Mapping the hospital and health service workforce for Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework alignment: Working with adults who use family violence

Strengthening Hospital Responses to Family Violence (SHRFV)

June 2022

Mapping the hospital and health service workforce for Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework alignment: Working with adults who use family violence

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Executive Summary

Background

The Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework, released in 2018, outlines best practice for family violence risk assessment and management. It aims to increase the safety and wellbeing of Victorians through:

- a system-wide shared understanding of family violence
- a shared responsibility for risk assessment and management
- ensuring services can effectively identify, assess, and manage family violence risk[1].

Purpose

This document is a guide to assist hospitals and health services to undertake workforce mapping for working with adults who use family violence. It has been developed following the Victorian Government's 2021 release of the MARAM Practice Guides concerning working with adults who use family violence, and compliments existing SHRFV MARAM Alignment Resources.

This guide is not prescriptive, and hospitals and health services have the discretion to lead and tailor the mapping process to their specific context and clinical practice environment; however, *each organisation is responsible for ensuring they meet their legislative obligations* concerning alignment with the MARAM Framework.

***Not in scope* for this document:**

- guidance for *working* with adults who use family violence
- MARAM alignment action planning
- actions required to embed practices for working with adults who use family violence within your hospital/health service
- hospital and health service employees who use family violence
- young people who use violence

Guide to workforce mapping

The following steps provide a guide to workforce mapping activities for working with adults who use family violence.

1. Ensure victim survivor work within your hospital/health service is well established, this being an essential foundation for safe engagement with adults who use family violence.
2. Familiarise yourself with the relevant documents, in particular:
   a) MARAM Alignment for hospitals and health services[2] – overview of MARAM alignment requirements
   b) Supporting Resource A - Workforce Mapping for MARAM Alignment[3] – methodology for mapping hospitals and health services' workforce against the 10 MARAM Responsibilities for risk assessment and management (focus on victim survivors)
   c) relevant MARAM Practice Guides and resources for working with adults using family violence found on this Victorian Government website.

3. Map workforce to practice levels outlined in Figure 1 below (see Figure 2 in document for expanded details):

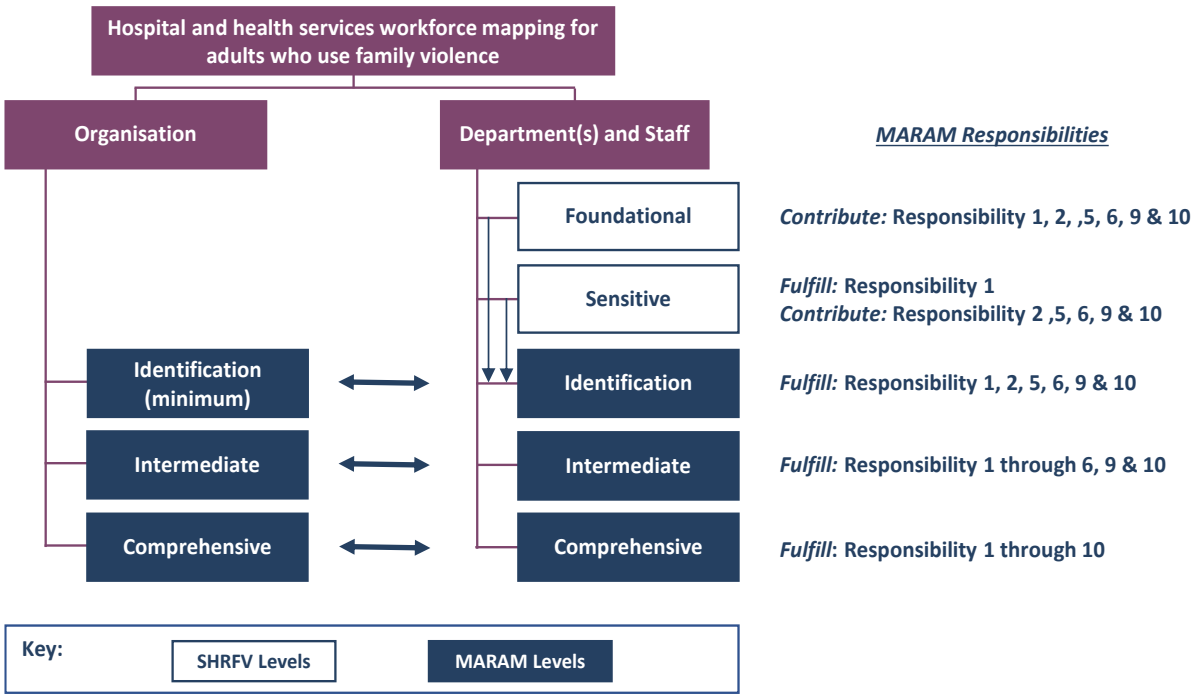
   a) *Organisation – minimum* MARAM practice level required is *Identification*, but hospitals and health services may map at a higher level if this fits with the organisation's services, and there is the appropriate training, resources and support in place to undertake this work

   b) *Department(s)* and *Staff – minimum* requirement is that there is some/one (depending on size and services provided) mapped at *Identification* practice level, recognising that non-clinical staff and those primarily providing health care may be mapped at the SHRFV practice levels of *Foundational* and *Sensitive*.

(See Appendix 1 for sample workforce mapping documents).

4. Conduct mapping work in collaboration with executive directors, directors, managers, and leaders from all departments of a hospital/health service and meet your organisations endorsement requirements.

Figure 1: Summary of workforce mapping: Working with adults who use family violence



When undertaking workforce mapping please note the following.

- To meet the minimum *Organisational* practice level of *Identification*, hospitals and health services must ensure *Departments* and *Staff* mapped at *Foundational* and *Sensitive* practice level have access to a *Department*(s) or *Staff* mapped at *Identification* practice level.
- In general, the highest level at which any *Department(s)* and *Staff* are mapped should equate to the level at which the organisation is mapped.
- It is not anticipated that many hospitals and health services will have *Departments* or *Staff* mapped at *Comprehensive* practice level, however, should this arise, the appropriate staff must be trained, supported, and resourced to meet the associated MARAM responsibilities.

Practice levels and MARAM Responsibilities

The MARAM Responsibilities for each of the practice levels (*Organisation* and *Department(s)* and *Staff*) are outlined in Figure 1. (Further description can be found in section titled 'Practice knowledge and skills for working with adults who use family violence'). To reflect the diversity of roles within hospitals and health services', a distinction is made between being assigned to *fulfill* a MARAM Responsibility or *contribute* to a MARAM Responsibility in SHRFV practice levels (*Foundational* and *Sensitive*).

Key points

Prior to commencing your workforce mapping for adults who use family violence you should consider the following.

- ***Minimum level to meet legislative requirements – Identification:*** The primary function of hospitals and health services corresponds to the MARAM *Identification* practice level. This recognises that hospitals and health services are universal services and their primary role/function is *not* related to family violence risk, but rather to provide health care.
- ***Maturity model in operation:*** The decision to map your organisation at a higher level of practice for working with adults who use family violence (i.e., *Intermediate* or *Comprehensive*) must be linked to a clear rationale, associated organisational literacy, training, and support, and be accompanied by a communication strategy.
- ***SHRFV practice levels – Foundational and Sensitive:*** The SHRFV practice levels are unique to hospitals and health services. They articulate how non-patient facing roles and diverse clinical positions (i.e. roles where the primary function is not 'family violence response') contribute to the hospital's/health service's identification and response to family violence and the organisation-wide MARAM Responsibilities.
- ***Safe practice:*** Staff should not be expected to undertake work with adults who use family violence until the necessary infrastructure and support is in place including policies, procedures, tools, partnerships, training, resources, and leadership support. This is essential to enable safe, sensitive, and respectful engagement.
- ***Victim-survivor lens:*** It is recommended the response to victim survivors is well established within your hospital or health service *before* commencing work to establish practices for working with adults who use family violence. Maintaining a victim survivor lens, which prioritises the safety and needs of victim survivors, is essential when engaging with a person who uses violence.

Endorsement

This mapping recommendation was endorsed by Family Safety Victoria and the Department of Health on May 30, 2022.

