 **E:** ncasa@austin.org.au **W:** http://www.austin.org.au/northerncasa/
Dardi Munwurro Indigenous Men's Group	Aboriginal and Torres Strait Islanders, Men	Men's Group	**P:** 1800 435 799 **E:** info@dardimunwurro.com.au **W:** https://www.dardimunwurro.com.au/

For the Northern region, many of the resources can be found on the online directory https://www.nifvs.org.au/find-services/. This online service directory has a full range of services available in the northern metropolitan region. They include:

Family violence intake

After hours crisis

Case management – Women

Perpetrator Intervention Programs

Alcohol and Other Drug services or Mental health services

Intake pathway charts including:

Intake pathway for women experiencing violence or

Intake pathway for children experiencing violence or

Intake pathway for men who use violence

Accessing the Family Violence Service System in the West

(Brimbank, Hobson's Bay, Maribyrnong, Melbourne, Melton, Moonee Valley, Wyndham)

Western Service Providers			
Organisation	**Who**	**Services**	**Contact**
Western Region Centre Against Sexual Assault Inc (West CASA)	All	sexual assault counselling service	**P:** 9216 0411 (general) **P:** 9216 0444 (COUNSELLING) **E:** info@westcasa.org.au **W:** https://westcasa.org.au/
Gatehouse Centre	All	Centre Against Sexual Assault for children, young people and their families in the North Western regions, who may have experienced sexual abuse.	**P:** 9345 6391 **After Hours:** 9345 5522 **E:** gatehouse.centre@rch.org.au **W:** https://www.rch.org.au/gatehouse/
Women's Health West	Women and children	Intake, counselling	**P:** 9689 9588 **W:** https://whwest.org.au/ **A:** 317-319 Barkly St, Footscray VIC 3011
cohealth	Women	Case management, specialist family violence counselling	**P:** 9448 5502 (Footscray, Braybrook, Werribee & Melton) **W:** https://www.cohealth.org.au/health-services/social-work/

McAuley Community Services for Women	Women and children	24/7 safe house, medium term accommodation, case management, women's employment program and children's programs.	**P:** 9362 8900 (general enquires) **E:** mcsw@mcauleycsw.org.au **W:** https://www.mcauleycsw.org.au/
Good Shepherd	Women and children	case management, safety planning, counselling, links to legal support, housing services and support groups for women and children.	**P:** 8312 8800 (St Albans, Brimbank Melton) **E:** stalbans@goodshep.org.au
Salvation Army Social Housing and Support Network	Women and children	case management, safety planning, housing support, financial counselling, private rental brokerage and parenting support.	**P:** 1313 7258 **W:** https://www.salvationarmy.org.au/sashs/programs/families-unit/
West Melbourne Child First-*Anglicare*	Children	Intake	**P:** 1300 775 160 **W:** http://wcfsa.org.au/contact
Brimbank/Melton Child First-Mackillop Family Services	Children	Intake	**P:** 1300 138 180 (Brimbank/Melton) **P:** 1300 775 160 (Western Melbourne) **W:** https://www.mackillop.org.au/programs/child-first
Lifeworks	Men	Men's behavioural change	**P:** 8650 6200 Located in Williamstown, Wyndham and Melbourne.
iHeal Thorne Harbour Health	LGBTIQ	Counselling, case management, advocacy	**P:** 1800 134 840

Accessing the Family Violence Service System in the South East

Service info for GPs – services in South East Melbourne available for (migrant) woman impacted by domestic violence

Emergency

Police Stations

EMERGENCY: 000

W: www.police.vic.gov.au

Dandenong Police Station A: 50 Langhorne St Dandenong VIC 3175 P: (03) 9767 7444

Springvale Police Station A: 314 Springvale Road, Springvale VIC 3171 P: (03) 8558 8600

Endeavour Hills Police Station A: 80 Heatherton Rd Endeavour Hills VIC P: (03) 9709 7666

Narre Warren Police Station A: 8 Coventry Rd Narre Warren VIC 3805 P: (03) 9705 3111

Cranbourne Police Station A: 168 Sladen St Cranbourne VIC 3977 P: (03) 5991 0600

Services include:

