Identifying and Responding to Family Violence Procedure: Foundational Practice

1. Background

The hospital system is an early contact point for many people who have experienced family violence. Creating a safe environment can reduce the barriers for victim survivors to disclose their concerns and be a catalyst for action. An empathetic and professional response from a trusted healthcare professional can reinforce a victim survivors understanding that they are entitled to healthy relationships and a life free from violence. By respecting their decisions and offering a range of options, [insert org name] has a vital role in ensuring that a patient’s health needs are met, inclusive of their safety. Such interventions have the potential to not only empower people affected by family violence but to also contribute to enhanced health outcomes.

1. Purpose

This procedure outlines [insert org name]’s expectations and processes for staff mapped at Foundational Practice level to identify and respond to family violence in line with the Victorian Government’s Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM).

Throughout a patient’s journey should they choose to disclose family violence staff who operate at a Foundational Practice level can respond by offering to connect the patient to support through their treating team through which they can be provided a pathway to specialist family violence support. In addition it is expected that if staff observe a sign or indicator of family violence or if a disclosure is made and the patient is not wanting to discuss this with their treating team, the staff member will notify the appropriate staff member as outlined in this procedure.

As child abuse and neglect often occurs within the context of family violence, it is required that all staff responding to family violence are also familiar with the [insert org name] Child Safe Standards. This will support staff to identify children and young people who are at risk of harm.

It is recommended that this guideline is read in conjunction with:

* [Insert relevant Identifying and Responding to Family Violence policy]
* [Insert relevant Child Safe Standards]
* [Insert relevant organisation Information Sharing policy and procedures]

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| Implementation considerationHospitals and health services may also determine that this procedure is relevant to some clinical staff. It may be useful to outline in this section which staff groups this procedure is relevant to.  |

1. Definitions

[Insert org name] uses the following operational definition of family violence:

Family violence is defined by the [Family Violence Protection Act 2008 (Vic)](http://www5.austlii.edu.au/au/legis/vic/consol_act/fvpa2008283/) as behaviour that occurs in family, domestic or intimate relationships that is:

* Physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive; or is in any other way controls or dominates and causes a person to feel fear for their safety or wellbeing or that of another person.
* Causes a child to hear or witness, or otherwise be exposed to the effects of the behaviour.

The act recognises that family violence can occur in family relationships between spouses, domestic or other current or former intimate partner relationships , in other relationships such as parent/carer–child, child–parent/carer, relationships of older people, siblings and other relatives, including between adult-adult, extended family members and in-laws, kinship networks and in family-like or carer relationships

The Victorian Indigenous Family Violence Task Force (2003) defines family violence in the context of Aboriginal communities as:

* An issue focused around a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide.’ The definition also acknowledges the spiritual and cultural perpetration of violence by non-Aboriginal people against Aboriginal partners which manifests as exclusion or isolation from Aboriginal culture and/or community.

The Dhelk Dja (2018) definition of family violence also acknowledges:

* The impact of violence by non-Aboriginal people against Aboriginal partners, children, young people and extended family on spiritual and cultural rights, which manifests as exclusion or isolation from Aboriginal culture and/ or community.
* Elder abuse and the use of lateral violence within Aboriginal communities. It also emphasises the impact of family violence on children.
* That the cycle of family violence brings people into contact with many different parts of the service system, and efforts to reduce violence and improve outcomes for Aboriginal people and children must work across family violence services; police, the justice system and the courts; housing and homelessness services; children and family services; child protection and out-of-home care; and health, mental health, and substance abuse.
* The need to respond to all forms of family violence experienced by Aboriginal people, children, families and communities.
1. Responsibilities

MARAM outlines 10 responsibilities for risk assessment and management which combine to create an effective response to family violence across the integrated service system and cover all aspects of practice. The practice expectations outlined in this procedure align to the MARAM Identification level of response tailored to the health non-clinical operating environment, referred to as Foundational Practice. At a Foundational Practice level staff are required to competently perform and fulfil MARAM responsibility 1, and contribute to responsibilities 2,5,6,9 & 10.

Appendix 1 provides further information about the MARAM responsibilities and practice expectations for non-clinical staff.

Alignment to MARAM includes contributing to information sharing with other services as permitted by legislations. Foundational Practice staff contribute to their organisation meeting their information sharing and privacy legislative obligations through having an awareness of relevant information sharing legislations and through proactively sharing information about a disclosure or observed sign or indicator of family violence with the appropriate staff member as outlined in this procedure.

