Strengthening hospital responses to family violence

Project management guide

A practical guide for establishing and implementing a service model

Fifth edition • October 2020

Strengthening Hospital Responses to Family Violence Project is funded by the Victorian Government and managed by the Department of Health and Human Services.

The Women's Hospital and Bendigo Health are working in partnership to lead the project.

Further information:
Jess Wilson
The Royal Women's Hospital
03 8345 2801
jessica.wilson@thewomens.org.au

Angela Crombie
Bendigo Health
03 5454 6397
acrombie@bendigohealth.org.au

Contents

Introduction 1
Defining family violence 3
Tips for Success 5
Adapting the approach to suit your health service 6
Changing practice environment 6
Respect and gender equality 8
An overview of the SHRFV approach 9
The SHRFV approach: five elements of the approach 9
Staff-centred approach 10
Patient-centred care 12
Elements of the SHRFV approach 15
Engage leadership and build momentum 16
Leadership briefing 16
Executive Sponsor commitment 17
Project manager 17
Health service position statement 18
MARAM Alignment implementation 18
Establish project objectives 18
Performance indicators 19
MARAM reference/ implementation group 19
Communication plan 20
Ideas to build momentum 21
Lay a foundation for success 22
Policy, procedures and guidelines 22
Environmental scan 24
Build capacity, capability and compliance 25
Training materials 25
Continuous improvement 28
Collaborative Practice 29
Involve consumers 30
Internal and external referrals 30
Secondary consultation 30
Information Sharing 31
Multi-agency practice 31
Create the evidence base 33
Data collection 33
SHRFV and MARAM alignment project evaluation 34
MARAM Alignment 35
Definition of terms 36
Endnotes 41

Introduction

The aim of the Strengthening Hospital Responses to Family Violence (SHRFV) Project is to support public Victorian hospitals and health services to implement a whole-of-organisation response to family violence. From 2014, the Victorian Government funded the Royal Women's Hospital (the Women's) and Bendigo Health to develop and support the implementation of the SHRFV service model.

This fifth edition of the SHRFV Toolkit, is designed to enhance work already undertaken as part of SHRFV and focuses on supporting Victorian public health services to align to the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM). As SHRFV was initially based on the previously utilised Common Risk Assessment Framework (CRAF), it is appropriate that SHRFV evolves to align with the new MARAM Framework.[1]

In response to Recommendation 1 of the Royal Commission into Family Violence[2] (the Commission), MARAM was developed and established in law under a new Part 11 of the Family Violence Protection Act 2008. MARAM reflects best practice for family violence risk assessment and management, based on the current evidence and research. It aims to establish a system-wide shared understanding of family violence, along with consistent and collective responsibility for identification, risk assessment and management. Under the Family Violence Protection Act, prescribed organisations, including hospitals once prescribed, are required to progressively align their policies, procedures, practice guidance and tools to the Framework legislative instrument. The first phase of organisations became prescribed to align with the MARAM in September 2018, and included state funded Sexual Assault Services, Alcohol and Other Drug Services and designated Mental Health Services. Additional organisations will become prescribed in the first half of 2021 under phase two, including hospitals (subject to Ministerial approval).

Under MARAM, organisations need to ensure the responsibilities for risk assessment and management can be met by their workforce in practice by putting into place the appropriate policies, procedures, practice guidance and tools and associated systems to facilitate their practical application. The purpose of this Guide is to assist Victorian public health services to drive the change necessary to strengthen the response to family violence and support them to meet their legislative requirements to align with MARAM.

The SHRFV approach has been developed as a framework for change based on experience at the Women's, Bendigo Health and many other hospitals who have implemented the model since 2014. It is acknowledged that each health service operates in its own unique environment with a different set of resources and this will need to be taken into account when applying the SHRFV approach.

This work has been developed in recognition that the health system is an

early contact point for many people who have experienced family violence. As family violence has major social and health impacts, and accounts for substantial repeat presentations at hospitals, all health service staff should be supported to identify and effectively provide support to people affected by family violence.

An empathetic and professional response from a trusted doctor, nurse, midwife or other health professional can reinforce a patient's understanding that they are entitled to healthy relationships and a life free from family violence. By respecting the decisions of patients and offering a range of options, health professionals have a vital role in ensuring that health needs are met, inclusive of a patient's safety. Such interventions have the potential to empower people affected by family violence, contribute to enhanced health outcomes and potentially save lives.

Given the prevalence of Australians affected by family violence it is likely that a number of staff will have personal experience or have been indirectly impacted by such violence. For this reason, it is recommended for health services to prioritise the establishment of a Family Violence Workplace Support Program for staff experiencing family violence. This includes training for managers to support staff both personally and professionally.

Although alignment to MARAM is a legislative requirement, it is also understood as a maturity model, and expected to take time. MARAM alignment will be an ongoing process for hospitals, and will be achieved by utilising opportunities for continuous improvement,

Like all change processes, strengthening a health service's approach to family violence will take time, and need to be responsive to the reform context. It requires a sustained effort and total commitment from the health services' board, executive and a cross functional reference/ implementation group. It cannot be the responsibility of any individual working in isolation. The experience of the Women's, Bendigo Health and other health services implementing the SHRFV approach is that committed, engaged executive and senior management leadership teams is critical to success.

If you have been tasked with implementing the SHRFV approach and supporting alignment to MARAM (as the project manager or as a member of the reference/ implementation group) you can be proud to know that this is vitally important work and your efforts will make a positive difference to the lives of your patients and staff, and the wider community.

It is recommended that this Guide and the MARAM Framework is read thoroughly at the outset to fully understand the various elements of work that will need to be undertaken in order to strengthen a health service's response to family violence.

Defining family violence

Family violence is complex. People may be affected across the life span, in many different ways, and by different types of perpetrators. It involves a spectrum of seriousness of risk and presentations.

Australian statistics indicate that family violence is deeply gendered, most frequently and most severely perpetrated by men against women, children and other vulnerable individuals. Clearly, all violence is unacceptable, and anyone can be a victim or perpetrator of family violence.[3]

The SHRFV approach aligns with the Family Violence Protection Act 2008 (Vic) (the Act).

Family violence is defined within the Act as a behaviour that is:

- Physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive; or is in any other way controlling that causes a person to live in 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.[4]

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'.[5]

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.[6]

The SHRFV approach has been developed based on the understanding that violence-tolerant attitudes and gender inequality drives family violence. The SHRFV approach also recognises that the drivers of family violence risk intersect with

other forms of structural inequalities and discrimination, including but not limited to patriarchy, colonization, racism, ableism, ageism, homophobia and transphobia. Experiences of discrimination and structural inequalities can affect the prevalence, experiences and impact of family violence and can create barriers to service access and response. As such, to address the issues and impacts of family violence, health services must have an understanding of, and be responsive to, barriers that at-risk cohorts face and take steps to ensure their services are accessible, inclusive and non-discriminatory to ensure equity of access and outcomes for all victim survivors

Please note that throughout this Guide we refer to family violence, health professionals and victim survivors and perpetrators in recognition that these are the terms most widely used in the community. The term victim survivor refers to any person (adult or child) who has a current or past experience of family violence or sexual assault.

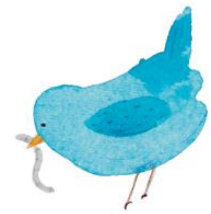
Recognised variations from this language include:

- Aboriginal people and communities may prefer to use the term 'people who use violence' or "people who experience violence".
- For adolescents, the term 'adolescent who uses family violence' is used.
- An older person who is experiencing family violence is often described as experiencing 'elder abuse'.[7]

The following statistics demonstrate the prevalence and severity of family violence, and the groups most at-risk of experiencing it:

- In Australia nearly one woman a week is killed by a partner or former partner in Australia.[8]
- In Australia on average one man per month is killed by a partner or former partner in Australia.[9]
- One in six women and one in 16 men have experienced physical or sexual violence from a current or former partner since the age of 15.[10]
- One woman in four had experienced emotional abuse by a current or former partner.[11]
- One in six Australian women have experienced physical or sexual violence by a cohabitating partner since age of 15.[12]
- Women in Australia are at least three times more likely than men to experience violence from an intimate partner.[13]
- More than half of the women who experienced violence had children in their care when the violence occurred.[14]
- Aboriginal women are 32 times more likely than non-Aboriginal women to be hospitalised and 10 times more likely to die from violent assault.[15, 16]
- Women and girls with disabilities are estimated to be twice as likely to experience violence as those without disabilities.[17]
- Rates of intimate partner violence within lesbian, gay and queer relationships are as high as the rates experienced by cisgender women in intimate heterosexual relationships.[18]
- The following groups are identified as facing particular risks and forms of family violence as well as barriers to accessing support:
  - Aboriginal and Torres Strait Islanders women
  - Diverse communities
  - Children and young people
  - Pregnant women
  - Women who have a disability
  - Older people.[19]
- Victoria Police crime statistics indicate 84,550 family incidents were recorded in 2019.[20]

Tips for Success



Undertaking a project of this nature will involve a significant investment of resources for any health service. The work undertaken to date at the Women's, Bendigo Health and other health services funded for this work has revealed several factors key to successful implementation.

Health service commitment, investment and support

A demonstrated commitment to this project from the leadership team will significantly enhance the outcomes and benefits that can be realised. Introducing change into any health service environment requires careful planning and strong leadership to ensure that staff embrace new ways of practice.

Past history of related initiatives

Having a clear understanding of any previous initiatives, projects and services undertaken by the health service in any way related to family violence will be valuable. Knowing what worked well and what didn't in relation to other change initiatives at the health service will also provide valuable insights. Also, having a clear understanding of concurrent relevant work – such as Rainbow Tick, Health Care that Counts, and the Child Safe Care Standards may assist in reducing workload and change fatigue.

Visibility and communication

The project will benefit from having high visibility across the health service. A strong communication strategy and plan to reach each stakeholder with relevant messages at the right time needs to be developed to build and maintain awareness and engagement. The SHRFV Toolkit provides templates for various communication materials that can be adapted to include your health service's brand/logo. This is also important moving towards MARAM alignment for the health service to ensure that staff and the health service's responsibilities and obligations are clearly communicated to relevant staff.

A committed multi-disciplinary team led by a dedicated family violence project manager

Establishing a team of staff from across programs and divisions (including a clinical lead) who are committed to the process of change and to attending team meetings to guide the change is crucial.

Workforce support

Establish a Family Violence Workplace Support Program to support your own staff experiencing family violence. This should include relevant family violence learning and development for managers prior to health professional training.

Realistic work plan

It is important that a realistic and achievable work plan is set. For example, the Women's and Bendigo Health identified priority areas for roll out of the SHRFV initiative, and now for the MARAM alignment process.

