Strengthening Hospital Responses to Family Violence

Training manual

Introduction to delivering the SHRFV training modules

Fifth edition • October 2020

The Strengthening Hospital Responses to Family Violence Project is funded by the Victorian Government and managed by the Department of Health and Human Services. The Royal Women's Hospital and Bendigo Health are working in partnership to lead the project.

The content of the SHRFV training modules was developed by:

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Introduction to the Strengthening Hospital Responses to Family Violence training modules

This resource supports the facilitation of the Strengthening Hospital Responses to Family Violence (SHRFV) training modules that were released with the fifth edition of the SHRFV Toolkit (2020).

The training modules are ideally delivered by an experienced family violence training facilitator in collaboration with hospital staff. The SHRFV Training Manual, facilitator's guides and the SHRFV Project Overview are to be provided to any external facilitators that hospitals and health services engage, so that these trainers understand the SHRFV approach.

The aim of SHRFV training is to:

- **support/embed/facilitate a whole of hospital approach to identifying and responding to family violence**
- **build a shared understanding of family violence across the hospital that is consistent with the broader family violence service sector**
- **support health professionals to identify signs of family violence and risk factors and respond to family violence as experienced by patients across the life span, and in different circumstances.**
- **support health professionals (both clinical and non-clinical) to align to the Multi Agency Risk Assessment and Management (MARAM) Framework practice expectations (as set out in the Workforce Mapping for MARAM Alignment resource on the SHRFV toolkit website) through provision of health sector specific MARAM aligned and endorsed training**
- **support health professionals to understand their role and contribute to organisation's safe, ethical application of the Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS) (the "Information Sharing Schemes")**
- **Prepare health professionals (especially managers) to support their staff and colleagues that may be personally or professionally affected by family violence.**

What are the changes to the SHRFV 5th Edition toolkit training resources?

Whilst the main aims of SHRFV training remain unchanged, the SHRFV training structure has been updated to align with the MARAM framework practice expectations and the Information Sharing Schemes. SHRFV training modules align with Foundational and Sensitive practice responsibilities as set out in the *Workforce Mapping for MARAM Alignment resource* also contained in the SHRFV 5th edition toolkit.

- **See section:** Alignment of SHRFV training with Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) for more details.

The new training structure consists of standalone training modules of Foundational Practice (previously Module 1) and Sensitive Practice (previously Module 1 & 2). There is no longer a Combined Module 1&2 training module due to the need for clear distinctions for staff mapped at either Foundational or Sensitive Practice responsibilities. Mapping responsibilities first will help determine the relevant training required for each staff member.

These training modules have undergone a rigorous review and endorsement process with Department of Health and Human Services and Family Safety Victoria (FSV) in order to ensure SHRFV content is aligned with the MARAM framework and practice guides. The endorsement of these modules means that there is no expectation that staff groups with identification responsibilities need to complete any other external MARAM training in order to meet their practice expectations. As such, these training modules have more content and have longer suggested running times than previous SHRFV training to accommodate MARAM alignment. Staff that have been trained in SHRFV previously will need to complete new training modules as a refresher and develop an understanding of MARAM and Information Sharing Schemes and what their role is in meeting their organisation's responsibilities.

Depending on the decisions your organisation makes on how to implement MARAM you will need to amend the training (in particular, the Sensitive Practice module) to reflect your internal procedures and requirements. For example, if your organisation incorporates identification questions into a tool in EMR, the training will need to be updated. If your organisation uses a separate identification tool, this will now need to link to the MARAM tool. Health services can also develop separate training to cover additional content specific to their organisation. There are a number of slides in the modules that are optional due to time constraints, choices in case studies or consideration of target audiences; please refer to the provided Facilitators guides and notes beneath slides in the training presentations for more information.

The Women's are also working on this training content to be offered as e-Learning to be responsive to need and sustainability concerns and hope to have resources to release to SHRFV partners as soon as possible.

The SHRFV training materials

The SHRFV training materials include:

- Foundational Practice Module
- Foundational Practice Module-Facilitators guide
- Sensitive Practice Module
- Sensitive Practice Module-Facilitators guide
- Supplementary modules (to Sensitive Practice) for health professionals to identify and respond to situations involving:
    - children
    - older people
    - sexual assault
    - rural and regional settings
- Family Violence Workplace Support Manager Training
- There are also a number of handouts to support facilitation of the training modules available on the toolkit website, especially for the Workplace Support Manager training.

Detailed explanations of training resources are included in this document.

Alignment of SHRFV training with Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)

The Royal Commission into Family Violence recommended the review and redevelopment of the Family Violence Risk Assessment and Risk Management Framework (often referred to as the common risk assessment framework or 'CRAF'), and to embed it into the Family Violence Protection Act 2008 (Vic).
The result is the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM).

MARAM has been established in law under a new Part 11 of the Family Violence Protection Act 2008. MARAM aims to establish a system-wide shared understanding of family violence and collective responsibility for risk assessment and management. It guides professionals across the continuum of service responses, across the range of presentations and spectrums of risk. It provides information and resources that professionals need to keep victim survivors safe, and to keep perpetrators in view and hold them accountable for their actions.
The MARAM Framework supports workers across the service system to better understand their responsibilities to undertake risk assessment and management, including information sharing and working collaboratively.
To meet their legislative requirements, hospitals and health services are expected to align policies, procedures, practice guidance and tools to the Framework requirements as appropriate to the roles and functions within the organisation. Training will be required to support these changes.

MARAM covers all aspects of service delivery from early identification, screening, risk assessment and management, to safety planning, collaborative practice, stabilisation and recovery.

MARAM refers to three broad levels of response to family violence within the integrated service system: **identification and screening; intermediate; and comprehensive.**

Each broad level corresponds to a different combination of the ten MARAM responsibilities for risk assessment and management that an organisation is required to meet. Assigning these levels to each department will set clear expectations within and between organisations, indicate the level of family violence risk that the organisation is required to hold and manage, and establish what responsibilities need to be assigned between staff groups.

Note: Within the Identification and Screening level there are three levels of response: Foundational Practice, Sensitive Practice and Screening. These distinctions are specific to the operating environment within hospitals and health services.