Relevant policies and procedures:

* [Insert relevant organisation Information Sharing policy and procedures]
1. Procedure: Respectful, sensitive and safe engagement
	1. Shared understanding of family violence

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# A shared understanding of the nature and dynamics of family violence underpins a respectful, sensitive and safe engagement with patients. As such, it is the expectation that all staff will have completed Foundational Practice training [insert link to training]. Staff can also refer to the [MARAM practice guides foundational knowledge](https://www.vic.gov.au/maram-practice-guides-and-resources) for more information.

# Due to structural inequalities and discrimination, some people and communities are known to experience additional barriers to safety leading to increased risks of experiencing family violence including;

* Women in pregnancy and early motherhood
* Aboriginal and Torres Strait Islander women
* Women from culturally and linguistically diverse communities
* Women in rural communities
* Women living with a disability
* Older women
* Women experiencing mental health issues
* Gay, lesbian, bisexual, transgender and intersex people

All staff are responsible for facilitating an appropriate, accessible, culturally responsive environment for all patients. This is to ensure that at any point in a patient’s journey they feel safe to make a disclosure of family violence and receive a response that is respectful, sensitive and safe and can access support to enhance their safety. Safely and respectfully responding to the individual’s culture and identity includes:

# Asking about a person’s identity

# Upholding all peoples right to receive a culturally safe and respectful service

# Ensuring a patient’s identity and experience is not challenged or denied

# Showing respect for their culture

# Practitioners are mindful of one’s own potential biases and how it may influence their practice.

# The environment is one where the patient feels safe and respected to talk about their experience of family violence

# Responses are tailored to the individual’s identity and needs

# Barriers to accessing appropriate support are acknowledged and addressed

# Recognising a patient as the expert in their own experience and response are client led; this includes respecting an Aboriginal and Torres Strait Islander’s right to self determination

# Staff should refer to the [MARAM practice guides foundational knowledge](https://www.vic.gov.au/maram-practice-guides-and-resources) for further information relating to the key concepts for practice for responding to different groups and recognising and addressing barriers to accessing support for different communities. Staff should also be guided by [insert org name]’s policy and procedures regarding cultural safety [insert link].

# Any engagement of patients/family/carers/visitors who may be a perpetrator must occur safely and not collude or respond to coercive behaviours. Staff should not engage with a person directly about family violence if they are suspected of perpetrating family violence, unless trained. This is because confrontation and intervention may increase risk for the victim survivor. Engagement with patients/family/carers/visitors who may be a perpetrator needs to be respectful and the support provided to needs not around their use of violence. Staff should also consider obligations to share information in line with [insert org information sharing procedures].

* 1. Responding to disclosures of family violence

How staff who operate at a foundational level respond to a patient’s disclosure of family violence is crucial to eliciting feelings of safety, respect and control for the patient. The following principles should be used as a guide to respond to a patient’s disclosure. These have been drawn from the World Health Organisation (2013) LIVES model:

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| LISTEN: | Listen to the person with empathy and without judging |
| VALIDATE: | Show that you understand and believe them.Use statements such as: ‘I’m sorry that has happened to you’ or ‘I can hear that you are concerned about how your partner behaved towards you. |
| ENHANCE SAFETY and SUPPORT: | Support them to make their own decisions by providing information (such as a brochure) and offering a referral to the appropriate internal supports. Use statements such as ‘I want to make sure you get the support you need. I can help by connecting you to support through your treating team. Would you like me to do that?’ |

**Remember: You are not expected to be a family violence expert and there is no expectation for you to engage in a conversation or inquire any further. Only to respond respectfully and sensitively and refer.**

# If a disclosure of family violence is made you must respond by offering to connect the patient to support through their treating team and then escalate this to an appropriate staff member. Staff who operate at a Sensitive Practice level have been trained in first line identification and response and can provide a pathway to specialist support services. An example of an appropriate staff member to escalate to includes but is not limited to:

# The patient’s primary nurse

# The patient’s treating doctor

# Associate Nurse/Midwife Unit Manger

# Nurse Unit Manager

# Social Worker

If a disclosure of family violence is made and the patient does not wish to discuss this further with their treating team you must let them know that you have a responsibility to tell an appropriate staff member about the disclosure. Reassure the patient that any follow up or immediate action will only occur with their knowledge. Any action taken in relation to their disclosure should always be with the patient’s informed knowledge and led by the patient’s views and wishes.

In these cases, you are required to inform an appropriate staff member. You should provide them information about the interaction and information disclosed so they can determine if further action is required.