Contents

Terminology

Young people who use violence	A young person who chooses to use coercive and controlling techniques and violence against family members, including intimate partners. Young people who use family violence often coexist as victims of family violence and therapeutic responses should be explored. Working with young people who use violence is an emerging practice area. This is a distinct form of family violence and requires a unique response. MARAM Practice Guides in this area are currently in development therefore this language is subject to change.
Adults who use family violence	The term 'adults who use family violence' is used throughout this resource and the MARAM Practice Guides to refer to the person causing family violence harm. The term 'perpetrator' is used at a legal and policy level in Victoria. When professionals are working with a person who uses family violence, they should use the term 'person who uses violence' to engage them and emphasise their agency for change.
Department	The term 'department' has been used to refer to clinical and non-clinical departments, teams and services within a hospital or health service.
Hospitals and Health Services	Reference to hospitals and health services throughout this document refers to Victorian public hospitals and health services prescribed under MARAM.
MARAM	The Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework was released in 2018. Based on current evidence and research MARAM outlines best practice for family violence risk assessment and management and aims to increase the safety and wellbeing of Victorians.
MARAM practice levels	The MARAM Framework articulates practice levels for working with victim survivors and adults who use family violence across the family violence service system. The MARAM practice levels are *Identification*, *Intermediate* and *Comprehensive*.
MARAM workforce mapping	MARAM workforce mapping is the first phase of the MARAM alignment process. Workforce mapping articulates both the organisational and practice level expectations of MARAM in hospitals and health services. It does not address the implementation or embedding of this work in hospitals and health services.
Organisation	The term 'organisation' has been used to refer a public hospital or health service.

Perpetrator	Has the same meaning as the words "a person of concern" in s 144B of the *Family Violence Protection Act 2008* (FVPA) (Vic). The FVPA provides an individual is a person of concern if an information sharing entity reasonably believes that there is a risk that they may commit family violence. This will have been identified by undertaking a Framework based family violence risk assessment.
SHRFV	In 2014 and 2015 the Victorian Government funded the Royal Women's Hospital (the Women's) and Bendigo Health to develop and implement a framework for embedding the practice of identifying and responding to family violence experienced by patients. The Strengthening Hospital Responses to Family Violence (SHRFV) model was developed to provide a system-wide approach which is now being applied by hospitals and health services across Victoria. A range of evidence-informed resources and tools have been developed to support Victorian public hospitals and health services to implement the SHRFV model.
SHRFV practice levels	Endorsed by Family Safety Victoria and the Department of Health in 2020, SHRFV specific MARAM practice levels were created to ensure that hospitals and health services meet their organisational requirements as part of MARAM whilst acknowledging the diverse roles within health settings, including non-clinical roles. The SHRFV specific practice levels are ***Foundational*** and ***Sensitive***.
Victim/Survivors	Has the same meaning as the words "a primary person" (adult or child) in the FVPA. The FVPA provides a person is a primary person if an information sharing entity reasonably believes there is risk that the person may be subjected to family violence.

Introduction

This document aims to guide hospitals and health services as they *map* their workforce for working with adults who use family violence to *align* with the Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework. It also provides guidance on:

- where to apply the MARAM Responsibilities for working with adults who use family violence within the hospital/health service workforce
- the practice skills and knowledge associated with each of the Strengthening Hospital Responses to Family Violence (SHRFV) practice levels.

This document compliments and builds on other SHRFV MARAM Alignment Resources and activities developed to support hospitals and health services to align with MARAM – to date the focus of these resources has been on working with victim survivors. Therefore, it is recommended that you are familiar with the following *prior* to reading this resource:

- MARAM Alignment for hospitals and health services[2] – which provides an overview of MARAM alignment requirements and outlines a process to assist hospitals and health services to develop a *MARAM Alignment Action Plan*
- Supporting Resource A - Workforce Mapping for MARAM Alignment[3] – which provides a methodology for mapping hospitals and health services' workforce against the 10 MARAM Responsibilities for risk assessment and management (with a focus on victim survivors).

Staff responsible for workforce mapping concerning working with adults who use family violence should also be familiar with and informed by the relevant MARAM Practice Guides and resources which can be found on the Victorian Government website. These guides have been used to inform this document.

The MARAM Framework articulates practice levels for working with victim survivors and adults who use family violence across the family violence service system (referred to in this document as the *MARAM practice levels*): *Identification, Intermediate* and *Comprehensive*. However, given the complex nature of hospitals and health services, in 2020 Family Safety Victoria (FSV) and the Department of Health (DoH) endorsed specific practice levels for working with victim survivors in hospital and health service settings: *Foundational* and *Sensitive*. These levels have also been applied to working with adults who use family violence and are referred to as the *SHRFV practice levels* throughout this document.

Background

Setting the scene

The Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework was released in 2018. Based on current evidence and research, MARAM outlines best practice for family violence risk assessment and management and aims to increase the safety and wellbeing of Victorians. It seeks to achieve this through:

- a system-wide shared understanding of family violence
- a shared responsibility for risk assessment and management
- ensuring services can effectively identify, assess, and manage family violence risk.[1]

MARAM has been established in law under a new Part 11 of the *Family Violence Protection Act 2008* (Vic).[1] This means organisations, services and entities that are prescribed under MARAM must align their policies, procedures, practice guidance and tools to MARAM. In September 2018 the Phase One rollout of MARAM saw the first organisations become *prescribed framework organisations* under the legislation – this included state funded Sexual Assault Services, Alcohol and Other Drug Services, and designated Mental Health Services. Victorian public hospitals and health services became *prescribed framework organisations* in April 2021 as part of the Phase Two rollout.[4]

In 2014 the Victorian government funded the Royal Women's Hospital (the Women's) and Bendigo Health to develop a *Framework for change* with an accompanying *Toolkit* to assist hospitals and health services to implement a whole-of-hospital model for responding to family violence (Recommendation 95 of the Royal Commission into Family Violence).[5] These resources were designed to be used and applied by hospitals and health services across the state. This became known as the Strengthening Hospital Responses to Family Violence (SHRFV) model (see SHRFV Resource Centre). As of January 2022, there are eighty-seven Victorian public hospitals and health services participating in the SHRFV program.

The Women's released a suite of SHRFV MARAM Alignment Resources in May 2020. These are designed to enhance work already undertaken as part of the SHRFV program, and to support SHRFV hospitals and health services to align with MARAM. However, these focus on working with victim survivors as when they were produced the MARAM Practice Guides and resources for working with adults who use family violence were still being developed by Family Safety Victoria (FSV).

In July 2021, FSV released *MARAM Practice Guides and resources for working with adults who use family violence* – available on the Victorian Government website. These resources cover all aspects of effective response when working with adults who use family violence including:

- safe engagement
- identification of risk
- levels of risk assessment and management
- secondary consultation and referral
- information sharing and collaborative practice.[6]

Importantly, the practice guides apply to *all* prescribed framework organisations in Victoria who contribute to the family violence service sector and are not specific to the hospital/health services setting.

This document, titled *Mapping the hospital and health service workforce for Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework alignment: Working with adults who use family violence* is another in the suite of SHRFV MARAM Alignment Resources. Based on the publicly released MARAM Practice Guides and resources, it has been produced to assist hospitals and health services to *map* their workforce for working with adults who use family violence to *align* with the MARAM Framework.

Hospitals and health services response

At the time of writing this mapping document, it is recognised that SHRFV hospitals and health services are at different stages of MARAM alignment.

Workforce mapping for MARAM alignment

For SHRFV hospitals and health services who have *already mapped* their workforce for victim survivor identification and response, *and* developed a MARAM Alignment Action Plan focused on embedding practices to respond to victim survivors, the activities outlined in this document build on the existing SHRFV MARAM Alignment Resources and the work you have already undertaken.

For SHRFV hospitals and health services who have *not yet mapped* their workforce for victim survivor identification and response, *nor* developed a MARAM Alignment Action Plan focused on embedding practices to respond to victim survivors, it is recommended you first familiarise yourself with the other SHRFV MARAM Alignment Resources (in particular those listed in the Introduction) and undertake the before mentioned tasks.

