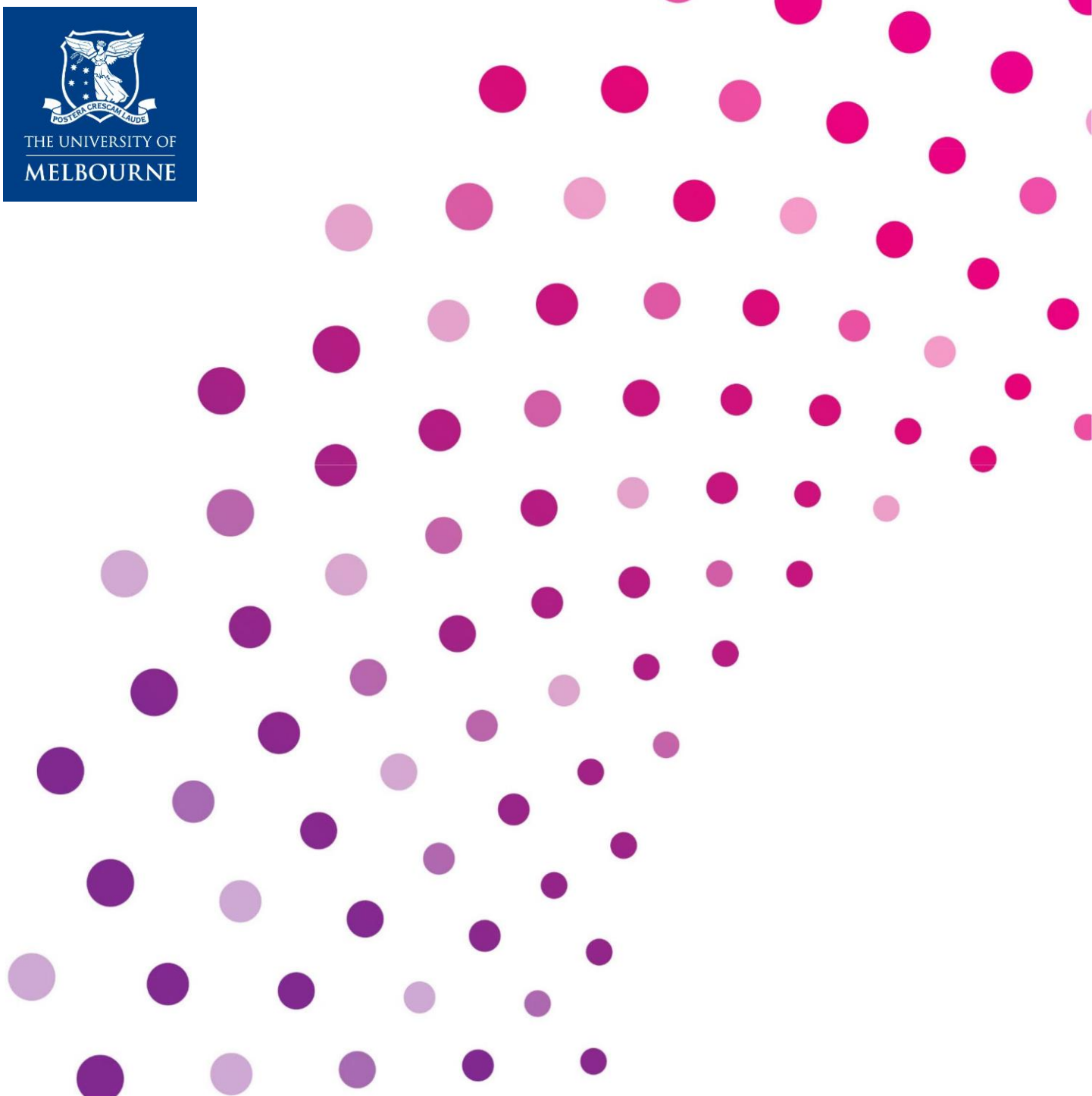
Evaluation of the Family Violence Clinical Champions and Contact Officer Programs

Final Report

13 December 2024



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Executive summary

Introduction

Family violence (FV) Clinical Champions support other staff responding to FV in healthcare settings. They can foster evidence-based practice, promote, and sustain first line responses to FV victim-survivors in those settings (Chapman and Hegarty, 2018). FV Contact Officers on the other hand, provide support to staff who are victim-survivors of FV. Australian research has shown that the prevalence of family violence against health workers is higher than in the general community (McLindon et al., 2018).

This evaluation examined the implementation and impacts of the FV Clinical Champions and Contact Officer Programs implemented in Victorian health settings. They comprised of a mix of metropolitan, regional, and rural health settings where these programs had been implemented or were in the process of being implemented. The project's overarching aim was to evaluate existing FV Clinical Champions and Contact Officer Programs across Victorian hospital or health settings to help build the evidence base to support family violence work in those settings.

Evaluation Methods

Semi-structured interviews were conducted with 19 FV Clinical Champions, FV Contact Officers and managers across six participating sites. A synthesis workshop was then held with participants from all sites. The evaluation team then summarised the main themes from the interviews and workshop.

Findings: Family Violence Clinical Champions Program

The FV Clinical Champions program is helping build workforce capacity in responding to FV. In most services, the program involved training and support of designated staff "champions" to lead education, provide clinical mentorship, and drive practice improvements within their local work areas.

Typically, health services established their Clinical Champion Programs by first identifying a core group of interested volunteer staff to undergo comprehensive train-the-trainer education. As part of their role, some designated Champions delivered training sessions to other staff across the organisation. Strong leadership support and formalised processes were critical to integrate the Clinical Champion roles with dedicated responsibilities.

Clinical Champions performed vital liaison functions between the FV program leadership and their local teams. Key responsibilities included:

- Secondary consultations (including escalating complex cases) and clinical mentorship;
- Keeping resources updated;
- Delivering training and promoting the program locally;
- Evaluating staff needs through surveys and other feedback mechanisms.

Well-implemented Clinical Champion programs raised awareness, increased staff knowledge/skills, promoted communication across teams, and helped embed FV response as routine practice. Measurable improvements in staff confidence and adherence to procedures were reported in some health services.

Implementation Challenges and Facilitators

Challenges	Facilitators
• lack of staff training in some areas • privacy concerns for sensitive enquiries, particularly in rural areas • reluctance to ask about FV • adapting training content to different clinical contexts; and • disruptions like COVID-19 impacting continuity of the program.	• mentorship from health services with advanced programs, • engaging interested staff as aspiring facilitators • comprehensive, interactive training; and • manager support and incentives for staff attendance.

Across all services, there were concerns for sustainability of the program into the future. The ending of Strengthening Hospital Responses to Family Violence (SHRFV) funding at most of the sites poses significant challenges including:

- loss of funded FV leadership positions,
- concerns about inability to centrally coordinate activities across services,
- lack of processes for timely updates to training resources, policies and procedures without dedicated personnel
- smaller rural services lacking internal capacity to embed and continue the program.

Despite the challenges faced, some services were exploring ways to transition elements of the program into existing structures and workforce roles.

Findings: FV Contact Officer Program

The Contact Officer Program aims to provide confidential support and information to staff experiencing family violence regarding their employee entitlements and access to other support services. The Contact Officer Program was typically situated within the Human Resources (HR) departments to maintain confidentiality and facilitate handling of employee entitlements, including FV leave. However, some services preferred having Contact Officers spread across departments for wider staff reach, while others opt for a more centralised model within HR.

Most Contact Officers had undergone comprehensive training covering FV dynamics, impacts on the workplace, employee entitlements and support as well as organisational procedures. Training utilised a mix of online modules and in-person interactive sessions. Significant learning also occurred on-the-job when handling staff cases. In some health services, mandatory manager training on FV response also supported the work of Contact Officers.

The key responsibilities of Family Violence Contact Officers included:

- Working within the boundaries of organisational FV Contact Officer-related policies and procedures, without playing a clinical role;

- Providing confidential support and clear information to staff on FV leave entitlements and processes;
- Collaborating with managers to ensure appropriate workplace support is provided to staff experiencing FV;
- Directing staff to relevant internal support services (e.g. Employee Assistance Program) and external specialist family violence services, where necessary.

Contact officers received support from their peers in similar roles, line managers, and clinicians working in FV services. This support system was critical for performing the role effectively. However, the additional workload could impact their main job responsibilities, especially in large organisations with very few Contact Officers.

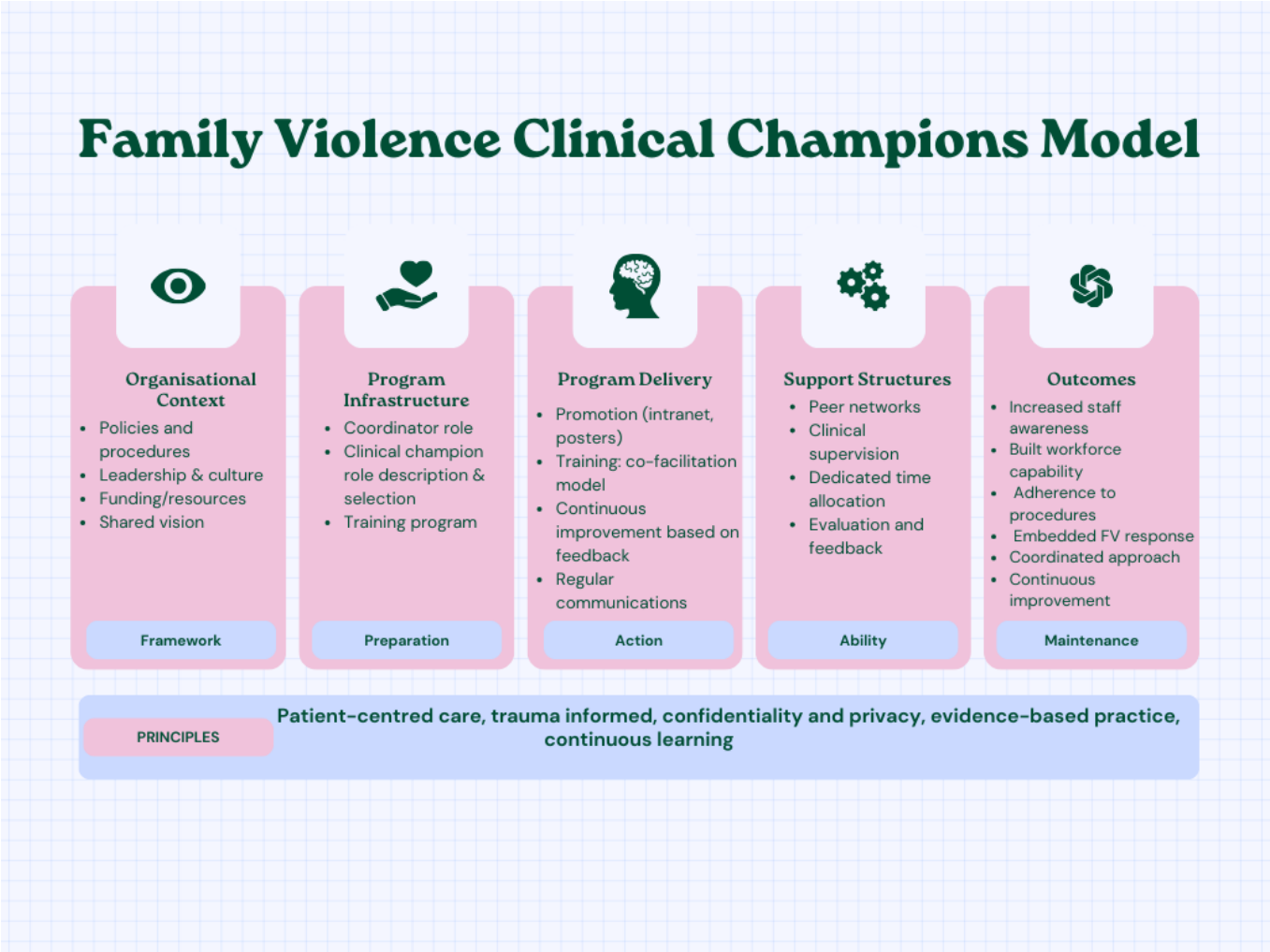
Health services promoted the Contact Officer Programs through various channels such as intranet pages, policy documents, videos and posters. Typically, staff experiencing FV were entitled to a specific number of days of paid FV leave per year (pro rata) across the participating health services. Workplace safety planning was undertaken to assess specific support needs of staff on a case-by-case basis.