Don't reinvent the wheel

A comprehensive set of tools is provided with this Guide to help implement various tasks to realise the cultural and practice change goals. They can be adapted to suit your operating environment.

Adapting the approach to suit your health service

Recognising that each health service has a unique operating environment, the fifth edition of the toolkit content and resources can be adapted to suit. While the SHRFV approach was developed, and piloted, for hospitals it will have relevance, and can potentially be adapted, to other health care settings.

Resourcing should take into account the need to ensure sustainability and ongoing quality improvement.

Once key elements of the program have been established it is important to ensure there is resourcing (staff and funding), to continue to embed this work across the health service, to continue to train new and existing staff and be responsive to further legislative and policy changes.

Changing practice environment

The Commission presented our community with a unique opportunity to change. It challenged the sectors that intersect with family violence to work collaboratively to implement the reforms recommended by the Commission. This fifth edition of the SHRFV Toolkit has been developed during a period of intense reform and associated consultation. Project managers therefore need to keep abreast of how the following reforms develop and be mindful of the impact any changes will have on SHRFV implementation plans.

At the time of publishing this fifth edition of the Toolkit, reforms are underway in the following areas of specific relevance:

- Alignment to MARAM from Common Risk Assessment Framework (CRAF)
- Information sharing for prescribed organisations
- Antenatal screening
- The Orange Door (previously referred to as Support and Safety Hubs)
- Perpetrator accountability.

Alignment to MARAM from CRAF

As outlined in the Introduction of this Guide, the MARAM Framework replaces the CRAF and reflects best practice for family violence risk assessment and management, based on the current evidence and research. The Framework and its legislative requirements now underpin the SHRFV model and facilitates the mechanisms to drive changes necessary to strengthen health services' response to family violence.

Information sharing

Despite the importance of information sharing, agencies in the integrated family violence system have not shared information routinely or systematically. The Commission acknowledged that organisations working with victims and perpetrators of family violence collect a wide variety of information in order to keep victims safe and hold perpetrators to account.

The Commission also identified barriers that prevent information from being effectively shared. It found that the failure to share crucial information with frontline workers can have significant consequences.

In response to the Commission's findings, two new information sharing schemes have subsequently been legislated, creating additional opportunities to request and share risk relevant information in addition to existing legislation.

1. The Family Violence Information Sharing Scheme (FVISS) enables 'prescribed information sharing entities' to share information to

2. assess and manage family violence risk.
3. The Child Information Sharing Scheme (CISS) enables prescribed entities to share information to promote the wellbeing and safety of children.

The FVISS began for a select group of organisations and services in February 2018 and CISS for a select group of organisations in September 2018. Victorian public health services are scheduled to become 'prescribed framework organisations' under the Family Violence Protection Act 2008 and the Child Wellbeing and Safety Act 2005 (Vic) in the first half of 2021 (subject to Ministerial approval).

The Act also removes the requirement in existing Victorian privacy legislation that a serious threat to an individual's life, health, safety or welfare must be imminent before information can be lawfully shared.

While MARAM is a maturity model, prescription under FVISS and CISS are immediate, and as such health services will need to be able to respond to requests from the date of prescription.

Updated information about the schemes can be found on the [Victorian Government website](). SHRFV Information Sharing implementation resources are currently being developed.

The Orange Door

In response to the Commission, the Victorian Government introduced Support and Safety Hubs, known as The Orange Door. The Orange Door provides an integrated intake pathway to women's and children's specialist family violence services, services for men who use violence, Aboriginal services and family services. The Orange Door holds perpetrators to account by planning interventions to address the risk they pose and challenging their controlling, violent and abusive behaviour. They help connect people directly to services and provide a coordinated response to a range of different needs, and where required a whole-of-family response.

The Orange Door model has been refined, based on local co-design, with the initial implementation of five hubs located in the Barwon, Bayside Peninsula, Inner Gippsland, Mallee and North East Melbourne regions. When fully implemented, there will be seventeen Hubs across Victoria. Once the Hubs are established in each region health services should review and adapt their referral pathways and local partnerships to incorporate their local Orange Door.

Perpetrator accountability

A key principle of the MARAM Framework is keeping perpetrators in view and holding them to account for their actions and behaviours.[21] This objective guides current reform activities. While responding to perpetrators is a requirement of MARAM and we know that all health services will have contact with perpetrators of violence as patients, families and employees, the practice guides and tools for working with perpetrators is currently being developed by Family Safety Victoria and will likely be released in early 2021. As such working directly with perpetrators is beyond the scope of the existing SHRFV resources.

Antenatal screening

For hospitals that provide antenatal care, it is important to be aware of Recommendation 96 of the Royal Commission into Family Violence.

This recommendation sets out the requirement of routine screening for family violence in all public antenatal settings. The Recommendation also acknowledges that screening guidance should be aligned with the MARAM Framework, and that implementation will require the development of specific guidelines, along with targeted and continued training, and clinical support. Implementation of this recommendation is likely to be incremental. For hospitals where this is relevant, it will mean Sensitive Practice or universal screening using sensitive inquiry and first-line response to all antenatal patients, not just those presenting with clinical indicators of family violence risk.

Respect and gender equality

Family violence is a serious health issue, predominantly determined and reinforced by gender inequality and adherence to rigid gender roles and stereotypes.

The promotion of gender equity, respectful relationships and a zero tolerance to violence, are ways in which we can prevent family violence. In doing this, health services can contribute to improved health and social wellbeing of staff and service users, as well as improved health service performance.

Research from the 2016 ABS Personal Safety Survey and Australian Institute of Criminology shows that both men and women in Australia experience substantial levels of violence.[22] However, domestic and sexual violence is overwhelmingly committed by men against women.[23]Likewise the Family Violence Protection Act 2008 (Vic)[24] acknowledges that women and children are most likely to experience family violence at the hands of male partners.

The gendered nature of family violence is communicated throughout the SHRFV training, policy and procedures. While it is acknowledged that men can also be victims of family violence, their experience of violence is different from that of women. This is because they are more likely to experience violence from other men. When men do experience violence from a female partner they are less likely to report sustained experiences of fear.[25] Women are:

- most likely to experience physical and sexual violence in their home, at the hands of a male current or former partner[26]
- more likely to experience violence from someone known to them[27]
- likely to experience more serious harm[28]
- more likely to experience fear and anxiety.[29]

It is acknowledged that broader conceptions of gender apply to individuals' identities, experiences and manifestations of family violence. And that family violence can take place in any relationship where a power imbalance exists and affects all genders, relationship and family types.

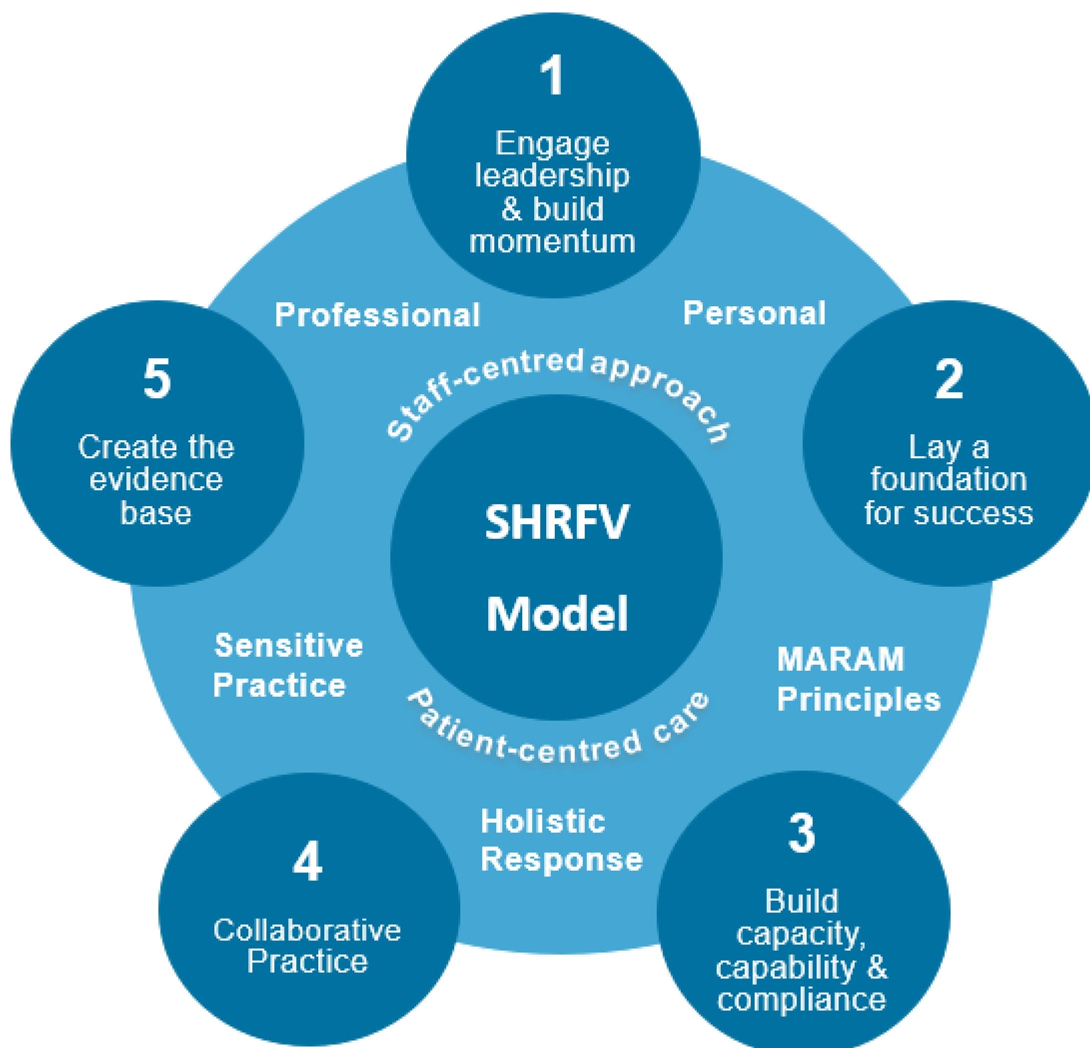
It is a commonly held myth that there is no power imbalance in same sex relationships. However, a lesbian, gay, bisexual, transgender, intersex, queer (LGBTIQ) person can also be the victim of many forms of abuse used by their partner or other family member to establish and maintain control.[30]

A 'family violence across the life span' approach provides knowledge and skills that can be applied by staff when working with people identifying as victim survivors of family violence regardless of their age, gender or gender identity, family type or circumstance. For example, responding to family violence towards older people, adolescents and family violence within wider family relationships and communities.