This resource is a *guide* and should not be considered prescriptive. Workforce mapping within hospitals and health services may differ across the sector depending on a variety of factors including:

- the clinical services delivered by the hospital/health service
- the workforce structure within the hospital/health service
- the unique settings of individual hospitals and health services
- the challenges faced by rural and regional health services.

Hospitals and health services have the discretion to lead and tailor the mapping process to their specific context and clinical practice environment. However, in doing so each *hospital/health service is responsible for ensuring their legislative requirements concerning alignment with the MARAM Framework are met.*

Determining how workforces are mapped requires executive oversight and input from leaders across the organisation. Workforce mapping should be a collaborative process undertaken with executive directors, directors, managers, and leaders from all departments of a hospital/health service.

Prior to undertaking this work, staff leading the mapping process within their organisation should read the updated Foundation Knowledge Guide and the Practice Guides for the 10 MARAM Responsibilities for working with adults who use family violence. The Practice Guides detail the key capabilities for working with adults who use family violence and should be used to inform decision making concerning mapping of departments and staff (and future policy and procedure development).[6]

What's not in scope?

Young people who use family violence

Family violence used by young people (for example adolescents) is a distinct form of family violence and requires a different service response to that for family violence used by adults. MARAM practice guidance for young people who use family violence is currently under development – hospitals and health services are not expected to embark on work in this area (workforce mapping, developing policies etc.) until further guidance from the Victorian Government is provided.

Embedding practices for working with adults who use family violence

This document does *not* provide guidance on the actions required to *embed practices* within your hospital/health service for working with adults who use family violence. Therefore, actions related to staff training and resourcing, clinical practice guidelines, etc that concern enabling your workforce to *implement* practices for responding to adults who use family violence are not in scope for this resource. (Please note the resource MARAM Adults Using Family Violence Practice Guides Organisational Readiness Checklist[7] can be referred to as an example of what actions *may* be required by organisational leaders).

It is recognised adults who use family violence may attend hospitals and health services as visitors. Please follow your organisation's policies and procedures and/or seek appropriate legal and/or policy advice when this arises.

Hospital and health service employees who use family violence

Hospital and health service employees who use family violence are *not* in scope for the work described in this document. This document is specific to hospital and health service patients and their families.

(Note that information and resources concerning hospital/health service staff use of family violence can be found on the SHRFV Family Violence Workplace Support Program Resources webpage).

Mapping MARAM Responsibilities for working with adults who use family violence at the *Organisation* and, *Department and Staff* levels

Overview

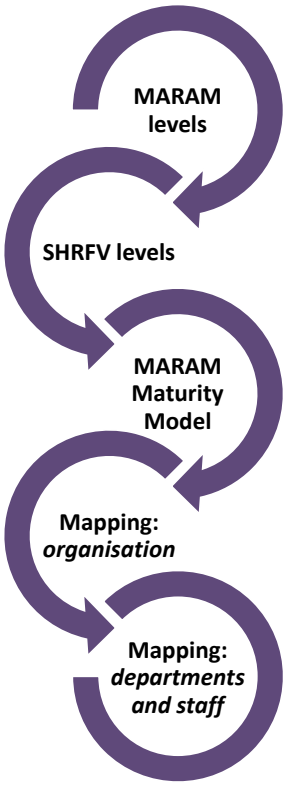
To meet their legislative requirements, hospitals and health services need to map MARAM Responsibilities for working with adults who use family violence at an:

1. *Organisational* level (hospital/health service)
2. *Department* and *Staff* level (within the organisation).

A *Mapping Overview model* for hospitals and health services is provided in Figure 2. This has been designed in recognition that hospitals and health services:

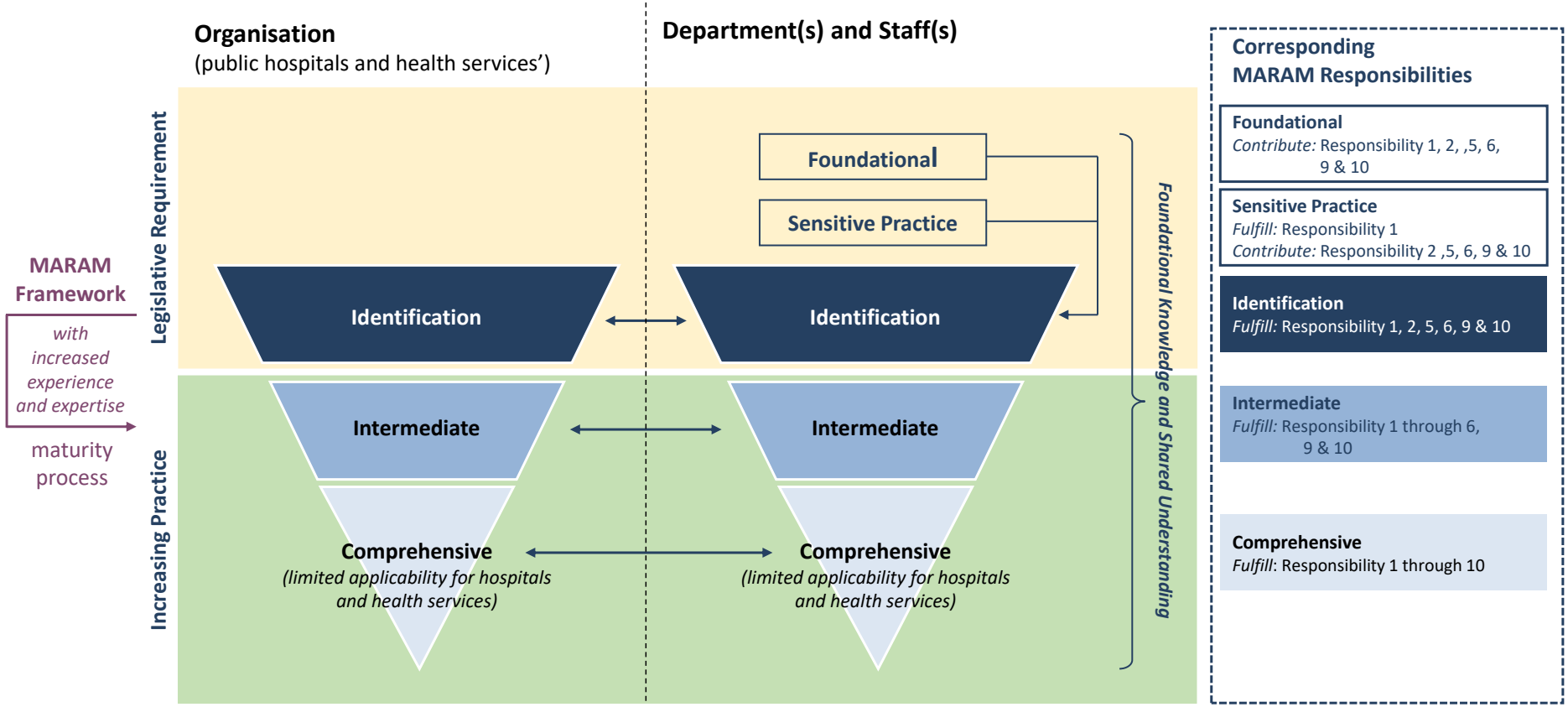
- are complex organisations that employ a wide range of staff (both clinical and non-clinical)
- vary in location – metropolitan, regional, and rural
- differ in many ways including:
    - size (from small to very large)
    - resourcing levels
    - experience and expertise in the area of working with adults who use family violence
    - referral and secondary consultation options available (both internal and external).

In summary, the Mapping Overview model (Figure 2) sets out Organisation and Department and Staff mapping to the three MARAM practice levels (Identification, Intermediate and Comprehensive) and the relationship between the two. For Department and Staff mapping, two additional levels are also outlined in the model – these being the SHRFV practice levels (Foundational and Sensitive). Figure 2 also illustrates the interrelationship between mapping organisational MARAM Responsibilities and mapping for individual departments and staff roles.



This document describes the MARAM and SHRFV practice levels in the context of working with adults who use family violence, then considers alignment to MARAM in the context of a *maturity model*, before detailing mapping at the *Organisation* and *Department* and *Staff levels*.