Implementation Challenges and Facilitators

Challenges	Facilitators
• ensuring managers had adequate knowledge to support staff experiencing FV. • confidentiality concerns (especially in rural areas). • with the cessation of the SHRFV funding, health services were challenged with exploring ways to continue supporting staff.	• peer support networks • comprehensive training • incentives for training attendance, assurances of confidentiality • an organisational culture supportive of staff experiencing FV

Conceptual Model: FV Clinical Champions Program

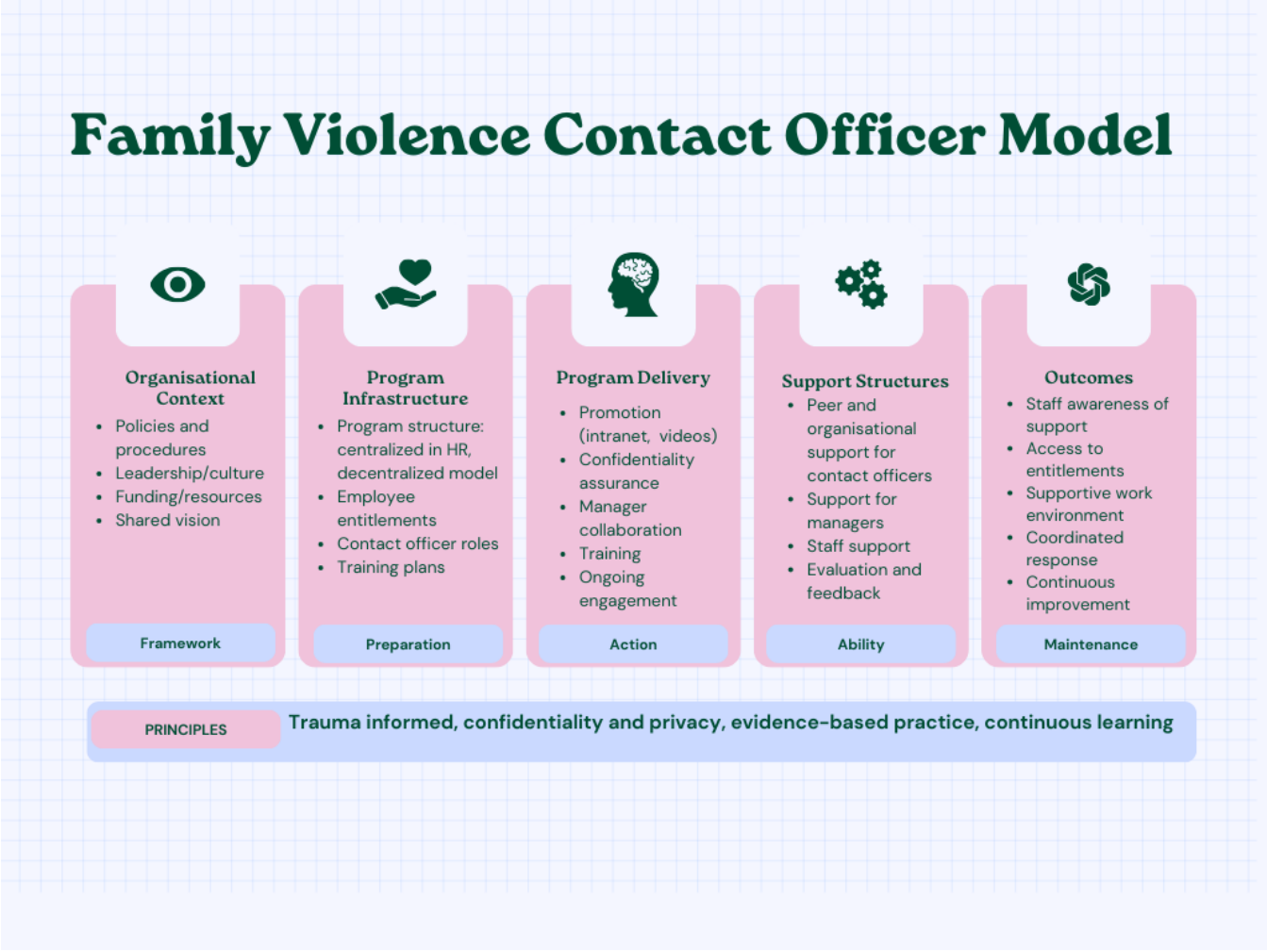
This model outlines the key components of the Clinical Champions Program and how they interact with the broader organisational context which includes factors that enable program implementation. Program Infrastructure covers the foundational structure that needs to be organised to enable program delivery for the attainment of intended outcomes. The program components can be adapted based on outcomes and evolving organisational requirements.



Conceptual Model: FV Contact Officer Program

The organisational context encompasses factors like policies, leadership and funding that shape program implementation. The program infrastructure outlines the core program elements. Program delivery involves promoting the program, assuring confidentiality, and facilitating collaboration with managers.

The intended outcomes include increasing staff awareness of available support, ensuring access to entitlements like paid leave, fostering a supportive work environment, enabling a coordinated organisational response, and continuous improvement based on feedback and changing organisational contexts.



Key Lessons and Recommendations

Based on the **Clinical Champion Program** evaluation across the six services, the following key recommendations were made:

Program Structure and Development

1. Establish a centralised clinical champions coordinator role or committee to provide ongoing leadership, mentorship, and quality oversight across the health service.

2. Implement an expression of interest and vetting process to select champions with passion, skills, and manager support for the role.

3. Develop a clear role description outlining champions' responsibilities, time commitments and organisational supports

Training

4. Design a comprehensive, competency-based training content utilising blended learning approaches (online, in-person, on-the-job).

5. Incorporate training on tailoring educational content to different clinical contexts and learner needs.

6. Provide training for champions on skills like adult education principles, group facilitation and providing supportive supervision.

Program Delivery

7. Implement a co-facilitation model where champions deliver training in pairs initially while being mentored.

8. Develop mechanisms for champions to gather staff feedback to inform continuous improvement of training and resources.

9. Leverage champions to promote the family violence program and sustain engagement through regular communications.

Support Structures

10. Facilitate regular champion network meetings for peer support, information sharing and ongoing professional development.

11. Establish clinical supervision pathways connecting champions to family violence specialists for case support and debriefing.

12. Ensure champions have dedicated time allocated for their responsibilities, as approved by their managers.

Sustainability Planning

13. Advocate for a permanent clinical champions coordinator role to be embedded within the organisation's workforce structure.

14. Develop a succession planning process to continually identify, orient, and upskill new champions over time.

15. Explore sustainable funding models through organisational budgets or other relevant sources.

16. For rural/regional services, collaborate on developing shared training resources and communities of practice.

Evaluation and Continuous Improvement

17. Implement an evaluation framework to systematically measure program outcomes like staff capabilities and adherence to procedures.

18. Capture data on program outputs (number of champions, training sessions, staff attendance, etc.) to demonstrate value.

19. Establish formal feedback channels from champions to identify implementation gaps and inform quality improvement initiatives.

Recommendations for the Family Violence **Contact Officer Program** are outlined below:

Program Structure and Governance

1. Establish a statewide governance committee or community of practice to provide centralised leadership, coordination, and quality oversight of Contact Officer programs across health services.

2. Explore sustainable funding models to resource centralised program functions.

3. For individual health services, embed Contact Officer roles within workforce portfolios and ensure dedicated personnel are assigned coordination responsibilities.

Training

4. Develop a standardised, evidence-based training covering family violence dynamics, workplace impacts, legal/policy requirements, and trauma-informed practice principles.

5. Implement a blended learning approach utilising online modules supplemented by face-to-face interactive sessions and communities of practice.

6. Incorporate training on communication strategies, managing confidentiality concerns, and supporting staff in rural/remote contexts.

Promotion and Accessibility

7. Implement education campaigns to increase awareness of the Contact Officer Program and reduce stigma around disclosing violence.

8. Establish a centralised online hub with up-to-date information on Contact Officers, services, and employee entitlements at each health service.

Manager Support

9. Mandate comprehensive family violence response training for all people managers focused on supportive communication, safety planning and facilitating staff referrals.

10. Develop clear procedures and protocols for managers to collaborate effectively with contact officers while maintaining staff confidentiality.

11. Implement accountability measures to ensure managers create a supportive environment and do not discriminate against staff experiencing violence.

Rural/Remote Considerations

12. Provide additional funding and resources to rural/remote health services to increase staffing of contact officers and mitigate high turnover.

13. Establish regional Contact Officer networks and communities of practice to facilitate peer support and information sharing.

Monitoring and Evaluation

14. Develop program evaluation focusing on outcomes like staff awareness, safety, retention, and workplace safety standards.

15. Implement secure data collection and reporting processes to monitor program outputs and capture qualitative feedback from staff.

16. Establish formal mechanisms for Contact Officers to raise implementation issues and shape continuous quality improvement efforts.

Conclusion

The FV Clinical Champions Program demonstrated success in building workforce capacity and strengthening FV response capabilities. The FV Contact Officer Program showed significant potential for supporting staff experiencing FV when implemented thoughtfully with adequate resourcing and leadership backing. The evaluation findings highlight strengths, challenges and considerations for sustainably continuing these critical programs into the future. Addressing the identified implications can further strengthen the programs.

Overall, for both programs, the evaluation highlighted implications around optimal program structure, Contact Officer and Clinical Champions role boundaries, blended training approaches, peer support mechanisms, promotion strategies, measuring intended outcomes, addressing implementation challenges (especially in rural contexts), nurturing a supportive organisational culture, and developing sustainable funding models for program continuity.

1 Background

The Royal Women's Hospital (the Women's) obtained a grant from the National Partnership Agreement Funding to lead the implementation and evaluation of Family Violence Clinical Champions and Contact Officer Programs at the Women's and across other health services in Victoria, investigating how hospitals and health services are engaging with these programs. The Women's, with expert input from the University of Melbourne, undertook a project to implement and evaluate, sustainable Family Violence (FV) Clinical Champion and Contact Officer Programs at six public hospitals/health services.

FV Clinical Champions support other staff responding to FV in healthcare settings. They can foster evidence-based practice and promote and sustain first line responses to FV victim-survivors in those settings (Chapman and Hegarty, 2018). FV Contact Officers on the other hand, provide support to staff who are victim-survivors of FV. Australian research has shown that the prevalence of family violence against health workers is higher than in the general community (McLindon et al., 2018), so providing this support to staff through specifically trained FV Contact Officers further advances FV practice in health services. To build capacity and capability within Victorian hospitals and health services there is a need for sustainable and evaluated FV Clinical Champions and FV Contact Officer Programs.

Healthcare services play an essential role in assisting service users experiencing family and domestic violence. For many people affected by FV, a health professional visit is the first, and perhaps the only step that enables them access to support and care. In 2014 and 2015 the Victorian Government funded the Royal Women's Hospital (and Bendigo Health) to develop and implement a framework for embedding the practice of identifying and responding to family violence experienced by patients. The Strengthening Hospital Responses to Family Violence (SHRFV) model was developed to provide a system-wide approach which is now being applied by hospitals across Victoria. (State Government of Victoria, The Women's Hospital and Bendigo Health, 2020). A crucial part of the SHRFV initiative is the role Clinical Champions and contact officers play. Clinical Champions support staff to appropriately respond to patients and ensure that it is consistent with practice recommendations (Chapman and Hegarty, 2018). Implementation of a well-run Clinical Champions Program provides a sub-set of staff with high knowledge levels in FV responses who provide ongoing support, through secondary consultation, and support staff conducting this work (Fisher et al. 2022). It can also contribute to an increase translation of knowledge into clinical practice (Fisher et al. 2020). Contact Officers are part of a FV workplace support program, supporting staff who are experiencing FV themselves. This contact officer role sits within the Family Violence Workplace Support Program at the Women's Hospital (The Royal Women's Hospital, 2023).

The Royal Women's Hospital (The Women's) has a strong commitment to implementing FV Clinical Champions and Contact Officer Programs and recognise the value of these. The Women's undertook the System Audit Family Violence Evaluation (SAFE) Project, which implemented a purpose designed System Audit Tool (SAFE Tool) to evaluate the impact of the SHRFV Program. The SAFE evaluation made the following recommendation under building capacity; 'develop strategies to implement and sustain Family Violence Clinical Champions (who support staff responding to family violence) and Contact Officers (who support staff who have experienced family violence) Programs along with an evaluation plan (McKay et al., 2021, p.50). In addition, evidence from a large survey of Australian nurses indicates that the prevalence of family violence against health workers is higher than in the general population (McLindon, Humphreys, &

Hegarty, 2018). These point to the need for systematically developed guidelines/frameworks to underpin ongoing FV work in a manner that will efficiently and sustainably support both patients and staff.

Clinical Champion and Contact Officer models can take different forms across hospitals or health services. However, existing models in hospital or health services has yet to be formally evaluated in Victoria. It is currently unclear how effective these programs have been at improving the response to FV. A recent systematic review demonstrated that despite indications that Champions generally have a positive impact, there is inadequate published evidence specifically investigating FV Clinical Champions in health care settings (Saberi et al. 2022). To ensure that programs are effective and lead to desired outcomes, it is essential that they are designed in line with evidence-based best practice, to strengthen response to FV when supporting both patients and staff. An evaluation of ongoing programs will help capture relevant contextual factors needed to be considered for successful programs across different settings. It also contributes to the development of an evidence-informed Clinical Champion and Contact Officer Program framework to provide guidance for ongoing work as well as health services looking to initiate or adopt similar models.

This evaluation was undertaken to assess FV Clinical Champions and Contact Officer Programs in Victoria with the purpose of developing a framework to guide hospitals and health services in their program implementation efforts for responding to patients and staff experiencing FV. This evaluation focused on program models, its implementation, sustainability, and program effectiveness from the perspective of the Clinical Champions and Contact Officers. It provides a much-needed evidence base for the impact of FV Clinical Champions and Contact Officer Programs in health service settings.

