Identifying and Responding to Family Violence Procedure: Sensitive 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 a Sensitive Practice level to identify and respond to family violence aligned to the Victorian Government’s Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM).

At this level, under MARAM staff have a responsibility to:

* Have a shared understanding of the nature and dynamics of family violence
* Provide first-line support to individuals who are identified as experiencing or at risk of experiencing family violence
* Engage respectfully, sensitively and safely
* Competently and confidently assess for the presence and risk of family violence as part of sensitive enquiries
* Competently and confidently address immediate risk and safety concerns
* Undertake basic safety planning
* Provide a pathway to specialist family violence support
* Recognising and addressing barriers that impact a person’s support and safety options
* Contribute to the organisation’s responsibility to share information, and collaborate at a multi-agency level

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 also 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 Information Sharing policy and procedures]

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| Implementation consideration  Hospitals and health services should determine which clinical and non-clinical staff groups this procedure is relevant to. 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 clinical operating environment, referred to as Sensitive Practice. At a Sensitive Practice level staff are required to competently perform and fulfil MARAM responsibility 1 & 2, and contribute to responsibilities 5, 6, 9 & 10.

Appendix 1 provides further information about the MARAM responsibilities and associated practice expectations for staff assigned Sensitive Practice.

Alignment to MARAM includes contributing to information sharing with other services as permitted by legislations. Sensitive Practice staff contribute to their organisation meeting their information sharing and privacy legislative obligations through having an understanding of relevant information sharing legislations and their obligations in line with their organisations information sharing policy and procedures.

Relevant policies and procedures:

* [Insert relevant organisation Information Sharing policy and procedures]

1. Procedure
   1. Respectful, Sensitive and Safe Engagement

# A shared understanding of the nature and dynamics of family violence underpins a respectful, sensitive and safe engagement. As such it is the expectation that all staff will have completed Sensitive Practice training, which covers foundational knowledge of family violence. [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, meets their needs and ensures they can access support to enhance their safety. Safely and respectfully responding to the individual’s culture and identity includes:

# Ask or acknowledge a person’s identity and sensitively enquire about individual needs

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

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

# They are shown respect for their culture

# Practitioners are mindful of one’s own potential biases and reflect on how it may influence practice or reinforce stigma, stereotypes or discrimination

# 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 recognised and addressed

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

* Offer Aboriginal patients support from the Aboriginal Health Liaison Officer
* Ensure disability access
* Consider if mainstream referral may be more appropriate rather than a culturally specific service-in smaller communities, as the patient may have concerns around privacy or the perpetrator finding out

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 when 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 their use of family violence if they are suspected of perpetrating family violence, unless it is part of their role and they have been trained to do so. 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].

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.

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| Implementation consideration  Following the release of perpetrator tools from Family Safety Victoria it may be necessary to update your hospitals policy and procedures. |

* 1. The 6 Step Model of Sensitive Practice

The model of Sensitive Practice is to assist and support clinicians to identify and respond to patients experiencing family violence. The primary goal of Sensitive Practice is to facilitate feelings of safety, choice and control for the patient during their interaction with health professionals (Schater, 2008).

See Appendix 2 for 6 Step Model of Sensitive Practice: quick reference flowchart

* + 1. STEP ONE: Notice the signs

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 adolescence, 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 sign of trauma 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 3 – Observable signs of trauma that may indicate family violence (adults and children)

See Appendix 4 – 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 steps to explore whether family violence might be occurring.

Where one or more family violence indicators or risk factors are present, the following steps should be used to guide a conversation with the patient.

* + 1. STEP TWO: Ask Sensitively

# Creating a safe environment for disclosure

# It is important to take steps to create an environment where the person feels safe to talk about their experiences of family violence. Before you start asking questions, ask yourself whether the conditions are right to proceed. The inquiry must not increase risk for the patient – only make an inquiry if it is safe to do so.

# Consider the following;

# The immediate health and safety needs of each person (adult or child) who may be experiencing family violence.

# Is the perpetrator present in the hospital?

# Does a senior staff member (NUM/ANUM) need to be made aware?

# Does security need to be made aware of any immediate risk or threats to the patient?

# Is it a suitable time to ask about family violence? It may not be if the patient is in pain or anxious about their medical care.

