



Strengthening hospital responses to family violence

Project overview

Fifth edition • September 2020

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# Introduction

Health services are an early contact point for many people who have experienced family violence. Health professionals are in a unique position to identify indicators of family violence, respond sensitively, respectfully and safely to patients and provide support.

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 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.

With appropriate education and support, health professionals can reduce the barriers to disclosing family violence, respond sensitively, respectfully and safety to patients experiencing family violence and be a catalyst for action.

Given the prevalence of Australians affected by family violence it is likely that a number of health service staff will have personal experience, or been indirectly impacted by such violence. Given this, as a priority, health services need to have a Family Violence Workplace Support Program in place.

In 2014, the Women’s and Bendigo Health, in partnership with Our Watch, piloted the Strengthening Hospital Responses to Family Violence Project (SHRFV) with funding from the Victorian Government.

To assist Victorian hospitals and health services to embed this model, the Victorian Government funded the Royal Women’s Hospital (the Women’s) and Bendigo Health in 2015 to develop an approach and suit of resources that could be adapted across the state to increase and strengthen hospitals and health services capacity and capability to respond to family violence. The project became known as Strengthening Hospital Responses to Family Violence (SHRFV). This work was informed by international best practice and evaluated by Our Watch in 2015. Subsequent editions of the SHRFV Toolkit have been developed based on feedback and input received from participating hospitals and other specialist organisations The Victorian Government has invested $38.4 million from 2017 to 2021 to support hospitals to implement the SHRFV approach.

The critical importance of this work is reflected in recommendation 95 of the Royal Commission into Family Violence (Victoria 2016) (the Commission) which called for a whole- of-hospital approach when responding to family violence drawing on evaluated approaches, and the inclusion of family violence in the Statements of Priority for all Victorian public hospitals in 2018-19.1

The Commission recognised the unique role the health sector has as a critical entry point for identifying people affected by family violence, providing medical care and a pathway to specialist support and assistance. It noted that ‘some victim survivors will not contemplate engaging with a specialist family violence service but will interact with health professionals at times of heightened risk of family violence or seek treatment for injuries or medical conditions arising from violence they have experienced.’2

This fifth edition of the SHRFV Toolkit, is designed to enhance work already undertaken as part of SHRFV and focus on supporting health services to align to the Multi-Agency Risk Assessment and Management Framework (MARAM).

In response to Recommendation 1 of the Royal Commission into Family Violence (Victoria 2016) MARAM was developed and established in law under a new Part 11 of the Family Violence Protection Act 2008. [MARAM](https://www.vic.gov.au/maram-practice-guides-and-resources) 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. The first phase of organisations became prescribed to align with 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 identification, 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 initial scope of this project was limited to a particular focus on violence against women and their children, and substantially on intimate partner violence, however, with the inclusion of general public hospitals, the scope broadened to family violence, incorporating all family relationships and abuse types. In 2017, this was expanded to recognise the broader impact of family violence and sexual assault across the life span. Under MARAM, family violence is recognised as a misuse of power to achieve control over another person, which can take place in any relationship where a power imbalance exists, and affects all genders, relationships and family types. As such services should also be informed by broader community understandings and experiences of family violence, also included in the definition of family violence in the Family Violence Protection Act 2008, and the broader definition of family violence for Aboriginal communities. This Toolkit recognises these broader experiences of family violence

While anyone can be a victim or perpetrator of family violence, the evidence base both globally and in Australia shows that family violence is a gendered crime and is predominantly committed by men against women. Children and other vulnerable family members are also victimised by directly experiencing and/or witnessing the effects of violence in the home. Australian statistics also show that when men are the victims of family violence, the perpetrators are also predominantly other men.3

Family violence is driven by violence-tolerant attitudes and gender inequality. The drivers of family violence risk also intersect with other forms of structural inequality and discrimination, including but not limited to patriarchy, colonisation, racism, sexism, ableism, ageism, homophobia and transphobia. Experiences of discrimination and structural inequalities can affect the prevalence, experiences and impact of family violence and can increase risk and create barriers to service access and response. For example, for Aboriginal communities, the historical and ongoing impacts of colonisation, dispossession and the structural and systemic violence since then have contributed to increased rates of family violence perpetrated against Aboriginal people and communities and the range of complex and compounding barriers they face to reporting and seeking support, including a lack of culturally safe services, an ongoing fear of child removal, and a profound mistrust of mainstream services. 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.



