



**DOMESTIC
VIOLENCE
VICTORIA**

Expanding early interventions in family violence in Victoria

Prue Cameron

November 2016

YOUR VOICE AGAINST VIOLENCE

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Executive Summary

The Victorian Royal Commission into Family Violence (RCFV) envisaged a family violence system in which all universal services are enabled to engage in early interventions in family violence. Such a significant broad-based reform has major implications for organisations and their staff. This project scoped a range of specialist family violence and universal services and organisations in Victoria to ascertain their capability and perspectives on early intervention in family violence. Its findings reveal a readiness to engage with the issue across these services. The organisations interviewed shared the expectation that they had a role and a responsibility to help address family violence in their client group and within their workforce, although there was uncertainty about what that role would be. The insights of women affected by family violence provide the foundation for this work. Their experiences illustrate the complex nature and dynamics of family violence, including the often covert effects of coercive and controlling behaviours. Understanding these dynamics is the foundation for all practitioners in all universal services engaging in early intervention responses.

To be effective, universal services engaging in early intervention in family violence must be supported by, and work with, specialist family violence services.

The project provides a qualitative snapshot of the early intervention landscape through the perspectives of specialist family violence practitioners and universal service providers in education, early childhood and health settings, as well as women who have experienced family violence. In all, 52 organisations were interviewed, including 20 specialist family violence and women's services, 16 women participated in focus groups discussions, and 30 family violence services completed an online survey. The data was collected between October 2015 and June 2016; at the time the RCFV was conducting its inquiries. This report locates its findings and recommendations within the policy context provided by the RCFV.

Defining early intervention in family violence

A clear, shared definition of early intervention in family violence is critical to ensure that the roles and responsibilities of all services are well delineated and articulated. But the multi-layered nature and dynamics of family violence make early intervention a contested concept. Family violence does not readily conform to the public health model of intervention. It is embedded in a complex interplay of individual, cultural and social factors. The cause of the violence, or pathogen, is the perpetrator, external to the victim who is seeking support. The trajectory of family violence is not linear. Women living with family violence may not seek help until their situation reaches crisis point; they may never seek help; they may leave and return to a violent partner multiple times; and they may not recognise or acknowledge that their experience is family violence.

As the women who told their stories for this project demonstrate, interventions in family violence work when women receive the right response at the right time for them. This project developed an operational definition of early intervention that is applicable in the complex, non-linear and multi-factoral context of family violence:

Identification and support for individuals and families experiencing family violence with the aim of stopping early signs of violence escalating, preventing a recurrence of violence or reducing longer-term harm.

Key findings:

The role of specialist family violence services in early intervention responses

To be effective, universal services engaging in early intervention in family violence must be supported by, and work with, specialist family violence services. Specialist family violence practice should underpin all aspects of early intervention work. This practice combines a gendered lens, trauma-informed practice, attachment theory and a strengths-based approach to work with women and children experiencing family violence. Specialist family violence practitioners employ a sophisticated understanding of the complex nature and dynamics of family violence that prioritises the safety and the agency of women and children. Without this, interventions can increase the risks for everyone, including workers. This project found many examples of effective partnerships between universal services and specialist family violence services, and identified opportunities for collaborations in a variety of settings.

The role of specialist family violence practitioners in early intervention is to: maximise the opportunities in their first contact with women, particularly in response to police incident reports, to 'plant the seed'; to inform and support universal services through outreach work and secondary consultations; and to run early intervention programs in schools and group work with women and children in diverse settings. Each of these activities requires a specialist response, and is an important component of the work of these services, but historically, funding for early intervention work is unfunded or through short-term project grants.

Building consistent, standardised, best practice early intervention responses

The primary health, education and early childhood services interviewed for this project reported significantly different responses to their engagement with family violence, across and within sectors. The interviews revealed a patchwork environment that includes well-developed structured responses, nascent awareness, and localised approaches to practice, training and organisational policy frameworks. The early childhood services, which have not previously engaged with family violence, were primarily concerned with clarifying expectations about their role in responding to family violence. They are seeking advice, detailed guidelines, tailored training and partnerships with the specialist family violence sector to build capability across their workforce.

The primary health sector was more likely to be actively engaging with family violence, seeing it as an expansion of their current practice. These services were also more likely to be proactively developing internal family violence responses and training for their staff.

The evidence from this project strongly indicates the need for guidelines and training for consistent, standardised, high quality and integrated practice to support universal services in family violence early intervention. This will assist universal services workers across diverse settings to identify the signs of family violence, know how to respond appropriately, know where to get specialist advice through secondary consultations, and where and how to refer to support services. The revised Family Violence Risk Assessment and Risk Management Framework (the CRAF) will provide this foundation across its differentiated roles, responsibilities and practice guides for different services. The Family Violence Industry Taskforce should prioritise developing a Statewide Framework for Early Intervention in Family Violence, based on the CRAF. The framework should also contain guides for organisational structures and policies to support staff, such as the policies for supervisory support to reduce the risk of vicarious trauma, and internal policies to support staff experiencing family violence. Oversight of the implementation and monitoring of the Framework should be the responsibility of the Family Violence Agency, with the support of specialist family violence peak bodies.

A regulated high quality family violence training regime

In the current urgent environment to incorporate family violence responses into workplaces, there is a serious risk that organisations with no experience or links to the family violence sector are stepping into the 'market place' of training and organisational policy development. Family violence training, with the Statewide Framework, will be pivotal to building the skills and capability for workforces across all universal services. The training must meet high standards of consistency and content and should be integrated into workplace practice, in staff induction with refresher courses for all staff on a regular basis. Without this, skills and knowledge are lost when staff turnover, and family violence practice becomes stale and outdated. The revised CRAF will provide the basis for a consistent approach to family violence training, based on specialist family violence practice. It is recommended that all family violence training is delivered by accredited trainers with family violence expertise and based on the use of the CRAF. The training model will need to take account of the organisations' practical constraints, including time availability, staff size, workloads, capacity and resourcing.

Increased sustainable investment to build capability in the early intervention workforce

The work required to implement effective, high quality and sustainable early interventions in family violence is substantial. Achieving the goal of a co-ordinated, systematic statewide approach that incorporates cross-sectoral training for consistent, best practice responses presents considerable challenges. It will require dedicated and recurrent funding to build and maintain an early intervention workforce across all sectors. Total investment in early intervention accounted for less than six per cent (approximately \$4.8 million) of the Victorian Government's 2014-15 budget for family violence services. Clearly, implementation of the transformative changes recommended by the RCFV to extend early interventions in family violence across into the work of universal services will require a substantial increase in sustainable funding.

Recommendations

To develop consistent, high quality and standardised early interventions in family violence:

Recommendation 1

The Industry Taskforce should develop a Statewide Framework for Early Intervention in Family Violence as a priority. The framework should:

- be based on the revised Family Violence Risk Assessment and Risk Management Framework (the CRAF), and its delineated roles and responsibilities for different service sectors
- include detailed practice procedures and protocols, including secondary consultation information and referral pathways
- outline best practice organisational structures and policies to respond to the effects of family violence in the workplace, including supervisory support structures for staff (drawing on of the workplace programs of Our Watch, Women’s Health Victoria, Women with Disabilities Victoria and InTouch Multicultural Centre Against Family Violence Service)
- recommend organisational training requirements, including continuous professional development.

Recommendation 2

The Centre for Workplace Excellence (announced in the ten year plan) should have oversight and administrative responsibility for the Statewide Framework for Early Intervention in Family Violence, with support from the specialist family violence peak bodies, such as Domestic Violence Victoria and No to Violence.

Recommendation 3

The Family Violence Industry Plan should require that family violence training for ‘prescribed organisations’ be aligned with the revised Family Violence Risk Assessment and Risk Management Framework (the CRAF) and recommended for all other universal services.

Recommendation 4

The Family Violence Industry Plan should require accreditation for organisations providing family violence training (to be delivered by the Centre for Workplace Excellence) that is:

- Delivered by trainers with family violence expertise
- CRAF-aligned
- Informed by a gendered analysis of family violence
- Standardised in content and delivery modules that conform to service roles and responsibilities defined by the CRAF and the Statewide Framework for Early Intervention in Family Violence
- Supported by organisational processes and procedures to respond to staff experiencing family violence.

Recommendation 5

The Centre of Workplace Excellence should establish and maintain a mechanism for continuous monitoring and oversight of CRAF training.

Recommendation 6

The Centre for Workplace Excellence or relevant body should maintain a central register for all CRAF-aligned training tools and resources (as recommended by the CRAF review).

Recommendation 7

The Victorian Government should establish a standing Women's Family Violence Advisory Group, with a membership of women from diverse backgrounds with experience of family violence, as a formal and ongoing mechanism to provide advice on family violence policy development, service delivery and training.

To support and strengthen the early intervention work of specialist family violence services:

Recommendation 8

The Family Violence Industry Plan should recognise the expert role of specialist family violence services in providing early interventions through individual contacts, universal service outreach and secondary consultations, and working with groups and allocate/recommend funding to support and expand this work.

Recommendation 9

The Victorian Government should recognise the role of specialist family violence services in leading practice in early intervention, risk assessment and crisis responses to family violence and develop a Support and Safety Hubs model that is built around led by existing specialist family violence services.

Recommendation 10

The Victorian Government should commit additional, recurrent funding commensurate with building a statewide workforce response to family violence.

Recommendation 11

The Australian Government should increase funding for the National Sexual Assault, Domestic and Family Violence Counselling Service 1800 RESPECT to increase its capacity to provide early intervention responses to individuals, communities and service providers.

Introduction

“Universal services that are available to all community members are ideally placed to have a much greater role in identifying and effectively responding to family violence at the earliest possible stage.”

The Victorian Royal Commission into Family Violence¹

Family violence has received unprecedented media, community and political attention over the past two years. This has increased demand on specialist family violence services and generated recognition that this pervasive social problem requires a community-wide response. Part of that response is developing opportunities for earlier interventions before family violence escalates to crisis point. Early intervention can reduce the immediate and long-term impacts of family violence by limiting the physical and psychological harms, as well as the likelihood of homelessness and financial insecurity. To be effective, these early interventions need to occur in a range of settings outside the specialist family violence service system. Although the benefits and practice of early intervention generally are well established in health, education and early childhood development, there has never been a comprehensive, systematic and, importantly, cross-sectoral approach to early interventions in family violence.

Project aims and methodology

This project contributes to the development of a framework for consistent and effective practice in early intervention approaches to family violence in Victoria. In October 2015, Domestic Violence Victoria was awarded an ‘exploration grant’ by the Lord Mayor’s Charitable Foundation to scope a systematic approach to early intervention for family violence. The aim of the project is to reduce the harms of family violence through consistent and effective early intervention approaches by:

1. Establishing a shared definition of early intervention in the context of family violence across the specialist family violence sector and key universal services.
2. Scoping of the level of understanding, preparedness and existing practices in family violence by universal services, and the early intervention practice by specialist family violence services.
3. Identifying the core elements for a safe, consistent and effective statewide approach to early intervention in family violence.

While early intervention can be imagined in any setting across the community, time and resource restrictions limited our inquiries primarily to specialist family violence services and universal services in the health, education and early childhood sectors. Interviews with service providers, peak bodies and other organisations across these sectors detailed their experience of working with family violence, their current work practices, and

¹ State of Victoria, Royal Commission into Family Violence: Summary and recommendations, Parl Paper No 132 (2014-16) p11

their organisational requirements to take up a greater role in early intervention. We also sought the views of women who have experienced family violence.

Data was collected using three methods:

1. **In depth, semi-structured interviews** with 52 organisations and individuals including 20 specialist family violence and women's services and 32 primary health and education and early childhood services and organisations (see Appendix A) for a list of organisations and individuals interviewed). Organisations representing or providing universal services were selected as identified key stakeholders and by referral (snowball sampling). The two-hour interviews were conducted between November 2015 and June 2016.
2. **An online survey** with questions developed from the interview data was sent to all specialist family violence services and organisations on DV Vic's membership database, consisting of approximately 80 agencies. The survey was live from 16 February to 1 March 2016. It was completed by 30 agencies (37.5 per cent). The primary focus of the online survey was to validate the findings from the interviews with specialist family violence services and test consistency around the role of specialist services in early intervention work.
3. **Two focus groups** were held with women who had experienced family violence, one in Melbourne and the other in regional Victoria. Focus group participants were recruited by specialist family violence services. Both focus groups were held at the services, with workers available to support participants if required. Each participant received a \$100 gift voucher. The focus groups were facilitated by the project team, ran for approximately two hours and were audio-recorded and transcribed verbatim. The format of the focus group was unstructured, informal and conversational, allowing space for each woman to tell her story. The women were asked to reflect on their own experience of early intervention, for example if and when they had disclosed their experience of family violence to a service provider such as their GP, a nurse or doctor at the hospital, someone at their children's school or early childhood facility or anyone else in a professional setting. They discussed whether that conversation had been helpful or not and the reasons why. Finally, the women were asked to consider what in hindsight would have helped. Of the 16 women, one was Aboriginal and three were from refugee or immigrant communities.

The policy context

The project was conducted during the Victorian Royal Commission into Family Violence (RCFV), which began in February 2015 and reported in March 2016. The RCFV's discussion and specific recommendations about early intervention provide the policy context for a statewide family violence early intervention framework. This project's findings are consistent with the RCFV's and inform its recommendations on workforce development, including the 10-year Industry Plan to address the family violence capability and workforce needs across the justice, health, education and human services sectors, as well the specialist family violence workforce. It also

supports and informs the RCFV recommendation for the legislated use of the revised The Family Violence Risk Assessment and Risk Management Framework (CRAF) by prescribed agencies, such as police, child protection, community and health services and child and family services, to ensure consistent practice.

