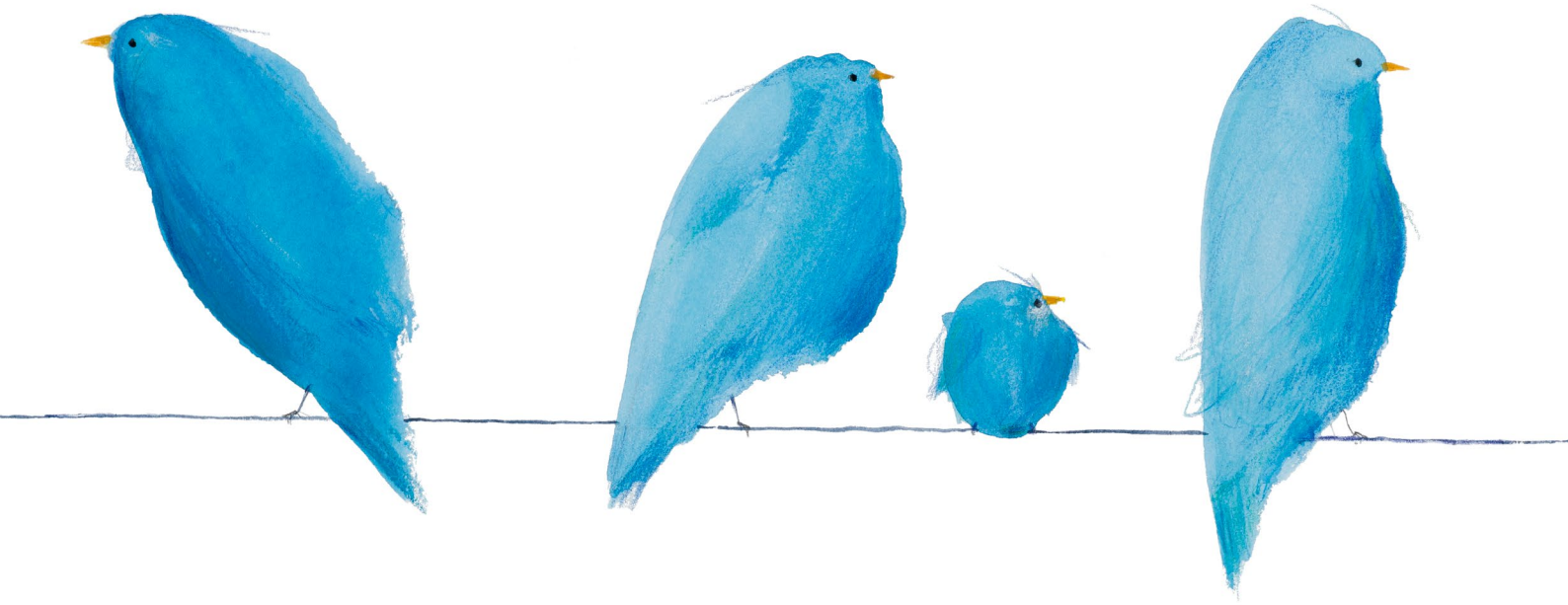

# Strengthening hospital responses to family violence

## Training manual

Introduction to delivering the SHRFV training modules

VICTORIA State Government

the women's the royal women's hospital victoria australia

BENDIGO HEALTH

Fourth edition • August 2018

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

The content of the SHRFV training modules was developed by:

- The Royal Women's Hospital
- Bendigo Health
- CASA Forum
- The Royal Children's Hospital
- St Vincent's Hospital

Further information:
Jane Hooker
The Royal Women's Hospital
03 8345 2804
**jane.hooker@thewomens.org.au**

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

VICTORIA State Government

the women's the royal women's hospital victoria australia

BENDIGO HEALTH

# Contents

# Introduction to the SHRFV training modules

**This resource has been developed to support the facilitation of the Strengthening Hospital Responses to Family Violence (SHRFV) training modules released with the fourth edition of the SHRFV Toolkit (2018). Ideally the training modules will be delivered by an experienced family violence training facilitator in collaboration with a hospital staff member. This SHRFV Training Manual and the SHRFV Project Overview should be provided to any external facilitators so that they fully understand the SHRFV approach.**

The aim of the training modules is to:

- prepare managers and staff to support their staff and colleagues personally or professionally affected by family violence
- build a shared understanding of family violence across the hospital
- support health professionals to apply sensitive practice to identify and respond to family violence and sexual assault as experienced by patients across the life span, and in different circumstances.