Figure 2: Mapping overview for hospitals and health services: working with adults who use family violence



Note: SHRFV Levels = Foundational and Sensitive Practice
MARAM Levels = Identification, Intermediate and Comprehensive Practice

MARAM practice levels

MARAM refers to three broad levels of response to family violence within the integrated service system:

1. Identification
2. Intermediate
3. Comprehensive

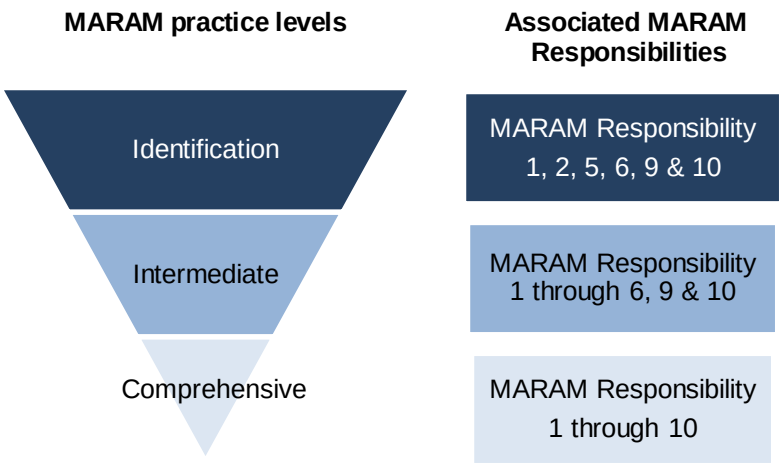
These are outlined in the resource titled MARAM Responsibilities decision guide for: Leaders of services engaging potential victim survivor or/and perpetrators in service delivery[8] *however, please note the following:

- while MARAM previously referred to *Identification* and *Screening*, this has been streamlined by Government in the revised version and is now referred to as *Identification* for both victim survivors and adults who use family violence
- *Comprehensive* has been used in this document to correspond with the MARAM Practice Guides.

(* You may also find it useful to refer to the older version of this document titled MARAM Responsibilities: Decision Guide for Organisational Leaders[9] which featured the four Tiers of workforces).

Each of the three MARAM practice levels (*Identification*, *Intermediate* and *Comprehensive*) correspond to a specified combination of the 10 MARAM Responsibilities for risk assessment and management – see Figure 3. Note that MARAM Responsibilities and resources are cumulative. This means the practice skills and knowledge are designed to build upon each other. This cumulative approach has been used to articulate SHRFV practice skills and knowledge in this document.

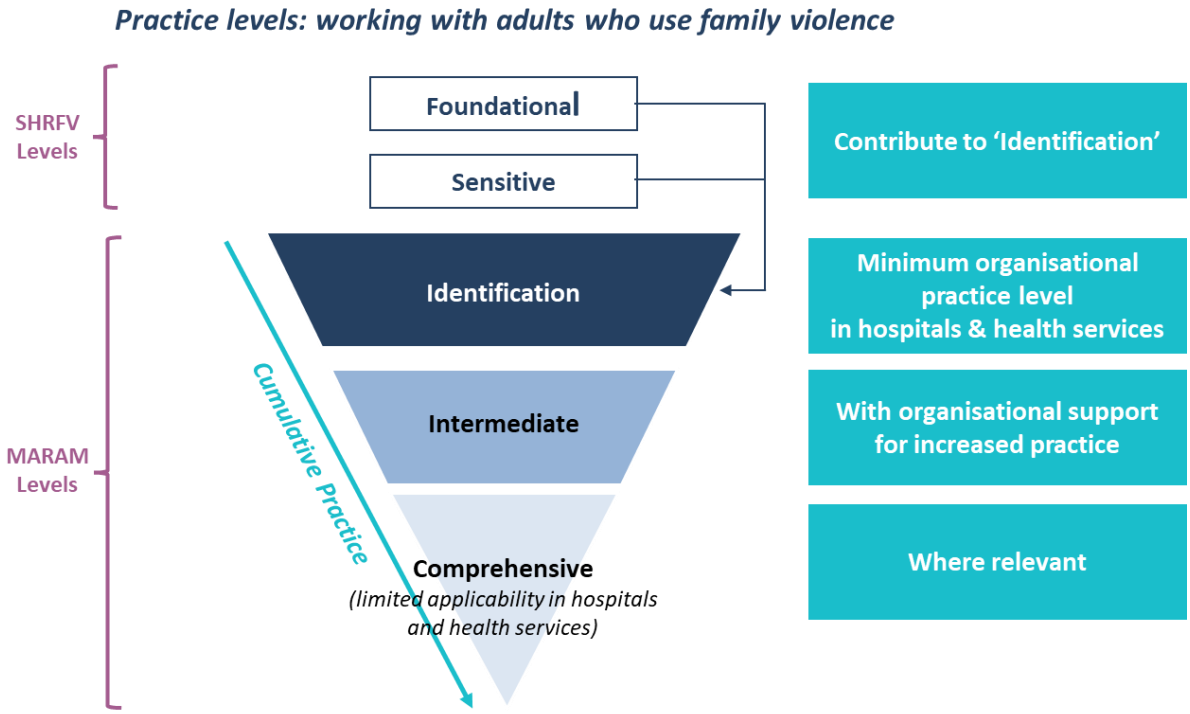
Figure 3: MARAM practice levels and the associated MARAM Responsibilities for working with adults who use family violence



SHRFV practice levels

In addition to the three MARAM practice levels (i.e. *Identification*, *Intermediate* and *Comprehensive*) there are two unique SHRFV practice levels – *Foundational* and *Sensitive.* The SHRFV practice levels only apply to mapping *Departments and Staff* (i.e. *not* organisations), and they are outlined in Figure 3.

Figure 3: MARAM and SHRFV practice levels for Departments and Staff (in hospitals and health services) for working with adults who use family violence



In preparation for Phase 2 MARAM prescription in April 2021, SHRFV developed an approach to MARAM workforce mapping which is unique to hospitals and health services. The SHRFV approach provides a framework which acknowledges the specific operating environment within SHRFV hospitals and health services and reflects the diversity of roles. To assist with this, a distinction is made between being assigned to perform and fulfill a MARAM Responsibility *or* contribute to a MARAM Responsibility. This approach was endorsed by Department of Health and Family Safety Victoria in May 2020 and used to map victim survivor practice expectations. For simplicity 'perform and fulfill' has been reduced to 'fulfill' in this document.

The updated SHRFV approach can be summarised as follows:

- staff mapped to contribute to a MARAM Responsibility are required to have an understanding and awareness of this responsibility and additionally, play a role in enabling others in the organisation to effectively fulfil this responsibility
- staff mapped to fulfill a MARAM Responsibility must be able to fulfill that responsibility in their everyday practice. This entails them having the required knowledge to competently perform the key capabilities associated with the assigned MARAM responsibilities tailored to their level.

This approach has been used to inform the understanding of practice expectations for working with adults who use family violence – see Figure 2 for details concerning the MARAM Responsibilities for *Foundational* and *Sensitive* practice in the context of working with adults who use family violence.

Process of alignment: MARAM maturity model

MARAM is a framework which is expected to be applied by way of a maturity model process and alignment to the MARAM Responsibilities for working with adults who use family violence should be seen as a maturity process. Guidance developed by Family Safety Victoria to support organisations to align with the MARAM Framework acknowledges that 'alignment is progressive, and will require change over time'.[10 p.25] At the time of writing Family Safety Victoria is developing a MARAM Maturity Model expected for completion in 2023 – 24.

Working with adults who use family violence is an emerging area of practice and implementation of this work within hospitals and health services will require significant cultural and practice changes, as well as system reforms. This will take time and effort to achieve. The implementation process should reflect an approach that is most appropriate for each organisation's unique operating environment, resources, and current level of maturity.

It is recommended the response to victim survivors is well established within your hospital or health service before commencing work to establish practices for working with adults who use family violence. Maintaining a victim survivor lens, which prioritises the safety and needs of victim survivors, is essential when engaging with a person who uses violence.

It is not expected that hospitals and health services would begin to establish this practice unless they have the resources and capabilities to do so. Furthermore, staff should not be expected to undertake this work until the necessary infrastructure and support are in place, including policies, procedures, tools, partnerships, training, resources and leadership support.

