Strengthening Hospital Responses to Family Violence

Guide 1
Service Model and Toolkit

First Edition
Acknowledgements

The Royal Women’s Hospital would like to thank the following people for their input into the Strengthening Hospital Responses to Family Violence (SHRFV) series of Guides:

- Allison Kenwood (Executive Director, the Royal Women’s Hospital)
- Angela Crombie (Project Manager, Bendigo Health)
- Cara Gleeson (Project Manager, Our Watch)
- Family Violence and Sexual Assault Unit, Department of Health and Human Services
- Professor Kelsey Hegarty (Director of Researching Abuse and Violence Program Department of General Practice, The University of Melbourne)
- Michelle Schwensen (Manager - Engagement, Advocacy and Innovation, the Royal Women’s Hospital)
- Office for Women, Department of Premier and Cabinet
- Patty Kinnersly (Director, Practice Leadership, Our Watch)
- Pippa van Paauwe (Project Manager, the Royal Women’s Hospital)
- Planning, Diversity and Integration Division, Department of Health and Human Services
- Prue Cameron (Policy and Communications Officer, Domestic Violence Victoria)
- Sarah Kearney (Coordinator, Evaluation and Learning, Our Watch)
- Sharan Ermel (Project Officer, Bendigo Health)

We would also like to thank the following organisations for their contribution:

- Austin Health
- Ballarat Health
- Berry Street
- Domestic Violence Resource Centre Victoria
- Domestic Violence Victoria
- Gay and Lesbian Health Victoria
- Hepburn Health
- InTouch Multicultural Centre Against Family Violence
- Members to the Strengthening Hospital Responses to Violence Against Women Network
- Mercy for Women
- Northern Health
- The Royal Children’s Hospital
- St Vincent’s Health Melbourne
- Western Health
- Women with Disabilities Victoria
### Table of Contents

Introduction to the guide series ........................................................................................................... 3  
The Women’s and Bendigo Health’s experience – About the pilot ................................................... 5  
Family violence and violence against women and their children ....................................................... 6  
Why a service model for hospitals? ..................................................................................................... 8  
  - Hospitals’ role in responding to family violence ........................................................................ 8  
  - Hospitals’ role in primary prevention of family violence ............................................................ 8  
About this guide .................................................................................................................................. 9  
Definition of terms .............................................................................................................................. 10  
Abbreviations ...................................................................................................................................... 15  
Adapting the service model to suit your hospital .............................................................................. 16  
Operationalising the service model ..................................................................................................... 16  
Six elements of the service model ........................................................................................................ 19  
Attachment A - Examples of promotional posters, cue cards and lanyards ...................................... 42  
Attachment B - Sample staff survey .................................................................................................... 43  
Attachment C - Sample family violence assessment, response and referral policy ......................... 50  
Attachment D - Sample family violence assessment and response procedure ............................... 54  
Attachment E – Sample family violence assessment form ............................................................... 65  
Appendix 4 - Algorithm – Family violence management and referral pathway chart ..................... 69  
Attachment F – Pre and post training to do checklist ......................................................................... 70  
Attachment G - Mapping the partnerships and connections ............................................................. 71  

Note: This version of the SHRFV series of Guides, published in January 2016, is a first edition and will be further refined and expanded following feedback and input from hospitals during 2016.
Introduction to the guide series

Welcome to the series of guides developed by the Royal Women’s Hospital (the Women’s) and Bendigo Health, in partnership with Our Watch, and funded by the Victorian Government to assist hospitals in further strengthening their responses to family violence.

The hospital system is an early contact point for many people who have experienced family violence, presenting an opportunity for early identification, improved responses and referral for victims/survivors.

With education and support, health professionals can reduce the barriers for victims/survivors and be a catalyst for action. An empathetic and professional response from a trusted doctor, nurse, midwife or other health provider can reinforce a victim’s/survivor’s understanding that they are entitled to a healthy relationship and a life free from violence. By offering a range of options and respecting their decision\(^1\), health care providers have a role in ensuring that victim’s/survivor’s health needs are met, inclusive of a patient’s safety. These interventions have the potential to be empowering, may contribute to enhanced health outcomes and are potentially lifesaving.

For these reasons, hospitals need to invest in a service model that supports staff (doctors, nurses, midwives etc.) to be better equipped to identify and respond to the issue of family violence.

To assist hospitals to do this, three guides have been developed from the Women’s and Bendigo Health’s experience of implementing and evaluating the Strengthening Hospital Responses to Family Violence project (SHRFV). The guides have a particular focus on intimate partner violence in the context of family violence, in recognition that while anyone can be a victim or perpetrator of family violence, it is predominately committed by men against women, children and other vulnerable individuals\(^2\). These ‘how-to’ guides are available to your hospital to assist in the process of improving your service responses to family violence, and may require some adaptation to suit the demographics and populations you serve.

- **Guide 1 – Service model and toolkit** describes the model containing key principles and elements, and offers sample templates for each element to assist your hospital during implementation.
- **Guide 2 – Service model implementation** is a practical guide designed to provide a project methodology, tools, templates, processes and checklists for supporting hospitals to plan and successfully implement the service model.
- **Guide 3 - Service model training package** contains a ‘how to guide’ for delivering two training modules in family violence to clinical and non-clinical staff to build capacity and capability.

The guides summarise the key principles and elements that were relevant across both sites in the pilot and include potentially transferrable resources and templates that may be used in your hospital setting.

Each hospital is unique in its size, structure, resourcing and culture. For this reason we present suggestions and ideas on how to introduce the service model to your hospital setting and where to target the initial rollout of training. This is purely a guide, and your hospital might choose to adapt this information to best suit your environment.

---

2 Family Violence Protection Act 2008 (VIC) (Austl.)
The Women’s and Bendigo Health’s experience – About the pilot

In 2014 and 2015, the Women’s and Bendigo Health, in partnership with Our Watch, piloted the *Strengthening Hospital Responses to Family Violence* (SHRFV) project with funding from the Victorian Government.

Both hospitals selected specific clinical areas for the rollout of this pilot – Emergency Care at the Women’s, and the Emergency Department, Mental Health and Women’s Health services, at Bendigo Health.

A number of products were successfully developed and trialled including:

- **Policies, procedures and guidelines** for clinical teams to identify and document consumer’s experiences of family violence and any subsequent referrals.
- Two modules of **clinical training** aimed at improving the ability of staff to identify and respond to family violence.
- A systematic **data capture strategy**, relevant to all Victorian public hospitals and an accompanying Excel template to filter the data.

These products have been incorporated into the series of guides for your implementation. Again, the guides are suggestions and your hospital may need to adapt these resources so that they are applicable to your local needs and the demographic populations you serve.

*Note - the two modules of clinical training make up Guide 3 – The service model training package.*

Pilot evaluation

The evaluation methodology used for the pilot was based on a program logic framework to focus the evaluation and develop a shared knowledge of how the project outcomes would be met. Outcomes were classified in terms of short, medium and long term. The short term outcomes realised from the pilot were intended to build a foundation to meet medium and long term outcomes.

Specifically medium and longer term outcomes include:

- **Identification** - Increased identification of victims of family violence within the hospital context
- **Response** - Increased referral of victims within the hospital and to external services.
- **Prevention** - Increased knowledge and skills of key staff in addressing the underlying causes of family violence through planning and implementing primary prevention initiatives
- **Evidence** - Building the evidence base on prevalence rates and presentations to hospitals by victims/survivors and children who have or are experiencing family violence
- **Transferability** - Coordination and program capacity building approaches and activities tested and evaluated at two hospital sites for potential transferability.

Both hospitals continue to rollout this important work organisation-wide. The full Our Watch evaluation report of Stage One of the SHRFV project can be accessed from the Our Watch website:

[https://www.ourwatch.org.au/What-We-Do-(1)/%E2%80%8BStrengthening-Hospital-Responses-to-Family-Violence](https://www.ourwatch.org.au/What-We-Do-(1)/%E2%80%8BStrengthening-Hospital-Responses-to-Family-Violence)
Family violence and violence against women and their children

The definition of family violence in the SHRFV series of guides is consistent with the Victorian Family Violence Protection Act 2008 and as described by the Royal Commission into Family Violence, it "may involve partners, siblings, parents, children and people who are related in other ways. It includes violence in many family contexts, including violence by a same sex partner, violence by young people against parents or siblings, elder abuse, and violence by carers in a domestic setting against those for whom they are responsible."

The primary focus of the SHRFV guides and tools is currently on violence against women and their children, and substantially on intimate partner violence (IPV), as this was the primary focus of the work at the Women’s and Bendigo Health. Please note that this version of the SHRFV Guides, published in January 2016, is a first edition and will be further refined and expanded following feedback and input from hospitals during 2016.

The World Health Organization defines intimate partner violence as any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship. This focus is in recognition of family violence incidence data that highlights that the experience of family violence is often gendered, and is most frequently and most severely perpetrated by men against women. In the year to March 2015, there were 69,446 family violence incidents reported to Victoria Police. Of these incidents 75.24 per cent of victims were identified as female, and 76.8 per cent of ‘other parties’ were identified as male. Of female victims, a current or former partner was identified as the ‘other party’ at 68.7 per cent. There is further evidence that men’s violence is more severe, and more likely to inflict severe injury:

- women are more likely to be killed by current or former male partners than by anyone else, and
- less than 10 per cent of Australian male homicides are carried out by an intimate partner. When women do kill their male partners, there is a history of domestic violence in more than 70 per cent of cases.

Intimate partner violence does not just affect the victim/survivor. As per the Australian Bureau of Statistics Personal Safety Survey 2012, since the age of 15, over 400,000 women had experienced intimate partner violence during pregnancy and over half a million women reported that their children had seen or heard it. Furthermore intimate partner violence has harmful impacts on the unborn, infants, children and adolescents even if they do not witness it. The impact of living in a violent environment upon a child’s emotional wellbeing, social capacity and cognitive ability, are both immediate and long term. As a result of these broader impacts, intimate partner violence cannot be addressed in isolation. Hospitals need to ensure that interventions and pathways seek to also ensure the safety of the children.

The broader issue of violence against women and children at a societal level is described by international agencies, such as the World Health Organization, as centring on a broader definition of violence against women rather than family violence. It tells us there is no single

---

9 Ibid
cause of violence against women, however, key drivers are low support for gender equality and adherence to rigid gender roles and stereotypes. These two factors, particularly when combined with broader support for violence, foster the conditions for violence against women and their children to occur. As gender inequality and violence supportive attitudes are the core of the problem, addressing them is the heart of the solution.\(^{13}\)

---

\(^{13}\) World Health Organization (WHO) and London School of Hygiene and Tropical Medicine (2010) *Preventing intimate partner and sexual violence against women: taking action and generating evidence* Geneva, Switzerland.
Why a service model for hospitals?