This project provides further evidence of the need for a systemic, comprehensive and specialist approach to supporting universal services in early intervention in family violence. It highlights the need for family violence training for universal services to be consistent across the state and based on specialist expertise to ensure that early intervention is effective and does not increase the risks to women and children. Clearly defined roles and responsibilities for universal services and specialist family violence services is a key theme, in addition to the need for well-articulated referral pathways and appropriate, relevant and current resources. A framework that sets out protocols and guidelines for early intervention practice will be critical for supporting universal services to undertake this work professionally and safely, including building workforce resilience to engage with family violence. Critically, the project demonstrates the breadth of the scope of family violence early intervention work across service systems that will require an urgent investment of additional, recurrent funding.

Part one of the report provides a brief discussion of the limited research literature on interventions in family violence. Despite the limited evidence, the recurrent themes are instructive for developing a sound early intervention practice base. Part two sets out the policy context for early intervention in family violence. It discusses definitional issues in the concept of early intervention in the context of family violence and outlines the relevant findings from the RCFV and the review of The Family Violence Risk Assessment and Risk Management Framework (CRAF). The project findings are discussed in Parts three, four and five: first, the experiences of women who have lived with family violence, then the perspectives of the specialist family violence and universal services providers. This structure sets out the building blocks for a statewide framework for early intervention in family violence: the safety and experience of women and children must be prioritised and underpin practice; the knowledge, expertise and practice of specialist family violence practitioners inform all early intervention practice; and the role, responsibility and practice of the universal service providers must be clearly articulated based on these foundations. The concluding section of report discusses the findings and sets out recommendations for a framework for early intervention in family violence in Victoria.

Limitations of the project

Funding, time and resources have determined the scope of the project. This restricted the number and range of universal services consulted for this project. Having identified primary health and education settings, we recognise that the participating organisations do not encompass the full range of key services operating in those settings, nor do they represent all services in these sectors. In some cases it was not possible to engage key organisations in the project. For this reason, the findings and recommendations are presented as preliminary and indicative. They represent a scoping of the landscape and a framework for the more detailed policy work to come.

Part One: Evidence on early interventions in family violence

There is a strong evidence-base to support early interventions in health, justice, education and child development, but this brief review of the international and Australian literature on early intervention in family violence found relatively limited evidence-based data. Where it exists, the literature focuses on interventions in primary health settings, primarily on the role of general practitioners and nurses working with women during pregnancy and early years. There is limited research on the efficacy of universal interventions in schools and no research studies on family violence interventions in early childhood settings were found.

This literature review covers some of the key findings from research studies of family violence interventions by general practice and maternal and child nurses. It includes evaluations of community-based family violence intervention programs with Aboriginal and Torres Strait Islander women in Victoria and New South Wales, and early interventions for children and young people, including the schools-based Respectful Relationships Education program. However limited, the research literature points to a number of important themes that are instructive for effective interventions in family violence.

What women want from service providers' family violence interventions

While many victims of family violence do not want, or are not able to, seek help from specialist family violence services, they may disclose their circumstances to a health professional while accessing primary care for themselves or their children. The RCFV cites evidence that at least 80 per cent of women experiencing family violence ask healthcare professionals, most commonly general practitioners, for help. The RCFV report also notes that only one in ten women experiencing family violence are asked about it directly by their general practitioner.² The research literature shows that while general practitioners and maternal and child health nurses can play a central role in effective family violence interventions, their practice is inconsistent.

A meta-analysis of qualitative studies on the experiences of victims of intimate partner violence in primary care³ found, unsurprisingly, that women want their healthcare professional to be sensitive, compassionate and non-judgemental; and to have a sound understanding of the nature, complexity and long-term effects of family violence, including the social and psychological impacts. The study found that women identify the need for trust and confidentiality from their health care providers, confirmation that the violence and abuse is unacceptable and undeserved. Women want to progress at their own pace and not be pressured to disclose, to leave their partner or to make a police report. It is important to note that the literature overwhelmingly focuses on interventions with the woman as the primary victim of family violence, but as a recent study finds, the traumatic effects of family violence is commonly misdiagnosed in children. This study finds that, although rarely asked

² RCFV Vol 4, p6

³ Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006) Women Exposed to Intimate Partner Violence, Archives of Internal Medicine 166, 22–37

about their experiences of family violence, when professionals do engage with children it builds their sense of agency and is important for their recovery.⁴

Barriers to early interventions in family violence

The evidence suggests that healthcare professionals do not intervene effectively in family violence. Two qualitative studies, one in Australia⁵ and one in the United Kingdom⁶ identify a range of barriers to general practitioners' ability to recognise and respond appropriately to family violence. Taft et al's 2004 Australian study found that some GPs were reluctant to engage with family violence because of the long consultations required and their frustrations with 'non-compliant' patients. They found that GPs showed a lack of awareness of barriers to women disclosing, expressing frustration at their patients' inability to disclose information even when asked directly. The study also reported examples of bad practice such as breaches confidentiality and couples counselling when family violence was identified. The researchers found that most clinicians used counselling as a management strategy but often lacked the expertise or support to provide an appropriate response. In contrast, the clinicians in Yeung et al.'s later study in the UK considered that their role was to identify family violence and refer to specialist external agencies. The findings of the RCFV show the situation for general practitioners in Australia is relatively unchanged since this research.⁷

Women want to progress at their own pace and not be pressured to disclose, to leave their partner or to make a police report.

A comprehensive review of the research, practice and policy in early interventions for children and young people conducted for the Early Intervention Foundation in the United Kingdom⁸ examines international evidence across a range of settings, particularly in healthcare, early childhood and schools. The study supports the findings of other studies discussed in this review. In finding that health settings, particularly general practitioners and health visitors, (MCH nurses) are best placed to identify domestic violence and abuse, it also concludes that there is little evidence of an effective approach to recognition and referral to specialist services.

The report identifies consistent barriers to effective interventions across all settings:

- Preventing and responding to domestic violence and abuse is not considered to be the core business of universal services, including parenting-based early intervention programs

⁴ Morris, A (2015) Safety and resiliency at home: voices of children from a primary care population, PhD thesis, University of Melbourne; Morris, A.; Toone, E., Utter, M., & Christovitchin, F. 2011, Extending the reach: A timely and tailored response to children who experience family violence. *Parity*, vol. 24, no. 8, pp. 37-38.

⁵ Taft, A., Broom, D. H., & Legge, D. (2004) General practitioner management of intimate partner abuse and the whole family: qualitative study. *BMJ (Clinical Research Ed.)*, 328(7440), 618. <http://doi.org/10.1136/bmj.38014.627535.0B>

⁶ Yeung, H., Chowdhury, N., Malpass, A., & Feder, G. S. (2012) Responding to Domestic Violence in General Practice : A Qualitative Study on Perceptions and Experiences, 2012. <http://doi.org/10.1155/2012/960523>

⁷ RCFV Vol 4 p28

⁸ Guy et al, pp73-80

- The lack of practitioner confidence to act
- The lack of universal screening tools and a fragmented approach to application
- The lack of clearly articulated referral pathways
- Lack of universal training standards in domestic violence and abuse identification
- Lack of guidance for universal service providers
- The report also notes that varying statutory threshold requirements across agencies as a barrier to effective domestic violence intervention because of the over-reporting to child protection services.

Elements of effective family violence interventions

A focus on the woman's agency

The research on primary care-based interventions in family violence covers a variety of locations from general practice and family medical clinics to antenatal and reproductive health clinics. A systematic review of primary care-based interventions found only six studies, five based in the United States and one in Hong Kong, where primary care-based interventions resulted in a significant reduction in levels of family violence.⁹ The common elements of successful interventions: a focus on the woman's agency, empowerment and self-sufficiency, access and referral to family violence-related resources and non-physician delivery of interventions.

Identifying family violence: Case-finding rather than screening

Reluctance to disclose family violence as well as the fact that the signs of family violence are often not immediately evident means that a sophisticated understanding and professional judgement is required for an intervention to be effective. Although universal family violence screening in primary care is becoming more prevalent in policy globally, the effectiveness of routine universal screening is contested in the research literature. While screening has been shown to increase identification of family violence, there is no rigorous evidence that shows that routine screening reduces abuse, improves women's health and safety, or increases referrals.¹⁰ A meta-analysis of screening trials for family violence by O'Doherty et al.¹¹ found relatively low rates of identification, inconclusive evidence of increased referrals to support services and no evidence of improved outcomes for women screened for intimate partner violence. The study concludes that screening alone is not effective and suggests the need for further research on screening in combination with therapeutic interventions to assess the effect on women's long-term wellbeing. A trial on enhanced screening practice of Maternal and

⁹ Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., Lenahan, P. & Cronholm, P. (2014) Primary care-based interventions for intimate partner violence: A systematic review. *American Journal of Preventive Medicine*, 46(2), 188–194. <http://doi.org/10.1016/j.amepre.2013.10.001>

¹⁰ Kirst, M., Zhang, Y. J., Young, A., Marshall, A., O'Campo, P., & Ahmad, F. (2012). Referral to health and social services for intimate partner violence in health care settings: a realist scoping review. *Trauma, Violence & Abuse*, 13(4), 198–208.

<http://doi.org/10.1177/1524838012454942>; Reisenhofer, S., & Taft, A. (2013). Women's journey to safety - The Transtheoretical model in clinical practice when working with women experiencing Intimate Partner Violence: A scientific review and clinical guidance. *Patient Education and Counseling*, 93(3), 536–548. <http://doi.org/10.1016/j.pec.2013.08.004>

¹¹ O'Doherty, L, Taft, A Hegarty, K Ramsay, J Davidson, L & Feder, G. (2014) Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis *BMJ* Published online 2014 May 13. doi:10.1136/bmj.g2913

Child Health nurses (MCHN) in Victoria made similar findings, with no evidence of increased identification and referral rates, although improved safety planning was reported.¹²

The World Health Organisation clinical guidelines for responding to intimate partner violence¹³ and the Royal Australian College of General Practitioners¹⁴ currently recommend clinical case-finding based on clinical signs and symptoms in health care encounters. However, the UK National Institute for Health and Care Excellence recommends routine screening in specific settings: reproductive health, postnatal care, and children's health.¹⁵ This highlights the critical importance of training and professional judgement for healthcare and other universal service providers to recognise and respond appropriately to the indicators of family violence.

Effective responses to family violence

Two studies, the IRIS trial (UK)¹⁶ and the WEAVE trial (Aus.)¹⁷ tested interventions by general practitioners who received training in responses to women experiencing family violence. The IRIS trial evaluated a training and

A supportive organisational culture is an important factor in promoting effective interventions in family violence.

support program for general practitioners, focusing on identification, support and referral. An educator from a family violence specialist agency ran the training, provided advocacy for women referred by the doctors, and supported clinicians and administration staff. As part of the trial, a prompt to ask about family violence was added to the electronic medical record. This program had a significant impact. Doctors who received the training were found to be three times as likely to identify women experiencing family violence and seven times more likely to refer a woman to specialist family violence services compared to the control. The WEAVE trial investigated the effectiveness of brief counselling performed by general practitioners with women who had declined referrals to specialist services. General practitioners received eight hours of counselling training, including role-play. This study found no behavioural changes around safety planning and no improvements in quality of life of the women who received counselling.

¹² Taft, A., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011). Mothers' AdvocateS In the Community (MOSAIC)--non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomised trial in primary care. *BMC Public Health*, 11(1), 178. <http://doi.org/10.1186/1471-2458-11-178>

¹³ WHO (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, WHO, Geneva

¹⁴ RACGP (2014) Clinical Guidelines, Abuse and Violence: Working with our patients in general practice <http://www.racgp.org.au/your-practice/guidelines/whitebook/>

¹⁵ National Institute for Health and Care Excellence (NICE) (2014) Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse. NICE Public Health Guidance: 50 <https://www.lgcplus.com/Journals/2014/02/25/r/c/z/NICE-domestic-report.pdf>

¹⁶ Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths C., Gregory A., Howell A. Johnson M. Ramsay, J., Rutterford, C. & Sharp, D. (2011) Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomised controlled trial. *The Lancet*, 378(9805), 1788–1795. [http://doi.org/10.1016/S0140-6736\(11\)61179-3](http://doi.org/10.1016/S0140-6736(11)61179-3)

¹⁷ Hegarty, K, O'Doherty, LJ, Taft, A, Chondros, P, Brown, SJ, Valpied, JL, Astbury, JA, Taket, AR, Gold, L, Feder, GS & Gunn, JM (2013) 'Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial' *Lancet*, vol 382, no. 9888, pp. 249 - 258. DOI: 10.1016/S0140-6736 (13)60052-5

The role of specialist services

The evidence of the IRIS and WEAVE studies points to the significance of a close partnership with specialist family violence services and the clear definition of roles for professionals in effective early interventions in family violence. These factors are also identified as essential to effective intervention in evaluations of the MOVE trial with MCH nurses¹⁸ and the Respectful Relationships programs that are now part of the national curriculum. Evaluation of the initial Respectful Relationships initiative projects¹⁹ and the schools- based programs²⁰ found significant benefits for students in terms of their engagement with the content and delivery. Both studies identified the importance of established relationships between schools and local specialist support services to enable effective referrals and provide expertise. The Our Watch evaluation notes the need to develop a strong process for responding to disclosures of violence and safety risks of students and staff. It recommends that schools work with local family violence and sexual assault responses services to prepare for the potential increase in disclosures as the program rolls out.²¹

Organisational support

A supportive organisational culture is identified as an important factor in promoting effective interventions in family violence in a number of research studies. A systematic review of fifteen randomised controlled trials found that organisational change within healthcare systems and training healthcare professionals in family violence are the two most influential requirements to improve outcomes for women.²² The evaluation of the MOVE trial with MCH nurses found that organisational support was critical for new interventions to be effective,²³ as did the evaluations of the Respectful Relationships programs, which cited the organisational capacity of schools to train and support staff and students as central to program success.²⁴ In this context, organisational support includes a commitment to responding to family violence, and instituting policies, procedures and guidelines to support staff and mitigate the risks of vicarious trauma.