Responding to family violence can be challenging, and staff wellbeing is a priority of [insert org name], therefore it is important that you seek internal supervision from your manager after responding to a patient experiencing family violence.

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| Implementation considerationThe purpose of including the responsibility of staff at Foundational Practice level to inform the appropriate staff member if the patient does not wish to discuss the disclosure further with their treating team, is to ensure the staff member is supported and the patient is provided the appropriate support. This process will ensure there is the appropriate oversight if further action is required, so the responsibility does not sit with the individual staff member. The procedure should outline who the appropriate staff member/s within each department. |

* 1. Responding to the signs of family violence

It is important for staff to be aware of the possible indicators and risk factors for family violence. Indicators can be related to a person’s physical or emotional presentation, behaviour or circumstances and may be expressed differently across a person’s lifespan, from infancy, childhood and adolescent, through to adulthood and old age. Risk factors reflect the current and emerging evidence-base relating to family violence risk that can signal that family violence may be occurring.

The presence of one or more observable signs of trauma for children and young people or risk factors may indicate that a child is experiencing direct family violence or is being exposed to family violence and its impacts. Consider these signs with other information about the child’s circumstances.

See Appendix 1 – Observable signs of trauma that may indicate family violence (adults and children)

See Appendix 2 – MARAM Evidence-based risk factors

It is important to note that these signs and symptoms do not by themselves indicate family violence. In some situations and combinations, however, they may raise a suspicion of family violence**.**

Adults and children experiencing family violence may also not exhibit any of these signs and indicators. If you don’t observe any signs or indicators but think that something is ‘not quite right’, you should continue with the following step to ensure the appropriate healthcare professional can explore whether family violence might be occurring.

# Where one of more family violence indicators or risk factors are present and no disclosure has been made or, you feel that something is ‘not quite right’, you must escalate this to an appropriate staff member. You should provide them information about what indicators or risk factors you have observed. All clinical staff have been trained in first line identification and response. An example of an appropriate staff member to escalate to includes but is not limited to:

# The patient’s primary nurse

# The patient’s treating doctor

# Associate Nurse/Midwife Unit Manger

# Nurse Unit Manager

# Social Worker

In the case where you witness escalating aggression or violence occurring within the hospital, it is important to respond to this as per the [insert org name]’s emergency management procedures. It may be necessary to call a code grey in order to maintain the immediate safety of the patient(s) and staff.

**Remember: You are not expected to be a family violence expert and there is no expectation for you to engage in a conversation or inquiring any further, only to share relevant information with the appropriate staff member**

Responding to family violence can be challenging, and staff wellbeing is a priority of [insert org name], therefore it is important that you seek internal supervision from your manager after responding to family violence.

* 1. Information Sharing

To ensure you are contributing to information sharing with other services under MARAM in accordance with [Insert relevant Information Sharing policy and procedures] you must:

* Understand that the organisation has a legal obligation regarding information sharing and all staff contribute to this though proactively sharing information about a disclosure, observed sign of family violence or the safety or wellbeing of a child with the appropriate staff member as per the [Insert Org name] information sharing policies and procedures.
* Following internal information sharing procedures supports [insert org] to contribute to an effective system wide response to family violence
1. Evaluation, monitoring and reporting of compliance to this guideline or procedure

Compliance to this policy will be monitored, evaluated and reported annually through the number of staff trained in Foundational Practice, training records, training feedback surveys, and monitoring of Victorian Health Incident Management System (VHIMS) reports.

Quality and safety committees and hospital quality account

Non-clinical audit processes

1. Endnotes
2. State of Victoria, Department of Health and Human Services, 2018. [‘Dhelk Dja: Safe Our Way - Strong Culture, Strong Peoples, Strong Families’](https://w.www.vic.gov.au/system/user_files/Documents/fv/Dhelk%20Dja%20-%20Safe%20Our%20Way%20-%20Strong%20Culture%2C%20Strong%20Peoples%2C%20Strong%20Families%20Agreement.pdf). Melbourne. Victorian Government
3. Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne. Victorian Government.
4. World Health Organisation, 2013. Health care for women subjected to intimate partner violence or sexual violence. Geneva, Switzerland. WHO.
5. Legislation/regulations related to this procedure

[Family Violence Protection Act 2008](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/15A4CD9FB84C7196CA2570D00022769A/%24FILE/05-096a.pdf)

[Child Youth and Families Act 2005](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/15A4CD9FB84C7196CA2570D00022769A/%24FILE/05-096a.pdf)

[Child Wellbeing and Safety Amendment (Child Safe Standards) Act 2015](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/edfb620cf7503d1aca256da4001b08af/690DA8EB155B14D6CA257F0E000657C6/%24FILE/15-063aa%20authorised.pdf)