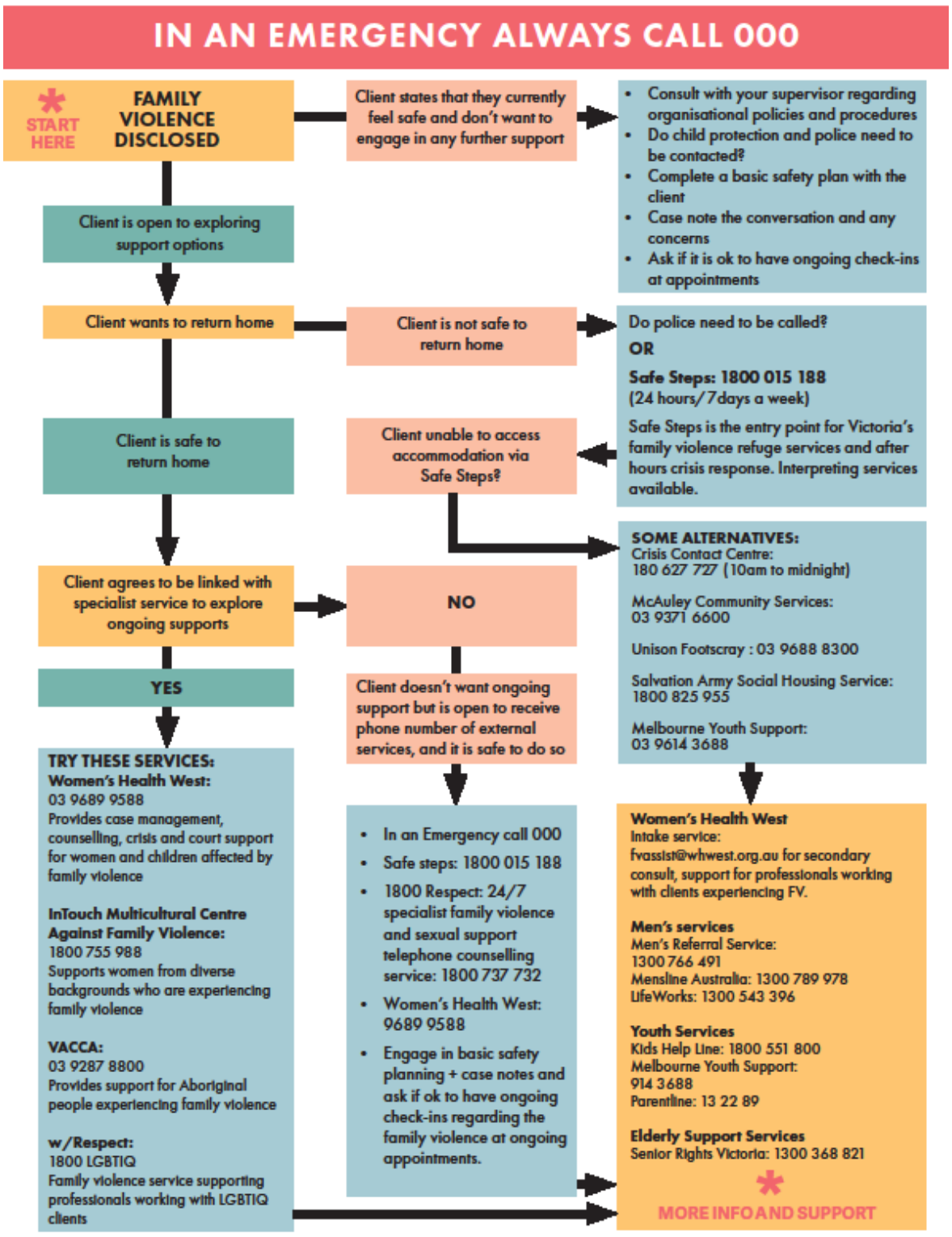
- Responding to calls for assistance in matters of personal and public safety, emergencies and serious incidents.
- Detecting and investigating offences and bringing to justice those responsible for committing them.
- Supporting the judicial process to achieve efficient and effective court case management, providing safe custody for alleged offenders, supporting victims and ensuring fair and equitable treatment of victims and offenders