# What does the Toolkit include?

The materials provided in the 5th edition of the Toolkit detail the approach that the Women’s and Bendigo Health developed to support health services to build on work already undertaken as part of SHRFV and align to the Victorian Government MARAM Framework. It is recommended as an evidence-based approach appropriate to the needs of Victorian health services. It can be adapted to suit different health service’s operating environments and the communities they serve, ensuring that any adaptions retain the integrity and intention of the MARAM Framework. In this edition of the toolkit all resources have been reviewed and updated to align to MARAM, and additional resources have been developed to support organisation to align to the MARAM Framework and meet their legislative requirements.

The Toolkit contains:

* **SHRFV Project Overview** – an overview of the SHRFV approach
* **SHRFV Project Management Guide** – practical information to help project managers establish and implement a whole-of-hospital approach to family violence
* **MARAM Alignment resources** – designed to support hospitals and

health services to align to the Family Violence Multi-Agency Risk Assessment and Management Framework.

* **SHRFV Project Management Tools** –
* Recommended MARAM aligned policy and procedures for Foundational Practice and Sensitive Practice.
* Other MARAM aligned project management tools and resources to support implementation.
* **SHRFV Family Violence Workplace Support Program Resources**
* An overview of the key components of a health service approach to supporting staff who experience or perpetrate family violence
* Sample policies and procedures for responding to staff who experience family violence and staff who perpetrate family violence
* Manager training modules and supporting resources
* **SHRFV Training Materials** - developed for facilitators tasked with building the awareness, capacity and capability of hospital staff. These training resources have been endorsement by Family Safety Victoria to ensure they align with MARAM practice expectations
* Training manual
* Foundational Practice and Sensitive Practice modules
* Supplementary modules which address the specific issues of sexual assault, working with children, older people and people living in regional and rural locations in the context of family violence and antenatal screening for family violence.
* Handouts, session plans, facilitators guides and supporting resources
* **SHRFV Communication materials** - These materials have been developed following extensive consultation with leading family violence experts and women who have experienced family violence. They include:
* Posters to promote the hospital as a safe place for people to discuss family violence
* Posters for staff to prompt them to ask about family violence
* Other resources such as palm cards and buttons.
* SHRFV logo images which can be used to develop other SHRFV communication materials.



# Defining family violence

The SHRFV whole-of-hospital approach aligns with the *Family Violence Protection Act 2008* (Vic).

Family violence is defined within the Family Violence Protection Act 2008 (Vic) (the “Act”) as a behaviour that occurs in family, domestic or intimate relationships that is:

* Physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive; or is in any other way 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 behaviour4.

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*.

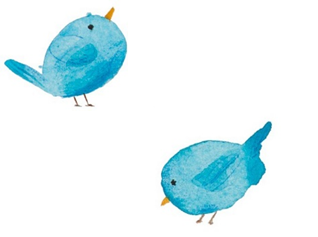
The Dhelk Dja (2018) definition of family violence also acknowledges:

*‘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 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.7
* In Australia on average one man per month is killed by a partner or former partner in Australia.8
* 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 15.9
* One woman in four had experienced emotional abuse by a current or former partner.10
* One in six Australian women have experienced physical or sexual violence by a cohabitating partner since age. 11
* Women in Australia are at least three times more likely than men to experience violence from an intimate partner.12
* More than half of the women who experienced violence had children in their care when the violence occurred.13
* Aboriginal women are 32 times more likely than non-Aboriginal women to be hospitalised and 10 times more likely to die from violent assault. 14
* Women and girls with disabilities are estimated to be twice as likely to experience violence as those without disabilities.15
* 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.16
* 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.17
* Victoria Police crime statistics indicate 84,550 family incidents were recorded in 2019.18



# Why strengthen health service responses to family violence?

Research shows that family violence and broader violence has major and long-term physical and psychological health impacts and contributes to repeat presentations in hospitals and associated health care costs.19

Data published by the Australian Institute of Health and Welfare reports that eight women and two men are hospitalised each day after being assaulted by their partner.20 This is supported by American research which found family violence from a current or former partner contributed to higher use of health services, particularly mental health services.21

It is known that women experiencing family violence commonly first disclose to health professionals and that their first response is pivotal.22 Doctors, nurses, midwives, social workers and other health professionals working in a health setting are therefore uniquely placed to help people affected by family violence seek the safety and support they require.