Community-led culturally sensitive interventions

The evaluations of two early intervention programs with Aboriginal and Torres Strait Islander women found positive outcomes, based on a focus on culture and community. The Aboriginal Women Against Violence Program (AMAVP) in South-West Sydney²⁵ and The Aboriginal Family Violence Prevention and Legal Service

¹⁸ Hooker, L., Small, R., Humphreys, C., Hegarty, K., & Taft, A. (2015) Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial. *Implementation Science : IS*, 10(1), 39. <http://doi.org/10.1186/s13012-015-0230-4>

¹⁹ Le Brocque, R., Kapelle, N. Meyer, S. & Haynes M. (2014) Respectful Relationships Evaluation Institute for Social Science Research, University of Queensland

https://www.dss.gov.au/sites/default/files/documents/01_2016/3-1-respectful-relationships-evaluation-summary-of-findings.pdf

²⁰ Gleeson et al.

²¹ Gleeson et al. p21

²² Feder et al.

²³ Hooker et al.

²⁴ Le Brocque et al. p17

²⁵ Rawsthorne, M. (2014) "Helping Ourselves , Helping Each Other ": Lessons from the Aboriginal Women against Violence Project. *Advances in Social Work and Welfare Education*, 16(1), 7–21.

Victoria's early intervention program, 'Sisters Day Out'²⁶ in Victoria use an informal community development approach to increase Aboriginal and Torres Strait Islander women's ability to identify and understand family violence and increase their knowledge of services and the law. The evaluations reported that a number of factors contributed to the success of both programs. These included: culturally appropriate and informal environments, flexibility in design and delivery, the positioning of the women as experts in their own experiences and the acknowledgement of the historical systemic violence and mistreatment experienced by Aboriginal and Torres Strait Islander people. Another strength of the two programs was the shift in the client-professional dynamic. By inviting non-Aboriginal service providers into the Aboriginal women's space, the women interacted on their own terms and the service providers improved their culturally appropriate practice. Positive outcomes are also evident in evaluations of other community-led intervention programs with Aboriginal women and their families, such as Bumps to Babes and Beyond, a two-year home visiting and parent education program for vulnerable Aboriginal and Torres Strait Islander mothers.²⁷

Training to build effective responses to family violence

The research does not provide evidence of the optimum training required by universal service providers to implement effective family violence interventions.

A number of studies find that despite training, clinicians do not feel confident to ask about family violence.^{28,29,30} The Respectful Relationship Education program evaluation notes the limited capacity of most teachers to handle disclosures and 'potentially embarrassing material' and pressure experienced by teachers when they are required to link students in with appropriate specialist support services.³¹ Similarly, evidence from the RCFV suggests the current training regimes in most sectors are sub-optimal. In Australia, training received by general practitioners in responding to family violence is varied. Most Australian medical students receive only two hours or less of family violence education.³² All Australian GPs currently have access to the Royal Australian College of General Practitioners' (RACGP) clinical guidelines, the White Book.³³ The guidelines provide clear recommendations on screening for and responding to disclosures of family violence. There is also a six-hour, non-compulsory online training program to aid discussions about family violence between GPs and their

²⁶ Karahasan, B. (2014) Evaluation report of the Aboriginal family violence prevention and legal service Victoria's early intervention and prevention program. <http://www.fvpls.org/images/files/Evaluation%20report%20EIPP%20Document%20REV%20WEB.pdf>

²⁷ Burrows, A., Allen, B., & Gorton, S. (2014) Evaluation of the Bumps to Babes and Beyond program. Queen Elizabeth Centre and Mallee District Aboriginal Services, Victoria
http://www.qec.org.au/sites/default/files/news_pdf/Evaluation%20of%20the%20Bumps%20to%20Babes%20and%20Beyond%20Program.pdf

²⁸ Taft, A., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011) Mothers' Advocates In the Community (MOSAIC)—non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomised trial in primary care. *BMC Public Health*, 11(1), 178. <http://doi.org/10.1186/1471-2458-11-178>

²⁹ Sundborg, N., Saleh-Stattin, Wandell, P., & Tornkvist, L. (2012) Nurses' preparedness to care for women exposed to intimate partner violence: a quantitative study in primary health care. *BMC Nursing*, Vol, 11 article 1.

³⁰ Yeung et al

³¹ Gleeson et al

³² Valpied, J., Aprico, K., Clewett, J., & Hegarty, K. (2015). Are Future Doctors Taught to Respond to Intimate Partner Violence? A Study of Australian Medical Schools, 1–14. <http://doi.org/10.1177/0886260515592616>

³³ RACGP (2014) Clinical Guidelines, Abuse and Violence: Working with our patients in general practice <http://www.racgp.org.au/your-practice/guidelines/whitebook/>

patients.³⁴ Funding has also been provided to the RACGP to develop and deliver additional family violence training to general practitioners.

Lifeline provides nationwide training for health professionals and other frontline workers through the Commonwealth funded DV-Alert program, which supports workers to better respond to and refer people experiencing family violence. The National Sexual Assault, Domestic and Family Violence Counselling Service (1800 RESPECT) has an online toolkit for frontline workers to help them better recognise and respond to sexual assault and family violence, along with organisational resources on family violence information and policies. Evidence presented to the RCFV suggests that health practitioners are generally unaware of these resources.³⁵

Conclusions

From this brief review of evidence, the key components to effective family violence interventions by universal service providers include:

Effective response:

- Based on a sound understanding of the complex nature and dynamics of family violence
- Responses that are confidential, non-judgemental, supportive and allow the woman to disclose at her own pace, with a focus on empowerment and self-sufficiency.
- An ability to recognise indicators of family violence and respond appropriately (case-finding rather than universal screening). This requires training to inform professional judgement and practice.
- An established relationship with specialist family violence services for support and stronger referral pathways
- Interventions with Aboriginal and Torres Strait Islander people that are community-based and community-led
- Aboriginal and Torres Strait Islander people should always be offered the option of referral to an Aboriginal community-controlled service.

Professional practice development:

- Family violence training for practitioners in universal services provided by specialists
- Understanding of the family violence system
- Practice policies, guidelines and protocols
- Access to family violence resources
- Organisational commitment to responding to family violence, including staff support structures
- Continuous professional development in family violence interventions.

³⁴ State of Victoria, Royal Commission into Family Violence: Report and Recommendations, Vol 4 Parl Paper No 132 (2014-16) p8

³⁵ RCFV Vol 4:42

Part Two: Policy context

This section sets out the contemporary policy context for early intervention in family violence in Victoria. The RCFV's report highlights the need for a broader engagement in family violence across diverse sectors, and makes broad recommendations for a stronger, integrated and systematic approach to developing workforce capability in early intervention. However as the limited research evidence shows, early intervention in family violence is not a straightforward or simple process. The definitional issues are set out first to provide a framework for the findings of the RCFV. It also discusses revision and implementation of the Family Violence Risk Assessment and Risk Management Framework (or Common Risk Assessment Framework (CRAF)) that will be the foundation for the expansion of early intervention in family violence by universal and specialist family violence services.

Defining early intervention in family violence – a shared understanding

A clear, shared definition of early intervention in family violence is critical to ensure that the roles and responsibilities of all services are well delineated and articulated. It is the complex multi-layered nature and dynamics of family violence and its non-linear processes that makes defining early intervention a contested concept. Family violence does not readily conform to the public health model of intervention;³⁶ in which a therapeutic intervention at the preliminary signs of an illness or in a child's development can change or stop its trajectory to a serious or permanent condition.

Family violence is embedded in a complex interplay of individual, cultural and social factors. The cause of the violence, or the pathogen, is the perpetrator who is external the victim who is seeking support. The complex trajectory of family violence does not take a linear course. Women living with family violence may not seek help until their situation reaches crisis point; they may never seek help; they may leave and return to a violent partner multiple times; and they may not recognise or acknowledge that their experience is family violence.

For family violence practitioners, early intervention incorporates a range of approaches, reflecting the non-linear and particular dynamics of family violence. Work with children is early intervention. Supporting children and young people to overcome the immediate and long-term psychological, emotional and physical impact of family violence also reduces the risk of intergenerational transfer of abusive behaviours and values in adulthood. It is more complex to define early interventions in work with adults. For some practitioners, early intervention is the first contact with a woman, whenever it occurs in her experience of family violence. This includes providing information about family violence in response to an inquiry, appropriate response and referral following a disclosure to a GP, or when a family violence service contacts a woman in relation to an L17 issued from a police incident report. For some family violence practitioners, each time a woman seeks help is

³⁶ for example, Freiden T. (2010) A Framework for Public Health Action: The Health Impact Pyramid *American Journal of Public Health* April Vol 100, No. 4 590-5; <https://aifs.gov.au/cfca/publications/defining-public-health-model-child-welfare-services-context>

potentially early intervention, as every contact is an opportunity to prevent the further escalation of violence. This means that the first contact with a woman in crisis accommodation can be an early intervention, although most consider that once a woman has sought crisis accommodation, her situation has escalated beyond the scope of early intervention. In summary, a specialist family violence perspective of early intervention takes into consideration three key elements: the level of risk (not high); the life course (intervening as early as possible in the child's life) and the first contact (planting the seed).

The universal services and organisations interviewed for this project had an unproblematic understanding of early intervention in family violence locating it within a public health model. For them early intervention means targeting those at risk to prevent the problem escalating into a crisis requiring tertiary intervention. To play an effective and safe role in early intervention, universal service providers need to understand these complex dynamics of family violence.

The definition for early intervention in family violence adopted in this project seeks to synthesise these approaches. This definition sets out on the purpose and function of early intervention and provides a foundation for an early intervention practice framework applicable for both specialist family violence services and universal service providers:

Identification and support for individuals and families experiencing family violence with the aim of stopping early signs of violence escalating, preventing a recurrence of violence or reducing longer-term harm.³⁷

'Identification and support' articulate the two principal elements of early intervention for both specialist family violence practitioners and universal service providers: the ability to recognise the signs of family violence; and 'support' points to their specific roles and responsibilities once family violence has been identified.

For universal services, the practice of 'identification' requires the ability to recognise the signs of family violence, to do a preliminary risk assessment through a conversation using sensitive non-judgemental questions and responses; and to 'support' through discussing protective factors with the woman, and providing access to relevant information and referral options.

For specialist family violence practitioners, 'identification' includes a comprehensive on-going risk assessment with the woman, and 'support' encompasses the range of specialist practice such as managing risk, safety planning and case management whether the woman chooses to leave a violent partner or remain in the relationship. They also support her by providing advocacy through the family violence system. 'Support' also

³⁷ Draws on models in Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth (2015) *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, Our Watch, Melbourne and Morris, A. 2015, Safety and resiliency at home: voices of children from a primary care population, unpublished PhD thesis, University of Melbourne.

incorporates the targeted early intervention programs run by some specialist family violence services, and providing secondary consultation advice to other services.

By addressing the need to mitigate ‘longer term harm’, the definition encompasses the impact of family violence on children and the need to work directly with children and young people as victims in their own right.

The Victorian Royal Commission into Family Violence: Creating the policy context

One of terms of reference for the RCFV was to ‘improve early intervention so as to identify and protect those at risk of family violence and prevent the escalation of family violence’, and consequently early intervention in family violence, particularly the role of universal services, is a major theme of the RCFV report. The RCFV report lays the groundwork for a statewide approach to early intervention in family violence. Its findings create the context for building a consistent and systematic early intervention response.

In identifying the role of universal services in early intervention, the RCFV focuses primarily on health, (including community health staff, GPs, hospital staff, ambulance and paramedics, maternal and child health nurses, midwives and dentists) and education services, specifically early childhood services and schools. It also acknowledges the need to build capacity in family services, housing, employment, mental health and drug and alcohol services to identify family violence and respond appropriately. In particular the RCFV emphasises the “importance of building the capacity of universal services to deliver family violence services in order to facilitate an effective, locally based response.”³⁸ The RCFV also draws attention to the creative and effective early intervention programs currently implemented by and for the Aboriginal community, as well as those working with refugee and immigrant communities. However, the RCFV found that existing early intervention programs are ‘piecemeal and often left to small community organisations to develop and implement’³⁹.

The RCFV report highlights the lack of a consistent, systematic approach to identifying and responding to family violence across universal services. It notes that there is a lack of understanding of the prevalence, nature and impact of family violence on children and adults, and that, particularly in the early childhood sector, there is generally ‘silence’ in relation to family violence. Where early childhood worker training about family violence does occur it is in the context of mandatory child protection training. The RCFV notes the sector’s strong connections with the child protection system are not replicated with the specialist family violence sector⁴⁰. Similarly, the RCFV found that teachers received online training on mandatory reporting to child protection but were not currently trained to identify family violence and respond appropriately to disclosures, despite the likely increase in disclosures as Respectful Relationships programs are rolled out across the schools system. As discussed later in this report, these established relationships and reporting pathways with child protection services can result in unintended consequences from services’ responses to family violence.

³⁸ RCFV Vol 6 p231

³⁹ RCFV Summary and recommendations p11

⁴⁰ RCFV Vol 2, p131-2

The RCFV notes some promising practice in family violence interventions in the health sector, particularly in hospitals and community health settings and suggests this work could provide a basis for more widespread programs. However, it also identifies concerns about practice inconsistency across the health sector. For example, the report discusses the critical role of Maternal and Child Health (MCH) nurses in the early identification of family violence through their mandatory post-natal screening process. It finds that the effectiveness of this work would be greatly enhanced with ongoing training and more professional support to address the vicarious trauma of family violence work.⁴¹ This is important, given that MCH nurses are often cited as an exemplar of early intervention since the introduction of mandatory screening in 2009 and staff training in the use of the family violence Common Risk Assessment Framework (CRAF). The findings of this project mirror the concerns raised in submissions to the RCFV, highlighting the need for continuous evaluation and training, and a more sophisticated approach to universal service providers' early interventions in family violence.