South-East Service Providers			
Organisation	**Who**	**Services**	**Contact**
Orange Door - Bayside Peninsula	All	Intake for specialist family violence services, children and includes aboriginal services	**P:** 1800 319 353 **E:** bpa@orangedoor.vic.gov.au **A:** 60-64 Wells Street, Frankston, 3199
Red Cross (Dandenong)	All	Information, referrals and migration resources centre /community support	**P:** 8327 7370 **A:** Level 4, 311 Lonsdale Street Dandenong VIC 3175 **W:** http://www.redcross.org.au
WAYSS	All	Crisis Assistance and housing Assistance	**P:** 9791 6111 **E:** info@waysslтd.org.au **A:** 294 Thomas Street Dandenong VIC 3175 **W:** www.waysslтd.org.au For after-hours support, contact Salvation Army Crisis Services: **P:** 1800 627 727
The South Eastern Centre Against Sexual Assault (SECASA)	All	Counselling, support group, case management	**P:** 9594 2289 ask for the duty worker **W:** www.secasa.com.au
Uniting Connections Family Support Services	All	Support services	**P:** 8792 8999 **W:** www.connections.org.au
Windermere	All	Support Services & counselling	**P:** 9705 3200 **W:** www.windermere.org.au
South Eastern Melbourne Primary Health Network - Access and Referral	All	Links and refers to services (non-emergency).	**W:** https://www.semphn.org.au/resources/access.html

South East Region refugee and asylum seeker service directory	All	Services and programs (including crisis/emergency, medical, mental health, social/cultural support, accommodation, legal, financial, education and employment services)	**W:** https://www.semphn.org.au/South_East_Region_Refugee_Asylum_Seeker_Service_Directory_7.3.pdf
Monash Health Refugee Health and Wellbeing service	All	Primary care services. A Refugee Health Nurse on Triage service is also available daily to support local agencies in determining where to refer clients and how to make an appropriate referral.	**P:** 9792 8100 **A:** Monash Health Community Level 1, 122 Thomas Street, Dandenong **W:** http://monashhealth.org/services/services-o-z-monash-health/refugee-health-and-wellbeing/refugee-health-service-info/refugee-health-our-service/
Southern Migrant and Refugee centre	All	Services to refugees and migrants in Melbourne's South and East.	**P:** 9767 1900 **E:** reception@smrc.org.au **W:** https://smrc.org.au/
Brotherhood of St Laurence	All	Services and programs. https://www.bsl.org.au/services/	**P:** 1300 015 107 **A:** BSL Epping Community Services Hub 713 High Street, Epping **W:** eppingcommunityserviceshub.org.au
The Asylum Seeker Resource Centre (ASRC)	All	Information, education and services, in particular to people seeking asylum, which are in the process of, or waiting to apply for a protection visa in Australia.	ASRC Dandenong Monday to Thursday: 10am – 3pm **A:** 179 Lonsdale Street, Dandenong **P:** 8772 1380 **E:** dandenong@asrc.org.au **W:** https://www.asrc.org.au/get-help/
Anglicare Victoria	All	Family violence support and Men's behaviour change	**A:** 131-147 Walker Street, Dandenong **P:** 03 9293 8500 Frankston **A:** 60-64 Wells Street, Frankston **P:** 03 9781 6700

Crossway Lifecare	All	Services, programs, women's centre	**A:** 709 Highbury Road, Burwood East **P:** 9886 3899
Southeast Community Links Inc. (SECL)	All	Referrals and support services	Springvale **A:** 5 Osborne Avenue Springvale VIC 3171 **P:** (03) 9546 5255 Dandenong: **A:** 186 Foster Street East Dandenong VIC 3175 Noble Park: **A:** 49 Douglas Street Noble Park VIC 3174 **P:** (03) 9547 0511 W https://www.secl.org.au/ E: info@secl.org.au
Monash Health Community Services	All	Support services	**Greater Dandenong Community Health Service Springvale** **A:** 55 Buckingham Ave, Springvale **P:** 8558 9000 **Greater Dandenong Community Health Service Dandenong** **A:** 122 Thomas Street, Dandenong. **P:** 9792 8100 **W:** http://monashhealth.org/about-us/monash-health-sites/monash-health-community/
Women's Health in the South East	Women	Information, education and service support	**P:** 9794 8677 **E:** whise@whise.org.au **A:** 2/31 Princes Highway Dandenong VIC 3175
Connections Uniting Care	Women and Children	Services and programs	**A:** 51 Princes Highway, Dandenong **P:** 8792 8999 **W:** https://www.unitingconnections.org.au/
Ngwala Willumbong	Aboriginal and Torres Strait Islanders	Support Services	**P:** 9510 3233 **W:** www.ngwala.org
Springvale Indochinese Mutual Assistance Association - SICMAA.	For the Vietnamese Community	Support services	**P:** 9547 6161