# The physical environment

# Can the conversation be overheard? You must use a private environment when asking about sensitive and personal information

# Is the patient alone? It is not safe to ask in the presence of others including children who are verbal (above the age of 2)

# Do not ask questions in the presence of a perpetrator

# Make the person feel safe and ask about the things they need to feel comfortable

# Communicating effectively

# Consider any barriers to communication. Organise an interpreter or other communication tools. When using an interpreter it is important to ask if the patient would prefer a person of the same gender.

# Engage in a culturally sensitive manner i.e. would the patient benefit from an Aboriginal liaison officer?

# Has the patient been informed about the limits of confidentiality and how their information can be shared? You must clearly explain your role, information sharing requirements and confidentiality as outlined by [insert relevant policy]. Inform the patient any disclosure of family violence is voluntary.

# If the conditions are not right to proceed, you should take in consultation with your manager steps to address this before proceeding. If the conditions are right to proceed, continue with the steps below.

Sensitive inquiry

A sensitive inquiry establishes whether a patient is experiencing family violence and the patient’s level of risk.

Sensitive inquiry relies on a structured professional judgement model through the observation of signs and risk factors that may indicate family violence is occurring, and then confirming this by undertaking the MARAM identification questions.

Structured Professional Judgement is informed by:

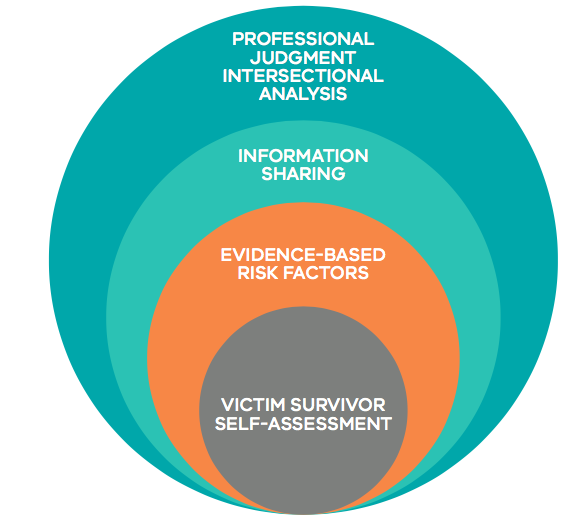
* a person’s self-assessed level of risk, safety and fear
* assessment against evidence-based risk factors

(Ascertained through asking the questions outlined below)

* information sharing to inform assessment

(Sensitive Practice staff are not required to seek information from external services but only to seek secondary consultation and support internally)

* professional judgement using an intersectional lens

(Clinicians should consider the above information as well as the presence of protective factors and other contextual information that is risk relevant to assess the seriousness of the risk

Beginning the conversation

Provide a prompting or ‘lead in’ statement, before moving on to specific questions. You may also start by linking some of the observable signs into the conversation. For example:

* *"Violence affects many families and can have serious health impacts which is why we routinely ask our patients about safety in their relationship.”*
* *“ I noticed that you appear to be experiencing X, is there something worrying you?”*

Sensitively inquire (ask) about the patient’s exposure to violence using the following evidence based identification questions. These questions are to be used with **ADULT** victim survivors to identify family violence for BOTH ADULT and CHILD victim survivors

1. *Has anyone in your family done something to make you or your children feel unsafe or afraid?*
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 hit, slapped, kicked or otherwise physically hurt you?*

See Appendix 5 – MARAM Adult Screening and Identification Tool

Implementation considerations

The above questions are those covered in the MARAM Screening and Identification Tool. [Responsibility 2: Appendix 2 – Practice guidance on screening tool](https://www.vic.gov.au/maram-practice-guides-and-resources) provides further guidance about asking these questions and follow up questions that can be asked to explore the nature, severity and frequency of the risk factors.

Decisions about practice implementation may include the direct use of the MARAM Screening and Identification Tool or the questions may be incorporated into an EMR workflow or MR.