## The SHRFV training materials

The SHRFV training materials include:

- Family Violence Workplace Support Manager Training – to support staff professionally and personally
- Family Violence Workplace Support Staff and Volunteer Training – to respond to disclosures from peers and provide information on how to access support themselves
- Module One Foundation – to build a shared understanding of family violence across the hospital
- Module Two Clinical Practice – applying sensitive practice to identify and respond to family violence
- Supplementary modules – for health professionals to identify and respond to situations involving:
  - children
  - older people
  - sexual assault
  - rural and regional settings.

### Where to begin?

It is recommended you start training your managers first, using the Family Violence Workplace Support Managers Training Module, so managers have the skills and confidence to support their staff with family violence issues professionally and personally. Once managers are trained, they will have a greater comprehension of the issues of family violence and are more likely to support the release of staff for ongoing SHRFV Modules One and Two training and other associated activities. Workplace Support Manager training should ideally occur before training clinicians in sensitive practice takes place.

**Modules One and Two should be undertaken before moving on to the supplementary modules. This is because Module Two provides essential training in sensitive practice, which must be understood by health professionals as a prerequisite to the supplementary modules.**

The supplementary modules were introduced in 2018. They are highly recommended to enhance the capacity and capability of health professionals. This is particularly important in rural settings where referrals to specialist support services may be less readily available.

The SHRFV training modules are designed to meet the needs of health professionals as first responders. Accordingly, the training is designed to prepare staff with the skills to provide a brief first-line intervention, and a supportive response that enhances safety regardless of whether or not a referral to social work or other support service is accepted by the patient. The SHRFV approach recognises that other clinical support services within the hospital, such as social work teams, may provide a more specialist and comprehensive family violence response.

It should be noted that these training materials have been developed using adult teaching principles, are based on family violence data and evidence, have been reviewed/approved by family violence experts and have been tested by the Royal Women's Hospital (the Women's) and Bendigo Health. To maintain the quality of the training materials it is recommended health services do not make major changes to the training content, facilitator notes or the order in which the slides are presented. (This excludes reference to information that needs to be specific to your health service, for example, referral pathways.)

## The Family Violence Workplace Support Program

The SHRFV approach is underpinned by two main streams of training. The SHRFV clinical training modules provide practice guidance to first-line staff in clinical and non-clinical roles. The Family Violence Workplace Support Program training provides information about family violence leave and guidance for managers responding to family violence disclosures in the workplace. It also provides information for staff about family violence leave and responding to disclosures of family violence from colleagues in a workplace setting.

### Family Violence Workplace Support Manager Training

**Target audience: all line managers (and HR staff)**

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

### Family Violence Workplace Support Staff Training

**Target audience: all staff and volunteers**

- Provides staff and volunteers with the knowledge, skills and procedural understanding to respond to disclosures from peers.
- Provides staff with information on how to access family violence support for themselves.

## SHRFV modules

These training modules have been developed and enhanced by the Women's and Bendigo Health. In 2017 CASA Forum, the Royal Children's Hospital, Bendigo Health and St Vincent's Hospital contributed their expertise to develop and test the supplementary modules.

### Module One Foundation A shared understanding

**Target audience: all hospital staff and volunteers**

- Provides a foundation for understanding family violence and sexual assault across the life span.
- Includes the definitions and drivers of family violence and sexual assault, the gendered nature and impacts of family violence and sexual assault, and an understanding of the correlation between family violence/sexual assault and negative health outcomes.
- Provides opportunity for hospitals to outline their commitment to a Family Violence Workplace Support Program.

## e-Learning Module One Foundation A shared understanding

**Target audience: clinical staff exclusively**

As with Module One, e-Learning Module One offers clinical staff the opportunity to build a shared understanding of family violence. This style of learning is flexible, self-pacing and scalable for any number of employees.

Face-to-face training is recommended best practice for all family violence training. The opportunity of debriefing, challenging preconceived ideas, interactive discussion and experiences will not be covered within an e-Learning environment.

Therefore this e-Learning module should only be made available to clinical staff under the following criteria:

- inability to attend Module One or Modules One and Two combined training
- staff are booked to attend Module Two face-to-face training within a four-week timeframe.

## Module Two Clinical Practice Identifying and responding

**Target audience: health professionals**

- Provides health professionals with the tools to feel confident and competent in identifying, inquiring, responding, assessing, referring and recording disclosures of family violence and sexual assault.
- Includes the six-step model of sensitive practice framework.
- Outlines the roles and responsibilities of health professionals in relation to disclosures of family violence and sexual assault.
- Supports health professionals to enhance safety regardless of whether or not a referral to a social worker or a specialist service is accepted by the patient.