An empathetic and sensitive first response has added importance when working with individuals from communities that have been identified as facing particular risks and forms of family violence as well as barriers to accessing support. Such as:

* Aboriginal people
* People from culturally and linguistically diverse and faith communities
* People from lesbian, gay, bisexual, transgender, intersex, queer or questioning (LGBTIQ+) communities
* People with a disability
* People who experience mental health issues or mental illness
* Older people
* Rural and remote communities
* Women in or exiting prison
* Children and young people 23

However, anecdotal surveys of health professionals conducted prior to training often indicate that while the majority of staff recognise the importance of identifying and responding to family violence, they lack the confidence to do so. As such, building confidence and capability in the workforce to respond respectfully, sensitively and safely to presentations of family violence is the key aim of the SHRFV model. And why the SHRFV model is built upon a foundation of two key concepts - that of a staff-centred approach which considers each staff member’s professional and personal situation, and the patient centred care that is both holistic and epitomises sensitive practice.

Given the prevalence of Australians affected by family violence it is likely a number of health service staff will have a personal experience, been indirectly impacted by such violence24, or who perpetrate family violence. The Toolkit therefore recognises family violence as a workplace issue and includes resources health services can use to ensure that their own staff are appropriately supported personally and professionally.

Working with people affected by family violence can be taxing. As such, fundamental to the SHRFV approach is a staff-centred approach

# About the SHRFV approach

The SHRFV approach provides a whole-of-hospital approach to strengthen the response of Victorian public health services to family violence. To achieve this goal requires a sustained process of culture change.

Like all change processes, strengthening a health service’s approach to family violence will not happen overnight. It requires a sustained effort and total commitment from the health service’s board, executive and a multi-disciplinary reference/ implementation group. It cannot be the responsibility of any individual working in isolation.

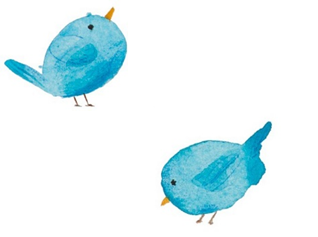
The experience of the Women’s, Bendigo Health and other health services implementing the SHRFV approach is that committed, engaged executive and senior management leadership teams are critical to success.

It is also important to be mindful of the many interrelated environmental factors which will impact on this work, including the law, media attention, research, practice innovations and your health services’ role within the integrated service system. To effectively accommodate such environmental factors it is important to approach implementation of the project with a flexible mindset.

At every stage of the work, effective communication – the right message to the right people at the right time – is vital for success.

The SHRFV approach aims to:

* address the need to support staff both professionally and personally
* introduce evidence-based practices in health services which will help patients affected by family violence be more inclined to disclose and seek help
* ensure that health professionals have a shared understanding of family violence, feel confident, and have the capacity to recognise indicators of family violence, respectfully, sensitively and safety respond to disclosures of family violence
* Undertake identification, risk assessment and management of family violence in line with their role and responsibilities under MARAM.



# Underlying principles

The following fundamental principles inform the SHRFV approach.

## Respect and gender equity

Respect and gender equity recognises that 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.

The SHRFV approach aligns with the Family Violence Protection Act 2008 (Vic), which acknowledges that family violence is a gendered issue, particularly within the context of intimate partner violence which is overwhelmingly committed by men against women.25

Within the context of intimate partner violence, data demonstrates that women experience far greater harm than men.

Women are five times more likely to be hospitalised and five times more likely to suffer serious injury than men.26

A ‘family violence across the lifespan’ approach provides knowledge and skills that can be applied by staff when working with people identifying as victims of family violence regardless of their age, gender or circumstance.

## Sensitive practice

A central element of the experience of violence is the loss of control and feelings of powerlessness. Sensitive practice increases a patient’s sense of safety, respect and control regardless of whether or not they choose to disclose violence. Sensitive practice enables health services to ensure victim survivors have control over their healthcare and engagement with the service system. Indeed, any action taken by a health service to support a victim survivor to increase their safety must be done in partnership with a patient. A sensitive practice assists with alignment to MARAM Responsibility 1 and the MARAM principles.

## MARAM Framework principles

The Framework is based on the belief that to provide consistent, effective and safe responses for people experiencing family violence, services need a shared understanding of family violence and of the responsibilities of the professionals involved.

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
8. 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
9. Services and responses provided to diverse communities and older people should be accessible, culturally responsive and safe, client-centred, inclusive and non-discriminatory
10. 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
11. 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.