If someone isn’t ready or isn’t in a position to respond to your questions about family violence, you need to respect this and let them know that if they are ready in the future to talk about any experience, you are open to doing this. If a staff member strongly suspects and/or has serious concerns for the patient’s safety or the safety of their children, it is suggested that staff seek secondary consultation with a social worker or senior staff member about these concerns.

Children and young people

It is important to be considering and asking about any child’s individual experience of violence and their safety, needs and well-being even if only working with an adult. Any interactions with the non-perpetrating parent/caregivers and children and young people needs to be supportive of their relationship. Staff should also refer to [insert org name’s] Child Safe Standards when assessing the wellbeing and general safety of children and young people.

If you have identified any observable signs of trauma, you should consider asking sensitively about family violence. If you have expertise and training in working with children, and it is safe, appropriate and reasonable in the circumstances, you can speak with the child or young person directly about the indicators you have observed. Assess all children and young people in ways that are appropriate to their stage of development.

For children and young people you can screen for family violence by asking:

* The child or young person prompting questions to provide you with more information about what may be causing the trauma
* A parent/carer who is not using violence identification questions as listed above.

Staff should refer to [MARAM practice guides Responsibility 2: Identification of family violence](https://www.vic.gov.au/maram-practice-guides-and-resources) for example prompting questions for children and young people.

When using prompting questions with children and young people, please keep the following considerations in mind:

* Do not ask questions in a way that feels like a list
* Use language that is age and developmentally appropriate, as well as relevant to the culture and community that the child is part of. Some children and young people may not like the words ‘violence’ and ‘abuse’. Some cultures and communities have other words that they use with the same meaning
* It is important to use words that children themselves use
* If a child is experiencing family violence their trust in adults may already be damaged
  + 1. STEP THREE: Respond Respectfully

How clinicians respond is crucial to eliciting feelings of safety, respect and control for the patient. Use the World Health Organisation model LIVES as a guide for the remaining steps of Sensitive Practice.

LISTEN: Listen to the person closely with empathy and without judging

INQUIRE: Assess and respond to their various needs and concerns – emotional, physical, social and practical

VALIDATE: Show that you understand and believe the person. Assure them that they are not to blame

ENHANCE SAFETY: Discuss a plan to protect themselves from further harm if violence occurs again

SUPPORT: Support them by helping connect to information, services and social support

If a patient answers **NO** to **ALL** of the identification questions in STEP TWO:

* Thank the patient for answering the questions and inform them about the help that is available and that they are able to contact your service in future should they ever experience family violence.
* You must respect this. The patient might not be ready or not feel comfortable to talk to you about the family violence they are experiencing. They may also not be experiencing family violence.
* No further action is needed.

If a patient answers **YES** to **ANY** of the identification questions in STEP TWO:

* Reassure the patient that you believe them and state clearly that the violence is not their fault.
* You will be required to offer a referral to the Social Work Team [or other appropriate role]. You may choose to respond with:

“*It must be difficult going through what has happened to you. You have the right to feel safe. There are services that can help you with your safety and wellbeing, either here at the hospital or in the community. Can I refer you to a social worker/care co-ordinator who can help you further?”*

* If the patient does not consent to a Social Work Referral or if there is no social worker available– see STEP FOUR.
  + 1. STEP FOUR: Respond to Risk

If a patient answers **YES** to **ANY** of the screening questions in STEP THREE and does **NOT** consent to an internal referral OR there is no social worker available:

* You must ask them three additional questions to determine any immediate risk:

1. *“Do you have any immediate concerns about the safety of your children or someone else in your family?”*
2. *“Do you feel safe to leave here today?”*
3. *“Would you engage with a trusted person or police if you felt unsafe or in danger?*

If the patient answers **NO** to question **5** and **YES** to question **6** – which indicates the patient is not in immediate danger but are at risk:

* Seek secondary consultation with social work/manager
* Consider whether a child is at risk and mandatory obligations apply
* Provide information about help and support that is available
* Discuss a brief safety plan (outlined below)

If the patient answers **YES** to question **5** or **NO** to question **6** – this indicates the patient is in immediate danger:

This response may indicate an imminent threat to the patient’s life, health, safety or welfare. Remember that a patient’s self-assessed level of fear, risk and safety is a good indicator of risk.