1. Appendices

Appendix 1 – MARAM roles and responsibilities

Appendix 2 – MARAM Observable signs of trauma that may indicate family violence (adults and children)

Appendix 3 – MARAM Evidence Based Risk Factors indicating increased risk of victim being killed or almost killed

Appendix 1 – MARAM Roles and Responsibilities

MARAM refers to three broad levels of response to family violence within the integrated service system: identification and screening, intermediate and comprehensive. Within the identification and screening level, there are three distinct levels, Foundational, Sensitive and Screening. These distinction are specific to the operating environment within hospitals and health services as outlined in the [Workforce Mapping for MARAM alignment resource](https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/shrfv-resource-centre) in the Strengthening Hospital Responses to Family Violence toolkit. Each level corresponds to a different set of the ten MARAM responsibilities for risk assessment and management. The illustration below outlines [insert organisation]’s staff groups assigned to each level.

Comprehensive

* Staff groups are assigned MARAM Responsibilities 1 through to 5 and 7 through to 10 (and either contribute to or perform 6)
* ‘MARAM Comprehensive Tool’

Intermediate

* Staff groups are assigned MARAM Responsibilities 1 through to 5, 9 &10 (and either contribute to or perform 6)
* ‘MARAM Brief or Intermediate Tool’

Foundational Practice

* Staff groups are assigned MARAM Responsibility 1 (and contribute to 2,5,6, 9 & 10)

Sensitive Practice and Screening

* Staff groups are assigned MARAM Responsibility 1 & 2 (and contribute to 5, 6, 9 & 10) \*\*
* ‘MARAM Identification and Screening Tool’

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| Broad level responsibilities  | Associated MARAM Responsibilities and Tools. |

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| **Implementation consideration**Hospitals and health services should indicate which staff groups and departments are assigned to each level. The *Workforce* *Mapping for MARAM Alignment Guide* can assist hospitals with this process.\*\* Health services without departments assigned intermediate or comprehensive responsibilities are required to in addition assign responsibility 5, 6, 9,& 10 to relevant staff groups.  |

**Practice expectations for Foundational Practice**

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| Note: These practice expectations reflect the minimum requirements of staff groups assigned Foundational Practice responsibilities outlined in the *Workforce* *Mapping for MARAM Alignment Guide*, which is to perform and fulfil MARAM responsibilities 1 and to contribute to the MARAM responsibilities of 2, 5, 6, 9 and 10.  |

**Responsibility 1: Respectful, sensitive & safe engagement**

Understand:

* The gendered nature and dynamics of family violence
* Respectful, sensitive and safe engagement
* How to respond to disclosures sensitively and prioritise the safety of victim survivors
* Recognising and addressing barriers that impact a person’s support and safety options

**Responsibility 2: Identification of family violence**

Contribute to this through:

* Have an awareness of the evidence-based family violence risk factors
* Be familiar with observable signs and indicators
* Know who to refer a victim survivor internally to if they disclosure of family violence. There is no expectation that a staff member with foundational practice responsibilities will engage in a conversation to gather further information, only to respond respectfully and sensitively and offer a referral to a staff member with higher responsibilities
* Know who to share information with if they observe a sign or indicator of family violence, or a victim survivor does not want a referral after a disclosure

**Responsibility 3 & 4: Intermediate risk assessment and management**

* There are no practice expectations for non-clinical

**Responsibility 5: Seek secondary consultation for comprehensive risk assessment, risk management and referrals**

Contribute to this through

* Ensure they have an understanding of the organisation’s family violence policy and procedure to guide active internal referrals of patients who disclose family violence
* Seek internal supervision when a disclosure of family violence is made or when they observe a sign or indicator of family violence

**Responsibility 6: Contributes to information sharing with other services (as permitted by legislation)**

Contribute to this through:

* Have an awareness of relevant information sharing, child safety and privacy legislations and relevant organisational policies and procedures
* Understand that the organisation has a legal obligation regarding information sharing and they contribute to this though proactively sharing information about a disclosure or observed sign or indicator of family violence with the appropriate professional within their organisation who holds a higher responsibility as per their organisation’s information sharing policies and procedures.