An overview of the SHRFV approach

This diagrammatic model is used to illustrate the SHRFV approach. It has evolved based on feedback from SHRFV project managers across the state who have been working to apply it in different settings. The model in this fifth edition has been updated to reflect alignment to MARAM.

The SHRFV approach: five elements of the approach



As the family violence project manager or member of the reference/implementation group it is important for you to understand the SHRFV approach and consider at the outset how it may need to be adapted to suit your setting. The five key elements of the model are built upon a foundation of two key concepts - that of a staff-centred approach which considers both the professional and personal staff situation, and the patient centred care that is both holistic and epitomises respectful, sensitive and safe engagement.

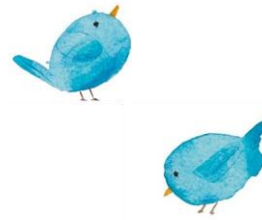
The main changes to the SHRFV model are:

1. The inclusion of the reference to 'compliance' in element 3. This change recognises the importance of organisational compliance with the new family violence reforms including MARAM, FVISS and CISS.
2. The changed terminology in element 4 from 'Build partnerships' to 'Collaborative Practice' which is an essential component in the MARAM Framework.
3. Inclusion of the MARAM Framework Principles that now underpin the SHRFV approach.

Staff-centred approach and patient-centred care

As the SHRFV model evolved in health services across the state it became apparent how important it is to balance the focus on patients with a focus on staff. This has also been supported by recent research undertaken at the Women's by Professor Kelsey Hegarty.[31]

Fundamental to effectively applying a staff-centred approach across the workplace is line management support. Therefore, relevant family violence learning and development for managers should be an early priority.



Staff-centred approach

Health services are very familiar with the concept of patient-centred care. The SHRFV approach recognises the need to apply the same care to staff when the focus on family violence in all its forms is heightened across the health service.

Professional

At a professional level, all staff need to have a shared understanding of family violence not only as a health issue, but of its drivers, presentation, prevalence, impacts and of perpetrator behaviours. In addition to this, all staff need to have an awareness of the health service's responsibilities under MARAM to identify and respond to family violence.

Health professionals need to be further trained and resourced to confidently identify and respond respectfully, sensitively and safely and provide support to victim survivors of family violence across the life span and keep perpetrators in view and accountable.

Before any training and development programs take place for health professionals it is recommended that health services establish the policy, procedures and infrastructure necessary to support them in applying the process in line with staff responsibilities under MARAM tailored for health.

Working with people affected by family violence can be taxing. Hearing about traumatic events can be overwhelming

and vicarious trauma is not uncommon. Vicarious trauma recognises that working with trauma victim survivors greatly affects health professionals and that the effects must be addressed in order to protect both them and patients. Vicarious trauma can be the natural consequence of being human, connecting to and caring about our patients as we see the effects of trauma on their lives.[32]

Recognising and addressing the need for self-care for health professionals is important. Providing the opportunity to support colleagues informally or more formally through group reflective practice sessions, or individually with external providers should be facilitated and encouraged.

One suggestion, based on the experience of the Women's and Bendigo Health, is to develop and implement a network of Clinical Champions (of change) across your health service. These people would be members of staff who are trained to assist other employees with accessing confidential, impartial, evidence-based information in relation to responding and supporting patients.

» See Tool: Clinical Champions role overview

» See Tool: Clinical Champions implementation Guide

» See Tool: Clinical Champions FAQs Having the right education, support and resources in place for staff is fundamental to the successful implementation of the SHRFV approach.

Personal

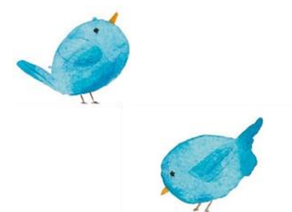
Family violence is also a workplace issue. It affects attendance, performance, productivity and the safety of the person experiencing family violence and their colleagues. Therefore, the SHRFV approach recognises that, as employers, health services must prioritise the safety and wellbeing of staff exposed to family violence professionally or personally. In a study of Australian health professionals, almost half of the 471 female health professionals surveyed had experienced intimate partner and/or family violence.[33]

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. It is reasonable to expect that increasing the attention given to family violence across the health service may trigger emotions and issues for any staff affected personally by family violence.[34]

In the Victorian public health sector, enterprise bargaining agreements contain a family violence leave clause. This clause provides for 20 days of family violence leave, together with other entitlements for employees experiencing family violence.

Further to this, access to specialist family violence support services and Employee Assistance Program (EAP) providers, safety planning support, family violence contact officers and education for staff and managers should be considered.

Before recommending EAP as a point of referral for family violence issues, it is important that a check is made with the EAP provider to ensure that they triage for family violence and have counsellors with experience and training in this area.



Developing and implementing a Family Violence Workplace Support Program with these key elements that align with EBA requirements is recommended as a priority in the SHRFV approach. It is recommended this work occurs prior to training health professionals to identify family violence and respond to victim

survivors. The Family Violence Workplace Support Program resources have been updated in this edition of the toolkit. Key components of the Workplace Support Program include mandatory family violence training for managers, implementation of family violence leave and the development of policies and procedures and intranet resources.

» See Tool: Family Violence Workplace Support Program Overview

» See Tool: Workplace Support – Responding to staff who are victim survivors of FV

» See Tool: Workplace Support – Responding to staff who perpetrate FV

» See Tool: Workplace Support Managers Training and supporting resources

Patient-centred care

Respectful, sensitive and safe engagement

Respectful, sensitive and safe engagement provides a framework for health professionals to engage with patients in a way that increases their sense of safety, respect and control.[35] Respectful, sensitive and safe engagement assists with alignment to MARAM Responsibility 1.

Australian family violence statistics tell us there are a large number of people who require a sensitive approach. The 2016 ABS Personal Safety Survey shows that women are most likely to know the perpetrator (often their current or previous partner) and the violence usually takes place in their home.[36]

This means health care professionals - whether or not they are aware - will regularly encounter victim survivors of family violence in their practice.

It has been reported by patients that feeling judged or without control in interactions with health professionals can be re-traumatising. The aim of respectful, sensitive and safe engagement is to avoid this situation by creating a practice environment where patients feel safe and supported in disclosing their experiences of family violence.

Examinations and procedures that health care professionals might consider innocuous or routine can be distressing for victim survivors, because they may be reminiscent of the original trauma.

Exclusive focus on the body, lack of control, invasion of personal boundaries, exposure, vulnerability, pain and sense of powerlessness are common experiences in the health care environment and may be extremely difficult for victim survivors because they can mirror aspects of past abuse. An appreciation of the dynamics and long- term effects of abuse is the first step toward a better understanding of victim survivors' needs and responses to care. Respectful, sensitive and safe engagement builds on core competencies to help health care professionals be more understanding of, and responsive to, the specific needs of victim survivors of violence and abuse.

The key elements of respectful, sensitive and safe engagement, based on the lessons learned from working with victims and victim survivors of childhood sexual abuse, are trauma informed and align with World Health Organization's (WHO) recommendations for a first-line response.[37, 38]

The principles of respectful, sensitive and safe engagement are:

- demonstrating understanding of abuse and violence
- respect
- dignity
- rapport

- taking time
- sharing information
- sharing control
- respecting boundaries
- mutual learning
- Understanding non-linear healing.

Feeling genuinely heard, and therefore valued, may be healing in itself and in some cases may be the most valuable intervention a health professional can offer.

Project managers should familiarise themselves with the WHO Clinical Handbook.

Provider knowledge of patients' experiences of violence can have momentous and positive impacts on their health care experience and outcomes.

A key aim of the SHRFV approach is to make the process of respectful, sensitive and safe engagement universal and routine in all Victorian public health service encounters for the benefit of all health care consumers.

Holistic response

In the context of the SHRFV approach reference to a holistic response is no different to the general understanding of the term. Health practice and service delivery should acknowledge the range of influences that affect a person's health and wellbeing and provide a range of treatment, rehabilitation, psycho-social and recovery support.

The SHRFV approach applies respectful, sensitive and safe engagement which adheres to the core principles of a holistic response and includes:

- Acknowledging and accepting people's lived experience and seeking to create environments which enable people to direct their own lives and meet the needs they have identified for their own recovery.
- A service response and care which acknowledges and is tailored to people's preferences, life circumstances and aspirations, and to their family and personal supports.
- Recognising and accounting for the multiple elements that affect individuals' wellbeing, including personal beliefs, cultural background, values, social and family contexts, physical health, housing, education and employment.
- Acknowledging the right to self-determination of Aboriginal and Torres Strait Islander people. Self-determination means:
    - Prioritising and promoting full control of one's own safety, healing, connections to land and culture, communities, futures and lives
    - Access to community-led information, options and supports
    - The right to safety in all relationships, through community-led education and the sharing of knowledge about what respect and safety looks like.[39]

MARAM Framework principles

The Framework states that to provide consistent, effective and safe responses for people experiencing family violence, services and professionals need a shared understanding of family violence and of the responsibilities involved. To help achieve a shared understanding, the Framework is comprised of four pillars which are underpinned by ten principles

and these principles are incorporated into the SHRFV approach.

The Framework principles are:

1. *Family violence involves a spectrum of seriousness of risk and presentations, and is unacceptable in any form, across any community or culture*
2. *Professionals should work collaboratively to provide coordinated and effective risk assessment and management responses, including early intervention when family violence first occurs to avoid escalation into crisis and additional harm*
3. *Professionals should be aware, in their risk assessment and management practice, of the drivers of family violence, predominantly gender inequality, which also intersect with other forms of structural inequality and discrimination*
4. *The agency, dignity and intrinsic empowerment of victim survivors must be respected by partnering with them as active decision-making participants in risk assessment and management, including being supported to access and participate in justice processes that enable fair and just outcomes*
5. *Family violence may have serious impacts on the current and future physical, spiritual, psychological, developmental and emotional safety and wellbeing of children, who are directly or indirectly exposed to its effects, and should be recognised as victim survivors in their own right*
6. *Services provided to child victim survivors should acknowledge their unique experiences, vulnerabilities and needs, including the effects of trauma and cumulative harm arising from family violence*
7. *Services and responses provided to people from Aboriginal communities should be culturally responsive and safe, recognising Aboriginal understanding of family violence and rights to self-determination and self-management, and take account of their experiences of colonisation, systemic violence and discrimination and recognise the ongoing and present day impacts of historical events, policies and practices*
8. *Services and responses provided to diverse communities and older people should be accessible, culturally responsive and safe, client-centred, inclusive and non-discriminatory*
9. *Perpetrators should be encouraged to acknowledge and take responsibility to end their violent, controlling and coercive behaviour, and service responses to perpetrators should be collaborative and coordinated through a system-wide approach that collectively and systematically creates opportunities for perpetrator accountability*
10. *Family violence used by adolescents is a distinct form of family violence and requires a different response to family violence used by adults, because of their age and the possibility that they are also victim survivors of family violence.*

Elements of the SHRFV approach

The SHRFV approach contains five key elements to enable a whole-of-organisation approach to family violence. The approach is drawn from the experiences of the Women's and Bendigo Health and is an adaptation of international best practice, in particular Kaiser Permanente, one of the largest not-for-profit, integrated health care delivery systems in the United States of America.[40]

1. Engage leadership and build momentum
2. Lay a foundation for success
3. Build capacity, capability and compliance
4. Collaborative practice
5. Create the evidence base

These five key elements are explained in detail on the following pages in consecutive order. In practice, activities identified in this Guide will likely overlap and they can be undertaken in an order which best suits the capacity of your health service.