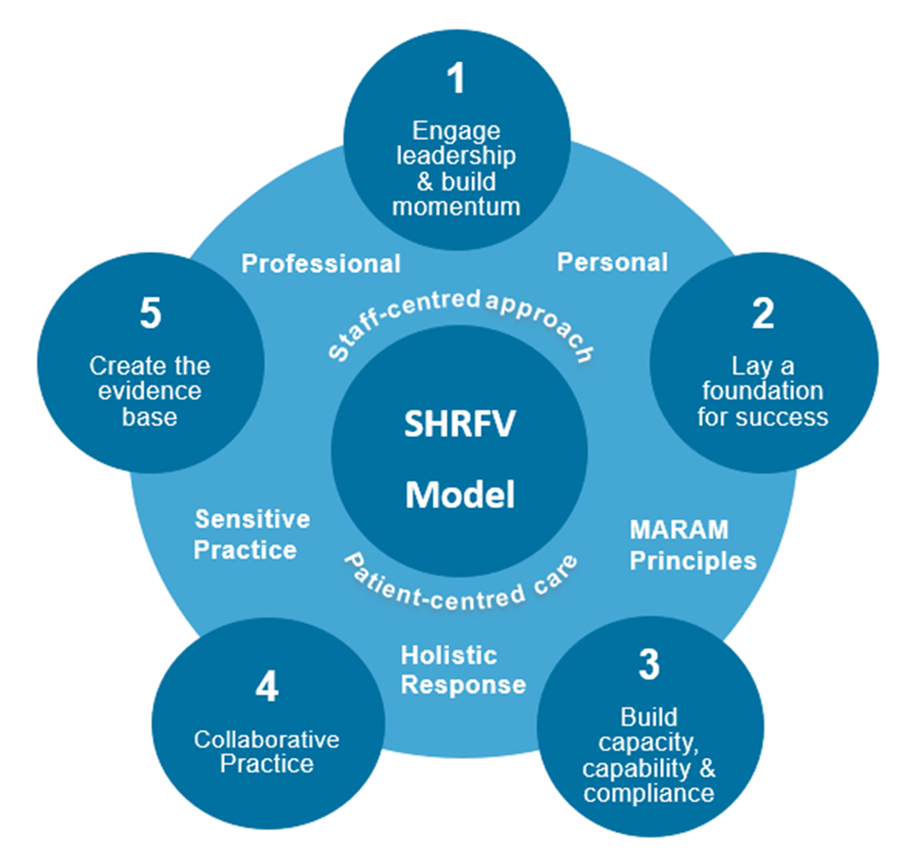
# Five elements of the approach

The SHRFV approach includes five elements to introduce a whole- of-hospital approach to family violence.

The elements and associated tasks will drive culture and practice change. They are described in a consecutive order, but in practice work in each element is likely to overlap and can be undertaken in an order which best suits the needs and capacity of the health service.

With the introduction of MARAM, it is acknowledged that for the Victorian public hospital and health sector who have embedded the SHRFV approach, additional work is required to ensure alignment to MARAM.

## The SHRFV approach: five elements of the approach



# Key tasks

Element 1

## Engage leadership and build momentum

* Engage leadership and decision makers to confirm commitment.

» See Tool: Executive MARAM briefing in FSV’s [Organisational Embedding Guide](https://www.vic.gov.au/maram-practice-guides-and-resources)

* Establish a SHRFV/MARAM position statement.

» See Tool: Sample Family Violence Position Statement

* Establish a SHRFV reference group.

» See Tool: Reference Group Terms of Reference

» See Tool: Reference Group meeting agenda

* Establish project objectives and indicators of success.

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

» See Tool: Project Management Guide

» See Tool: Family Violence Workplace Support Program Overview

» See Tool: MARAM Framework and supporting resources on a page

* Develop a communication plan.

» See Tool: Communication Action Plan



Element 2

## Lay a foundation for success

* Map service relationships.

» See Tool: MARAM Alignment: Supporting Resource A - Workforce Mapping for MARAM Alignment

* Adapt or develop policies and, procedures to identify and document patients’ experiences of family violence and any subsequent referrals.

» 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:

» See Tool: MARAM Practice Guides

* Develop policies and procedures to support staff professionally and personally.

» 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

* Identify opportunities in the prevailing culture which can be harnessed to support the project.

» See Tool: Baseline Culture Change Survey

* Identify barriers to change which will need to be addressed in order for the project to succeed.

» See Tool: Risk Management Plan

Element 3

## Build capacity, capability and compliance

* Raise awareness across the health service so all staff better understand family violence and its drivers.

» See Tool: Special Event Communication Plan

» See Tool: Communication materials.