Women's Health West integrated family violence services flow chart



Posters and support resources for the clinic

Below are links to resources that provide posters and other family violence related information if you should like to display any in your waiting room, bathrooms etc.

Northern Integrated Family Violence Services

https://www.nifvs.org.au/resources/nifvs-resources/posters/

Women's Health West

https://whwest.org.au/resource/family-violence-support-services/

Consent, Empower & Respect: Women Rights are human rights - Poster

Domestic Violence Resource Centre Victoria (DVRCV)

Is this violence - Poster

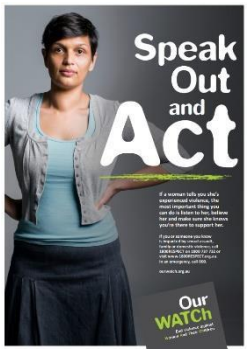
Know you're A-Z: Prevention violence against women, challenge stereotypes and promote respect - Poster

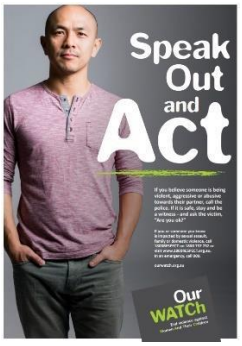
Our Watch

Poster 1 – Listen

Poster 2 – Report

Poster 3 – Say Something





5. What Next?

Clinic systems and sustaining change

Follow-up

Future support from the project team

CPD points

Clinic Systems and Sustaining Change

Thinking about sustaining change

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

You can play a role in promoting positive change in your clinic through building awareness, sharing knowledge, and reviewing processes with the administrative and clinical teams. For example, we could provide you with a handout that you could give to colleagues who are interested in learning more about responding to family violence but could not participate in the educational program, or you could share your experiences of the educational program at clinic meetings. In the role of 'champion for change' you can look at ways of developing support mechanisms for the whole clinic to respond 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 to support 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 clinic 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 handbook for health managers.
http://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/

Support from the Project Team

The second clinic visit signals the formal conclusion of the face to face training. However, the team will be available to provide further support and to contribute to efforts to sustain change for the subsequent three months culminating in the follow-up. We will advise and respond to any queries as best we can.

You may contact:

harmony@latrobe.edu.au

Felicity Young (Research Officer) – 03-9479 3539

Molly Allen (Research Assistant) – 03-9479 8807

Support on linking into the local service system

The Western region

For assistance in linking your clinic to the local service system in western metropolitan region contact the Integrated Family Violence Services at Women's Health West on 9689 3861.

The Northern region

For assistance in linking your clinic to the local service system in northern metropolitan region, contact the Northern Integrated Family Violence Services Partnership Team at Women's Health In the North on 9484 1666.

The South-East region

For assistance in linking tour clinic to the local service system in south-eastern metropolitan region, contact Women's Health in the South East 9794 8677.

inTouch advocate educators are available also for consultation and to provide advice and guidance on how to engage with local women's health services.

Follow-up

The follow-up allows for an exploration of your experiences of the training and responding to patients and children experiencing family violence. The follow-up provides a convenient means of discussing relevant issues with a GP Facilitator and /or the Advocate educator who is an expert in the area and can link the clinic into local services.

During the follow-up, you could explore:

- Barriers and facilitators to providing care for patients who have been afraid of their partner and who may have experienced intimate partner abuse
- Discuss overcoming challenges in delivering care
- Identify strategies in your clinic that could contribute to sustaining change

Support for yourselves

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

Contact your own GP

1800RESPECT
National Sexual Assault, Domestic Family Violence Counselling Service (24-hour, 7-day helpline, information and support) 1800 737 732

Victorian Doctors' Health Program
A confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use problems, or any other health issues. Call on (03) 92808712 (www.vdhp.org.au).