The five elements should be viewed as a broad grouping of associated tasks required to strengthen a health service's approach to family violence and provide a solid foundation for the process of aligning to MARAM.

1

Element 1

Engage leadership and build momentum

This element focuses on the activities required to engage leadership and build organisation-wide commitment and momentum to achieve the change required to embed SHRFV and align with the MARAM Framework. This element supports meeting alignment requirements of Pillar 4.

Senior leadership engagement has been identified as the main enabler to implementing and embedding SHRFV. Given MARAM's legislative requirements, senior leadership oversight and engagement is essential. Previous editions of the Guide identified a number of critical steps to engage and promote strong leadership at all levels. This approach can be utilised by those responsible for leading MARAM alignment within a health service, which may or may not be SHRFV project staff.

Leadership briefing

Health services executive leadership teams must have a strong understanding of the MARAM Framework and information sharing reforms, and the requirements associated with their organisation's legislative compliance. An executive leadership team who are committed to MARAM alignment and its implementation will significantly enhance the outcomes and benefits for victim survivors, and effectively support their staff to operationalise these family violence reforms.

It is recommended that a MARAM briefing for leadership be undertaken in various forums. In the first instance the Board and Executive will require a high-level overview of MARAM and the Information Sharing Schemes.

A presentation for managers will be required to build a shared understanding of alignment requirements. Engaging management as early as possible will assist the change process. Do not underestimate the importance of your leadership team in the SHRFV approach. Without their ongoing commitment and engagement, your success and progress can and will be limited.

An Executive MARAM briefing can be found in Family Safety Victoria's Organisational Embedding Guide. This can be adapted to suit your audience and aims.

1

Executive Sponsor commitment

As with legislative compliance, MARAM alignment requires an executive sponsor to lead this process.

An important first step is to identify an executive sponsor. This person will be ultimately responsible for alignment to MARAM, strengthening the health service's response to family violence and reporting legislative compliance to the Department of Health and Human Services (DHHS). They will make project-related decisions on behalf of the health service and direct the project manager.

The role of the executive sponsor is to:

- Ensure that the project complies with the health service's legislative requirements
- Support the development of a MARAM Alignment Action Plan and its implementation
- Ensure resolution of issues identified by the project manager
- Lead communication about MARAM alignment
- Ensure availability of essential project resources
- Provide direction and control over the use of resources and time
- Review and approve changes to plans, priorities, deliverables and schedule
- Establish roll-out reporting arrangements
- Gain agreement amongst the stakeholders (including consumers) when differences of opinion occur
- Chair MARAM governance or advisory committee and reference group meetings
- Promote high level stakeholder (including consumers) relations
- Advise the project manager of protocols, political issues and potential sensitivities
- Report implementation progress to the health service executive.

Project manager

A project manager should be appointed to manage the development of a MARAM alignment Action Plan and its implementation under the direction of the executive sponsor. The project manager should work closely with the SHRFV team. The project manager role may be allocated to a SHRFV team members with additional hours and resources.

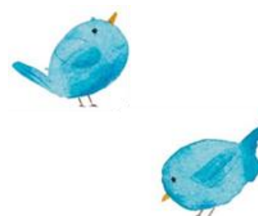
Ideally the project manager will have family violence experience and project management skills. Project management skills are essential, however mentoring may be available through each health service.

Key areas of responsibility for the project manager are to:

- Clarify the project vision, scope and objectives
- Develop a MARAM Alignment Action Plan
- Liaise with the executive sponsor
- Establish a multi-disciplinary MARAM reference group/team
- Develop a communication plan to support the change
- Coordinate implementation of MARAM Alignment actions
- Complete a project risk management plan
- Arrange for collection of data
- Monitor and report on MARAM alignment activities
- Evaluate progress.

» See Tool: Reference Group Meeting Agenda

» See Tool: Risk Management Plan



Health service position statement

The majority of health services now have a family violence position statement. This may require updating in line with MARAM alignment requirements.

The statement should detail why your health service is adopting a stronger response to family violence. The position statement once endorsed by executives will help to clarify the health service's vision and provide the first key message for staff. This edition of the toolkit includes an updated sample position statement below.

Posting the health service's position statement on your website will raise awareness and educate the community about the health impacts of family violence and the work underway at your health service to strengthen its response to family violence.

» See Tool: Sample Family Violence Position Statement

MARAM Alignment implementation

To align to MARAM, health services must undertake actions to effectively incorporate the four pillars and principles of the Framework into existing policies, procedures, practice guidance and tools, as appropriate to the roles and functions of the prescribed entity and its place in the service system.[41]

The MARAM Alignment resources included in this edition of the toolkit have been developed to support health services to undertake this work.

The purpose of the MARAM Alignment Action Plan is to provide a health service's Chief Executive Officer and Senior Leadership with a plan to support full MARAM Alignment for their endorsement.

It is critical that health service Executives are involved in the development and final endorsement of the action plan. This will ensure that appropriate resources are committed to the project and implementation of the MARAM Alignment Action Plan.

Toolkit Update:

The MARAM alignment resources have replaced the Project Implementation Plan and Project Implementation Report that were included in the 4th Edition of the SHRFV toolkit.

Establish project objectives

Every project requires a set of clearly defined, practical objectives against which the implementation can be measured.

The key is not to set too many objectives, otherwise the task can become onerous and unachievable. Before objectives can be written, clarity is needed about what the health service's vision is in terms of strengthening its response to family violence. This may be determined at Executive or by the reference group.

When writing objectives think SMART: make them Specific, Measurable, Achievable, Realistic and Time appropriate. Think about what you are seeking to achieve. For example:

- When do you want to have policies and procedures in place? Do they need to be in place first for other actions to occur?
- Which managers do you want trained and by when?
- How can you measure that your clinical practice has improved post implementation?
- How have you improved your collaborative practice both internally and externally?

- How will you know if all your staff are aware of why you are making SHRFV and MARAM a priority?

These answers can be translated into objectives that are easy to measure because they clearly state what you are striving for.

The MARAM alignment checklist provides recommended steps organisations can take in the first three, six and twelve months to undertake alignment.

Your objectives for the first six months might be as follows.

1. By end of month 1 establish a multi- disciplinary reference group chaired by the project sponsor that meets monthly to undertake the work.
2. Between month 2 and 5 develop a MARAM Alignment Action Plan.
3. By month 6 have the Action Plan endorsed by the CEO and executives

The MARAM alignment for hospitals and health services and supporting resources are designed to assist the development of a MARAM Alignment action plan. Once endorsed by the organisation's Chief Executive Officer and Senior Leadership it can be used to set objectives and timelines for implementation.

» See Tool: MARAM alignment for hospitals and health services and supporting resources

Performance indicators

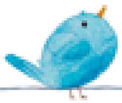
A set of key performance indicators (KPIs) for the project should be endorsed by the Executive. KPIs will help you to see your progress towards the goal of strengthening the health service's response to family violence and aligning to the MARAM framework.

KPI's could be determined in the following four areas:

- Timeliness
  Are we on schedule? Have planned activities been completed on time? Have milestones been reached?
- Resources
  Are appropriate resources allocated to support the activities?
- Quality
  Are health professionals, staff and patients benefitting and satisfied?
- Effectiveness
  Has the investment of time and money in the project delivered the desired results? Are staff trained, clinical practice improvements implemented, referrals made, staff supported, data collected? Is there a process for continuous improvement and evaluation in place?
- Compliance
  Do we have mechanisms to review and monitor alignment progress?

MARAM reference/ implementation group

A MARAM reference/implementation group will assist to build organisation-wide momentum for the project. A governance or advisory committee with executive representatives is a requirement under Pillar 4. The role of this committee is to have oversight of key decisions to support MARAM alignment and resourcing associated with its implementation. Existing SHRFV reference groups may take on this function. The membership of the group will depend on available internal resources and expertise. Including external appointments such as family violence experts from local specialist services and consumer advocates (victim survivor of family violence) will potentially build capacity and capability within the health service to better respond to family



violence and also help build important partnerships and collaborative practice. Membership must include executive representation and should include a range of staff at different levels from across the health service to provide diverse and multi-disciplinary perspectives. Clinical representation on the group is essential. Representation from your human resources team is also key in regards to workplace support.

Draw up a matrix of staff levels and roles you want included to ensure that you establish a team with the representation you require.

The terms of reference for the group will need to be drafted so that expectations are clear for everyone involved. They are generally drafted prior to the first meeting of the group and tabled for discussion and endorsed at the meeting. They may also need to be formally endorsed by the health service executive.

The terms of reference would include:

- Purpose of the group
- Role of participants
- Membership
- Meeting schedule
- Administration and other systems support.

» See Tool: MARAM Reference Group Terms of Reference

Ideally a reference group would:

- Ensure alignment of activities across the health service to enable successful implementation
- Lead some of the tasks relevant to their area
- Research best practice and bring ideas to the table
- Bring a diverse perspective to the project plan and initiatives
- Provide a communication conduit with colleagues in their respective areas
- Help to overcome barriers to change
- Be SHRFV champions – know what is going on
- Engage local family violence agencies and other stakeholders in the health service's approach
- Increase the health service's understanding of the role and responsibilities of specialist family violence services
- Be interested to develop their skills and experience beyond the training offered at the health service
- Be a testing ground for new initiatives
- Undertake or delegate work within their department
- Be able to make decisions and authorise change.

Communication plan

Communication is everything when driving cultural change, and strengthening your health service response to family violence and aligning with the MARAM Framework will require good and ongoing communications.

Change is about people. People who are affected by the change, and people who will implement the change. The success of embedding SHRFV and aligning with the MARAM Framework will depend on the reactions of people to the changes you are proposing.

People generally don't like change and change fatigue is rampant in busy organisations so it can be hard work. That means a lot of thought needs to be given to communication and how it will encourage change.