There are 10 MARAM responsibilities which SHRFV have mapped across the three levels, however there are distinctions with practice expectations at these levels to either performing or fulfilling these responsibilities:

Responsibility 1: Respectful, sensitive and safe engagement

Responsibility 2: Identification of family violence risk

Responsibility 3: Intermediate risk assessment

Responsibility 4: Intermediate risk management

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

Responsibility 6: Contribute to information sharing with other services (as authorised by legislation)

Responsibility 7: Comprehensive assessment

Responsibility 8: Comprehensive risk management and safety planning

Responsibility 9: Contribute to coordinated risk management

Responsibility 10: Collaborate for ongoing risk assessment and risk management

Hospitals and health services main function within the service system is to provide health care and a first line response to screen, identify and respond to family violence victim survivors including referring to specialist support services, where appropriate.

These functions are in line with MARAM Identification and Screening level of response. This means all hospital and health services have an obligation to ensure they meet MARAM Responsibilities 1, 2, 5, 6, 9 & 10 as an organisation.

To meet these responsibilities it is recommended that within hospitals and health services:

- At a minimum non-clinical departments are assigned **Foundation Practice**. Foundational Practice responsibilities align to the identification responsibilities under MARAM tailored to the health clinical context, which is to perform and fulfil MARAM responsibilities 1, and to contribute to the MARAM responsibilities of 2, 5, 6, 9 and 10.

- At a minimum clinical departments are assigned **Sensitive Practice** and where appropriate **Screening** (for example: antenatal screening). It is also recommended that non-clinical departments responsible for the Workplace Support Program and departments with specific clinical support roles that work with at-risk cohorts, such as Aboriginal Health departments are assigned Sensitive Practice. Sensitive Practice responsibilities align to the identification responsibilities under MARAM tailored to the health clinical context, which is to perform and fulfil MARAM responsibilities 1 & 2, and to contribute to the MARAM responsibilities of 5, 6, 9 and 10.

Hospital and health services may also have particular departments or services within their organisation that have higher responsibilities under MARAM because of the nature of their work and engagement with victim survivors (i.e. a non clinical department may have staff members who undertake sensitive practice). It is therefore important to consider the target audience for the training you are planning to deliver.

To guide this work, The Women's, Bendigo Health and Family Safety Victoria have redeveloped the SHRFV training modules to meet the practice expectations for staff assigned to Foundation and Sensitive Practice.

The SHRFV Foundational Practice Module has been tailored specifically for the non-clinical operating environment within the health sector as set out in the Workforce Mapping for MARAM Alignment resource on the SHRFV toolkit website.

The SHRFV Sensitive Practice Module has been tailored specifically for the clinical operating environment within the health sector as set out in the Workforce Mapping for MARAM Alignment resource on the SHRFV toolkit website.

Information Sharing Schemes

Hospital and health services are prescribed framework entities under the Child Information Sharing Scheme (CISS) and the Family Violence Information Sharing Scheme (FVISS) from early 2021.

The introduction of the Information Sharing Schemes guides effective responses to family violence and child safety across the entire Victorian service system.

The Family Violence Information Sharing Scheme (FVISS) allows authorised organisations to share information related to assessing or managing family violence risk.

The Child Information Sharing Scheme (CISS) allows authorised organisations to share information to support child wellbeing or safety.

The schemes have expanded legal permissions for certain professionals to proactively share and request information from other professionals and organisations. Information can only be shared under the reforms by organisations prescribed as Information Sharing Entities (ISEs). Under the Family Violence Information Sharing Scheme some ISEs are also prescribed as Risk Assessment Entities (RAEs).

- For more detailed information on the Information Sharing Schemes, please visit: https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework

The SHRFV Foundational and Sensitive Practice training modules have been designed to provide non-clinical and clinical staff the required information to understand how these reforms will impact their practice.

However, if as part of their role, staff are required to proactively share and respond to requests for information sharing under Responsibility 6 they will need specific information sharing training and practice guidance as per your organisation's policy and procedure.

Where to begin with SHRFV training

Where hospitals and health services map their workforce and the associated practice expectations will inform decisions on how to train and resource the workforce, as outlined in the *MARAM Alignment Action Plan*.

The SHRFV approach recognises that other clinical support services within the hospital, such as social work teams, may be assigned to an Intermediate or Comprehensive level of response and have additional practice expectations under MARAM (further information can be found in the Workforce Mapping for MARAM Alignment resource on the SHRFV toolkit website)**.**

The SHRFV training modules do not cover the practice expectations for staff groups with brief, intermediate and comprehensive practice expectations and as such, these staff groups will need to attend external MARAM training (i.e. Leading Alignment Training; MARAM Collaborative Practice Training, Comprehensive Renewing Practice: CRAF to MARAM Training; Comprehensive Newer Family Violence Specialist Training, and Brief and Intermediate). Information on available MARAM training can be found at https://www.vic.gov.au/training-for-information-sharing-and-maram.

The current recommendation is to have staff with brief, intermediate and comprehensive practice expectations undertake the Foundational Practice module to cover content such as the Workplace Support Program information, referral pathways and to develop a solid understanding of SHRFV in general if they haven't had the opportunity to previously do so.

Further direction will be provided to hospitals and health services on the SHRFV training requirements for these groups of staff with higher responsibilities under MARAM in due course.

Based on previous experience within SHRFV, it is recommended managers are trained before the training is rolled out to other staffing groups. This is in line with the Workplace Support Manager Program broader piece of work that has been developed.

Further details and resources for the Workplace Support program are available: https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/shrfv-resource-centre#a_downloads

The Workplace Support Managers Training Module has been developed, and revised to ensure that managers have the skills and confidence to support their staff who are impacted by family violence both professionally and personally, and that they have an understanding of the MARAM reforms and implications for their work environment. Once managers are trained, they will have a greater understanding of family violence and are more likely to support the release of staff for ongoing SHRFV training and other associated activities.

For clinical staff, the SHRFV Sensitive Practice module should be undertaken before moving on to the supplementary modules. This is because the sensitive practice module provides an essential foundation of knowledge in responding to disclosures of family violence sensitively, which must be understood as a prerequisite to the supplementary modules. Whilst the supplementary modules are not compulsory, it is highly recommended that all clinical staff complete them, in order to raise staff capability to apply an intersectional lens to family violence, particularly in recognising child victim survivors in their own right even if they are not direct patient cohort. It is expected that these modules are to be utilised if staff are working with particular patient cohorts or in particular settings that relate to the supplementary modules.

The supplementary modules were introduced in 2018. They are highly recommended to enhance the capacity and capability of health professionals. This is particularly important in rural settings where referrals to specialist support services may be less readily available. The supplementary modules have been designed to be delivered as either complementary modules after staff have completed the Sensitive Practice Module, or in the case of the Rural and Regional module, can replace the Sensitive Practice module and act as a standalone training for staff assigned Sensitive Practice. The supplementary modules can also be used by incorporating the specialist content into the Sensitive Practice module. The modules themselves have full guidance of how the content can be utilised under different circumstances. The aim is for flexibility in meeting training needs dependent on the target audience.

