Antenatal screening for family violence

Implementation guide

Prepared by the Strengthening Hospital Responses to Family Violence (SHRFV) leadership team

Document purpose and rationale

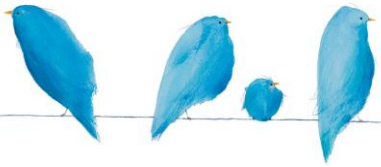
The Antenatal screening for family violence implementation guide ("implementation guide"), forms part of the broader suite of screening for family violence in antenatal care resources, which now forms part of the 5th edition of the SHRFV Toolkit. This implementation guide is designed to be a practical resource for project managers, clinicians and others, either planning or refining a model of antenatal screening for family violence. Hospitals and health services will be in scope for alignment to the Multi-Agency Risk Assessment and Management (MARAM) Framework, and this guide and associated resources have embedded best-practice MARAM screening and identification tools. This guide is not intended to be prescriptive, and acknowledges that establishing and resourcing a sustainable model of screening in antenatal clinics takes time, and will look different in different antenatal clinics.

The implementation guide complements the Antenatal Screening for family violence Evidence Brief ("evidence brief"), which is designed to be a high level, accessible brief of relevant international and Australian research. The evidence brief forms the best practice framework for the Implementation Guide, and the implementation guide describes the translation of evidence into clinical practice.

This guide forms part of a suite of resources that have been developed to support implementation of a MARAM-aligned antenatal screening for family violence. Below is an outline of the resources and the target audiences.

Project team	Clinicians	Training
• Evidence brief • Implementation guide	• Clinical practice guideline • Flowchart • Sample screening tool • Pregnancy support cards	• eLearn module • Face to Face training • Case studies

This Implementation Guide, Evidence Brief and associated tools have been endorsed by the Department of Health and Human Services, Recommendation 96 Team and Family Safety Victoria (November 2020).



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Is antenatal screening part of the Strengthening Hospital Responses to Family Violence (SHRFV) initiative?

In 2016, the Royal Commission into Family Violence ("The Commission") made 227 recommendations to improve Victoria's responses to family violence. The Strengthening Hospital Responses to Family Violence (SHRFV) initiative is Recommendation 95, and was funded in 2017. The funding was for four years, to implement a whole-of-hospital approach to the identification and response to family violence. The need for routine screening for family violence in public antenatal clinics was identified in Recommendation 96. [i]

In 2020, the Department of Health and Human Services (DHHS) funded the SHRFV leadership team to develop an education package for antenatal services which aligned with the Multi-Agency Risk Assessment and Management (MARAM) Framework, to support the implementation of safe routine screening for family violence in antenatal clinics, and to ensure training and practice expectations are aligned to the MARAM Framework. [ii]

Antenatal screening for family violence resources will now be a specialist resource within the 5th edition of the SHRFV toolkit. [iii]

Who is responsible for the implementation of antenatal screening for family violence within each health service?

The responsibility for the implementation of antenatal screening for family violence needs to be clearly agreed and articulated in each health service. Governance is important, and may sit with existing SHRFV team governance, MARAM alignment governance structures and/or maternity service directorates.

It is important to consider sustainability of this project, as it is anticipated that SHRFV funding may cease in June 2021.

What if we already have an embedded model of antenatal screening, do we need to make changes?

It is important to note that many antenatal clinics have well established screening for family violence models in place, whilst some are yet to begin. For those settings with a well-established model, it is important to review this for MARAM alignment and make any changes necessary for this to occur, to ensure questions and screening practice is aligned to the MARAM framework and practice guidance

What is the best practice approach to routine screening for family violence in antenatal care?

It is important to understand the definition of screening in a hospital and family violence identification context when considering the implementation of routine screening for family violence in antenatal care. Screening, in a health context, has a specific meaning. The definition of screening in health according to the Victorian Government is:

- A test offered to all individuals in an eligible or target group.
- The group is eligible because there is strong scientific evidence that they are at most risk and will get the most health benefit from screening.
- For a screening program to succeed there must be evidence that early diagnosis and treatment increases the chance of successfully treating or managing the disease.[iv]

SHRFV do not recommend routine screening be implemented across all areas of the hospital, or across all patient cohorts. International evidence does not support the screening of all individuals for family violence who present to hospitals. There is evidence, however, that screening women in antenatal clinics may be beneficial due to pregnancy being a high risk time for family violence, and the length of time antenatal staff work with women.