Hospitals’ role in responding to family violence

Research shows that family violence, and broader violence against women has major health impacts and accounts for substantial repeat presentations in hospitals.\textsuperscript{14} A South Australian trial found that victims/survivors of family violence in one of their hospital emergency departments used services up to a third more than those who had not been victims.\textsuperscript{15} The National Plan to Reduce Violence against Women and their Children 2010-22 indicates victims/survivors commonly disclose to health professionals and that the first response is pivotal to their safety and support.\textsuperscript{16}

Doctors, nurses, midwives, social workers and other health professionals working in a hospital setting therefore have an important role to play to responding to family violence. An empathic, sensitive and inclusive first response has further importance when working with individuals from diverse and vulnerable populations who may be reluctant to disclose due to concerns of judgement, dismissal, and discrimination. For example, individuals who identify as lesbian, gay, bisexual, transgender, intersex (LGBTI) may have concerns about a homophobic and/or transphobic response from a health care professional or dismissal to its seriousness, i.e. ‘how could there be intimate partner violence between two women – they are in a gender-equal relationship?’

Clinical and non-clinical hospital staff are keen to effectively respond and prevent family violence but often do not know how to do this. Taking action is partly influenced by an individual’s level of confidence and, in the hospital setting, whether or not a staff member feels that they have the support of colleagues.\textsuperscript{17}

The implementation and adaptation of the SHRFV service model provides hospitals a model to support clinical staff (doctors, nurses, midwives, etc.) to be adequately equipped to respond to the issue of family violence. It also offers non clinical staff, for example administrative and security staff, an introductory session designed to raise awareness and improve understanding of family violence.

Hospitals’ role in primary prevention of family violence

Primary prevention of family violence aims to reduce or prevent new instances of violence across whole populations before they occur, by promoting positive shifts in attitudes, behaviours, practices and power differentials that are understood to cause or drive it.\textsuperscript{18}

Hospitals can have a significant and important role in primary prevention of family violence. As a major employer, building equal and respectful relationships between men and women in workplaces will help in the prevention of family violence, and build a culture that actively challenges violence, and the discriminatory attitudes that contribute to it.

Secondary and tertiary prevention occurs within hospitals at the direct service level. Efforts to prevent family violence at a secondary level will relate to working with vulnerable populations who are at higher risk of experiencing family violence and tertiary prevention seeks to reduce family violence from reoccurring and will be a large area of focus for hospitals.

\textsuperscript{16} Department of Social Services (2011) National Plan to Reduce Violence Against Women and Their Children 2010-2022
About this guide

This guide is designed to assist a hospital to implement activities described in Guide 2 – Service model implementation, such as:

- Coordinating professional development of the two clinical modules
- Ensuring strong hospital leadership
- Partnership mapping of the family violence sector
- Consumer partnerships in development of appropriate materials
**Definition of terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Child Abuse | Is any action, or lack of action, that significantly harms the child’s physical, psychological or emotional health and development. The Child Youth and Families Act 2005 (VIC) enables consideration of the pattern and history of harm and the impacts on a child’s safety, stability and development. There is an overwhelming body of evidence which indicates that chronic neglect, abuse and family violence are harmful and have a cumulative and detrimental effect on a child’s development. Child abuse can occur within a single incident or on multiple occasions and is categorised in the following manner:  
(1) Physical abuse  
(2) Sexual abuse  
(3) Emotional/psychological abuse  
(4) Neglect. |
| Elder abuse | Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect. |
| Family Violence (FV) | As per the family Violence Protection Act 2008 (Vic);  
(a) behaviour by a person towards a family member of that person if that behaviour—  
i. is physically or sexually abusive; or  
ii. is emotionally or psychologically abusive; or  
iii. is economically abusive; or  
iv. is threatening; or  
v. is coercive; or  
vi. in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or  
(b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a)  
(c) The Act also contains a preamble that states that ‘The Parliament also recognises the following features of family violence—  
(d) That while anyone can be a victim or perpetrator of family violence, family violence is predominantly committed by men against women, children and other vulnerable persons’.  
(e) That children who are exposed to the effects of family violence are particularly vulnerable and exposure to family violence may have a serious impact on children's current and future physical, psychological and emotional wellbeing; |

---


(f) That family violence— (i) affects the entire community; and (ii) occurs in all areas of society, regardless of location, socioeconomic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion;

(g) That family violence extends beyond physical and sexual violence and may involve emotional or psychological abuse and economic abuse;

(h) That family violence may involve overt or subtle exploitation of power imbalances and may consist of isolated incidents or patterns of abuse over a period of time.

<table>
<thead>
<tr>
<th>Family member</th>
<th>As per the Family Violence Protection Act 2008 (VIC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a) a person who is, or has been, the relevant person's spouse or domestic partner; or</td>
</tr>
<tr>
<td></td>
<td>b) a person who has, or has had, an intimate personal relationship with the relevant person; or</td>
</tr>
<tr>
<td></td>
<td>c) a person who is, or has been, a relative of the relevant person; or</td>
</tr>
<tr>
<td></td>
<td>d) a child who normally or regularly resides with the relevant person or has previously resided with the relevant person on a normal or regular basis; or</td>
</tr>
<tr>
<td></td>
<td>e) a child of a person who has, or has had, an intimate personal relationship with the relevant person.</td>
</tr>
<tr>
<td></td>
<td>(2) For the purposes of subsections (1)(b) and (1)(e), a relationship may be an intimate personal relationship whether or not it is sexual in nature.</td>
</tr>
<tr>
<td></td>
<td>(3) For the purposes of this Act, a &quot;family member&quot; of a person (the &quot;relevant person&quot;) also includes any other person whom the relevant person regards or regarded as being like a family member if it is or was reasonable to regard the other person as being like a family member having regard to the circumstances of the relationship, including the following—</td>
</tr>
<tr>
<td></td>
<td>a) the nature of the social and emotional ties between the relevant person and the other person;</td>
</tr>
<tr>
<td></td>
<td>b) whether the relevant person and the other person live together or relate together in a home environment;</td>
</tr>
<tr>
<td></td>
<td>c) the reputation of the relationship as being like family in the relevant person's and the other person's community;</td>
</tr>
<tr>
<td></td>
<td>d) the cultural recognition of the relationship as being like family in the relevant person's or other person's community;</td>
</tr>
<tr>
<td></td>
<td>e) the duration of the relationship between the relevant person and the other person and the frequency of contact;</td>
</tr>
<tr>
<td></td>
<td>f) any financial dependence or interdependence between the relevant person or other person;</td>
</tr>
<tr>
<td></td>
<td>g) any other form of dependence or interdependence between the relevant person and the other person;</td>
</tr>
<tr>
<td></td>
<td>h) the provision of any responsibility or care, whether paid or unpaid, between the relevant person and the other person;</td>
</tr>
</tbody>
</table>
i) the provision of sustenance or support between the relevant person and the other person.

**Example**

A relationship between a person with a disability and the person's carer may over time have come to approximate the type of relationship that would exist between family members.

(4) For the purposes of subsection (3), in deciding whether a person is a family member of a relevant person the relationship between the persons must be considered in its entirety.

<table>
<thead>
<tr>
<th>Intimate Partner Violence</th>
<th>This refers to behaviour by an intimate partner that causes &quot;physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours&quot;. This definition covers violence by both current and ex-partners and other intimate partners.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>A person’s spouse or domestic partner irrespective of gender</td>
</tr>
<tr>
<td></td>
<td><strong>Example</strong></td>
</tr>
<tr>
<td></td>
<td>Two women living together in an intimate personal relationship</td>
</tr>
<tr>
<td>Victim/survivor</td>
<td>A term used in conventional practice and throughout this document to refer to those that may have identified as experiencing family violence. It is in recognition of language on our patterns and behaviours. 'Victim' is commonly understood as emphasising the innocence of one against who a crime is perpetrated, the term 'survivor' alone does not alert us to this major actor.</td>
</tr>
<tr>
<td>Gender equitable organisation</td>
<td>A gender equitable organisation is a workplace as one in which women and men are equally represented, valued and rewarded. For example committing to regularly report on pay equity, family friendly policies that promote men and women in the caring roles outside of work and gender equitable leadership. In the area of primary prevention, working to promote gender equity and respectful relationships are ways that an organisation can address the key determinants of violence against women.</td>
</tr>
<tr>
<td>Guidelines or protocols</td>
<td>Also known as standard procedures</td>
</tr>
<tr>
<td>Patient</td>
<td>Generally refers to the consumer/client of the health service who is experiencing violence, also known as the ‘victim/survivor’.</td>
</tr>
<tr>
<td>Policy</td>
<td>Statements of principle that guide decision-making and service delivery</td>
</tr>
<tr>
<td>Procedures</td>
<td>More detailed instructions about how policies should be carried out by staff</td>
</tr>
</tbody>
</table>

---


| **Primary Prevention** | Refers to the efforts of society to promote, protect and sustain the health of the population. In family violence and violence against women it involves seeking to prevent violence before it occurs by addressing the root causes; the unequal distribution of power between men and women, rigid gender roles and attitudes, norms, behaviours and practices that support violence.\(^{24}\) A holistic approach to prevention involves also challenging structural inequalities, negative stereotypes and discrimination, including those based on Aboriginality, disability, class and socio-economic status, ethnicity, religion, sexual identity and refugee status\(^{25}\). |
| **Secondary prevention** | Secondary prevention within the context of family violence and violence against women is targeted towards individuals and groups who display early signs of perpetrating violent behaviour or of being subject to violence\(^{26}\). |
| **Tertiary prevention** | Tertiary prevention in relation to family violence and violence against women involves providing intervention, support and treatment to those who are affected by violence or to those who use violence. Intervention strategies are implemented after violence occurs\(^{27}\). |
| **Response** | Action or strategy to prevent or minimise risks of family violence from re-occurring. |
| **Sensitive Practice** | The framework\(^{28}\) for a way of operating as a health professional that is designed to increase a patient’s sense of safety, respect and control, ultimately reducing the risk of re-traumatisation for victim/survivors, who may chose not to disclose it. |
| **Sensitive Inquiry** | An approach of routinely asking patients about their experience(s) of family violence underpinned by a framework of sensitive practice. The approach used here is based on the World Health Organization’s clinical\(^{29}\) enquiry approach and Health Canada’s principles of sensitive practice, which drew on lessons from victim/survivors of childhood sexual abuse.\(^{30}\) |
| **Sexual assault** | Sexual assault or sexual violence is any sexualised behaviour perpetrated against a victim/survivor whereby informed consent is not given by the victim/survivor. It can include rape, sexual assault with

---


\(^{25}\) Our Watch (2015) *Change the Story: A Shared framework for the primary prevention of violence against women and their children in Australia*, retrieved from

\(^{26}\) VicHealth (2007) *Preventing Violence Before it Occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*, retrieved from

\(^{27}\) Ibid.