The MARAM maturity model means that whilst hospitals and health services must meet the legislative requirement for working with adults who use family violence, there is the potential to progress to a higher level of engagement with adults who use family violence when the organisation is confident that the literacy and capability required to underpin a higher level of practice has been achieved (see Figure 2).

Note: it is not a requirement to progress beyond the assigned responsibilities at *Identification* practice level, however if a hospital/health service decides to increase the minimum practice level at which the organisation is mapped, then the decision must be linked to a clear rationale, associated literacy within the organisation and be accompanied by a communication strategy.

Safety consideration

Staff should not be expected to undertake work with adults who use family violence until the necessary infrastructure and support is in place, including policies, procedures, tools, partnerships, training, resources, and leadership support.

The decision to progress to a higher practice level with adults who use family violence must be linked to a clear rationale, associated organisational literacy, training, and support and be accompanied by a communication strategy.

Ensuring the necessary infrastructure is in place when undertaking work with adults who use family violence is essential to enable safe, sensitive and respectful engagement.

Mapping at the *Organisational* level

Minimum requirements for *Organisational* mapping concerning working with adults who use family violence should reflect the main function of the hospital and health service sector. Universal health services' primary function within the service system is to provide health care; however, it is understood they can also be an early contact point for adults who use family violence.

When considering *Organisational* mapping to the three MARAM practice levels outlined in Figure 3 (i.e. *Identification*, *Intermediate* and *Comprehensive*), the primary function of hospitals and health services corresponds to the *Identification* practice level. This recognises that for hospitals and health services who are universal services, their primary role and function is not related to family violence risk, but rather to provide health care.

As indicated on the previous page, hospitals and health services may decide to map their organisation at a higher level than the minimum *Identification* practice level based on the type of services the organisation offers and increased experience and expertise in working with adults who use family violence (see Figure 2).

This is particularly the case where a hospital or health service has a department(s) and/or staff engaging with adults who use violence at an *Intermediate* practice level and they are supported to meet the associated MARAM Responsibilities – i.e., MARAM Responsibility 1 through 6, 9 & 10 (see Figure 2). Examples of the *Department(s)* and/or *Staff* positions where this might apply may include Social Work, Alcohol and Other Drugs (AOD) and Mental Health services.

Of note, mapping to the *Comprehensive* practice level is only appropriate for services that:

- in a specialist capacity, work with adults who use family violence, directly addressing their use of violence and supporting them to take responsibility for changing their behaviour
- are mandated or funded to provide specialist family violence case management, crisis support or family violence therapeutic interventions for adults using violence.

It is not anticipated that many hospitals or health services will be mapped at the *Comprehensive* practice level, however, should this arise, the organisation must meet MARAM Responsibilities 1 through 10 for working with adults who use family violence. (Example would be where a hospital or health service provide family violence specialist services such as men's behaviour change programs).

Minimum mapping for hospitals and health services at the *Organisational* level

At a minimum, to fulfill their legislative requirements for working with adults who use family violence, hospitals and health services must be mapped at the MARAM *Identification* practice level. At a minimum hospitals and health services must have Foundational Knowledge and meet MARAM Responsibilities 1, 2, 5, 6, 9 & 10 for working with adults who use family violence.

How does adults who use family violence mapping compare with victim survivor mapping at an *Organisational* level?

This document outlines the minimum legislative requirements for hospitals and health services working with adults who use family violence, that is, *Identification* practice level. It is likely organisations are already mapped at *Intermediate* practice level for responding to victim survivors as hospitals and health services have had more time to engage with victim survivor work, therefore victim survivor work is well established in hospitals and health services.

Hospitals and health services may choose to map their organisation (and *Departments* and *Staff*) at the same MARAM practice level for working with adults who use family violence as they do for responding to victim survivors. It must be understood, however, that if this decision is taken, this would result in the organisation committing to a higher level of responsibility for working with adults who use family violence than is required to meet their minimum legislative requirements (see Figure 2).

Who makes the decision concerning *Organisational* mapping?

Decisions concerning *Organisational* mapping should be made by the executive leadership group within the hospital/health service and informed by consultation with department(s) leaders and staff from across the

hospital/health service. This will include consultation with both clinical and non-clinical departments e.g. environmental services, maternity services, and allied health.

Mapping *Departments* and *Staff*

In addition to mapping their organisation, hospitals and health services need to consider how specific *Departments* and *Staff* are mapped in relation to working with adults who use family violence (see Figure 2).

Department and *Staff* mapping incorporates the three MARAM practice levels used for *Organisational* mapping (i.e. *Identification*, *Intermediate* and *Comprehensive*) as well as the two unique SHRFV practice levels – *Foundational* and *Sensitive*. The MARAM Responsibilities associated with each practice level is outlined in Table 1 below.

Table 1: MARAM Responsibilities associated with the practice levels for Departments and Staff mapping: working with adults using family violence

Practice level		Responsibilities
SHRFV	Foundational	Foundational Knowledge *Contribute* to Responsibility 1, 2, ,5, 6, 9 & 10
	Sensitive	Foundational Knowledge *Fulfill* Responsibility 1 *Contribute* to Responsibility 2 ,5, 6, 9 & 10
MARAM	Identification	Foundational Knowledge *Fulfill* Responsibility 1, 2, 5, 6, 9 & 10
	Intermediate	Foundational Knowledge *Fulfill* Responsibility 1 through 6, 9 & 10
	Comprehensive	Foundational Knowledge *Fulfill* Responsibility 1 through 10

When mapping *Departments and Staff* the following should be noted (see Figure 2):

- the two SHRFV practice levels are designed to account for mapping the many professionals and staff within a hospital or health service whose role is either:
    - not patient-facing, or
    - primarily associated with the presenting need – that is health care.
    - Staff mapped at the SHRFV practice levels may observe behaviour or receive direct disclosures in relation to adults who use family violence, but they are not responsible for engaging with a person who uses family violence, in relation to their use of family violence.
- To meet the minimum organisation practice level of *Identification*, hospitals and health services must ensure *Departments* and *Staff* mapped at *Foundational* and *Sensitive* practice level have access to a Department(s) or Staff mapped at *Identification* practice level.
- A hospital/health service *may* map a/some *Department(s) or Staff* at an *Intermediate* practice level if they are supported and resourced to meet the associated MARAM Responsibilities.
- It is not anticipated that many hospitals and health services will have *Departments or Staff* mapped at the *Comprehensive* practice level, however, should this arise, the appropriate staff must be supported and resourced to meet the associated MARAM Responsibilities (see section Mapping at the Organisational level for further information on the *Comprehensive* practice level).

- In general, the highest level at which any *Department(s)* and *Staff* are mapped should equate to the level at which the organisation is mapped.

How does mapping adults who use family violence compare with victim survivor mapping at the *Department* and *Staff* level?

The main difference is that the SHRFV practice level *Screening* used for victim survivor mapping has been removed from the practice levels for working with adults who use family violence (and from the practice guides by Government) as routine screening for adults who use family violence is not appropriate and should not be used. In hospitals and health services, the SHRFV practice level *Screening* is primarily used in services required to undertake routine antenatal screening and is predominantly performed by midwives. Therefore, it is suggested that *Departments* and *Staff* mapped at the *Screening* practice level for responding to victim survivors be mapped at *Sensitive* practice level for working with adults who use family violence.

Similar to mapping for victim survivor work please note the following:

- you may distinguish between mapping departments and staff to allow a more nuanced approach – see Supporting Resource A - Workforce Mapping for MARAM Alignment[3] for further details
- clinical staff within the department who engage closely with patients should be assigned to the *Sensitive* practice level whilst non-clinical staff (e.g. Clerical staff) in this department be assigned to the *Foundational* practice level
- not every staff member within the department must be mapped to the practice level at which the department is mapped. For example, an administrative worker in a clinical team is unlikely to engage with patients, so mapping this staff member at the *Foundational* practice level, irrespective of where their department is mapped, is appropriate.