**Responsibility 7 & 8: Intermediate risk assessment and management**

* There are no practice expectations for non-clinical

**Responsibility 9 & 10: contribute to coordinated risk management and safety planning and collaborate for ongoing risk assessment and management**

Contribute to this through:

* Have an awareness of MARAM and the health sectors role in an effective system wide response to family violence
* Understand that they play a role in this by ensuring they refer a victim survivor internally if they disclosure family violence and share information with the appropriate person if they observe a sign or indicator of family violence, or a victim survivor does not want a referral after a disclosure.
* Ensure they follow the organisation’s family violence procedure (or the appropriate clinical governance structure in their work unit or area).

Appendix 2 – MARAM Observable signs of trauma that may indicate family violence (adults and children).

Table 1: Signs of trauma in adult victims

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| Form | Signs of trauma that may indicate family violence is occurring for adult victims |
| Physical | * bruising
* fractures
* chronic pain (neck, back)
* fresh scars or minor cuts
* terminations of pregnancy
 | * complications during pregnancy
* gastrointestinal disorders
* sexually transmitted diseases
* strangulation
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| Psychological | * depression
* anxiety
* self-harming behaviour
* eating disorders
* phobias
* somatic disorders
 | * sleep problems
* impaired concentration
* harmful alcohol use
* licit and illicit drug use
* physical exhaustion
* suicide attempts
 |
| Emotional | * fear
* shame
* anger
* no support networks
 | * feelings of worthlessness and hopelessness
* feeling disassociated and emotionally numb
 |
| Social/financial | * homelessness
* unemployment
* financial debt
 | * no friends or family support
* isolation
* parenting difficulties
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| Demeanour | * unconvincing explanations of any injuries
* describe a partner as controlling or prone to anger
* be accompanied by their partner, who does most of the talking
 | * anxiety in the presence of a partner
* recent separation or divorce
* needing to be back home by a certain time and becoming stressed about this
* reluctance to follow advice
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Table 2: General signs of trauma in a child or young person

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| General observable signs of trauma for a child or young person that may indicate family violence is occurring  |

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| Signs of trauma can manifest as either physical, emotional or behavioural and can include:* Being very passive and compliant
* Showing wariness or distrust of adults
* Demonstrating fear of particular people and places
* Poor sleep patterns and emotional dis-regulation
* Becoming fearful when other children cry or shout
* Developmental regression (i.e. reverting to bed-wetting)
* Bruises, burns, sprains, dislocations, bites, cuts
* Fractured bones, especially in an infant where a fracture is unlikely to have occurred accidentally
* Poisoning
* Internal injuries
* Wearing long-sleeved clothes on hot days in an attempt to hide bruising or other injury
* Being excessively friendly to strangers
* Being excessively clingy to certain adults
* A strong desire to please or receive validation from certain adults
* Excessive washing or bathing
* Unclear boundaries and understanding of relationships between adults and children
* Excessive sexualised behaviour/advanced sexual knowledge
* Violence or sexualised behaviour to other children.
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Table 3: Signs of trauma for a child (unborn to young child)

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| Observable signs of trauma that may indicate family violence for: |
| an unborn child | a baby (under 18 months) | a toddler |
| * Poor growth and neural development caused by rushes of maternal adrenalin and cortisol
* Injuries sustained via injury to mother or by the perpetrator targeting the unborn child directly (such as inflicting blows to mother’s abdominal area).
 | * Excessive crying
* Excessive passivity
* Underweight for age
* Significant sleep and/or feeding difficulties
* Reactions to loud voices or noises
* Extreme wariness of new people
* No verbal ‘play’ (such as imitating sounds)
* Frequent illness
* Anxiety, overly clingy to primary caregiver
 | * As for baby (under 18 months), and also:
* Excessive irritability
* Excessive compliance
* Poor language development
* Delayed mobility
* Blood in nappy, underwear
 |

Table 4: Age-related signs of trauma that may indicate family violence in a child or young person

