Updated June 2020

This facilitator’s guide has been designed to assist your delivery of the SHRFV Sensitive Practice Module.

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

This training has undergone a vigorous review and endorsement process with Family Safety Victoria in order to ensure the training aligns with MARAM framework and Information Sharing Schemes. This training has been tailored specifically for the clinical operating environment within the health sector and covers the MARAM practice expectations for staff groups assigned sensitive practice responsibilities as set out in the *Workforce Mapping for MARAM Alignment Guide,* and these staff groups should not be required to undertake further external training for MARAM alignment.

Total suggested training time: 2 hours approx. (with interaction).

Topic 1: Introduction

Nominal duration

10 minutes

Purpose

To provide participants with an overview of the training and to establish a group agreement

Outcomes

At the conclusion of this topic, participants will understand:

* Training requirements
* Expected behaviour in training environment
* Purpose of the training

Resources

PPT, computer, projector & screen, whiteboard and or Post It notes and whiteboard markers, Quiz handout; What do I already know about Family Violence?

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation on safety and essential information | **Trainer(s) to introduce self**  **Acknowledgement of traditional owners**  **Acknowledgement of survivors**  **Welcome participants**  **Self-care and support** | * My name is …, my role as …in the Strengthening Hospital Responses to Family Violence program * Introduce colleague   **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.”   **Acknowledgement of survivors**   * I would also like to recognise any survivors of family violence in the room, I hope what we say is empathetic to their experience and I also pay my respects to those women and children who have been killed in the setting of family violence or violence against women.   **Self-care and support**   * We acknowledge that the subject matter of this day is particularly heavy and that there may be people in the room who have experienced violence. We know that often these discussions can prompt memories of trauma or other strong emotions – if you would like to take a break, we’re more than happy for you to step out and take a breather, and it will not be assumed because someone leaves the room that they are not coping. * We also encourage you to practice self-care. Look after yourselves and each other. Self-care can take many forms, spiritual, emotional, physical. For you, self-care might be completely different as it is for the next person. The important thing is to figure out what works for you! There are many support options here at (insert hospital name)  And we will discuss these at the end of the session. | PPT, computer, projector & screen | PPT 1 |
| Group discussion | **Develop Group Agreement**  **Provide participants with guideline to ensure safe learning environment** | Establishing group agreements is an excellent tool for managing safety within the training room.  Group agreements help a group to come to an agreement on how it will work together respectfully and effectively. This in turn enables people to interact more co-operatively and maintain respect for each other.   * Can I suggest the following guidelines today; * FV is a complex and sensitive topic, ensure that interactions are supportive and provides everyone with the opportunity to participate. * Welcome to take a break at any time during the training without asking permission * One person at a time to speak * De-identify examples from practice to protect confidentiality * Anything shared in the training session should remain confidential so everyone can feel safe. * Mobile phones to be switched off or on silent   Acknowledge that no-one knows everything –but together we know a lot!  Is there anything else anyone would like to add to this agreement? | PPT, computer, projector & screen, participant handouts | PPT 1 |
| Individual Participant Presentation  **\*This activity is dependent on time available\*** | **Ask participants to introduce themselves and state what they are wanting to achieve as a result of the training.** | * We now ask you to introduce yourselves, just your name and what you are hoping to achieve or ‘get out of’ todays training. I am going to note your comments on the whiteboard (or on Post Its) and at the end of the training we will have an opportunity to reflect on how they have been addressed. * \*If learning outcomes won’t be covered in the session, or are not achieved, please don’t be disheartened, as this provides useful feedback for future revisions of the training content. | Whiteboard (or post it notes), markers | PPT 1 |
| Presentation- Specialist Family Violence Services | **Discussing Family Violence can be distressing, particularly for people who have been impacted by violence.** | * If the discussion today causes you any concern for yourself or a colleague or family member or friend, please contact one of these services for support. These are listed in your notes as well as local and workplace services you can access. * 1800RESPECT and Safe Steps are 24 hour services. SACL is an after hours service. * If you feel you need to discontinue at any time, you may do so, but we encourage to reach out to available supports. | PPT, computer, projector & screen | PPT 2 |
| Presentation-Learning Objectives | **This training aims to build a shared understanding of family violence, as we all have a responsibility to create safe and supportive environments for patients and staff who experience family violence.** | * The purpose of this training is to ensure that we all have a shared understanding of family violence across the lifespan and recognise that all hospital staff have a vital role in an integrated system response to family violence. Following this training, we hope that participants: * Understand the gendered nature and dynamics of family violence * Identify family violence observable signs and risk indicators * Engage with patients or colleagues respectfully and sensitively and prioritise the safety of victim survivors * Ensure the organisation is a safe, accessible and culturally responsive environment for patients and staff to disclose * Understand how to ask risk relevant identification questions * Tailor engagement for all patients and maintain a person-centred approach * Know what to do if disclosures of family violence are made (support and referral options) * How to document family violence appropriately and safely and contribute to organisation’s safe, ethical application of information sharing schemes | PPT, computer, projector & screen | PPT 3 |
| Presentation-Background and Rationale  **Play video**  **(dialogue suggested if video not accessible)** | **This work is a priority for Government and this hospital.** | * You will recall the Victorian Royal Commission into Family Violence – one of the recommendations was a ‘whole-of-hospital service model’ for responding to family violence in public hospitals within three to five years because the health sector was identified as key to driving an integrated community response to family violence The SHRFV project is making that happen * Each hospital has family violence in its Statement of Priorities. We are required to progress implementation of a whole of hospital model for responding to family violence. It is mandatory work for every Victorian hospital * We have received funding to help us with this work and we are being guided by the SHRFV project materials developed by the Women’s and Bendigo Health * Hospitals are well placed to identify and provide support to people affected by family violence before it gets to crisis stage where police and other authorities are involved * Evidence tells us that health professionals are often the first person someone will talk to about family violence – we need to prepare health professionals to have these conversations * Hospital can then more effectively provide a gateway to specialist support services, located either internally or externally through family violence agencies * Family violence is a serious health issue which has profound physical and psychological affects * An early intervention response can prevent serious harm and death. It is also an efficient way to manage because providing early intervention means less hospital presentations * The position of this hospital is that family violence in any form is not acceptable [refer to / handout / insert a slide on your hospital’s position statement] | PPT, computer, projector & screen | PPT 4 |
| Quiz  **Provide as handout (available in the Toolkit)**  **\* This activity is optional particularly if there are time constraints\*** | **Checking what participant understanding of family violence is now.** | * Before we begin, lets check what your understanding of family violence is now. * Todays training will either build upon or enhance existing understanding and skills | PPT, computer, projector & screen, Quiz handout; What do I already know about Family Violence? | PPT 5 |

Topic 2: What is my role?

Nominal duration

10 minutes

Purpose

To provide participants with an understanding of their role as part of an effective response to family violence under family violence reforms

Outcomes

At the conclusion of this topic, participants will understand:

* Family Violence reforms in the Health Care sector
* Their role as part of an effective response to family violence under the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)
* Their role as part of an effective response to family violence under the Information Sharing Schemes