Safe engagement with adults who use family violence

Safe engagement with a person who uses family violence keeps them in view of the system to monitor their risk, address needs that may be contributing to their use of violence and encourages disclosure through rapport building. It is important to recognise that engagement with adults who use family violence can increase the risk for victim survivors when not done safely, sensitively in an appropriate setting by staff with the required knowledge and skills. All engagement with adults who use family violence aims to keep victim survivors safe.

The practice level at which staff are mapped influences the level of engagement they are required to have with adults who use family violence. Whether an adult who uses family violence makes a direct disclosure of family violence will also influence the level of engagement required. Note, a direct disclosure of use of violence is when a person is aware they are using family violence.

Below is a summary of safe engagement at all levels of working with adults who use family violence.

Foundational and Sensitive practice level

Staff mapped at *Foundational* and *Sensitive* practice level **<u>are not</u>** required to ask direct questions about observed indicators of use of family violence *or* in response to a direct disclosure of use of family violence.

They should only respond respectfully to a direct disclosure of use of family violence and know who to refer the person to internally for the presenting issue they raised.

It is important to note that *'it is more likely that you will have concerns that family violence is occurring based on the service user's narrative, presentation and disclosed behaviours, rather than a direct disclosure of family violence perpetration.'* [11 p.40]

Identification practice level

Staff mapped at *Identification* practice level have a role in identifying whether family violence is present. They are not required to assess the level of risk, its impacts, or to directly intervene with a person using family violence (unless required by the use of code grey/black). Staff at this level of practice should only ask direct questions about observed narratives and/or behaviours or in response to a direct disclosure if:

- 'it is relevant to the primary purpose of their engagement with you (for example, it relates to a presenting need or circumstance that is relevant to your service)
- each of you know they (the service user [patient/person]) are using family violence, for example:
    - they are attending your service due to a related referral or court order *or*
    - they have directly disclosed they are aware they are using family violence (as opposed to disclosure of behaviours that they are not aware are family violence)
- you can do so in a non-confrontational or non-accusatorial manner, ensuring your communication is respectful and curious to minimise feelings of mistrust or shame, reducing the likelihood they become defensive or escalate their risk to the victim survivor'. [11 p.38]

Intermediate practice level

Staff mapped at *Intermediate* practice level have responsibilities to ask questions to support undertaking an *Intermediate* risk assessment (which may be undertaken by external specialist services), such as engaging in a conversation to:

- Uncover a person using family violence's 'understanding and narrative about themselves and their presenting needs'
- 'Build an understanding of how the person using violence views themselves in their context'
- 'Link presenting needs to the impact on relationships and identity, open a conversation about family violence behaviours and encourage disclosure of family violence perpetration (if present)'
- 'Support a conversation to uncover information about their underlying beliefs, attitudes and accepted norms that contribute to their intention or choice to use family violence behaviours'
- 'Support early conversations about readiness and motivation to address presenting needs and/or use of family violence, and connect to specialist perpetrator intervention services'.[12 p.66]

Comprehensive practice level

Staff mapped at *Comprehensive* practice level have responsibilities to engage and undertake direct comprehensive assessment of risk and needs to support behavior change for the person using violence. The practice guidance for staff mapped at *Comprehensive* practice level is available from FSV.

For further details about effective engagement please refer to the MARAM Practice Guides: Guidance for professionals working with adults using family violence.

Developing a *Workforce Mapping Document*

A *Workforce Mapping Document* can be developed to represent how each department and staff position within a hospital/health service is mapped against the MARAM practice levels (*Identification, Intermediate,* and *Comprehensive*) and the 10 MARAM Responsibilities for working with adults who use family violence. Appendix 1 provides two examples for hospitals and health services to consider as they produce their own *Workforce Mapping Document* – one for an organisation mapped at *Identification* practice level (minimum requirement), the other for an organisation mapped at *Intermediate* practice level (more advanced practice).

In seeking endorsement regarding how the workforce is mapped for working with adults who use family violence, it is recommended that hospitals/health services take a similar approach to that used when mapping the workforce for responding to victim survivors. This can be summarised via the steps below.

1. Undertake a consultation process with department leaders and staff (including how this work intersects with victim survivor mapping) to develop the recommendations which will be put forward in the *Workforce Mapping Document.*
2. Ensure the *Workforce Mapping Document* is reviewed by the appropriate strategic advisory and operations groups.
3. Provide the reviewed *Workforce Mapping Document* to senior executives for their endorsement – senior leaders should also be given the opportunity to be briefed individually prior to the document being presented for final endorsement.
4. Present the final *Workforce Mapping Document*, along with an accompanying pre-prepared briefing paper, to the hospital's/health services' Chief Executive Officer and executive leaders for endorsement.

Further details about the approach taken when mapping the workforce for responding to victim survivors, which may be useful for mapping concerning working with adults who use family violence, can be found in the following resource Supporting Resource A - Workforce Mapping for MARAM Alignment.[3]

Practice knowledge and skills for working with adults who use family violence

The MARAM Practice Guides explore in depth the key capabilities for each of the 10 MARAM Responsibilities for working with adults who use family violence. The guides should be used by hospitals and health services to inform action planning (when this commences) related to building workforce capability to ensure staff have the required knowledge and skills to meet their responsibilities under MARAM.

Table 2 (below) details the following:

- *key capabilities* from each of the 10 MARAM Practice Guides for working with adults who use family violence[6]
- *recommended practice knowledge and skills* required of *Foundational* and *Sensitive* practice level staff where they are mapped to *contribute* to a MARAM Responsibility. (Note: where staff are mapped to fulfill a MARAM Responsibility the expectation is they will meet the key capabilities of the corresponding MARAM responsibility in full).

Also see Appendix 2 which provides scenarios demonstrating the practical application of the required knowledge and skills for *Foundational* and *Sensitive* practice level.

Table 2: Practice knowledge and skills for working with adults who use family violence

Responsibility	Key capabilities	***Recommended* practice knowledge and skills to *contribute* to the responsibility** ***(ONLY Foundational and Sensitive practice level)***
Foundation Knowledge Guide	• Awareness of the MARAM Framework and hospitals and health services role in an effective system wide response to family violence. • Awareness of the Victorian legislative environment relevant to family violence. • Awareness of the evidence-based family violence risk factors across age groups, communities and relationships. • Understand the gendered nature and dynamics of family violence.	All staff are required to have knowledge of the content covered in the *Foundation Knowledge Guide* to support a shared understanding of family violence across the service system (updated version including people who use family violence). This knowledge can be imparted through family violence training.

Responsibility	Key capabilities	*Recommended* practice knowledge and skills to *contribute* to the responsibility *(ONLY Foundational and Sensitive practice level)*
Responsibility 1: Respectful, sensitive and safe engagement	• Respectful, sensitive and safe engagement as part of Structured Professional Judgement. • How to facilitate an accessible, culturally responsive environment for safe disclosure of information. • How to prioritise the safety and needs of victim survivors when engaging with a person who uses violence. • How to tailor safe engagement with Aboriginal people and people from diverse communities. • The importance of using a person in their context approach. • Recognising and addressing barriers that impact a person's help-seeking for their use of violence and the safety of their family members. • Safe engagement to build rapport and avoid collusion with people you suspect or know are using family violence.	Staff mapped at *Foundational* practice level *contribute* to Responsibility 1 by: • Communicating respectfully with a person who may be using family violence and addressing the patient's presenting healthcare needs, *not the person's use of family violence.* • Understanding it is not their role to engage with a person using family violence *around their use of violence* as engagement can increase risk for a victim survivor when not done safely, sensitively, and competently in an appropriate setting. • Having knowledge of and complying with the organisation's code black and code grey procedures. • Responding to immediate risk through internal escalation processes. Staff mapped at *Sensitive, Identification, Intermediate* and *Comprehensive* practice level must be able to competently *fulfill all key capabilities of Responsibility 1.*
Responsibility 2: Identification of family violence risk	• Understanding how to identify indicators a person is likely to be using family violence by observation of common narratives and behaviours, including denial, minimisation, justification and externalisation of responsibility for violence. • Understanding when it is safe to ask about presenting needs and circumstances, with awareness that they may be linked to likelihood, change or escalation of family violence risk behaviours. • Using information gathered through engagement with service users and other providers via information sharing, to identify observable narratives and behaviours indicative of family violence perpetration and potentially identify people using, or	Staff mapped at *Foundational* and *Sensitive* practice level, *contribute* to Responsibility 2 by: • Understanding how to identify indicators a person is likely to be using family violence. • Knowing who, internally, to share information with if an indicator a person is likely to be using family violence is *observed.* • Knowing how to respond sensitively if a person using family violence makes a *direct disclosure* of their use of violence and know who to refer the person to within the organisation.