SHRFV modules

These training materials have been developed using adult teaching principles, are MARAM aligned and evidence based and have been co-designed with family violence experts and have been reviewed by the Royal Women's Hospital (the Women's) and Bendigo Health, and the Foundational and Sensitive Practice modules have also been endorsed by Family Safety Victoria. In 2020, CASA House, the Royal Children's Hospital, Bendigo Health, and Peninsula Health contributed their expertise to develop and review the supplementary modules.

NOTE: To maintain the quality of the training materials hospitals and health services are requested not to make major changes to the training content, facilitator notes or the order in which the slides are presented unless it is consultation and it is deemed necessary for contextualisation to your health service. It is recommended to update any statistics as more current data becomes available. It is also expected that hospitals and health services tailor training information that is specific to their organisation, such as referral pathways, local protocols and documentation procedures.

Foundational Practice Module:

Target audience: non clinical staff and volunteers (and clinical staff assigned to Foundational Practice)

- Provides a foundation for understanding family violence and sexual assault across the life span.
- Includes the definitions, impacts and the gendered drivers of family violence and sexual assault, and an understanding of the correlation between family violence and negative health outcomes.
- Includes recognising and addressing barriers that impact a patient's support and safety options, including the intersection of gender and other forms of discrimination and marginalisation and the importance of culturally responsive engagement.

- Supports non-clinical staff (and clinical staff assigned Foundational Practice) to understand how Foundational Practice responsibilities align to the identification responsibilities under MARAM tailored to the health clinical context, which is to perform and fulfil MARAM responsibilities 1, and to contribute to the MARAM responsibilities of 2, 5, 6, 9 and 10.
- Provides opportunity for hospitals to outline their commitment to a Family Violence Workplace Support Program, including responding to disclosures from colleagues and accessing supports for themselves.

- A facilitator's guide has been designed to assist your delivery of the SHRFV Foundational Practice Module. For each topic in the training, there is suggested facilitation techniques (presentation, group discussion, handouts to be provided), these are suggestions and are not designed to be prescriptive. A number of factors such as time available, resources, target audience and participant's level of experience will determine what is suitable to deliver and how it is to be delivered. Each topic also includes key messaging, suggested facilitator dialogue and/or background information, nominal duration, suggested resources and the PowerPoint slide number. The suggested facilitator notes are repeated both in the guide and under each slide in the presentation for ease of use and reference. If a slide is optional, it is noted in both the guide and on the presentation itself. Facilitators can choose to hide or delete slides that indicate they are 'optional'. There are also slides that **must** be amended to reflect each individual hospital or health service's family violence procedures, particularly in the implementation of MARAM practice obligations.

- In order to ensure staff have the required understanding of MARAM identification responsibilities and Information Sharing Schemes at a foundational level, it is essential that the content in the training modules relating directly to MARAM and the Information Sharing Schemes are not deleted or changed (aside from the internal procedures of the hospital or health service). A general rule of thumb is only the slides that state (in the notes underneath the slide or in the facilitator's guide) they are optional or can be modified are the only ones that should be. This is to ensure there is a minimum standard is reached for staff training in Foundational Practice responsibilities and align to the identification responsibilities under MARAM tailored to the health clinical context.

Sensitive Practice Module:

Target audience: clinical health professionals (and non-clinical staff assigned Sensitive Practice)

- Provides health professionals with the (MARAM aligned) tools to feel confident and competent in identifying, inquiring, responding, assessing, referring and recording disclosures of family violence and sexual assault.
- Includes the six-step model of sensitive practice framework.
- Outlines the roles and responsibilities of health professionals in relation to disclosures of family violence and sexual assault.
- Supports health professionals to enhance safety regardless of whether or not a referral to a social worker or a specialist service is accepted by the patient.
- Supports clinical staff (and non-clinical staff assigned Sensitive Practice) to understand how Sensitive Practice responsibilities align to the identification responsibilities under MARAM tailored to the health clinical context, which is to perform and fulfil MARAM responsibilities 1 and 2, and to contribute to the MARAM responsibilities of 5, 6, 9 and 10.
- Provides opportunity for hospitals to outline their commitment to a Family Violence Workplace Support Program, including responding to disclosures from colleagues and accessing supports for themselves.
- A facilitator's guide has been designed to assist your delivery of the SHRFV Sensitive Practice Module. For each topic in the training, there is suggested facilitation techniques (presentation, group discussion, handouts to be provided), these are suggestions and are not designed to be prescriptive. A number of factors such as time available, resources, target audience and participant's level of experience will determine what is suitable to deliver and how it is to be delivered. Each topic also includes key messaging, suggested facilitator dialogue and/or background information, nominal duration, suggested resources and the PowerPoint slide number. The suggested facilitator notes are repeated both in the guide and under each slide in the presentation for ease of use and reference. If a slide is optional, it is noted in both the guide and on the presentation itself. Facilitators can choose to hide or delete slides that indicate they are 'optional'. There are also slides that **must** be amended to reflect each individual hospital or health service's family violence procedures, particularly in the implementation of MARAM practice obligations.

- In order to ensure staff have the required understanding of MARAM identification responsibilities and Information Sharing Schemes at a Sensitive practice level, it is essential that the content in the training modules relating directly to MARAM and the Information Sharing Schemes are not deleted or changed (aside from the internal procedures of the hospital or health service). A general rule of thumb is only the slides that state (in the notes underneath the slide or in the facilitator's guide) they are optional or can be modified are the only ones that should be. This is to ensure there is a minimum standard is reached for staff training in Sensitive Practice responsibilities and align to the identification responsibilities under MARAM tailored to the health clinical context.

Supplementary Modules

Target audience: primarily all health professionals working with specific patient cohorts or in particular settings, however, it is recommended that all clinical staff complete the modules with the aim of raining staff capability:.

Provides health professionals with the knowledge and skills to apply sensitive practice in relation to:

- identifying and responding to children experiencing family violence
- identifying and responding to family violence when working with older people
- responding to sexual assault – practice considerations of trauma-informed care within the context of family violence
- responding to family violence and sexual assault within rural and regional settings (this module can also act as a standalone in place of the Sensitive Practice module).

Training materials

- PowerPoint slides with facilitator notes and a comprehensive facilitator's guide for each module is available. This includes suggested interactive learning activities, handouts and video resources.
- The supplementary modules are designed to be delivered in their complete form, as well as in a condensed version that can be adapted and supplemented into the Foundational and Sensitive Practice modules at the discretion of the health service, depending on the training needs of the audience.