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| Observable signs of trauma that may indicate family violence for: |
| a pre-schooler | a primary school-aged child | an adolescent |
| * Extreme clinginess
* Significant sleep# and/or eating difficulties
* Poor concentration in play
* Inability to empathise with other people
* Frequent illness
* Poor language development and/or significant use of ‘baby talk’
* Displaying maladaptive behaviour such as frequent rocking, sucking and biting#
* Aggression towards others
* Adjustment problems (for example, significant difficulties moving from kindergarten to school)
* Anti-social play or lack of interest in engaging with others
 | * Rebelliousness, defiant behaviour
* Limited tolerance and poor impulse control
* Temper tantrums or irritability, being aggressive or demanding\*
* Physical abuse or cruelty of others, including pets
* Avoidance of conflict
* Showing low self-esteem\*
* Extremely compliant behaviour, being passive, tearful or withdrawn\*
* Excessively oppositional or argumentative behaviour
* Risk-taking behaviours that have severe or life-threatening consequences
* Lack of interest in social activities
* Delayed or poor language skills\*
* Experiencing problems with schoolwork#
* Poor social competence (few or no friends, not getting on well with peers, difficulties relating to adults)\*#
* Acting like a much younger child\*
* Poor school performance
* Poor coping skills
* Sleep issues#
* Bed wetting#
* Excessive washing
* Frequent illness
* Complaining of headaches or stomach pains#
* Self-harm
* Displaying maladaptive behaviour#
* Displaying sexual behaviour or knowledge unusual for the child’s age#
* Telling someone sexual abuse has occurred#
* Complaining of pain going to the toilet
* Enacting sexual behaviour with other children
* Excessive masturbation
 | As for primary school aged children, and also:* School refusal/avoidance (absenteeism/disengagement)
* Criminal or antisocial behaviours, including using violence against others
* Eating disorders
* Substance abuse
* Depression
* Suicidal ideation
* Risk-taking behaviours
* Anxiety
* Pregnancy
* Controlling or manipulative behaviour
* Obsessive behaviour
* Homelessness or frequent changes in housing arrangements
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Table 5: Signs and indicators of neglect

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| Observable signs and indicators of neglect of a child or young person |
| * Being frequently hungry
* Being poorly nourished
* Having poor hygiene
* Wearing inappropriate clothing, for example, wearing summer clothes in winter
* Being unsupervised for long periods
* Not having their medical needs attended to
 | * Being abandoned by their parents
* Stealing food
* Staying at school outside school hours
* Often being tired and/or falling asleep in class
* Abusing alcohol or drugs
* Displaying aggressive behaviour
* Not getting on well with peers.
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Appendix 3 – MARAM evidence based risk factors indicating increased risk of victim being killed or almost killed

There are evidence-based risk factors which may indicate and increased risk of the victim being killed or almost killed. These serious risk factors are highlighted with bold/yellow shading below.

Factors that are emerging as evidence informed family violence risk factors are indicated with a hash (#).