2 Aim and Objectives

The project's overarching aim was to evaluate existing Family Violence Clinical Champions and Contact Officer Programs across six Victorian hospital or health settings to help build the evidence base to support family violence work in those settings, with the specific objectives to:

- better understand the implementation, benefits, and challenges of current models/programs;
- identify essential factors for the long-term sustainability of these programs;
- identify any existing gaps in the models and highlight areas for improvement.

3 Sites

This evaluation involved six sites with Clinical Champion and/or Contact Officer Programs operating within their organisation. They comprised of a mix of metropolitan, regional, and rural health settings where these programs had been implemented or were in the process of being implemented (Table 1). There were three metropolitan sites, two regional sites, and one remote rural health service. All participating sites had a dedicated SHRFV or Family Violence Program in place with a workforce capacity ranging from 280 to 12,000.

Five of the sites had ongoing Family Violence Clinical Champion positions, and one was in the process of filling the role. However, the level of ongoing active engagement differed across sites for a variety of reasons. FV Clinical Champion numbers ranged from 5 to 500 across the sites. All sites had ongoing Contact Officer positions. At the time of the evaluation, sites were in different stages of program implementation. This project was conducted in two parts – Program Implementation Phase and Evaluation Phase.

4 Implementation Phase

The Family Violence Project Officer at the Royal Women's Hospital led the implementation phase under the direction of the Senior Program Manager Family Violence. It involved an investigation of how hospitals and health services are engaging with FV Clinical Champion and Contact Officer Programs. The Women's recruited sites to the project through an expression of interest process. Six sites with Clinical Champion and/or Contact Officer Programs operating within their organisation, or sites that were willing and able to implement such program(s) within the timeframe of the project and participate in its evaluation were then selected. Each site nominated a site representative who acted as the main contact person for the Women's and the University of Melbourne, assisting the Project Team as appropriate.

The Family Violence Project Officer explored the models, training, implementation, roles and sustainability of the programs amongst the recruited sites and provided support for sites in the process of implementing these programs. Through this process, and with consideration of the results from the Evaluation Phase and existing relevant literature, The Women's developed a Clinical Champion and Contact Officer Program framework/model which will be made accessible to health services via the SHRFV Resource Centre on the Women's website.

5 Evaluation Phase

The evaluation phase led by researchers from the University of Melbourne consisted of an appraisal of the program models, implementation of the programs, sustainability of the programs, and program effectiveness from the perspective of the FV Clinical Champions and FV Contact Officers. Ethics approval was obtained from the University of Melbourne (Ethics ID: 27635).

Methods

Data collection

The evaluation methods included:

- Semi-structured interviews

Semi-structured interviews were conducted with staff from each site including a total of 19 FV Clinical Champions, FV Contact Officers and managers across participating sites.

- Synthesis workshop

The project team held a half-day synthesis workshop for staff from participating sites on 13th June 2024, where findings were brought together and discussed.

Data analysis

The interview data was thematically analysed to identify and organise themes, guided by the steps outlined by Braun and Clarke (2006). The transcripts were thoroughly read and descriptive codes created by categorising and labelling the data based on similarity. They were organised into meaningful groups by identifying general relationships and patterns among these codes. The predominant themes were those most prevalent in the interviews. To refine the themes, transcripts and themes were continually checked to ensure that all themes were fully explored and representative of the data. Supporting quotes were selected for illustrative purposes.

6 Findings

In this section, the findings of the FV Clinical Champions Program are first presented, followed by results from the FV Contact Officer Program evaluation. The results of the FV Clinical Champions Program includes a case study illustrating how a participating service initiated and successfully implemented a Clinical Champion Program, challenges encountered as it progressed, and changes made to counter or adapt to them.

6.1 Family Violence Clinical Champions Programs

This sub-section is organised under four main themes which represents important aspects of the Clinical Champions Program. They include the context, program infrastructure, implementation and impact. Several factors contributing to each main theme are explored.

Context

The evaluation settings varied by multiple criteria, which are important contextual considerations for program implementation. Table 1 provides a snapshot of the settings across sites.

Table 1**:** Context summary for sites

Criteria	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Setting	Small rural health service	Tertiary metropolitan hospital	Regional health service	Rural health service		
Number of staff employed (EFT)	~ 280	~11,000	~ 9,000	~ 6,500	~ 12,000*	~ 1,535
Number of Clinical Champions	~ 4	~ 30	~ 5 key staff and the broader social work team	~ 6	~ 500	~30
Implementation Stage	Had only just established the Clinical Champions Program, with some key staff trained. They were yet to engage with other staff and provide	Program developed following introduction of MARAM and the FV Information Sharing Scheme. The program is based on the SHRFV	Successfully developed and implemented the program, starting in 2018 and rolling it out across several areas of the service.	Currently not active due to COVID-19 priorities. Looking to re-establish	Has a highly engaged program in place with regular professional development sessions, shared	The program was developed after the implementation of SHRFV and the family violence

	additional training. Training comprised face-to-face sessions with the Multi-Agency Risk Assessment & Management (MARAM) Team in their region and online MARAM training. Development of their policies and procedures were ongoing.	Clinical Champions Model but for those who are aligned to MARAM intermediate such as social workers, psychologists, community case managers and some managers. Monthly meetings and training schedules in place with guest speakers.	Due to the COVID-19 pandemic restrictions, most of the program's in-person activities were rolled back and has not resumed yet, with training moving online. Currently, social workers are the go-to staff for FV issues.	across all its service sites.	resources for champions who disseminate information and support other staff in their local areas.	information-sharing schemes. It is specifically tailored for individuals in patient-facing roles aligned with MARAM, such as nurses, midwives, social workers, and managers. The program includes bi-monthly communities of practice and an annual "Acting on the Warning Signs" training, featuring guest speakers and community resources
Method of recruitment	Clinical Champions are nominated by other staff by submitting their names. Nominees are then asked if they want to fill the role.	Initially recruitment was via expression of interest. More recently offering membership to professionals consulting regularly and showing an interest in FV.	Interested personnel self-nominate for position	Currently not active	Interested staff are required to undertake a day's training and added to the group.	Expressions of interest via internal newsletter, formal application and interview process with line manager present.
Internal evaluations undertaken	No	No	No	Yes	Yes	Yes

*Number of people not EFT

Program Infrastructure

This theme constitutes elements forming the basic framework upon which Clinical Champion Programs were organised in participating services. These can be conceptualised as the building blocks for developing a Clinical Champion Program. They include institutional mentoring and leadership, capacity building, and role responsibilities.

Pivotal to the program development process was having another health service that had made strides in their own Clinical Champion Program providing guidance and resources. ***Institutional mentoring and leadership*** were seen as critical to emergent programs as it allowed less experienced services to apply lessons learned by the mentoring institutions as well as adapt useful and sometimes tested program models/templates.

> *When we set up our Clinical Champions Program here, I was the SHRFV lead. …And having interactions with [name] from the [name of service]. She was sharing what they were doing around their Champion Model. So, we decided to look at whether we could implement something similar here at [name of participants' service] and we were starting to roll out the SHRFV.* CC_CO1

In the early stages of program development, a key area of focus was ***building the workforce capacity*** among staff.

> *… Particularly in 2018, we really focused on the workforce response. Making sure our staff were getting an appropriate response. Late 2018/19, we moved into starting to deliver the education. So, our education back then was delivered face-to-face.* CC_CO1

The level of training received across the participating health services varied significantly. While some had completed full day training sessions, others had received no additional training compared to their colleagues who were not in that role.

> *So as far as additional training to my colleagues, I haven't had any; it came from being a part of the group and getting education through those sessions and having the opportunity to talk about cases and be updated. That's probably where the additional Clinical Champion bit comes from, is having one person to then disseminate that information to the team in team meetings. There have been other guest speakers come to the group. So that's been informal education.* CC4

> *Staff attend an 8.5-hour training day to become a [Clinical Champion]. They are then added to the [name of service Clinical Champions] forums (Workplace, group email, group chat).* CC7

> *[Name of service] provides mandatory training to the staff. We have SHRFV and MARAM programs to strengthen the knowledge regarding FV for staff. In addition, we have a team and designated clinical and supportive wellbeing officer to assist in case of family violence.* CC5

In settings with broad acceptance and support for the program, some staff members were incentivised to attend by having the training session paid for as overtime.

> *And they, the actual nurse unit manager on the paediatric ward, paid Staff to come in and do the training. She funded that extra hour on their overtime.* CC_CO1

Some staff reported that they felt ill-prepared for work and needed more training. This was particularly relevant in services where the program was not yet well-established.

> *We need a little bit more training, someone coming to the organisation and do training. How do we actually face someone, how do we interview people with family violence? Proper interview. …The other thing is, if we were to have someone who comes into urgent care with family violence, I just would like to know, if they're not safe to go home, what kind of accommodation we can provide for the person to be safe, or what other things that we could do for them? Is there any means that we can provide to them. Are there any kids that need the support, those sorts of things, how we kind of manage if we were to have someone present today in urgent care.* CC2

> *It comes back to the reassurance for the team of the confidence in identifying family violence. And when should we do an assessment versus when we should refer to the [name of service] and let them do the assessment? And what do we do in that gap? I think any additional support in that area is always going to be helpful, because it's not going away.* CC4

Guided by a mentoring health service, a Clinical Champions Program could more efficiently became formalised through development of expression of interest protocols and defining ***role responsibilities***. Requiring support from Clinical Champions' local managers before uptake of the role ensured Clinical Champions could dedicate time to their additional responsibilities.

> *It was very much that initially we also did what [name] shared with us. We had a template. That was where people had an expression of interest to be a Clinical Champion and that it explained that in being a Clinical Champion there would be expectations that you would run training potentially, you would be a go-to person in your work area on questions around family violence. So, they had responsibilities. We also, as SHRFV, had responsibilities in guiding them with extra support, extra education, and their manager had to sign off on that expression of interest, that their managers supported them. To do that enabled them the time to do that extra work. So that model ran for a couple of years and then as SHRFV has got more embedded.* CC_CO1

FV Clinical Champions worked within relevant frame of reference. Their scope of work included providing secondary consultations to providing a range of clinical mentorship support to peers, keeping guidance documents updated, and escalating issues beyond their scope to appropriate staff.

> *When I first started doing this role, I was in a team leader role, so it was a bit different back then, because I was taking a lot of the clinical escalations. …Now I'm out of that role, I'm not getting as many clinical escalations, but I do get peers calling to ask about documentation, which is a massive, obviously a massive change since the introduction of the MARAM to check where notes should go and how we should write things. So, I would say, … keeping our work instructions and guidance documents up-to-date, making sure the folders on our [shared] drive have all the latest and most relevant information, keeping the team leaders informed of any changes and flagging any concerns with the team leaders and with the [name of service] family violence team, where the changes don't suit or don't align with how we do our practice, so that we can organise a meeting to deal with it.* CC4

Clinical Champions also undertook evaluation of the program to help them understand staff needs and priorities, and to inform quality improvement activities.

So, we use that information [surveys of staff they support], …I use it to guide what training we're looking for with the family violence team and what cases we're looking at in the bi-monthly reviews. And yeah, I guess when we're looking at team meetings and things like that. What we need to talk about and review in them to provide reassurance, and reassurance is a big thing that needs to be provided so that you are doing what you need to do. CC4

Participants shared that, overall, the demands of the role did not have an enormous impact on their main job roles. They did not feel negatively impacted by the pressures of the Clinical Champion role.

No, I don't think it has an enormous impact. Obviously, it takes me out for the meeting once a month. We do a bi-monthly family violence case discussion that I'm a part of organising and arranging. But it doesn't have an enormous impact. CC4

One of the evaluation sites had champions who were not employed in clinical job roles. They were referred to as "***non-clinical champions***" and could be embedded across different departments, including management roles. Their work differed from Clinical Champions in the sense that they did not provide clinical FV services such as sensitive inquiry and secondary consultations. However, with their high FV knowledge, their role was primarily centred on advocacy to help promote best practices across the service.

I think that they could be great advocates for sure and like pointing maybe situations out to clinical staff who are then going to have to take it and run with it. CC9

Program Implementation

Once a program is in place, there has to be ***on-going engagement, promotion and collaboration*** with stakeholders to keep it running. However, implementation of programs was not without significant challenges, some of which are described in this section.

Clinical Champions often play a vital ***liaison role*** between their local areas and the FV leadership, depending on the structure of the program. Another aspect of that liaison role was attending regular networking and debriefing meetings with peers, promoting the program at local work areas and being supported by the FV leadership or through organisational provisions for employees.

In some settings, there were regular scheduled meetings for Clinical Champions, providing a multi-purpose platform, including training, relationship/team building, and debriefing.

So, we meet once a month, using the Teams program to meet. … It's also used to have relevant guest speakers come in those sessions, and we've been invited to other education sessions through that as well. …and I think a big benefit or big use for me has been building the relationships with the family violence team at [name of service], so that escalating and checking things has just been a lot easier and smoother. You know, you don't feel like you're introducing yourself to new people, you know who they are. They know who you are and what your role is. CC4

In advancing the program, local staff were kept engaged and cognisant of FV issues in their day-to-day practice. This allowed the organisation to progressively work at embedding best practices. Staff needed to know who they could reach out to for support, when and how to do so.