A good place to start is by visiting and talking with key stakeholders to explain MARAM and what it is aiming to achieve and understand their perspective. Seek out people at all levels who are well connected, sensitive to the health service culture, and widely respected to get their input to the MARAM alignment Action plan

as well as their views on how things should be implemented. Conversations like this will help to identify problems a project manager needs to be alert to and opportunities such as cultural strengths which can be harnessed.

Lack of good communication is often why change initiatives fail. Communication is everything!

Communication considerations

People need information from the outset that is consistent, clear and relevant. They must get that information when they need it and in a form that they can easily access.

Both formal and informal communication will raise awareness about your health service's commitment to strengthen its response to family violence, understand MARAM alignment requirements, motivate people to participate in training and develop infrastructure. This will ultimately create the culture you want.

Begin by formulating what changes you may need to make to support MARAM Alignment. Determine the messages that will need to be introduced across the health service as implementation progresses. Remember that there needs to be the opportunity for two-way communication, an understanding of how that will be achieved and who could be key influencers. Always look to build in opportunities to celebrate success and learn from experiences.

A key question to ask might be 'How well has our health service implemented previous SHRFV initiatives?' Understanding your health service's prevailing culture and barriers to change will determine the strategies adopted in this element.

When staff are involved in and feel some ownership of the change process, sustained cultural change is more likely. Consider how you can involve staff.

» See Tool: Communication Action Plan

» See Tool: Communications Plan – Special Events

» See Tool: Clinical Champions Role Overview

Ideas to build momentum

- Staff forum/grand round with high profile speaker or family violence expert to communicate the changes required for MARAM alignment.
- Stakeholder conversations or roundtable.
- Call for expressions of interest to join the MARAM reference group.
- Leadership briefing and key messages for team managers.
- Signing of the memorandum of understanding between the health service and family violence service provider partners formalising referral processes.
- Announce reaching particular training targets.
- Establish a dedicated page on your intranet for staff support, including an interview with CEO/executive sponsor.
- Present local data and information to executive, managers and staff meetings to raise awareness and make a call to action.
- Participate in sector days of relevance, for example, 25 November – 10 December are the 16 Days of Activism Against Gender-Based Violence (including the International Day for the Elimination of Violence against Women and Human Rights Day). Host a staff competition for the best team effort to support the theme.

2

Element 2

Lay a foundation for success

This element of work focuses on establishing the policy, procedures, guidelines and infrastructure necessary to support:

- Staff personally affected by family violence
- Health professionals in their work to identify and respond to patients affected by family violence.
- Meeting alignment requirements of Pillar 1 & 2.

Policy, procedures and guidelines

Policy, procedures and guidelines are a crucial aspect of the SHRFV approach. Many health services have developed policies, procedures and guidelines to support staff and patients as part of the SHRFV initiative. These existing documents may be revised and adapted to reflect the MARAM requirements and in some cases new policies, procedures and guidelines may need to be developed.

Workplace Support Program

To begin, it is recommended you develop a Family Violence Workplace Support Policy and Procedure to support staff professionally and personally. These should clearly explain the support and options available to staff experiencing or perpetrating family violence. This edition of the toolkit has updated Workplace Support resources.

» See Tool: Family Violence Workplace Support– Responding to staff who are victim survivors of FV

» See Tool: Family Violence Workplace Support – Responding to staff who perpetrate FV

Responsibilities for risk assessment and management under MARAM

In order to meet the alignment requirements for Pillar 2 and Pillar 3 under MARAM, health services need to understand their responsibilities in risk assessment and management, assign responsibilities to their workforce and enable their workforce to implement the responsibilities in practice to ensure consistent and collaborative practice.

» See Tool: Supporting Resource A – Workforce mapping for MARAM Alignment

Where health services map their workforce and the associated practice expectations, will inform decisions on how to amend clinical practice guides. This edition of the toolkit includes a recommended policy and procedures for staff mapped at a Foundational Practice and Sensitive Practice level under MARAM. These can be adapted to suit the operating environment and reflect internal and external relationships and referral pathways.

» See Tool: Identifying and Responding to Family Violence Policy

» See Tool: Identifying and Responding to Family Violence Procedure: Foundational Practice

» See Tool: Identifying and Responding to Family Violence: Sensitive Practice

If your health service does not have policy, procedure or guidelines on Family Violence Identification and Response for patients or for supporting staff experiencing family violence, drafting them should be a priority.

Issues to consider when developing or updating policies, procedures and guidelines

There are a number of issues that need to be considered when updating policies, procedures and guidelines including:

- Differentiating levels of risk and health service responses aligned with MARAM responsibilities that determine appropriate response and referral pathways to the family violence service sector
- Clarifying the roles and responsibilities under MARAM of health professionals, social workers (if you have one/any), and local family violence services in responding to family violence with regard to your local operating environment
- Procedures are contextualised for each clinical area or site (for example, maternity, emergency department or urgent care)
- Identifying documentation and data collection processes required by the health service
- Consulting with relevant stakeholders, including those in the family violence sector and consumers, to ensure that policies, procedures and guidelines align with current processes
- Incorporating the release and education about endorsed policies into the communication plan prior to any workforce training and development activities
- Deciding how practice compliance with policies, procedures and guidelines will be determined
- Deciding how these documents will be linked or referenced as a way of meeting Australian Council on Health Care Standards
- Deciding how these documents will be linked to other relevant policies, procedures and guidelines.
- Identifying the ‘owner’ of the relevant policies, procedures and guidelines
- Determining the process and timelines for review, updating and authorisation of relevant policies, procedures and guidelines
- Patient referral pathways are clearly defined
- Details of referral agencies are accurate and up to date
- Related forms and documentation are available for staff reference
- Linkage is made with other relevant health service policies (for example, OH&S)
- The policy and procedure has been endorsed, distributed and all health service staff are made aware of it
- The policy and procedure is considered in the context of the dynamic external policy and reform environment.

2

Environmental scan

Another aspect of laying the foundation for success would be to understand the internal and external operating environment. For example, an external environmental scan will identify the various areas of reform which need to be taken into account when project planning. Internally this could include looking at clinical areas to make an assessment of their suitability in terms of ensuring privacy for patients when making a disclosure. Most important are conversations with stakeholders in the project to:

- Uncover any concerns about the project
- Understand different perspectives on what will be required to ensure that the project achieves its goal
- Gain insight into opportunities which can be harnessed to support culture change and project implementation
- Identify any barriers that will need to be considered in the project implementation.

An aspect of the environmental scan might also involve speaking with another project manager in an organisation where MARAM alignment is more advanced.

3

Element 3

Build capacity, capability and compliance

This element of work involves the provision of training and development for staff tailored to their particular roles and responsibilities under MARAM. It is important that a program of training is provided for line managers around their important workplace support role prior to health professional training. This element supports meeting alignment requirements of all four Pillars.

Under MARAM all staff have a role in contributing to their organisation's whole of organisation response to family violence and meeting their legislative requirements. The revised MARAM aligned SHRFV training modules are designed to build a whole-of-organisation shared understanding of family violence and cover the practice expectations for staff mapped at Foundational Practice (i.e. to perform and fulfil MARAM Responsibility 1 and contribute to MARAM Responsibility 2, 5, 6, 9 & 10) and Sensitive Practice (i.e. to perform and fulfil MARAM Responsibility 1 & 2 and contribute to MARAM Responsibility 5, 6, 9 & 10). These modules complement the external MARAM training for staff mapped at Intermediate (i.e. to perform and fulfil MARAM Responsibility 1, 2, 3, 4, 9 & 10) and Comprehensive level of response (i.e. to perform and fulfil MARAM Responsibility 1 through 10).

Additionally all line managers need to undertake training to develop the skills necessary to support staff working with patients affected by family violence, or who may have personal experiences of family violence.

Human resources professionals/Family Violence contact officers will also require training to assist them in their role of providing workplace support to staff experiencing family violence.

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

» See Tools: SHRFV training materials and handouts.

» See Tools: Workplace support training materials and handouts:

The following SHRFV training has been developed and revised to align with MARAM:

3

Foundational Practice

Target audience: Health service staff mapped at a Foundational Practice level.

The module covers the MARAM practice expectations for staff groups assigned Foundational Practice responsibilities as set out in the Workforce Mapping for MARAM Alignment Guide, that is to perform and fulfil MARAM Responsibility 1 and contribute to MARAM Responsibility 2, 5, 6, 9 & 10) . That is:

- The gendered nature and dynamics of family violence
- How to identify family violence observable signs and risk indicators
- An understanding of the barriers that impact support and safety options
- How to respond to disclosures respectfully and sensitively and prioritise the safety of victim survivors
- What to do if a patient or colleague discloses family violence
- How staff mapped at Foundational Practice contribute to a whole of health service response to family violence
- It also includes information regarding family violence leave and other support available for staff to access themselves or to assist their peers, and how assist colleagues experiencing family violence.

Sensitive Practice

Target audience: Health service staff mapped at a Sensitive Practice level.

This module covers the MARAM practice expectations for staff groups assigned Sensitive Practice responsibilities as set out in the Workforce Mapping for MARAM Alignment Guide, that is to perform and fulfil MARAM Responsibility 1 & 2 and contribute to MARAM Responsibility 5, 6, 9 & 10). That is:

- The gendered nature and dynamics of family violence
- How to identify family violence observable signs and risk indicators
- How to engage with patients or colleagues respectfully and sensitively and prioritise the safety of victim survivors
- Ways to ensure the organisation is a safe, accessible and culturally responsive environment for patients and staff to disclose

- How to ask risk relevant identification questions
- How to tailor engagement for all patients and maintain a person-centred approach
- Know what to do if disclosures of family violence are made
- How to document family violence appropriately and safely and contribute to organisation's safe, ethical application of information sharing schemes
- How staff mapped at a Sensitive Practice level contribute to a whole of health service response to family violence
- It also includes information regarding family violence leave and other support available for staff to access themselves or to assist their peers, and how assist colleagues experiencing family violence.

> Toolkit Update:
>
> The Foundation Practice and Sensitive Practice training modules replace Module 1, 2 and the combined module in the previous toolkit editions.

Please note that the current modules do not build upon each other like previous modules, they are standalone modules.

Staff who have previously undertaken SHRFV training will be required to undertake additional training relating to the new practice expectations under MARAM.

Supplementary modules

Target audience: all health professionals working with people in these settings

Provides health professionals with the knowledge and skills to apply respectful, sensitive and safe engagement in relation to:

- Identifying and responding to family violence within a paediatric setting
- Identifying and responding family violence when working with older people
- Responding to sexual assault – practice considerations of trauma-informed care
- Responding to family violence and sexual assault within rural and regional settings.
- Antenatal Screening for Family Violence

Workplace support

Target audience: all line managers, HR staff and FV Contact Officers

- Provides line managers with the knowledge, skills and procedural understanding to support staff at a professional and personal level.