## Combined Modules One and Two A shared understanding and identifying and responding

**Target audience: health professionals**

- Provides a combined and condensed version of Modules One and Two for health professionals with time limitations.

## Supplementary Modules

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

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

- identifying and responding to family violence within a paediatric setting
- identifying and responding to 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.

## Training materials

- PowerPoint slides with facilitator notes and a comprehensive facilitator's guide for each module, including suggested interactive learning activities, handouts and video resources. To retain the quality of the training materials it is recommended facilitators do not change or adapt the content or order of slides, while noting it may be necessary to reference specific information about your health service.
- Recordings of train-the-trainer information for the supplementary training modules for children and young people, elders and family violence in a rural and regional setting presented by people involved in developing each module.
- A recording of the supplementary module on sexual assault presented by a Centre Against Sexual Assault counsellor.
- Participant pre- and post-training surveys.

Additional tools supporting the SHRFV training include:

- lanyards with prompting questions to support health professionals to conduct a sensitive inquiry
- posters for clinical areas reinforcing the message to notice the signs of family violence
- badges to be distributed to training participants at the end of a training session
- email banner to help promote training
- posters for patient areas to make patients aware your staff understand family violence and it's a safe place to talk
- various handouts referred to throughout the training modules.

» ***See* Tool: SHRFV LIVES Lanyard**

» ***See* Tool: SHRFV Patient Facing Poster**

» ***See* Tool: SHRFV Staff Badge**

» ***See* Tool: Email Banner for Internal Staff Communications**

» ***See* Tool: Asking About Violence**

# Planning to deliver the SHRFV training modules

**There are a range of considerations that need to be taken into account when planning to deliver the SHRFV training modules. Securing the support and commitment of unit managers for their staff to participate is a primary consideration.**

## How should the training sessions be delivered?

The training modules and materials are based on adult learning principles that promote participation and interaction among the participants. Family Violence Workplace Support Program managers training has been designed to be delivered over four hours. Staff training would be ideally delivered over 90 minutes. Modules One and Two have been developed to be delivered as a 60-minute training session, however, the Combined Modules One and Two option ideally requires at least 90 minutes.

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

Access to training time is difficult in busy clinical environments. While ideally 60 to 90 minutes is required to most effectively deliver Module One, Module Two and the Combined Module to clinicians, this amount of time may not be available. It is recommended that facilitators make the most of any time given. It should be noted that delivering training in shorter time frames reduces the ability to incorporate activities and role plays, and therefore effectiveness and impact of the training.

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

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

- a training room or ward as a small group education session during staff handover periods or double staff time
- by remote delivery (via video conference or webinar)
- integrating the modules into professional development days for clinical staff
- as a stand-alone training session that can be time expanded to allow for facilitated discussion, role plays and case scenarios
- as lunch and learn forums.

## Who should deliver the training?

Family violence is a complex and sensitive topic that requires experienced facilitation. The clinical training is best delivered by two highly experienced facilitators. Where a skill set exists, collaboration between your internal staff subject matter experts (for example, social workers) with staff from the family violence sector to deliver this training is ideal. This collaborative approach would be valuable in many ways. Not only would it utilise the sector's expertise and inform hospital staff of the agency's role but it would help to build important operational partnerships. Alternatively, you may consider employing family violence trainers in house to work in partnership with your social work team to deliver the training.

It is recommended that Family Violence Workplace Support Program training is co-facilitated with a Human Resources, Family Violence Contact Officer or Health, Safety and Wellbeing practitioner. It is the role of this person to educate managers on what the implications of violence against women/family violence means for their role as a manager. While this co-facilitator does not need to have specialist knowledge of family violence, a sound understanding of the key issues is necessary.

Recognising that the supplementary modules involve a level of specialist knowledge, which is unlikely to be available in all situations, train-the-trainer information has been recorded and provided as part of the SHRFV Toolkit. Facilitators should familiarise themselves with that information when planning to deliver the supplementary modules.

It is important that both the lead and co-facilitator have excellent knowledge and responses regarding the causes and gendered drivers of family violence. Ideally, those facilitating the training will have attended family violence specific training such as CRAF 1 & 2, DV Alert training or a train-the-trainer session.