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| **Risk factors relevant to****an adult victim’s****circumstances** | **Explanation** |
| **Physical assault while pregnant/following new****birth** | Family violence often commences or intensifies during pregnancy and is associated with increased rates of miscarriage, low birth weight,Premature birth, foetal injury and foetal death. Family violence during pregnancy is regarded as a significant indicator of future harm to the woman and child victim. This factor is associated with control and escalation of violence already occurring. |
| Self-assessed level of risk # | Victims are often good predictors of their own level of safety and risk, including as a predictor of re-assault. Professionals should be aware that some victims may communicate a feeling of safety, or minimise their level of risk, due to the perpetrator’s emotional abuse tactics creating uncertainty, denial or fear, and may still be at risk.  |
| **Planning to leave or recent separation** | For victims who are experiencing family violence, the high risk periodsinclude when a victim starts planning to leave, immediately prior totaking action, and during the initial stages of or immediately afterseparation. Victims who stay with the perpetrator because they are afraid to leave often accurately anticipate that leaving would increase the risk of lethal assault. Victims (adult or child) are particularly at risk during the first two months of separation. |
| **Escalation — increase in severity and/or frequency of violence** | Violence occurring more often or becoming worse is associated with increased risk of lethal outcomes for victims. |
| Imminence # | Certain situations can increase the risk of family violence escalating in a very short timeframe. The risk may relate to court matters, particularly family court proceedings, release from prison, relocation, or other matters outside the control of the victim which may imminently impact their level of risk.  |
| Financial abuse/difficulties | Financial abuse (across socioeconomic groups), financial stress and gambling addiction, particularly of the perpetrator, are risk factors for family violence. Financial abuse is a relevant determinant of a victim staying or leaving a relationship.  |
| **Risk factors for adult or child victims caused by perpetrator behaviours** | **Explanation** |
| **Controlling behaviours** | Use of controlling behaviours is strongly linked to homicide. Perpetrators who feel entitled to get their way, irrespective of the views and needs of, or impact on, others are more likely to use various forms of violence against their victim, including sexual violence. Perpetrators may express ownership over family members as an articulation of control.Examples of controlling behaviours include the perpetrator telling thevictim how to dress, who they can socialise with, what services they can access, limiting cultural and community connection or access to culturally appropriate services, preventing work or study, controlling their access to money or other financial abuse, and determining when they can see friends and family or use the car. Perpetrators may also use third parties to monitor and control a victim or use systems and services as a form of control of a victim, such as intervention orders and family court proceedings. |
| **Access to weapons** | A weapon is defined as any tool or object used by a perpetrator to threaten or intimidate, harm or kill a victim or victims, or to destroy property. Perpetrators with access to weapons, particularly guns and knives, are much more likely to seriously injure or kill a victim or victims than perpetrators without access to weapons. |
| **Use of weapon in most recent event** | Use of a weapon indicates a high level of risk because previous behaviour is a likely predictor of future behaviour. |
| Has ever harmed or threatened to harm victim or family members | Psychological and emotional abuse are good predictors of continued abuse, including physical abuse. Previous physical assaults also predict future assaults. Threats by the perpetrator to hurt or cause actual harm to family members, including extended family members, in Australia or overseas, can be a way of controlling the victim through fear.  |
| **Has ever tried to strangle or choke the victim** | Strangulation or choking is a common method used by perpetrators to kill victims. It is also linked to a general increased lethality risk to a current or former partner. Loss of consciousness, including from forced restriction of airflow, is linked to increased risk of lethality (both at the time of assault and in the following period of time) and hospitalisations, and of acquired brain injury. |
| **Has ever threatened to kill victim** | Evidence shows that a perpetrator’s threat to kill a victim (adult or child) is often genuine and should be taken seriously, particularly where the perpetrator has been specific or detailed, or used other forms of violence in conjunction to the threat indicating an increased risk of carrying out the threat, such as strangulation and physical violence.This includes where there are multiple victims, such as where there has been a history of family violence between intimate partners, and threats to kill or harm another family member or child/children. |
| **Has ever harmed or threatened to harm or kill pets or other animals** | There is a correlation between cruelty to animals and family violence, including a direct link between family violence and pets being abused or killed. Abuse or threats of abuse against pets may be used by perpetrators to control family members. |
| **Has ever threatened or tried to self-harm or commit suicide** | Threats or attempts to self-harm or commit suicide are a risk factor for murder–suicide. This factor is an extreme extension of controlling behaviours. |
| **Stalking of victim** | Stalkers are more likely to be violent if they have had an intimate relationship with the victim, including during, following separation and including when the victim has commenced a new relationship. Stalking, when coupled with physical assault, is strongly connected to murder or attempted murder. Stalking behaviour and obsessive thinking are highly related behaviours. Technology-facilitated abuse, including on social media, surveillance technologies and apps is a type of stalking. |
| **Sexual assault of victim** | Perpetrators who sexually assault their victim (adult or child) are also more likely to use other forms of violence against them. |
| Previous or current breach of court orders/Intervention Orders | Breaching an Intervention Order, or any other order with family violence protection conditions, indicates the defendant is not willing to abide by the orders of a court. It also indicates a disregard for the law and authority. Such behaviour is a serious indicator of increased risk of future violence.  |
| History of family violence # | Perpetrators with a history of family violence are more likely to continue to use violence against family members and in new relationships.  |
| History of violence behaviour (not family violence) | Perpetrators with a history of violence are more likely to use violence against family members. This can occur even if the violence has not previously been directed towards family members. The nature of the violence may include credible threats or use of weapons, and attempted or actual assaults. Perpetrators who are violent men generally engage in more frequent and more severe family violence than perpetrators who do not have a violent past. A history of criminal justice system involvement (e.g. amount of time and number of occasions in and out of prison) is linked with family violence risk.  |
| **Obsession/jealous behaviour toward victim** | A perpetrator’s obsessive and/or excessive behaviour when experiencing jealousy is often related to controlling behaviours founded in rigid beliefs about gender roles and ownership of victims and has been linked to violent attacks. |
| **Unemployed / Disengaged from education** | A perpetrator’s unemployment is associated with an increased risk of lethal assault, and a sudden change in employment status — such as being terminated and/or retrenched — may be associated with increased risk.Disengagement from education has similar associated risks to unemployment. |
| **Drug and/or alcohol misuse/abuse** | Perpetrators with a serious problem with illicit drugs, alcohol, prescription drugs or inhalants can lead to impairment in social functioning and creates an increased risk of family violence. This includes temporary drug-induced psychosis. |
| Mental illness/ Depression | Murder–suicide outcomes in family violence have been associated with perpetrators who have mental illness, particularly depression. Mental illness may be linked with escalation, frequency and severity of violence.  |
| Isolation | A victim is more vulnerable if isolated from family, friends, their community (including cultural) and the wider community and other social networks. Isolation also increases the likelihood of violence and is not simply geographic. Other examples of isolation include systemic factors that limit social interaction or facilitate the perpetrator not allowing the victim to have social interaction.  |
| Physical harm # | Physical harm is an act of family violence and is an indicator of increased risk of continued or escalation in severity of violence. The severity and frequency of physical harm against the victim, and the nature of the physical harm tactics, informs an understanding of the severity of risk the victim may be facing. Physical harm resulting in head trauma is linked to increased risk of lethality and hospitalisations, and of acquired brain injury.  |
| Emotional abuse # | Perpetrators’ use of emotional abuse can have significant impacts on the victim’s physical and mental health. Emotional abuse is used as a method to control the victim and keep them from seeking assistance.  |
| Property damage # | Property damage as a method of controlling the victim, through fear and intimidation. It can also contribute to financial abuse, when property damage results in a need to finance repairs.  |
| **Risk factors specific to children caused by perpetrator behaviours** | **Explanation** |
| Exposure to family violence # | Children are impacted, both directly and indirectly, by family violence, including the effects of family violence on the physical environment or the control of other adult or child family members. Risk of harm may be higher if the perpetrator is targeting certain children, particularly non- biological children in the family. Children’s exposure to violence may also be direct, include the perpetrators’ use of control and coercion over the child, or physical violence. The effects on children experiencing family violence include impacts on development, social and emotional wellbeing, and possible cumulative harm.  |
| Sexualised behaviours towards a child by the perpetrator # | There is a strong link between family violence and sexual abuse. Perpetrators who demonstrate sexualised behaviours towards a child are also more likely to use other forms of violence against them, such as: * talking to a child in a sexually explicit way
* sending sexual messages or emails to a child
* exposing a child to sexual acts (including showing pornography to a child)
* having a child pose or perform in a sexual manner (including child sexual exploitation).