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation- Family Violence in the health sector | **Read through slide**  **Everyone’s role is vital in an effective response to family violence** | * Everyone’s role is vital in an effective response to family violence * The Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) guides effective identification, assessment and management of family violence risk across the entire Victorian service system * The Framework has been established in law under the Family Violence Protection Act 2008 * MARAM is underpinned by an understanding that different sectors and services within the integrated service system have a role to play in supporting effective responses to family violence, as appropriate to their role, functions and expertise. MARAM refers to three broad levels of response to family violence within the integrated service system: identification and screening; intermediate; and comprehensive. * Under MARAM, hospitals and health services in the course of providing a first line response and health care, play a pivotal role in identification and where appropriate screening of family violence and providing a pathway to specialist family violence support * It is important to note the difference between family violence screening and identification within a health setting * **Screening** in a hospital refers to the consistent use of a validated set of short questions to detect family violence in all patients (i.e. women who are screened in antenatal care) * **Identification or sensitive inquiry** refers to using the opportunity of a clinical encounter to check for family violence and associated health problems should a clinician observe signs of family violence (or risk factors) * Hospital and health services may also have particular departments or services within their organisation that have higher responsibilities under MARAM because of the nature of their work and engagement with victim survivors. | PPT, computer, projector & screen | PPT 6 |
| Presentation- MARAM responsibilities for risk assessment and management  **This slide has animation to assist with presentation.**  **On first click all the responsibilities will appear.**  **On a second click Responsibilities 3, 4, 7 & 8 will fade.**  **On a third click, a circle and text will appear around Responsibility 1 & 2 to represent practice responsibility required to perform and fulfil, and text will appear to represent responsibilities required to contribute to (5, 6, 9 & 10).** | **You are not required to be a family violence expert, but you are required to have an understanding of family violence, sensitively inquire and respond sensitively to disclosures of family violence from patients or staff and refer to the appropriate service either internally or externally.** | * MARAM outlines 10 responsibilities which combine to create an effective response to family violence across the integrated service system and covers all aspects of practice. * Each broad level corresponds to a different set of the ten MARAM responsibilities for risk assessment and management. * Broadly, the identification and screening responsibilities specific to the clinical operating environment within the health sector is referred to as Sensitive Practice. Health services may also determine that some non-clinical roles should also be mapped at this level. In line with the Sensitive Practice responsibilities, staff mapped at this level in health settings are required to competently perform and fulfil MARAM responsibilities 1 and 2, and contribute to MARAM responsibilities 5, 6, 9 & 10. * **What does this mean for my role?** * You are at this training because your role and responsibility under MARAM is to align to the Sensitive Practice responsibilities. This is achieved through compliance with your organisation’s family violence policies and procedures. * This training has been developed to cover your practice requirements. Staff should refer to your organisation’s Family Violence Policy and Procedure for more guidance. | PPT, computer, projector & screen | PPT 7 |
| Presentation: Information sharing and legislative reforms | **Key message: Decisions about when to share information, what to share and with whom, requires careful consideration of the relevance of information in managing risk and victim survivor safety.** | * Effective information sharing is crucial in keeping victim survivors safe, holding perpetrators to account, and to promote the safety and wellbeing of children * Two new information sharing schemes have been introduced, creating additional opportunities to share risk relevant information to enable effective responses to family violence and child safety across the Victorian service system, on top of existing legislation. * **Family Violence Information Sharing Scheme (FVISS):** allows authorised organisations to share risk relevant information related to assessing or managing family violence risk. * **Child Information Sharing Scheme (CISS):**allows authorised organisations to share information to support child wellbeing or safety. * The schemes have expanded legal permissions for certain professionals to proactively share and request information from other professionals and organisations. These schemes aim to create a significant cultural shift in information sharing practices. | PPT, computer, projector & screen | PPT 8 |
| Presentation: Information Sharing Schemes and Consent  **Information on slide can be provided as a handout if necessary.** | **Both schemes recognise the importance of seeking the views and promoting the agency of children and adults (who are not perpetrators of family violence) wherever appropriate, safe and reasonable to do so.** | * **When does each information sharing scheme apply?** * There are three possible scenarios to determine which scheme applies: * Where you wish to share information to promote a child/children’s wellbeing or safety and family violence is not believed to be present, use the Child Information Sharing Scheme (CISS). * Where family violence is believed to be present and a child is at risk, use the Family Violence Information Sharing Scheme (FVISS) to assess and manage family violence risk to both children and adults as well as the CISS to share information to promote the child’s wellbeing and/or other aspects of their safety. * Where no children are at risk, use the FVISS to share information to assess or manage family violence risk to adults. It is important to remember when sharing information about an adult victim survivor without children to seek consent to share information and therefore, respect the victim survivor’s agency and dignity. * Both information sharing schemes recognise that a child’s safety takes precedence over any individual’s privacy. Under the FVISS, both adult and child victim survivors’ safety takes precedence over a perpetrator’s privacy. As a result, consent is not required under either scheme to share information to keep a child safe. | PPT, computer, projector & screen | PPT 9 |
| Presentation: How does MARAM and the Information Sharing Schemes work together? | **These schemes are underpinned by the MARAM Framework, as well as relevant best interests and developmental frameworks.** | * MARAM must always be applied to identify and guide the assessment and management of family violence risk — for children and adults. This is to ensure that information is shared appropriately safely and lawfully, so as not to escalate family violence risk. * MARAM provides the risk factors to enable identification of risk relevant information that may be shared under FVISS. Therefore it is important those using FVISS are familiar with MARAM and the risk factors.      * **Your role:** * Have an awareness of your organisations legal obligations * Understand you organisation information sharing policies and procedures * When family violence is suspected or assessed as present and you determine that information, guidance, support or collaboration from another professional or service is required, know how to trigger internal processes for sharing information proactively * Ensure patients are informed about the limits of confidentiality in relation to these legislations * Ensure patient records are up-to-date | PPT, computer, projector & screen | PPT 10 |

Topic 3: What is Family Violence?

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of Family Violence

Outcomes

At the conclusion of this topic, participants will understand:

* Legal definitions of Family Violence
* Different forms of Family Violence
* Family Violence causes fear through the use of abusive and controlling behaviours
* Family violence is complex

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation- definition of FV | **Read through slide**  **Family violence causes fear through the use of abusive and controlling behaviours** | * There are many different forms of family violence * The *Family Violence Protection Act 2008 (Vic)* takes a broad understanding of family violence and ‘family’, to include ‘family like’ relationships. For example, it includes Aboriginal and Torres Strait Islander kinship relationships and carers of people living with a disability if that carer is in a ‘family like’ relationship with their client * Fear is what differentiates family violence from relationship conflict. Family violence involves abusive and controlling behaviour that causes a person to fear for their safety or the safety of others, including children * Examples of family violence that are referred to in the Act (section 5(2)) include: * Assaulting or causing personal injury to a family member, or threatening to do so * Sexually assaulting a family member or engaging in another form of sexually coercive behaviour, or threatening to engage in such behaviour * Intentionally damaging a family member’s property, or threatening to do so * Unlawfully depriving a family member of their liberty or threatening to do so * Causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the family member to whom the behaviour is directed, so as to control, dominate or coerce the family member. | PPT, computer, projector & screen | PPT 11 |
| Presentation- Family violence is complex | **Family violence is complex and it occurs across the lifespan**  **Sometimes it can be hard to recognise family violence** | * Family violence is complex * It occurs **throughout the lifespan** **(pink)–** it affects girls, boys, women and men * There are **many types of abuse (black)** – all are a violation of human rights and are unacceptable * And there are **many different perpetrators (blue)** – family violence occurs in all kinds of families, and in family relationships extending beyond intimate partners, parents, siblings, and blood relatives. It includes violence perpetrated by older relatives, by younger family members, or against a same-sex partner, or from a carer towards the person they are looking after. * It can sometimes be hard for victims to recognise their experience of family violence * Responses to children and young people perpetrating violence can be complex and should consider their age and developmental status, including if they have experienced or are currently experiencing family violence themselves. Responses to family violence behaviours exhibited by children or adolescents requires a specific and targeted response which should include specialist treatment services supporting behaviour change. | PPT, computer, projector & screen | PPT 12 |

Topic 4: Prevalence and the gendered nature of family violence and family violence impacts

Nominal duration

10 minutes

Purpose

To provide participants with an understanding of the prevalence and gendered nature of family violence

Outcomes

At the conclusion of this topic, participants will understand:

* Victims of family violence are predominantly women and children
* Family violence is a health issue with severe and persistent impacts on a person’s physical, psychological and social wellbeing
* Groups at greater risk of family violence

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Prevalence and the gendered nature of family violence | **Victims of family violence are predominantly women and children. People affected by family violence are our patients and our colleagues** | * **Note:** It is important that when citing statistics, the facilitator is familiar with the terminology definitions. It is recommended that ANROWS *Violence Against Women: Accurate use of key statistics* is used to support this * This infographic illustrates prevalence rates and the gendered nature of family violence * Men perpetrate the majority of all violence in Australia against women, children and other men. Most of the violence against men is perpetrated by other men (ABS, 2017). * Women and men both experience intimate partner violence. However, the prevalence, severity and impacts are greater for women than for men, so it requires a greater focus * Women are far more likely than men to experience ongoing violence, require medical attention, fear for their lives, and to be murdered * Men and boys are more likely to experience violence outside the home at the hands of other men and boys | PPT, computer, projector & screen | PPT 13 |
| Presentation  Family violence is a health issue | **Family violence is a health issue with severe and persistent impacts on a person’s physical, psychological and social wellbeing** | * Family violence has severe and persistent impacts on a person’s physical, psychological and social wellbeing and is the leading cause of homelessness * In 2016-2017, there were 1,328 people who presented to Victorian hospital emergency departments with a family violence related injury and of those 40% had sustained a brain injury (Brain Injury Australia, 2018) * Women who experience family violence rate their health as poorer and use health services more frequently than other women * The psychological impacts of family violence - such as depression, anxiety, and post traumatic stress disorder - are profound and endure long after the violence has stopped * The social, behavioural, cognitive and emotional effects on children are significant and may have a lasting impact on their education and employment outcomes | PPT, computer, projector & screen | PPT 14 |
| Presentation-  Groups at greater risk of family violence | **There are a number of factors that when they intersect with gender can greatly increase the risk of family violence.** | * **Note:** Avoid using the term ‘vulnerable’ as it reinforces power imbalances and locates the responsibility of violence with victim survivors. * There are a number of factors that when they intersect with gender can greatly increase the risk of experiencing family violence. The Australian Institute of Health and Welfare (2018) identified the following groups of women to be at greater risk of family violence: * Aboriginal and Torres Strait Islander women * Young women * Pregnant women * Women separating from their partners * Women with disability * Women experiencing financial hardship. * These groups do not experience more violence because of their identity, but rather because of the structural inequality and discrimination they experience. Community attitudes that normalise, tolerate and excuse increased rates of violence towards these communities along with services not being as accessible to these groups, creates opportunities for perpetrators to target these groups. Community attitudes towards these groups (such as women with disability being vulnerable and dependent) limit women’s choices and autonomy. * Family violence is not part of Aboriginal culture. However, Aboriginal women are disproportionately impacted by family violence due to the structural inequalities and discrimination they experience underpinned by racist and sexist attitudes and the on-going impacts of colonisation. Violence towards Aboriginal people is often perpetrated by non-indigenous men. * Research has shown that women who are about to or have recently separated from their partners are at a greater risk of experiencing violence and a high number of deaths and near fatal assaults occur three to six months post-separation. This is why we need to challenge the long held misconception that a woman ‘can just leave’ an abusive relationship, it may simply not be safe for her to do so. * These factors reflect the current and emerging evidence-base relating to family violence risk as defined by the MARAM Practice Guide (Family Safety Victoria, 2019). In recognition of this, MARAM applied a stronger intersectional lens to risk assessment and management. | PPT, computer, projector & screen | PPT 15 |