It is important that if the patient discloses they are in immediate danger you seek support from your manager so that the organisations escalation process can be enacted and if required a multi-disciplinary and multi-agency response.

Practical ways to respond to this risk may include some or all of the following:

Lead in statement ”*I am very concerned about your safety and would like to help you get assistance today. How do you feel about us contacting specialist assistance?*”

* Consider contacting Victoria Police (000) – be guided by the patient. Victoria Police are the only service that can respond to immediate danger. Consult with your manager or social work department.
* Perform a brief safety plan (outlined below)
* Consider information sharing obligations, including in relation to children at risk and any mandatory reporting obligations [Insert link to relevant Information Sharing policy and procedures].
* Provide information and referrals about help and support that is available. (outlined in STEP FIVE)
* Let the person know that if their circumstances change they should seek assistance
* Seek secondary consultation with Social Work/manager

If the patient answers **NO** to question **7**, ask the following questions:

* *“Is there a reason you would not contact or would be hesitant to contact police?”*
* *“Is there something I can do to support you to feel confident in contacting police?”*
* *“Would you contact another support service, such as a family violence service who could provide you with support?”*

If the patient is not wanting police assistance, consult with your manager or your social work department to determine if the police need to be contacted without the patient’s consent and whether your hospital needs to share information under FVISS.

* If there is an immediate threat, calling the police is an appropriate response. However, if the person indicated that calling police may increase their risk this information needs to be provided to the police to inform their response.
* A patient should be informed about any action taken irrespective of whether they give consent.
* Consider whether a child is at risk and mandatory reporting obligations apply.
* Consider information sharing obligations, including in relation to children at risk and any mandatory reporting obligations [Insert link to relevant Information Sharing policy and procedures].

Children and young people

You should always ask the parent/carer about what their child/ren might be experiencing directly or exposed to from a person who may be using violence (even if the person does not live with them). This includes if a child is being exposed to the aftermath of family violence (for example, broken furniture or an upset or injured victim survivor). Explain to the parent/carer that they may be experiencing family violence and that it may be impacting their children.

It is important for you to also ask:

* *“What are your worries for each of your children?”*
* *“What have you noticed about how this is affecting the children?”*

Basic safety plan

If a patient has disclosed they are experiencing family violence, and have not been referred to social work you should construct a brief safety plan with them. Every safety plan will be unique and based on the needs of the adult or young person. You should be guided by the victim survivor on what is important and safe for them in their basic safety plan.

Example lead in statement: “*From what you have told me, I am concerned about your safety. Do you have a plan of what you would do if you needed to leave or if X happened?*”

* *“If you need to leave home in a hurry, where would you go?”*
* *“Is there someone close you can tell about the violence or ask to call the police on your behalf?”*
* *“Do you need to arrange anything for anyone in your care? i.e children/older people”*
* *“Do you have access to a phone or internet?”*
* *“What essential things like documents, keys, money, clothes or other things should you take with you when you leave? Do you have access to these?”*

**Key message: Although clinicians are not expected to be family violence experts, when a patient is declining an internal or external referral, it is important to explore how they would manage safety.**

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| Implementation consideration  The above safety planning questions are based on the questions outlined in [MARAM resource Responsibility 2: Appendix 4 – Flow Diagram of Response Options and Safety Plan](https://www.vic.gov.au/maram-practice-guides-and-resources). The questions above are not as extensive as those outlined in this resource. Hospitals and health services can tailor this safety plan to suit their operating requirements. |

* + 1. STEP FIVE: Referral

Connecting the patient to support services both internal and external can be an important strategy for providing a pathway to safety. Appropriate referrals are important in ensuring patients experiencing family violence access professionals and services that can effectively assess and manage the risk associated with family violence.