\(^{29}\) World Health Organization (2014) *Health care for women subjected to intimate partner violence or sexual violence* Geneva, retrieved from

implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator.\(^{31}\)

**Abbreviations**

CEO  Chief Executive Officer
CRAF  Family Violence Risk Assessment and Risk Management Framework, also known as the Common Risk Assessment Framework
DHHS  Department of Health and Human Services
ED  Emergency Department
FV  Family violence
FVIO  Family violence intervention order
HIS  Health Information Services
IFVS  Integrated Family Violence Sector
ICT  Information, Communication and Technology
IPV  Intimate Partner Violence
MOU  Memorandum of Understanding
MH  Mental Health
OH&S  Occupational Health and Safety
PAS  Patient Administration System
PP&Gs  Policies, Procedures and Guidelines
RIC  Family Violence Regional Integration Coordinator
SHRFV  Strengthening Hospitals Response to Family Violence
The Women’s  The Royal Women’s Hospital
WHO  World Health Organisation
VAED  Victorian Admitted Episodes Dataset
VCAT  Victorian Civil and Administrative Tribunal
VEMD  Victorian Emergency Minimum Dataset
VINAH  Victorian Non-Admitted Health dataset
Adapting the service model to suit your hospital

Each hospital is unique in its size, structure, resourcing and culture. The degree to which your hospital adapts the SHRFV materials and tools offered to fully implement the service model is largely dependent upon these factors.

For example your hospital may be a large metropolitan hospital that has previously implemented a number of key family violence related initiatives and has developed and socialised a Family Violence Policy and Procedure across one or more of its departments such as emergency, urgent care and maternity care.

Hospitals who undertake this role should ensure that their social work department is properly trained and resourced to respond appropriately. Such a hospital may have a social work department that is highly experienced in assessing patient experiences of family violence. It would also need a strong referral process in place that may include ‘warm’\(^{32}\) referrals to specialist family violence agencies in the designated metropolitan area.

Alternatively your hospital may be a small rural hospital which may have a part time or visiting social worker that has strong links to the local specialist family violence services. This role is responsible for referring patients to community and family violence services and has good local knowledge of many of the families. Where social workers are not accessible or available, the senior nurse or doctor may need to take on the role of referring to local family violence specialist services.

You may choose to establish an Implementation Team and appoint a Family Violence Coordinator from within the hospital staff (or externally appoint) to build capacity and capability within the hospital and its workforce to better respond to family violence. This is highly recommended to achieve outcomes.\(^{33}\)

The relevance of the SHRFV series of guides will depend upon whether your hospital has previously undertaken work around family violence issues, or if this is entirely new to your organisation. Resourcing should be based on your experience and in consideration of your hospital’s own demographics. While the SHRFV project was piloted for hospitals, it will have relevance in other health care settings and similarly require adaptation to suit the organisation and its consumers.

Examples of where this service model could be implemented include:

- Large community health centres
- Bush nursing hospitals
- Small rural or regional hospitals
- Large regional hospitals
- Metropolitan hospitals

Operationalising the service model

Figure 1 describes the SHRFV service model that comprises two overarching Principles:

1) Respect and gender equity, and

2) Sensitive practice

It also includes six key ‘elements’ as identified in the outer circle.

---

\(^{32}\)Warm referrals refers to providing referrals in a way that may increase their uptake, i.e. tell a patient about the service, offer to telephone to make an appointment for them if this would be of help, if they want it, provide the written information that they need – time, location, directions, name of contact person they will see, etc. If possible, arrange for a trusted person to accompany her. World Health Organization. (2014). Op. cit.

The SHRFV service model illustrated in Figure 1 and associated guides provide a toolkit of sample templates for each element to assist hospitals during implementation. The next section of this guide provides an expanded description of the service model and hints on adopting it in your hospital setting.

**Figure 1.** Service model

---

**How early in the implementation of this service model should a hospital prepare to release public communication materials?**

Ideally, the sequence would be:

- Develop and release a family violence policy and procedure in assessing, responding and referral
- Promulgate these documents to key hospital staff (clinical and non-clinical) through training
- Release promotional posters and cue cards to reinforce the messages

---

**Principle 1 – Respect and gender equity**

This fundamental principle recognises that family violence is a serious health issue, determined and reinforced by gender inequality and adherence to rigid gender roles and stereotypes.

Many industries are dominated by employees of one gender, such as health care being largely dominated by women. Gender segregation and rigid adherence to gender roles is one contributing factor to the gender pay gap, with female-dominated industries usually offering lower pay than male-dominated industries.

Consideration of how ‘gender’ is constructed is also paramount, particularly how gender is identified at an individual level, and therefore, how family violence is experienced within gender identities. A lesbian, gay, bisexual, transgender, intersex (LGBTI) person, like any other person, can be the victim of many forms of violence used by their partner to establish and maintain control over them, including physical, sexual, emotional, verbal, social and economic abuse. In

---


35 University of New South Wales (2014) Calling it What it Really Is: A Report into Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Intersex and Queer Experiences of Domestic and Family Violence, retrieved from
order to minimise the effects of the additional risks and vulnerabilities that might be experienced by people in LGBTI relationships, it is important that organisations as employers and service providers are respectful of people’s choices regarding the pronouns and identities they use to describe themselves and others in their family and community.36

By fostering respect and addressing gender inequity, hospitals can contribute to:

- better health and social wellbeing
- improving organisational performance, and
- preventing family violence.

Your hospital has a key role in leading change across policy, planning, and service delivery.

This guide identifies a number of strategies and activities that can be undertaken by your hospital that will contribute to creating a supportive environment for patients to feel safe in disclosing their experiences and build an inclusive and fair environment for all employees. One way in which to achieve this is through the use of awareness raising materials such as posters and brochures as well as the use and distribution of cue cards to assist staff who have received training in the model of sensitive inquiry (see next section). It is recommended that distribution of awareness raising materials only occur where training has been provided.

See Attachment A - Sample awareness raising posters, informative brochures, cue cards

**Principle 2 – Sensitive practice**

Sensitive practice provides a framework37 for health professionals to work with and provide care to victims/survivors that increases their sense of safety, respect and control, ultimately reducing the risk of re-traumatisation for victims/survivors, regardless of whether they choose to disclose or not.

It recognises person-centred care as a general principle in public health, allowing clinicians and hospitals to consider the many contributing factors to a person’s health and to target their health care responses appropriately.

As per the framework of sensitive practice, ‘sensitive inquiry’ refers to an approach of routinely asking patients about their experience(s) of family violence. The practice of sensitive inquiry is based on the World Health Organizations clinical enquiry approach of ‘case finding’ and the principles of sensitive practice based on lessons from victim/survivors of childhood sexual abuse for Health Canada.38 The model has been adapted for, and piloted in, the SHRFV project.

The World Health Organization (WHO) recommends that first-line responders are equipped to identify and respond to intimate partner violence, particularly when assessing for clinical conditions caused or complicated by intimate partner violence.39 Inquiry should routinely occur in women’s reproductive health, mental health and alcohol and drug services or in areas where assessment relating to these health issues occurs (also see Attachment D, Appendix 1). Provider knowledge of patients’ experiences of violence can have momentous and positive impacts on the experiences of health care behaviours and outcomes.

This practice approach has been developed by the Women’s and Bendigo Health during the pilot project, in partnership with Our Watch, and has been included in the clinical training module – Module 2 - Identifying and responding. It is targeted to clinical staff in the hospital setting (and is

---

not suitable for non-clinical staff). The practice approach describes a six step model of brief intervention commonly referred to in these materials as the “Model of sensitive inquiry”.

As this kit focuses most on intimate partner violence as a part of family violence, it is recommended that hospitals prioritise the roll out of training in the Model of Sensitive Inquiry into areas where conditions associated with intimate partner violence (as identified by WHO) are likely to be most prevalent, such as women’s health, mental health, and emergency or urgent care departments. Guide 2 – Service model implementation outlines the planned approach to introducing the service model and discusses how the hospital executive might identify priority areas for rollout of this training.

Figure 2 outlines the Sensitive Practice Umbrella of Safety. The umbrella symbolises safety with the principles of sensitive practice being the spokes that hold the umbrella open. When the umbrella is open, an individual feels safe, and can participate in the examination or treatment at hand.

The principles are components of patient-centred care.

Facilitating sensitive practice in the clinical setting involves:

- Awareness of violence - Respecting boundaries
- Rapport - Sharing control
- Learning process – Respect
- Ebbs and flows – Sharing information

For more details on sensitive practice, refer to Guide 3 – Training package, Module 2 - Identifying and responding.

Six elements of the service model

The service model has six key elements:

1. **Create cross hospital leadership and momentum**
   a) Strategies to engage the hospital personnel from top down

2. **Changing culture**
   a) Identifying the prevailing culture within the hospital and building capacity for change
   b) Partnerships with hospital consumers who have experienced violence
   c) Ensuring staff safety

3. **Laying the foundation for through policy, procedures and guidelines**
   a) Adaption or development of relevant policies, protocols and guidelines to identify and document consumers experiences of family violence and any subsequent referrals. To ensure the hospital’s role is complementary, these will need to recognise the role and expertise of Family Violence services, and that any

---

40 An adapted model of practice piloted in the Strengthening Hospital Responses to Family Violence project and based on the World Health Organizations case finding or clinical enquiry approach (WHO, 2013), the principles of sensitive practice (Schachter et al., 2008) and the New Zealand Ministry of Health Family Violence Intervention Guidelines (Ministry of Health 2002).
41 “…depression, anxiety, PTSD, sleep disorders, suicidality or self-harm, alcohol and other substance abuse, […] unexplained reproductive symptoms […], adverse reproductive outcomes […], repeat vaginal bleeding and sexually transmitted infections […]” (World Health Organization, 2013, p.19).
44 Ibid
implemented policies, protocols and guidelines integrate with the family violence system.

4. **Building capacity and capability**
   a) Increasing the competence of key staff within the hospital environment to better identify and respond to family violence
   b) Provision of clinical training aimed at improving the knowledge and ability of staff to identify and respond to family violence; and to increase understanding of risk assessment and family violence
   c) Provide support to clinicians to undertake the work

5. **Building partnerships with wider community and family violence sector**
   a) Supporting consumer participation and consultation in the process
   b) Building partnership with the wider community and family violence sector
   c) Increasing referrals of victim/survivors within the health service and to external services

6. **Evidence leads best practice**
   a) Improving data collection on identification and responses to victim/survivors of family violence, within the hospital context
   b) Evaluating the success of the model into the hospital environment

---

**Element 1 – Create cross-hospital leadership and momentum**

This element focuses on identifying strategies to promote strong leadership from the top down. It requires establishing structures and processes within the hospital environment as enablers to successfully implement the service model.

The intent is to create a momentum across the hospital that will promote the adoption of the service model and ensure sustainability over time.

**Guide 2 – Service model implementation** includes a number of strategies that were identified in the establishment stage of the pilot project to promote strong leadership from the top down and bottom up. These included:

i. Establishment of an implementation team as the governance body with representation from hospital executive. Its mandate was to build hospital engagement and buy-in and ensure successful implementation and ongoing sustainability of the model.

ii. Appointment of a senior manager as the executive sponsor to provide formal supervision to your Family Violence Project Coordinator throughout the project.

iii. Development of a position statement detailing why your hospital should adopt a stronger response to family violence that can then be communicated to all hospital staff.

iv. Inclusion of a range of staff being invited to sit on the implementation team as well as representatives from external family violence agencies.


vi. Display awareness raising materials across the hospital.

vii. Modification and delivery of clinical training modules (tailored to suit your setting).

viii. Development of a communication strategy and plan to engage and inform key stakeholders (including consumers), including senior management during the change process.