The facilitator must be confident and competent in responding to a range of issues that commonly emerge during a training session including:

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

## What resources are required to support the training?

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

All participants should receive a training pack that includes a copy of the slides with space for adding handwritten notes, personal support options and the training feedback form.

Module Two participants should also receive any relevant hospital policies and procedures relating to referral pathways and family violence and child protection reports. This is ideally done electronically and via the hospital intranet.

You may also find these resources useful.

- **The Domestic Violence Resource Centre** (DVRCV) provides infographic posters presenting the facts of family violence in Victoria: **http://www.dvrcv.org.au/knowledge-centre/our-publications/poster/facts-family-violence-2016**
- **Australia's National Research Organisation for Women's Safety Limited** (ANROWS) provides a quick reference guide to key statistics on violence against women in Australia: **https://www.anrows.org.au/publications/insights/violence-against-women-accurate-use-key-statistics**
- ANROWS provides digital stories presented by five women about accessing help for sexual violence and mental health problems: **https://anrows.org.au/node/1352**
- **Australian Institute of Health and Welfare** (AIHW) provides a summary report using the latest data on family, domestic and sexual violence in Australia: **https://www.aihw.gov.au/getmedia/d1a8d479-a39a-48c1-bbe2-4b27c7a321e0/aihw-fdv-02.pdf**
- **1800RESPECT** provides a video on cultural competence when working with women from culturally and linguistically diverse (CALD) communities: **https://www.youtube.com/watch?v=DbNaYzbXCd8**
- **The Commonwealth Bank and Domestic Violence NSW** have produced a resource for addressing financial abuse: **https://www.commbank.com.au/content/dam/commbank/assets/about/opportunity-initiatives/addressing-financial-abuse-guide.pdf**

## What processes should be used to evaluate the training?

Training feedback forms are available in the Toolkit to help assess the shift in understanding about the key concepts and learning outcomes. They also help staff provide feedback on the quality of the training session.

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

Distributing the pre-training survey several weeks prior to commencing the training provides greater potential to tailor the content of the training to the knowledge and experience of people in the group. It will thus allow additional time for discussion and role plays which focus on areas of knowledge identified as lacking. Presenting the results of the pre-training survey at the start of a training session is a great way of demonstrating to the group that the training is responsive to their identified needs.

## Support after training

The training is designed to build clinical capacity to identify and respond to disclosures of family violence and sexual assault. Project managers need to be aware that as health professionals commence this work, ongoing support and action will be required. It is likely health professionals will identify policy and procedural changes necessary to improve effectiveness. For example, at the Women's staff identified such things as:

- improvements required to streamline internal referral processes
- barriers to documenting family violence disclosures
- additional areas of education required to ensure that the diversity of hospital service users had their needs met
- the need to respond to staff experiences of vicarious trauma.

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

- attending staff team meetings
- being available in the ward at a regular time to answer queries
- conducting family violence case review/ reflective practice sessions
- supporting a network of family violence clinical champions
- including clinical staff in the project reference group or an operational committee.

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

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

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

# Prerequisite for facilitators

**As a prerequisite to delivering the training content it is important for facilitators to have knowledge in the following areas.**

## Strategic direction and policy environment

Facilitators must fully understand the SHRFV approach rationale and how it aligns to the hospital's strategic direction, the hospital's statement of priorities and the wider range of reforms being implemented in Victoria following the Royal Commission into Family Violence (Victoria 2016), including Recommendation 95 of the Royal Commission which states that:

> *The Victorian Government resource public hospitals to implement a whole-of-hospital model for responding to family violence, drawing on evaluated approaches in Victoria and elsewhere [within three to five years].*

## Family violence workforce support

In a study of Australian health professionals, almost half of the 471 female health professionals surveyed had experienced intimate partner and/or family violence. Many also reported experiencing violence as a child. For many women, the violence was current. One in nine had experienced intimate partner violence in the past year. Facilitators should keep this in mind and be prepared for disclosure of personal experiences of family violence and sexual assault triggered by the delivery of training.[1]

All publicly funded hospitals within Victoria now have family violence clauses included in their Enterprise Bargaining Agreements that allows for family violence leave, and facilitators must be aware of staff entitlements and what internal supports are provided by the hospital for staff experiencing violence, and the pathways to accessing these supports. In addition, the trainer must be able to refer staff to a range of external support services, such as the organisation's EAP.

## Gendered nature of family violence

SHRFV training aligns with the *Family Violence Protection Act 2008* (Vic), which acknowledges that family violence is a gendered issue, particularly in the context of intimate partner violence.