Topic 5: Attitudes & gender equality

Nominal duration

10 minutes

Purpose

To provide participants with an understanding of the misconceptions, attitudes and myths about Family Violence

Outcomes

At the conclusion of this topic, participants will understand:

* According to research, men are more likely to perpetrate abuse if they hold negative attitudes towards women and gender roles
* Gender inequality is seen to be both a cause and a consequence of violence against women

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation on Attitudes and gender equality-Video  **Select whichever video you prefer.**  **Please note: New video as an alternative from Women's Health Gippsland "Make the Link" This one we already use in Manager's training https://youtu.be/dZHKQkdQs8E**  **Please note: New video as an alternative - Women's Health Gippsland Make the link attitudes. https://youtu.be/RxjIp4sDkH0**  **Group discussion** | **As a society we need to promote respectful relationships and work to advance gender equality if we are to prevent men’s violence against women** | * We are now going to consider what drives family violence * Research shows that gender inequality is both a cause and a consequence of violence against women (Our Watch, 2015). Men are more likely to perpetrate abuse if they hold attitudes and beliefs that condone or support violence, gender inequality or rigid gender roles. Communities with attitudes reflecting greater levels of gender inequality generally have higher rates of family violence and sexual violence. * **Ask participants:** What stood out for you about this video? To what extent do you agree or disagree with its key messages? * **Note:** Alternative video from Women's Health Gippsland "Make the Link“: https://youtu.be/dZHKQkdQs8E or Women's Health Gippsland “Make the link attitudes”: https://youtu.be/RxjIp4sDkH0 | PPT, computer, projector & screen | PPT 16 |
| Presentation-Common Myths  **Possible activity-ask group for any myths or misconceptions they have heard about FV and write each on the whiteboard or post-its before clicking through slide.**  **This slide has animation. Each myth or misconception will appear with a click of the mouse. Once all comments have appeared, then ‘Distort, Excuse, Minimise and Perpetuate’ will appear.**  **Group discussion** | **Responsibility for the use of violence rests solely with the perpetrator, and victim survivors are not to be blamed, held responsible or placed at fault.** | * We all have our own unconscious biases, beliefs and values that we gain from our family, culture and a life time of experiences that will influence how we each view family violence * Here are some statements about family violence that you may be familiar with * Note that these mainly focus on what the person experiencing family violence does not do, rather than questioning the perpetrator’s behaviour. These community attitudes and myths distort, excuse, minimise and perpetuate family violence. * Family violence is a choice by a perpetrator to use behaviours for the purposes of power and control. * Some factors reinforcing violence against women and their children include current or past adversity experienced by perpetrators. However, this does not excuse violent behaviour. The use of violence is a choice and it is important that men who use violence are keep in view and held accountable for their behaviour through informal and formal social and legal sanctions. * **Ask: What perpetuates these attitudes?** * This includes social structures, systems, gender norms and attitudes. For example, gender roles and relationships and attitudes that support male dominance in relationships. * More information for facilitators can be found at: * https://www.ourwatch.org.au/What-We-Do/National-Media-Engagement-Project * https://anrows.org.au/publications/horizons-0/media-representations | PPT, computer, projector & screen, whiteboard, post-its | PPT 17 |

Topic 6: Barriers to disclosure of Family Violence

Nominal duration

7 minutes

Purpose

To provide participants with an understanding of barriers to making a Family Violence disclosure and how to overcome these barriers

Outcomes

At the conclusion of this topic, participants will understand:

* There are many barriers that will prevent victims/survivors from disclosing Family Violence
* Which groups in particular might be less likely / less comfortable to disclose family violence
* How can health practitioners/services help to overcome these barriers as a practice response

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation-Barriers to disclosure  **Group discussion** | **Key message: Hospital and health services must work to overcome these barriers to ensure accessible, inclusive and non-discriminatory services that promote the safety for all victim survivors.** | **Discuss: What stops people from disclosing? Some suggestions below to encourage responses:**   * They have never been asked * They have had a bad experience in the past and lack trust ‘in the system’ * Don’t know their rights or understand what behaviours constitutes family violence * Worried about privacy and confidentiality * Feelings of shame and judgement   **Discuss: Which groups are less likely to disclose family violence?**   * Aboriginal or Torres Islanders communities * Culturally and linguistically diverse communities as well as refugees and asylum seekers * People with disability * People who experience mental health issues * People experiencing homelessness * People who have experienced incarceration * Lesbian, gay, bisexual, transgender, intersex and androgynous people * People living in rural and regional settings * People experiencing alcohol or drug dependency   **Discuss: Why might some of these groups be less likely to disclose family violence?**   * Structural inequalities in our society such as sexism, ableism, racism, homophobia, transphobia, ageism, and mental health discrimination can lead to services being inaccessible to particular groups * This creates systemic barriers for these groups to find appropriate and adequate support and responses that increase their safety * How barriers manifest for an individual will differ, and will depend on their lived experience * Barriers may result from past experiences of inadequate system responses, experiences of services that haven’t been accessible or responsive to their needs * Shame, fear of not being believed, language barriers, visa status, experiences of discrimination, historic and ongoing systemic oppression, fear of reprisals or ostracisation, and concerns about their safety. * Fear of authority, fear of having children removed - stolen generation or past history with child protection * Loss of connection with family-fear of being shifted into care, causing family conflict or alienation. | PPT, computer, projector & screen | PPT 18 |
| Group discussion- | ***Clinical staff are not expected to be family violence experts. The way we treat people will provide an opportunity to disclose family violence and facilitate engagement with a specialist family violence service*** | ***Discuss: What can we do in our practice at this hospital to make it easier for people to disclose family violence and seek support? How can we engage with patients respectfully, sensitively and safety?***   * Know how to respond non-judgementally and in a way that demonstrates you believe them. * Prioritise the safety of patients. * Allow the patient to lead any engagement around risk assessment or management. * Respect a patient’s right to choose. Support informed decision making by providing information and discussing referral options. * Maintain a person-centred approach. * Place the responsibility with the violence and the impacts of violence with the person choosing to use violence * Recognise and acknowledge the strengths of an individual * Remember psychological trauma is commonly experienced by people affected by family violence – from both current and past experiences. Health professionals must always be mindful of this because you never know who has experienced family violence trauma Recognise that presentations such as anxiety, fear, dissociation may be related to their experiences of trauma. * What we think is ‘routine’ clinical practice could be traumatic for a patient. | PPT, computer, projector & screen | PPT 19 |
| Presentation: Tailoring engagement to provide a culturally safe, accessible and inclusive service | ***The way we treat people will reduce the barriers to disclosure for patients*** | **How can we tailor engagement for all patients to facilitate an accessible, inclusive and non-discriminatory service provision, including for Aboriginal people and people from diverse communities?**   * Acknowledge a person’s identity and sensitively enquire about individual needs * No challenge or denial of a person’s identity and experience * Ensure the appropriate use of interpreters – they must be professionals (not family or friend) and offer a choice of interpreter * Offer Aboriginal patients support from the Aboriginal Health Liaison Officer. * Providing a culturally safe response includes recognising a victim survivor as the expert in their own experience and supporting them to make to make decisions about their own risk management, particularly for Aboriginal people this includes respecting an individual’s right to self-determination * Ensure disability access. * Be aware of our own biases and reflect on how it may influence our work, such as influencing the judgements and assumptions we have about a person’s particular experience of family violence or assessment of their risk, or how are responded may create or fail to address existing barriers * Ensure our practice does not reinforce stigma, stereotypes of discrimination * Hear and acknowledge how systems place constraints and barriers on an individuals life and access to support * Take steps to remove identified barriers to a patient disclosing or seeking help * Continue to develop own knowledge about identities, barriers and experiences of family violence across the community * Consider if mainstream referral may be more appropriate rather than a culturally specific service-in smaller communities, the victim survivor may have concerns around privacy or perpetrator finding out. | PPT, computer, projector & screen | PPT 20 |

Topic 7: Principles of Sensitive Practice

Nominal duration

3 minutes

Purpose

To provide participants with an overview of the 6 Principles of Sensitive Practice

Outcomes

At the conclusion of this topic, participants will understand:

* Sensitive practice is a way to make people feel safe, respected and in control in relation to their experience of family violence
* Sensitive practice approach is important in health care settings
* What they can do in their practice to increase feelings of safety, respect and control