Additional tools supporting the SHRFV training include:

- lanyards with prompting questions to support health professionals to conduct a sensitive inquiry
- posters for clinical areas reinforcing the message to notice the signs of family violence
- badges to be distributed to training participants at the end of a training session
- email banner to help promote training
- posters for patient areas to alert patients that staff within the area understand family violence and it's a safe space to disclose their experience of family violence and sexual assault.
- various handouts referred to throughout the training modules

The Family Violence Workplace Support Program

The Family Violence Workplace Support Program training provides information about family violence leave and guidance for managers responding to family violence disclosures in the workplace. Under the SHRFV training model, there is a Foundational Practice module that covers a shared understanding of family violence and provides staff and volunteers with the knowledge, skills and procedural

understanding to respond to disclosures of family violence from colleagues in a workplace setting and this training can be used to support the work of the Workplace Support Program.

The Foundational Practice Module will also provide staff with information on how to access family violence support should they or a colleague be experiencing family violence.

Family Violence Workplace Support Manager Training

Target audience: all line managers (also human resources staff and family violence contact officers)

- Provides line managers with the knowledge, skills and procedural understanding of how to support staff at a professional and personal level.
- Includes the six-step model of sensitive practice.

Planning to deliver the SHRFV training modules

There are a range of considerations that need to be taken into account when planning to deliver the SHRFV training modules.

How should the training sessions be delivered?

The training modules and materials are based on adult learning principles that promote participation and interaction among participants.
The Family Violence Workplace Support Program Managers Training has been designed to be delivered over four hours. If the Family Violence Workplace Support Program Managers Training is to be delivered via the blended delivery model, staff would need to complete either the Foundational practice module as e-Learning or in person as a pre-requisite to the 90min-2 hour managers training.

The Foundational Practice module ideally takes 1.5 hours in person and the Sensitive Practice module ideally will need a minimum of 2hours for an in-person training session, however, this is dependent on the level of interaction the facilitator chooses to include.

Including additional time for interactive activities, discussion and role plays can greatly enhance the quality and effectiveness of the training. Research suggests that interactive training is a strong indicator of information retention in adult learners. With that in mind, a longer session will allow participants to fully explore the complexity associated with family violence and sexual assault. This also provides the time required to practise the required skills and capabilities. A range of activity options are provided that can be included when time allows.

Access to training time is difficult in busy clinical environments. To most effectively deliver the SHRFV modules to clinicians it is recommended to schedule the nominated running time, however, this amount of time may not be available. It is recommended that facilitators make the most of anytime given. It should be noted that delivering training in shorter time frames reduces the ability to incorporate activities and role plays, and therefore the effectiveness and impact of the training.

Ideally training groups should comprise of no more than 25 people to enable discussion.

Each of the training modules can be delivered in a range of settings, including:

- a training room or ward as a small group education session during staff handover periods or double staff time
- by remote delivery (via video conference or webinar)
- integrating the modules into professional development days for clinical staff
- as a stand-alone training session that can be time expanded to allow for facilitated discussion, role plays and case scenarios
- each module broken into smaller training sessions to respond to time constraints, experience of target audience and if training is acting as refresher training for staff
- as 'lunch and learn' forums.

What resources are required to support the training?

A training space is required that includes audio visual facilities with internet connection, audio speakers and a whiteboard. Setting up the room in a U-shape or to support small group discussion is generally considered the most conducive to interactive discussions during a training session.

All participants are to receive a training pack that includes a copy of the slides with space for adding handwritten notes, any training handouts you are choosing to use, personal support options and the training feedback evaluation form.

Staff attending the Sensitive Practice Module are to receive relevant hospital policies and procedures relating to referral pathways and family violence and child protection reports. This is ideally done electronically and via the hospital intranet.

You may also find these resources useful:

- The Domestic Violence Resource Centre (DVRCV) provides infographic posters presenting the facts of family violence in Victoria: https://www.dvrcv.org.au/knowledge-centre/our-publications/poster/facts-family-violence-2016
- Australia's National Research Organisation for Women's Safety Limited (ANROWS) provides a quick reference guide to key statistics on violence against women in Australia: https://www.anrows.org.au/publication/violence-against-women-accurate-use-of-key-statistics/
- Australian Institute of Health and Welfare (AIHW) provides a summary report using the latest data on family, domestic and sexual violence in Australia: https://www.aihw.gov.au/ getmedia/d1a8d479-a39a-48c1-bbe24b27c7a321e0/aihw-fdv-02.pdf
- 1800RESPECT provides a video on cultural competence when working with women from culturally and linguistically diverse (CALD) communities: https://www.youtube.com/watch?v=DbNaYzbXCd8

What processes should be used to evaluate the training?

The SHRFV training modules aim to increase the capabilities (knowledge, skills and abilities) required of hospital and health service staff to respond effectively to family violence.

Training evaluation forms are recommended to measure staff capability in identifying and responding to family violence. They also help staff to provide feedback on the quality of the training session.

Ideally a follow-up survey is provided to clinical staff three months after participating in a training session. This survey assists to identify the extent to which the learning outcomes have translated to changes in practice.

Distributing the pre-training survey several weeks prior to commencing the training provides greater potential to tailor the content of the training to the knowledge and experience of people in the group. It will allow additional time for discussion and role plays that focus on areas of knowledge and the desired capabilities for family violence practice that require further development. Presenting the results of the pre-training survey at the start of a training session is a useful way of demonstrating to the group that the training is responsive to their identified needs.

Post Training Capacity Building

The training is designed to build clinical capacity to identify and respond to disclosures of family violence and sexual assault. The staff leading the family violence training need to be aware that as health professionals commence this work, ongoing support and action is required. It is likely health professionals will identify policy and procedural changes necessary to improve effectiveness.

The MARAM practice guide states; ‘undertake activities to change organisational culture and practice to promote continuous improvement in risk assessment and management practice, information sharing and enhanced collaboration with other services.

Family violence training can support **MARAM pillar 4: Systems, outcomes and continuous improvement**, as staff can identify areas of clinical practice that require review and development as the training begins to roll out and decisions are made on process and procedures.

It is recommended that in this context, facilitators should provide mechanisms for collecting feedback from participants (usually in the form of post-training questionnaires) and then the organisation should provide the facilitator the mechanism for reporting the feedback to relevant departments/services.