Family violence training and skill development

Family violence is noticeably lacking in the core curriculum of key professional groups. The RCFV identifies the needs to build family violence skills in undergraduate training for general practitioners, psychologist and psychiatrists. It also notes the need to strengthen skills in family violence in the curriculum for new social work graduates, as well as standardising social work qualifications across the specialist family violence sector. It makes three specific recommendations to address this. The deficits in training for general practitioners, in particular is discussed later in this report.

In general, this project's findings strongly support the need for specific training in family violence, and continuous professional development in family violence for early intervention responses to be effective. Interviews with key professional groups for this project found they acknowledge the need to enhance family violence expertise into their professional training. The Australian Association of Social Workers (AASW) has commenced work with their members to build family violence into the core curriculum and establish credentialing for family violence training and skills.

A clear, shared definition of early intervention in family violence is critical to ensure that the roles and responsibilities of all services are well delineated and articulated.

⁴¹ RCFV Vol 3, p17

The RCFV recommends:

Recommendation 103

The Victorian Government, through its membership of the Australian Health Workforce Ministerial Council, encourage the Ministerial Council to approve standards that facilitate a mandatory requirement that general practitioners complete family violence training as part of their continuing professional development [within 12 months].

Recommendation 102

The Chief Psychiatrist—in consultation with the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Psychiatrists and psychologists’ peak bodies—coordinate the development of a family violence learning agenda [within two years] that includes:

- *undergraduate and graduate training in relation to family violence*
- *continuing professional development in relation to family violence*
- *guidance on responses to people with mental illness who have also suffered family violence.*

Recommendation 108

The Australian Association of Social Workers amend the Australian Social Work Education and Accreditation Standards to require that a ‘working with family violence’ subject be required as a component of the core curriculum in all social work undergraduate degrees [within two years].

Since 1991 the Domestic Violence Resource Centre Victoria (DVRCV) has been the major provider of family violence training in Victoria, and following the introduction of the CRAF in 2007, DVRCV has provided CRAF training for over 20,000 people across a range of services and organisations.⁴² Family violence training is also provided by other specialist organisations, including No to Violence, which delivers training on working with men who are perpetrators. In their submission to the RCFV, DVRCV makes the case for family violence educators, with a comprehensive understanding of the complex nature and dynamics of family violence, to provide appropriate training. It also notes that the organisation is overwhelmed by demand for specialist training. This highlights the critical need for investment and capacity building to develop a workforce of specialist training providers to meet the requirements of the Industry Plan.

The Family Violence Industry Plan

To address the wide-ranging recommendations for building workforce capacity to respond to family violence, the RCFV recommends a 10-year Industry Plan. The Industry Taskforce, with broad cross- sectoral representation, was convened in October 2016 to undertake this work.

⁴² DVRCV (2015) Submission to the Victorian Royal Commission into Family Violence <http://www.rcfv.com.au/getattachment/903B778A-B83A-47A5-8F6F-699C966B7E55/Domestic-Violence-Resource-Centre-Victoria>

Recommendation 207

The Victorian Government develop or commission the development of a 10-year industry plan for family violence prevention and response in Victoria, to be delivered by 31 December 2017, with commensurate funding for workforce transition and enhancement to begin from that date. The plan should cover:

- *the workforce requirements of all government and non-government agencies and services that have or will have responsibility for preventing or responding to family violence—among them specialist family violence services, perpetrator interventions, police, legal and justice services, and universal and secondary service systems*
- *remuneration, capability and qualifications, workforce diversity, professional development needs, career development and workforce health.*

The RCFV's key points and recommendations to build family violence capability in universal and specialist family violence services will guide the work of the Industry Taskforce. These can be summarised as:

A comprehensive, co-ordinated approach

- Early interventions in family violence should be prioritised with a cohesive coordinated approach across diverse disciplines. This requires a significant increase in capability across various service systems so they are better able to identify family violence risk and respond accordingly.
- This comprehensive workforce development and intersectoral learning requires embedded systems change, supported by policy and funding commitment. A unit in government could oversee the delivery of family violence education across departments, agencies and funded community service organisations similar to NSW Education Centre Against Violence.

The role of specialist family violence expertise in training and capacity building

- This coordinated, consistent approach should be informed by a strong understanding of the dynamics of family violence and its multi-dimensional nature, including the need for specialist support across services.
- Specialist family violence expertise is essential in the extensive training across workforces. The RCFV specifically recommends that specialist family violence expertise and the Domestic Violence Resource Centre Victoria (DVRCV) should be used in the delivery of training,⁴³
- Family violence principal practitioner roles to be established in major service delivery departments: the Department of Health and Human Services, Department of Justice and Regulation and the Department of Education and Training; and specialist family violence advisors to be established in major mental health and alcohol and drug services.
- The Support and Safety Hubs (to be established by July 2018) to employ an advanced family violence practitioner with responsibility to provide secondary consultations to universal services.

⁴³ RCFV Vol 6, p208

Funding commitments to support these broad-based reforms

- Greater investment in “prevention, early intervention and recovery could in the long term reduce costs borne by individuals, as well as future budgetary costs – including costs associated with children’s experience of family violence.”⁴⁴ It notes that funding for early intervention currently accounts for 6 per cent of the \$80.6 million spent on specialist family violence services by the Victorian Government in 2014-15, stating it would be even less if spending on police and courts were included.⁴⁵

The Victorian Family Violence Risk Assessment and Risk Management Framework (CRAF) review, revision and implementation

The Family Violence Risk Assessment and Risk Management Framework was introduced in Victoria in 2007. Commonly referred to as the common risk assessment framework (CRAF), it was intended to build shared understanding of risk and family violence, primarily intimate partner violence, across the range of service providers in contact with family violence. Specifically, the CRAF was intended to enable service providers to “identify family violence; provide helpful, supportive and timely responses to victims; and contribute to holding perpetrators accountable for their actions.”⁴⁶ The design of the CRAF provides a tiered approach to family violence responses across different sectors. As the recent review found, while useful the original practice guides do not provide enough clarity of roles or details for practice.

The three CRAF Practice Guides are currently designed for use by different sectors:

Practice Guide 1 is a guide to identifying family violence for use by professionals in universal service settings such as health, education and drug and alcohol services.

Practice Guide 2 is based on a preliminary risk assessment for use by professionals, for whom family violence is a part of their broader work, such as police, courts, corrections and child protection.

Practice Guide 3 provides a comprehensive risk assessment for specialist family violence services.

The RCFV finds that the CRAF provides a strong foundation to build shared understandings of family violence across sectors and their various roles and responsibilities in responding to it. However, it makes specific content recommendations for the revised CRAF to include a rating of risk factors, risk indicators for children, a comprehensive practice guide and capacity to respond to the needs of diverse communities. Importantly, it also recommends the legislated use of the revised by prescribed agencies, such as police, child protection, community and health services and child and family services, to ensure consistent practice and a workforce development and training strategy to be included in the Industry Plan. The CRAF has recently been reviewed and will be redeveloped for use by 31 December 2017.

⁴⁴ RCFV Vol 6 p243

⁴⁵ RCFV Vol 6 p232

⁴⁶ Department of Health Services (2012) Family Violence: Risk Assessment and Risk Management Framework and Practice Guides 1-3. Victorian Government, Department of Human Services: Melbourne

Recommendation 2

The Victorian Government amends the Family Violence Protection Act 2008 (Vic) [within 12 months] so that it:

- *empowers the relevant minister or secretary to approve a Family Violence Risk Assessment and Risk Management Framework (and roles and responsibilities, standards and practices under it) for family violence risk assessment in Victoria*
- *sets out that ‘prescribed organisations’ and agencies contracted by the Victorian Government to provide family violence services (if not otherwise prescribed organisations) are required to align their risk assessment policies, procedures, practices and tools with the Family Violence Risk Assessment and Risk Management Framework as approved by the relevant minister or secretary*

The RCFV makes a recommendation for a sustained workforce development strategy as part of the Family Violence Industry Plan. This will be central to consistent, standardised training for universal service providers, as well as best practice guidelines and operational protocols in delivering early interventions in family violence.

Recommendation 3

The Victorian Government implement the revised Family Violence Risk Assessment and Risk Management Framework and develop a sustained workforce development and training strategy as part of the recommended family violence industry plan [from 1 January 2018]. The framework should provide for:

- *minimum standards and core competencies to guide identifying, risk assessment and risk management practice in family violence specialist services, mainstream and universal services*
- *whole-of-workforce training for priority sectors—including general practitioners and hospital, mental health, drug and alcohol, child protection, aged care and disability workers—that takes into account and aligns with their roles and standards of practice.*

The CRAF review makes a series of recommendations to strengthen its use and effectiveness as the best practice guide to responding to family violence.⁴⁷ The revised CRAF will provide the foundation for an early intervention policy and practice framework. Several of the 27 recommendations in the CRAF review are particularly pertinent to this project; in particular those that focus on strengthening practice in universal settings.

⁴⁷ McCulloch J, Maher J, Fitz-Gibbon K, Segrave M, & Roffee J, (2016) Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF) Prepared for the Department of Human and Health Services by the School of Social Science, Focus on Gender and Family Violence: New Frameworks in Prevention, Monash University

Key recommendations from the CRAF review:

- Clarify the type of family violence risk that is being assessed and risk categorisation (Rec 3)
- Ensure the CRAF can be used in a variety of settings while maintaining a common approach to risk, including health and education settings (Rec 6 and 8)
- Establish a central register of all CRAF aligned tools (Rec 6)
- Review three levels of training to ensure each is aligned with the needs of targeted professional groups (Rec 14)
- Provide comprehensive practice guidance, including referral pathways, information sharing protocols and prompts for interagency collaboration and safety planning (Rec 15)
- Mechanisms for the continuous monitoring and oversight of CRAF training (Rec 17)
- Development of CRAF training and protocols to respond to the risks of children living with family violence (Rec 19)
- Better responses to risks and needs of diverse communities experiencing family violence (Rec 20)
- Work with Aboriginal communities to build on the draft Aboriginal CRAF (Rec 21)
- Include specific questions and risk factors for people with disability (Rec 22)
- Include specific questions and risk factors for CALD women, underpinned by specific training across services (Rec 23)
- Modify the CRAF to enhance family violence risk assessment and responses for older people (Rec 24) and LGBTIQ people (Rec 25).

Part Three: Women who have experienced family violence

The safety and wellbeing of women and children affected by family violence is the first priority of all interventions and responses to family violence. For service providers to engage with early intervention work, it is essential, as the RCFV notes, that they understand the nature and dynamics of family violence and its multi-dimensional characteristics.⁴⁸ The most powerful way to capture this, and the potential for effective early interventions, is through the experiences of women and children who have lived with family violence.

The project held two focus groups with sixteen women, one regional and one metropolitan based. Their experiences and insights illustrate the complexity of family violence and the skills required for effective interventions. Three key themes emerged from the discussions:

1. the reasons women do not disclose family violence even when opportunities arise
2. the first response must be the right one and
3. the characteristics of an effective intervention.

Reasons for not disclosing family violence

Shame, isolation and silence prevent women from disclosing their experience of family violence and seeking help. Women living with family violence characteristically feel ashamed and guilty.⁴⁹ The nature and dynamics of power and coercive control means that women are likely to blame themselves for the abuse and lose their confidence and self-worth as they internalise the perpetrator's view that they are the cause of the violence. Fear that her disclosure will receive a negative response from the service provider or cause the violence to escalate were two main reasons for not disclosing cited by women in the focus groups. However, the participants identified a range of reasons for their reluctance to disclose family violence:

“Because you're too scared of them judging you as a bad mother.”

“But I don't think I could have gone to the maternal and child health nurse. I would have been too scared of them judging my parenting.”

“They're not always prepared to hear it. I mean if you're there for another reason.”

“Because you're so confused you don't know what to tell them anyway.”

⁴⁸ RCFV Vol 5 p206

⁴⁹ For example, Beck JG, McNiff J, Clapp JD, Olsen SA, Avery ML, Hagewood JH. (2011) Exploring negative emotion in women experiencing intimate partner violence: shame, guilt, and PTSD. *Behavioural Therapy* Dec, 42(4): 740-50

“[I think] You don’t want to hear me sit and go on about my hard luck story. I’m sure you’ve got better things to do.”

“You do, you think, well I’m not important enough to even talk about what is happening to me.”

“For me, I just wasn’t willing to admit what was really happening.”

Sally’s response sums up the range of emotions and fears many women feel about talking about family violence:

“I remember I was pretty discreet because I was embarrassed, which is a funny thing. It’s just funny. You know it’s not your fault you’re getting hit. You do get scared to speak out because you don’t know what sort of support you’re going to get... You’re scared, you’re frightened and you don’t know what’s going to happen to you. I didn’t know what the process was going to be like.” (Sally, mother of a toddler).

It is common for women not to recognise or acknowledge what they are experiencing as family violence. This is particularly the case if the abuse is not physical, even if threats or irregular incidents of physical violence occur. Amanda lived with a highly manipulative and controlling perpetrator who was not physically violent, for seven years. Her statement illustrates the complexity of effectively working with women in this situation.

“We’d been in [relationship] counselling and I went on my own one day and the lady said to me ‘You need to go into a shelter with your girls’. I just couldn’t accept that. I wasn’t in that headspace. I’m like, I’m not one of those women. It was left at that. She never pursued it. It was just left at that. I really wish she’d got me by the shoulders and gone ‘No, you’re going and I’m going to get you started.’