The SHRFV approach to the screening and identification of family violence is that the Sensitive Practice model – which prompts a sensitive inquiry about family violence based on clinical indicators – should be used in all settings, and that routine screening should be implemented only in antenatal clinics.

The SHRFV approach to antenatal screening for family violence which is aligned to MARAM emphasises that it is important to ensure the minimum requirements for a safe screening program are met. These requirements are:

- All women are screened alone in a safe and private environment
- Staff screen women sensitively with a trauma and violence informed model of care
- Antenatal screening processes are aligned with the Multi-Agency Risk Assessment and Management (MARAM) Framework. including MARAM responsibilities 1,2, 5,6, 9, and 10
- Appropriate referral pathways exist, and staff are confident in referring women for further support
- Staff receive training and reflective practice opportunities tailored to their specific role in antenatal screening
- Screening and disclosure rates are in line with best practice evidence

What guidance does the MARAM framework and Screening and identification tool offer?

In Victoria, the MARAM Framework provides guidance for the screening and identification of family violence. It emphasises that identification and screening may be performed by a number of health professionals, on multiple occasions of service, throughout the health care intervention. MARAM also distinguishes between settings in which routine inquiry is mandated (such as antenatal care), and settings where inquiry is based on clinical indicators of violence (the broader health service).

Key things to consider include:

- In service settings such as antenatal clinics where a person has multiple contacts, MARAM suggests that best practice is to screen over time, and review at each contact to ensure any changes in the relationship or use of violence is identified.
- Screening involves asking questions defined in a ‘tool’ to enable a person to disclose whether they are experiencing family violence. The questions are designed to identify information about evidence-based family violence risk factors.
- The purpose of the Screening and Identification Tool is to identify:
    - If family violence is occurring
    - The victim survivor’s level of fear for themselves or another person

- The person using violence/perpetrator. [v]

What are the MARAM Responsibilities for Antenatal Services staff?

Under MARAM the Responsibilities relevant for Screening are:

Responsibility 1.	Respectful, sensitive and safe engagement
Responsibility 2.	Identification of family violence risk
Responsibility 5.	Seek consultation for comprehensive risk assessment, risk management and referrals
Responsibility 6.	Contribute to information sharing with other services (as authorised by legislation)
Responsibility 9.	Contribute to coordinated risk management
Responsibility 10.	Collaborate for ongoing risk assessment and risk management

It is recommended that all clinical Antenatal staff are required, at a minimum, to align to the Screening practice expectations as outlined in the Workforce Mapping for MARAM Alignment resource in the SHRFV toolkit. Specifically, this requires them to perform and fulfil Responsibility 1 and 2, and contribute to Responsibility 5, 6, 9, and 10. This means antenatal staff will engage respectfully, sensitively and safely, and undertake sensitive enquiries of patients to identify if family violence is occurring. The MARAM evidence-based screening tool will guide this work, and assist in referring for support. Antenatal staff also need be aware of, and contribute to, the organisation's responsibility to share information, refer for specialist support and collaborate at a multi-agency level.

It is important to ensure that screening for family violence in antenatal care is mapped clearly in your hospital's ***Workforce Mapping document***. Associated actions required to facilitate any change in culture or practice should also be included in your ***MARAM Alignment Action Plan***. This includes updates to policies, procedures, training needs, communication strategy and changes to clinical systems and infrastructure. This will ensure that staff are clear about practice expectations, and that the organisation can meet their responsibilities under MARAM.

What screening tool should we use?

It is strongly recommended that the MARAM Screening tool be utilised for antenatal screening for family violence. This will not only ensure alignment with the MARAM framework, and assist your organisation in meeting your legislative requirements under MARAM, but will also ensure consistency of tools across your organisation. It is important to note that all hospitals which deliver antenatal and/or maternity services also deliver many other streams of care. The MARAM screening tool can be used in all settings, but utilised differently in each setting. For example, a nurse in an emergency department, on the basis of clinical indicators of family violence, will ask the same evidence-based MARAM screening questions to commence a sensitive inquiry, as will a midwife who asks the same questions routinely of all antenatal patients.