Training materials

A suite of training materials are provided within the SHRFV Toolkit for download:

- The SHRFV Training Manual provides more detail and instructions for training facilitators
- PowerPoint slides for each module with presenter notes, including suggested interactive learning activities and film clips (it is envisaged that facilitators will adapt the training to suit the health service's operating environment while maintaining the key messages)
- Facilitator's guides to support those delivering Family Violence Workplace Support Program Manager's training.
- Handouts and other supporting resources.

Raise awareness post-training

To make patients aware that your health service is a safe place to disclose family violence and that your staff understand family violence, it's important that post-training, awareness-raising materials are clearly displayed in patient-facing areas. Likewise, staff need to be reminded to practise sensitive inquiry.

Various promotional materials are available for health service's to download and produce with their own logo.

» See Tool: Preview of Communication Material

» See Tool: SHRFV Patient-facing Poster

» See Tool: SHRFV Staff-facing Poster

» See Tool: SHRFV Staff Badge

» See Tool: SHRFV LIVES Lanyard

» See Tool: SHRFV Bookmark

» See Tool: SHRFV Pull-up Banner

Continuous improvement

Every effort should be made to increase the effectiveness and/or efficiency of the health service to fulfil its SHRFV goal and alignment to MARAM. The MARAM Organisational Embedding Guide has a useful tool 'Review Implementation activities' that can assist this process.

Staff should be encouraged to provide formal, informal and anonymous feedback about lessons learned and bright ideas. Such feedback can be gathered in a variety of ways including:

- SHRFV\MARAM email point
- SHRFV\MARAM suggestion box
- Post-training surveys
- Community of Practice with other Victorian public health services embedding the SHRFV approach and aligning to MARAM
- Conversations with clinical champions
- Stakeholder focus groups or roundtables
- Team meetings
- Case review and staff support sessions including reflective practice and collaborative practice reviews

» See Tool: Family Violence Workplace Support Manager Training – Post-training Survey

» See Tool: Clinical Champions Role Overview

Celebrating the project milestones and tangible benefits that arise throughout MARAM alignment will also help to maintain interest and encourage feedback from staff. This could take the form of newsletter stories, including interviews with the SHRFV team, clinical champions or health professionals about a change in their area to improve patient experience or about the impact of training on their clinical practice.

Regular service analysis is another form of continuous improvement. This analysis involves putting yourself in the shoes of the patient and identifying the journey they would travel if they disclose and accept or decline a referral. For example, mapping out the patient experience from initial contact or presentation through assessment, service receipt, referral, transfer, ongoing care and/or discharge. This analysis will enable the health service to identify opportunities to improve patient experience and inter-agency relationships.

» See Tool: Communications Plan Special Events

4

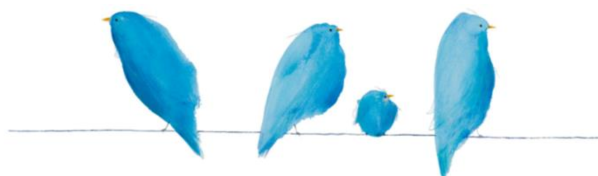
Element 4

Collaborative Practice

This element of work focuses on establishing collaborative practice internally, with the wider community and with the local family violence services sector. Establishing or strengthening partnerships and developing processes to support collaborative practice improves outcomes for patients and supports meeting alignment requirements of Pillar 2.

Collaborative practice is an essential component in the MARAM Framework. It recognises the role the service system has in upholding the safety of victim survivors and keeping perpetrators in view and accountable for their behaviours and actions. It supports effective family violence identification, risk assessment and management through establishing connections and partnerships that facilitate secondary consultation, referrals, information sharing and effective and timely family violence multi-agency practice. The success of risk management strategies depends on coordination, communication and consistent responses among services, which establish a web of accountability. Strengthening and establishing relationships to facilitate collaborative practice between departments and external services is part of an organisation's MARAM alignment responsibilities.

Working in partnership with other agencies recognises the diverse expertise within the wider community and family violence sector and strengthens the ability of the health services to respond to family violence in the most appropriate way.



The particular demographic and cultural groups served by your health service will inform which agencies the health service may wish to prioritise partnering with. Building community partnerships to support people affected by family violence should not be limited to the family violence sector. Health services may want to seek out partnerships with other external agencies. These can also contribute to supporting patients and their families.

The following organisations and services can provide support to patients. These are examples of where valuable partnerships could be formed:

- The Orange Door in your region
- Centres Against Sexual Assault
- legal services (health justice partnership)
- Women's and men's health organisations
- Aboriginal and Torres Strait Islander organisations
- Migrant support services
- Child and family services
- Community policing services.

The Women's recommends establishing a health justice partnership with your local legal

service. Through such a partnership, lawyers can offer on-site legal assistance to your patients experiencing family violence. To learn more about establishing a health justice partnership go to: https://www.healthjustice.org.au/

Involve consumers

Involving consumers, particularly victim survivors, in developing and improving the health service's response to family violence will undoubtedly lead to better outcomes and quality of care. Patients with lived experience will have a different perspective of what health services do compared to that of the health professionals, so can provide a different view about what a health service does, how it does it and how it can improve. For example, a victim survivor could be a member of the MARAM reference group, speak at an event or tell their story on film for use in training. Safe Steps have experience in this area through the Advocates Program, which could inform work such as this.

Consider conducting a research project with the required ethics approval to gain insight about clinical practices and the outcomes for victim survivors.

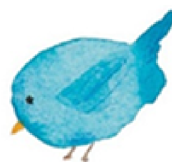
» See Tool: Engaging Survivor Advocates

Internal and external referrals

A key goal of strengthening your health service's approach to family violence is to create an environment where patients feel safe and supported in disclosing their experiences of family violence. This involves providing patients with referral options, and is linked to MARAM responsibility 5.

Respectful, sensitive and safe engagement respects a patient's right to make choices. Regardless of whether or not a patient accepts a referral it is important that a health professional remains supportive and allows the patient to progress at their own pace wherever possible. This will ensure that a patient does not feel pressured or 'out of control' in making decisions. However, when there are children at risk or there is a serious threat to a person's life, health, safety or welfare professionals need to consider their mandatory reporting requirement and obligations under FVISS and CISS.

Most health service utilise their social workers (where they are available) to coordinate family violence referrals from health professionals. Where there is a disclosure, social workers conduct risk assessment and safety planning as well as provide counselling and referrals to the family violence sector.



Social workers may not always be available or, for a variety of reasons, some patients may choose not to accept such assistance. If that is the case health professionals need to be able to advise patients of other support options using specialist family violence agencies.

Patients are more likely to engage with external providers where a 'warm' referral is made. That is, the referring practitioner offers to call the service to make an appointment and provides information about that service to the patient.[42]

Secondary consultation

The SHRFV approach encourages health professionals to use secondary consultation when working with patients who may be experiencing family violence. Secondary consultation is a process of seeking advice from a line manager, hospital social worker/ family violence

expert or an external service such as Safe Steps, and is linked to MARAM responsibility 5. Where multiple co-morbidities exist, mental health and drug and alcohol services can be accessed for support. Health professionals can seek advice on how to proceed and best support a patient experiencing family violence.

Secondary consultation:

- Can be by telephone, email or in person
- Promotes understanding of family violence and intersectionality considerations
- Is especially important if child protection considerations are identified
- Facilitates access to family violence services
- Promotes improved practice in family violence responses to meet the needs of the person accessing support
- Provides reflection opportunities and support to staff responding to family violence.

When family violence training is provided to health professionals it is common for an increase in disclosures and referrals to family violence services to occur. For this reason it is helpful to advise referral partners (internal and external) prior to any training being rolled out.

In smaller rural health services, access to social work professionals may be limited. This makes it even more important for health professionals to be aware of local specialist family violence services, or those specialist agencies that provide outreach services to rural areas. Connecting with the wider community and family violence sector can be challenging in rural areas where these services may not always have a physical presence. However, working with these services in developing referral pathways will assist to build these vital relationships.

Information Sharing

Developing relationships and connections that facilitate information sharing is linked to organisations enabling MARAM responsibility 6.

Information sharing facilitates a patient's access to support, enables the service system to make timely, informed and decisive actions to respond to family violence and assists with ongoing risk assessment and management activities that contribute to enhance a patient's safety and a child/ren's safety and wellbeing. Information sharing creates opportunities to keep perpetrators in view and hold them accountable for their behaviours and actions. Information sharing supports a coordinated risk management response, rather than risk assessment and management resting on one service in isolation.

To meet their MARAM responsibilities, health services need to ensure clear information sharing processes are in place, as permitted by relevant information sharing legislation. Working with other agencies to improve information sharing processes also helps meet MARAM responsibilities 5, 6, 9 and 10.

Multi-agency practice

Developing relationships and connections that facilitate multi-agency practice is linked to organisations fulfilling MARAM Responsibility 9 & 10.

It is important to establish strategies and processes for working collaboratively with key local partners for coordinated risk assessment and management purposes to improve outcomes for patients. This will be

4

guided by the requirements associated with the MARAM responsibilities that a department or organisation holds. All staff have a responsibility to understand and work within multi-agency responses. Coordinated multi-agency practice is a responsibility of staff groups and departments who hold intermediate and comprehensive MARAM responsibilities and organisational leaders responsible for coordinating and leading risk management responses both internally and as part of a multi-disciplinary and multi-agency approach.

To meet their MARAM responsibilities, health services need to build relationships between departments and external services to set up clear expectations and processes around multi-agency practice.

Undertaking a mapping exercise of the family violence service providers in your local area will help to determine which service providers and relationships require strengthening, and identify gaps in service linkages including protocols and pathways for referrals and secondary consultations.

» See Tool: Supporting Resource E – Facilitating Collaborative Practice

» See Tool: Building and sustaining partnerships

5

Element 5

Create the evidence base

This element of work focuses on the collection of data and evaluation of the SHRFV project and MARAM alignment, which will contribute to continuous improvement. This element supports meeting alignment requirements of Pillar 4.

Data collection

The collection of data has been the most challenging aspect of the SHRFV approach to date. The Women's and Bendigo Health have adopted a variety of data collection and evaluation methods. Health services may have their own preferred evaluation framework.

This element aligns with Pillar 4 of the MARAM Framework, "Systems, outcomes and Continuous Improvement". The MARAM Organisational Embedding Guide Implementation Review Guide can be utilised to check that the implementation activities are being successfully embedded into your organisation.

Although this is the final element of the SHRFV model, it is important to think about evidence and how you will collect data early on in the project so that you can establish a baseline against which outcomes can be measured. For example, you will need to consider what data you are going to collect, how you will collect it, when you will collect it, how you are going to analyse and report the data, and who to.