> *In the team meetings, I am brought up to be like, what are the changes what's happening again, the bimonthly meetings about family violence case discussions. I'm there. So, people are. It's very obvious and very visible that that's my role. Yeah, that's how the whole team knows. Everyone in our service knows that that's what I do*. CC4

According to participants, one of the things they valued most was the support they received to perform their role as Clinical Champions.

> *Probably the one-on-one meetings with the family violence team. I think when we've needed to work through an issue in process, being able to set that up with them, having knowledge of our service and having knowledge of what they were asking for and being able to have a meeting between the family violence team and our team leaders, and be part of that, to be able to kind of find a halfway point, I've found that that's been good to be able to organise. That has been really helpful to do my role and to make sure the service is doing what we need to do, which is part of my role.* CC4

All participating sites had an Employee Assistance Program (EAP) which they could always fall on if needed.

> *I'd probably follow the typical paths of you know my team leader, EAP. Also feel very comfortable contacting anyone from the family violence team to check. Yeah, have that conversation. But yes, I do feel confident in that*. CC4

The program provided a platform for bringing together ***valuable local initiatives.*** These were practical ideas from staff to meet local, context-based needs; a feat which would have been harder to attain without a well-structured program or model.

> *We've created a task list for workers to be able to look at when they're working with family violence cases to be like yes, I've done this. Yes, I've done this. Yes, I've done this. We've also created a work instruction, a local work instruction for family violence cases that include prompting questions that are relevant to our assessment. So that's been really helpful. We do the bi-monthly case discussions, which, again, is about information sharing between ourselves about services and supports. They're obviously de-identified, these cases. But it's an opportunity to talk about how we're doing our work and to learn from other people. They're probably the big changes we've made that have been positive.* CC4

By involving staff from all areas of the service, feedback can be received to develop targeted solutions for clinicians.

> *So, in Emergency, for example, they felt there was a need to have some simple flow charts on the walls for staff. So, what we have is, you know, with SHRFV, there are very detailed procedures but if you're in an emergency department and someone's in front of you, and you're not sure what to do. You're not going to pull out a 30-page procedure and go, oh, I need to ask this, and I need to do this, and I need to do that. So, we developed… I think, it's a 6-step pathway. And that was really from feedback, from our Clinical Champions, that people needed more simplistic, visual, graphic breakdown of how to do things.* CC_CO1

Program Impact

Across participating sites, the success of the Clinical Champions Program left considerable and observable changes in awareness, ***knowledge and skills,*** with regard to responding to family violence within services. It raised the profile of family violence as an issue by increasing its visibility as well as garnering interest and support of staff across the service. The heightened level of awareness, knowledge and skills can promote a sense of embracing and normalising family violence practices as routine.

> *I don't think prior to SHRFV, we really flew the flag that this is something that we're good at. This is something we have skills in understanding, families and children and people experiencing family violence but SHRFV for us at [name of service] has really embedded that part of social works' core business. I suppose we've moved from needing to encourage people to put themselves forward as a Clinical Champion to now being in a space where this is what we do, if that makes sense.* CC_CO1

Networking activities embedded in the program promoted better communication across teams, making it easier to consult with colleagues, where required.

> *It was particularly relevant in the direct period following the changes that were brought on by the MARAM, and the Information Sharing Schemes to check all the changes we were making, because we had to make a lot of changes in our service. And I would, I happen to think, and I'm probably biased that we've been quite proactive in making the relevant changes. … Now, the relevance is more from my perspective, networking to have that relationship with the family violence team to feel comfortable to be able to ask questions and check things and escalate cases without feeling like we're over-escalating or we're under-escalating.* CC4

There was measurable increase in ***confidence*** in identifying and responding to family violence and in adhering to relevant procedures or practices.

> *We survey the team once a year. And particularly between year one and year 2, there was a jump between confidence in identifying when they need to ask, confidence in documenting things appropriately, confidence in asking the questions and completing the assessments had increased. Is it perfect? Absolutely not! But it had definitely jumped from quite low to the mid-range to slightly above the mid-range. So yeah, huge improvements really.* CC4

Having staff across a large health service setting often demanded different approaches and solutions for different units/departments. The program allowed a ***coordinated response*** across the whole service.

> *So, they were, you know the staff out there, but then they would meet with us, and they helped us develop the whole model, and how it would work, and what was gonna cause what. What needed to be customised to each setting to make it workable. Every place is different. Every place has different resources, has different pressures, you know, different issues. So, having people out there who are very passionate about this work who then really see what's happening in their area.* CC_CO1

Implementation Challenges

Implementation challenges were multifaceted, some were context-specific, others were more generic, or even unexpected. Notably, funding issues had far-reaching consequences on all aspects of the program, threatening its survival.

Context-specific issues were particularly relevant for rural and remote settings as well as community settings.

Rural and remote settings faced some challenges based on its specific characteristics. Barriers included resourcing issues that impact practice as well as geographic and demographic factors. There was evidence of some early challenges particularly in places where screening and/or routine enquiry had not yet been embedded. In some work environments, staff felt that it might not be suitable to enquire about FV, or that more thought needed to go into when and how patients are asked. This was particularly the case in urgent care settings where ensuring privacy could be challenging. There was also the need for specific training for sensitive enquiry, including scripts to guide clinicians.

> *One of my staff members actually, not long ago, recently asked a lady who came with a shoulder injury. And she did ask the question straightforward. I think the question was, have you been experiencing any family violence? And what happened was after that her mom [patient's mom] made a complaint that the staff had asked inappropriate questions. I think we need to do lot of education around the staff as well on how we go with that sort of question. And whether it's an appropriate place to ask, because in urgent care, two beds are close to each other, I don't want to ask that question.* CC2

Concerns about enquiring about FV in a community where people knew each other was raised. This is particularly relevant for small, rural settings.

> *It's a small community, they [the staff and patient] might be known to each other.* CC2

An important implementation challenge in remote areas relates to resourcing staff to undertake training. Staff in the Clinical Champions Program sometimes had to undertake training in their own time.

> *I know that some of them rely on one wage. Some of the nurses, they have to sacrifice their time to look after kids, young kids. If the people, those who are involved in this program, sometimes they have to come on this in their spare time. Yeah, whether there's funding for them, that's the question they are actually asking me, whether we get paid for doing this. I know everyone is willing to do their best for the community, but I have to think about the benefits right now for staff.* CC2

A rather high reliance on agency nurses to fill shifts was problematic. In this setting acute nurses were permanent staff but had a high workload. They also had only one social work staff at the time of the evaluation.

> *We're pretty much running on agency nurses*. *…There's a lot of changes. Yeah, the consistency is not there. That's why it's hard for us to implement something straight away. … That's why we decided to go on acute nurses, they are permanent here, and then the community nurses, they are those who are permanent, but they've got workload to do as well.* CC2

In community settings, there were constraints to referral and collaboration among services. Participants expressed a sense of frustration from being unable to get their clients seen on time by external services due to long waitlists. This could sometimes lead to uncertainty about the best actions to take for their clients.

> *I mean, other than the community barriers of waitlist to get, you know, into the [name of external service], into better place because they're more better [sic] placed to do the risk assessments and the*

MARAMs. Their waitlist can be 4 to 6 weeks plus. So, sitting in that space of do we wait for the appropriate service to do the assessments, or do we do the assessments with them? So, waitlists are definitely a big issue. CC4

It appeared that a consistent approach to FV screening was not applied across hospitals, leading to a high outflow of cases to community health settings. It was added that this was occurring despite the fact that the community setting was often less conducive to sensitive enquiry.

I think something we [community-based service] have stumbled across within the [name of service], but also with other hospitals, because we have a bigger catchment than [name of service] … So, we get a few different hospitals referring to us. MARAMs should be done when a person is in hospital, from our perspective, with a social worker where it's safe to do so. And often we do find that it's when they get discharged home that those assessments haven't been done. …We have had clients that are going into the hospital, and we only do work over the phone, and we've tried to arrange someone at the hospital to do a MARAM when they're there face-to-face because they're away from their care recipient, who, in our instance, is majority of the times, the perpetrator. And they haven't been able to support that because they don't have the staffing, or they don't have the training to do it. And that is definitely a barrier and creates additional work for us where it could be better placed somewhere else. CC4

Given the reported high disclosure rates in community settings, staff were of the opinion that additional on-site support by a family violence practitioner would be valuable.

It's really, there are a lot of disclosures in the space that I work in, which is community-based. So, when it was initially introduced, the increase in workload and the discomfort for a lot of the team to step into a space that you know they're not employed in. They're not employed as family violence workers. But all of a sudden, we were doing a lot of MARAMs and safety plans. And so, I guess there's always, from that perspective in an ideal world, there would be a specific family violence practitioner working in this service, who would manage most of those cases. So, I think the only thing that could be improved would be having an onsite family violence practitioner or a service that's not just consulting. CC4

Programs may face ***unforeseen threats to its sustainability.*** Capacity to adapt programs to changing environments and times may impact its survival and sustainability. Since the Clinical Champions Program was interrupted by the COVID-19 pandemic, some services were unable to resume face-to-face activities previously in place. The program lost momentum as a result, with social workers doing the bulk of the work as part of their usual role at the time of the evaluation, but without the structures needed to promote it across all areas of the service.

The shame is, and I think COVID did cause part of it. So many other things during COVID that became important that SHRFV lost quite a bit of momentum. …So, our Clinical Champions, now, that program doesn't exist anymore. It's our staff who just really have taken that on as part of their role, if that makes sense. Well, we, in our policies and procedures here at [name of service], we have it written in there for our social workers, who are all the go-to people for family violence. So, if someone in Emergency Department or on a kids ward or out in our aged care, rehab or whatever, and its staff notice a sign of family violence, they will make sure that social work are referred to. CC_CO1

The ***impact of funding challenges*** cannot be overemphasised***.*** Without nominated positions leading the Clinical Champions Program, most of its activities became challenging to meet. For most organisations, SHRFV had oversight responsibilities for the program with dedicated personnel assigned to family violence response, including the Clinical Champions Program. With the SHRFV funding cuts in 2024, services lost their allocated paid SHRFV positions, the impact of which was felt across most Clinical Champions activities including program coordination within services and across regions, training, and quality improvement. Smaller and remote settings faced other barriers.

The adverse consequences of funding issues are supported by concerns raised in the case study site where the program had been previously well-established.

On long-term program survival

Although SHRFV funding had ended, most services had not made internal funding allocation or plans for continuity of the work it initiated and advanced.

> *We don't have any funded positions; family violence-specific, unlike some hospitals [which] have been able to advocate for that. … [We] don't have the resources really to support the whole organisation. You can't rely on individual people for this stuff. …I think, for the best sustainability what we should have had was each health service, I reckon, was if you take the money for SHRFV, this is on the proviso that you will embed a role at your organisation that has family violence as part of its responsibility.* CC_CO1

For many services, the loss of SHRFV positions could potentially result in losing the capacity to centrally coordinate family violence-related activities across services and even large geographic regions.

> *I think SHRFV, where they've had good buy-in from their social work departments will do well. SHRFV that haven't done that, I would be very concerned about because, as I said, I think for social workers, we do see ourselves naturally as family violence Champions. So, we're going to keep doing that. As far as making sure our doctors and nurses and dentists, and all the people, midwives and all those other people across our health services, I won't have the time or scope to be doing that. So, luckily, we do have our training. As I said, mandatory now, and we have a mandatory training procedure here at [name of service], and in that it spells out medical staff what they have to do, and there's a family violence module, nursing staff, what they have to do, and there's a family violence module, allied health, what they have to do, even our non-clinical staff now here have to do the foundational module. It's mandatory.* CC_CO1

On training

Dedicated face-to-face training hours from experienced clinical educators enhances responses to family violence. The loss of SHRFV funding has resulted in a loss of accumulated experiences garnered through the SHRFV program, the impact of which is currently unclear across the Victorian state.

> *Here at [name of service], we have a lot of clinical educators.... We should have a family violence clinical educator who has the time and the ability and the experience, and can, you know, make it interactive and meaningful. And people can have a go at practicing the skills in a real life, simulated sort of, more real life, like a simulated setting. Just watching a computer screen, I don't think that's best practice. I really don't. …We expect our workers to be able to ask safely and sensitively about family violence by doing a one-hour online module. It's not enough.* CC_CO1

Trainers may find it challenging to find the time to adapt their work to the needs of different areas of work without being supported and assigned the resources (personnel and time) needed to do so.

> *At the peak of SHRFV when we had the most funding, we had 3 full-time staff doing this work and we were busy. We're busy. We're running education with …our medical imaging department. You can't just get a module and run it when you're running it for radiographers versus anaesthetists versus medical students. It has to be adapted to it all. To go in and understand what the issue is in their area and then you get something that's meaningful. Used to make, but we had case examples in our PowerPoints when we ran it face to face, and when I knew I was going into an area, I would make sure the case example was relevant to their area. I would change it and adapt it and make it relevant so that that would engage them, make it interesting and meaningful for them.* CC_CO1

On feedback and quality improvement

The Clinical Champions Model facilitated a feedback mechanism that led to practice improvement, without which progress may be stalled.