The MARAM screening tool has also been embedded into all SHRFV statewide resources for antenatal screening and is listed below:

1. Has anyone in your family done something that made you or your children feel unsafe or afraid? (Are there multiple perpetrators?)
2. Have they controlled your day-to-day activities (e.g. who you see, where you go) or put you down?

3. Have they threatened to hurt you in any way?
4. Have they physically hurt you in any way? (hit, slapped, kicked or otherwise physically hurt you) [vi]

The following immediate risk questions should be used if family violence is identified via the screening questions above:

5. "Do you have any immediate concerns about the safety of your children or someone else in your family?"
6. "Do you feel safe to leave here today?"
7. "Would you engage with a trusted person or police if you felt unsafe or in danger?

What screening process should we use?

While there are universal considerations when deciding which screening approach to take (please see the Evidence brief for further detail on these considerations such as screening tool, timing, frequency, face-to-face vs digital or paper-based methods), it is very important to consult with clinicians and managers about what will work in your specific setting. Some questions to consider include:

- What is the main record of information and is this electronic or paper-based?
- How long are your consultations across the whole pregnancy journey, is there enough time in the booking in appointment to incorporate screening for family violence?
- What models of care does your maternity service offer? i.e. GP Shared Care, Koori Maternity Services or Midwifery Group Practice? Where in the pregnancy journey will these women be screened?
- Does your hospital use the Birthing Outcomes System (BOS) or have you transitioned to an Electronic Medical Record (EMR) or is your organisation paper-based?
- Are you able to consider implementing Dedicated Consultation Time in your clinic, and
- if not how will you assist midwives and doctors to create a safe environment for family violence screening?

It is very important to consider some of these procedural elements of the antenatal screening for family violence process prior to piloting or training staff.

What are the minimum requirements for screening?

As per the WHO Clinical Handbook (2013) minimum standards for family violence inquiry, screening should only occur when:

- a woman is on her own and partners and/or other family members (above the age of 2 years) are not in the room
- With an official interpreter if required[vii]

What is Dedicated Consultation Time and how does it work?

The biggest barrier to screening routinely for family violence in antenatal clinics is the presence of a partner, support person or child above the age of two. Dedicated Consultation Time (DCT) is an effective way to manage the presence of others in antenatal appointments.

The term 'Dedicated Consultation Time' refers to a brief period of the antenatal clinic appointment where the woman is seen on her own by the clinician midwife without a support person/s accompanying her. This principle is consistent with the World Health Organization (WHO) Clinical Handbook minimum standards for family violence inquiry, which is that women are alone when this occurs.[viii] Dedicated consultation time is recognised as an important component of screening for family violence in an antenatal care setting, as it is not safe to ask family violence questions when women are in the presence of others. This practice is also identified and supported in MARAM.

Dedicated Consultation Time (DCT) also allows for other sensitive areas of women's health to be openly discussed, relevant to a woman's antenatal care, such as sexual health, contraception and abortion history. It is a standard component of other women's health areas, used in areas such as family planning and contraception, sexual health and abortion care.

DCT is an important part of ensuring that all women can be screened safely for family violence, although careful consideration must be made about how this is implemented in different hospitals. There are many considerations including but not limited to:

- Which appointment, or when in the pregnancy journey can DCT be utilised?
- Can any information be removed from an appointment, to ensure that clinic consultation times are maintained?
- Should DCT be used at the beginning, middle or the end of a consultation?
- How is DCT communicated to staff, women, partners and other family members?
- How can staff be trained about how to introduce DCT and manage any women or partners who object?

Practice example at The Women's Hospital

When screening was piloted at The Women's Hospital in 2018 -19, women could not be screened due to a partner being present in 62% of cases at one site, and 37% at another. As a result of this, Dedicated Consultation Time (DCT) was introduced to provide formalised protected time in which to screen for family violence.

At The Women's, DCT is integrated into the pregnancy journey during the first ten minutes of the booking in appointment. Women are advised when they arrive for their appointment that it is standard practice that women meet with the midwife for the first 10 minutes alone, at which point the partner or support person is invited to join the consultation. This was a significant practice change for midwives, who were very concerned that partners would not respect this policy, and that it could be viewed as inconsistent with family-centred care. Despite this concern, since DCT was routinely introduced in July 2019, midwives have found the practice supported by the majority of women and partners, with very few partner's/support persons objecting to the practice.