Those staff delivering SHRFV training have an important role to play in building and maintaining lines of communication with clinical staff and their managers so areas for improvement can be identified and actioned and the whole-of-hospital response to family violence can be achieved. This may involve:

- attending staff team meetings
- being available in the ward at a regular time to answer queries
- conducting family violence case review/ reflective practice sessions

- supporting a network of family violence clinical champions
- including clinical staff in the project reference group or an operational committee.

Reflective practice is an important part of the continuous improvement process. It involves scheduling time to reflect on the experience of identifying and responding to family violence, determining what worked well, what didn't, and what could be done differently next time.

It is an opportunity to identify what impacts upon effective responses, including the workplace environment, our interactions with others, and our own personal beliefs, assumptions, and skillset that we bring to the role. Reflective practice provides participants with the opportunity to continue to build their knowledge and confidence. It should be led by a staff member with expertise and experience in responding to family violence.

Following Family Violence Workplace Support Training, managers and staff have the opportunity to attend refresher sessions. Other post-training support can include access to further reading material on your organisation's intranet, management assistance through your Employee Assistance Program (EAP) provider, and consultation with and advice from the Human Resources team. Your Human Resources team may also benefit from access to secondary consultation resources (for example, social work).

Who should deliver the training?

Family violence is a complex and sensitive topic that requires experienced facilitation. The clinical training is best delivered by two highly experienced facilitators. Where a skill set exists, collaboration between your internal staff subject matter experts (for example, social workers) with staff from the family violence sector to deliver this training is ideal.

This collaborative approach is valuable in many ways, as it utilises the sector's expertise and informs hospital staff of the agency's role, which can support inter-agency partnerships and risk assessment and management. Alternatively, you may consider employing in-house family violence trainers or upskilling staff in clinical education to work in partnership with your social work team to deliver the training.

It is recommended that Family Violence Workplace Support Program Training is co-facilitated with a Human Resources, Family Violence Contact Officer or Health, Safety and Wellbeing practitioner. The facilitator's role is to build the knowledge and capabilities of managers to understand family violence and how this applies to their role as a manager. The co-facilitator of this training does not need to have specialist knowledge of family violence. However, a sound understanding of the organisation's policies and procedures to support staff experiencing family violence, an understanding of staff entitlements under the EBA and key industrial relation concerns with regards to family violence is essential.

Recognising that the supplementary modules involve a level of specialist knowledge, which is unlikely to be available in all situations. Facilitators are to familiarise themselves with all training information when planning to deliver the supplementary modules, including facilitator notes, MARAM practice guides and it is recommended collaborating with relevant specialists for further advice and support. It is encouraged where possible to co-deliver training with a specialist provider.

It is important that both the lead and co-facilitator have a high-level of knowledge regarding the causes and gendered drivers of family violence. It is recommended that those facilitating the training will have attended MARAM identification and screening training (or MARAM training relevant to their role within the organisation), specialist family violence training (for example; *Course in Identifying and Responding to Family Violence Risk (22510VIC) – accredited training covering foundational family violence knowledge and MARAM screening an identification responsibilities 1, 2, 5, 6, 9 and 10.*

- *To access this training email: cwe@familysafety.vic.gov.au).*

The facilitator must be confident and competent to respond to a range of issues that commonly emerge during a training session that includes:

- managing participants' personal experiences of trauma relating to family violence and sexual assault and maintaining the safety of participants within the training room
- managing conflicting perceptions, backlash and resistance relating to women and men's gender roles and social status
- supporting participants to examine how they bring individual and professional values, beliefs and cultures that influence their analysis and understanding of family violence
- supporting participants to explore and address structural barriers to implementation within their workplace setting
- supporting participants' thorough knowledge of workplace processes and pathways, including processes for documentation and data recording
- supporting participants to understand intersectionality and acknowledge the different aspects of a person's identity that can expose them to multiple forms of discrimination and marginalisation.

Family violence workforce support

In a study of Australian health professionals, almost half of the 471 female health professionals surveyed had experienced intimate partner and/or family violence. Many also reported experiencing violence as a child. For many women, the violence was current. One in nine had experienced intimate partner violence in the past year.[1]

All publicly funded Victorian hospitals have family violence clauses included in their Enterprise Bargaining Agreements that allows for family violence leave. Facilitators must be aware of staff entitlements and what internal supports are provided by the hospital for staff experiencing violence, and the pathways to accessing these supports.

The Workplace Support Program training also covers perpetrator disclosures in the workplace and how managers can best handle these and it is therefore important that the facilitator has an understanding of their organisation's expected response and appropriate referral options as well.

Gendered nature of family violence

SHRFV training acknowledges that family violence is a gendered issue, particularly in the context of intimate partner violence.

While anyone can be a victim or perpetrator of family violence, the evidence base globally and in Australia shows that family violence is gendered and is predominantly committed by men against women and children.[2]

Men do experience violence; however, it is more likely to take place outside the home and be perpetrated by other men who are not known to them.[3] Children of all genders are victims of family violence and sexual assault.

Family violence also occurs within same sex relationships, between siblings, from parent and carers towards children, from adolescents towards parents, and from adult children towards older family members. It is also important to recognise broader definitions of family violence can include extended families, kinship networks and community violence.

In taking a family violence across the life span approach the training provides information that staff can apply when working with victim survivors of family violence regardless of their age, gender or circumstance.

Attitudes towards family violence

People's understanding of violence against women and their attitudes to gender equality have significant impacts on their attitudes to violence against women.

Evidence from the findings of the National Community Attitudes Survey by VicHealth in 2017 suggests that such attitudes that condone or tolerate violence are recognised as playing a central role in shaping the way individuals, organisations and communities respond to violence[4].

This does not mean that people who hold violence-supportive attitudes would necessarily use or condone violence themselves. However, such views expressed by influential individuals or held by a substantial number of people can create a culture where violence is not clearly condemned and even subtly condoned or encouraged[5.]

These attitudes (and/or biases) are the beliefs and values gained from family, culture and a lifetime of experiences that heavily influence how a person views and evaluates themselves and others. Biases (both conscious and unconscious) can occur when this experience and understanding leads to assumptions or stereotypes about individual people or communities based on their circumstances or aspects of their identity including their age, gender identity, sexual orientation, disability, language and cultural background. All people, including health professionals have these biases and need to be aware of how this affects responses to service users[6].

In the hospital setting, this may translate to a health professional having a negative or judgemental view of a patient experiencing violence presenting for health services. This has the potential to override rational decisions, logical thinking and the professional attitude of a hospital staff member.

The SHRFV training modules challenge myths held by participants about family violence. Prejudicial myths are dangerous because they influence how we think and feel about violence against women and children. These beliefs and attitudes then

influence how we act when confronted with violent behaviour or how we respond when we hear about violence.