Collection of data will achieve various outcomes including:

- Measuring the progress of alignment activities
- Providing evidence about changed clinical practice and service delivery
- Informing the improvement of service delivery
- Helping build business cases
- Evaluating the project itself.

For the purpose of initial evaluation of this work, quantitative data will be a useful starting point and (if available) might include:

- Baseline and post-implementation surveys on the level of knowledge and confidence of staff to identify family violence
- Number of increased identification of family violence incidents recorded in the health service's database/systems
- Number of referrals to specialist family violence services and/or Social Work
- Suite of policies, protocols and guidelines developed.

The collection and observation of qualitative data will provide an insight into the culture of the health service and its adoption of the changed practice. This could also be collected by way of focus

groups, interviews, online discussion forums etc.

Observation and attending staff meetings of the clinical staff and non-clinical staff who have completed various levels of training might provide an indication of how well the training has been integrated into everyday practice.

Engagement with key stakeholders and consumers will also be a sound way to collect qualitative data, but will require meeting stringent ethical processes in order to do so safely.

Other information that will assist health services with the ability to monitor and evaluate (and therefore improve) the impact and efficacy of the SHRFV and MARAM alignment implementation include:

- Partnerships with the family violence services established
- Change in organisational culture
- Change in clinical practice
- Change in staff knowledge
- Level of staff comfort to apply practice expectations.

To show marked change in organisational culture and clinical practice following implementation of the approach, it is fundamental to implement a baseline evaluation of each of these indicators, and repeat at periodic intervals to assess change in practice.

To survey clinical staff on their level of knowledge and confidence in family violence before and after the training is a great way to identify changes to clinical practice and measure the success of the implementation.

One of the key findings of the pilot project at the Women's and Bendigo Health was that understanding the existing data sets within a health service and the ability to capture family violence data, can take time and requires expertise from across the health service.[43]

Until such time as specific data fields are mandated health services need to develop their own solutions to data collection.

SHRFV and MARAM alignment project evaluation

The evaluation of a project is a structured process of assessing the success of the project in meeting its objectives and to reflect on the lessons learned.

Findings of evaluation reports are a precious input into future decision making and planning processes. Evaluation enables continuous improvement by incorporating lessons learned from past evaluations into new strategies, programs and projects.

Evaluation is part of the project cycle and is best planned for in the establishment phase by defining SMART objectives and asking who is the evaluation for and what do they want to know?

Identifying your key target audiences for any evaluation will determine the type of information you need to provide and what evaluation questions you ask.

You will also want to align the project evaluation with the KPIs of the project and the reporting system your health service uses for its Statement of Priority and strategic plan.

The Project Evaluation tool incorporates the framework known as RE-AIM. RE-AIM stands for Reach, Effectiveness, Adoption, Implementation and Maintenance. This framework was developed to evaluate public health interventions for short-term clinical engagement with patients.

It will enable project managers to report on the following key project measures.

- Do staff have an increased understanding of family violence and its drivers?
- Do health professionals know how to ask and respond to patients with signs of family violence?
- Post training, do managers know how to support a staff member to access a workplace safety plan?
- Post training, are health professionals putting sensitive inquiry into practice?
- What response are health professionals receiving? Disclosure or non-disclosure?
- What type of referrals are being made? Internal or external?
- Are referrals being accepted?
- What is the patient perspective of being asked about family violence in the health service setting?
- What is the patient perspective of the support/referral provided?

MARAM Alignment

A requirement of Pillar 4 under MARAM is for organisations to contribute to, and engage with system-wide data collection, monitoring and evaluation of tools, processes and implementation. Health services can demonstrate alignment to Pillar 4 by:

- Establishing or utilising existing governance advisory structures to implement the framework.
- Establishing internal mechanisms that support data collection, disaggregation and reporting in line with the Victorian Government Family Violence Data Collection Framework (such as relating to patient demographics, the evidence-based family violence risk factors and the patient's individual experience of family violence including the nature of relationships and identification of victim survivor and perpetrator)
- Establishing internal mechanisms that support data collection, disaggregation and reporting relating to information that supports opportunities for continuous improvement and to inform policy decision making, such as service delivery and client outcomes relating to family violence
- Contribute to, and engage with, system-wide data collection, monitoring and evaluation of tools, processes and implementation when requested
- Undertake activities to change organisational culture and practice, and promote continuous improvement in risk assessment and management practice, information sharing and enhanced collaboration with other services

» See Tool: MARAM alignment for hospitals and health services

Definition of terms

Term	Definition
Aboriginal definition of family violence	The Victorian Indigenous Family Violence Task Force defined 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.[44]
Child abuse	Any action, or lack of action, that significantly harms the child's physical, psychological or emotional health and development. The *Child Youth and Families Act 2005* (Vic) enables consideration of the pattern and history of harm and the impacts on a child's safety, stability and development. There is an overwhelming body of evidence which indicates that chronic neglect, abuse and family violence are harmful and have a cumulative and detrimental effect on a child's development. Child abuse can occur within a single incident or on multiple occasions and is categorised in the following manner: – physical abuse – sexual abuse – emotional/psychological abuse – neglect.[45]
Domestic partner	A person who is in a registered relationship within the meaning of the *Relationships Act 2008*[46] with the person; b) an adult to whom the person is not married but with whom the person is in a relationship as a couple where one or each of the persons provides personal or financial commitment and support of a domestic nature for the support of the other person. The definition of domestic partner – is inclusive of all genders – whether or not the persons are living under the same roof.
Elder abuse	Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, and social and/or neglect.[47]
Family member	As per the Family Violence Protection Act 2008 (Vic)[48] a) a person who is, or has been, the relevant person's spouse or domestic partner; or

	b) a person who has, or has had, an intimate personal relationship with the relevant person; or c) a person who is, or has been, a relative of the relevant person; or d) a child who normally or regularly resides with the relevant person or has previously resided with the relevant person on a normal or regular basis; or e) a child of a person who has, or has had, an intimate personal relationship with the relevant person 2) For the purposes of subsections (1) (b) and (1) (e), a relationship may be an intimate personal relationship whether or not it is sexual in nature. 3) For the purposes of this Act, a 'family member' of a person (the 'relevant person') also includes any other person whom the relevant person regards or regarded as being like a family member if it is or was reasonable to regard the other person as being like a family member having regard to the circumstances of the relationship, including the following: (a) the nature of the social and emotional ties between the relevant person and the other person; (b) whether the relevant person and the other person live together or relate together in a home environment; (c) the reputation of the relationship as being like family in the relevant person's and the other person's community; (d) the cultural recognition of the relationship as being like family in the relevant person's or other person's community; (e) the duration of the relationship between the relevant person and the other person and the frequency of contact; (f) any financial dependence or interdependence between the relevant person or other person; (g) any other form of dependence or interdependence between the relevant person and the other person; (h) the provision of any responsibility or care, whether paid or unpaid, between the relevant person and the other person; (i) the provision of sustenance or support between the relevant person and the other person. Example A relationship between a person with a disability and the person's carer may over time have come to approximate the type of relationship that would exist between family members. (4) For the purposes of subsection (3), in deciding whether a person is a family member of a relevant person the relationship between the persons must be considered in its entirety.
Family violence	As per the *Family Violence Protection Act 2008* (Vic);[49] (a) Behaviour by a person towards a family member of that person if that behaviour – i. is physically or sexually abusive; or ii. is emotionally or psychologically abusive; or iii. is economically abusive; or

	iv. is threatening; or v. is coercive; or vi. in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or (b) Behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a); (c) The Act also contains a preamble that states that 'The Parliament also recognises the following features of family violence; (d) That while anyone can be a victim or perpetrator of family violence, family violence is predominantly committed by men against women, children and other vulnerable persons'; (e) That children who are exposed to the effects of family violence are particularly vulnerable and exposure to family violence may have a serious impact on children's current and future physical, psychological and emotional wellbeing; (f) That family violence – i. affects the entire community; and ii. occurs in all areas of society, regardless of location, socioeconomic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion; (g) That family violence extends beyond physical and sexual violence and may involve emotional or psychological abuse and economic abuse; (h) That family violence may involve overt or subtle exploitation of power imbalances and may consist of isolated incidents or patterns of abuse over a period of time.
Integrated family violence system	The integrated family violence system (IFVS) is a network of specialist domestic and family violence services and community and statutory service providers who work together to improve the safety of people who experience violence.[50]
Intersectionality	Intersectionality refers to the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation.[51] Taking an intersectional approach means looking beyond a person's individual identities and focusing on how those identities affect each other. These points of intersection will alter the way people experience family violence, and in many instances will increase risk and amplify barriers to disclosure and service access.[52]
Intimate partner violence	This refers to behaviour by an intimate partner that causes 'physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviours'.[53]

	This definition covers violence by both current and ex-partners and other intimate partners.
Patient	Generally refers to the consumer/client of the health service who is experiencing violence, also known as the 'victim/survivor'.
Perpetrator accountability	The process by which the perpetrator themselves acknowledge and take responsibility for their choices to use family violence and work to change their behaviour. It sits with all practitioners, organisations and systems through their collective, consistent response to promote perpetrators capacity to take responsibility for their actions and impacts, through formal or informal services response mechanisms.[54]
Policy	Statements of principle that guide decision-making and service delivery.
Primary prevention	Refers to whole-of-population initiatives that target the primary (first or underlying) gendered drivers of violence against women with the aim that violence does not happen at all. This can be achieved through a combination of universal strategies as well as tailored actions or strategies for different settings, groups and contexts.[55]
Procedures	More detailed instructions about how policies should be carried out by staff.
Respectful, sensitive and safe engagement	A WHO framework that provides a way of operating as a health professional that is designed to increase a patient's sense of safety, respect and control, ultimately reducing the risk of re-traumatisation for victim survivors, who may chose not to disclose it.
Risk Assessment	The process of applying structured professional judgement to determine the level of family violence risk.[56]
Risk Management	Any action or intervention taken to reduce the level of risk posed to a victim and hold perpetrators to account. Actions taken and interventions that are implemented appropriate to the level of risk identified in the risk assessment stage.[57]
Secondary prevention	Secondary prevention (also called 'early intervention') works in more targeted ways to stop early signs of violence in specific individuals, communities or contexts from escalating.[58]
Sensitive inquiry	An approach of routinely asking patient's about their experience(s) of family violence underpinned by a framework of respectful, sensitive and safe engagement. The approach used here is based on the WHO's clinical[59] inquiry approach and Health Canada's principles of sensitive practice, which drew on lessons from victim survivors of childhood sexual abuse.[60]
Sexual assault	Any sexual behaviour that makes a person feel uncomfortable, frightened or threatened. It is sexual activity to which a person does not consent. The use of emotional or physical violence to force another person to engage in sexual activity also constitutes sexual assault. Sexual assault can take various forms, some of which are criminal offences: touching, fondling, kissing, being made to look at, or pose for, pornographic photos, voyeurism, exhibitionism, sexual harassment, verbal

	harassment/innuendo, rape, incest/intrafamilial child sexual assault, stalking.[61]
Sexual violence	Defined by the Australian Bureau of Statistics as 'any incidents of sexual assault and/or sexual threat'.[62] This describes a range of sexual behaviours that make someone feel uncomfortable, frightened, intimidated or threatened. These behaviours are all 'violent' in the sense that they are a violation, whether they involve physical violence or not. Some can be life-threatening. They include:[63] – sexual harassment (for example, unwanted sexual comments or jokes) – sexual coercion (pressuring or forcing someone into having sex) – unwanted sexual touching of any kind – being forced to watch sexual things, including pornography – voyeurism (being watched doing intimate things without having given your permission) – sexual assault, including rape – threats or other kinds of intimidation of a sexual nature.
Tertiary prevention	Tertiary prevention (also called 'response') seeks to stop the recurrence of existing violence and/or minimise its impacts[64]
Victim/survivor	A term used in conventional practice and throughout this document to refer to those that may have identified as experiencing family violence. It is in recognition of language on our patterns and behaviours. 'Victim' is commonly understood as emphasising the innocence of one against who a crime is perpetrated, the term 'survivor' alone does not alert us to this major actor.[65]
Violence against women	A broad umbrella term, defined by the United Nations as 'any act of gender- based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'. It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.[66]