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

While men do experience violence, it is more likely to take place outside the home and be perpetrated by someone unknown to them.[3] Children of all genders are victims of sexual assault in the context of family violence.

Be prepared to find that mention of this may cause participants of all genders to feel upset or uncomfortable. It is therefore important to emphasise that most men are not violent, however, within the context of intimate partner violence, data demonstrates that women experience far greater harm than men.

Family violence also occurs within same sex relationships, between siblings, from parent/carers towards children, from adolescents towards parents, and from adult children towards older family members.

In taking a family violence across the life span approach the training provides information that can be applied by staff in working with people identifying as victims of family violence regardless of their age, gender or circumstance.

## Attitudes towards family violence

Violence-supportive attitudes are those that 'justify, excuse, minimise or trivialise physical or sexual violence against women, or blame or hold women at least partly responsible for violence perpetrated against them'.[4]

Evidence from the findings of the National Community Attitudes Survey by VicHealth in 2014 suggests that such attitudes can create a culture in which violence is 'at best not clearly condemned and at worst condoned or encouraged'.[5]

These attitudes are the beliefs and values gained from family, culture and a lifetime of experiences that heavily influence how a person views and evaluates both themselves and others. Community attitudes are apparent within the language we use around family violence.

In the hospital setting, this may translate to a health professional having a negative or judgemental view of a person experiencing violence presenting for health services.

This has the potential to override rational decisions, logical thinking and the professional attitude of a hospital staff member.

The SHRFV Training Modules gently challenge any myths held by participants about family violence. Prejudicial myths are dangerous because they influence how we think and feel about violence against women and children. These beliefs and attitudes then influence how we act when confronted with violent behaviour or how we respond when we hear about violence.[6]

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

Some common myths include:

- men should make the decisions and take control in relationships
- there's nothing wrong with a sexist joke
- family violence is understandable if the perpetrator gets so angry they lose control
- women could leave a violent relationship if they wanted to
- woman deliberately provoke violence (she pushed him to his limits)
- men have urges they just can't control.

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

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

## Sensitive practice

Sensitive practice is at the foundation of the SHRFV approach. Facilitators should familiarise themselves with the World Health Organization (WHO) Clinical Handbook: **www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/**

## ‘Disbelievers’ and contentious comments

If the SHRFV approach is being challenged as being ‘metro centric’ then reiterate that these resources and tools are designed and tested to suit all environments.

The Regional/Rural Module ‘Unique Complexities of Family Violence in Rural and Regional Settings’ has brought together the strengths and risk factors inherent in rural and regional communities, and identified practice strategies that may be utilised to address each of the risk factors. The Regional/Rural Module also includes case study examples that can be used to explore potential risk factors and useful strategies and apply sensitive practice in these settings.

When asked ‘What about violence towards men?’ or ‘Why are you saying only males commit violence?’ the response that could be made is in line with the information provided by initiatives that came from *The National Plan to Reduce Violence Women and Their Children 2010–2022*, namely *The Line and Our Watch*. Firstly, it is important to clarify that the SHRFV approach does not deny that males are victims of family violence, nor that only males perpetrate violence. Raising awareness of the issue of family violence and violence against women is in no way meant to diminish the experience of other types of violence.

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

### Some key statistics to support the gendered nature of violence

- 99 women were killed by a current or former partner between 2012 and 2014, which equates to over **one woman every week**.[7]
- Women continue to be over-represented as victims of intimate partner homicide, accounting for 79% of all intimate partner homicides.
- Women are five times more likely to be hospitalised and five times more likely to suffer serious injury than men.[8]
- Women were nearly three times more likely to have experienced partner violence than men, with approximately one in six women (17% or 1.6 million) and one in sixteen men (6.1% or 547,600) having experienced partner violence since the age of 15.[9]
- Intimate partner violence causes more illness, disability and deaths than any other risk factor for women aged 25–44.[10]
- One in three women has experienced physical violence; one in five women has experienced sexual violence; and one in four women has experienced intimate partner violence since the age of 15.[11]
- Over 90% of those assisted by homelessness services for the purpose of escaping family violence were women and children.[12]
- Violence against women and their children is costing the Australian economy $21.7 billion per year.[13]

## Context and intersectionality

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

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

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

### People from Aboriginal and/or Torres Strait Islander communities

For Aboriginal and Torres Strait Islander peoples, the definition of family violence includes physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuse that occurs within families, intimate relationships, extended families, kinship networks and communities.