It is appropriate for clinicians to facilitate internal referrals for patients experiencing family violence and to contact Victoria Police if there is an immediate threat. For external services, clinicians are expected to provide information about referral options only to allow the patient to make an informed self-referral or refer to those clinicians or professionals who are be able to facilitate external referrals [insert departments or services which hold higher MARAM responsibilities and can assist with referrals].

Where an internal referral is not accepted, provide the patient with information about what external services can assist and how they can be contacted. It is essential to first discuss with the patient as to whether providing leaflets or written information could compromise their safety. Alternatively it may be safer to save the number discretely in their phone, or record in some other way.

Internal

* Social work department during and outside of business hours
* Hospital coordinator
* Appropriate internal care-coordination roles
* Aboriginal Health Liaison Officer
* Mental Health Clinicians

External

* Victoria Police 000
* Safe Steps Family Violence Response Centre (24 hour State-wide Crisis Response Service) Phone: (03) 9322 3555.
* 1800 RESPECT (National Sexual Assault and Family Violence Crisis Service) Phone: 1800 737 732
* InTouch – Multicultural Centre Against Violence Phone: 1800 755 988
* W/Respect – Provides resources and advice for LGBTIQ+ people Phone: 1800 542 847
* Djirra – Provides culturally safe support to Aboriginal people Phone: 1800 105 303
* The Orange Door [insert appropriate contact details for region]
* Community legal centres [insert appropriate contact details for region]
* Centres against sexual assault [insert appropriate contact details for region]
* Regional specialist family violence service (including local Aboriginal family violence services) [insert appropriate contact details for region]
  + 1. STEP SIX: Documentation

It is important that you succinctly and accurately document the following information in the patients’ medical record:

* + - * + The signs or risk factors indicated to you that family violence may be occurring.
        + If family violence has been identified as present or not present.
        + If you completed the Identification questions and immediate risk questions (if required).
        + Has immediate danger been identified?
        + If an interpreter was required and used.
* Children’s details and if they were present.
* Perpetrator details if known.
* Contact details for the victim survivor, including method of contact (such as text before call) and time it may be safe to make contact.
  + - * + Emergency contact details of a safe person if the victim survivor cannot be contacted.
* Any actions you have undertaken or that have been referred to another person/role.

5.3 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:

* Ensure patients are informed about the limits of confidentiality in relation to these legislations and have provided consent to share information. This must be documented.
* Ensure patient records are up-to-date with risk relevant information that was disclosed and any risk assessment or safety plans that have been prepared with a patient.
* Ensure any information about your patient you believe is risk relevant is communicated with the person(s) responsible for managing the information sharing responses at [insert org name] or escalate to your manager if unsure.

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 to sensitively inquire about family violence, training records, training feedback surveys, and monitoring of Victorian Health Incident Management System (VHIMS) reports.

Quality and safety committees and hospital quality account

Clinical audit processes

1. Endnotes
2. Schachter, C.E., 2008. Handbook of Sensitive Practice for Health Care Practitioners: lessons from adult survivors of childhood sexual abuse. Ottawa. Public Health Agency of Canada.
3. 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.
4. Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne. Victorian Government.
5. World Health Organisation, 2013. Health care for women subjected to intimate partner violence or sexual violence. Geneva, Switzerland. WHO.
6. 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 – 6 Step Model of Sensitive Practice: quick reference flowchart

Appendix 3 – MARAM Observable signs of trauma that may indicate family violence (adults and children)

Appendix 4 – MARAM Evidence Based Risk Factors indicating increased risk of victim being killed or almost

Appendix 5 –MARAM Adult Screening and Identification Tool

Appendix 1 – MARAM 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. If required the practice expectations below should be adjusted to facilitate this. |

**Practice expectations for staff groups assigned Sensitive Practice**

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

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

Understand:

* The gendered nature and dynamics of family violence
* Creating a safe environment to ask about family violence
* 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 respond to disclosures sensitively and prioritise the safety of victim survivors
* How to tailor engagement with adults, children and young people, including Aboriginal people and people from diverse communities
* The importance of using a person-centred approach
* Recognising and addressing barriers that impact a person’s support and safety options