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| * Presentation: Discussing sensitive issues   **\*\*This activity is optional and dependent on available timeframes and level of comfort of facilitator.** |  | * Ask people to individually reflect on the questions displayed on the slide. * Please advise the group that this exercise is not designed to examine participants own personal experiences of family violence, but to get participants to reflect on how they felt talking about these experiences. * Advise participants to be careful not to disclose traumatic personal experiences. Give group 30 seconds to reflect. * This exercise is really to get participants to try to understand how someone who has experienced abuse may feel. * Ask 1-2 members of the group to give feedback on the last question on the slide: Think back to when you were in that situation – what sort of response would have been helpful? | PPT, computer, projector & screen | PPT 21 |
| Presentation: Sensitive Practice | **Sensitive practice makes people feel safe, respected and in control** | * The response someone receives from a health practitioner is crucial to help-seeking and recovery. * A central element of experiencing family violence is a loss of control and feeling of powerlessness. It is therefore essential that we support victim survivors dignity, autonomy and sense of control over their healthcare disclosures of family violence and support. * **A sensitive response:** * makes people feel safe, respected and in control * ensure health needs are met, inclusive of safety * respects a person’s dignity and intrinsic sense of empowerment * supports autonomy and active decision making * acknowledges unique experiences and support needs * can be a catalyst for action * Best practice is to assume everyone is affected by family violence trauma until you ascertain it is not the case. Either way, the patient will have a respectful interaction with you as a clinician and a sense of control and choice about their healthcare. | PPT, computer, projector & screen | PPT 22 |
| * Presentation: Six steps of sensitive practice |  | * Sensitive practice is a six-step process. We will go through each in more detail now | PPT, computer, projector & screen | PPT 23 |

Topic 8: Observable signs of family violence and evidence based risk factors

Nominal duration

10 minutes

Purpose

To provide participants with an understanding of the observable signs and evidence based risk factors of family violence

Outcomes

At the conclusion of this topic, participants will understand:

* The observable signs of family violence across the lifespan
* That some signs of family violence may not be as obvious
* Evidence based risk factors

Resources

PPT, computer, projector & screen, handout: ‘Signs of family violence across the lifespan’

*Appendix 1 MARAM Practice Guide 2, accessible through the following link:* [***https://www.vic.gov.au/maram-practice-guides-and-resources***](https://www.vic.gov.au/maram-practice-guides-and-resources)

*MARAM Foundation Practice Guide, accessible through the following link:* [***https://www.vic.gov.au/maram-practice-guides-and-resources***](https://www.vic.gov.au/maram-practice-guides-and-resources)

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| **Give participants the handout: Signs of Family Violence Across the Life Span**  **Discuss: What might be some signs or indicators of family violence in patients you see at this hospital?** | **These signs may indicate that family violence is occurring, but is by no means an exhaustive list** | * **Discuss: What might be some signs or indicators of family violence in patients you see at this hospital?** * While the physical symptoms arising from family violence may be apparent, other impacts of trauma may be less obvious. * Any of these signs may be caused by a range of other health conditions, but the signs are enough to explore family violence * It is important to remember that this is by no means an exhaustive list * Step one is to notice the signs; These signs may indicate that family violence is occurring. Knowledge of these signs can occur differently across a person’s lifespan, from childhood, adolescence through to adulthood and old age. | PPT, computer, projector & screen, handout: ‘Signs of family violence across the lifespan’  *These observable signs of trauma have been taken from Appendix 1 MARAM Practice Guide 2, and is accessible through the following link:* ***https://www.vic.gov.au/maram-practice-guides-and-resources*** | PPT 24 |
| Presentation-  Evidence based risk factors | **Knowledge of risk factors underpins a shared understanding of family violence, and ensures clinical staff use information gained through engagement with patients to identify indicators of family violence risk and affected family members.** | * These risk factors reflect the current and emerging evidence-base relating to family violence risk as defined by the MARAM Practice Guide (Family Safety Victoria, 2019). * The following are considered serious risk factors — those which may indicate an increased risk of the victim survivor being killed or seriously injured in the context of family violence. * Knowledge of risk factors underpins a shared understanding of family violence and identification of family violence. * MARAM provides the risk factors to enable identification of risk relevant information that may also be shared under FVISS. Therefore it is important those using FVISS are familiar with MARAM and the risk factors. * Physical assault while pregnant and/or following new birth * Planning to leave or recent separation * Escalation — increase in severity and/or frequency of violence * Controlling behaviours * Perpetrator has access to weapons * Perpetrator’s use of weapon in most recent event * Perpetrator has ever tried to strangle or choke the victim survivor * Perpetrator has ever threatened to kill the victim survivor * Perpetrator has ever harmed or threatened to harm or kill pets or other animals * Perpetrator has ever threatened or tried to self-harm or commit suicide * Perpetrator has ever engaged in stalking the victim survivor * Sexual assault of the victim survivor * Obsessive and jealous behaviour toward the victim survivor * Unemployed or disengaged from education * Drug and/or alcohol misuse and abuse * **Not all professionals need to ask about each risk factor** — but clinicians do have a role in understanding and identifying risk factors | PPT, computer, projector & screen  *MARAM Foundation Practice Guide, and accessible through the following link:* ***https://www.vic.gov.au/maram-practice-guides-and-resources*** | PPT 25 |

Topic 9: Notice the signs: Case Studies

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of Step 1 of Sensitive Practice: Notice the Signs with optional Case studies

Outcomes

At the conclusion of this topic, participants will understand:

* What signs or indicators of family violence are evident that would prompt sensitive inquiry
* The signs of family violence are not always visible and not just physical

Resources

PPT, computer, projector & screen,

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Case study: Julie  **\*\* Note: There are two case studies provided. Please use the one that is most appropriate to your hospital setting or target audience.** | **The signs of family violence are not always physical** | * **Ask: What signs or indicators of family violence are evident that would prompt sensitive inquiry?** * Late presentation could indicate that the perpetrator is preventing access to healthcare * Experiencing anxiety and issues bonding could indicate that the mother child bond has been is undermined by the perpetrator, which is a common tactic. * Julie checking her phone could indicate she is experiencing coercive and controlling behaviours * Recent separation is known to be a time of very high risk * We will work through this case study throughout the remainder of the training. | PPT, computer, projector & screen | PPT 26 |
| Case study: Mr S.  Group discussion  **\*\* Note: There are two case studies provided. Please use the one that is most appropriate to your hospital setting or target audience.** | **The signs of family violence are not always physical** | **Ask: What signs or indicators of family violence are evident that would prompt sensitive inquiry?**   * Mr S. is fearful of his son * He has reported behaviours consistent with psychological and financial abuse and is emotionally distressed * As per the ‘Observable Signs of Trauma’ in Appendix 1 of MARAM Practice Guide 2, consider if there are signs under the following categories; Physical, Psychological, Emotional, Social/financial or Demeanour. Resource is *accessible through the following link:* [*https://www.vic.gov.au/maram-practice-guides-and-resources*](https://www.vic.gov.au/maram-practice-guides-and-resources) * We will work through this case study throughout the remainder of the training. | PPT, computer, projector & screen | PPT 27 |

Topic 10: Sensitive Practice: Step 2

Nominal duration

12 minutes

Purpose

To provide participants with an understanding of Step 2 of Sensitive Practice: Sensitive Inquiry

Outcomes

At the conclusion of this topic, participants will understand:

* Create an environment where the patient feels safe and respected to talk about their experience of family violence.
* The inquiry MUST not increase risk for the patient – only make an inquiry if it is safe to do so however if family violence is suspected then an attempt should be made to see the patient in a safe place.
* It can seem hard to make this sort of inquiry - practice will help
* It is important to normalise asking about family violence
* The sensitive inquiry process relies on the elements of structured professional judgement to ascertain if family violence is occurring and the patient’s level of risk.
* Clinicians are not required to screen every patient for family violence (unless they work in antenatal care). Their role is to be alert to the signs that this might be occurring and ask the appropriate identification questions

Resources

PPT, computer, projector & screen, LIVES handout/lanyard, ‘Asking about Family Violence’ Handout, MARAM Family Violence Screening and Identification Tool (or similar tool developed for use in your workplace)