In the family violence context, there are many myths (or incorrect assumptions) about people experiencing violence that have been perpetuated by families, communities and society that have influenced how this topic is viewed and understood.

Challenging our understanding and perceptions of myths commonly perpetuated by society allows us to understand how family violence and sexual assault is excused, minimised, or how blame is directed at the victim survivor rather than assigning accountability to the perpetrator.

Participants should be encouraged to think about how these myths may inform their own or the responses of others to family violence disclosures. In addition, hospital staff need to be aware that many patients will perpetuate these myths, by blaming themselves for the violence, or excusing the perpetrator. Practitioners can gently challenge these myths with statements such as 'You have the right to be safe', or 'It is a choice to use violence'.

Sensitive practice

Sensitive practice is at the foundation of the SHRFV approach.

- Facilitators should familiarise themselves with the World Health Organization (WHO) Clinical Handbook:https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/

The WHO clinical handbook outlines the LIVES model and it is important that facilitators understand this model and how this needs to be applied as an overarching framework for how to respond to patient disclosures sensitively and respectfully. The Sensitive Practice: Responding to Family Violence Training Module and the Workplace Support Managers Training Module outline LIVES as part of the SHRFV six step model.

Other SHRFV resources in the toolkit also refer to LIVES and can be provided to training participants as printed resources to further reinforce the need for a sensitive response.

'Disbelievers' and contentious comments

It is important to remember there may be training participants that disbelieve or object to the messages in your training. Understanding gender inequality as the main driver of violence against women can be challenging for some and there may be some contentious comments to this effect. It is important that facilitators are prepared to respond with appropriate facts, research and key messaging.

When asked 'What about violence towards men?' or 'Why are you saying only males commit violence?' the response that could be made is in line with the information provided by initiatives that came from *The National Plan to Reduce Violence Women and Their Children 2010–2022*, namely *The Line and Our Watch*.

Firstly, it is important to clarify that the SHRFV approach and the MARAM Framework does not deny that males are victims of family violence, nor that only males perpetrate violence. Raising awareness of the issue of family violence and

violence against women is in no way meant to diminish the experience of other types of violence.

All violence is unacceptable irrespective of gender. The principles of sensitive practice are universal, do not rely on a disclosure of trauma, and can be used with all patients. The purpose of this work is to raise awareness of the issue of family violence, and equip health professionals to identify, respond and refer. This will ultimately benefit all members of the community.

Some key statistics to support the gendered nature of family violence

- **Women continue to be overrepresented as victims of intimate partner homicide, accounting for 79% of all intimate partner homicides[7].**
- **Approximately 8 women per day are hospitalised after being assaulted by their spouse or partner[8].**
- **Women were nearly three times more likely to have experienced partner violence than men, with approximately one in six women (17% or 1.6 million) and one in sixteen men (6.1% or 547,600) having experienced partner violence since the age of 15 [9].**
- **Intimate partner violence causes more illness, disability and deaths than any other risk factor for women aged 22-44[10]**
- **One in three women has experienced physical violence; one in five women has experienced sexual violence; and one in four women has experienced intimate partner violence since the age of 15. [11]**
- **Over 90% of those assisted by homelessness services for the purpose of escaping family violence were women and children. [12]**
- **Violence against women and their children is costing the Australian economy $22 billion per year. [13]**

Context and intersectionality

Intersectionality is a concept used to understand how an individual experiences the world through overlapping social identities and circumstances related to race, gender, sexuality, culture, ethnicity, citizenship and economic status.[14]

In this context, intersectionality refers to our understanding of how experiences of family violence are impacted by these identities (sometimes multiple), and the consequential barriers to safety people encounter due to racism, sexism, homophobia, bigotry, structural discrimination and other forms of oppression.[15]

The practice model of Structured Professional Judgement (as a key component of the MARAM practice guidance) enables assessment of information to determine the level or seriousness of family violence risk. The model asks those conducting the assessment to utilise their experience, skills and knowledge with a key element of the model is the application of an intersectional lens to family violence risk assessment. This means taking into account relevant information

about a victim survivor or perpetrator's circumstances and how the experiences of structural inequality, barriers or discrimination can also alter the way an individual or community experiences family violence, and in many instances contribute to increased risk and amplify barriers to disclosure and service access.

Understanding the concept of intersectionality is important when facilitating the training and recognising that people within diverse social groups may experience different types of violence, and experience additional cultural or structural barriers to safety.

Family violence against Aboriginal people and communities [16]

Family violence perpetrated against Aboriginal people and communities includes a range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur in families, intimate relationships, extended families, kinship networks and communities.
Family violence occurs at higher rates for Aboriginal and Torres Strait Islander people than for others, despite family violence not being a part of Aboriginal culture. However, Aboriginal people are disproportionately impacted by family violence.

Family violence within Aboriginal and Torres Strait Islander communities needs to be understood as both a cause and effect of social disadvantage and intergenerational trauma.[17]

It is essential that staff are trained to understand family violence from an Aboriginal perspective and how to engage and work with Aboriginal families within the family violence context.

The impacts of colonisation on Aboriginal and Torres Strait Islander peoples have created further barriers to disclosing family violence and seeking assistance, including:[18]

- fear or distrust of the justice system and government agencies due to negative experiences with police, courts and child protection systems
- fear of not being believed and reluctance to report abuse
- pressure to protect the offender, relationship, children and greater community from state intervention
- fear of retaliation by the perpetrator and further negative repercussions from family and the community
- distorted perceptions within and outside communities that violence and abuse are part of Aboriginal culture
- lack of availability of appropriate services
- concerns around confidentiality in close-knit communities and family networks.

Aboriginal and Torres Strait Islander women community members may or may not want to access Aboriginal Community Controlled specialist family violence services. Therefore, options for both Aboriginal Community Controlled and general services should be offered.

Family violence against people from multi-cultural communities

It is important to note that all communities and cultures have violence-condoning and violence-supporting values, systems and practices and these are different in each community.

Women from multicultural, faith and linguistically diverse communities face additional barriers to seeking support, including language barriers, lack of knowledge about Victorian laws and support services, and their visa status. Some communities might have different understandings of what constitutes family violence. They might also have community mechanisms for responding to family violence, alongside a criminal justice approach.[19]

To avoid the possibility of escalating risk and to ensure accurate translation of information, a professional interpreter should always be provided. Given the sensitive nature of family violence, victim survivors should be offered the choice of a same sex professional interpreter either in person or over the phone. Where the person is from a small cultural community, requesting a telephone interpreter from interstate can help to ensure confidentiality and safety for the person disclosing.