**Responsibility 2: Identification of family violence**

* Awareness of the evidence-based family violence risk factors and explanations
* Being familiar with questions to identify family violence, observable signs and indicators, using the Screening and Identification Tool and how-to-ask identification questions
* Using information gathered through engagement with victim survivors to identify signs and indicators of family violence (for adults, children and young people) and potentially identifying victim survivors
* Know how to respond if it seems family violence is not occurring
* Know how to respond if family violence is occurring
* Know what to do if an immediate risk management response is required
* Discuss support options and provide information to support informed decision making
* Support connection to relevant internal and external services
* Support the victim survivor to make a basic safety plan

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

* No practice expectations for clinical staff

**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
* Provide information about external specialist family violence services, and in some cases they may also assist a patient to call a specialist family violence service.
* Seek information, guidance, support and consultation from another colleague who holds a higher responsibility and has greater family violence literacy and specialisation. Staff with sensitive practice and screening responsibilities are not required to routinely consult with family violence specialists to collaborate on risk assessment and management.
* 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 relating to information sharing
* Ensuring patients are informed about the limits of confidentiality in relation to these legislations
* Ensure that patient records are up-to-date
* In line with their policies and procedures, know when and how to trigger internal processes for sharing information proactively.

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

* No practice expectations for clinical staff

**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
* Understanding how their role and organisation contributes to an integrated service system response to family violence.
* Ensure patient records are up-to-date
* Follow the organisation’s family violence procedure (or the appropriate clinical governance structure in their work unit or area).
* Enact their organisations escalation process to support staff with higher responsibilities to undertake risk assessment and coordinated risk management as part of a multi-disciplinary and multi-agency approach

Appendix 2 – Quick reference flowchart

Appendix 3 – MARAM Observable signs of trauma that may indicate family violence (adults and children).

Table 1: Signs of trauma in adult victims

|  |  |  |
| --- | --- | --- |
| 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 |
| 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 |
| 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 |

Table 2: General signs of trauma in a child or young person

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

Table 3: Signs of trauma for a child (unborn to young child)

|  |  |  |
| --- | --- | --- |
| 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

|  |  |  |
| --- | --- | --- |
| 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 |

Table 5: Signs and indicators of neglect

|  |  |
| --- | --- |
| 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. |

Appendix 4 – 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 (#).

|  |  |
| --- | --- |
| **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 periods  include when a victim starts planning to leave, immediately prior to  taking action, and during the initial stages of or immediately after  separation. 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 the  victim 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. |

Appendix 5 - MARAM Adult Screening and Identification Tool

|  |  |
| --- | --- |
| Victim Survivor Details | |
| Full Name: | Alias: |
| Date of Birth: | Also known as: |
| Gender:  ☐ Woman/Girl ☐ Man/Boy ☐ Self-described (please specify)  ☐ Client preferred not to say ☐ Unknown | Intersex:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown |
| Transgender:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | Sexuality:  ☐ Same sex/gender attracted  ☐ Heterosexual/other gender attracted  ☐ Multi-gender attracted ☐ Asexual ☐ None of the above  ☐ Client preferred not to say ☐ Unknown |
| Primary address: | Current Location: |
| Contact number: | Comments: |
| **Aboriginal and/or Torres Strait Islander**  ☐ Aboriginal ☐ Torres Strait Islander  ☐ Both Aboriginal and Torres Strait Islander  ☐ Client preferred not to say ☐ Neither ☐ Not known | **CALD** ☐ Yes ☐ No ☐ Not known  **LGBTIQ** ☐ Yes ☐ No ☐ Not known  **People with disabilities** ☐ Yes ☐ No ☐ Not known  **Rural** ☐ Yes ☐ No ☐ Not known |
| Was an interpreter used during this assessment? | ☐Yes ☐No (If yes, what language): |
| Country of birth: | Year of arrival in Australia: |
| Bridging or Temporary Visa? | ☐Yes ☐No (If yes, what type): |
| Language mainly spoken at home: | Service provider client ID: |
| Emergency contact:  Relationship to victim survivor: | Name:  Contact Number: |