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Sensitive inquiry | **Create an environment where the patient feels safe and respected to talk about their experience of family violence. Sensitive inquiry must not increase the risk for the patient. Only make an inquiry if it is safe to do so.** | Before you start asking questions, ask yourself whether the conditions are right to proceed. The inquiry must not increase risk for the patient – only make an inquiry if it is safe to do so.   * Can the conversation be overheard? Always use a private space * Is the patient alone? Its not safe to ask in the presence of others including children who are verbal (above the age of 2). * **Be aware** - it is not safe to ask about family violence if others are present * Is it a suitable time to ask about family violence? It may not be if the patient in pain or anxious about surgery? * Clearly explain your role and confidentiality and information sharing requirements, and how their information can be shared. It is also important to explain why you are preforming certain tests or asking particular questions. Inform the patient any disclosure of family violence is voluntary * Safely and respectfully respond to the individual’s culture and identity. Is an interpreter required? Ensure the interpreter is a professional and ask if the patient would prefer a person of the same gender. Offer a support person and explore access to culturally appropriate internal and external services | PPT, computer, projector & screen | PPT 28 |
| Presentation:  Structured Professional Judgement  Group discussion | **The sensitive inquiry process relies on the elements of structured professional judgement to ascertain if family violence is occurring and the patient’s level of risk.** | Sensitive practice relies on structured professional judgement through the observation of signs and risk factors that may indicate family violence is occurring, and then confirming this by undertaking the MARAM identification questions.  Structured Professional Judgement is informed by:  • a person’s self-assessed level of risk, safety and fear  • assessment against evidence-based risk factors  • information sharing to inform assessment (sensitive practice practitioners are not required to seek information from external services but only to seek secondary consultation and support internally)  • professional judgement using an intersectional and child safety lens    The victim survivor – whether adult or child – is represented at the centre of the model, highlighting the importance of keeping a victim survivor at the centre in all of our work.  This component involves asking about and understanding what a victim’s own assessment of their risk or level of danger is. Research has found that this is a strong predictor of level of risk.  A victim survivor is the expert in their own lives, and they have been managing their own risk so far. They are likely to have been continually responding to changes in risk and have an awareness of what factors influence these changes.  Whilst you are not required to undertake a full risk assessment, the elements of structured professional judgement help to inform your next step. Linking a victim survivor’s self assessment and the evidence based risk factors will identify key points to convey when escalating internally to a manager or to social work, and the information gathered will help them to make decisions on the level of risk and the next step.  It is possible that at times family violence risk may become normalised to a victim survivor due to high risk or multiple experiences of violence. However, clinicians should always explore the situation and find out why the victim survivor is less concerned than the clinician, before making assumptions that they are minimising. | PPT, computer, projector & screen | PPT 29 |
| Presentation: How to begin? | **It is important to normalise inquiries about family violence** | * If family violence is disclosed or if indicators of family violence are observed, your role is to sensitively and respectfully open up a conversation. * A prompting statement is a helpful way to start a conversation. The purpose of a prompting statement is to position the inquiry about family violence as a routine part of hospital care – to normalise it. * This will make the person feel less ‘singled out’, reducing the stigma associated with being identified as a victim of family violence and/or sexual assault. * You can also start by linking some of the observable indicators into the conversation. * It may feel uncomfortable but clinicians ask a lot of uncomfortable questions in clinical practice * You need a statement that works for you so that it is authentic – not scripted. | PPT, computer, projector & screen | PPT 30 |
| Presentation: Family violence identification  **NOTE: This slide MUST reflect the hospital or health service’s own Family Violence Policy and Procedure and practice implementation of MARAM.**  **Decisions about practice implementation may include the direct use of the MARAM Screening and Identification Tool (and Responsibility 2 Practice Guide) or the questions may be incorporated into an EMR workflow. The information presented here is a general representation of the Screening and identification process due to the variance in each hospital’s implementation.** | **Clinicians are not required to screen every patient for family violence (unless they work in antenatal care). Your role is to be alert to the signs that this might be occurring and ask the appropriate identification questions if you think a patient is experiencing family violence.** | The next step is to ask a series of questions outlined in the ‘MARAM Screening and Identification Tool’.  Please refer to Appendix 2 (Practice Guidance on Screening Tool) and Appendix 3 (Adult Screening and Identification Tool) in practice guide 2.   * The purpose of which is to identify:   If family violence is occurring  The victim survivor’s level of fear for themselves or another person  Identify the person using violence (e.g. the perpetrator).  This tool should be used as part of routine screening (in antenatal clinics only) or when a health practitioner has noticed the signs of family violence and is undertaking sensitive inquiry.  The tool has been developed for use with adult victim survivors to identify family violence for both adult and the child who may also be victim survivors of family violence.  The outcome of the ‘MARAM Screening and Identification Tool’ will guide you on what to do next, that is, whether immediate action, further assessment and/or risk management is required.  Before beginning, always make sure the patient knows that answering these questions is voluntary. If someone isn’t ready to respond to your questions, you need to respect this. Your role is to encourage the person to tell their own story in their own words.  The questions relate to the evidence based risk factors and are purposely direct, because research indicates that victim survivors are more likely to accurately answer direct questions.  In the first instance you are required to ask the following question to identify if risk is present.   * **1. Has anyone in your family done something to make you or your children feel unsafe or afraid?** * If the patient answers yes, ask: **Who is making you feel unsafe?** (Note that there may be one or multiple perpetrators – if there are multiple ask following undertake questions relating to each of them) * (The MARAM practice guidance suggests also asking “Has the frequency changed or the experience increased in severity?). * The next three questions establish the level of risk. * **2.Have they controlled your day-to-day activities (e.g. Who you see, where you go) or put you down?** (The MARAM practice guidance suggests also asking **Has the frequency changed or the experience increased in severity?**)**.** * **3.Have they threatened to hurt you in any way?** (The MARAM practice guidance suggests two three follow questions to support an understanding of the threat, **What have they threatened you with? How specific in detail are the threats?** “**Has the frequency changed or the experience increased in severity?**). * **4. Have they physically hurt you in anyway (hit, slapped, kicked or otherwise physically hurt you)?** (The MARAM practice guidance suggests four additional follow on questions to support an understanding of the physical harm. **How have they physically harmed you? Have you ever been hit in the head or face? Have you ever been pushed or shoved and banged your head against something? Have you ever lost consciousness?**) * If the answers to these questions indicate that family violence is **not** occurring, **no action** is required, but it is important to ensure the patient is aware that if circumstances change or they ever need assistance, the hospital is a safe place to disclose and seek support. * You should always ask the parent/carer about what their child/ren might be experiencing directly or exposed to from a person who may be using violence (even if the person does not live with them). This includes if a child is being exposed to the aftermath of family violence (for example, broken furniture or an upset or injured victim survivor). Explain to the parent/carer that they may be experiencing family violence and that it may be impacting their children. * **Asking questions to an adult about children’s experiences when using the Identification Tool. Building rapport with an adult also supports keeping a child’s experience in view.**   • “What are your worries for each of your children?”  • “What have you noticed about how this is affecting the children?”  There is more information on exploring the risk to children on the following slide. | PPT, computer, projector & screen | PPT 31 |

Topic 11: Children and Older persons

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of at risk cohorts of Children and Older persons as victim survivors of family violence

Outcomes

At the conclusion of this topic, participants will understand:

* Children and young people who experience family violence and sexual assault can experience long term health impacts and trauma
* Older people are increasingly dependent on others, including persons of concern, so reporting is less common.

Resources

PPT, computer, projector & screen,

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Children and family violence  **There is a supplementary training module on Children and violence for those requiring more information on working with these patient cohorts. Please see the SHRFV Toolkit for access.** | **Children and young people who experience family violence and sexual assault can experience long term health impacts and trauma** | Children are to be recognised as victim survivors of family violence in their own right, whether they are directly targeted by a perpetrator, or being exposed to or witnessing violence or its impacts on other family members.  Children and young people do not have to be physically present during violence to be negatively affected by it, or to be considered victim survivors.   * Exposure to violence can include:   • Hearing violence  • Being aware of violence or its impacts  • Being used or blamed as a trigger for family violence  • Seeing or experiencing the consequences of family violence, including impacts on availability of the primary caregiver and on the parent-child relationship.   * Children are present in many family violence situations and are therefore subject to physical, emotional and social impacts, including psychological trauma, disrupted attachment, delays to development, lack of predictability and stability * Family violence should be seen as an attack on the mother child relationship because of the effect this has on her ability to parent * Children and their mothers/carers are especially vulnerable if the child has a disability * Family violence and the physical or sexual abuse of children are highly correlated * Family violence was a factor in 80% of child deaths known to child protection in 2013 (Commission for Children and Young People, 2013) * Health professionals have a duty of care to report to Child Protection when there is a reasonable belief that a child has suffered, or is likely to suffer significant harm from physical or sexual abuse or exposure to it   For workers required to use the Identification and Screening Tool, a child focus under MARAM includes:   * Considering and asking about a child’s safety, needs and wellbeing, even if only working with an adult. * This includes identifying children’s needs and making appropriate referrals. A child focus under MARAM does not mean that every clinician will suddenly be having individual appointments with children to identify risk; however, knowing about evidence-based risk factors specific to children, noticing when these are present and asking about family violence is essential. * Where young people have experienced family violence, abuse and/or neglect, it is important to use a trauma-informed approach that is appropriate to their age and developmental stage, as risk is likely to present quite differently depending on the age and maturity of the child * Where it is safe, appropriate and reasonable, a child or young person should be directly engaged with to ascertain their assessment of their risk, their identification of risk factors, and their consideration of risk management strategies * Where it is not safe, appropriate and reasonable to engage directly with a child or young person, services should seek to collaborate with the parent who is not using violence or other professionals who interact with that child (e.g., schools) to ensure accurate and detailed information about the child or young person’s experience is collected and assessed | PPT, computer, projector & screen | PPT 32 |
| Presentation: Elder Abuse  **There is a supplementary training module on Elder abuse for those requiring more information on working with these patient cohorts. Please see the SHRFV Toolkit for access.** | **Older people are increasingly dependent on others, including persons of concern, so reporting is less common.** | * **Instructions for facilitators: Refer to the slide and suggested facilitator dialogue** * Elder abuse is a form of family violence. An ‘elder’ is usually defined as someone aged 65 years or over * Elder abuse is usually carried out by someone close to an older person. Sons are most likely to be responsible, however, the abuser may be a grandchild, partner, other family member, carer, friend or neighbour * There are six main types of elder abuse - physical, financial, sexual, psychological and emotional, neglect and abandonment and social abuse, which is where restrictions are placed on social contact with others. The most common form of abuse reported to Seniors Rights Victoria is financial abuse * Elders subject to abuse face a greater risk of hospitalisation * Elder abuse is underreported, with an estimated 5% of older people at risk of abuse, with women at greater risk than their male counterparts * Consumer based transactions, professional misconduct and abuse, which may occur in residential aged care, are dealt with under specific aged care legislation, consumer legislation and professional registration acts. | PPT, computer, projector & screen | PPT 33 |