I’d let doctors know little bits about his controlling behaviours, how I was feeling. A few of them did say ‘You can ring people’, but I wasn’t at that space where I could do anything with it. So it was me, it was – I really needed someone to actually take my hand and say ‘I’ll walk you through it’. It didn’t happen. I wasn’t at that space where I could think for myself.” (Amanda, two daughters)

Amanda left her partner and accessed specialist support after talking to another mother at her daughters’ pre-school, who happened to work in family violence. Amanda describes the process of effective early intervention:

“One of the ladies at school recognised what I was going through. She started talking to me. Without me realising what she was doing, she got me to open up. She’s the one who got me the help I needed and gave me the courage to take that step to ring someone and say ‘I’m in an abusive relationship. I’m really scared. What should I do?’” (Amanda, two daughters)

Culture and religion are also identified as barriers to disclosure, reinforced by limited language skills and the social isolation as a refugee in a new country. As Abyan, a Somali refugee, describes through an interpreter:

“Culture and religion normally tells you, like your experience, you keep it to yourself. I kept it to myself; I didn’t speak about it... I was asked privately through an interpreter three times if I am having issues at home and if he is hitting me. Even though I was admitted at Royal Women’s I still didn’t speak about it. I said ‘No, it wasn’t him’. Even though the bruises were on my body I would kind of say that I fell down the stairs or tripped in the bathroom or something similar to that. I would hide and say ‘Look, he wasn’t even around. He was at work. Check that time. This happened at that time. He was at work’.

(Abyan, Somali background, six children)

Abyan described an experience that is common experience for women in her situation, of her ex-partner using her cultural isolation as newly arrived refugee as tactic of abuse.

“He used to say he can prove I am a criminal in Australia. Like I have done things even though I haven’t done anything wrong. He said he had evidence that I’ve done some things wrong. They will lock me up in an underground jail and I will never come out and he will be rewarded because he is the hero who saved the situation.

He lied about even the visa. That I came to the country he said that visa is not valid anymore and it got cancelled and therefore I have no rights in Australia. Even though I could speak to the police and everything I still believed that he was more powerful than anybody else. I felt like he was in charge of everything and he was more powerful than the police of Australia itself.”

Eventually, Abyan disclosed her situation to the Maternal and Child Health nurse at the local council when she took her children for their vaccinations and was referred to specialist family violence crisis services.

The first response must be the right one

The women in the focus group described a variety of examples in which the professional or service provider to whom they disclosed responded by minimising or blaming them for the violence. This included a psychologist telling Jennifer, “*You need to not egg him on*”; and a police officer advising Eleanor, “*it’s probably best if you leave and let him calm down*”. Natasha, living in a small regional town, told how the police and GP focused on her drug use, ignoring her reports of family violence. These types of responses reinforce the abusive narrative of the perpetrators, that no one will believe her. They left the women feeling guilty and further isolated. As Tina explains of her initial attempts to get help:

“It was swept under the rug so I didn’t know what I was doing. So I just thought it was me over-reacting and that it was normal.”(Tina, three children)

A number of women in the focus groups reported that their first disclosure had resulted in a report to Child Protection. As a result, they were reluctant to disclose again to anyone for fear of losing their children. The threat of involving Child Protection was subsequently repeatedly used by the perpetrators. As Sada describes, this as well as her lack of family and social connections, caused her to stay with a violent perpetrator for many years:

“I never spoke to anybody other than police about it but the police were no help. They did however - their protocol is to ring DHS and report that there’s family violence which stopped me from phoning the police because I felt DHS should not be involved when I wasn’t a cause. I was doing everything right by my children. He was the problem. He wasn’t doing right by me or the children but yeah, I was the one questioned by DHS. The report was made about me. That stopped me from ringing the police. That stopped me from seeking help and I stayed in that relationship for 21 years. I have no family systems. I had nowhere else to go.” (Sada, Iranian background, three children)

Fear of a report to Child Protection is a powerful and commonly reported disincentive for women to disclose family violence. In Sada’s case, the children, while exposed were not directly subjected to the violence. Her fear of losing her children resulted in increased risks to both her and her children, as they received no support services and remained living with a very violent man. This problematic interaction between family violence and child protection services has been well documented,⁵⁰ including by the RCFV.⁵¹ A number of initiatives are currently underway in Victoria to address it. This issue will have to be addressed in the early intervention

⁵⁰ For example, Humphreys C, Thiara, RK, and Skamballis A (2010) Readiness to Change: Mother–Child Relationship and Domestic Violence Intervention *British Journal of Social Work* 1–19; Humphreys, C 2015 Witness Statement to the RCFV http://www.rcfv.com.au/MediaLibraries/RCFamilyViolence/Statements/WIT-0006-001-0001_1.pdf;

⁵¹ RCFV Vol 2 Ch 11.

framework and training, so that universal service providers understand these complexities and their impact on women and children experiencing family violence.

Characteristics of an effective early intervention

The focus group participants reported examples where a simple intervention was the catalyst for change. The lack of money and financial dependence, and ‘having nowhere to go’ are powerful disincentives to leaving a violent partner, particularly when children are involved.

Jennifer, a mother of four children spoke of her experience of leaving and returning to a violent partner numerous times over many years, staying because *“at least my kids have a home and he’s paying the rent.”*

Jennifer describes the intervention that worked for her:

“So when I found out that there was that sort of support - in the beginning I didn't know that there was anything available for women. I found that out through one of the nurses at the hospital who had asked me. She must have - I was very emotional and she just asked me, she said ‘Are you okay? Is this what's happening?’ I couldn't even say yes but I think she could tell. She gave me Berry Street's number and she said ‘Go give them a call if you want to’.” (Jennifer, four children)

Despite a long history of family violence and interactions with many services, Jennifer had never been given information about the specialist support available. This example illustrates three key elements of an effective early intervention: an ability to identify and ask about family violence; knowledge of and information about local specialist family violence support services and the practice of warm referral.

The women in the focus groups identified the importance of ‘being ready to leave’ and knowing what support is available to be the critical factors in effective interventions.

“I can't keep loving him because it's not going to get better. Unless you're at that point in your life I don't think anybody can really help you.” (Abyan, six children)

“You have to be ready... but at the same time I felt like there wasn't enough support out there. For me it was financial. I have so many kids. How am I going to rent if I'm a single parent paying rent. It wasn't until I went into Berry Street that I knew that there was that sort of support out there. That gave me a bit more courage to leave...” (Eleanor, six children)

The effective intervention occurred for Eleanor who left her violent partner after twenty years, when she spoke with the family violence worker at Centrelink. As she says,

“It’s a very financial thing too because you have to think of your children. I had no family. I had no assistance and nobody to talk to until I had the [police] officer send me to Centrelink and I spoke to the Berry Street worker at Centrelink. It was full steam ahead from there. If I didn’t have that advice from that officer to go visit Centrelink, to get me on the right path, I’d still be there.”

This example points to two important elements for an effective intervention: the police officer being able to have the conversation with Eleanor that gave her the knowledge and confidence to go to Centrelink for financial help, and importantly, the specialist family violence worker co-located there was able to provide the specialist support she needed. Eleanor has since qualified as a pastry chef, supports herself and her children in a life free from violence.

For other women, a responsive workplace provided the opportunity for an effective intervention. The supportive behaviour of her workplace enabled Sally to leave her extremely violent partner. Encouraged by her work friend, Sally disclosed to staff member working in HR.

“Surprisingly enough they were extremely supportive. I don’t get paid if I don’t work. They paid me to time off work which was a huge support for me because I was a contractor. They said to me that we will help you to legally break your lease to help you move premises, so that was a huge support for me.

My boss would ring me at 10 o’clock at night and say to me ‘Do you need anything? Are you OK?’ So when I had that support from work that was early intervention for me to help me get out of the situation I was in.”(Sally, a toddler)

Sally’s experience highlights the importance of the workplace in identifying and responding to family violence. While not all workplaces may be in a position to respond as supportively as this one, this case highlights the need for family violence leave as a workplace entitlement, and the value of the organisational training accompanying it to raise awareness of family violence in the workplace.

A number of women in the focus groups described experiences in which a positive response from a service provider is undermined by a lack of understanding of appropriate referral pathways.

Katie’s experience illustrates how intervention opportunities are missed in this process. Trapped in a relationship with a violent man, Katie cut herself in desperation.

“It was actually an ambulance driver that came in and spoke to me, and he was fantastic. Because at first I said I cut myself on glass. The ambulance driver came in and he said ‘You did that - that's not an accident’. He asked what had happened and I went through it with him. He was really, really great. He had given me numbers that I should call and stuff. He spoke to the nurses and said she needs to see the CAT team. The CAT team rang me the next day at home while I was there with him, so I couldn't talk about anything. Yeah, there was no follow up whatsoever.” (Katie)

Katie’s experience highlights three recurring themes: the common diagnosis of mental illness for women living with family violence, without consideration of the underlying cause of psychological distress; the need for family violence training and practice guidelines across the health sector and the need for clear referral pathways to specialist family violence services.

In this account, the ambulance officer intervened effectively by engaging in a conversation that allowed Katie to disclose her experience of family violence and providing her with information about support services. However, his decision to focus on the self-harm incident rather than the family violence meant that Katie was contacted by mental health services instead of a specialist family violence service. With a better understanding of the nature and dynamics of family violence, and clear practice and referral guidelines, both the ambulance officer and the mental health workers could have provided a better outcome for Katie.

The focus group discussions provide a snapshot of the complex nature of family violence. They highlight a number of important lessons for professionals practising early intervention in family violence, including the importance of understanding how its nature and dynamics influence the actions and responses of women and children living with it.

The women who took part in the focus groups described the range of barriers they faced in disclosing their situation, including feelings of shame, guilt, love, fear of violence, fear of losing their children, fear of authorities, lack of money, lack of knowledge of support services and options. They illustrate the importance of the service provider’s first response to disclosure, in particular the validation of their experience, and the need for a skilled response to the signs of family violence. A positive, informed response allows the woman to open up through conversation; it gives her agency to make decisions about her situation and establishes a trusted contact when she is ready to leave. An uninformed, judgemental or ineffective response reinforced a woman’s sense of isolation and hopelessness about her situation. At worst, a poor response will result in the woman and children remaining with a violent partner for years, increasing the risks to her and her children.

Part Four: Specialist family violence service responses

The safety and wellbeing of women and children affected by family violence is the first priority of all interventions and responses to family violence.

While the RCFV report places great emphasis on the role universal services in early intervention in family violence, it stresses that this work must be based on a specialist informed understanding of family violence. The systemic reforms recommended by the RCFV have significant implications for both specialist family violence services and universal services in terms of service delivery, workforce, practice and resourcing. Notably, the RCFV also makes the point that currently less than 6 per cent of the \$80.6 million of government spending on family violence in 2014-15, is allocated to early interventions, equating to just \$4.8 million.⁵² The project findings discussed in this section investigate some of the broad implications for these services. They illustrate the multiple ways that specialist family violence practitioners engage in early interventions.

The project investigated current approaches in early intervention by specialist family violence services, including existing programs and relationships with universal services. It sought the views of specialist services on the potential for early interventions in a reformed family violence system. Data was collected through in-depth semi-structured interviews with 20 specialist family violence and women's services (including 5 regional services) and in a short survey of DV Vic member agencies, completed by 30 (37.5 per cent).

Specialist family violence practice

The research evidence and the RCFV report conclude that specialist family violence practice and its 'strong understanding of the nature and dynamics of family violence' should underpin early intervention work. DV Vic' submission to the RCFV sets out in detail the elements of specialist violence practice.⁵³ In summary, it can be described as the use of a consistent, articulated practice framework in relation to women and children that combines:

- **A gendered lens:** an evidence based approach that understands women are overwhelmingly the victims of family violence perpetrated by a male partner; power and control are the drivers of family violence, and this power is exercised in the form of coercive control as well as overt physical violence; and these behaviours are embedded in a complex web of individual, social, cultural and economic factors
- **Trauma-informed practice:** This is a strengths-based approach to understanding and responding to the impact of trauma on women and children. The need for physical, psychological and emotional safety of women and children is prioritised along with their need to establish a sense of control in their lives. It

⁵² RCFV Vol 6, p232

⁵³ DV Vic (2015) Specialist Family Violence Services: The Heart of an Effective System, Submission to the Victorian Royal Commission into Family Violence <http://www.rcfv.com.au/getattachment/C7B3D161-D430-4305-BAD6-BF02095D02E5/Domestic-Violence-Victoria---02>

provides a safe environment, prioritises the woman's agency, and supports women and children to understand why they behave in particular ways, so that they are not blamed or pathologised for the ways they manage traumatic stress.

- **Attachment theory:** practice that supports women to rebuild and repair secure attachment relationships with their infants and children that have been damaged by family violence.⁵⁴

The role of specialist family violence services in early intervention

As described previously, specialist family violence services define and engage in early intervention work in a number of ways. Their practice can be considered to be early intervention based on three main factors that often overlap: the level of risk (lower risk, working with women before they self-identify family violence); the life course (working with children and young people) and the first contact (planting the seed). Specialist family violence practitioners also see their role in raising community awareness and building capacity across the community to respond to family violence, as early intervention.

First contact

Most specialist family violence services (75 per cent of survey respondents) provide early intervention through community awareness and information sharing that includes speaking about family violence in a variety of general and professional forums, and schools. A number of services work with their local schools, running targeted early intervention programs (such as the Solving the Jigsaw program conducted by the Centre for Non-Violence in Bendigo) and other programs to meet the needs of the school community. These programs provide an important vehicle for partnerships between schools and specialist family violence services to strengthen referral pathways. They also generate disclosures and opportunities for early interventions with individual students and staff members.

The specialist family violence service's first contact with a woman is an important opportunity for early intervention. It may occur either by providing information in person or over the phone (72 per cent of respondents report doing this work) or following up on a police incident report (L17s) (40 per cent respondents). As one interviewee explained:

“First contact is critical. It is an opportunity to build a rapport with the woman by responding to her immediate needs. We can also empower her to know her rights and inform her about the supports available to her. This is ‘planting the seed’ so that the woman knows that she can make a difference.”