|  |  |  |
| --- | --- | --- |
| Perpetrator Details | | |
| Full Name: | Alias: | |
| Date of Birth: | Also known as: | |
| Gender:  ☐ Woman/Girl ☐ Man/Boy ☐ Self-described (please specify)  ☐ Client preferred not to say ☐ Unknown | Intersex:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | |
| Transgender:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | Sexuality:  ☐ Same sex/gender attracted  ☐ Heterosexual/other gender attracted  ☐ Multi-gender attracted ☐ Asexual ☐ None of the above  ☐ Client preferred not to say ☐ Unknown | |
| Primary address: | Current Location: | |
| Relationship to victim survivor: | Service provider client ID: | |
| **Aboriginal and/or Torres Strait Islander**  ☐ Aboriginal ☐ Torres Strait Islander  ☐ Both Aboriginal and Torres Strait Islander  ☐ Client preferred not to say ☐ Neither ☐ Not known | **CALD** ☐ Yes ☐ No ☐ Not known  **LGBTIQ** ☐ Yes ☐ No ☐ Not known  **People with disabilities** ☐ Yes ☐ No ☐ Not known  **Rural** ☐ Yes ☐ No ☐ Not known | |
| **Further details** | | |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Child 1 Details# | | | #Separate risk assessment must be completed |
| Full Name: | Alias: | | |
| Date of Birth: | Also known as: | | |
| Gender:  ☐ Woman/Girl ☐ Man/Boy ☐ Self-described (please specify)  ☐ Client preferred not to say ☐ Unknown | Intersex:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | | |
| Transgender:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | Sexuality:  ☐ Same sex/gender attracted  ☐ Heterosexual/other gender attracted  ☐ Multi-gender attracted ☐ Asexual ☐ None of the above  ☐ Client preferred not to say ☐ Unknown | | |
| Primary address: | Current Location: | | |
| Contact number: | Comments: | | |
| Relationship to victim survivor: | Relationship to perpetrator: | | |
| **Aboriginal and/or Torres Strait Islander**  ☐ Aboriginal ☐ Torres Strait Islander  ☐ Both Aboriginal and Torres Strait Islander  ☐ Client preferred not to say ☐ Neither ☐ Not known | **CALD** ☐ Yes ☐ No ☐ Not known  **LGBTIQ** ☐ Yes ☐ No ☐ Not known  **People with disabilities** ☐ Yes ☐ No ☐ Not known  **Rural** ☐ Yes ☐ No ☐ Not known | | |
| Child 2 Details# | | #Separate risk assessment must be completed | |
| Full Name: | Alias: | | |
| Date of Birth: | Also known as: | | |
| Gender:  ☐ Woman/Girl ☐ Man/Boy ☐ Self-described (please specify)  ☐ Client preferred not to say ☐ Unknown | Intersex:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | | |
| Transgender:  ☐ Yes ☐ No ☐ Client preferred not to say  ☐ Unknown | Sexuality:  ☐ Same sex/gender attracted  ☐ Heterosexual/other gender attracted  ☐ Multi-gender attracted ☐ Asexual ☐ None of the above  ☐ Client preferred not to say ☐ Unknown | | |
| Primary address: | Current Location: | | |
| Contact number: | Comments: | | |
| Relationship to victim survivor: | Relationship to perpetrator: | | |
| **Aboriginal and/or Torres Strait Islander**  ☐ Aboriginal ☐ Torres Strait Islander  ☐ Both Aboriginal and Torres Strait Islander  ☐ Client preferred not to say ☐ Neither ☐ Not known | **CALD** ☐ Yes ☐ No ☐ Not known  **LGBTIQ** ☐ Yes ☐ No ☐ Not known  **People with disabilities** ☐ Yes ☐ No ☐ Not known  **Rural** ☐ Yes ☐ No ☐ Not known | | |

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

|  |
| --- |
| NEEDS AND SAFETY |
| **Needs assessment** |
|  |
| **Safety plan has been completed? (see separate template)** |
| ☐Yes ☐No ☐Not known |

\*May indicate an increased risk of the victim being killed or almost killed (serious risk factors)