Responsibility	Key capabilities	*Recommended* practice knowledge and skills to *contribute* to the responsibility *(ONLY Foundational and Sensitive practice level)*
	suspected to be using, family violence. Responsibilities 5 and 6 discuss information sharing laws and practice in more detail.	In addition to the skills and knowledge above, staff mapped at *Sensitive* practice level also *contribute* to Responsibility 2 by: • Documenting indicators that a person may be using family violence, as per minimum requirements for documenting in a Health record (use of the Identification Tool is not required at this level). • Engaging the victim survivor, or with services working with them (where consent is provided, as required) to support victim survivors' (adults and children) safety, where safe and appropriate to do so. Staff mapped at *Identification, Intermediate* and *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 2.
Responsibility 3: Intermediate risk assessment	• Asking questions to obtain information related to risk factors. • Using the model of Structured Professional Judgement in practice. • Using intersectional analysis and inclusive practice. • Using the Adult Person Using Violence Intermediate Assessment Tool. • Understanding how observed narratives and behaviours and presenting needs or circumstances link to evidence-based risk factors. • Forming a professional judgement to determine the level or seriousness of risk, including 'at risk', 'elevated risk' or 'serious risk'/'serious risk and requires immediate protection/intervention'.	Only staff mapped at *Intermediate* and *Comprehensive* practice level are required to *fulfill* key capabilities of Responsibility 3.

Responsibility	Key capabilities	*Recommended* practice knowledge and skills to *contribute* to the responsibility *(ONLY Foundational and Sensitive practice level)*
Responsibility 4: Intermediate risk assessment	• Understanding and aligning your actions with existing risk management strategies and, where safe and appropriate to do so, engaging the victim survivor themselves, or with services working with them (where consent is provided, as required). Services include specialist family violence services, therapeutic, advocacy and professional services. • Where safe and appropriate to do so, working with the person using violence to develop a Safety Plan based on their presenting needs and circumstances and disclosed family violence behaviours and risk. • Developing a Risk Management Plan targeted at addressing the person's use of family violence risk behaviours, including coercive controlling behaviours, and related presenting needs. This is undertaken in collaboration and coordination with specialist family violence services, targeted services or other professionals working with the person using violence and/or adult or child victim survivor/s. • Responding to the assessed level of risk presented by the person using violence, including serious and immediate risk. • Documenting evidence of family violence and risk management responses. • Monitoring behaviour, change in risk and collaborating and sharing information with other parts of the system. • Reporting any breaches of a family violence intervention order or other family violence crimes to police.	Only staff mapped at *Intermediate* and *Comprehensive* practice level are required *fulfill* key capabilities of Responsibility 4.

Responsibility	Key capabilities	*Recommended* practice knowledge and skills to *contribute* to the responsibility *(ONLY Foundational and Sensitive practice level)*
Responsibility 5: Seek consultation for comprehensive risk assessment, risk management and referrals	• Seek internal supervision through their service or organization. • Consult with family violence specialists to collaborate on risk assessment and risk management for adult and child victim survivors and perpetrators. • Make active referrals for comprehensive specialist responses, if appropriate.	Staff mapped at *Foundational* and *Sensitive* practice level *contribute* to Responsibility 5 by: • Seeking internal support if an indicator a person is likely to be using family violence is *observed.* • Seeking internal support if a person *directly discloses* that they are using family violence. Staff mapped at *Identification, Intermediate* and *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 5.
Responsibility 6: Contribute to information sharing with other services (as authorised by legislation)	• Proactively share information and make requests seeking relevant to the assessment and management of family violence risk, including under the FVIS Scheme, privacy law or other authorisation at law. • Proactively share information relevant to broader safety and wellbeing issues for children using the CIS Scheme. • Respond to requests to share information from other services.	Staff mapped at *Foundational* and *Sensitive* practice level *contribute* to Responsibility 6 by: • Being aware of the Child Information Sharing Scheme (CISS) and Family Violence Information Sharing Scheme (FVISS). • Being aware of their organisations FVISS and CISS policy and procedure. • Knowing where in the organisation to refer requests for information under the FVISS and CISS. In addition to the skills and knowledge above, staff mapped at *Sensitive* practice level also *contribute* to Responsibility 6 by: • Ensuring the patient record is up to date and documenting any indicators a person may be using family violence, as per minimum requirements for documenting in a Health record (use of the Identification Tool is not required at this level). Staff mapped at *Identification, Intermediate* and *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 6.

Responsibility	Key capabilities	*Recommended* practice knowledge and skills to *contribute* to the responsibility *(ONLY Foundational and Sensitive practice level)*
Responsibility 7: Comprehensive risk assessment	Practice guide only available to specialist services.	Only staff mapped at *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 7.
Responsibility 8: Comprehensive risk management	Practice guide only available to specialist services.	Only staff mapped at *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 8.
Responsibility 9: Contribute to coordinated risk management	• Contribute to coordinated risk management as part of a multi-disciplinary and multi-agency approach. This includes proactively requesting and sharing relevant information to facilitate coordinated risk management (refer also to Responsibility 6). • Have an ongoing role in collaboratively monitoring, assessing and managing risk over time including identifying any changes in the assessed level of risk. This includes ensuring the Risk Management and Safety Plan for the person using violence responds to escalation of risk and changed circumstances. • Participate in joint action planning, coordination of responses and collaborative action including enacting and monitoring the Risk Management and Safety Plan of the person using violence. This includes proactive engagement with the person using violence across organisations and practitioners in order to work towards sustained risk reduction over time.	Staff mapped at *Foundational* and *Sensitive* practice level *contribute* to Responsibility 9 by: • Having an awareness of MARAM and the health sector's role in an effective system wide response to family violence. • Participating in internal meetings, as relevent to their role, where site-specific risk assessment is undertaken in relation to anticipated, or an escalation of violence from a person using family violence. Staff mapped at *Identification, Intermediate* and *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 9.

Responsibility	Key capabilities	*Recommended* practice knowledge and skills to *contribute* to the responsibility *(ONLY Foundational and Sensitive practice level)*
Responsibility 10: Collaborative for on-going risk assessment and management	Work collaboratively with other professionals and services to ensure ongoing monitoring, assessment and management of risk over time to identify changes in patterns of coercive controlling behaviour and assessed level of risk and ensure risk management and safety plans are responsive to changed circumstances, including escalation.	Staff mapped at *Foundational* and *Sensitive* practice level *contribute* to Responsibility 10 by: • Following the organisation's procedure for identifying and responding to family violence or the equivalent procedure in their work unit or area for working with adults who use family violence (when available). In addition to the skills and knowledge above, staff mapped at *Sensitive* practice level also *contribute* to Responsibility 10 by: • Ensuring the patient record is up to date and documenting any indicators a person may be using family violence, as per minimum requirements for documenting in a Health record (use of the Identification Tool is not required at this level). Staff mapped at *Identification, Intermediate* and *Comprehensive* practice level must be able to competently *fulfill* all key capabilities of Responsibility 10.

Appendices

Appendix 1: Examples for hospitals and health services to consider as they produce their own Workforce Mapping Document

Two examples of workforce mapping for *Departments* and *Staff*, according to the 10 Responsibilities under MARAM for working with adults using family violence:

1. Broad organisation level mapped at *Identification*
2. Broad organisation level mapped at *Intermediate*

Example one: Broad organisation level mapped at *Identification*

Please note the example below is a *sample only* and is included as an example for mapping a generic hospital, in recognition that this is emerging practice in hospitals and health services.

Key:

Practice level	
Foundational	
Sensitive	
Identification	
Intermediate	
Comprehensive	

Staff groups	
Contribute to responsibility	
Fulfill responsibility	

Staff groups assigned to contribute to a MARAM Responsibility are required to have an understanding of this practice and contribute to others in the organisation effectively fulfilling this responsibility.