> *So, having people out there who are very passionate about this work who then really see what's happening in their area and then they can feed back to a lead person, which was the SHRFV [lead], about what else needs to be developed and changed. So that's my, that's my terrible worry. Now that there's no more funding who will continue to be that central contact for staff. So, you know staff will still be up there. The e-modules, and I suppose, I'll in some way, I'm responsible for those. Who knows whether they'll be updated in the future? What will come I don't know. Eventually they'll be going, become out of date. What will happen? But I don't have the time anymore. …So, at the moment, there's very real concerns about sustainability, and it looks like the way things have run, despite all evidence points into the fact that it was positive, it was a successful, you know, thing, that people were actually interested in [it], you have to have someone with the time to do that.* CC_CO1

On smaller regional/rural services

During the implementation of SHRFV, smaller services were assigned to a lead organisation for support in the implementation of SHRFV. This included mentorship, training support, development of policies and procedures and other activities needed. With conclusion of the SHRFV program and withdrawal of its leadership and support, larger organisations with a larger workforce and social work department may have had more room to adapt compared to smaller services.

> *…You know, [smaller services] only have 200 staff. A lot of them don't have social workers. So, for them, to try to embed a response will be much harder than for us …trying to get some sort of sustainability in those smaller health sites.* CC_CO1

Case study

An example of the Clinical Champions Program development is described here in a case study. A description of how the program was introduced and developed, its trajectory, and threats to its long-term survivability is shared.

Program Infrastructure

Building of staff capacity in this institution naturally evolved from having staff across several areas of the service electing to receive training to enhance their own practice, to wanting to lead and influence others positively. These aspiring facilitators were staff who not only had a keen interest in family violence, but also possessed skills for training, educating and leading others.

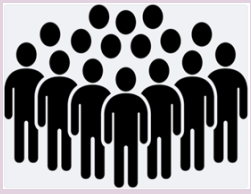
So, we had a couple of really key people coming forward from social work. We had a couple of people from the paediatric Nurse educators... We had a number of midwives from midwifery and antenatal care. We had staff from our HR Team that were wanting with the workplace response. What we did was, we ran a number of workshops then really around, I suppose, train-the-trainer, you would call it where we had actually [name] come down and do some workshops with us, and [name] from [place], who were the regional leads on train-the-trainer, teaching people how to deliver the SHRFV education. So that was, sort of, I think that was the real driver initially rather than just one or two of us doing all this because we knew we had to deliver. At that time, we had 9,000 staff. Now we have over 10,500. You know, the 2 or 3 of us could not do all that ourselves. CC_CO1

Program Implementation

For any program to thrive, having the backing of organisational leadership was essential in prioritising and promoting it, motivating staff, ensuring compliance, and continuous improvement**.** This helps embed it into practice.

We were so pleased last year. Our executive signed off on all the shift modules being mandatory here at [name of service]. So, we've mapped the modules to different staff. So, for social workers, they have to do the sensitive practice. They have to do the intermediate shift module, for e.g., for mental health staff, they need to do this for nursing staff. If they work in antenatal care, they need to do the antenatal. So, all those things are sort of in place. We've got embedded screening for family violence now in the antenatal area in midwifery. So, all the things we wanted to achieve we now have pretty well in place. CC_CO

Program Impact



The Clinical Champions Program delivered an array of benefits to the health service beyond training and education. The program had a feedback loop which supported continuous improvement.

So, it wasn't just delivering education. It was helping, getting the message out to staff in a meaningful way and it was really hearing back through them. They would feed back to us what was going well, what wasn't going so well, the sorts of themes and issues that were coming up across the organisation around what we needed to really develop a better response to family violence. So, they were our ears, our Clinical Champions were our ears, if you know, to workers across such a big setting. CC_CO1

Implementation Challenges

The implementation trajectory of this case study demonstrated that successfully setting up a Clinical Champions Program alone may be insufficient if it does not include plans to ensure it survives and thrives in the long term. During the COVID-19 pandemic, the service had to pivot to workable solutions to ensure continuity of the program activities.

> *But I think the main thing that changed for us was COVID, …we weren't allowed to deliver face-to-face training anymore. So, all our modules had to go online. …I suppose we should say that there wasn't an ongoing need for that anymore and our training now is online, people can do the training online. We have all our training.* CC_CO1

The interruption to the program implementation combined with funding challenges greatly impacted its sustainability. Social workers continued to keep up with their skill development to maintain their knowledge and skills. However, despite the advancements made, the need for the program to be maintained in a more formalised and well-structured manner across the whole hospital cannot be overstated.

> *What I do now as a manager, is, make sure our social workers keep their education up to date. …So ideally, it should be more than just social workers, I know, in mental health, you know, a lot of mental health clinicians are not social workers, and they still don't feel as confident and comfortable in the family violence space. So, there's more work that needs to happen there. But in mental health, they have a funded, permanent, ongoing family violence [role]. It's called family violence advisor which we don't have now, as you know, through the funding [which] is ending.* CC_CO1

Looking ahead: beyond implementation challenges and funding cuts

Some staff that were highly engaged in the implementation of SHRFV, including the Clinical Champions Program made efforts to sustain some of the program's initiatives that worked well. These included transformation of some existing processes into activities, procedures or even organisation structures in a manner that could remain relevant for ongoing needs.

> *What I'm actually working on at the moment that came from that, we've got a new program, and it's called [name of program]. … I think it's a web-based application where you turn procedures into interactive flows. The concept will be that the medical and nursing staff on the ward, they've got their phone or a tablet, they'll be able to go to family violence. This will come up and it will take them through a flow. I ask this question, I ask this. No, we go this way. If it's a year, so, this way. If there's a child involved, we go this way. If it's high risk, we go this way. If it's low risk, we go this way right through to the end. And you can put in links to procedures.* CC_CO1

Of great concern was how family violence-related work could continue at the regional level without any recognised leadership.

> *We now have a [name of service] family violence / MARAM Advisory Committee, and that committee will advise our executive here on things around family violence, so clinical risk, staff training, how we're responding to the family violence, information sharing legislation that we were required to respond to, all those things... I'm on that committee, but there's also the manager of Health Information services, then one of our senior managers from our [name of department], our family violence Contact Officers… Yeah, the director of safety and quality, the nurse, director of nursing in*

mental health and drug and alcohol, the family violence specialist, mental health advisor. So, what I've been trying to do now is transition from things being relying on SHRFV to think this committee actually having formal responsibility because what was happening is people kept thinking that [participant's name] can do that... No, I can't do it anymore. I'm not the SHRFV person anymore. CC_CO1

We're wanting to explore with that committee when SHRFV ends. Is there some way that they can provide some sort of regional for our [number] health services, some sort of leadership in the family violence space? Because as far as we're aware, there's going to be no one leading us. We're thinking we don't want all these [number] health services having to reinvent the wheel. …But when it comes time for procedures to be updated, when it comes time for education to be updated, we can do that as a team that potentially might be able to have some sort of resource or support through this regional committee. But we're also going to ask our CEOs. We're currently writing a submission at the moment whether we'll get anywhere with it, that we just we really want to push home the point that if there isn't some sort of ongoing something for our region, each of those [number] health services are going to be continuously reinventing the wheel. CC_CO1

The need to keep training and other resources relevant, updated and accessible to all was also highlighted.

Has to be some sort of central coordination. Even if it's a day of week or a day a fortnight, or a day a month, someone that you know, with a region wide website where all we can put our resources. Or you know, hopefully, the health, you know. Really, the Health Department needs to be thinking about that and have something family violence central for health services to connect into to be able to update things like procedures. And as we know, we've got all that perpetrator stuff coming, and we're probably not going to have time to do a lot of work in that space. But yeah, that's the biggest sustainability question. CC_CO1

The [name of service] website. That's had all the resources on it over the years. …To me, it is the essential thing that needs to be maintained somewhere. A central resource that someone somewhere can *keep up to date education and policies and procedures and templates for health services. That would be amazing If someone could fund because, yeah, whether that's the [name of service], or if they don't get the funding, what they've developed goes somewhere and is then maintained by someone. So, it's a health, a family violence health resource kit that's accessible for all health services [in Victoria]. That would be my key request.* CC_CO1

6.2 Family Violence Contact Officer Programs

The FV Contact Officer Program is described under the broad themes program infrastructure, implementation, and challenges. A number of related factors are explained under each theme.

Program Infrastructure

In most services, the FV Contact Officer Program sat within Human Resources departments in the ***organisational structure***. Some participants were of the opinion that due to the unique role contact officers played, particularly in relation to FV leave and other employee entitlements, the best fit was a more centralised place within Human Resources departments.

> *I don't think that it would work very well outside of the industrial background team. It's really important for confidentiality. We're not there to provide clinical advice but we do have people that do call us in crisis mode. So, it really, it depends on the person and what they've trained, and how empathetic they can be, and how they can have difficult conversations. So, I think appropriate training is really important. But I think for our organisation, it's really important that it sits mostly in the workplace relations team, because we know the areas and we have the relationship with the nurse unit managers or the directors that are going to be predominantly speaking with these staff. And I guess we could change our tact for anything or the way we would approach something by knowing further information about that particular area.* CO7

Additional concerns were raised about the implications of having contact officers in various departments across a service.

> *We just worried a bit that if there were more contact officers, that it would be hard to sort of maintain the level of knowledge in those people? And also. yeah, how do we then centrally record all of the information about contacts? Other people from other areas in the organisation wouldn't necessarily have a relationship with payroll to be able to approve leave. Would we want other people to be able to do that?* CO8

Others preferred to have a spread-out presence within the organisation with the intention of having more reach to staff.

> *After the approval for the project, we teamed up. We did internal meetings in the department of people and culture. We voluntarily invited the people from different departments. So, our plan was to recruit Contact Officers that may have a presence in different departments so that we may engage most of our staff.* CO2

> *So, each business partner is trained in family violence. So, there's 8 of us, and I'd say there's about 10 to 12 of us in the hospital. Some of them are in OH&S as well. …because we have a family violence kind of department, and they can assist too, but like, when it comes to accessing the leave, it has to come through Human Resources.* CO10

Conversely, in some settings, having the Contact Officer role sitting in Human Resources departments/units alone did not work well due to expressed staff concerns that a disclosure might impact their conditions of work.

Contact Officers moved to Workforce Business Partners as they were providing Workplace Response to Family Violence. We want to re-establish peer Contact Officers due to an increase in staff disclosure to colleagues and feedback from staff that they do not wish to disclose to People and Culture and Managers in fear of losing hours at work or being performance managed. CC_CO2

Potentially, this fear might have resulted from poor communication between Contact Officers working on a staff's case and other personnel working with the staff in a supervisory capacity.

Because we do want to keep people engaged in the workplace. We have seen people resign as part of a performance management process when it was suspected there was family violence leave happening, but it was never told to the manager or the relations so that they couldn't actually take that into consideration. So, we do know that there's really detrimental impacts. If people are in an environment when they don't feel like they can disclose that in the workplace. CO8

The element of confidentiality as a core feature of the program was seen as facilitative as it gave staff the confidence to reach out for the support they require if the need arose.

I think it runs well because of the confidentiality. I think also as well that we've got the staff member have the options to speak to just HR on their own if they want to. CO10

The ***FV Contact Officer role*** encompasses provision of a consistent understanding of FV entitlements and processes, and facilitation of staff access to those entitlements, sensitively and confidentially. This also includes directing staff to internal and external support services, including specialist FV services, where appropriate.

Any questions really that they ask, I respond to. So, one of them, can I take family violence leave? What is my entitlement to family violence leave? What is family violence leave? How do I take it? Do I have to speak to my manager about it? How is it processed? What happens if I exhaust the family violence leave? And they usually ask how much they're entitled to? We've also had on occasion people ask to advance their pay. And something that I'm finding a lot at the moment is questions around the differentiation between carers leave and family violence leave. So, I just provide support by referring, not referring, directing to [external service], but providing support and referral options from an external perspective. I provide options from an internal perspective for support for our staff or EAP program. … They don't read policies. They don't read procedures, some of them, I mean. They don't know enterprise agreements and those sorts of things. So, it's being able to communicate in a way that they're going to understand, especially when they're going through such a traumatic experience. CO7

FV Contact Officer roles also involves supporting managers who are supporting staff experiencing FV. They maintain a collaborative relationship with managers of staff accessing FV support and entitlements. This is critical to ensure that the staff has adequate support from their manager in their work role. It also allows managers to have plans in place to cover shifts or positions if the staff would be away or unable to continue in their role. For confidentiality reasons, FV Contact Officers encouraged staff to initiate the inclusion of their managers, rather than having the FV Contact Officers reaching out to their managers first.

So, at the moment we have a lot of really good resources online. So sometimes people will come straight to us, or they'll say, I've seen this detail online and then go through the managers, so the manager knows who to contact. But all of our staff have to do family violence training. So, I think that now it's a lot more broader [sic] in their knowledge of who to go to... But when I do talk to them, I do try and make sure that

they do move their manager in, because the manager is the one that confirms the shifts and the shift dates, and the times for me to be able to then work out their entitlement to family violence. CO7

FV Contact Officers receive a broad range of ***training*** in relation to their role. Several were of the opinion that gaining experience on the job provided practical knowledge and skills.