Topic 12: Sensitive Practice: Step 3

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of Step 3 of Sensitive Practice: Respond respectfully

Outcomes

At the conclusion of this topic, participants will understand:

* How clinicians respond is crucial to eliciting feelings of safety, respect and control for the patient and it can make a big difference.
* LIVES is a World Health Organisation model – it is a way of reminding us how best to respond.
* LIVES is a first-line support that involves five simple tasks. It responds to both emotional and practical needs at the same time.
* Patient safety, self-determination and decision making is a priority

Resources

PPT, computer, projector & screen, LIVES handout/lanyard, ‘Asking about Family Violence’ Handout

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Respond respectfully  Group discussion  Participants could be provided with a handout about LIVES for further reading:  <http://www.who.int/reproductivehealth>/publications/violence/vaw-clinical-handbook/en/  The lanyards in the tool kit provide a reminder about LIVES | LIVES is a World Health Organisation model that includes five practical steps of how to best respond. | LIVES is a World Health Organisation model that provides a first-line response of five simple tasks that respond to patient’s emotional and practical needs.  It is important to respond to the person before responding to the situation, be present with them and their story. This person centred approach gives a person space to describe their experience of family violence, their relationship with the perpetrator and the impact of violence on their daily functioning, allowing you to sensitively identify presenting risk. This response is trauma informed and can empower the person experiencing violence.   * **LISTEN:** Being listened to can be an empowering experience for a person who has been abused. Listen with empathy and without judgment and reflect back what you have heard: *‘That must have been very frightening for you. Your partner has been controlling and made you feel unsafe’.* * **INQUIRE**: Assess and respond to the patient’s emotional, physical, social and practical (e.g. childcare) needs and concerns. *‘What I’m hearing is that at the moment you need support around..’* * **VALIDATE:** Show the patient that you understand and believe them. Assure them that they are not to blame. *‘Violence is unacceptable and you do not deserve to be treated this way.’* * *We will cover Enhance safety and support later.* * **NOTE:** The facilitator needs to highlight that LIVES is a framework and that the two steps of ‘Enhancing safety’ and ‘Support‘ will be covered in more detail later in the presentation | PPT, computer, projector & screen | PPT 34 |
| Presentation: Helpful/not helpful responses  **Handout - Asking about Family Violence**  **Activity: Work in pairs to think back to Julie or Mr S. How could you respond to demonstrate LIVES?** | **A sensitive and non-judgemental response is vital to a patient feeling safe and supported and keeping the perpetrator in view and accountable for their actions.** | Helpful responses:   * Validates and offers support to enhance safety * Include rights-based statements * Assigns accountability to the perpetrator * places control with the patient * Provides support that is unconditional.   Unhelpful responses:   * Blames the person experiencing violence * Fails to understand the complexity of the issue * Diminishes perpetrator responsibility and offers support that is conditional on the victim survivor ending the relationship | PPT, computer, projector & screen, Handout-Asking about family violence | PPT 35 |
| Presentation: Step 3: respond respectfully |  | If a patient answers **yes** to **any** of the identification questions you should offer a referral to your hospital’s social work department or other appropriate professional (as defined by your hospital’s Family Violence Procedure and referral pathways).  If a patient answers **no** to **all** of the identification questions no further action is needed. You must respect this. The person might not be ready or not feel comfortable to talk to you about the family violence they are experiencing. They may also not be experiencing family violence.  Thank the person for answering the questions and inform them that help is available and that they are able to contact the hospital or other community services in the future should they ever experience family violence. | PPT, computer, projector & screen, Handout-Asking about family violence | PPT 36 |

Topic 13: Sensitive Practice: Step 4

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of Step 4 of Sensitive Practice: Respond to risk

Outcomes

At the conclusion of this topic, participants will understand:

* The need to assess the risk and consider the safety plan for the patient
* Health professionals should be aware of the risks
* When a patient is declining an internal or external referral, it is important to explore how they would manage an immediate or serious threat to their life, health, safety or welfare.

Resources

PPT, computer, projector & screen, Appendix 4: Basic Safety Plan in MARAM Practice Guide 2.

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Step 4: respond to risk | **Health professionals should be aware of the risks** | * If a patient answers **yes** to **any** of the identification questions and does not consent to a referral, you should ask the patient three immediate risk questions.   **5. Do you have any immediate concerns about the safety of your children or someone else in your family?**  **6. Do you feel safe to leave here today?**  **7. Would you engage with a trusted person or police if you felt unsafe or in danger?**   * You should always ask the parent/carer about what their child/ren might be experiencing directly or exposed to from a person who may be using violence (even if the person does not live with them). This includes if a child is being exposed to the aftermath of family violence (for example, broken furniture or an upset or injured victim survivor). Explain to the parent/carer that they may be experiencing family violence and that it may be impacting their children. * It is important for you to also ask:   “What are your worries for each of your children?”  “What have you noticed about how this is affecting the children?” | PPT, computer, projector & screen | PPT 37 |
| Presentation:  Step 4: respond to risk  **\*\*This is another slide that can be amended to reflect your organisation’s family violence procedures (for example; utilise screen shots of EMR interface instead)** |  | If the patient answers YES to question **5** and NO to question **6**; indicating the patient is in immediate danger (in other words, the patient has let you know they are experiencing an immediate and/or serious threat to their life and their health, safety or welfare):   * Ask if they require police assistance. Victoria Police are the only service that can respond to immediate danger. * Before contacting police you should: * Ask the victim survivor about their views on calling the police. * Consult with your manager or social work department. * Consider whether a child is at risk and mandatory reporting obligations apply   If the patient answers **NO** to question **7,** follow up with the questions:   * Is there a reason you would not contact or would be hesitant to contact police? * Is there something I can do to support you to feel confident in contacting police? * Would you contact another support service, such as a specialist family violence service who could provide you with support?   If the patient is not wanting police assistance, consult with your manager or your social work department to determine if the police need to be contacted without the patient’s consent and whether your hospital needs to share information under FVISS and/or CISS:   * If there is an immediate threat, calling the police is an appropriate response. However, if the person indicates that calling police may increase their risk this information needs to be provided to the police to inform their response. * A patient should be informed about any action taken irrespective of whether they give consent * Consider whether a child is at risk and mandatory reporting obligations apply * Seek consent (if required) so you can share information under FVISS and CISS voluntarily or explain circumstances when consent to share may not be required.   If the patient answers NO to question **5** and question **6** (in addition to question 1-4) indicating the patient is not in immediate danger but is at serious risk you should:   * Seek secondary consultation with social work, your manager or a specialist family violence service as appropriate * Consider whether a child is at risk and mandatory reporting obligations apply * Provide information about help and support that is available | PPT, computer, projector & screen | PPT 38 |
| Presentation: Safety Plan | **Although clinicians are not expected to be family violence experts, when a patient is declining an internal or external referral, it is important to explore how they would manage an immediate threat to their life, health, safety or welfare.** | It is important to remember that discussing a safety plan with your patient is needed in the circumstances where there is immediate risk identified, serious risk identified and if there is no internal referral pathways available (not able to refer to social work).  These are suggested elements of a safety plan and questions you can ask to help the patient experiencing family violence make a plan.  Every safety plan will be unique and based on the needs of the adult or young person. You should be guided by the victim survivor on what is important and safe for them in their basic safety plan.  Below are some questions that can be used to explore these safety considerations. They have been taken from MARAM Practice Guide and form a basic safety plan.   * If you need to leave your home in a hurry, where would you go? * Would you feel comfortable calling the police (000) in an emergency? If not, how can we support you to do so? * Where is the perpetrator right now? * Is there someone close by you can tell about the violence who can call the police? * How many children do you have in your care? Where are they right now? * Do you have access to a phone or internet? * Do you have access to a vehicle or other public transport options? * What essential things like documents, keys, money, clothes or other things should you take with you when you leave? * Do you have access to money if you need to leave? | PPT, computer, projector & screen, Appendix 4: Basic Safety Plan in MARAM Practice Guide 2. | PPT 39 |

Topic 14: Sensitive Practice: Step 5 Referral

Nominal duration

3 minutes

Purpose

To provide participants with an understanding of Step 5 of Sensitive Practice: Referral

Outcomes

At the conclusion of this topic, participants will understand:

* Know how to access support for patients

Resources

PPT, computer, projector & screen, ‘Specialist Family Violence Services’ handout

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Referrals  Provide handout: contact details for specialist family violence services  **Note: This slide should be amended to reflect your hospital’s referral pathway for internal and external services noting where 24/7 assistance is available** | **Appropriate referral is important in ensuring patients experiencing family violence access professionals and services that can effectively assess and manage the risk associated with family violence.** | It is important for clinicians to understand what services are available and their hospital’s referral pathways for patients experiencing family violence  Refer to the intranet for more information or seek secondary consultation from your manager, clinical staff or social work department.  Provided are details of external family violence services that could assist.  Clinicians should provide information about referral options to patients to support informed decision making. It is important to check it is safe for the patient to take the information.  **Safe Steps**  24/7 Family Violence Response Service. Safe Steps provide assistance with risk assessment, crisis accommodation, safety planning, support and information for women and children experiencing violence.  **Centre Against Sexual Assault (CASA)**  Provides a free counselling and support service to people who have experienced sexual assault either recently or in the past.  **Sexual Assault Crisis Line (SACL)**  The Sexual Assault Crisis Line Victoria (SACL) is a state-wide, after-hours, confidential, telephone crisis counselling service for people who have experienced both past and recent sexual assault.  **Local Family Violence Specialist**  Specialist family violence services provide direct support to women and children experiencing family violence. Women can contact them directly, or they may be referred by police, GPs, hospitals or other services.  **Child Protection**  The Victorian Child Protection Service is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them  **iHeal**  iHeal provides a range of supports tailored to suit you, and where appropriate your family’s needs.  Support may include: Counselling, Case work and advocacy: helping you navigate complex systems such as court, child protection, mental health, housing, Alcohol and Other Drug services and education  Support groups to help you reconnect with community & Recovery education.  **1800 Respect**  National Sexual Assault, Domestic and Family Violence Counselling Service. Confidential information, counselling and support service  **InTouch**  inTouch Multicultural Centre Against Family Violence works with women & children from culturally and linguistically diverse backgrounds (CALD) who are victims/survivors of domestic violence  **Djirra (Formerly Aboriginal Family Violence Legal Service)**  Djirra is a culturally safe place where culture is celebrated and practical support is available Men's Referral Service The Men’s Referral Service is a men’s family violence telephone counselling, information and referral service operating in Victoria, New South Wales and Tasmania and is the central point of contact for men taking responsibility for their violent behaviour.  **The Orange Door**  The Orange Door is a new way for women, children and young people who are experiencing family violence or families who need assistance with the care and wellbeing of children to access the services they need to be safe and supported. The Orange Door will be rolled out across Victoria by 2021, with operations beginning in some of the first locations from May 2018. | PPT, computer, projector & screen, handout: contact details for specialist family violence services | PPT 40 |

Topic 15: Sensitive Practice: Step 6 Documentation

Nominal duration

3 minutes

Purpose

To provide participants with an understanding of Step 6 of Sensitive Practice: Documentation

Outcomes

At the conclusion of this topic, participants will understand:

* Maintaining records is an integral and important part of practice for all health professionals.
* Information documented must impartial, accurate and complete
* The practice expectations of staff with sensitive practice responsibilities outline that they are not responsible for receiving or responding to information sharing requests, but under MARAM Responsibility 6: Contribute to information sharing with other services, they have practice expectations as part of their role

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Documentation | **Maintaining records is an integral and important part of practice for all health professionals.** | **Document in the patient’s medical record:**   * Signs family violence may be occurring * If family violence has been identified as present or not present * If you completed the identification questions and immediate risk questions (if required) * If an interpreter was required and used * Children’s details and if they were present * Perpetrator details if known * Contact details for the victim survivor, including method of contact (such as text before call) and time it may be safe to make contact * Emergency contact details of a safe person if the victim survivor cannot be contacted * Any actions you have undertaken or that have been referred to another persons role | PPT, computer, projector & screen | PPT 41 |
| Presentation: Documentation and information sharing | **The practice expectations of staff with sensitive practice responsibilities outline that they are not responsible for receiving or responding to information sharing requests.**  **Each organisation will be required to make decisions about who fulfils this responsibility and how it will be managed.** | **Under MARAM Responsibility 6: Contribute to information sharing with other services, you have practice expectations as part of your role**  Ensure patients are informed about the limits of confidentiality in relation to these legislations and this is documented  Ensure that patient records are up-to-date - with risk relevant information that was disclosed, the date on which the information was disclosed and any risk assessment or safety plans that have been prepared with a patient  Ensure any information about your patient you believe is risk relevant is communicated with the person(s) responsible for managing the information sharing responses in your organisation or escalate to your manager if unsure. | PPT, computer, projector & screen | PPT 42 |
| Presentation: Collaborative practice | **Clinicians are expected to contribute to collaborative practices and have practice expectations as part of their role** | Under MARAM Responsibility 9 & 10: Contribute to coordinated and collaborative risk management including ongoing risk assessment, you have practice expectations as part of your role to:   * Have an awareness of MARAM * Understanding how your role and organisation contributes to an integrated service system response to family violence. * Ensure patient records are up-to-date * Follow the organisation’s family violence procedure (or the appropriate clinical governance structure in your work unit or area). * Enact their organisations escalation process to support staff with higher responsibilities to undertake risk assessment and coordinated risk management as part of a multi-disciplinary and multi-agency approach | PPT, computer, projector & screen | PPT 43 |
| Presentation:  Documentation  **This slide could be optional depending on level of experience/comfort of audience or could be provided as a handout** |  | Lead participants through a discussion about the examples of poor documentation, using this as a prompt to discuss the example of good documentation. | PPT, computer, projector & screen | PPT 44 |

Topic 16: Putting it into practice

Nominal duration

20 minutes

Purpose

To provide participants with an opportunity for interaction through role play sensitive practice in action or working through provided case studies as group discussion

Outcomes

At the conclusion of this topic, participants will understand:

* How to respond to a person experiencing family violence using the steps of sensitive practice.

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Putting it into practice  **Play video (note this is still in development) or alternatively, use either the Julie or Mr S. case study and work through as a group discussion or role play. There is some scripting on subsequent slides if you do choose to use one of the case studies.** |  | This role play demonstrates a nurse identifying and responding to a patient experiencing family violence who is an inpatient at the hospital.   * **Discuss** * What did the nurse do well? What could be improved? * What did you notice about the patient’s behaviour and body language? * One point to highlight: The nurse noted that everything said is confidential without explaining the limits of confidentiality. One of the more difficult and complex factors in maintaining trust is to ensure transparency about confidentiality, and the limits to confidentiality. That is, reassuring the patient that everything they tell us is confidential, however there are limits to that where there are serious concerns to the safety of children. This should be communicated to the patient as soon as they begin to disclose their situation. | PPT, computer, projector & screen | PPT 45 |
| Julie Case study: putting it into practice  **Note: There are two case studies provided, please use the one that is most appropriate to your hospital setting.** |  | Previously, we identified signs that Julie was experiencing family violence, what are the next steps?  **Step 2. Sensitive Enquiry**   * Ask: Are the conditions right to proceed? * Can proceed if have private space for conversation, Julie is alone, confidentiality and its limitations have been explained and it is a suitable time. * Ask: How could you begin a conversation? * Example answer: ‘I noticed that when your ex-partner visited to see your baby earlier, you appeared anxious, was there something worrying you at the time that you would like to talk about? When we notice situations like this, which is common, we ask patients about their safety. Is it alright if I ask you some questions about your safety so that we can make sure we connect you with appropriate support? * You would then ask Julie the initial identification questions.   **Step 3. Respond Respectfully**   * Ask: If Julie responded by saying ‘My ex-partner is very controlling. When we were together he controlled when I could see my family and friends**’,** how could you respond in a respectful way? * Example answer: ‘What I am hearing is that your ex-partner is controlling, it is not ok for someone to control you’. * Ask: If Julie responded by saying ‘He has been physically violence in the past’, how could you respond in a respectful way? * Example answer: ‘That’s not ok he assaulted you, there is no excuse for violence.’ * **At this point you will be required to offer a referral to the Social Work Team. You may choose to respond with:** * It must be difficult going through what has happened to you. You have the right to feel safe. There are services that can help you with your safety and wellbeing, either here at the hospital or in the community. Can I refer you to a social worker/care co-ordinator who can help you further? * If Julie declines support, you should proceed with asking the remaining identification questions.   **Step 4: Respond to Risk**   * Ask: If Julie disclosed that ‘I am concerned about seeing my ex-partner, I am afraid of him’, how could you explore safety planning with her? * Example answers: * If your ex-partner came to your house, and you felt unsafe, have you thought about what you might do? * How would you call the police? * Could you plan how a friend or family member could help you at this time?   **Step 5: Referral**   * Ask: What referral options could you provide Julie? * Example answer * Local specialist family violence service/Orange door * Child FIRST   **Step 6: Documentation**   * Example of documentation on slide 47. | PPT, computer, projector & screen | PPT 46 & 47 |
| Mr S. Case study: putting it into practice  **Note: There are two case studies provided, please use the one that is most appropriate to your hospital setting.** |  | Previously, we identified signs that Mr S. was experiencing family violence, what are the next steps?  **Step 2. Sensitive Enquiry**   * Ask: Are the conditions right to proceed? * Can proceed if have private space for conversation, Mr S is alone, confidentiality and its limitations have been explained and it is a suitable time. * Ask: How could you begin a conversation? * Example answer: ‘I noticed that when your son came in earlier, he was quite aggressive towards you and you were visibly distressed. When we notice situations like this, which is common, we ask patients about their safety. Is it alright if I ask you some questions about your safety so that we can make sure we connect you with appropriate support? * You would then ask Mr S the initial identification questions.   **Step 3. Respond Respectfully**   * Ask: If Mr S responded by saying that ‘My son can be controlling, and often demands money from me’, how could you respond in a respectful way? * Example answer: ‘It sounds like the way your son behaves is not ok with you. It is not ok for someone to make you do something you don’t’ want to do. * Ask: If Ms responded by saying ‘Often he threatens to lock me out of the house for good if I don’t give him more money, which is why I never have enough money’, how could you respond in a respectful way? * Example answer: ‘It sounds like your son’s behaviour is having a huge impact on you, there is not excuse to threaten someone or make them feel afraid’. * **At this point you will be required to offer a referral to the Social Work Team. You may choose to respond with:** * It must be difficult going through what has happened to you. You have the right to feel safe. There are services that can help you with your safety and wellbeing, either here at the hospital or in the community. Can I refer you to a social worker/care co-ordinator who can help you further? * If Mr S declines support, you should proceed with asking the remaining identification questions.   **Step 4: Respond to Risk**   * Ask: If Mr S disclosed that he was not concerned his son would be physically abusive but was concerned his son will continue to be emotionally, verbally and financially abusive. How could you explore safety planning with him? * Example answers * If your son did become physically abusive and you were concerned for your safety, have you thought about what you might do? * How would you call the police? * Could you plan how a friend or family member could help you at this time?   **Step 5: Referral**   * Ask: What referral options could you provide Mr S? * Example answer * Senior Rights Victoria * Victims of Crime   **Step 6: Documentation**   * Example of documentation on slide 49. | PPT, computer, projector & screen | PPT 48 & 49 |