Although Women's staff are advised that dedicated consultation time be standard practice for all women in their first antenatal visit, if enforcing this practice will jeopardise a woman's safety, then it can be attempted again in subsequent clinic visits, and/or the woman referred to social work for further assessment and management.

Alternative methods which may support privacy to screen include:

- Asking the partner to leave the appointment early to make the next appointment
- Asking the woman to leave for a short period, while information on parenting is provided to the partner, then asking the partner to leave and conducting the screen for family violence
- Feigning a physical examination
- Asking the woman to accompany the midwife for a urine test, and screening in another clinic location[ix]

While these methods are often utilised, they do not provide a routine method to ensure screening is conducted for all women attending an antenatal clinic.

How can we screen for family violence in different populations?

There are some groups of women and communities that are known to experience additional barriers to safety leading to increased risks of family violence including;

- Aboriginal and Torres Strait Islander women
- Women from culturally and linguistically diverse communities
- Women in rural communities
- Women living with Disabilities
- Women experiencing mental health issues
- Gay, lesbian, bisexual, transgender and intersex people

Women from these groups are often at higher risk of experiencing family violence due to structural inequality and discrimination, including, but not limited to patriarchy, colonisation, racism, sexism, ableism, ageism, homophobia and transphobia. These factors may limit a woman's ability to disclose and understand their experiences of family violence and access resources for support. A woman may identify with more than one of these high risk groups.

Taking an intersectional approach to antenatal screening will allow hospital staff to understand how a woman's identities may overlap and create structural inequality, barriers or discrimination that exacerbate the impacts of their experience of family violence risk and the actual or potential barriers to accessing supportive responses.

When using an intersectional approach, it is important to be aware that all people, including clinicians, have biases. All staff in antenatal care should be supported, with reflective practice and supervision, to recognise their own biases in their approach to family violence identification and screening. Staff may be conscious or unconscious of the biases they hold. Bias can occur when this experience and understanding leads to assumptions about individual people or communities based on their circumstances, personal attributes, behaviour and background.[x]

Women who are from culturally and linguistically diverse (CALD) backgrounds should be offered culturally appropriate processes and communication strategies, including appropriately qualified interpreters.. Partners, children or other family members should not be used as interpreters. It is recommended that patient education materials be translated into the top community languages in your catchment. [xi]

How can family violence screening be conducted for Aboriginal and Torres Strait islander women?

It is important to understand that family violence is not normal or customary in Aboriginal or Torres Strait Islander communities. Despite underreporting, Aboriginal and Torres Strait Islander women are disproportionately impacted by family violence. Family violence is perpetrated against Aboriginal and Torres Strait Islander women by both non-Aboriginal and Aboriginal people at significantly higher levels than experienced by non-Aboriginal women. Family violence perpetrated against Aboriginal and Torres Strait Islander people and communities includes a range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur in families, intimate relationships, extended families, kinship networks and communities.[xii]

Aboriginal and Torres Strait Islander women may face barriers to reporting and disclosing family violence, and in finding appropriate responses and support. These barriers may include, but are not limited to, intergenerational trauma, removal of children, previous experiences of discrimination and historic and ongoing systemic oppression. Women should be offered choices in who they would like involved in their care and provided with culturally appropriate referral options including both Aboriginal-specific and mainstream services.

It is important to note that indigenous populations globally experience higher levels of domestic violence; however, their decision to disclose may be influenced by multiple factors including, in particular, cultural safety as well as concerns of perpetrator awareness, and safety from shame and institutional control. [xiii]

Screening programs should be sensitive to these cultural considerations, and responses to Aboriginal and Torres Strait Islander women who disclose family violence during screening need to be appropriate to the woman and her community.[xiv]

In other jurisdictions, supports have been implemented to address cultural safety. For example, in Queensland, Aboriginal and Torres Strait Islander women attending antenatal care may be accompanied by a support person whose presence during screening may be deemed appropriate.[xv]

What is reproductive coercion and how can it present as part of screening for family violence?