Further promotional strategies to engage the hospital personnel from top down might include:

---

46 Ibid
48 Ibid
• Organise an official launch of the service model with your hospital CEO as guest speaker.
• Signing of a memorandum of understanding (MOU) between your hospital and family violence service provider partners regarding the referral processes.
• Hospital executive and staff forum to introduce the model.
• Garnering support and buy-in from senior managers who are receptive and likely to be supportive of introducing a change in practice will facilitate positive influence with other key managers.
• Identifying and addressing areas of concern and resistance with key stakeholders (including consumers) initially will enable momentum to build.
• Identify and engage clinical champions in key roll-out areas to enable a constant and consistent presence and promotion of key messages in target areas.
• The Family Violence Project Coordinator attending unit staff meetings to raise awareness and the call to action within the organisation.

For an endorsed policy position from the hospital executive see Attachment C Family Violence – Assessment, Response and Referral Policy
Element 2 – Changing culture

This element focuses on recognising that introducing change into any hospital environment requires careful planning and strong leadership to guide staff to embrace new ways of practice.

As a focus group participant in the SHRFV pilot evaluation\(^{49}\) stated “executive support is really key – you can’t have a bottom up approach”.

The success of the adoption of the service model into everyday hospital practice (at both organisational and operational levels), ultimately depends on how receptive staff are, across all levels, to embrace cultural change.

One of the key questions for the implementation team might be to ask ‘how well has our hospital implemented major change in the past?’ Understanding your hospital’s prevailing culture and its capacity or readiness for change will determine the strategies adopted in this element.

It is paramount that key stakeholders, including senior and executive management, are informed and engaged in the change process. Initially, garnering support and buy-in from ‘receptive’ senior managers will facilitate positive influence with other key managers. When frontline staff are involved in and feel some ownership of the change process, sustained cultural change is more likely. Some key principles for stakeholder, consumer and community participation can be viewed in the Department of Health and Human Services (VIC) Strategy “Doing it with us, not for us”.\(^{50}\)

Being able to identify and address areas of concern and resistance with key stakeholders initially will enable positive momentum to build.

Guide 2 - Service model implementation provides a project methodology to support hospitals to plan and successfully implement the Service Model. It focuses on establishing systems and processes to help prepare senior management and staff for the impending changes that will be required to strengthen its ability to identify and respond to family violence.

Some key considerations to influence change:

- Providing information on the rationale for adopting changes such as why, what and how.
- Promoting tangible benefits that will arise from the changes, describing the benefits in ways that appeal to both the rational and the emotional.
- Promoting opportunities and encouragement for staff to develop the skills and knowledge required for change, i.e. sensitive practice.
- Reinforcing the importance of the hospitals commitment to responding to family violence.

\(^{49}\) Our Watch (2015) Strengthening Hospital Responses to Family Violence Final Evaluation Report, Melbourne

Element 3 – Laying a foundation through policy, procedures and guidelines

This element focuses on the development of relevant policies, procedures and guidelines to provide the context for the work of staff in identifying and documenting patients’ experiences of family violence and referrals. Furthermore, as part of a ‘whole-of-system’ approach it is integral that policies, procedures and guidelines are also identified or developed in relation to workforce support for staff who may be experiencing family violence, and how to respond as well as policies, procedures and guidelines that address the issue of employees who may use workplace resources (e.g. phones and computers) to perpetrate such acts of violence.

Each hospital may be at a different stage along the continuum of adopting family violence related initiatives such as having an existing family violence policy and procedure, and occupational health and safety policies with specific reference to staff experiencing family violence.

Some hospitals may have identified family violence related roles such as family violence portfolios, (maintained by a social work team leader) or may have established family violence related programs and working groups (e.g. Complex Pregnancy Care Program and Vulnerable Children Working Party).

Depending upon whether your hospital has already developed a policy, procedure and/or guideline in this area, will determine the next step.

Policy stocktake

*If your hospital has a policy and procedure on Family Violence Assessment and Response:*

- Check that the procedures are contextualised for each area or site (e.g. maternity, Emergency Department or Urgent Care)
- Check that the procedures include the principles of sensitive practice
- Are patient referral pathways clearly defined?
- Are accompanying forms and documentation available for staff to refer?
- Check that details of referral agencies are accurate and up to date
- Are there cross links with other key hospital policies (e.g. OH&S)?
- Have all Family Violence policy directions and papers developed by the hospital been referenced?
- Ensure that the policy and procedure is distributed and known by all hospital staff

*If your hospital does not have a policy, procedure or guideline:*

Sample documents are available in the Attachments section:

- Family violence - Assessment, response and referral policy
- Family violence - Assessment, response and referral procedure
- Family violence assessment form (or your hospitals equivalent)

A policy should define the broad areas it covers, for example, family violence policy (as distinct from policies for child abuse, elder abuse and partner abuse).

The policy should cover:

- purpose
- definitions
- scope
- principles
- policy statement
- relevant legislation
• associated documentation and
• review/audit processes.

A procedure should detail the:
• responsibilities
• clear intervention process with a referral pathway (algorithm), and
• related documents.

**Consider conducting a gap analysis of current policies and practice**

It is a good idea for a hospital to conduct a gap analysis or stocktake of existing policies and procedures to identify gaps in current family violence resources, references, entry points and referral options.

**Policy, procedure and guideline development**

Consulting with the many people that will use the policies, procedures and guidelines will ensure accurate information is collected for inclusion in their development, and engages all sites and areas in the process for buy in and "ownership" of the outcomes, i.e. what and how it is going to be achieved. It can also serve as an educative process for staff at all levels.

Issues to consider:

• Differentiation of levels of risk and hospital responses aligned with components of the Common Risk Assessment Family Violence Risk Assessment and Risk Management Framework that determine appropriate referral pathways into the family violence sector
• Documentation processes required within the hospital environment
• You may also wish to consider consultation with relevant stakeholders, including those in the family violence sector and consumers, to ensure that policies, procedures and guidelines align with current policies and best practice in the field.

**Policy, procedure and guideline endorsement**

Once drafted, the relevant policies, procedures and guidelines will need to be endorsed by the hospital’s relevant committees and socialised consistent with the communication strategy and plan prior to any workforce development activities. The implementation team is responsible for undertaking the process to develop and seek endorsement of the policies, procedures and guidelines.

**Policy, procedure and guidelines training**

Once the relevant policies, procedures and guidelines have been developed, staff will require access to these new documents to support and ensure practice is consistent. Choosing a way to disseminate the policies, procedures and guidelines will depend upon your hospital’s preferred methods, but it is recommended that these policies would be housed in a generic, easy accessed location, i.e. on the intranet or alerting staff via an e-bulletin that they are available. Unit or service managers might choose to agenda the policies, procedures and guidelines at a regular staff meeting or during clinical supervision. Depending upon resources, the Family Violence Project Coordinator may be in a position to offer small group or one to one sessions with clinical and non-clinical staff.

Regardless of your hospital’s individual processes it is strongly advised that policies, procedures and guidelines should be introduced and socialised for use during training in the Model of Sensitive Inquiry (See Guide 3 – Service model training package, Module 2).

**Post policies, procedures and guidelines implementation**

The responsibility for ensuring there is an organisation wide policy or policies for the management of Family Violence and monitoring adherence to these, sits with your hospital board via your quality and
safety committee. Options for consideration may include a clinical audit or staff survey to determine adherence to the policies.

A clinical audit provides a means of quantifying practice compliance with relevant policies, procedures and guidelines. A survey offers staff the opportunity to comment on how familiar they are with them post implementation. Consulting via a survey enables staff to input anonymously and may also serve to identify specific requirements and challenges in different areas. If your hospital already conducts an annual survey, it could be considered to include questions here to reduce the impact on staff responding to multiple surveys.

Linked policies

Each hospital will potentially have a workplace development strategy and public and population health strategies or similar as a way of meeting Australian Council on Health Care Standards. It would be advisable that these documents are either linked or referenced in the development of your Family Violence policies, procedures and guidelines.

See Attachment C - Sample family violence assessment, response and referral policy
See Attachment D - Sample family violence assessment, response and referral procedure
See Attachment E – Sample family violence assessment form

Element 4 – Building capacity and capability

This element of the service model is designed to ensure that key staff within the hospital environment are up-skilled to better identify and respond to family violence. In addition, engaging senior management will promote stronger adoption of the model across all levels of the hospital workforce.

Staff support in the workplace

Best practice would ensure that all staff are informed about how family violence may affect their workplace and colleagues, and have an outline of their responsibilities, particularly where the safety and performance of colleagues is affected.

Developing any safety plans for the workplace should ideally be discussed between the staff member needing support and protection and HR or management. Colleagues and other key personnel may need to be informed and engaged on a ‘need-to-know’ basis.


It is crucial to recognise that while capacity building is required for service delivery, capacity building among internal staff to support the workforce is also necessary. Family violence can be a workplace issue which affects attendance, performance, productivity and the safety of the victim/survivor and their colleagues. Therefore, organisations will need to implement staff support strategies, simultaneous to service delivery capacity building, by creating an informed and supportive work environment where an employee experiencing family violence feels safe to disclose their situation. This will typically involve work being lead in partnership with your human resources and employee assistance program provider, alongside your local integrated family violence service and/or women’s health organisation.

Your hospital also has a responsibility to respond appropriately to staff who are perpetrators of violence. Perpetrators may use work time and resources to conduct abusive acts. A good place to start might be liaising with your local men’s referral service.

Providing training to employees and clinicians helps define family violence, sensitises staff to indicators and provides them with the skills to inquire, respond, assess and refer patients who disclose, as well as how to document disclosures based on hospital protocol.

First-line support to patients involves simple tasks, and can be similarly adapted in providing support to employees. The Model of Sensitive Inquiry, underpinned by principles of sensitive practice and gender equity, is aligned to recommendations by WHO that responding to both emotional and practical needs at the same time can be pivotal.53

Ideally, suitable resources for staff should be available before the two clinical staff training modules are delivered. Resources include:

- readily available policies, procedures and guidelines to support and direct practice
- cue cards for staff with suggested scripting (received post training)
- pamphlets on family violence including referral options
- community directories
- flow charts in care areas
- posters (only displayed in areas where staff are trained)
- family violence documentation form
- support for staff for vicarious trauma and personal experiences that may be triggered by the work, i.e. employee assistance programs as well as information on where and how to access your local specialist family violence services (at a minimum).

### Examples of Services

#### Local organisations
- Family violence specialist services (see The Lookout for local referral information)
- Family violence Regional Integration Coordinator (RIC)
- Aboriginal family violence services
- Centre Against Sexual Assault
- Refuges
- Community legal centres
- Women’s health services

#### State-wide services
- Safe Steps – 24 hour state-wide response service for information on family violence support services, legal rights and accommodation options.
- Sexual Assault Crisis Line - 24 hour state-wide confidential telephone crisis counselling service for victim/survivors of both past and recent sexual assault.
- Domestic Violence Resource Centre - Statewide resource centre that provides training, publications, information and resources, undertakes research and hosts comprehensive websites to support workers and the community.
- Women with Disabilities - is the peak body of women with disabilities in Victoria.
- Women’s Health Victoria – undertakes strategic health promotion, advocacy work and direct services to improve
- Gay & Lesbian Health Victoria - health and wellbeing policy and resource unit.