Family violence occurs at higher rates for Aboriginal and Torres Strait Islander people than for others. Family violence within Aboriginal and Torres Strait Islander communities needs to be understood as both a cause and effect of social disadvantage and intergenerational trauma.[16]

The impacts of colonisation on Aboriginal and Torres Strait Islander peoples have created further barriers to disclosing family violence and seeking assistance, including:[17]

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

Aboriginal and Torres Strait Islander women community members may or may not wish to access Aboriginal and Torres Strait Islander specific services. Therefore, options for both Aboriginal and Torres Strait Islander and general services should be offered.

### People from culturally and linguistically diverse communities

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

Women in some CALD communities face additional barriers to seeking support, including language barriers, lack of knowledge about local laws and support services and visa status. Some CALD communities might have different understandings of what constitutes family violence. They might also have community mechanisms for responding to family violence, alongside a criminal justice approach.[18]

To avoid the possibility of escalating risk and to ensure accurate translation of information, a professional interpreter should always be provided rather than relying on friends or family of the victim/survivor – even where they appear to be trusted. Given the sensitive nature of family violence, victims/survivors should be offered the choice of a female professional interpreter either in person or over the phone. Where the person is from a small cultural community, requesting a telephone interpreter from interstate may be required to ensure confidentiality and safety for the person disclosing.

## People with disabilities

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

Women and girls with disabilities experience higher rates of violence in comparison with women within the general community. In particular, those who are most excluded from social and economic participation, such as women and girls with intellectual disabilities, may experience forms of both gender-based and disability-based violence such as over/under medicating, not attending to personal hygiene needs, or denying access to support services.[19]

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

## People from rural communities

The incidence of family violence and family violence-related homicide is higher in rural and regional locations. Access to firearms in rural settings is thought to be associated with the disproportionate number of family violence-related homicides in rural areas. People in rural and regional areas experience greater vulnerability due to the limited availability of professional support, distance and transport options and associated costs in gaining access to resources, including translators, for support. Extra challenges may also surround the level of privacy in smaller communities and the potential to re-encounter perpetrators.[20]

## People identifying as lesbian, gay, bisexual, transgender, intersex, queer

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

Some LGBTIQ people are at higher risk of family violence, and have less access to supportive services. These include people who are transgender, people with a disability, and people from communities or areas with rigid gender roles and conservative views about sexuality.[21]

To minimise the effects of the additional risks and vulnerabilities that might be experienced by people in LGBTIQ relationships, it is important that organisations, as employers and service providers, are respectful of people's choices regarding the pronouns and identities they use to describe themselves and others in their family and community.[22]

## Cultural competence

Cultural competence refers to a set of congruent behaviours, attitudes and policies that come together to enable professionals to work effectively in cross-cultural situations.[23] This is particularly relevant in a hospital setting where work colleagues and patients come together from different cultural/ethnic backgrounds.

In practical terms, cultural competence comprises four components:

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

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

## Recognising the signs of family violence

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

### Noticing signs/assessing risk

A risk assessment is most often undertaken by a social worker or specialist family violence service such as Safe Steps, once a patient is referred by a health professional.

At the time of publishing this manual, health professionals as first-line responders following the SHRFV approach are not expected to undertake a risk assessment. They are expected to notice indicators of family violence and be aware of key risk factors. It is anticipated that this will change when the new Common Risk Assessment Framework (CRAF) comes in and may include brief risk assessment that needs to be completed by clinicians.

The term 'evidence-based risk factors' refers to the characteristics of a person's family violence situation that may provide a 'red flag' for concern that the situation is escalating towards serious harm or potential lethality. Some examples of evidence-based risk factors include pregnancy, recent separation, threats of harm or access to firearms. These risk factors have been developed in response to Australian and international research into the circumstances that have led to a family violence homicide.

The Family Violence Risk Assessment and Risk Management Framework, often referred to as the Common Risk Assessment Framework (CRAF), has been developed to help a range of professionals to better identify and respond to women and children who are experiencing family violence. It is not currently mandated for hospitals to use the CRAF. The CRAF is currently being redesigned in accordance with Recommendation 1 of the Royal Commission into Family Violence (Victoria 2016). The new version will apply to a hospital setting. Please refer to the most current information regarding the CRAF that can be obtained on the Family Safety Victoria website: **https://www.vic.gov.au/familyviolence/family-safety-victoria**

# Training considerations

### Facilitator notes

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

Facilitators need to be mindful that throughout the training modules there are places where individual hospitals will need to insert site-specific information. For example, in relation to referral, self-care and documentation procedures.