AMA Victoria Peer Support Service Peer support phone advice service on 03 92808722 or 1800 810451(country Vic toll free) amavic@amavic.com.au.

RACGP GP Support Program

A free service offered by the RACGP. It is available to all Australian RACGP members who are registered medical practitioners, regardless of where they live or work. Members can access professional advice to help cope with life's stressors which may include personal and work-related issues that can impact on their wellbeing, work performance, safety, workplace morale and psychological health. Call Optum 1300361008.

CPD Points

- **As a GP:** As a part of participation in the training for this study, you are GPs are eligible for Category One CPD points. To acquire these, please speak to the La Trobe staff members to get your voucher number. All training sessions and online modules must be completed to get this.
- **As a Nurse:** Nurses participating in this program may consider the hours spent undertaking both the distance learning and clinic visit participation as Continuing Professional Development hours. For further information, go to the Nursing and Midwifery Board of Australia website: www.nursingmidwiferyboard.gov.au

Whole of Clinic checklist

The whole of clinic checklist objective is to:

1. Examine current practices and systems within the clinic.
2. Assist GPs in undertaking an audit of 10 consecutive migrant/refugee female patients (aged 18 to 64)
3. Identify areas for change within the clinic.
4. Consider supports for staff experiencing family violence

Checklist	Describe
The waiting room and other communal area	.
Are there **posters** saying the clinic supports those who are experiencing family violence?	.
Are the posters in a community language?	.
Are there **factsheets** available on family violence?	.
Are the factsheets available in different languages?	.
Are the factsheets available in different formats, e.g. Braille, large print, audio?	.
Is **information** about local and national family violence **support services** clearly displayed?	.
Is there the **facility** for patients to **speak privately** to any member of the clinic staff so they cannot be overheard?	.
Is the clinic **culturally sensitive**?	.
Does the clinic employ reception staff who are from the same background and speak local community language?	.
Do staff know how to use interpreter services?	.
Does the clinic display specific information pamphlets on local services and support groups for culturally and linguistically diverse and gay, lesbian, bisexual and transgendered patients?	.

Checklist	Describe
Clinic procedures	
Has the clinic established **access to regular training** in responding to family violence for clinical and administrative staff	.
• Are they trained to recognise the **warning signs** of family violence? • Are they aware of **privacy protocols** and **reporting requirements**? • Are all GPs and nurses trained in **responding** to family violence? • Are all GPs and nurses specialising in antenatal care trained to **screen** for family violence?	. . . .
Has the clinic established a **referral pathway** to specialist family violence agencies? Including: • Patients who have disclosed family violence • Migrant/refugee patients who have disclosed • Perpetrators of family violence • Children affected by family violence	. . . .
Is there a **procedure** in place to ensure patients who may be experiencing family violence **can be seen on their own**	.
Do all staff know, or have access to, **information about local specialist family violence services**, their policies & procedures in relation to family violence?	.
Does the clinic have a **family violence champion** to oversee and regularly monitor clinic protocols and act as a secondary consult?	.
Clinic staff	
Does the clinic have **policies** and **procedures** for **staff who have been affected by family violence**?	.
Is **support** available to staff who may experience **vicarious trauma**?	.

6. Style of Clinic Visits

Small group learning

Using role-play

Working with simulated patients

Guidelines for giving feedback

Small Group Learning

Key points

- Set ground rules for small group function, especially when using videoconferencing software such as Zoom
- Encourage all participants to engage in discussions and activities
- Summarise main points of session
- Highlight preparation for next session

The participants are likely to know each other well and be used to working together as part of their professional roles. However, learning within a small group using adult learning principles may be new to some participants. Setting 'ground rules' for group function will be important in the settling in phase and assist in developing the cohesiveness of the group. Concepts of mutual support, confidentiality, valuing the contributions of everyone and respecting the time of others are fundamental components of developing a team. The environment of small groups is to immerse the participant in the learning experience and promote learning from the experience within the group. Small groups also allow the presenter the opportunity to 'model' particular communication skills.