Follow up on police L17 reports is the basis for many family violence services (17 specialist family violence services currently receive L17 reports) to provide ‘assertive outreach’ to women who are not yet self-identifying

⁵⁴ Buchanan, F. (2008) Mother and Infant Attachment Theory and Domestic Violence: Crossing the Divide Australian Domestic & Family Violence Clearinghouse <http://www.dvrcv.org.au/sites/default/files/Stakeholder-Paper-5.pdf>

family violence. However, inadequate funding means that this important early intervention opportunity is being missed. According to one service provider:

“L17s are a wasted opportunity. We know that early intervention is best if the follow up call comes within 24 hours, but I have two workers doing L17 follow-ups all day and they can’t keep up with the demand. It is so important to use that opportunity to provide a specialist voice, but we need the resources to meet the huge demand.”

Specialist family violence workers use their knowledge and skills in these first contacts to initiate conversations and ‘make the pathway’ to information and supports. Providing court support for intervention orders applications is another important early intervention service provided by 58 per cent of respondents.

Early intervention work with groups

Much of the early intervention work provided by specialist services is group work, often involving children. The survey found around 40 per cent of specialist family violence services work with children in groups and individually, and run targeted programs. These include programs for mothers and children, including programs for at risk groups such as new parents (such as the Baby Makes Three programs); and programs for mothers and children experiencing family violence (such as the Peekaboo programs; and the Animal Assisted Education and Therapy Group at WAYSS). Other services have programs that work directly with young children in primary schools and playgroups, such as the Early Learning is Fun (ELF) program run by Berry Street. These programs link specialist children’s workers with education services to provide early identification and responses, and build family violence capacity in those services. Another example of this approach to early intervention is the MABELS (Mothers and Babies Engaging & Living Safely) project, a collaboration between the Eastern Domestic Violence Service (EDVOS), the Boorndawan Willam Aboriginal Health Service, the Eastern Community Legal Centre and Maternal and Child Health services through two local councils. Specialist services also collaborate with other agencies to provide early intervention programs for young people, such as the Inspiring Women program for young women living in youth refuge in Gippsland, provided by Quantum with VACCA, Relationships Australia and Victoria Police.

Outreach workers in universal service settings

A number of services (21 per cent) have specialist family violence outreach workers located in universal services to build skills and capacity of other practitioners and professional networks. Services report positive outcomes where workers are co-located in services such as Centrelink, community health services and Victoria Police, however, they commonly report that they do not have ‘enough EFT to sustain them’. As a result these outreach programs tend to be short-term and reliant on uncertain project funding.

Services that work with specific communities emphasise their targeted early intervention programs. For example, while the Aboriginal Family Violence Prevention and Legal Service (AFVPLS) view their legal advice as early intervention, the service also runs culturally safe, effective early intervention programs for Aboriginal women to break the cycle of family violence and raise awareness of the support services available. The 'Sisters Day Out' program (discussed previously) offers one day workshops across Victoria to 'engage with Koori women, and in particular young Koori women, for the purpose of preventing family violence by facilitating community networks to reduce social isolation, raising awareness of family violence and by providing information and tools to promote community safety.' The service also runs the 'Dilly Bag' program, a two-day intensive workshop for Koori women, and the 'Young Luv' program for younger Aboriginal women that promotes healthy relationships. AFVPLS is also developing a Koori Women's Hub that will expand its early intervention work. The service reported that insecure funding is a barrier to extending these programs in a more targeted and systematic way in response to community need. Other services, such as Boorndawan Willam Aboriginal Healing Service, provide a range of programs for individuals and families to prevent family violence with a focus on culture and community.

inTouch Multicultural Centre Against Family Violence also runs a range of early intervention programs for women and children, as well as men, from diverse refugee and immigrant communities to reduce the risks of family violence. These consist of community leadership education programs and culturally specific young parenting programs and men's programs, for different cultural groups. The service also participates in research projects designed to increase the skills of health professionals to identify and respond to family violence experienced by individuals from different culturally diverse backgrounds.⁵⁵ All these programs have been funded through one-off funding grants from government or philanthropic organisations, making it difficult to develop best practice approaches and establish and maintain skills and resources within the organisation.

A number of specialist family violence services participate in collaborative research partnerships to improve family violence responses. This can be resource and time intensive but is considered by many services as an important part of their role in promoting and improving cross-sectoral family violence early intervention capability.

Funding

In an environment of increasing demand, specialist family violence services direct limited resources to crisis responses and intensive case management, (76 per cent according to the Victorian Government submission to

For family violence practitioners, early intervention incorporates a range of approaches, reflecting the non-linear and particular dynamics of family violence.

⁵⁵ <http://intouch.asn.au/projects/>

the RCFV).⁵⁶ As a result, early intervention programs are under-resourced, and generally fragmented and localised, with little opportunity to develop consistent best practice. Project interviewees reported the lack of secure and adequate funding as the primary barrier to their early intervention work. Their frustration is reflected in the following quotes from two participants:

“It would nice to be funded for our early intervention activities. The group work, the work with children that we do should be recognised and resourced. Specific funding for early intervention needs to be structured into the practice model so it isn’t eaten up by crisis work.” (Manager, family violence service)

“The group work we do is really effective, but it is basically unfunded. This work is resource heavy; it takes time to do the preparation and planning for each session and then following up with the group members afterwards, but we’re not funded for this.” (Manager, family violence service)

Relationship with universal services

“Identification of emerging issues and strategic connections between family violence services and early intervention providers is quite disconnected and often misses the key underpinning dynamics of family violence.” (Survey respondent)

Current relationships between specialist family violence and universal services tend to be ad hoc and localised. Services interviewed report these relationships are more likely to be based on individuals than established guidelines or protocols. A number of services report that they are developing more formal partnerships with local government, health services and schools; and as previously noted, some services routinely deliver programs in schools but this tends to be localised and driven by individual services. However, there is evidence that some specialist services are developing innovative approaches to facilitate early interventions by universal services by establishing dedicated early intervention roles to work on training and capacity building.

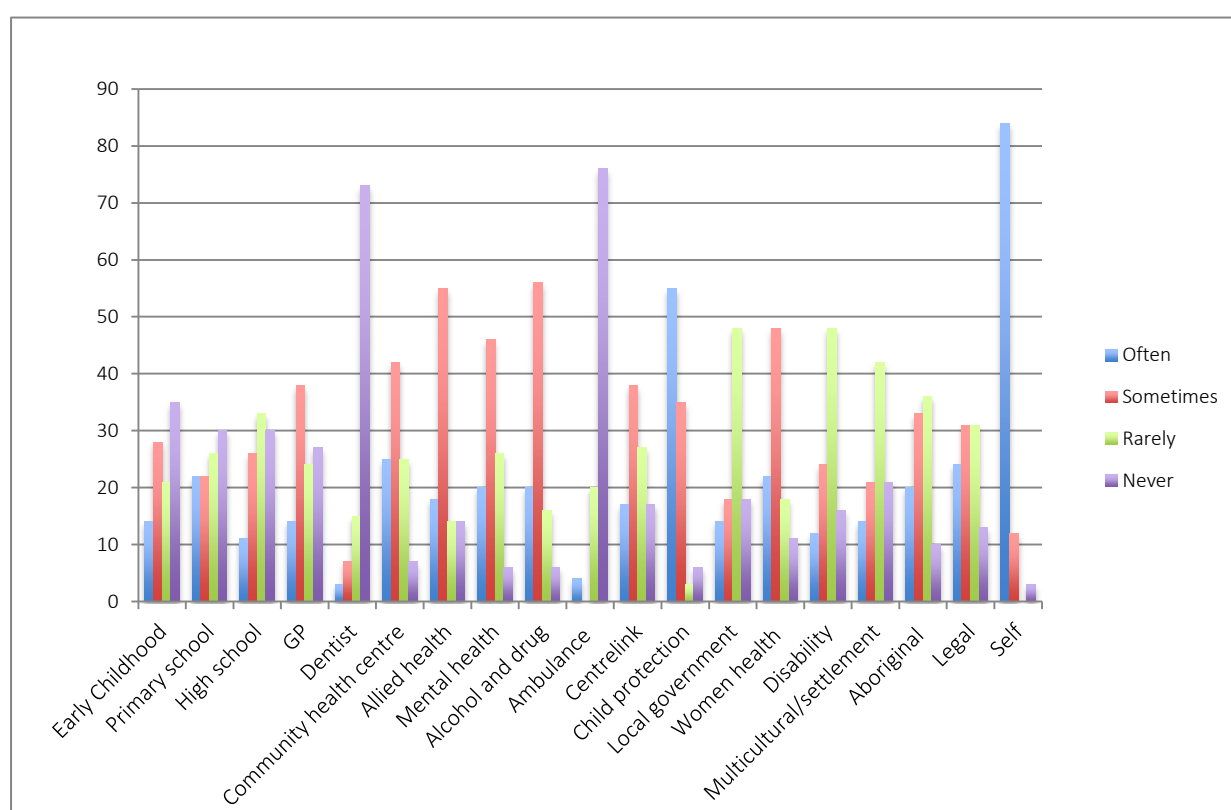
One example is the Universal Services Case Management Team at the Eastern Domestic Violence Service (EDVOS) to provide outreach to hospitals, community health, maternal and child health and local government services. There are also a number of examples of specialist family violence services forming partnerships with organisations to inform their family violence policy development, such as Good Shepherd’s work with the ANZ bank and South East Water.

⁵⁶ RCFV Vol 6:232

Referral pathways

As Table 1 illustrates these inconsistent relationships with universal services are reflected by the pattern of referrals to specialist services. When asked about the frequency of referrals to their service, respondents reported that of referrals that occurred ‘often’, the overwhelming majority are self-referrals (84 per cent), followed by Child Protection (55 per cent). Of the referrals that occur ‘sometimes’ alcohol and drugs services (57 per cent); allied health professionals (55 per cent) women’s health services (48 per cent); community health centres (43 per cent) are well ahead of any other services. It is important to note that the survey did not include referrals from police and homelessness services as it is recognised that the overwhelming majority of referrals to specialist family violence services are received from these agencies.

Table 1: Referrals from universal services to specialist family violence services

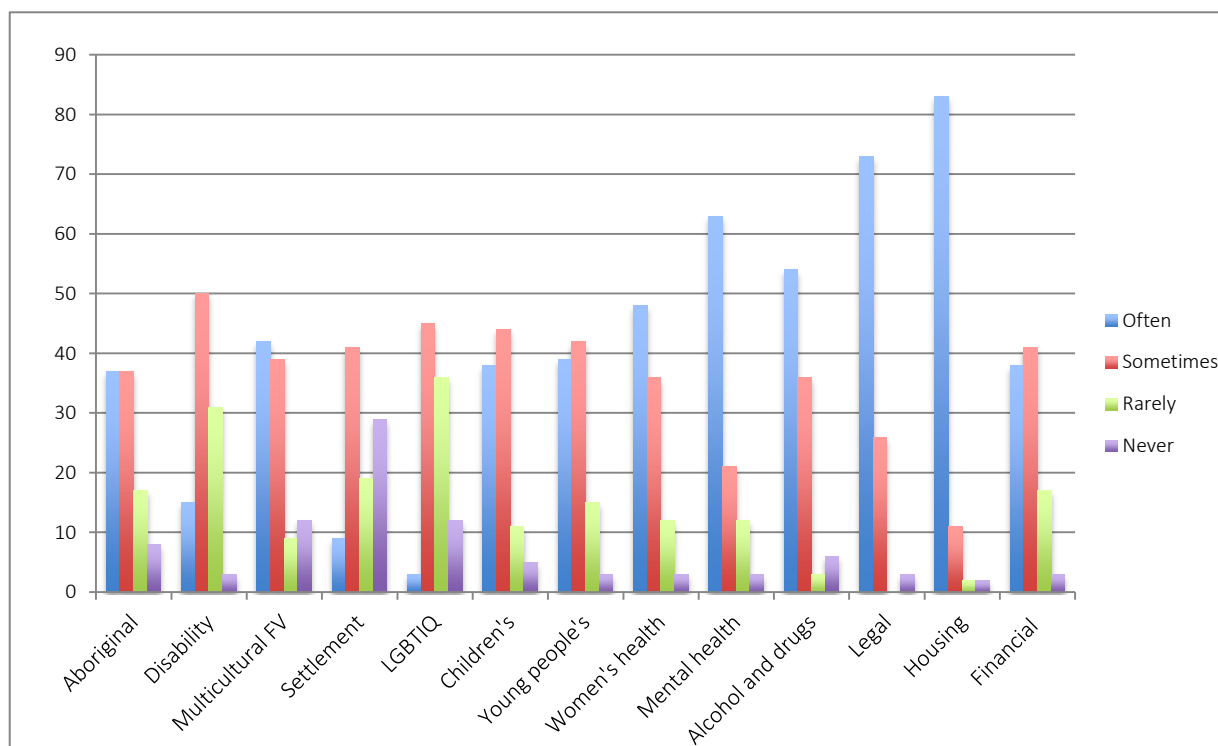


The relatively low referral rate from health, education and early childhood services, while only indicative, illustrates the work required to build an effective early intervention response into the system.

Only 14 per cent reported GPs referring ‘often’ and 38 per cent said GPs referred ‘sometimes’. Early childhood and childcare providers, and high schools are also unlikely to refer ‘often’; only 14 per cent and 11 per cent respectively referring to the services surveyed; with primary schools more likely (22 per cent) to refer ‘often’. Notably, dentists (73 per cent) and paramedics (76 per cent) are most likely to ‘never’ refer to specialist family violence services. The low referral rates from these key universal services, suggests a lack of understanding of family violence and the family violence services system.

Referrals from other services are equally likely to be ‘formal’ (written) referrals (53 per cent) or ‘warm referrals’ (58 per cent). Specialist family violence practitioners note that ‘warm referrals’ can result in more timely and effective engagement with the woman.