#### National services
- **1800 RESPECT** - national sexual assault, domestic and family violence counselling service; 24 hour phone and online service.

Kids Helpline – 24 hour telephone and online counselling and support service for young people aged between 5 and 25 years.

Men’s Referral Service - Anonymous and confidential telephone counselling, information and referrals to help men stop using violence and controlling behaviour.

QLife – National Telephone and web counselling service for lesbian gay bisexual, transgender, intersex (LGBTI) people, family and friends.

Professional development of hospital workforce

Different staff groups will require tailored information to suit their role. Staff have been categorised into the following three groups:

a) Senior management
b) Clinical staff
c) Non-clinical staff – for example administrative staff, food services and security etc.

When should professional development be delivered across the three groups?

Once all policies, procedures, staff support processes, referral pathways and resources have been developed and are available for distribution.

a. Senior management

Within the context of the professional development program for executive, senior and people management staff, a session on primary prevention and hospital responses to family violence would enhance and build on their existing knowledge. This should also encompass a level of training around how to support and respond to employees experiencing family violence.

Timing of this session ideally would be as early as possible in the project lifetime and prior to any clinical staff training. Senior staff will act as champions of the approach being introduced.

Training might cover:

- The nature and impact of family violence on individuals and communities
- Effective prevention and response strategies
- Overview of the sensitive practice approach and its intended outcomes
- Actions to promote gender equity in the workplace
- Their role and responsibilities in supporting staff experiencing violence as well as supporting them in capacity building for service delivery

b. Clinical staff

All hospital staff including doctors, nurses, midwives, and other health professionals can access two 45 minute clinical modules:

- Module 1: A shared understanding - covers demystifying family violence; its prevalence and impact; myths and health impacts.
- Module 2: Identifying and responding – covers clinical risk indicators; sensitive practice approach; professional responsibility and staff support

c. Non-clinical support staff
This target group includes all non-clinical staff – for example administrative staff, food services and security etc. and the aim would be for them initially to attend the first Module - A shared understanding.

Preparing for training delivery

A checklist is provided (refer to Attachment F) for the Family Violence Project Coordinator or education team to assist in the preparation of training delivery to staff.

Clinical staff training delivery

Staging of the roll out of the training to hospital professionals by clinical area will assist to manage and monitor how well it is being received. Recommendations for priority areas are discussed earlier in this guide.

The delivery of training will need to be flexible, i.e. offered on different days, and at different times to capture the highly variable shift work nature of hospital environments.

Training is best delivered by two highly experienced staff; a combination of ‘subject matter’ experts and industry professionals.

Where there is an opportunity and a skill set exists, collaboration with staff from the family violence sector to deliver this training would be ideal. This collaborative approach would both utilise the sectors expertise and inform hospital staff of the agency’s role.

For more details on training delivery, refer to Guide 3 – Service model training package

Post Training

After training, staff should be provided with cue cards on their lanyards to wear in their daily work and there should be posters in waiting areas, palm cards in consulting rooms, and fact sheets on your website to raise awareness and educate the community about the health impacts of family violence and to encourage victim/survivors to talk to health professionals in your organisation.

See Attachment F – Pre and post training to do checklist

For more details on sensitive practice, see Guide 3 – Training package Module 2 - Identifying and responding

Element 5 – Building partnerships and connections with the wider community and family violence sector

This element focuses on building partnerships with the wider community and the family violence services sector. This is designed to increase appropriate referrals of victim/survivors within the health services and to external services.

Your hospital may have a particular demographic/s you serve and it would be necessary to consider which agencies might be best to develop partnerships with. Building partnerships in the community should not be limited to the family violence sector; hospitals may want to seek out partnerships with other allied health sectors that can also contribute to supporting victims/survivors and their families, such as family services, legal services, women’s health services, Aboriginal community health services.

The core of the family violence service system in most states and territories consists of crisis responses, short to medium term support and intervention responses, and high security refuge accommodation. Traditionally hospitals have interacted via their social work departments in referring victims/survivors to additional services within the family violence sector.

Clinical staff are often the first point of contact for those experiencing violence and therefore have the opportunity to identify abuse early, provide immediate support and offer referrals, which could prevent serious harm or death. Staff therefore require sound knowledge of the referral pathways in your hospital and integrating this into their everyday clinical practice. By establishing strong working relationships with local family violence services your hospital can provide an opportunity to improve referral processes and the outcomes for victims/survivors of family violence.
Where strong relationships already exist at a local level between your hospital and family violence services, further strengthening of these networks might be of value.

Partnering recognises the diverse expertise within the wider community and family violence sector, and strengthens the ability of the health and community sector to respond to family violence in the most appropriate way.

The partnerships approach with the family violence sector is based on:

- Engaging family violence agencies early in the development of the hospital approach, including in the planning and scoping phases
- Establishing the sensitive practice approach in collaboration with family violence agencies
- Enabling clinical staff to interact directly with family violence agencies via an established process
- Increasing your local family violence agencies understanding of your hospital as a key referral source

Current pathways

Many hospitals utilise staff in their social work department to coordinate referrals from clinicians. Once referred from clinical areas, social workers conduct a comprehensive psycho-social assessment and, where there is a disclosure, risk assessment, safety planning as well as supportive counselling, information and referrals into the integrated family violence sector.

While this may be an available pathway in your hospital, for a variety of reasons, some victims/survivors may choose not to accept or follow through with referrals. If they accept a referral, patients should be advised of their options, internal and external. Offering to call with or on their behalf, providing written information or talking through what people might expect from the referral may make it more likely that a patient seeks the help you have recommended.54

Regardless of their choices, it is important that health care professional remain patient and supportive, allowing patients to progress at their own pace wherever possible (i.e. when there are children at risk professionals will have a mandatory reporting requirement, regardless of patients’ wishes). Respect the patient’s wishes and do not pressure them into making any decisions.

It is common when work is done increasing people’s understanding of family violence that there can be an increase in disclosures and referrals to family violence services. It is important to work early with local family violence agencies and internal social work department to let them know there may be an increase in demand for the services, from either the patient or workforce population. You can then subsequently plan as to how to address this.

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

Service mapping

Undertaking a mapping exercise of the family violence service providers within the local area in which your hospital is located will assist in understanding current and potential referral pathways for hospital staff to refer victims/survivors. Local family violence service providers can be easily identified by utilising The Lookout ‘Find Support’ service map at http://thelookout.org.au/sector-info/victorian-services.

From this mapping exercise it is also possible to determine which service providers and relationships require strengthening, and where possible gaps lie in service linkages. Improved engagement with the broader family violence sector can lead to the establishment of protocols for primary referrals and secondary consultations, using the service structures that already exist.

For many hospitals, this will be a reasonably simple exercise of documenting the existing relationships with a number of agencies in the area. For smaller rural hospitals, this may include contacting specialist agencies in the wider region and gaining a shared understanding of the services and supports they can provide to rural communities.

The Family Violence Project Coordinator, supported by the implementation team, could conduct a partnership service mapping exercise of existing external family violence resources and referral points. This involves mapping the level and type of communications and partnerships with services outside of the hospital.

The analysis might include identifying 'patient pathways' through this network – that is from the service users various contacts including initial contact or presentation, assessment, service receipt, referral, transfer, ongoing care and/or discharge.

Ongoing work with the broader family violence sector may include:

- Conducting a service mapping of family violence service providers in local area.
- Identifying, scheduling and attending local service provider meetings to introduce your new model and processes.
- Engaging in wider family violence networks and forums within your geographical area to strengthen the relationships between your hospital and the broader family violence sector.

See Attachment G for mapping the partnerships and connections templates

Element 6 – Evidence leads to best practice

This final element of the service model is by no means the least important and should be considered from the outset of implementation of this service model.

While predominantly ‘data’ relating to family violence is considered in relation to the rates of prevalence (identification of family violence) and response, there are other areas of information that will provide hospitals with the ability to monitor and evaluate (and therefore improve) the impact and efficacy of implementation, such as:

- Partnerships with the family violence services
- Change in organisational culture
- Staff level of knowledge, and
- Staff level of comfort.

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

One of the key findings of the pilot project at the Women’s and Bendigo Health was that understanding the existing data sets within a hospital and their ability to capture family violence data, can take time and requires expertise from across the hospital. While each state funded hospital will be mandated to report information on the same ‘data sets’, how and where the raw data is extracted from will vary from one area of the hospital to the next, and from one hospital site to another. Therefore, it is difficult to advise how hospitals would collect and report on data pertaining to family violence without there being an agreed mandate.

Health services hold the local expertise on clinical information systems and governance processes for their specific service. Until such time as specific data fields are mandated and included in reporting extracts generated by health services, there will not be a single software solution that can solve the issue of family violence data capturing within health. As with other data fields, standardised definitions and agreed business rules must be established to ensure consistent interpretation and recording of data.

Note: a separate Guide on data collection, developed as part of the SHRFV series, is in development and will be made available in early 2016.
Attachment A - Examples of promotional posters, cue cards and lanyards

These materials are still in development and will be available for download at a later date.
Attachment B - Sample staff survey

*(Provided as an example and template that your hospital can adapt)*

Feedback Form

Strengthening Hospital Responses to Family Violence

Thank you for attending today’s session. Please complete the following questions for the evaluation and ongoing development of the *Strengthening Hospital Responses* Project.

**What happens to the results of this survey?**

Your answers will remain confidential and will be collated with feedback from other staff to inform an evaluation report. This report will be used to improve and potentially promote the Strengthening Hospital Responses Project and will not include any identifying information.

The following questions were developed by Our Watch, in partnership with the Royal Women’s Hospital (Parkville) and Bendigo Health, with support from the Victorian Office for Women and Department of Health and Human Services as part of the Strengthening Hospital Responses to Family Violence project conducted in 2014-15.

The following questions will take around 8 minutes to complete. Your answers will remain confidential.

On behalf of the project team, thanks again.

**SECTION 1: About You**

**What is the name of your hospital/clinic/organisation?** ___________________________

**In which clinical area/s do you usually work?** ___________________________

**Usual area (please tick all relevant boxes):**

☐ Emergency

☐ Women’s Health

☐ Maternal

☐ Inpatient care (please specify which area) __________________________

☐ Mental Health

☐ Outpatient clinic (please specify) __________________________

☐ Inpatient rehabilitation __________________________

☐ Home based care (please specify program) __________________________

☐ Other (please specify) __________________________
Which profession best describes your role? Please tick one box

☐ Nursing
☐ Social Work
☐ Allied Health
☐ Midwifery
☐ Medical support service (imaging, pharmacy)
☐ Medical Officer (Registrars, Consultants, HMOs)
☐ Patient support services including interpreters, aboriginal hospital liaison workers
☐ Other (please specify below) ________________________________

How long have you worked in your profession?

☐ <1 year
☐ 1-5 years
☐ 6-10 years
☐ 10 years

Your gender

☐ Male
☐ Female
☐ Please specify: ______________________

Had you had any previous training or any in-services on the underlying causes of violence against women?

☐ No
☐ Yes
If yes, what was your most recent training?