Initiating the Group-Goal setting

- It is important to establish the behaviour pattern for the group early.
- Encourage active participation by not talking too much at the beginning.
- Negotiate the learning goals with the participants.
- Get to know participants' names as soon as possible.
- Assist participants to set ground rules for the functioning of the group.

Preparation tasks

- Be one step ahead. Be aware of the course content for the next workshop as well as the current one. This allows adequate description of the tasks required by participants for the following week.
- Observe and encourage participants who come unprepared.
- Use the communication skills that are the basis of this program.
- Allow plenty of time for discussion, allow the occasional silence.
- Randomly select participants to respond rather than going around in a circle.
- Ask open rather than closed-ended questions.
- Use a relaxed conversational style.
- Interrupt infrequently to ensure flow of discussion.
- Arrange pairs or threes randomly and rearrange regularly.
- Encourage quiet participants by placing them in supportive smaller groups.

Provide regular feedback

- Observing their work within the role-plays and group participation and providing individual comment.
- Observing the role with simulated patients and allowing the group to provide constructive feedback.

Using Role-play

Key points

- Set ground rules
- Monitor time
- All group members to take turns
- Provide constructive feedback

Ground rules should be set prior to the commencement of the role-play. These guidelines act to maximise the involvement of participants and promote a non-threatening environment for learning.

You should monitor the time allocated to the role-play. The participants should be aware of these time limits. It is important to allow adequate time for participants to prepare for the role as well as time for debriefing after the role.

It is important that all group members take their turn in participating in the role-play.

Participants should be aware of the need to offer constructive feedback. All feedback should focus on examples within the role-play.

The learning within the role-play should remain confidential and not talked about outside the group forum.

Often you can ask what they think about role-plays and try and find someone who likes them (Don’t spend too long on this).

Working with Simulated Patients

Key points

- Case scripts are linked to learning objectives.
- Role-play should be as realistic as possible.
- Simulated patients are trained to provide feedback.
- Participants can experiment with different communication styles during the role-play.

Simulated patients are used to provide realistic portrayals of a family violence case. The script cases have been prepared to match the learning objectives of the program. Simulated patients provide the opportunity for participants to enhance skill development within the context of a challenging scenario at an appropriate level of complexity. For the cultural safety objectives of this training, the case script is of a South Asian victim with culturally specific risks and safety needs.

The skills of the simulated patient provide the participant with immediate feedback from the patient's perspective. This can be a very powerful learning experience.

The simulated patients are able to reproduce a case in a standardized manner. This means that when participants take the opportunity to practice with the simulated patient, they will be able to see the different outcomes of different approaches.

Using simulated patients provides a flexible teaching tool. The role-play can be stopped and started to provide feedback and to try different approaches.

Guidelines for Giving Feedback

Key points

- **Effective** – What worked?
- **Do more of** – What could there have been more of?
- **Improve** – What could have been done differently?

Characteristics of Effective Feedback

- Feedback should be descriptive, rather than evaluative or judgmental

  For example:

  You provided the patient with a lot of information regarding the management of their diet in pregnancy, but seemed uncertain how to explore her feelings of being worried about a vaginal examination versus *You'll become more comfortable dealing with people's emotions with more practice.*

- Feedback should be specific, rather than general

  For example:

  I noticed you avoided eye contact with the patient versus *You are rather weak in interviewing skills.*

- Feedback should focus on behaviour, rather than on assuming personality traits.

  For example:

Your attentive body language, silence and gentle probing demonstrated your interest and allowed the patient to tell you what's on her mind versus *You are warm and caring towards your patients.*

- Feedback involves sharing information and observations, rather than giving advice.
- Encourage learners to decide for themselves how to handle the problem.
- Feedback can often usefully be phrased as a question to draw attention to a specific issue.

For example:

What were your strategies to encourage the patient to talk about her lack of social supports?

- Feedback should be limited so learners are not overloaded - it is more valuable for a learner to take away one or two key messages to consider and act upon, rather than overwhelm them
- Feedback should be incomplete: encourage learners to reflect further on the issues.
- Feedback should be to the point, clear and unambiguous.
- Feedback should be verified or checked with learners.

For example:

How do you think the consultation went? … This is what I observed, does that match how you thought it went?

- Learners should be encouraged to comment and expand on the feedback.
- Avoid misleading, meaningless or dishonest feedback.