In the maternity setting it is important that staff are aware of reproductive abuse as another form of violence against women. This type of abuse is defined as a deliberate attempt to influence or interfere with a woman's reproductive autonomy and decision making. It most commonly presents in either the use of violence or coercion to force a woman to become pregnant against her will, or attempting to control a pregnancy outcome by forcing a woman to terminate a wanted pregnancy or continue an unwanted one. [xvi]

Reproductive abuse can be associated with intimate partner violence, however it may also exist in relationships where no other forms of violence are present. In addition, although it is most commonly perpetrated by a partner or ex-partner, other family members can also be perpetrators. These factors can make it difficult to identify.

Currently there is limited research to inform best practice specific to reproductive abuse. Despite this, the same principles of safely recognising and responding to family violence should apply. Like family violence, responding to this type of abuse can be difficult and complex. The available options will be

different for each woman, also their feelings about the pregnancy may change over time. Clinicians should be aware of the risk that continuing the pregnancy may trigger or escalate other types of family violence.

Acknowledging that reproductive abuse exists and validating a woman's experience will help to build therapeutic relationships where a woman feels safe and supported to discuss her concerns. Understanding reproductive abuse allows clinicians to better address a woman's need for contraception and promote her reproductive autonomy. Also, to appreciate the complex feelings that a woman may have about the pregnancy or them self.[xvii]

Are psychosocial models of screening effective?

You may like to consider collaboration with specialised services to develop a psychosocial model. This is an opportunity for a streamlined approach to identifying other needs during pregnancy. These services may include mental health, alcohol and other drugs, or legal needs. Screening for perinatal depression using the Edinburgh Postnatal Depression Scale has been integrated into many antenatal settings over a long period of time. Integrating family violence screening as a psychosocial domain may be easier if midwives are already familiar with screening for mental health concerns.[xviii]

What training is required to support antenatal screening for family violence?

Under MARAM all staff have a role in contributing to their organisation's whole of hospital response to family violence and meeting their legislative requirements to respond to family violence. The SHRFV training modules, which includes an antenatal screening for family violence eLearn supplementary module, are designed to build a whole-of-hospital shared understanding of family violence. The antenatal screening eLearn supplementary module covers the practice expectations for staff mapped at Sensitive Practice and Screening. The SHRFV modules complement the external MARAM training for staff mapped at Intermediate and Comprehensive level of response.

While training the workforce to build capacity and capability is a critical element of the SHRFV approach, and aligning to MARAM, it should not occur until the infrastructure such as policies, procedures and partnerships are in place to support the role of health professionals. This will ensure that health professionals can respond effectively to family violence disclosures.

It is important to note that the SHRFV antenatal screening for family violence supplementary eLearn module will provide an overview of the best evidence for screening practice, as well as alignment to MARAM. It is critical that each health service tailor the practical aspects of their own screening model, as well as referral pathways and tailor face-to-face training to support implementation of antenatal screening at each hospital.

When delivering face to face training for antenatal screening it is strongly recommended that trainers undertake relevant MARAM training when this is available for phase two organisations (hospitals). It may also be useful to co-facilitate training sessions with either a Clinical Support Midwife or a representative from your hospitals Clinical Education Team.

What about digital screening and electronic medical record considerations?

It is important that antenatal screening is integrated into medical records to meet legal and clinical documentation standards, but also to ensure clear communication of screening and when this has been completed. Many Victorian health services have or are moving towards electronic clinical platforms, and may have an EMR in situ, in development or a blend of systems (paper-based, Digital Medical Record, Scanned Record, Birthing Outcomes System). It is important to consider how clinicians will use these systems, and how screening data can be captured.

How can antenatal screening models be evaluated?

Health services are encouraged to evaluate their antenatal screening processes. This would be best conducted as part of a broad system wide evaluation to enable sustained screening in antenatal care.[xix] In 2019/20 a System Audit Tool is being trialled across 18 Victorian health services, which measures indicators across patient, staff and organisational domains.

An effective way to measure effectiveness in the patient domain of identification, response and referral is to conduct clinical audits of a random sample of patient files once a year, or a report run via an electronic clinical platform. Depending on the size of your clinic, a good number to audit is 50 files.[xx] These can then be used to assess the effectiveness of the program and if any changes need to be considered. It is also important to feed this data back to clinic staff. Feedback loops are one of the most effective agents of change, and regular data that is collected each year ensures that quality and progress can be tracked over time.