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

## Introducing the training

### Acknowledgements

**Traditional owners**

Training always commences with an acknowledgement of the traditional owners of the land.

For example, in Melbourne,

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

**Survivors**

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

For example:

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

**Self-care and support**

Acknowledge that discussing the issue of family violence has the potential to trigger thoughts about current or past situations or someone participants know affected by family violence. The training could be upsetting. Advise participants to seek support if needed. Hand out or point to available support options.

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

Facilitators need to be aware that the training may trigger disclosures and be prepared to respond appropriately.

## Safety within the training room

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

Establishing group agreements is an excellent tool for maintaining safety within the training room. Group agreements help participants to come to consensus on how they will work together respectfully and effectively. This enables participants to

engage and interact with each other in a constructive and productive manner.

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

Below is a sample group agreement which can be adapted by the trainer and the participants.

## Introductions

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

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

- Ask participants to describe the first image that comes to mind when thinking about family violence. List answers on the whiteboard and refer to these when talking about community attitudes and myths.
- Discuss what participants find most challenging when responding to patients experiencing family violence. Write their responses on the whiteboard and, if appropriate, group the answers into themes. Refer to the list on the white board at the end of the training and confirm the items have been addressed in the training session.
- Talk about how often participants work with patients who have experienced family violence. At the end of the introductions acknowledge that regardless of their answers, considering the prevalence rates, every health professional probably works with patients every day with experience of family violence.
- Invite participants to state what they are wanting to achieve as a result of the training. Note comments on a whiteboard and ensure that they are covered or confirm they will be covered in other modules. If they are not included anywhere, this provides useful feedback for future revisions of the training content.

### Group agreement

**One person at a time**

- Everyone has the right to be heard. Only one person talks at a time so that we can all hear what that person has to say.

**Confidentiality**

- We encourage examples from your professional experience, but please ensure that they are de-identified to protect the confidentiality of your patients and colleagues.
- Anything shared in the training session should remain confidential so everyone can feel safe.

**No one knows everything – together we know a lot!**

- This training relies on adult learning principles in recognition of the experience and expertise of those in the room. That means we are relying on you to contribute to the learning experience by sharing your knowledge and wisdom. If you have ideas regarding the discussion, please share them with us as a group, rather than with the person sitting next to you.

**Enjoy and explore the learning space**

- Please use this time to explore new concepts and examine how the information presented fits with your experience. Please also give us your full attention during the training time. If you need to take an important phone call or send a text, please leave the room to avoid distracting others. Make sure that mobile phones are on silent mode.

## Training breaks

Sessions of two or more hours should include a short training break and where possible provide refreshments. Including a PowerPoint slide for the break with a relaxing, tranquil visual can help set the tone for the break. If the participants are leaving the room, pause in the room to provide an opportunity for any participants to speak with the trainer in private.

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

## Concluding the training

At least 10 minutes should be allowed at the end of the training session for participants to complete their training evaluations and to conduct reflections around the room. Due to the 'heavy' content of the family violence training sessions, it is always good to make the final activity of the day positive and action focused.

### Reflection activities

Ask each participant to:

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

### Handouts

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

- quiz – What do I already know about family violence?
- signs of family violence across the life span
- asking about family violence
- specialist family violence support service contact details
- staff lanyards to prompt staff about sensitive inquiry
- staff badges to identify staff as someone patients can safely talk with about family violence
- rural and regional case study scenarios
- a list of family violence support service contact points, which can be adapted and used for providing workplace support information. The Women's provided staff with a bookmark to raise awareness about its workplace support intranet site when it was launched.