☐ Acting on the Warning Signs
☐ VicHealth short course
☐ VicHealth Leaders course
☐ Common Risk Assessment Framework (CRAF)
☐ Centre for Non-Violence
☐ Other ________________________________

SECTION 2: Today’s session

How relevant was this session to your role in the hospital?

<table>
<thead>
<tr>
<th>Not relevant at all</th>
<th>Low relevance</th>
<th>Medium relevance</th>
<th>Highly relevant</th>
<th>Extremely relevant</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comment:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Please rate your level of understanding of the following topics PRIOR to attending this training session:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Very low (1)</th>
<th>Low (2)</th>
<th>Medium (3)</th>
<th>High (4)</th>
<th>Very High (5)</th>
<th>N/A (not covered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The definition of family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The biggest risk factors for violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health impacts of family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please rate your *level of understanding* of the following topics AFTER attending this training session:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Very low (1)</th>
<th>Low (2)</th>
<th>Medium (3)</th>
<th>High (4)</th>
<th>Very High (5)</th>
<th>N/A (not covered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aims of the <em>Strengthening Hospital Responses Project</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The definition of family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The biggest risk factors for family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health impacts of family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
How confident were you in having the sufficient skills and understanding to do the following PRIOR to attending this training session?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Very low confidence (1)</th>
<th>Low confidence (2)</th>
<th>Some confidence (3)</th>
<th>High confidence (4)</th>
<th>Not sure (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying clinical risk indicators of violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asking a patient about family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding to patient disclosure of family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauging the level of risk for family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing referrals to a patient experiencing family violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documenting a patient's experience of violence (including use of the hospital’s alert systems)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Thinking about your experience of the session, please rate your impressions in regards to the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The session today was time well spent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend this session to other staff in my role at the hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend this session to all clinical staff across the hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What do you see as the main barriers to identifying and referring victims of family violence in the hospital context? (tick all applicable)

- Information management concerns (e.g.: recording in notes, privacy issues etc.)
- Clinical uncertainty
- Perceptions of liability
- Lack of supporting Policy, Procedures and/or Guidelines
- Lack of awareness of the issue
- Environmental constraints (e.g. lack of private areas to discuss sensitive issues)
- Other (please specify: __________________________________________________________)

Comment: ______________________________________________________________________

What do you think would be of most help to you in identifying victims of family violence in the hospital context?

______________________________________________________________________________

______________________________________________________________________________

Any other comments?

______________________________________________________________________________

______________________________________________________________________________

Thank you in advance for taking the time to complete this. We really appreciate your feedback!
SUPPORT IS AVAILABLE

Has this survey raised any personal concerns?

If you became upset or distressed as a result of any questions in the survey, please contact your workplace Employee Assistance Program.

[insert your EAP provider details here and local family violence services]

You can also talk to someone you trust, such as your manager.

You may wish to contact other services, such as:

- **NATIONAL FAMILY VIOLENCE SUPPORT SERVICES**

  o **1800 RESPECT**
    
    Free call 1800 737 732 or access online at:
    
    National Sexual assault, Domestic and Family Violence Counselling service. 24-hour phone and online services.

  o **Men’s Referral Service**
    
    Call 1300 766 491 or access online at:
    
    Anonymous and confidential telephone counselling, information and referrals to help men stop using violent and controlling behaviour.

- **VICTORIAN FAMILY VIOLENCE SUPPORT SERVICES**

  o **Safe Steps**
    
    Free call 1800 015 188. 24-hours, information support and safe accommodation for women and their children.

  o **inTouch (Multicultural Centre Against Family Violence)**
    
    Free call 1800 755 988. Free & confidential family violence support in your language.

  o **Sexual Assault Crisis Line (SACL)**
    
    Free call 1800 806 292. 24 hours, state-wide, confidential, telephone crisis counselling service for victim/survivors of both past and recent sexual assault.
Attachment C - Sample family violence assessment, response and referral policy

[Provided as an example and template that your hospital can adapt]

<table>
<thead>
<tr>
<th>Family Violence Assessment, Response and Referral Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Department</strong></td>
</tr>
<tr>
<td>Approved by</td>
</tr>
<tr>
<td>Authorised by</td>
</tr>
</tbody>
</table>

**INTRODUCTION**

[Insert hospital] believes that family violence is a serious health issue and is not something that happens out there, to other people. Victims/survivors of family violence are among our community, in workplaces, schools, community groups and present in our hospitals.

We believe our hospital has an important role in the health and safety of our community. Research shows that family violence, and broader violence against women has serious, lasting health impacts and accounts for substantial repeat presentations in hospitals. The Victorian public hospital system is an early contact point for many people who have experienced family violence, presenting an opportunity for earlier identification, and improved responses and referral of victims.

**PURPOSE**

This Policy states how [insert hospital] will provide inclusive high quality care and support services to individuals who have experienced, or who are at risk of experiencing family violence.

This Policy is designed to provide guidance to clinical staff whom are associated with the clinical care of patients/clients, in the identification, assessment, response and referral process when identifying family violence.

**DEFINITION OF TERMS**

<table>
<thead>
<tr>
<th>Sensitive inquiry</th>
<th>An approach of routinely asking patient’s about their experience(s) of family violence underpinned by a framework of sensitive practice. The approach used here is based on the World Health Organization’s clinical enquiry approach and Health Canada’s principles of sensitive practice, which drew on lessons from victim/survivors of child hood sexual abuse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual assault</td>
<td>Sexual assault or sexual violence can include rape, sexual assault with implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator.</td>
</tr>
<tr>
<td>[Insert term]</td>
<td>[Insert definition]</td>
</tr>
</tbody>
</table>

**PRINCIPLES**

---

• [Insert hospital] has a responsibility to respond to disclosures, witnessed or suspected family violence matters inclusive of patient, family/carers and staff.

• Safety and the best interest of the victim/survivor and children are of paramount concern.

• Best practice at [insert hospital] recognises the impact of violence on a victim/survivor’s health and their access to health care, whether or not there are any indicators of violence.

• A coordinated response to violence, across legal, health, child protection, welfare and other services, is the most effective response.

• Our response to violence recognises that people have different experiences, barriers to safety and needs due to their gender, race, class, age, cultural background, sexuality, and/or disability and other individual factors.

• Clinical staff will be competent in identification, response and management of actual or potential family violence through the hospitals’ family violence intervention policies, procedures and professional development program.

• We have adopted a six step model of brief intervention to identify and respond to family violence, underpinned by principle of sensitive practice, and respect and gender equity.

POLICY STATEMENT/RATIONALE

• [insert hospital] is committed to providing high quality care and support to individuals who have experienced, or who are at risk of experiencing family violence.

• [insert hospital]’s understanding of, and approach to violence against women is informed and influenced by the World Health Organization recommendations for best practice in high risk population groups such as women’s reproductive health, mental health and drug and alcohol services.60

• [Insert hospital] acknowledges the impact gender based violence has on women’s health, its prevalence and that we have a role in the identification and response to victim/survivors as first-line responders.

• [Insert hospital] is committed to equipping clinical staff to identify and respond sensitively and appropriately to family violence disclosures.

SCOPE

This policy applies to clinical staff in all departments.

The policy applies to all cases of actual and/or suspected family violence encountered by clinical staff.

This policy does not exclude mandatory reporting requirements of staff at [insert hospital] in reporting cases (or suspected cases) of child abuse or neglect when responding to concerns of family violence.

REFERENCES and ASSOCIATED DOCUMENTS

Policies, procedures and guidelines (PPGs)

Insert relevant PPGs from your hospital here, for example:

• Sexual assault PPGs

• Child abuse and neglect PPGs

• Elder abuse and neglect PPGs

---

- Managing and supporting staff experiencing family violence PPGs
- Respectful workplace behaviour PPGs
- Patient safety & risk management PPGs
- Employee leave PPGs
- Workplace aggression and management PPGs
- Health record information and documentation PPGs

State and Commonwealth Legislation
- Victoria:
  - *Family Violence Protection Act 2008* (Vic) and *Child Youth and Families Act 2005* (Vic)
  - *Wrongs Act 1958* (VIC) section 48 (3)
  - *Privacy and Data Protection Act 2014* (Vic)
- New South Wales: *Crimes (Domestic and Personal Violence) Act 2007* (NSW)
- Queensland: *Domestic and Family Violence Protection Act 1989* (QLD)
- South Australia: *Domestic Violence Act 1994* (SA)
- Tasmania: *Family Violence Act 2004* (Tas)
- Western Australia: *Restraining Orders Act 1997* (WA)
- Australian Capital Territory: *Domestic Violence and Protection Orders Act 2008* (ACT)
- Northern Territory: *Domestic and Family Violence Act 2007* (NT)

Standards / Codes of Practice / Industry Guidelines
- World Health Organization, Health care for women subjected to intimate partner violence or sexual violence 2014, World Health Organization: Geneva
• The Foundation to Prevent Violence against Women and Their children & Australia’s National Research on Women’s Safety (ANROWS) (2014) Violence against Women: Key Statistics

• The Royal Australian College of General Practitioners (RACGP) (2014) Abuse and violence: Working with our patients in general practice


• VicHealth (2007) Preventing Violence Before it Occurs

• VicHealth (2011) Preventing Violence against Women in Australia - Research Summary: Addressing the Social and Economic Determinants of Mental and Physical Health


Attachment D - Sample family violence assessment and response procedure

[Provided as an example and template that your hospital can adapt]

<table>
<thead>
<tr>
<th>Family violence assessment, response and referral procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Department</td>
</tr>
<tr>
<td>Approved By</td>
</tr>
<tr>
<td>Authorised By</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

RESPONSIBILITIES

[Insert hospital] Executive

The [Insert hospital] Board is responsible for:

- Ensuring there is an organisation wide policy for the management of family violence
- Regular and ongoing professional development of its clinical staff
- Processes to ensure the policy is adhered to such as a clinical audit
- Providing adequate support and supervision for staff.

CEO

The [insert hospital] Board has nominated the Chief Executive Officer to be responsible for ensuring that proper procedures are adhered in providing high quality inclusive support services to individuals who have experienced, or who are at risk of experiencing family violence.

Service directors and unit managers of all units that provide care to patients and families must ensure that:

- All clinical staff and non-clinical staff are aware of the [insert name of family violence assessment, response and referral policy] and fully understand [insert hospital]’s position in responding to family violence.
- All clinical staff are aware of, and have access to training in these procedures – [insert name of family violence assessment, response and referral procedure].

Clinical Staff

Clinical staff across all units providing care to patients and families are required to:

- Take responsibility to have read, understood and comply with these procedures and the accompanying policy
- Adopt the “Model of Sensitive Inquiry” when identifying and responding to family violence following the six step model of sensitive inquiry
- Promote a professional work environment in which family violence is recognised as a serious health issue.

Non Clinical Staff

Non Clinical staff (administrative staff, security) are required to take responsibility to have read, understood and comply with the family violence assessment, response and referral policy and fully understand [insert hospital]’s position in responding to family violence.

PROCEDURES
The following procedures outline the sensitive practice approach adopted by [insert hospital] to be followed by all clinical staff once they have receiving training.

These procedures are supported by the clinical training module, Module 2 – Identifying and responding (a 45 minute session for clinical staff) which introduces the principles of sensitive practice.