To determine if the antenatal screening process has been successful specific indicators of success should be incorporated into any evaluation framework on an annual basis. These should include:

- Policy and procedure in place for screening and response
- Referral pathways developed and reviewed
- Percentage of current clinic staff trained
- Percentage of women attending antenatal clinic screened (should be above 80%)[xxi]
- Percentage of disclosures made (should be between 5 – 10%, the usual prevalence)[xxii], [xxiii]
- Percentage of referrals made and referrals attended by patients

Antenatal screening for family violence: implementation checklist

Implementation consideration	Resources
Have all antenatal staff been mapped to MARAM practice expectations, and understand their role in antenatal screening and family violence identification and response?	Please see SHRFV ***Workforce Mapping document,*** on the SHRFV Resource Centre.
Are policy, procedure, and/or clinical practice guidelines in place and aligned to MARAM?	Please see sample ***Antenatal screening for family violence Clinical Practice Guideline.***
Does my organisation set clear expectations for when women will be screened? For example: • All women screened at booking in • Ask all women at booking in, 28 weeks and 36 weeks?	Please see Antenatal screening for family violence ***Evidence Brief*** for guidance on best practice screening.
Is the MARAM screening and identification tool used?	Please see ***MARAM Practice Guide Responsibility 2: Identification of family violence risk***,
Is the infrastructure in place to support safe antenatal screening for family violence? - Are there enough private spaces for inquiry? - Does my organisation have a formal policy of Dedicated Consultation Time? - Are qualified interpreters used and available?	Please see information on Dedicated Consultation Time in ***The Women's Antenatal Screening for family violence Practice Example.***
Are all antenatal staff (including midwifery, medical and administrative staff) trained in family violence identification and response appropriate to their MARAM practice expectations?	Please see ***Antenatal screening for family violence eLearn supplementary module*** and ***face-to-face Antenatal screening for family violence training*** module, case studies
Are referral procedures (internal and external) in place and communicated to all antenatal staff?	Please see ***Antenatal screening for family violence: response options.***
Are processes for recording screening practice, and any disclosures clearly articulated?	Ensure screening practice is integrated into the medical record

Are pregnancy support cards provided to all women attending antenatal care to ensure universal education for family violence and other psychosocial support services?	Please see ***Pregnancy Support cards*** on the SHRFV Resource Centre
Are Family violence clinical champions available to support clinic staff and provide information?	Please see ***Clinical Champion*** resources on the SHRFV Resource Centre
Is the antenatal screening for family violence program evaluated, and changes made if required?	Please see ***evaluation resources*** on the SHRFV Resource Centre, and Family Safety Victoria resource ***Review implementation activities - MARAM framework***

Further implementation resources

Australian Research

Sustainability of identification and response to domestic violence in antenatal care: The SUSTAIN Study

The SUSTAIN Study provides an evidence base for ways to improve and sustain practices to identify and respond to domestic violence in complex healthcare settings. The research draws on the experiences of women and practitioners in six antenatal hospital clinics across Victoria and New South Wales. Their responses emphasise the importance of building relationships with pregnant women during the screening process.

At the heart of SUSTAIN is the REAL Transformation model. REAL is a relationship-based model which promotes woman-centred, holistic and tailored care by antenatal health care services. It promotes an environment conducive to relationship building and engagement of women to facilitate domestic violence screening and response. It addresses practical actions a workplace can take to be supportive to its health practitioners. The model also promotes reflection and learning to build sustainable systems for meeting the health, safety and recovery needs of women, children and their families who are experiencing domestic violence.

The ***SUSTAIN research report*** can be found here:

https://www.anrows.org.au/project/the-sustain-study/

The ***REAL transformation model*** of antenatal screening, as well as videos and practical scripting for clinicians can be found here:

https://www.dvhealthtools.com/

Australian Policy

- ***Pregnancy Care Guidelines, Australian Government, Department of Health***

The guidelines and related documents summarise the available evidence on many aspects of antenatal care and have been designed to improve the experience and outcomes of pregnancy care for Australian women and their families. The Pregnancy Care Guidelines have been developed to provide a reliable and standard reference for health professionals providing antenatal care.