* When infrastructure and policy and procedure and partnerships are in place, provide training for clinical staff to improve confidence and skills to identify and respond to family violence.

» See Tool: SHRFV Training Manual, materials and handouts

* Provide training for managers to provide workplace support for staff.

» See Tool: Family Violence Workplace Support Program Training materials

* Provide opportunities for continuous improvement.

» See Tool: Clinical Champions Role Overview

» See Tool: Clinical Champion implementation plan

» See Tool: Clinical Champion FAQs

Element 4

## Collaborative Practice

* Build partnerships with the wider community and the family violence sector.

» See Tool: Building and Sustaining Partnerships

» See Tool: MARAM Alignment: Supporting Resource E - Facilitating Collaborative Practice

* Involve patients/victim survivors.

» See Tool: Engaging Survivor Advocates

Element 5

## Create the evidence base

* Collect data to build evidence base and in relation to changed practice.

» See Tool: MARAM alignment for hospitals and health services

» See Tool: MARAM Organisational Embedding Guide [Implementation Review Guide](https://www.vic.gov.au/sites/default/files/2020-06/Designed%20Implementation%20Review.pdf)



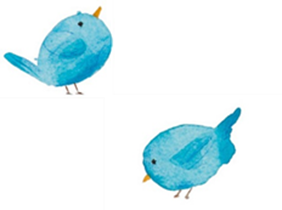
# Training your workforce

The SHRFV training modules recognise that a whole-of-hospital approach requires all health service staff to have a shared understanding of the complexities of family violence, and how health services can support people affected by it and how all staff contribute to the organisation’s legislative responsibilities to respond to family violence.

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 to respond to family violence. The SHRFV training modules are designed to build a 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 be trained to support staff working with patients affected by family violence, or who may have personal experience of family violence.

Human resources (HR) professionals /Family Violence contact officers will also require training to provide 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. 

Family Violence Workplace Support manager training

The 4-hour face-to-face module is for line managers and HR managers and covers considerations and procedures related to providing professional and personal support to staff who are victim survivors of family violence and information to support managers to understand the role of the workplace in responding to staff who use family violence.

The 2 hour face-to-face module is an abbreviated version of the 4 hour module and is recommended as a refresher training.

The 1 hour Workplace Support policy and procedure training covers the requirements and procedures relating to the family violence clause in the Health Services' Enterprise Agreements

## Foundational Practice

This module is for all hospital staff mapped at a Foundational Practice level. The module covers foundational knowledge and MARAM practice expectations for staff groups assigned foundational practice responsibilities as set out in the Workforce Mapping for MARAM Alignment Guide. It also includes information regarding family violence leave and other support available for staff to access themselves or to assist their peers.

## Sensitive Practice

This module is for all hospital staff mapped at a Sensitive Practice level. It covers foundational knowledge and the MARAM practice expectations for staff groups assigned sensitive practice responsibilities as set out in the Workforce Mapping for MARAM Alignment Guide. It also includes information regarding family violence leave and other support available for staff to access themselves or to assist their peers

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| **Note:** 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 on 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. |

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## Supplementary modules

These additional modules are designed to provide clinical staff with a deeper understanding of family violence in the context of working with children, older people and rural and regional communities, as well as sexual assault and antenatal screening for family violence.

# Conclusion

Health services are in a unique position to play a significant role in driving social change and helping to reduce the incidence and impact of family violence. It requires strong organisation-wide commitment and teamwork involving people in different areas of the health service to successfully implement the SHRFV approach and achieve the desired change.

The SHRFV approach and supporting resources are based on the experience of the Women’s and Bendigo Health embarking on their own change journey to strengthen their response to family violence. The 5th edition of the toolkit has been adapted and revised to align to the MARAM Framework and its legislative requirement. It has been demonstrated that there is no one size fits all approach to implementation and that it is not possible to effectively implement the SHRFV approach or align to MARAM overnight. The Women’s and Bendigo Health have each made adaptations for implementation to suit their own operating environments. Other health services are expected to do the same.

This work is vitally important for the benefit of patients experiencing family violence; for health professionals to feel supported to identify and appropriately respond to people affected by family violence; and for supporting staff on a professional and personal level.

While undertaking this work can certainly present challenges in a health setting, the evidence tells us that for many women, a health care professional is often the first person they will talk to about family violence. Given this knowledge, the health sector must do all it can to better equip staff and contribute to social change to reduce the occurrence and incidence of family violence in the Victorian community.



# Endnotes

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