Topic 17: Mandatory Reporting

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of Mandatory reporting requirements

Outcomes

At the conclusion of this topic, participants will understand:

* Under the Children Youth and Families Act 2005 doctors and nurses are required to report cases of suspected physical and sexual abuse to Child Protection services for any person under 18 years of age.
* All health professionals have a duty of care to report children/young people who are in need of protection to Child Protection services and to put the best interests of the child first.
* Under the Crimes Act 1958 everyone is mandated to report sexual offences against a child to police.

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Mandatory reporting | **Health professionals have a legal responsibility to report suspected physical and sexual abuse. The best interest of the child is paramount and consider allchildren and young people*-* whether they are your direct patient or whether they are the child of your patient and whether they are with your patient or reported to be at home or elsewhere.** | * Under the Children Youth and Families Act 2005 registered medical practitioners, nurses, midwives and registered psychologists among others are required to report cases of suspected physical and sexual abuse to Child Protection services for any person under 18 years of age. All health professionals have a duty of care to report children/young people who are in need of protection to Child Protection services and to put the best interests of the child first. Under the Crimes Act 1958 everyone is mandated to report sexual offences against a child to police. * Adults largely have complete autonomy and their wishes must be respected. However, when children/young people are involved, their safety and best interests are paramount. * The risk of emotional abuse, neglect and cumulative harm must be taken into account, as well of potential for physical or sexual abuse * This applies to children and young people who are your patients and to any other children or young people who may be in the family home or who are otherwise at risk. * If you have concerns for a child or young person's safety or wellbeing for any of these reasons, consult with your hospital’s Social Work department, or Child Protection services, and refer to your hospital’s procedures for responding to concerns of child abuse. * If you recognise the need for this, sensitive practice principles would encourage the involvement of the non-offending parent in the process, however it is best not to do so if this would heighten the risk to themselves or to the child/young person. * Reports contribute to a picture of cumulative harm over time (a series of reports to Child Protection might indicate a concerning pattern of harm)– so **always report** if you have significant concerns. * [Refer to hospital protocols] All organisations working with children and young people also have a duty to protect them from harm, under Victoria’s Child Safe Standards (and reportable conduct scheme). Presenters can explore this link to know more: <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/child-safe-standards-resources> and <https://ccyp.vic.gov.au/reportable-conduct-scheme>. It is essential to refer to your organisation’s own policy. | PPT, computer, projector & screen | PPT 50 |

Topic 18: Workplaces supporting staff experiencing family violence

Nominal duration

10 minutes

Purpose

To provide participants with an understanding of the workplace supports available for staff and how to respond to staff disclosures of family violence

Outcomes

At the conclusion of this topic, participants will understand:

* Workplaces have an important role in supporting victim survivors
* How to respond to staff disclosures of family violence
* What workplaces supports are available and how to access them

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation-Workplaces supporting staff experiencing family violence | **Workplaces have an important role in supporting victim survivors** | * Paid employment can be an important protective factor for people affected by family violence * Paid employment can increase victim survivor’s financial independence, wellbeing, social support, safety and security * The impact of family violence on the victim survivor is insidious, and may present in many ways including disrupted work records, decreased productivity, absenteeism (such as high use of sick leave) or fear of losing their job due to these factors * Victim survivors report the main impact of violence on their work performance is being distracted, tired or unwell (16%), needing to take time off (10%), and being late for work (7%) (McFerran, 2011) | PPT, computer, projector & screen | PPT 51 |
| Presentation-  Workplace supports | **To access further information on the supports available or seek support for yourself, please contact your human resources department or search your organisation’s intranet** | * Most hospitals and health services now contain a family violence clause in their Enterprise Bargaining Agreement (EBA). The clause outlines leave provisions and other measures to support an employee experiencing family violence: * Family Violence Leave is 20 days paid leave per year (pro rata for part-time employees) and is available to employees experiencing family violence * Development of a Workplace Safety Plan can include changes to work duties, span of hours, pattern of hours and/or shift patterns, relocation, changes to contact details * Trained managers and contact officers. Family violence workplace support training is provided to all managers and family violence contact officers who provide support to staff and volunteers experiencing family violence | PPT, computer, projector & screen | PPT 52 |
| Presentation-What if a colleague disclosures family violence? | **Health professionals are often common sources of support for people experiencing family violence.** | * If a colleague discloses to you that they are experiencing family violence you should; * Validate their experience and show you believe them by using statements such as; * ‘That must be hard for you, thank for telling me’ or ‘I’m sorry that has happened to you, no one deserves violence’ * Support them to make their own decisions; * Inform them of the available workplace supports and connect them to human resources or further family violence information available on the intranet * If you are a manager: you are required to undergo further training to support your staff. Contact your human resources department for more information. | PPT, computer, projector & screen | PPT 53 |

Topic 19: Staff resources

Nominal duration

3 minutes

Purpose

To provide participants with an understanding of resources available to staff

Outcomes

At the conclusion of this topic, participants will understand:

* It is important to recognise the need for self care when working with people affected by trauma from family violence.

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation:  Staff resources  **Note: This slide should be amended to outline the support available to staff at your hospital on a professional and personal level** | **It is important to recognise the need for self care when working with people affected by trauma from family violence.** | * It is not easy working with people who have experienced family violence and sexual assault and professionals can be personally affected by hearing about these traumatic events, and by witnessing the considerable impact and distress that it causes. * Listening to accounts of trauma can challenge your understanding of the world and can lead to cumulative stress, compassion fatigue or vicarious trauma. * Our stress can undermine the care and compassion we are able to give. When supporting people who have experienced trauma, your ability to ‘help’ them may fall short of your expectations and may make you question your professional capacity. This is why reflective practice and supervision can be important practices. * For some people this work can be experienced as a privilege, knowing the difference that we can make to the lives of those that we assist. It can also become personally draining, at times overwhelming. * Recognising and addressing the need for self-care is an important part of doing our job well. * Sometimes, simply sharing our emotions with colleagues, family and friends can help but sometimes more professional support is required. * Explain what is being done to train managers in the SHRFV Workplace Support Program. | PPT, computer, projector & screen | PPT 54 |

Topic 20: Conclusions

Nominal duration

5 minutes

Purpose

To provide participants with an understanding of the presentation in conclusion

Outcomes

At the conclusion of this topic, participants will understand:

* Key messages from presentation
* The need for reflective practice
* Key references

Resources

PPT, computer, projector & screen

| Suggested Facilitation | Key message/s | Facilitators Dialogue | Suggested resources | PPT slide reference |
| --- | --- | --- | --- | --- |
| Presentation: Key messages | **Clinicians must be aware of the signs of family violence, sensitively inquiry when you notice these signs, and if someone discloses to you, ensure that you can respectfully, sensitively and safely engage and provide appropriate support and referral.** | * Family violence is complex and affects people across the lifespan-but mostly women and children * Family violence could be a factor in a patient’s presentation * A sensitive response is vital – people have choices * Health staff are not expected to be family violence experts-but everyone’s role is vital in an effective response to family violence * We all have a duty of care to support patients and colleagues and keep perpetrators in view and accountable for their actions * There are policies and procedures to support you if you are experiencing family violence * There are experts and supports available for consultation or referral | PPT, computer, projector & screen | PPT 55 |
| Presentation: Reflections |  | * Thank the group for their participation, engagement and energy * Acknowledge that family violence and sexual assault are complex and that this training is brief * Encourage the uptake of any further training, including supplementary SHRFV training programs * Remind participants to complete the training evaluation form. | PPT, computer, projector & screen | PPT 56 |
| Presentation: References | * References and sources of further information | * **Handouts (optional):** * Relevant policy and procedure * Referral pathways and contact details * List of family violence contact officers / clinical champions * Lanyards to remind clinicians about LIVES and prompting questions * Badges * WHO sensitive practice reading material * Indicators of family violence across the lifespan * Specialist Family Violence Support Service Contact Details [tailored to your hospital] | PPT, computer, projector & screen | PPT 57 |