So, I did a family violence is a workplace issue training course. It was a full day one, I think, with [name of service] …. It was probably only half relevant, I think, sort of the second half of the day spoke about enterprise agreements, and how to put clauses around support into your enterprise agreements. We already had that, negotiated at a much higher level than our individual organisations. But that was a really useful training course. And then I think the rest of it is sort of been on- the-job sort of training throughout the SHRFV project, especially around like, the facilitating manager training. So, understanding all of the concepts, the impacts on the workplace. CO8

Family violence Contact Officers found different aspects of the training programs valuable.

So, the training goes for, I've done it twice, and the training is run by the family violence support team. And they essentially, they start with statistics, what's the likelihood of someone you know experiencing it? What's the gender breakdown? Then they show like a video of, it's a staff member who kind of talks about their experience with family violence… I think there's a bit of scenarios that we then go through. And say what we think we should do, or what should happen in each scenario and then we discuss that. CO10

Some services had mandatory training in place for managers to support their role in liaising with FV Contact Officers and supporting their staff.

It is [mandatory training]. Yup, any new manager. It's back face to face now that Covid's finished. So yeah, all the business partners have to do this. Unless they don't feel comfortable, but we all receive training every year to do it. CO10

And I think the manager training has been really helpful in that, too, that a lot of people have felt quite, very supported by their managers as well, which I think we couldn't have said that 6 years ago, before we did the manager training. CO8

A rural service in early stages of implementing their FV Contact Officer Program relied on online training as well as support from their lead regional health service for face-to-face interactive training.

Initially, we were not very clear what type of training we should do. And we talked with [name of lead service], [who] helped us, that in our learning hub there are foundational training and advanced training for them. So, [she] explained these modules you can do online. And we just followed that. They have been doing this training by themselves. But I was not very, you know, satisfied. I requested that we should arrange a specific training. So, 20th of this month, we have a three and a half hour training session on site, face-to-face. She's more experienced in that one, and she is modifying the, I mean, she's designing the more required thing for our contact officers. So, it will be more interactive session, I believe. CO2

Participants suggested that staff could be incentivised to attend training sessions to encourage attendance and help maintain interest.

> *I believe that we should have some organised incentive for them because training takes time. They come out of work. …But what we do here is, the day we have training, we arrange food, we give them free coffees, cookies to be a part of it. But I think that I was talking with executive that if we could have continuous funding so we may do every month some lucky draw or reward, not with big money, but at least something to encourage them, incentive to be, you know, be excited for it, and otherwise this is the additional work for them.* CO2

It was emphasised that FV Contact Officers did not play a clinical role. Hence, the ***scope of their work*** was within certain boundaries guided by relevant organisational policies and procedures.

> *Obviously, we're not doing anything clinically, or we're not referring them to the clinical space. But sometimes we do have to call the manager and say, hey, I think we need you to come and take your staff member to ED or somewhere, if we feel that they're quite unwell at that time. I've had that occur once. But I guess we're really bound by the enterprise agreement from a structural perspective. But it really is case by case basis.* CO7

> *So, we would refer them potentially, if they're unsure, like to the [external service]. We could even recommend that they speak to our family violence like department, put them in touch with them, and there's a few others. We've got a, I think, an intranet page which lists all of the supports that can be made available to them. So, we can also talk them through like flexible work arrangements if they're wanting to apply for that. But yeah, they're the main supports that we do. We kind of just tell them more what they can do from an employment standpoint. And if we're sensing that, there's, you know, they're requiring additional support and we have concerns, we would tell them that, we have these other resources to give them as well.* CO10

Participating sites largely had a range of similar ***entitlements for staff*** experiencing family violence. In addition to information on these entitlements being available from various resources, Contact Officers played a key role in sharing details with staff needing it.

> *Yeah, so the way it runs at the moment is that we have. So, we've got family violence leave, which is put into our enterprise agreement. So, we've got the 20 days per year that staff members can access. …Usually, it's enough. But our CEO is also very pro like, we very much have the mentality of If someone's claiming family violence, we will give them family violence [leave] unless they're being fraudulent. But yeah, I haven't had an issue, and I haven't had to turn someone like away for family violence [leave].* CO10

Some health services had a comprehensive workplace safety plan which allowed them to target support to the staff's particular needs. Having a guide also meant that most of the common needs were likely to be covered during discussions to help determine staff requirements.

> *We also have a workplace safety plan that we can do with people. So, either we can do it with the employee, the manager can do it with the employee, or the 3 of us can sort of do it together, which just means either I or the manager asks some prompts on questions and supports that could be provided to the employee for them to think about. So, things like changing their bank details. Next of kin, do they need to move to a different work location? So, are they in a really front-facing public-facing workspace*

at this point in time that they don't feel comfortable being in for whatever reason? Do they need security to walk them to their car, you know, if they're working a late shift, and it's dark or whatever the situation might be. So, it goes through a whole host of things that we can provide from a workplace perspective. CO8

Program Implementation

FV Contact Officers generally worked normal business hours. Therefore, ***coverage of the health service*** was dependent of the staff's regular hours of work.

When we're out of hours, they would have to go to their manager. So outside of our business hours, we don't have opportunity to speak to staff but basically our particular roles shouldn't need outside of hours. You know, anyone in crisis mode, they should be going through you know, [external services] or calling a crisis centre number. Because I guess, from the entitlement perspective or getting paid, that can wait till they still get paid. CO7

Those are all full-time employees here, so 2 or 3 of them are nurses. They have duty roster. …So, these key persons cover kind of 24 hour in a way like mainly 60, 70% are in the daytime 9 to 5. But if somebody wants to seek help, like, let's say, nursing, they have roster of evening and night. CO2

One issue raised with out-of-hours support was ensuring that leave entitlements were coded correctly in the payroll system for confidentiality reasons.

But it's just about coding that, having that then coded right... So that's something that we did ourselves is that we organised a different code to be in the background of our payroll system. It did come up as sick leave, and it didn't come up differently, so that on the off chance of perpetrators, could still say it would be identifiable. right? CO7

Health services' intranet and policy documents were the major means by which information about the program was disseminated to staff. Other means of ***promoting of Contact Officer Programs*** were via videos and posters.

So, I've made a page on our internal intranet which talks through. So, in the first paragraph we kind of talk about what would constitute family violence, what the leave entitlements are for everyone and then we have the process of how they apply for it, and then we have the Contact Officers. And then we also explain how it's recorded. …We also have a list of what we can do and what we don't do so that's, we're not counsellors, and we're not social workers but things we can do and then, yeah, we've got a thing about confidentiality at the end as well. …So, it's listed in the Enterprise agreements as like areas of support. CO10

We have an online training module that all staff do. And that's got details about our intranet site in it. And then on our intranet site, we have details around who the Contact Officers are and our contact details. And it's also in the procedure, so, like our policy, but the procedure that's available on prompt, which is our policy platform. So, all of our policies are held on there. And so, the procedure is on there, and that has our details in it as well. And then we also provide mandatory training for all of our

managers around family violence in the workplace. So, we talk about the Contact Officers in that as well. CO8

Contact Officers developed innovative and engaging ways to gain the attention of staff and get across information on the program.

But recently, let me say that we have done in a promotion way, we made a video on campus, including Champions and Contact Officers in it. And it's kind of 3-minute video, where we told them who we are and what is our contact number and what is the purpose of the program. So, it's a next step, we were thinking, like, it's more interactive. And they internally on our intranet, they have seen the video. And in addition, we made a poster of our team. CO2

The ***frequency of contacts*** by staff seemed to depend on the local area or even health service. Some had staff reaching out often for help and others did not.

So, I would say that I would have someone contacting me about it once a week. But I have talked to my colleagues about it, and I think my area that I look after for some reason, has a higher amount. I don't know why, but yeah, there's usually an email or two that comes through each week. But it's to be honest that it is mostly the same people that are accessing it. So, I've had the conversations with them. They're just, you know, either going through like court proceedings or things like that. Family violence is concerning but I'm not overly concerned. I just know that they're still yeah dealing with it. And I just kind of organise the leave, but there is like a couple of new people every so often, maybe a new person once every month or so, but it's kind of the same people. CO10

In terms of ***mode of contact***, across several health services, staff were free to reach out to their Contact Officers directly or to speak to their manager about needing family violence support.

So hopefully, if staff then go to their manager, their manager would know where to direct them to get support, so it can either be the manager or the employee who contacts myself or the other Contact Officer. CO8

Occasionally, staff had personal or other reasons why they did not want their manager involved in issues related to their experiences of family violence. In those instances, Contact Officers assisted staff to get the support they required without needing to inform their manager.

But we tend to ask them like, why that's the case. …what the main hindrance is for them not wanting their manager to know. Last time it was, she knew the manager outside of work and didn't want like it being, you know circulated that way. And we took that on. And we said, yeah, that's fine. You can just come to us, and so then we just go through them, you know the normal process. But we would just tell the manager that there's just a confidential issue that was happening with the employee, and they require leave on these days, and don't ask anything further. And they're corresponding with us. CO10

All in all, though, sometimes it's just someone to be able to talk to that's not their manager either. Disclose everything to and not feel judged, or anything or just someone else that is yeah, not someone that they see every day, or they ever might ever see in person to be able to chat to and understand the process from a layman's terms. CO7

In their line of work, Contact Officers come across very sensitive and personal staff information. A reliable system of ***documentation and record-keeping*** was important to safeguard that information.

…I send an email just to the payroll manager requesting them to put in family violence leave. And then we've got it coded in the system that it comes up as special leave, so it doesn't show up on the pay slip. So, it just comes up as special leave and only I think there's only certain people in the organisation who can actually see that it's actually special family violence leave. CO10

The information collected could also be used to inform quality improvement and for workforce planning purposes.

We provide the stats on the number of our contacts to the People and Culture officer. So that she's aware of it as well. CO7

It will be kept with the HR manager. So, we call it People and Culture manager. So, she is authority. She has data. … So, it's for our internal data collection keeping the record and then separating it. So, we may know that in this number of people there was these cases, and we are improving with the time. So, for our action plan for future, it will really help us, but we will give authority to one person, we call it People and Culture manager. She will have all confidential you know, information. Only executive members may know the numbers like there were 7 cases or 6 cases but don't know who. We will ensure confidentiality. CO2

Internal program evaluations undertaken have mostly been informal and often limited to the Contact Officers within an organisation. One of the main concerns regarding conducting evaluations was the potential of breaching privacy and confidentiality guidelines and a desire to maintain the integrity and credibility of confidentiality clauses as stipulated in policy documents.

At one stage we sort of reviewed how it was going. What our stats look like. And we've sort of made updates to our yeah, I guess, spreadsheet that we hold confidentially. We've had reviews post the new entitlements coming in as well. But all in all, we really haven't had to, because we believe the process that we've got at this point is working well. No big reviews. Just sort of discussions, I guess, between the particular people. CO7

We wanted to do sort of a survey with staff, who would access the support and the managers to see what their feedback is, because we only go off what they sort of say to us, and you know you just sort of get a few bits of feedback here and there, but we really did want to find out from everyone. But obviously it got a bit tricky with confidentiality, make contact with them, all of that sort of stuff. So, we didn't end up doing it. But I was really keen to understand how people found the service, and if they felt helpful or not so helpful, or other things that would have been useful. But the feedback that we do get is overwhelmingly positive, and that people do feel very supported. CO8

Contact Officers generally had both ***peer and organisational support.*** Participants cited having various levels of support, as being especially facilitative. They relied on the support of their peers in similar roles, social workers, managers, or other staff in specialist family violence roles.

So, we would talk to our manager or someone in our employee relations team as well, otherwise we've also got EAP, and those other service providers as well. CO10

So, out of 3 campuses we recruited, I think, 6 or 7 Contact Officers for our program, and we generally have one meeting every month where we discuss our future plans, our current strategies, any difficulty our Contact Officers are having, so that we can raise the questions to the seniors to take support from them. And on the monthly basis of meeting, we come with up new ideas like how we can reach to the maximum, you know, employees of organisation. CO2

Probably just being able to talk about things with [name] if I ever needed to, or [name] as clinical backgrounds and then knowing that there is another Contact Officer. I think also knowing that my

manager supports it, my area supports it, my team support it. I know that if anything comes through our inbox it gets sent to myself and knowing that if I'm on leave that there's someone else that'll be there. So, there's never, ever a concern that things won't be dealt with. CO7

In service settings with larger staff capacity and very few Contact Officers, they felt that their Contact Officer role had some ***impact on their main job role*** while others did not.

Well, so there's only 2 of us and we cover our whole organisation of nearly 10,000 staff… Yeah, it's in addition [to other work in our portfolio], where we hold a very, very busy position and there's not enough of us. So yeah, sometimes it does impact. But usually it's you know, a couple of conversations or a couple of emails and then we get the entitlement sent off to the payroll team but depending on how, like today, I've already had 3 or 4 contacts. So, it really depends. But all in all, I would say that yes, in some circumstances [it impacts the rest of our work]. CO7

I wouldn't say so, because it's just kind of like an initial meeting. And then when I have established and talked them through it, it's pretty much like they just send me an email. And then I forward the email on to payroll. So, it's not too intense. CO10

In one of the sites where the program was being revamped to align with current best practices, a participant who was also the coordinator for the program indicated that it was quite time-consuming to set it up.