Family violence against people with disabilities

The *Family Violence Protection Act 2008* (Vic) recognises that family violence and 'family like' relationships may exist between people with disability and their paid and unpaid carers, and accordingly, the Act applies to these relationships.

Women and girls with disability experience higher rates of violence in comparison with women within the general community. In particular, those who are most excluded from social and economic participation, such as women and girls with intellectual disability, may experience forms of both gender-based and disability-based violence such as over or under medicating, not attending to personal hygiene needs, reproductive coercion, or denying access to support services.[20]

People with disability may feel that they have more limited options, or that they may not be believed, particularly in the case of an intellectual disability. The dynamics of power and control that are relevant to all family violence situations, are particularly significant for someone who is also dependent on the perpetrator to care for their basic needs.

People from rural communities

The incidence of family violence and family violence-related homicide is higher in rural and regional locations. Access to firearms in rural settings is thought to be associated with the disproportionate number of family violence-related homicides in rural areas. People in rural and regional areas experience greater vulnerability due to the limited availability of professional support, distance and transport options and associated costs in gaining access to resources, including translators, for support. Extra challenges may also surround the level of privacy in smaller communities and the potential to re-encounter perpetrators.[21]

Family violence against lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) communities

LGBTIQ communities have a wide variety of experiences and should not be treated as one homogenous group.

People who are lesbian, gay, bisexual, transgender, intersex (LGBTIQ), or questioning their gender or sexuality, may be at greater risk of violence from family members such as parents, siblings and offspring, as well as within their intimate relationships.

Some LGBTIQ people are at higher risk of family violence, and have less access to supportive services. These include people who are transgender, and people from communities or areas with rigid gender roles and conservative views about sexuality.[22]

To minimise the effects of the additional risks and vulnerabilities that might be experienced by people in LGBTIQ relationships, it is important that organisations, as employers and service providers, are respectful of people's choices regarding the pronouns and identities they use to describe themselves and others in their family and community.[23]

Cultural competence

Cultural competence refers to a set of congruent behaviours, attitudes and policies that come together to enable professionals to work effectively in cross-cultural situations.[24]

This is particularly relevant in a hospital setting where work colleagues and patients come together from different cultural and religious backgrounds.

In practical terms, cultural competence comprises four components:

- awareness of one's own cultural world view
- attitude towards cultural differences
- knowledge of different cultural practices and world views
- cross cultural skills.

Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. This is particularly relevant in working with people affected by family violence.

To practice in a culturally safe way means to work in collaboration with the victim survivor with care and identification of their culture, whilst being mindful of one's own culture. A culturally safe environment is one where people feel safe and where there is no challenge or denial of cultural identity.

Recognising the signs of family violence

Recognising the physical and mental health signs which could be indicators of family violence is a first step for health professionals. The clinical training modules detail the sort of physical and behavioural indicators health professionals need to be alert to across the life span.

Noticing signs/assessing risk

Health professionals as first-line responders (heath professionals assigned Foundational or Sensitive Practice) following the SHRFV approach are not expected to undertake a risk assessment. Hospital staff assigned Intermediate or Comprehensive level of response will be required to undertake appropriate training to be deemed competent to conduct intermediate or comprehensive risk assessment.

All health professionals are expected to identify signs of family violence and be aware of key risk factors. Staff groups assigned Sensitive Practice are expected to sensitively inquire and respond to risk utilising embedded organisational procedures and tools or the MARAM Screening and Identification Tool.

The term 'evidence-based risk factors' refers to the characteristics of a person's family violence situation that may provide a 'red flag' for concern that the situation is escalating towards serious harm or potential lethality[25]. Some examples of evidence-based risk factors include pregnancy, recent separation, and threats of harm or access to firearms. These risk factors have been developed in response to Australian and international research into the circumstances that have led to a family violence homicide. The MARAM Framework has been developed to assist a range of professionals to better identify and respond to women and children who are experiencing family violence. It is now mandated for hospitals to use the MARAM Framework.

For a full list and explanation of evidence based risk factors see link:
https://www.vic.gov.au/maram-practice-guides-and-resources

Facilitator notes

It is important that the training slides provided to support implementation of the SHRFV approach are not used without reference to the detailed facilitator notes provided with each module.

Facilitators need to be mindful that throughout the training modules there are places where individual hospitals need to insert site specific information.

For example, in relation to referral, self-care and documentation procedures.

The facilitator notes also refer to various handouts and case studies that need to be organised prior to training delivery.

Training considerations

Introducing the training

Acknowledgement of Traditional owners

Training should commence with an acknowledgement of the Traditional Owners of the land. For example, in Melbourne,

> *'I'd like to acknowledge the people of the Kulin Nations as the traditional owners of the land and to pay my respects to their Elders, past and present, and any Aboriginal colleagues joining us today in the training room.'*

Victim survivors

When presenting family violence training, it's also important to acknowledge that many people are impacted by family violence. This is a reminder to participants why this training is so important and instantly gains the attention of the room. Referring to a recent family violence incident as part of the acknowledgement, highlights the urgency and locality of the issue.

For example:

> *'I'd also like to acknowledge the strength and resilience of victim survivors of family violence and, sadly, the many woman and children that have been killed within the context of family violence. The recent incident at XX is a sad reminder of why the work that we are doing to address family violence is so incredibly important.'*

Self-care and support

Acknowledge that discussing the issue of family violence has the potential to trigger thoughts about current or past situations or someone participants know who is affected by family violence.

Advise participants that the training could be upsetting and to seek support if needed. Hand out or point to available support options.

Advise participants to take time out of they need to. However, also state that it will not be assumed because someone leaves the room that they are not coping.

Facilitators need to be aware that the training may trigger disclosures from both victim survivors and perpetrators and be prepared to respond appropriately. It is advised that facilitators encourage participants to avoid disclosing their own personal experiences during training at the beginning of the session.

All SHRFV training modules include a 'Specialist Family Violence Services' slide with details on available supports that can referred back to for any training participants. And facilitators should be familiar with these services and change the slide to reflect any local or specific workplace supports.

Safety within the training room

It is important to recognise the range of cultural attitudes and views that participants bring into the training room, as well as the potential for conflicting opinions. Be mindful that some participants may have their own direct or indirect experience of family violence and sexual assault. It can be helpful to communicate that you intend for the training to be empathetic to their experiences.