Table 2: Specialist family violence referral to other services



Accessing support services for women and children is a core part of specialist family violence case management and advocacy. As Table 2 shows specialist family violence services refer most often to housing services (83 per cent) and legal service (74 per cent). Referrals to mental health services (64 per cent); alcohol and other drugs services (55 per cent); and women’s health services (49 per cent) are also common practice. This referral pattern from specialist family violence services to universal services is unsurprising. The low rate of referrals to disability services (16 per cent) and LGBTIQ service (3 per cent) reflects the barriers to accessing family violence services experienced by people in these groups as well as the limited family violence expertise in services specifically for LGBTIQ people and those with disabilities.

A number of services point to the complexity of the referral system for other services that can make the process of accessing support services for clients onerous and time consuming. As one specialist family violence service manager describes:

“The stupid referral systems are the biggest barriers. Why do workers and clients have to jump through so many hoops to get a service?”

This comment is indicative of the need for clearer and more straightforward referral pathways and processes between family violence and universal services. This would not only improve women’s access to the specialised supports they need but also enhance the capacity and opportunities for early intervention work across all service sectors.

Secondary consultations

The specialist family violence services interviewed indicated their willingness to provide secondary consultations to universal services. One service provider exemplified the position of many of those interviewed saying:

“I would much rather have a worker spend half an hour on the phone to someone from housing answering questions and talking them through the issues if they suspect or know a client is a victim than have her arriving here needing crisis support and case management down the track.”

The data however reveals that the practice of secondary consultation is relatively limited, predominantly provided to services where established relationships exist, as Table 3 shows. Survey respondents identified a range of services to which they ‘sometimes’ provided secondary consultations. This includes community health services (63 per cent), women’s health services (54 per cent), and 48 per cent to early childhood services, mental health services, Centrelink, legal services and disability services.

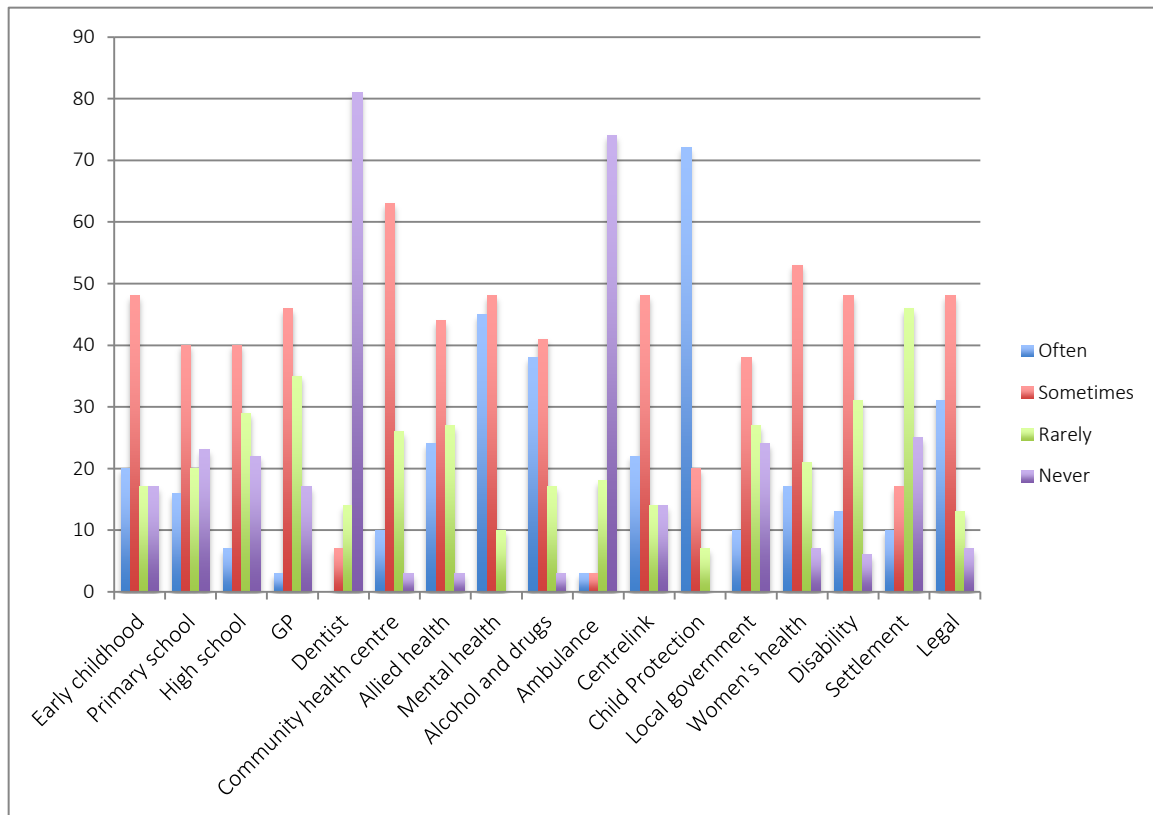
However, secondary consultations were ‘often’ provided to a much more limited range of services: predominantly, Child Protection (72 per cent), and mental health services (45 per cent) and alcohol and drug services (38 per cent). Family violence services are more likely to have historical or formal relationship with these agencies, including referral pathways, as they are traditionally considered to be part of the broader family violence system.

The survey data point to the need to develop secondary consultation relationships and warm referral pathways with universal services beyond the traditional support services network. In particular, the low rate of secondary consultations to dentists and ambulance services correlates with those services’ low rate of referrals to specialist family violence services. Both these services are in the frontline for identifying family violence and providing effective early intervention responses. As discussed later in the report,

Ambulance Victoria has recently developed family violence training for paramedics that provides guidance on recognising, responding and referring to specialist family violence services. There is also a growing awareness of family violence and the need to develop appropriate responses amongst oral health professionals.⁵⁷

⁵⁷ The annual oral health conference held by the North Richmond Community Health in November 2015 held a session on family violence at which many practitioners raised examples from their practice where they felt unsure of how best to respond. <http://www.wheremindmeetsmouth.com.au/2015-2>

Table 3: Secondary consultations provided by specialist family violence services



This data points to a range of areas where collaborative work could enhance early intervention approaches. However, importantly, the scope of this work, as this data shows, underscores the funding required to provide this important resource. A number of specialist family violence services interviewed reported having already established formal roles for secondary consultations, for example, the Salvation Army Family Violence Services have a staff member rostered on every day to provide secondary consultations. Others such as EDVOS are in the process of scaling up this role in their service with a dedicated team. However, without dedicated funding for early intervention, specialist family violence services will be unable to properly expand this role, particularly in secondary consultations.

Specialist family violence services are keen to expand their role in early intervention. Asked to identify their primary role in early intervention in the future, an overwhelming majority of survey respondents pointed to facilitating effective referral pathways between their service and universal services (81 per cent); providing secondary consultations (72 per cent). Around 60 per cent of respondents point to the role of specialist services in running targeted early intervention programs for women and children who are more likely to experience family violence (that is, women with disabilities, Aboriginal women and young women).

The role of universal services in early intervention

Consistent with the specialist family violence services responses in interviews, when asked to identify the role of universal services in early intervention the survey respondents overwhelmingly named identification of risk indicators (84 per cent), preliminary risk assessment (based on CRAF) (78 per cent), referral to specialist family violence services (81 per cent) and having conversations with women and children about safety (75 per cent). Notably fewer services considered safety planning with women and children (56 per cent), ongoing case monitoring with women and with children (31 per cent) as appropriate work for universal services.

The process and responsibility for safety planning was a key point in interviews with specialist family violence practitioners and universal service providers. For family violence specialists, safety planning applies in cases

To play an effective and safe role in early intervention, universal service providers need to understand these complex dynamics of family violence.

where the family violence risk is higher and therefore requires a specialised response. They consider the role of universal service providers, who would be working with women and children whose risk was lower, is to help them to strengthen protective factors by better understanding the characteristics of family violence, telling someone they trust, engaging with groups and building their support network and providing information about men's behaviour change programs.

In additional comments, respondents noted the need for workers in universal services to have completed the CRAF Level 2 to undertake preliminary assessment, to have effective links with Men's Referral Services, and to increase their referral practice to Aboriginal community-controlled organisations (or offer the option of attending these services). Others commented on the significant challenge of skill development and capability building required for workers in a range of universal services before they could undertake this work without increasing the risks to women and children living with family violence. In particular, specialist services noted the significant risks associated with children, couples or families being referred to therapists, relationship counselling or mental health services before a family violence risk assessment has been conducted.

Best practice models for early intervention – defined roles and responsibilities

The specialist family violence services interviewed and the survey respondents were strongly supportive of expanding the role of universal services in early interventions in family violence. Survey respondents were asked to list three options for the best model for effective family violence intervention, the majority (72 per cent) identified a model in which there is 'increased capacity in specialist family violence services to manage partnerships with, and provide advice and consultation to, non-specialist (family violence) services'. Sixty-two per cent also believed that specialist family violence services should have a 'primary role in delivering early interventions' and 56 per cent identified 'co-location of specialist family violence and universal services' as an optimum model.

In summary, all specialist services interviewed emphasised the importance of specialist family violence knowledge and practice as the foundation for early intervention approaches, and stressed the need for a clearly defined role for universal services that recognise the specialised nature of working with family violence. Specifically, specialist family violence practice is understood to be the use of a consistent, articulated practice framework in relation to women and children that combines a gendered lens, trauma-informed practice, attachment theory and a strengths-based approach.

Specialist services believe that a specialist family violence approach can and should be reinforced through secondary consultations with practitioners and via clear referral pathways between family violence and universal services. This can be established through a shared policy framework as well as formalised relationships.

Specialist family violence practitioners defined their role in early intervention as:

- Increasing family violence knowledge and practice through secondary consultations, co-located workers, community awareness and information provision
- First contact opportunities with women and children experiencing family violence
- Working with children and young people
- Place-based outreach to provide family violence support to women when and where they need it
- Delivering specialist targeted programs for groups at risk of family violence, including work with children, mothers and their children, at risk parents and culturally specific community-based programs.

Specialist family violence practitioners defined the role of universal service providers in family violence early intervention to be:

- Identifying the signs of family violence (using the CRAF)
- Responding appropriately including being able to have a conversation about family violence that enables an indication of risk (and how to respond in cases of serious and imminent risk)
- Providing information about family violence and referral options
- Assisting women to build or strengthen protective factors, in other words what does the woman do to keep herself and her children safe (rather than 'do' safety planning)
- Providing warm referrals to a specialist family violence service and/ or other support services.

The findings from this project strongly support the need for all early intervention work to be underpinned and informed by specialist family violence practice.

The Hubs will be a key part of this work.

The role of specialist family violence services in the Support and Safety Hubs

The RCFV model envisages early intervention in family violence to be an important part of the Support and Safety Hubs. The findings of this project are instructive for the development of Hubs. To be established across Victoria by July 2018, they will be a central entry point for intake, assessment and referral, and information centre for women, children and men and families experiencing family violence. They will receive all L17s as well as all referrals from other services and self-referrals. Given that the primary purpose of the Support and Safety Hubs is family violence risk assessment and early intervention, it is critical that specialist family violence practitioners lead the practice and service delivery to take full advantage of their expertise. The process will involve a comprehensive risk assessment to assess the level of risk for each individual and initiate an appropriate response. Specialist family violence services have been receiving and responding to L17s since their introduction. Risk assessment and response is their core business. Once the family violence risk is assessed, collaborative triage with specialist men's practitioners and child and family practitioners then ensures that appropriate referrals are integrated and co-ordinated.

The proposed advanced family violence practitioners in the Hubs (to support practice and provide secondary consultations to universal services) are problematic for specialist family violence services in a number of ways. This project identifies secondary consultation as an important and growing part of specialist family violence services' early intervention work, with several services building their capability for this role. However, it is unlikely that one position in each region could manage the demand for secondary consultations, and these roles could circumvent direct relationships between specialist family violence and universal services in their area.

This project's findings support the position that the Support and Safety Hubs should be developed around existing specialist family violence services, with expanded workforce capability and resourcing to build on their current work in family violence risk assessment, case management and early intervention, and should work collaboratively with other practice sectors.

The findings from this project strongly support all early intervention work to be underpinned and informed by the specialist family violence practice lens, where:

- The safety and well-being of the woman and her children is always the first priority
- The woman's understanding of her own situation and agency to make decisions is central
- Policy and practice informed by an analysis of the gendered nature of family violence
- Perpetrators are held accountable and responsible for their violence
- Family violence is complex, multi-dimensional and non-linear and requires a response appropriate to its nature
- Understanding the additional risks and barriers experienced by women from Aboriginal and Torres Strait Islander communities, refugee and immigrant women, women with disabilities, women living in remote and regional areas and LGBTI people, young people and older people.
- All Victorian women, children and men have access to services that are informed by these principles.

The Hubs will be a key part of this work.

Part Five: Universal service providers' responses

Thirty-two organisations, including peak and representative bodies and service providers, from the primary health, education and early childhood sectors were interviewed for this project. As the list of interviewees (Appendix A) shows the objective was to scope the landscape as broadly as possible within the limits of the project. To this end, interviews were also held with a range of organisations as well as individual researchers outside the health and education framework. The findings reported in this section focus on the primary health, early childhood and disability sectors. The majority of the interviews were conducted from November 2015 to March 2016 during the RCFV, anticipating recommendations for an increased role for universal services in a reformed family violence system. Organisations were asked about their current practice in responding to family violence and what they needed to expand their role in the post-RCFV family violence system. Their responses varied significantly, across and within the sectors, revealing a patchwork environment that includes well-established structured responses, nascent awareness and a myriad of ad hoc, localised approaches including training and organisational policies.

Broadly, the findings from this project are consistent with the RCFV's assessment that sectors and services outside the family violence system found it difficult to identify and access specialist family violence services. A number of interviewees expressed concerns that on occasions when they do make referrals to family violence services their clients don't receive services because their level of risk is assessed to be not sufficiently high. This points to the need for clarity around the work of specialist family violence services to inform the expectations and understanding of universal services. This will be important for effective referral pathways to specialist family violence services, as well as reinforcing the purpose and practice of secondary consultations. Effective partnerships between specialist family violence and universal services and training will produce best outcomes for women and children, whether they need a specialist family violence intervention or other forms of support.