It takes time. It needs more coordination, communication, just impact is generally positive for learning purposes, …getting new updates, but it consumes little bit time and to organise things, to align the thing with the program. So, … it's good and little bit time consuming. But overall, we are happy with this. CO2

FV Contact Officer Program Challenges

There were issues raised related to the ***level of knowledge*** of managers required to adequately support their staff experiencing family violence and problems with keeping the lines of communication open and following up through frequent check-ins.

I think new managers that haven't had to go through it before. It's going over the whole process again and trying to get them to understand you know our processes. At the moment, everything goes through to payroll for normal pay, but with family violence you don't send anything to payroll, you send to the Contact Officer. So, it's been hard in some ways to try and change that thought process to some managers just to make sure that they're aware, in everyday I would send it as medical certificate but if it's a family violence, I don't. It just goes to me. So, sometimes it's a challenge just getting them to change. You know what their normal, everyday processes that they've been doing for a long time. Also, *checking in. It's hard to sort of get them to check in sometimes on the on top of their everyday work. Sometimes the managers feel that they're overstepping*. CO7

Some staff experiencing violence expressed concerns about procedural and safety issues, especially in circumstances where the person using violence was also a consumer or client at the same service.

And the one challenge I think I've had recently, I had two people within the same week ask what the process is if the perpetrator becomes an inpatient or consumer within their area. Obviously, we have the utmost need to uphold the safety for the staff, but the consumer also has every right to be coming into the health Service. So that was probably not difficult, but we had to navigate around a few things. CO7

A participant described supporting a staff member who did not think they were a domestic violence victim/survivor despite their narration of experiences pointing to a type of family violence.

I did have a staff member who refused to believe that she was experiencing family violence. So, she had spoken to her manager, and the manager said, it sounds like you might qualify for family violence leave. And she was like, but I don't experience family violence. And then, she was like maybe you should speak to Human Resources about it. So, I spoke to her about it. And yeah, she took issue to the name of family violence leave which she doesn't think she's experiencing. But in reality, he [partner] was really manipulating her …That's been the most challenging one that I've done. But eventually, once I said, like, you know, it's confidential, accept the help, it's there for you to support yourself during this time, she was very on board, with it. So, I still don't think she likes the name, but she's been taking the leave. So that's a good thing. I guess the only thing which I've mentioned already twice, maybe a potential change of name of what it is [family violence leave]. But that's probably my only [suggestion]. CO10

Health services in remote and rural areas, where they were still in early stages of developing their own programs indicated that they could benefit from ***interactive training sessions*** with experienced staff in more advanced programs.

One thing I will say, like as we are in the rural side, if there are more interactive sessions with other bigger organisations who are really getting the real cases, maybe from Melbourne or Ballarat, or somewhere. So, if we meet again… let's say quarterly or monthly or bimonthly. So, where we can, you know learn from their real experiences. So that, I believe, is a gap at the moment that we are not, you know, in contact with other colleagues in different organisations who are working on the same type of work. CO2

Also, in small rural areas, despite the provisions of privacy and confidentiality, concerns remain about having others find out about their experiences.

I mean, generally there are not many cases, and if there are cases, because it's a small town, and if somebody registers their complaint of family violence, the news could spread around in the town, and people are scared to, you know, disclose they are having issues with the family. CO2

Another crucial barrier in rural settings is the ***high turnover of staff***, often requiring training of new staff as Contact Officers. The lack of stability may have implications for accumulation of experience and knowledge on the job.

It's sustainable but the turnover in our organisation is high. So, I believe that every 6 months we may recruit more Contact Officers and Champions, so that and there should be turns, and many people may get trained. CO2

Similar to the FV Clinical Champions Program, the end of SHRFV funding marks a new beginning for how Contact Officer Programs are run in some services. Services are continuing to think about which direction may be taken in the best interest of staff and the organisation.

> *So now, because that funding has ceased, the workplace relations director sort of owns the policy and procedure that we have for family violence for staff. But we are trying to get us a working committee, including non-clinical and clinical staff. As a whole organisation, understand where family violence sits within our whole organisational structure, and that's to Contact Officers as well as the clinical side of things, too. So, including the privacy team, and anything to do with disclosing family violence or how to pick up family violence from the clinical perspective. … We need to get it, I guess, up to our executive level to understand what business, as usual, is going to be.* CO7

7 Implications

The Family Violence Clinical Champions Program aims to build workforce capacity by training and supporting designated staff "champions" to lead education and drive practice improvements in responding to family violence within their health service. Several health services described the process of establishing their Clinical Champions Program, which often began with a core group of enthusiastic staff emerging organically and then being upskilled through train-the-trainer modules. In some services, these emerging Champions were mentored to co-deliver training sessions to other staff. Buy-in from managers and executives was critical to formalise the program and provide Champions with dedicated time for their additional responsibilities.

Key strengths of the Clinical Champions Model included institutional mentoring and leadership from health services with advanced programs, engaging staff as leaders, providing comprehensive and tailored training, facilitating peer support networks, and ensuring managerial backing for Champions to dedicate time to their responsibilities, including incentives for staff attendance of training sessions. Measurable improvements in staff confidence, adherence to procedures, and normalisation of family violence practices were reported as a result of the program. Difficulties ensuring privacy for sensitive enquiries in busy clinical settings.

The evaluation highlighted some implementation challenges such as lack of staff preparation in certain areas, difficulties ensuring privacy for sensitive inquiries in some clinical settings, overcoming initial reluctance to ask about family violence, and adapting generic training content to diverse clinical contexts. Disruptions like the COVID-19 pandemic further impacted program continuity and momentum in some health services.

Despite its demonstrated value, the sustainability of the Clinical Champions Program is significantly threatened by the cessation of Strengthening Hospital Responses to Family Violence (SHRFV) funding. Without a dedicated funding stream, health services face the loss of specialised family violence program leadership positions that previously coordinated Champions' activities. This loss of centralised coordination also jeopardises the ability to continue training new Champions, updating resources, facilitating peer networks, and driving continuous quality improvement.

Smaller regional and rural health services are particularly vulnerable due to lacking internal capacity, resources and support structures to continue family violence workforce development independently. Statewide and regional leadership and investment will be required to prevent reversing the significant progress made through the Clinical Champions Programs.

While some health services are exploring creative solutions to transition elements of the program into existing organisational roles and structures, there are concerns about sustaining consistent, high-quality implementation in the long term without dedicated personnel and funding. Embedding family violence response capabilities within core workforce portfolios and partnering with other health services in the same regions or across the state, present potential opportunities for continuation.

Ultimately, the Family Violence Clinical Champions Program model has proven to be an effective workforce development strategy deserving of ongoing investment and commitment from health services and the Victorian Government. By addressing the identified implications around optimal program structure, role clarity, training approaches, peer support, promotion strategies, and sustainable funding models, this critical initiative can be strengthened to support the building of a healthcare workforce equipped to respond to family violence.

Conceptual model: FV Clinical Champions Program

This model outlines the key components of the Clinical Champions Program and how they interact with the broader organisational context which includes factors that enable program implementation. Program Infrastructure covers the foundational structure that needs to be organised to enable program delivery for the attainment of intended outcomes. The program components can be adapted based on outcomes and evolving organisational requirements.

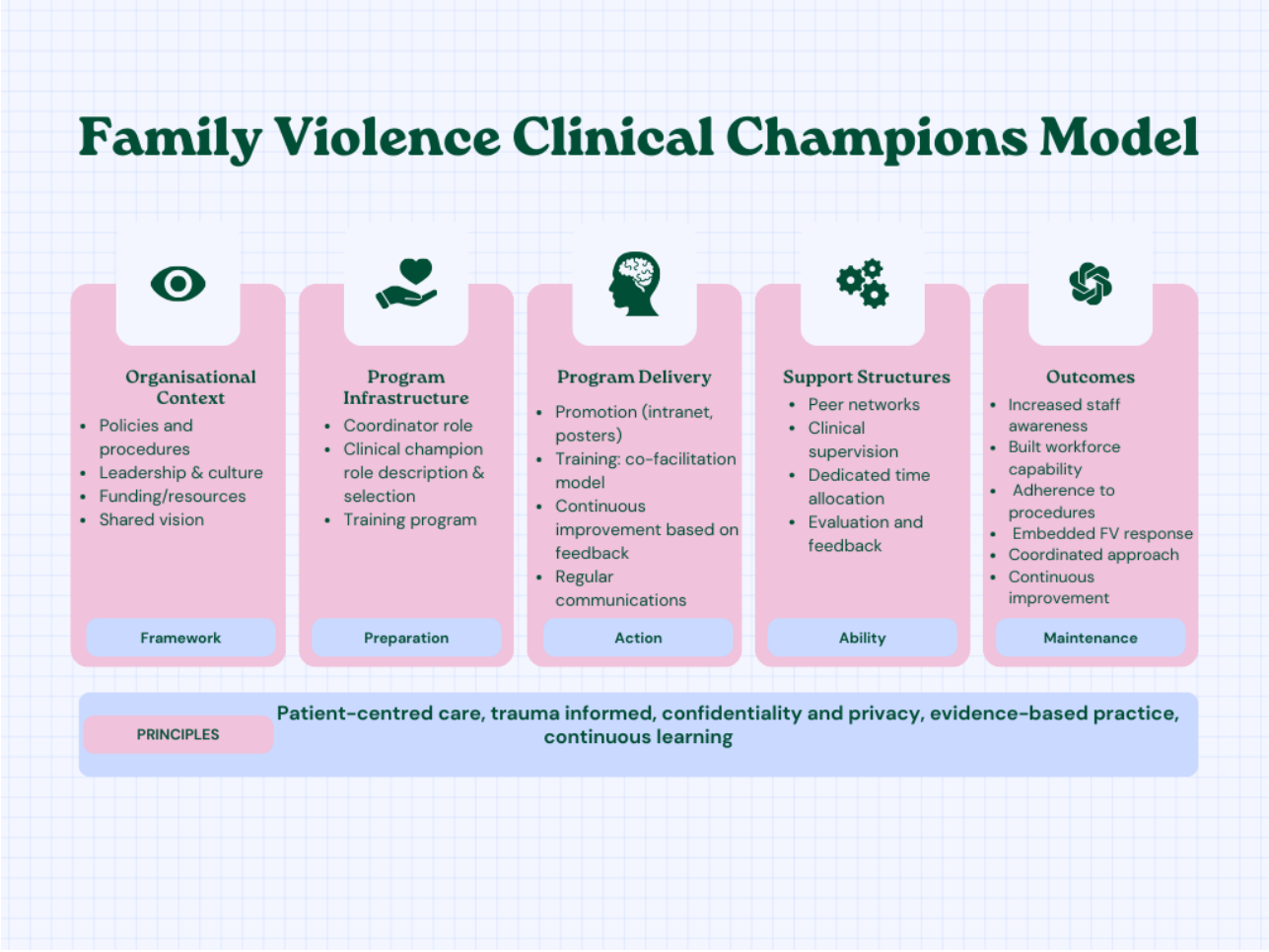


Figure 1: FV Clinical Champions Model

Key Lessons and Recommendations: FV Clinical Champions Program

Based on the Clinical Champion Program evaluation across services, the following key recommendations have been made.

Table 2: Lessons and Recommendations: FV Clinical Champions Program

Program Structure and Development 1. Establish a centralised Clinical Champions coordinator role or committee to provide ongoing leadership, mentorship, and quality oversight across the health service. 2. Implement an expression of interest and vetting process to select champions with passion, skills, and manager support for the role. 3. Develop a clear role description outlining champions' responsibilities, time commitments and organisational supports ***Training*** 4. Design a comprehensive, competency-based training content utilising blended learning approaches (online, in-person, on-the-job). 5. Incorporate training on tailoring educational content to different clinical contexts and learner needs. 6. Provide training for champions on skills like adult education principles, group facilitation and providing supportive supervision. ***Program Delivery*** 7. Implement a co-facilitation model where champions deliver training in pairs initially while being mentored. 8. Develop mechanisms for champions to gather staff feedback to inform continuous improvement of training and resources. 9. Leverage champions to promote the family violence program and sustain engagement through regular communications.	***Support Structures*** 10. Facilitate regular champion network meetings for peer support, information sharing and ongoing professional development. 11. Establish clinical supervision pathways connecting champions to family violence specialists for case support and debriefing. 12. Ensure champions have dedicated time allocated for their responsibilities, as approved by their managers. ***Sustainability Planning*** 13. Advocate for a permanent Clinical Champions coordinator role to be embedded within the organisation's workforce structure. 14. Develop a succession planning process to continually identify, orient, and upskill new champions over time. 15. Explore sustainable funding models through organisational budgets or other relevant sources. 16. For rural/regional services, collaborate on developing shared training resources and communities of practice. ***Evaluation and Continuous Improvement*** 17. Implement an evaluation framework to systematically measure program outcomes like staff capabilities and adherence to procedures. 18. Capture data on program outputs (number of champions, training sessions, staff attendance, etc.) to demonstrate value. 19. Establish formal feedback channels from champions to identify implementation gaps and inform quality improvement initiatives.