Child sexual abuse also includes circumstances where a child may be manipulated into believing they have brought the abuse on themselves, or that the abuse is an expression of love, through a process of grooming.  |
| Child intervention in violence# | Children are more likely to be harmed by the perpetrator if they engage in protective behaviours for other family members or become physically or verbally involved in the violence. Additionally, where children use aggressive language and behaviour, this may indicate they are being exposed to or experiencing family violence.  |
| Behaviour indicating non-return of child # | Perpetrator behaviours including threatening or failing to return a child can be used to harm the child and the affected parent. This risk factor includes failure to adhere to, or the undermining of agreed child care arrangements (or threatening to do so), threatened or actual removal of children overseas, returning children late, or not responding to contact from the affected parent when children are in the perpetrator’s care. This risk arises from or is linked to entitlement-based attitudes and a perpetrator’s sense of ownership over children. The behaviour is used as a way to control the adult victim, but also poses a serious risk to the child’s psychological, developmental and emotional wellbeing.  |
| Undermining the child-parent relationship # | Perpetrators often engage in behaviours that cause damage to the relationship between the adult victim and their child/children. These can include tactics to undermine capacity and confidence in parenting and undermining the child-parent relationship, including manipulation of the child’s perception of the adult victim. This can have long-term impacts on the psychological, developmental and emotional wellbeing of the children and it indicates the perpetrator’s willingness to involve children in their abuse.  |
| Professional and statutory intervention # | Involvement of child protection, counsellors, or other professionals indicates that the violence has escalated to a level where intervention is required and indicates a serious risk to a child’s psychological, developmental and emotional wellbeing.  |
| **Risk factors specific to children’s circumstances** | **Explanation** |
| History of professional involvement and/or statutory intervention # | A history of involvement of child protection, youth justice, mental health professionals, or other relevant professionals may indicate the presence of family violence risk, including that family violence has escalated to the level where the child requires intervention or other service support.  |
| Change in behaviour not explained by other causes # | A change in the behaviour of a child where there is known family violence that can’t be explained by other causes, may indicate presence of family violence or an escalation of risk of harm from family violence for the child or other family members. Children may not always verbally communicate their concerns, but may change their behaviours to respond to and manage their own risk, 33 which may include responses such as becoming hyper vigilant, aggressive, withdrawn or overly compliant.  |
| Child is a victim of other forms of harm # | Children’s exposure to family violence may occur within an environment of polyvictimisation. Child victims of family violence are also particularly vulnerable to further harm from opportunistic perpetrators outside the family such as harassment, grooming, and physical or sexual assault. Conversely, children who have experienced these other forms of harm are more susceptible to recurrent victimization over their lifetimes, including family violence, and are more likely to suffer significant cumulative effects. Therefore, if a child is victim of other forms of harm, this may indicate an elevated family violence risk.  |