Routine screening for family violence is recommended within the Pregnancy Care Guidelines, and recommendations about how this can be achieved are included in the guidelines, as well as a downloadable fact sheet.

Pregnancy Care Guidelines can be found here:

https://www.health.gov.au/resources/pregnancy-care-guidelines

Social and emotional screening – fact sheet for health professionals can be found here:

https://www.health.gov.au/resources/publications/social-and-emotional-screening

Victorian Policy

❖ ***Victorian Royal Commission into Family Violence***

In 2016, the Victorian Royal Commission into Family Violence made 227 recommendations to improve Victoria's responses to family violence. Recommendation 1, 95 and 96 are most relevant to this work.

Recommendation 1: The Victorian Government review and begin implementing the revised Family Violence Risk Assessment and Risk Management Framework (known as the Common Risk Assessment Framework, or the CRAF) [by 31 December 2017] in order to deliver a comprehensive framework that sets minimum standards and roles and responsibilities for screening, risk assessment, risk management, information sharing and referral throughout Victorian agencies. The revised framework should incorporate: a rating and/or weighting of risk factors to identify the risk of family violence as low, medium or high evidence-based risk indicators that are specific to children comprehensive practice guidance. The framework should also reflect the needs of the diverse range of family violence victims and perpetrators, among them older people, people with disabilities, and people from Aboriginal and Torres Strait Islander, culturally and linguistically diverse and lesbian, gay, bisexual, transgender and intersex communities.

Recommendation 95: The Victorian Government resource public hospitals to implement a whole-of-hospital model for responding to family violence, drawing on evaluated approaches in Victoria and elsewhere [within three to five years].

Recommendation 96: The Department of Health and Human Services require routine screening for family violence in all public antenatal settings. The screening guidance should be aligned with the revised Family Violence Risk Assessment and Risk Management Framework. Implementation will require targeted and continued training, the development of specific guidelines, and clinical support [by 31 December 2017].

Australian jurisdictions

❖ **Queensland**

QLD Domestic and Family Violence Toolkit

Queensland Health's **Domestic and Family Violence Toolkit** of resources for health workers was developed in 2016 to help health workers to use sensitive inquiry to safely and appropriately recognise, respond, and refer to suspicions and disclosures of domestic and family violence.

This resource includes practical tools for health professionals working in antenatal care, including policy and procedures on routine screening for domestic and family violence, as well as training resources and antenatal specific training videos.

The QLD ***Domestic and Family Violence Toolkit*** can be found here:

https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence/healthcare-workers

❖ **New South Wales**

NSW Domestic Violence Routine Screening Program

The NSW **Health Domestic Violence Routine Screening Program** is an early identification and intervention strategy to promote awareness of the health impact of domestic violence, ask questions about patients' safety in relationships and the safety of their children, and to provide information on relevant health services for victims.

Detailed information on the Domestic Violence Routine Screening Program, including the rates and outcomes of routine screening, are reported every year in the Domestic Violence Routine Screening Snapshot Report.

Further information about the NSW ***Routine Screening Program*** can be found here:

https://www.health.nsw.gov.au/parvan/DV/Pages/dvrs.aspx

❖ **Western Australia**

Strengthening antenatal responses to family and domestic violence

The Strengthening Antenatal Responses to Family and Domestic Violence (FDV) project is a result of WA Labor's election commitment to stopping family and domestic violence, and has a specific focus on embedding routine screening for FDV in all public antenatal settings.

For more information on the program, please email the project team on whcsp@health.wa.gov.au

General information about the program can be found here:

https://www.kemh.health.wa.gov.au/Our-services/Service-directory/Womens-Health-Strategy-and-Programs/Antenatal-Responses

Other relevant resources

❖ **World Health Organization**

WHO (2014) Health care for women subjected to intimate partner violence or sexual violence. A Clinical Handbook.

https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/

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[iii] Strengthening Hospital responses to Family Violence (SHRFV) 2020. A toolkit for health practioners. https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/shrfv-resource-centre/ [retrieved 30 August 2020]

[iv] Whole of Victorian Government website, [retrieved 22 September 2020] https://www2.health.vic.gov.au/public-health/population-screening

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