Staff groups assigned to fulfill a MARAM Responsibility are required to competently fulfill the associated key responsibilities in their everyday practice.

Department and practice level	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
Allied Health and Clinical Support Services												
Social Work	Social Work Manager											
	Social Workers											
Language Services	Interpreters – internal											
	Interpreters – agency											
Disability Liaison Service	Operations Manager											
	Disability Liaison Officer											

Department and practice level	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
Radiology/Ultrasound	Radiologists											
	Radiographers											
	Sonographers											
	Midwives											
	Nurses											
Aged Care Assessment Service	Manager											
	ACAS assessors											
	Senior clinicians											
	Administration staff											
Pharmacy	Pharmacists											
	Pharmacy technicians											
	Food Services Assistants											
Pathology	Pathologists											
Clinical Operations												
Emergency Department Department	Doctor/medical											
	Psych liaison											
	Registrar											
	Associate Nurse Manager											
	Care Coordinator											
	Nurse Practitioner											
	Clinical Nurse Consultant											
	Clinical Nurse Specialist											
	Medical Imaging Technologist											
	Ward clerk											
	Personal service assistant											
	Security											
	Cleaners											
General Ward	Associate Nurse Manager											
	Clinical Coordinator											
	Clinical Nurse Specialist											
	Enrolled Nurse Med Endorsed											
	Registered Nurse											
	Health Assistant											
	Ward Clerk											
	Cleaners											

Department and practice level	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
Adult Community Mental Health	Manager											
	Coordinator											
	Forensic Clinical Specialist											
	Clinical Psychologist											
	Senior Mental Health Clinician											
	Lead Clinician Social Worker											
	Social Worker											
	Lead Clinician Nurse											
	Registered Nurse											
	Clinician Occupational Therapist											
	Community Engagement Worker											
	Administration Support											
Psychiatry Adult	Clinical Manager											
	Senior Clinical Psychologist											
	Clinical Specialist											
	ECT Coordinator											
	Nurse Unit Manager											
	Social Worker											
	Enrolled Nurse											
	Registered Nurse											
	Occupational Therapist											
	Administration Support											
Maternity Services	Medical Staff											
	Midwives											
	Nurse Practitioner											
	Child birth education											
	Lactation Consultants											
	Diabetes Educators											
Drug Health Services	Dual diagnosis clinician (medical)											
	Psychologists											
	Counsellors											
	Social Worker											
	Case worker											
	Administration staff											
	Ward clerk											
	Auxiliary support											

Example two: Broad organisation level mapped at *Intermediate*

Please note the example below is a *sample only* and is included as an example for mapping a generic hospital, in recognition that this is emerging practice in hospitals and health services.

Key:

Practice level	
Foundational	
Sensitive	
Identification	
Intermediate	
Comprehensive	

Staff groups	
Contribute to responsibility	
Fulfill responsibility	

Staff groups assigned to contribute to a MARAM responsibility are required to have an understanding of this practice and contribute to others in the organisation effectively fulfilling this responsibility.

Staff groups assigned to fulfill a MARAM responsibility are required to competently fulfill the associated key responsibilities in their everyday practice.

Department and practice level	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
Allied Health and Clinical Support Services												
Social Work	Social Work Manager											
	Social Workers											
Language Services	Interpreters – internal											
	Interpreters – agency											
Disability Liaison Service	Operations Manager											
	Disability Liaison Officer											
Radiology/Ultrasound	Radiologists											
	Radiographers											
	Sonographers											
	Midwives											
	Nurses											
Aged Care Assessment Service	Manager											
	ACAS assessors											
	Senior clinicians											
	Administration staff											

Department and practice level	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
Pharmacy	Pharmacists											
	Pharmacy technicians											
	Food Services Assistants											
Pathology	Pathologists											
Clinical Operations												
Emergency Department Department	Doctor/medical											
	Psych liaison											
	Registrar											
	Associate Nurse Manager											
	Care Coordinator											
	Nurse Practitioner											
	Clinical Nurse Consultant											
	Clinical Nurse Specialist											
	Medical Imaging Technologist											
	Ward clerk											
	Personal service assistant											
	Security											
	Cleaners											
General Ward	Associate Nurse Manager											
	Clinical Coordinator											
	Clinical Nurse Specialist											
	Enrolled Nurse Med Endorsed											
	Registered Nurse											
	Health Assistant											
	Ward Clerk											
	Cleaners											

Department and practice level	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
Adult Community Mental Health	Manager											
	Coordinator											
	Forensic Clinical Specialist											
	Clinical Psychologist											
	Senior Mental Health Clinician											
	Lead Clinician Social Worker											
	Social Worker											
	Lead Clinician Nurse											
	Registered Nurse											
	Clinician Occupational Therapist											
	Community Engagement Worker											
	Administration Support											
Psychiatry Adult	Clinical Manager											
	Senior Clinical Psychologist											
	Clinical Specialist											
	ECT Coordinator											
	Nurse Unit Manager											
	Social Worker											
	Enrolled Nurse											
	Registered Nurse											
	Occupational Therapist											
	Administration Support											
Maternity Services	Medical Staff											
	Midwives											
	Nurse Practitioner											
	Child birth education											
	Lactation Consultants											
	Diabetes Educators											
Drug Health Services	Dual diagnosis clinician (medical)											
	Psychologists											
	Counsellors											
	Social Worker											
	Case worker											
	Administration staff											
	Ward clerk											
	Auxiliary support											

Appendix 2: Case scenarios of Foundational and Sensitive practice level knowledge and skills

Case scenario: Foundational practice level

Matias (62 years old) is attending the Oncology clinic for treatment with his wife Luciana. Joan is a volunteer at the hospital, and part of her role is to offer tea and coffee to patients while they wait for their appointments. While in the waiting room, Joan overheard the following conversation between Matias and Luciana:

Matias: '*Where were you this morning?'*

Luciana: '*I went to the chemist. I needed to refill my prescription, I told you I was going.*'

Matias: '*No you didn't, I don't care what you need, I don't want you going anywhere without me.'*

Joan noticed that Luciana became visibly upset.

Matias: '*You're so sensitive to everything.'*

The statements made by Matias may indicate common narratives and behaviours that reflect violence-supporting beliefs.

Joan is concerned about the conversation and reports the information to the nurse in charge of the clinic and/or her supervisor.

Case scenario: Sensitive practice level

Ahmed and Makena's son Khalid has recently been diagnosed with Cerebral Palsy. Makena has Monoplegia and can't move her left arm. They have attended the hospital for a routine out-patient appointment for Khalid.

During the consultation with paediatrician Fiona, Ahmed made the following comments during the consultation.

> *'I'm annoyed. The Physiotherapist has given us all these stretching exercises to do daily with Khalid, and I know Makena hasn't been doing them right, and its why Khalid isn't improving. She never does anything right when it comes to looking after the kids.'*

Fiona also observed that when Makena began talking, Amhed would talk over her or speak on her behalf.

This statement and behaviour made by Ahmed may indicate common narratives and behaviours that reflect violence-supporting beliefs.

A statement such as '*she never does anything right when it comes to looking after the kids'* criticises a partner's parenting and indicates an attitude that the partner is 'lesser than' the person who uses family violence. This indicates a belief by the person using family violence that they are entitled to hold power over the victim survivor.

For a person with a disability this narrative can take advantage of the lived experience of discrimination by people with a disability where their parenting capacity may have been questioned and can be used by an adult using family violence as a tactic for coercive control.

Interrupting, correcting and/or dominating a victim survivor in a conversation may indicate an adult who may be using family violence believes they have a right to control.

After the consultation Fiona contacted the Social Work department to advise of the interaction and her observations. Fiona also sought advice from the social worker about how to document the encounter safely in Khalid's medical record.

Resources informing the development of this document

- Family Violence Workplace Support Program Resources
- MARAM practice guides and resources
- MARAM practice guides: Foundation knowledge guide
- MARAM practice guides: Guidance for professionals working with adults using family violence
- SHRFV MARAM Alignment Resources
- SHRFV Resource Centre

Relevant legislation

- *Family Violence Protection Act 2008*

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