Establishing group agreements at the very beginning of the training session is an effective tool to maintain safety within the training room. Group agreements help participants to come to consensus on how they will work together respectfully and effectively. This enables participants to engage and interact with each other in a constructive and productive manner.

Proposing certain group agreements then asking participants to contribute is far more empowering than having a facilitator set out a 'code of conduct'. When problems or conflicts arise, you will be able to refer to this agreement, (for example, 'We all agreed at the beginning of the training that it's best if only one person speaks at a time').Below is a sample group agreement which can be adapted by the trainer and the participants.

Group agreement

- One person speaks at a time
- Everyone has the right to be heard. Only one person talks at a time so that we can all hear what that person has to say.
- Confidentiality
- We encourage examples from your professional experience, but please ensure that they are de-identified to protect the confidentiality of your patients and colleagues. Anything shared in the training session should remain confidential so everyone can feel safe.
- No one knows everything – together we know a lot
- This training relies on adult learning principles in recognition of the experience and expertise of those in the room. That means we are relying on you to contribute to the learning experience by sharing your knowledge and wisdom. If you have ideas regarding the discussion, please share them with us as a group, rather than with the person sitting next to you.
- Enjoy and explore the learning space
- Please use this time to explore new concepts and examine how the information presented fits with your experience.
- Please also give us your full attention during the training time. If you need to take an important phone call please leave the room to avoid distracting others. Make sure that mobile phones are on silent mode.

If training is online ask participants to:

- Keep video switched on
- All participants to have microphones on mute unless otherwise stipulated
- If wanting to contribute or ask a question, use the chat function
- Remind participant's to be aware of safety in attending training, consider who can overhear the training as much of the content is not suitable for children and if it may contribute to their own safety if perpetrators are present.

Introductions

The following are a few ideas for making introductions that can be adapted for use in any training setting.

After participants have introduced themselves and their roles, ask them to work through the following activities.

Ask participants to describe the first image that comes to mind when thinking about family violence. List answers on the whiteboard and refer to these when talking about community attitudes and myths.

Discuss what participants find most challenging when responding to patients experiencing family violence.

Write their responses on the whiteboard and, if appropriate, group the answers into themes. Refer to the list on the white board at the end of the training and confirm the items have been addressed in the training session.

Talk about how often participants work with patients who experience family violence. At the end of the introductions acknowledge that regardless of their answers, considering the prevalence rates, every health professional probably works with patients every day who are experiencing family violence.

Invite participants to state what they are wanting to achieve as a result of the training. Note comments on a whiteboard and ensure that they are covered or confirm they will be covered in other modules. If they are not included anywhere, this provides useful feedback for future revisions of the training content.

Training breaks

Sessions of two or more hours should include a short training break and where possible provide refreshments. If training is online, schedule regular breaks for participants to be able to stand and stretch their legs and step away from the screen. Including a PowerPoint slide for the break with a relaxing, tranquil visual can help set the tone for the break. If the participants are leaving the room, pause in the room to provide an opportunity for any participants to speak with the trainer in private.

Once all participants have left the training space, join them and use this as an opportunity to check in with participants. If someone is not contributing to the conversation during the session, ask them how they are finding the training. Following the break, try to draw them into the conversation.

Concluding the training

At least 10 minutes should be allowed at the end of the training session for participants to complete their training evaluation forms and to conduct reflections around the room. Due to the ‘heavy’ content of the family violence training

sessions, it is always good to make the final activity of the day positive and action focused.

Reflection activities

Ask each participant to:

- write or state one thing they will do differently in their practice or personal lives to address and/or prevent family violence
- create a brief resume listing the skills developed or improved through their training experience
- jot down three specific things they learned or were reminded about in their own clinical practice
- check their learning against a list of goals they established at the beginning of the training
- state one word that best describes how they are feeling about the hospital's approach to strengthening its response to family violence
- complete the sentence. 'At this hospital strengthening our response to family violence will depend upon…'.

Handouts

Various handouts are referred to in the facilitator notes and they are provided as part of the SHRFV Toolkit including:

- **Quiz – What do I already know about family violence?**
- **Signs of family violence across the life span**
- **Asking about family violence**
- **Specialist family violence support service contact details**
- **Staff lanyards to prompt staff about sensitive inquiry**
- **Staff badges to identify staff as someone patients can safely talk with about family violence**
- **Rural and regional case study scenarios**
- **A list of family violence support service contact points, which can be adapted and used for providing workplace support information.**

Key concepts reinforced by SHRFV training

- Family violence occurs across the life span in many different forms.
- Family violence is complex, and the health sector plays a key role in identifying and responding to family violence as part of a consistent and collaborative family violence service system.
- Consistent alignment to and the use of the MARAM Framework across organisations and sectors aims to increase the safety of people experiencing family violence and keep perpetrators in view and hold them accountable for their actions and behaviours and everyone's role is vital in this response.
- While anyone can be a victim or perpetrator of family violence, research shows it is predominantly committed by men against women.
- People with diverse social identities may experience different types of violence, or experience additional cultural or structural barriers to safety.
- Hospitals have a key role to play in reducing the incidence and impact of family violence.
- First-line health professionals are not expected to be family violence specialists. They are expected to recognise the signs and know how to sensitively respond and refer to appropriate internal or external services.
- Professional interpreters, not 'trusted' family and friends, should always be offered.
- Health professionals should assume every patient may have experiences of trauma, family violence, and/or sexual assault, and modify body language and clinical practice accordingly.
- While many people believe that leaving the relationship will resolve the family violence issue, this is in fact likely to escalate the violence. This is the time when a woman is most at risk of being murdered. Therefore, leaving needs to be planned very carefully, preferably with the support of a family violence specialist worker.
- Family violence is both controlling and disempowering. It is important that we don't perpetuate that control within our response by telling the person what they should do. Instead, the role of the health professional is to provide that person with all the tools and information they need to make their own informed decision.
- There are many reasons why a person at risk of violence chooses to remain in the relationship, including being dependent on that person financially or for carer support, lack of alternative housing, fear for safety (for self, children or pet) if leaving, or hope that the violence can be resolved while remaining within the relationship. A person remaining within a relationship should never be judged for doing so but should be encouraged to plan for safety when violence occurs.
- If there are serious concerns for the safety of children, and a report to child protection is required, this should be done as transparently as possible. Where possible involve the protective parent in the notification process, and also provide the protective parent with a referral for legal support.
- Any interaction about family violence is valuable even if people choose not to disclose or accept help because it is likely they will view the hospital as a safe place to go to in future to seek assistance in relation to family violence. They will also feel empowered simply by being believed, validated and supported.

Endnotes

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