**Step 1 - Identify family violence through sensitive inquiry**

The primary goal of sensitive practice is to facilitate feelings of safety for the client and is part of a person-centred care approach. Family violence can take a number of forms (*Appendix 1 - Types and examples of family violence*).

Clinicians should:

- Reference the risk factors (*Appendix 2 - Factors impacting on the likelihood and severity of family violence*)
- Provide a framing statement which outlines the ‘what’s, how’s and why’s’ of a conversation before beginning it; it sets the scene by preparing the patient and normalising that the following questions are part of a routine assessment.
- Explain and check the patient understands of confidentiality and its limitations.
- Suggestively inquire about the patient’s exposure to violence.

For example:

- “Are you ever afraid of someone in your family or household?”
- “Has someone in your household ever put you down, humiliated you or tried to control what you can or cannot do?”
- “Has someone in your household ever threatened to hurt you?”
- “Has someone in your household ever pushed, hit, kicked, punched or otherwise hurt you?”
- “Has anyone ever forced you to do something sexual that you didn’t want to do?”

**Step 2 - Provide a supportive response**

Clinicians should:

- Listen
- Acknowledge
- Inform
- Believe

**Step 3 - Identify risk factors**

The clinician’s role is to briefly undertake a preliminary assessment of risk, i.e. the need for immediate safety and referral or police involvement, and associated to factors relating to the patient, the perpetrator and the relationship (*Appendix 3 - Clinical risk indicators associated with family violence*).

Assessing for risk factors should be identified during the course of a conversation, rather than adopting a ‘check list’ approach.

If a comprehensive risk assessment is required, the clinician:

- Might undertake this if they have the appropriate expertise
- Refer on to the social work department if the patient is admitted
- Refer-on to specialist services in the local and/or integrated family violence sector.
Suspected family violence

If signs and symptoms are present but no abuse is disclosed, staff are to sensitively voice their concerns and make sure that the patient is aware that they are able to make contact with services in the future if they choose to.

If the patient does not disclose violence, but a health professional strongly suspects abuse, staff are to consult with a senior staff member and/or appropriate internal services regarding the protection of the patient and any children or other vulnerable people in the household.

Declined offers of support

If the patient, child or somebody else is ‘at risk’ of harm from self or another person, has disclosed but refuses any further assistance or support, the clinician will need to action Step 5 for consultation on how to proceed.

The risks identified will inform the next stage of the process; action planning and steps towards safety.

Step 4 - Action planning and steps towards safety

The clinician develops a plan of safety regardless of levels of risk with the patient and this should be based on:

- The patient/client’s own assessment- what is their level of fear?
- Evidence based risk factors- What risk indicators have you identified?
- Professional judgement- is there a need for immediate action to ensure safety?

Action planning and steps towards safety is an essential step to undertake after risks have been identified. Similar to the identification of risk factors this should be in collaboration with the victim/survivor, and where minimal assistance is needed can be a very empowering experience for a victim/survivor to do so independently.  

The level of planning, based on risk may require a more experienced professional’s assistance. Where there are children or other family members involved, there may need to be consideration of plans being tailored to each member of the family. At a minimum, the development of a plan could be as simple as asking a victim/survivor to consider some of the following.  

- A list of contact details for family violence services
- Emergency contact details
- Identification of a safe place to go to if they are in danger and how to get there
- Identifying a friend, family member or neighbour who may be able to assist in an emergency and how to contact them
- Identification of a way to access money if needed in an emergency
- Identification of place to store valuables and important documents
- Specifically address any barriers to the victim implementing the safety plan (for example leaving a pet behind, or having mobility or communication issues).

---


62 Ibid.
Step 5 – Referral

Referrals are best accepted when the patient is involved in the decision of which service is most appropriate for them, and when the transition from one professional to another is ‘warm’, i.e. clinicians offer to support the patient in initiating engagement with the relevant service or professional.

Internal referrals (within business hours - as required)

Contact the social worker [insert hospital’s social work department’s contact details here], or appropriate internal professional i.e. mental health professional, Aboriginal liaison officer. This will be dependent on the patients needs and situation.

External referrals

In the case of non-imminent situations, all clinical staff need to be aware of how to refer to external options of support, as there will be occasions for a range of reasons where patients cannot or chose not to accept internal referrals.

- [insert after hours family violence contact agency e.g. Safe Steps]
- [insert business hours family violence contact agency]
- [insert sexual assault contact agency]
- [insert Aboriginal Women’s family violence contact agency]
- [insert contact agency for male victim/survivors]
- [insert contact agency for mental health patients/clients]
- Child First

Where there are concerns of imminent risk to a patient and or their child, and in consultation with the multi-disciplinary team i.e. social workers, nursing unit managers, consultants, etc. referrals should be made to the appropriate authority, that is Police and Child Protection.

Step 6 - Documentation

Clinicians are to record:

- physical injuries; this includes the type, extent, age, and location of any physical injuries sustained
- what the patient has said, including disclosure of other forms of violence such as emotional abuse, (using quotation marks) and any relevant behaviour you have observed (in some cases, medical notes may be required as evidence if charges are laid against the perpetrator)
- Complete the family violence assessment form (see Attachment B Family Violence Assessment Form)
- Enter details on (insert area) specific patient administration system, were applicable [insert hospital name]

(See Appendix 4 Algorithm – Family violence management and referral pathway chart).

STAFF RESOURCES

Training

- Family violence training is highly recommended for all clinical staff
- The training includes two x 45 minute clinical modules
- Access to the Family Violence training can be obtained through [insert department]
- Staff are encouraged to undertake refresher training annually
- Advanced training will be offered to designated staff.
Note: Dependent on your hospital’s expectations for staff training it may pay to consider staff accessing training externally and within the community. Please see www.thelookout.org.au for information on training in Victoria.

Supervision and or peer support

- Clinical supervision and/or peer support for staff is recognised as an important requirement to ensure the practice of sensitive enquiry is actioned

REFERENCES AND RELATED DOCUMENTS

Family violence assessment, response and referral procedure
### Types and examples of intimate partner violence

Intimate partner violence can take a number of forms. These examples are not exhaustive. Behaviour may constitute family violence even if it would not constitute a criminal offence.

<table>
<thead>
<tr>
<th>Forms of intimate partner violence</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Intimidation                       | • Smashing things  
• Destroying possessions  
• Putting a fist through the wall  
• Handling guns or other weapons in the presence of the victim/survivor  
• Using intimidating body language such as angry looks, raised voice  
• Questioning the victim/survivor in a hostile way  
• Recklessly driving a vehicle with the victim in the car  
• Harassing the victim by making persistent phone calls, sending text messages or emails, following the victim/survivor, or loitering near their home or workplace. |
| Verbal abuse                       | • Screaming, shouting, making put-downs, name-calling,  
• Using sarcasm,  
• Ridiculing the victim/survivor in public or private, |
| Physical abuse                     | • Showing lack of consideration for the victim/survivor’s physical comfort or safety (such as dangerous driving)  
• Pushing, shoving, hitting, slapping, choking, hair-pulling, punching or using weapons  
• Destroying possessions  
**Note**: acts are physically abusive even if they do not result in physical injury |
| Emotional abuse                    | • Any behaviour that deliberately undermines the victim’s confidence (for example, that leads them to believe they are stupid, a ‘bad parent’, useless, or even crazy or insane)  
• Acts that humiliate, degrade and demean the victim  
• Threatening to harm the victim, their friend or family member; to take their children; or to commit suicide  
• Silence and withdrawal as a means to abuse  
• Threatening to report the victim/survivor to authorities such as Centrelink or Immigration |
| Social abuse                       | • Isolating the victim/survivor from their social networks and supports, either by preventing them from having contact with their family or friends or by verbally or physically abusing them in public or in front of others  
• Continually putting friends and family down so the victim/survivor is slowly disconnected from their support network  
• Preventing the victim/survivor from having contact with people who speak their language and/or share their culture |
| Economic abuse                     | • Denying the victim/survivor access to money, including their own  
• Demanding that the family live on inadequate resources  
• Incurring debt in the victim’s name  
• Making significant financial decisions without consulting the victim/survivor |
## Types and examples of intimate partner violence

Intimate partner violence can take a number of forms. These examples are not exhaustive. Behaviour may constitute family violence even if it would not constitute a criminal offence.

<table>
<thead>
<tr>
<th>Types and examples</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selling the victim/survivor’s possessions</td>
<td>Note: these can be contributing factors for victim/survivors becoming ‘trapped’ in violent situations</td>
</tr>
</tbody>
</table>
| Sexual abuse | - Rape (which includes being forced to perform unwanted sexual acts, or to have sex with others)  
- Being pressured to agree to sex  
- Unwanted touching of sexual or private parts  
- Causing injury to the victim’s sexual organs |
| Controlling behaviours | - Dictating what the victim/survivor does, who they see and talk to, or where they go  
- Keeping the victim/survivor from making friends, talking to their family, or having money of her own  
- Preventing the victim/survivor from going to work  
- Not allowing the victim/survivor to express their own feelings or thoughts  
- Not allowing the victim/survivor any privacy  
- Forcing the victim/survivor to go without food or water |
| Spiritual abuse | - Ridiculing or putting down the victim/survivor’s beliefs and culture  
- Preventing the victim/survivor from belonging to or taking part in a group that is important to their spiritual beliefs, or practising their religion  
- Loitering around places the victim/survivor is known to frequent  
- Stalking the victim/survivor, watching them, following them, making persistent telephone calls and sending mail including unwanted love letters, cards and gifts  
Note: stalking is a criminal offence. Under the stalking legislation more than one type of behaviour has to occur, or the same type of behaviour has to occur on more than one occasion. Stalking can occur before or after separation. |
| Spousal homicide | The death of the victim/survivor directly attributed to family violence |

Department of Human Services (DHS). (2012). *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3*. Victoria. Department of Human Services (Figure 4, pages 20-21)
Appendix 2 – Risk factors for increased violence

<table>
<thead>
<tr>
<th>Factors impacting on the likelihood and severity of family violence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk factors for victims</strong></td>
</tr>
<tr>
<td>Pregnancy/new birth*</td>
</tr>
<tr>
<td>Depression/mental health issue</td>
</tr>
<tr>
<td>Drug and/or alcohol misuse/abuse</td>
</tr>
<tr>
<td>Has ever verbalised or had suicidal ideas or tried to commit suicide/has a current plan</td>
</tr>
<tr>
<td>Isolation</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander origin</td>
</tr>
<tr>
<td><strong>Risk factors for perpetrators</strong></td>
</tr>
<tr>
<td>Use of weapon in most recent event*</td>
</tr>
<tr>
<td>Access to weapons*</td>
</tr>
<tr>
<td>Has ever harmed or threatened to harm victim</td>
</tr>
<tr>
<td>Has ever tried to choke the victim*</td>
</tr>
<tr>
<td>Has ever threatened to kill victim*</td>
</tr>
<tr>
<td>Has ever harmed or threatened to harm or kill children harm or kill children*</td>
</tr>
<tr>
<td>Has ever harmed or threatened to harm or kill other family members</td>
</tr>
<tr>
<td>Has ever harmed or threatened to harm or kill pets or other animals*</td>
</tr>
<tr>
<td>Has ever threatened or tried to commit suicide*</td>
</tr>
<tr>
<td>Stalking of victim*</td>
</tr>
<tr>
<td>Sexual assault of victim</td>
</tr>
<tr>
<td>Previous or current breach of Intervention Order</td>
</tr>
<tr>
<td>Drug and/or alcohol misuse/abuse*</td>
</tr>
<tr>
<td>Obsession/jealous behaviour toward victim*</td>
</tr>
<tr>
<td>Controlling behaviours*</td>
</tr>
<tr>
<td>Unemployed*</td>
</tr>
<tr>
<td>Depression/mental health issue</td>
</tr>
<tr>
<td>History of violent behaviour (not family violence)</td>
</tr>
<tr>
<td><strong>Relationship factors</strong></td>
</tr>
<tr>
<td>Recent separation*</td>
</tr>
<tr>
<td>Escalation—increase in severity and/or frequency of violence*</td>
</tr>
<tr>
<td>Financial difficulties</td>
</tr>
</tbody>
</table>
*May indicate an increased risk of the victim being killed or almost killed

Reference:
Appendix 3 – Clinical risk indicators associated with intimate partner violence

Health care providers should ask about exposure to family violence when assessing conditions that may be caused or complicated by intimate partner violence (as listed below), in order to improve diagnosis/identification and subsequent care.