# Key concepts reinforced by SHRFV training

- Family violence occurs across the life span in many different forms.
- Family violence is complex and there is no 'quick fix'. It should be managed collaboratively with family violence specialists.
- While anyone can be a victim or perpetrator of family violence, research shows it is predominantly committed by men against women.
- People with diverse social identities may experience different types of violence, or experience additional cultural or structural barriers to safety.
- Hospitals have a key role to play in reducing the incidence and impact of family violence.
- First-line health professionals are not expected to be family violence specialists. They are expected to recognise the signs and know how to sensitively respond.
- Professional interpreters, not 'trusted' family and friends, should always be used.
- Health professionals should assume every patient may have experiences of trauma, family violence, and/or sexual assault, and modify body language and clinical practice accordingly.
- While many people believe that leaving the relationship will resolve the family violence issue, this is in fact likely to escalate the violence. This is the time when a woman is most at risk of being murdered. Therefore, leaving needs to be planned very carefully, preferably with the support of a family violence specialist worker.
- Family violence is both controlling and disempowering. It is important that we don't perpetuate that control within our response by telling the person what they should do. Instead, the role of the health professional is to provide that person with all the tools and information they need to make their own informed decision.
- There are many reasons why a person at risk of violence chooses to remain in the relationship, including being dependent on that person financially or for carer support, lack of alternative housing, fear for safety (for self, children or pet) if leaving, or hope that the violence can be resolved while remaining within the relationship. A person remaining within a relationship should never be judged for doing so but should be encouraged to plan for safety when violence occurs.
- If there are serious concerns for the safety of children, and a report to child protection is required, this should be done as transparently as possible. Where possible involve the protective parent in the notification process, and also provide the protective parent with a referral for legal support.
- Any interaction about family violence is valuable even if people choose not to disclose or accept help because it is likely they will view the hospital as a safe place to go to in future to seek assistance in relation to family violence. They will also feel empowered simply by being believed, validated and supported.

# Endnotes


1 McLindon E, Humphreys C, Hegarty K, *'It happens to clinicians too': an Australian prevalence study of intimate partner and family violence against health professionals.* BMC Women's Health [serial online]. June 26, 2018;18(1):N, Academic Search Complete, Ipswich, MA. Retrieved July 6, 2018.

2 State of Victoria, 2014–16, *Royal Commission into Family Violence: Report and Recommendations*, Parliamentary Paper No. 132. Retrieved from **http://files.rcfv.com.au/Reports/Final/RCFV-All-Volumes.pdf**

3 Australian Bureau of Statistics, 2017b, *Personal Safety Survey 2016*, ABS Cat. No. 4906.0, Australian Bureau of Statistics, Canberra.

4 VicHealth, 2014, *Australians' attitudes to violence against women*, Victorian Health Promotion Foundation, Melbourne.

5 ibid.

6 ibid.

7 National Homicide Monitoring Program, 2010–2012, Australian Institute of Criminology.

8 Australian Institute of Health and Welfare, 2018, *Family, domestic and sexual violence in Australia 2018*, Cat. No. FDV 2, Australian Institute of Health and Welfare, Canberra.

9 Australian Bureau of Statistics, 2017b, op.cit.

10 Australian Institute of Health and Welfare, 2018, *Family, domestic and sexual violence in Australia 2018*, Cat. No. FDV 2, Australian Institute of Health and Welfare, Canberra.

11 Australian Bureau of Statistics, 2017b, op.cit.

12 Australian Institute of Health and Welfare, 2018, op.cit.

13 *A high price to pay: the economic case for preventing violence against women*, 2015, Our Watch, VicHealth and PriceWaterhouseCoopers.

14 Crenshaw, K, 1991, 'Mapping the Margins: Intersectionality, identity politics, and violence against women of colour', *Stanford Law Review*, 43(6), pp 1241–1299.

15 Knudsen, S, 2006, 'Intersectionality — A theoretical inspiration in the analysis of minority cultures and identities in textbooks', *Caught in the Web or Lost in the Textbook*, November 2007, pp 61–76.

16 Australian Institute of Health and Welfare, 2018, op.cit.

17 Domestic Violence Resource Centre Victoria, 2015, *Introduction to Domestic Violence V.15*, DVRC, Victoria, Melbourne.

18 Morgan A & Chadwick H, 2009, 'Key issues in domestic violence', *Research in practice*, No. 7, Australian Institute of Criminology, Canberra.

19 Women with Disabilities Victoria, 2014, *Position Statement: Violence against women with disabilities*, WDV, Melbourne. Retrieved from **www.wdv.org.au/documents/WDV%20Violence%20Position%20Paper%20(web%20version).pdf**

20 Department of Human Services, 2012, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1–3*, Edition 2, Department of Human Services, Melbourne.

21 Horsley, P, 2015, *Family violence and the LGBTI community: Submission to the Victorian Royal Commission into Family Violence on behalf of Gay and Lesbian Health Victoria*, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne.

22 Department of Human Services, 2012, op. cit.

23 Fisher-Borne, M, Cain, JM, & Martin, SL, 2015, 'From Mastery to Accountability: Cultural Humility as an Alternative to Cultural Competence' Social Work Education. *The International Journal*, Issue 2, Volume 43.