The Family Violence Contact Officer Program has played a vital role in supporting staff across Victorian health services who are experiencing family violence. By providing a confidential point of contact, clear information on leave entitlements and procedures, and facilitated access to support services, the program aims to create a supportive workplace environment that prioritises employee safety and wellbeing.

The evaluation findings demonstrate that Contact Officers' ability to navigate complex employment policies, liaise with managers, and maintain strict confidentiality provides reassurance and reduces barriers for those experiencing family violence. The program's promotion through multiple channels like intranet sites, policies, videos and manager training raises awareness of this family violence workplace support program for staff.

However, the implementation of the Contact Officer Program was not without its challenges. Ensuring managers have adequate knowledge to appropriately support staff experiencing FV emerged as a key issue, along with communication gaps and concerns around confidentiality, especially in rural/remote areas with small workplace contexts. The high turnover of staff in some rural health services also impacted program continuity and the accumulation of experience among Contact Officers.

Despite these challenges, the program benefited from several facilitating factors such as robust peer support networks, comprehensive training covering family violence dynamics and workplace procedures, incentives to boost training engagement, and strong organisational cultures that prioritised staff safety and family violence response.

Looking ahead, the cessation of Strengthening Hospital Responses to Family Violence (SHRFV) funding poses a significant threat to the sustainability and future development of the Contact Officer Program. Health services face the loss of centralised coordination for training, policy updates, resource development and quality assurance processes previously driven by dedicated SHRFV personnel and leadership structures.

Without a centralised driving force, the maintenance of a consistent, up-to-date program implemented with fidelity across all health services will be extremely difficult. Already stretched staff in human resources and other areas will struggle to absorb these additional responsibilities into their existing workloads. This raises concerns about diluting the program's impacts over time.

Some health services are proactively exploring ways to restructure the program's governance and embed Contact Officer roles within their organisational workforce frameworks. However, smaller rural services may face significant capability constraints in sustaining the program independently without external support and partnership opportunities.

Conceptual Model: FV Contact Officer Program

The organisational context encompasses factors like policies, leadership and funding that shape program implementation. The program infrastructure outlines the core program elements. Program delivery involves promoting the program, assuring confidentiality, and facilitating collaboration with managers.

The intended outcomes include increasing staff awareness of available support, ensuring access to entitlements like paid leave, fostering a supportive work environment, enabling a coordinated organisational response, and continuous improvement based on feedback and changing organisational contexts.

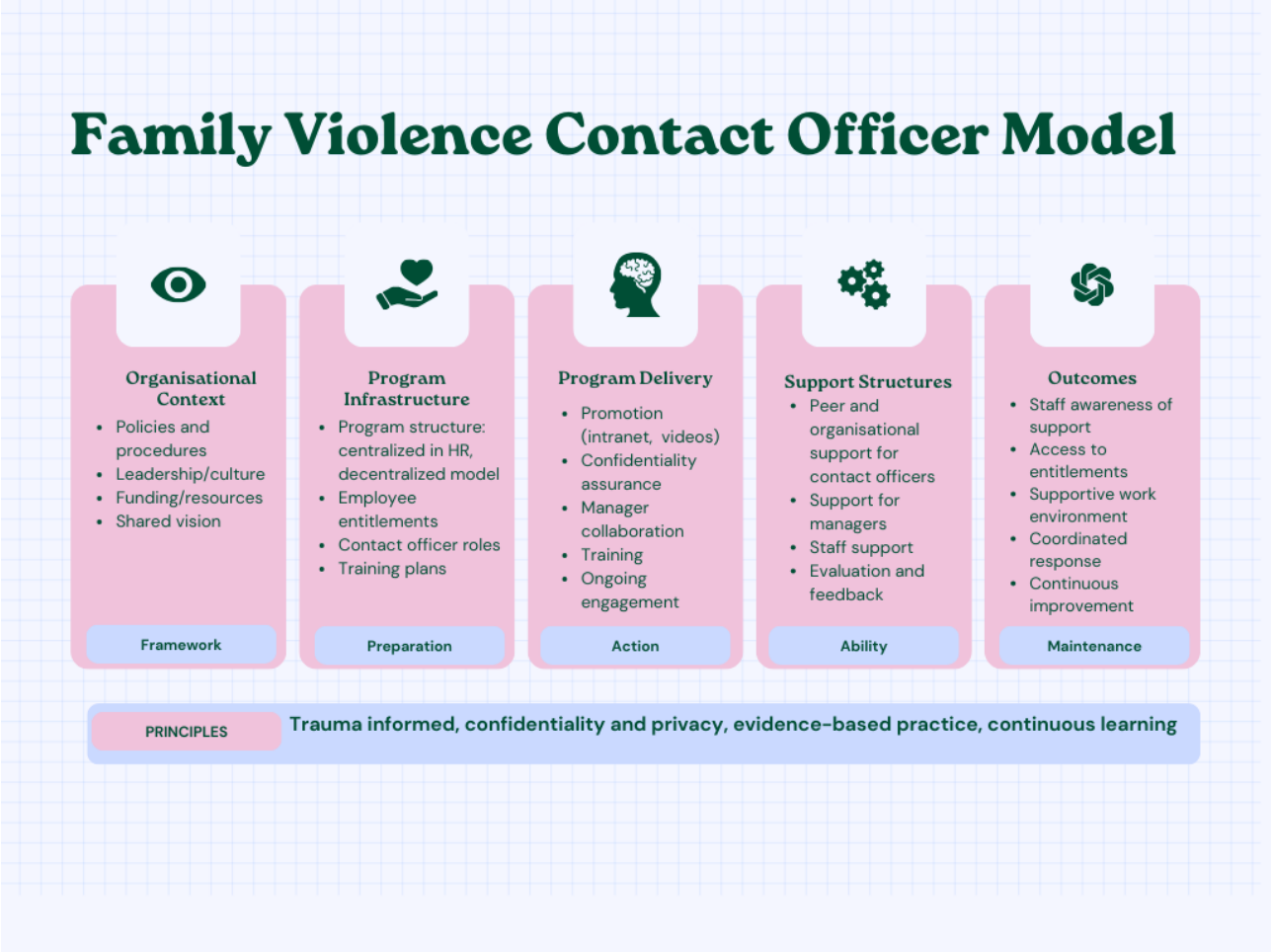


Figure 2: FV Contact Officer Model

Recommendations for family violence Contact Officer Program are outlined below.

Table 3: Lessons and Recommendations: FV Contact Officer Program

Program Structure and Governance 1. Establish a statewide governance committee or community of practice to provide centralised leadership, coordination, and quality oversight of Contact Officer Programs across health services. 2. Explore sustainable funding models to resource centralised program functions. 3. For individual health services, embed Contact Officer roles within workforce portfolios and ensure dedicated personnel are assigned coordination responsibilities. ***Training*** 4. Develop a standardised, evidence-based training covering family violence dynamics, workplace impacts, legal/policy requirements, and trauma-informed practice principles. 5. Implement a blended learning approach utilising online modules supplemented by face-to-face interactive sessions and communities of practice. 6. Incorporate training on communication strategies, managing confidentiality concerns, and supporting staff in rural/remote contexts. ***Promotion and Accessibility*** 7. Implement education campaigns to increase awareness of the Contact Officer Program and reduce stigma around disclosing violence. 8. Establish a centralised online hub with up-to-date information on Contact Officers, services, and employee entitlements at each health service.	***Manager Support*** 9. Mandate comprehensive family violence response training for all people managers focused on supportive communication, safety planning and facilitating staff referrals. 10. Develop clear procedures and protocols for managers to collaborate effectively with Contact Officers while maintaining staff confidentiality. 11. Implement accountability measures to ensure managers create a supportive environment and do not discriminate against staff experiencing violence. ***Rural/Remote Considerations*** 12. Provide additional funding and resources to rural/remote health services to increase staffing of Contact Officers and mitigate high turnover. 13. Establish regional Contact Officer networks and communities of practice to facilitate peer support and information sharing. ***Monitoring and Evaluation*** 14. Develop program evaluation focusing on outcomes like staff awareness, safety, retention, and workplace safety standards. 15. Implement secure data collection and reporting processes to monitor program outputs and capture qualitative feedback from staff. 16. Establish formal mechanisms for Contact Officers to raise implementation issues and shape continuous quality improvement efforts.

8 Conclusion

The **Family Violence Clinical Champions Program** has demonstrated significant potential in building workforce capacity and strengthening organisational responses to family violence across the participating health services. By strategically training and supporting designated staff champions, the program raised awareness, increased staff knowledge and skills, promoted communication across teams, and helped embed family violence response into routine clinical practice.

The **Family Violence Contact Officer Program** exemplifies the importance of workplace initiatives that support and empower staff experiencing family violence. By addressing the identified challenges around manager training, confidentiality, staff turnover and sustainable program governance, this program can continue providing a vital safety net for employees across health services.

Moving forward, sustainable funding models and centralised statewide leadership for FV responses must be prioritised to preserve and build upon the progress made so far in both programs. In addition, the programs' sustainability is threatened by funding and other context-specific constraints, requiring creative solutions to position and maintain them for long-term success.

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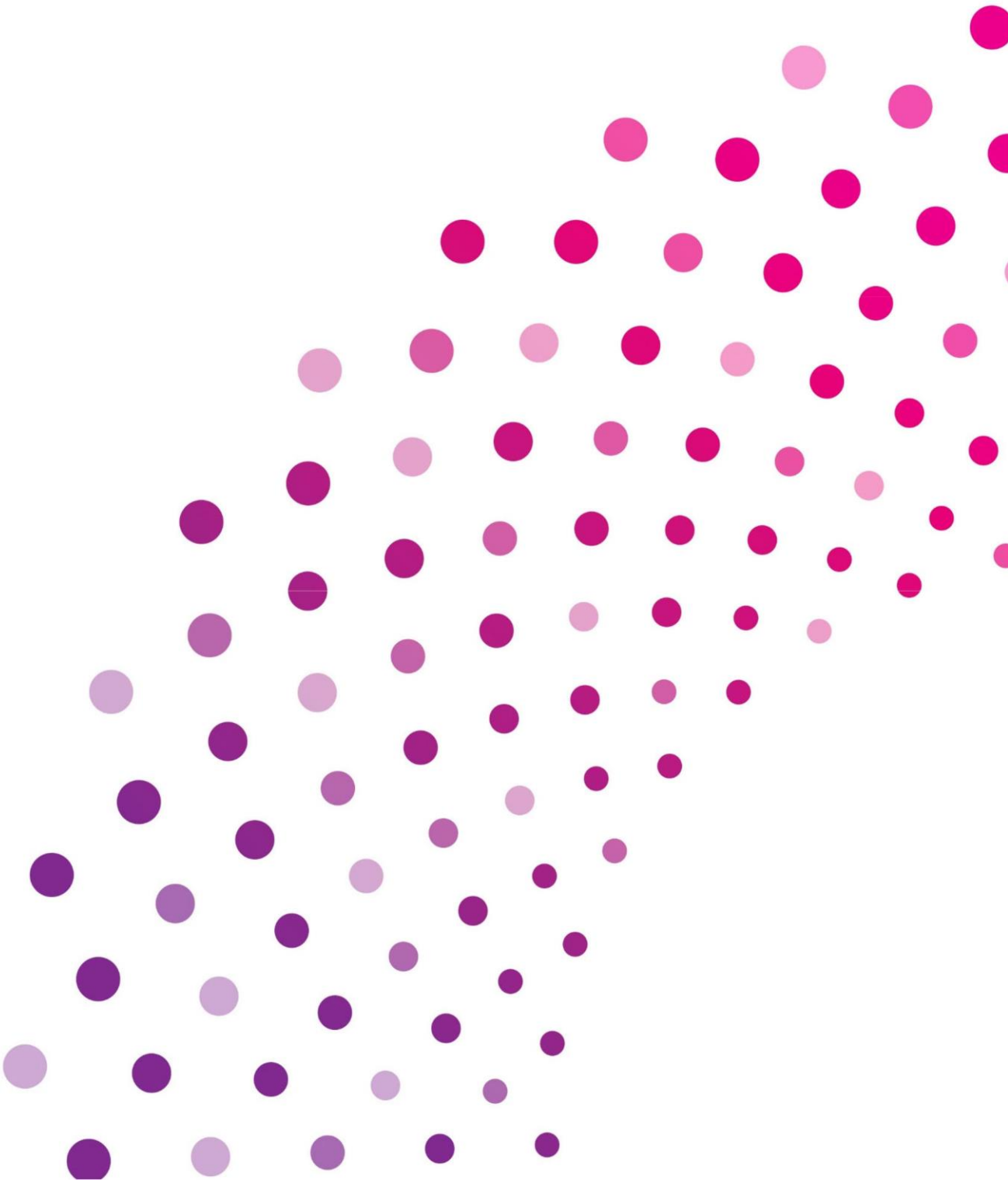
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