Endnotes

[1] Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework, Melbourne: Victorian Government. Retrieved from https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management

[2] State of Victoria, 2016. Royal Commission into Family Violence: Summary and recommendations, Parl Paper No 132 (2014–16), Melbourne: State Government of Victoria. Retrieved from https://www.vic.gov.au/family-violence-recommendations

[3] Australian Institute of Health and Welfare, 2018. Family, domestic and sexual violence in Australia 2018, Cat. No. FDV 2, Canberra: Australian Institute of Health and Welfare. Retrieved from https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/table-of-contents

[4] Family Violence Protection Act 2008 (Vic). Retrieved from https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/052

[5] Department of Victorian Communities, 2003. Victorian Indigenous Family Violence Task Force: Final Report, Melbourne: State Government of Victoria. Retrieved from https://catalogue.nla.gov.au/Record/3310516

[6] State of Victoria, Department of Health and Human Services, 2018. 'Dhelk Dja: Safe Our Way - Strong Culture, Strong Peoples, Strong Families', Melbourne: Victorian Government. Retrieved from https://www.vic.gov.au/sites/default/files/2019-06/Dhelk-Dja-Safe-Our-Way-Strong-Culture-Strong-Peoples-Strong-Families-Poster.pdf

[7] Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. op. cit.

[8] Australian Domestic and Family Violence Death Review Network, 2018. Australian Domestic and Family Violence Death Review Network 2018, Domestic Violence Death Review Team, Sydney. Retrieved from https://apo.org.au/node/174811

[9] ibid.

[10] Australian Institute of Health and Welfare, 2018. op. cit.

[11] ibid

[12] ibid

[13] Australian Bureau of Statistics, 2016, Personal Safety, Cat. No. 4906.0. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0

[14] Australian Institute of Health and Welfare, 2018. op. cit.

[15] Closing the Gap Clearinghouse (AIHW & AIFS), 2016. Family violence prevention programs in Indigenous communities. Resource sheet no. 37. Produced by the Closing the Gap Clearinghouse. Canberra: AIHW & Melbourne: AIFS. Retrieved from https://www.aihw.gov.au/getmedia/c0e5bdde-e9c4-4a1f-808e-256191835cde/ctgc-rs37.pdf.aspx?inline=true

[16] Australian Institute of Health and Welfare, 2006. Family violence among Aboriginal and Torres Strait Islander peoples. Cat. no. IHW 17. Canberra: AIHW. Retrieved from https://www.aihw.gov.au/reports/indigenous-australians/family-violence-indigenous-peoples/contents/executive-summary

[17] Dowse, L., Soldatic, K., Didi, A., Frohmader, C. & van Toorn, G., 2013. Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Background Paper. Hobart: Women with Disabilities Australia. Retrieved from http://www.wdv.org.au/documents/BTE%20Final%20Report.pdf

[18] 18. Our Watch, 2017. Primary Prevention of Family Violence Against People From LGBTI Communities: An Analysis Of Existing Research. Melbourne: Our Watch. Retrieved from https://www.ourwatch.org.au/resource/primary-prevention-of-family-violence-against-people-from-lgbtiq-communities-an-analysis-of-existing-research/

[19] Australian Institute of Health and Welfare, 2018.

[20] Crime Statistics Agency, 2019. Key Figure: Year ending December 2019. Retrieved from https://www.crimestatistics.vic.gov.au/media-centre/news/key-figures-year-ending-december-2019

[21] Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. op. cit.

[22] Australian Bureau of Statistics, 2016, Personal Safety, Cat. No. 4906.0. op. cit.

[23] ibid.

[24] Family Violence Protection Act 2008 (Vic). op. cit.

[25] Australian Institute of Health and Welfare, 2018. op. cit.

[26] ibid.

[27] ibid.

[28] ibid.

[29] ibid.

[30] Our Watch, 2017. op. cit.

[31] ANROWS, 2017. Women's Input into a Trauma-informed Systems Model of Care in Health Settings. Retrieved from https://www.anrows.org.au/publication/womens-input-into-a-trauma-informed-systems-model-of-care-in-health-settings-the-with-study-final-report/

[32] Saakvitne KW, Gamble S, Pearlman L, & Lev B, 2000. Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse. Lutherville, MD: Sidran Press.

[33] McLindon E, Humphreys C, & Hegarty K, 2018. 'It happens to clinicians too': an Australian prevalence study of intimate partner and family violence against health professionals. BMC Women's Health [serial online]. 18(1), Academic Search Complete, Ipswich, MA. Retrieved from https://dx.doi.org/10.1186%2Fs12905-018-0588-y

[34] ibid.

[35] Victorian Government, Family Safety Victoria, 2018. Practice Guides Responsibility 1: Respectful, sensitive and safe engagement. Retrieved from https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%201_0.pdf

[36] Australian Bureau of Statistics, 2016, Personal Safety, Cat. No. 4906.0. op. cit.

[37] World Health Organization, 2013. Responding to Intimate Partner Violence and Sexual Violence Against Women: Clinical and Policy Guidelines, WHO, Geneva. Retrieved from http://www.who.int/reproductivehealth/publications/violence/rhr1310/en/

[38] Schachter C, Stalker CA, Teram E, Lasiuk GC, & Danilkewich A, 2008. Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood

Sexual Abuse, Public Health Agency of Canada: Ottawa. Retrieved from https://www.cdho.org/docs/default-source/pdfs/reference/sensitivepractice.pdf

[39] State of Victoria, Department of Health and Human Services, 2018. 'Dhelk Dja: Safe Our Way - Strong Culture, Strong Peoples, Strong Families'

[40] Pines J, Selevan J, McStay F, George M, & McClennan M, 2015. Kaiser Permanente - California: A Model for Integrated Care for the Ill and Injured. Centre for Health Policy at Brookings. Retrieved from https://www.brookings.edu/wp-content/uploads/2016/07/KaiserFormatted_150504RH-with-image.pdf

[41] Victorian Government, Family Safety Victoria, 2018. op. cit.

[42] Department of Health, 2012, Elder Abuse Prevention and Response Guidelines for Action 2012–14, Department of Health, Melbourne. Retrieved from https://www.thelookout.org.au/sites/default/files/eap_guidelines.pdf

[43] Our Watch, 2015. Strengthening Hospital Responses to family Violence: Final Evaluation Report. Melbourne: Our Watch

[44] Department of Victorian Communities, 2003, op. cit.

[45] Department of Health and Human Services, 2015. Child Protection Practice Manual, Department of Health and Human Services, Melbourne. Retrieved from www.cpmanual.vic.gov.au/glossary#h3_74

[46] Relationships Act 2008 (VIC). Retrieved from http://classic.austlii.edu.au/au/legis/vic/consol_act/ra2008173/s39.html#domestic_relationship

[47] Department of Health, 2012, Elder Abuse Prevention and Response Guidelines for Action 2012–14, Department of Health, Melbourne. Retrieved from https://www.thelookout.org.au/community/practice/document_file/elder-abuse-prevention-and-response-guidelines-action-2012-2014

[48] Family Violence Protection Act 2008 (Vic). op. cit.

[49] ibid.

[50] Domestic Violence Victoria, 2018, The family violence system, Retrieved from http://www.thelookout.org.au/who-responds-family-violence-victoria

[51] Victorian Government. Understanding Intersectionality. Viewed14 September 2020 at https://www.vic.gov.au/understanding-intersectionality

[52] Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. op. cit.

[53] World Health Organization, 2013. op. cit.

[54] Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. op. cit.

[55] VicHealth, 2017, Violence against women in Australia. An overview of research and approaches to primary prevention, Victorian Health Promotion Foundation, Melbourne, Australia. Retrieved from https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/PVAW/Violence-Against-Women-Research-Overview.pdf

[56] Victorian Government, Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. op. cit.

[57] ibid.

[58] VicHealth, 2017, Violence against women in Australia. An overview of research and approaches to primary prevention, Victorian Health Promotion Foundation, Melbourne, Australia. Retrieved from https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/PVAW/Violence-Against-Women-Research-Overview.pdf

[59] World Health Organization, 2013, op. cit.

[60] Schachter et al. 2008. op. cit.

[61] Centre Against Sexual Assault, 2010. About Sexual Assault: Definitions, the Royal Women's Hospital, Melbourne. Retrieved from www.casahouse.com.au/index.php?page_id=156

[62] Australian Bureau of Statistics, 2013, Personal Safety Survey 2012, Cat. No. 4906.0, Australian Bureau of Statistics: Canberra. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/%20Lookup/4906.0Chapter1002012

[63] Our Watch, 2014. Reporting on Sexual Violence, Our Watch: Melbourne. Retrieved from https:// www.ourwatch.org.au/MediaLibraries/OurWatch/Images/ourwatch_reporting_on_sexual_violence_aa_v1.pdf

[64] VicHealth, 2017. Violence against women in Australia. An overview of research and approaches to primary prevention, Victorian Health Promotion Foundation: Melbourne, Australia. Retrieved from https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/PVAW/Violence-Against-Women-Research-Overview.pdf

[65] McCarthy, T. (1990), From margin to mainstream: Pioneering a feminist model of management in traditional hospital/medical organisation, Presented at the NCASA Conference, July, Denver, Colorado.

[66] World Health Organization, 2013. op. cit.