<table>
<thead>
<tr>
<th>Indicators in adults</th>
<th>Indicators in children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICAL</strong></td>
<td><strong>PHYSICAL</strong></td>
</tr>
<tr>
<td>• Unexplained chronic gastrointestinal symptoms</td>
<td>• Difficulty eating / sleeping</td>
</tr>
<tr>
<td>• Unexplained reproductive symptoms</td>
<td>• Slow weight gain (in infants)</td>
</tr>
<tr>
<td>• Adverse reproductive symptoms, including pelvic pain, sexual dysfunction</td>
<td>• Physical complaints</td>
</tr>
<tr>
<td>• Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes</td>
<td>• Eating disorders</td>
</tr>
<tr>
<td>• Unexplained genitourinary symptoms, including frequent bladder or kidney infections</td>
<td></td>
</tr>
<tr>
<td>• Repeated vaginal bleeding and sexually transmitted infections</td>
<td></td>
</tr>
<tr>
<td>• Chronic pain (unexplained)</td>
<td></td>
</tr>
<tr>
<td>• Traumatic injury, particularly if repeated and with the vague or implausible explanations</td>
<td></td>
</tr>
<tr>
<td>• Problems with the central nervous system - including headaches, cognitive problems, hearing loss</td>
<td></td>
</tr>
<tr>
<td><strong>PSYCHOLOGICAL / BEHAVIOURAL</strong></td>
<td><strong>PSYCHOLOGICAL / BEHAVIOURAL</strong></td>
</tr>
<tr>
<td>• Emotional distress e.g. anxiety, indecisiveness, confusion, and hostility</td>
<td>• Aggressive behaviour and language</td>
</tr>
<tr>
<td>• Symptoms of depression, anxiety, PTSD, sleep disorders</td>
<td>• Depression, anxiety and/or suicide attempts</td>
</tr>
<tr>
<td>• Anxiety / depression / pre-natal depression</td>
<td>• Appearing nervous and withdrawn</td>
</tr>
<tr>
<td>• Psychosomatic and emotional complaints</td>
<td>• Difficulty adjusting to change</td>
</tr>
<tr>
<td>• Alcohol and other Drug abuse</td>
<td>• Regressive behaviour in toddlers</td>
</tr>
<tr>
<td>• Self-harm or suicide attempts</td>
<td>• Delays or problems with language development</td>
</tr>
<tr>
<td>• Evasive or ashamed about injuries</td>
<td>• Psychosomatic illness</td>
</tr>
<tr>
<td>• Multiple presentations at the surgery / client appears after hours</td>
<td>• Restlessness and problems with concentration</td>
</tr>
<tr>
<td>• Repeated health consultations with no clear diagnosis</td>
<td>• Dependent, sad or secretive behaviours</td>
</tr>
<tr>
<td>• Intrusive partner or husband in consultations</td>
<td>• Bedwetting</td>
</tr>
<tr>
<td>• Partner does most of the talking and insists on remaining with the patient</td>
<td>• ‘Acting out’, for example cruelty to animals</td>
</tr>
<tr>
<td>• Seeming anxious in the presence of the partner</td>
<td>• Noticeable decline in school performance</td>
</tr>
<tr>
<td>• Reluctance to follow advice</td>
<td>• Fighting with peers</td>
</tr>
<tr>
<td>• Social isolation / no access to transport</td>
<td>• Overprotective or afraid to leave mother</td>
</tr>
<tr>
<td>Frequent absences from work or studies</td>
<td>Stealing and social isolation</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Submissive behaviour / low self esteem</td>
<td>Abuse of siblings or parents</td>
</tr>
<tr>
<td></td>
<td>Alcohol and other drug use</td>
</tr>
<tr>
<td></td>
<td>Psychosomatic and emotional complaints</td>
</tr>
<tr>
<td></td>
<td>Exhibiting sexually abusive behaviour</td>
</tr>
<tr>
<td></td>
<td>Feelings of worthlessness</td>
</tr>
<tr>
<td></td>
<td>Transience</td>
</tr>
</tbody>
</table>


### Violence against women risk assessment

<table>
<thead>
<tr>
<th>Identifying type(s) of Violence Against Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Physical</td>
</tr>
<tr>
<td>☐ Coercive/Threatening Behaviour</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship of the alleged perpetrator to patient, if known</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Partner/Spouse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identified Factors for Likelihood and Severity of Family Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(refer to [Name Hospital Procedure Here] Appendix XX for a detailed list of factors):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Pregnant/New Birth</td>
</tr>
<tr>
<td>Provide detail/list any other identified factors:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alleged Perpetrator Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.g. Use of weapons, threats to kill, substance use etc.:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Children</td>
</tr>
<tr>
<td>☐ Escalation and change in frequency and severity</td>
</tr>
<tr>
<td>Provide detail/list any other identified factors:</td>
</tr>
</tbody>
</table>
*A referral must be made to Social Work or if ‘out of hours’ consult with senior colleagues and refer to Child Protection Services

**Action Plan**

<table>
<thead>
<tr>
<th>Patients perception of own safety and needs</th>
<th>□ Patient feels safe to go home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>e.g. Patient feels unsafe to be discharged without further support, patient</td>
</tr>
<tr>
<td></td>
<td>declined supports offered etc.</td>
</tr>
</tbody>
</table>

**Consultation Sought**

Name: ___________________  Designation: ___________________

**Referrals Made**

**Internal**

- □ Social Work
- □ CASA
- □ Badjurr-Bulok Wilam
- □ WADS
- □ CWMH

**External**

- □ Child Protective Services
- □ Specialist FV Service
- □ Police
- □ Legal
- □ Other (please specify): ___________________

**Completing Clinician**

Name: ___________________  Designation: ___________________  Signature: ___________________

Time: ___________________  Date: ___________________  /  /  /
Violence against women risk assessment

<table>
<thead>
<tr>
<th>Identified Concerns</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Further Identified Risk Factors

<table>
<thead>
<tr>
<th>Safety Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Referrals Made

---

UR number: __________________________
Surname: ____________________________
Given name/s: _______________________
Date of birth: _____________________  Gender: ________

(AFFIX PATIENT LABEL)

- The following sections of this form are for the use of SW/CASA/WADS/CWMH/PAS or internal staff with skilled knowledge and proficiency in risk assessment and safety planning only.
- If the content of this work has been triggering for you, please seek support via your manager or directly to EAP on 1300 360 364

Risk Assessment (refer to [Name Hospital Procedure Here] Appendix XX for a detailed list of factors):
<table>
<thead>
<tr>
<th>Internal</th>
<th>Social Work</th>
<th>CASA</th>
<th>Badjurr-Bulok Wilam</th>
<th>WADS</th>
<th>CWMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td>Child Protective Services</td>
<td>Specialist FV Service</td>
<td>Police</td>
<td>Legal</td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key Contacts or Additional Documents**

---

**Completing Clinician**

Name: 
Designation: 
Signature: 

Time: : Date: / / 

☐ Corresponding electronic alert completed
Appendix 4 - Algorithm – Family violence management and referral pathway chart

[Provided as an example and template that your hospital can adapt]
Attachment F – Pre and post training to do checklist

[Provided as an example and template that your hospital can adapt]

Pre- and post-training
TO DO checklist

Course name: ________________________________ Date: ____________

Location: ________________________________

Pre-course checklist

Confirm target group
- Attend unit meetings to engage clinical staff in FV module training
- Confirm priority area for delivery e.g. ED or maternity
- Meet with Nurse Unit Manager to confirm dates (double handover Shifts; number of clinical staff, rostering issues) and confirm
- Confirm dates for training delivery
- Confirm room/s for delivery
- 2 weeks before and 1 week before, walk around unit to encourage staff (personal approach)

Promote clinical module training
- Advertise in educational calendar
- Prepare promotional flyer and distribute across unit
- Reserve AV equipment

Prepare resources
- Photocopy participant notes
- Prepare evaluation sheet
- Prepare certificates
- Prepare sign-in sheets (one for each module) in Microsoft Word

On the day
- On the day walk around the unit to encourage staff to ensure staff are attending
- Set up room
- Put out sign on day of training

Post-course checklist
- Pass out certificates at end of course
- Collect evaluations sheets
- Return room to original set-up
- Summarise evaluation sheets
- Send a copy of the evaluation sheets to NUM
Attachment G - Mapping the partnerships and connections

It is helpful to draw a partnership map showing the key family violence services within your local community and how well you are connected.

Step 1 - Identify

Identifying the relevant family violence service providers/agencies in the local area and state-wide bodies

How do you access this information? There are a number of ways hospitals can identify key players:

- Invite family violence sector representatives onto the Implementation Team and undertake this work as a small working party (comprising representatives from hospital and sector)
- Contact the family violence networks and forums in your area and hold a workshop with the Implementation Team and sector representatives
- Draft documents for feedback from external, local and specialist family violence and sexual assault services

Step 2 - Analyse

- Analyse the current links
- What is the link – referral agency;
  - How strong is the link?
  - Use the map to draw the links
- Decide which service providers and relationships are the most important or potentially important and should therefore be strengthened

Step 3 – Map out

- Draw a map to show current links and their strength (see key map below)

Step 4 – Record

- Record these in a template and include actions for the Implementation Team (see Recording the Partnerships and Connections).
Recording the partnerships and connections (provided as an example and template that your hospital can adapt)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Reason for connection</th>
<th>Strength of connection</th>
<th>Action</th>
<th>Who will Action</th>
<th>When</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre for Sexual Assault (CASA)</td>
<td>Referral (primary referrals and secondary consultations) Referral</td>
<td>weak</td>
<td>Invite CASA Representative onto the Implementation Team</td>
<td>FV Project Coordinator</td>
<td>Within 1 month</td>
<td>nil</td>
</tr>
</tbody>
</table>