As the RCFV states,

"The complexity of referral pathways and specialist family violence services' lack of visibility in the broader service system can make it difficult for universal services (such as general practitioners, maternal and child health nurses and schools) to know how and when to make referrals to specialist family violence services."⁵⁸

Another key theme emerging from interviews across the range of universal services and organisations is the importance of consistent and continuous professional development in family violence to improve responses, build practice and change organisational culture. A number of interviewees noted that one-off CRAF training for workers without follow up has not resulted in changes in practice. The CRAF training for workers in mental

⁵⁸ RCFV Vol 2:247

health, alcohol and other drug services and MCH nurses were cited as examples. An evaluation of Centrelink family violence training found that staff still did not ‘feel comfortable’ asking questions about family violence, following their initial training.

Primary health sector

To capture the position of the primary health sector, the interviews focused on the role of general practice and community health in responding to family violence. The role of ambulance services was also investigated. The interviews revealed a growing awareness of family violence across the sector and their role in responding to it. Larger community health organisations, such as Cohealth, are building family violence into their practice, in response to what is described by one interviewee as *‘the huge interest and demand across the sector’*. Another example of community health organisations taking the initiative to build family violence early intervention into health settings is the Inner North West Primary Care Partnership’s ‘Identifying and Responding to Family Violence’ Project.⁵⁹ This project, with advice from family violence experts and local services, has developed tools and resources on family violence that could usefully contribute to the development of a standardised statewide framework for early intervention. It is important that projects such as this are integrated with the broader systematic approach to early intervention or risk further fragmentation of this work. A key concern identified by community health sector participants is the difficulties universal services will experience in responding to both victims and perpetrators and they recognise the need for ‘systemic approach’ to manage this.

In focusing on primary health, this project does not examine the role of hospitals in early intervention; however, it notes the valuable work of the ‘Strengthening Hospitals Responses to Family Violence’ (SHRFV)⁶⁰. This ongoing project by the Women’s, Bendigo Health and Our Watch, has developed a series of guides and tools for hospitals to develop better practice in response to family violence, including early intervention. It provides a useful foundation to build stronger responses in hospital settings. This project illustrates the practical implications for broad-based training in family violence practice. The training model for hospital staff in this project is based on two 20-minute sessions, reduced from the two 45-minute sessions trialled in the pilot project. This highlights the need to take into consideration the practicalities of diverse workplaces, however it will be important that family violence training models are not compromised and adequately address the core competencies, skills and capacity in services. This will be a central concern for the Industry Taskforce.

The project revealed the need for more information about the family violence system generally, and specialist services in particular, in the primary health sector.

⁵⁹ <http://inwpcp.org.au/resources/identifying-and-responding-to-family-violence/>

⁶⁰ <https://www.thewomens.org.au/news/new-guides-to-help-strengthen-responses-to-family-violence/>

General practitioners

There is extensive evidence that general practitioners are often the first contact for women experiencing family violence, with five women each week presenting with symptoms of violence in the home.⁶¹ The RCFV cites evidence that approximately one-third of women disclose family violence to their GP but only one in 10 women experiencing family violence are asked about it directly by their GP. It also notes that least 80 per cent of women ask for help from health services, usually general practice.⁶²

As previously mentioned, research in this area has overwhelmingly focused on interventions with the woman as the primary victim of family violence, but children are often the catalyst for mothers to disclose family violence to a health practitioner.⁶³ General practitioners in primary care clinics see children who experience family violence every day in Australia. Like their mothers, these children deserve a timely, appropriate response to their fear and trauma. As a recent study finds, symptoms of complex trauma can be easily missed if there is no history or details of violence in the home, resulting in signs of trauma in children are being misdiagnosed as ADHD or autism spectrum disorder. Morris's study also finds that children are rarely asked about their experiences of family violence, but argues that encouraging them talk about their experiences of family violence and issues related to their safety is important to their sense of agency and their recovery.⁶⁴

General practice has a well-established practice guide to family violence in the White Book, first developed in the late 1990s. Currently in its fourth edition it provides clinical guidelines to working with patients experiencing abuse and violence.⁶⁵ There is also a six-hour, non-compulsory online training program to aid discussions about family violence between GPs and their patients. The evidence, including the focus group findings from this project, shows that in practice many GPs are not following up on indicators of family violence.⁶⁶ This comment from Amanda, a focus group participant, illustrates a common response women receive from their doctor:

“But as far as help, the doctors, I don’t know, they sympathise and they nod their head but there doesn’t seem to be anything else.”

⁶¹ Hegarty, K. (2015) Acting on family violence: How the health system can step up *The Conversation* 12 August <http://theconversation.com/acting-on-family-violence-how-the-health-system-can-step-up-45592>

⁶² RCFV Vol 4:6

⁶³ Taft, A (2003) 'Promoting Women's Mental Health: The Challenges of Intimate/Domestic Violence against Women', Australian Domestic & Family Violence Clearinghouse, Issues paper 8, pp. 1-24.; Morris, Anita (2015) Safety and resiliency at home: voices of children from a primary care population, PhD thesis, University of Melbourne

⁶⁴ Morris (2015)

⁶⁵ RACGP Clinical Guidelines, Abuse and Violence: Working with our patients in general practice <http://www.racgp.org.au/your-practice/guidelines/whitebook/>

⁶⁶ MAEVE (2015) Submission to the Victorian Royal Commission into Family Violence, May <http://www.rcfv.com.au/getattachment/6442E593-04E1-4C3D-839E-AEFFF15D00CC/Melbourne-Research-Alliance-to-End-Violence-Against-Women-and-Their-Children>

The findings of the RCFV confirm that these family violence resources are not producing better responses from GPs. As one witness to the RCFV states: “GPs are often unaware of the broader service system and are ill equipped to assess family violence risks.”⁶⁷

The RCFV identified a number of reasons why health practitioners don’t ask about family violence:

- high workloads and lack of time
- not knowing what questions to ask
- feeling ill equipped to assess risk
- concern they might be placing the woman at heightened risk by asking her to expose the violence
- a feeling of helplessness in not being able to provide a solution
- not knowing how and where to refer someone
- feeling they are being pushed into another role, with a tendency to categorize issues as ‘medical’ (their domain) and ‘social’ (not their domain)
- frustration at the perceived ‘passivity’ of victims
- lack of remuneration for their involvement in training activities relevant to identifying and responding to family violence.⁶⁸

The Royal Australian College of General Practice (RACGP) acknowledges these as reasons that many GPs are reluctant to engage effectively with family violence in their practice. They suggested that the fact that GPs are ‘contractors’ is another reason they are less likely to see their work within an integrated model. The RACGP is exploring ways to strengthen professional development to enable GPs to take a more proactive role in follow up and working with support services beyond the traditional response of referral. They are also developing webinar based training to address specific family violence issues, such as working with Aboriginal and Torres Strait Islander women; mental health and family violence; and elder abuse, because this training model offers the flexibility general practitioners need.

The Victorian branch of the Australian Medical Association (AMA) acknowledge that while a more proactive role in family violence is desirable, the type of response tends to depend on the individual doctor’s approach to clinical practice. They note that it is “*primarily a time-management issue, with red tape and paperwork taking time away from direct consultation hours.*”

In our interview, the AMA indicated that their members have a growing awareness of the issue and needed more family violence resources, information brochures and service directories to support their work with people experiencing family violence. They pointed to a lack of local pathways and the need for GPs to know their local specialist family violence service. In particular, the AMA suggested that larger practices could develop coordinated referral pathways with support services to enable feedback and continuity of care for patients

⁶⁷ Victorian Primary Health Care Partnerships Submission to the RCFV, cited RCFV Vol 4:7

⁶⁸ RCFV Vol 4: 28

experiencing family violence. The difficulties faced by GPs in rural and regional areas, where they are often the only medical practitioner in the town, was also raised. Responding to family violence in that situation is problematic because the GP is likely to treat the whole family; concerns around confidentiality and anonymity that are typical of small communities; and the lack of referral pathways. These problems are also barriers for women to disclose and for general practitioners to ask about family violence. The reported disparity between the high rates of family violence disclosures to GPs and low referral rates from GPs to specialist family violence services in the survey data (only 14 per cent report that GPs refer 'often') reflect the interplay of these factors.

The RCFV's recommendation in relation to general practitioners is intended to build referrals to professionals with family violence expertise. It will be important that this database is widely available to provide all universal and specialist family violence services access to professionals with family violence expertise in these sectors.

Recommendation 100

The Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Psychiatrists, and psychologist and drug and alcohol service peak bodies collaborate to develop a database of psychiatrists, psychologists, drug and alcohol practitioners and any other professionals with expertise in family violence to help general practitioners when making referrals [within 12 months].

Practice managers

One suggestion to address the low rate of GP referrals to specialist family violence services is to expand the role of GPs' practice managers to take greater responsibility for early interventions in family violence within the general practice setting. Employed nationally in a range of healthcare settings including general practice, allied health, dental, medical specialties, physiotherapy and podiatry, practice managers are well placed for this role. Their work involves developing practice processes and systems to improve healthcare outcomes, including policies, procedures, staff training, identifying referral points and providing materials for patients. Implementing consistent policies and practices for family violence across these practice settings fits well with this role.

The Australian Association of Practice Manager (AAPM) has only recently begun to consider family violence and the potential for practice managers to play a role in early intervention. While very receptive to taking on a more proactive role, the peak body acknowledged that building this into their work would require extensive workforce training and protocols and guidelines to inform practice. The potential for practice managers to make GPs' surgeries a safe and supportive environment for people experiencing family violence through the display of posters and brochures, as proposed in the SHRFV model, is a readily achievable example early intervention work. But it requires organisational commitment and investment in staff training as well as the production of consistent and appropriate materials.

Maternal and Child Health Nurses

Because women are at increased risk of family violence during pregnancy and early parenthood,⁶⁹ maternal and child health nurses (MCHN) play a key role in early intervention for family violence. This was often cited by other organisations, including the Department of Education and Training Victoria, as a best practice model for early intervention across the early childhood sector. In Victoria, MCHN see over 95 per cent of all mothers with newborns and since 2009, are mandated to screen for family violence when babies are 4 weeks old. As part of the mandatory screening regime, all MCHN were initially provided with three hours training in the use of the CRAF. Evaluation of the MCHN screening indicates it had a ‘normalising’ effect by increasing nurses’ awareness of, and discussion about, family violence and consequently, increasing the mothers’ disclosures, but there is no evidence that screening works better than case-finding. The study found that routine screening rates remain low among MCHN due to heavy workloads, lack of knowledge of referral pathways and belief that support services don’t have capacity to respond to referrals. It noted the need for greater investment in training, monitoring and support for family violence work to maintain sustainable practice.⁷⁰

This project’s findings support the evidence that MCHN practice is inconsistent, and that the lack of integration with specialist family violence services is often a problem for both sectors. Of concern was the view that some MCH nurses are reluctant to refer to specialist family violence services because they don’t have the necessary knowledge of the family violence system, or they believe that specialist services don’t have the capacity to respond appropriately. A comment by a specialist family violence practitioner is indicative of these concerns:

“Maternal and child health nurses feel they have to take all the responsibility because they’re not connected with family violence services.”

A MCH nurse observed of the practice generally that, “They ask the question but they don’t know how to respond.” Interviewees also noted the need for continuous professional development for all MCH nurses with regular CRAF training that includes current information about specialist family violence services. They gave examples where accessible and supportive supervision had increased their confidence to provide effective family violence interventions with their clients. This is supported in the evidence provided to the RCFV on the need for stronger supervisory structures to build consistency, confidence and competence in MCHN practice and additional professional support to respond to the emotional impact and vicarious trauma experienced by MCH nurses.⁷¹

⁶⁹ Campo, M. (2015) Domestic and family Violence in pregnancy and early parenthood: Overview and emerging interventions, Australian Institute of Family Studies <https://aifs.gov.au/cfca/publications/domestic-and-family-violence-pregnancy-and-early-parenthood>

⁷⁰ Hooker, L. Small, R. Humphreys, C. Hegarty, K and Taft, A. (2015) Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial Implementation Science 10-39

⁷¹ RCFV Vol 4:17

Ambulance Victoria

Paramedics are often first responders to family violence incidents, even when they are not identified as family violence. They are well placed to perform preliminary risk assessment through sensitive questions and provide appropriate information and referral options, as demonstrated in the case of focus participant, Katie. However, historically family violence has not been addressed in professional development by Ambulance Victoria or in paramedics' undergraduate training. As the survey results demonstrate, to date there has been little interaction between ambulance services and specialist family violence services.

When interviewed in November 2015, Ambulance Victoria was in the process of developing family violence training for paramedics in response to the increased community focus on family violence and anticipating the recommendations of the RCFV. The training was intended to increase paramedics' understanding of family violence and recognition of indicators, and to provide information and referral pathways to specialist services. It would also strengthen clinical practice guidelines, including refining the risk assessment, collection of evidence, and improved data collection. At the time of interview it was unclear how much the training package would draw on or be aligned with the CRAF.

Ambulance Victoria has subsequently developed a family violence and child abuse policy and family violence guidelines and training. It does not reference the CRAF, however it is a valuable tool for promoting and supporting early intervention. The 2016 Ambulance Victoria Continuing Professional Development Clinical Handbook provides a clear definition of the paramedic's role and responsibility is a useful model for other service providers:

"The intent of this program is NOT to make everyone experts in family violence, or to significantly change the role of the paramedics. The program encourages you to be alert for potential family violence and child abuse by increasing your awareness of family violence, including its prevalence and some signs to look for. We do not expect paramedics to change their role from that of clinician at the scene to that of investigator or social worker. Please continue to assess and treat as you have always done. We are providing some mechanisms to take the appropriate action to be part of the solution regarding assisting those in the setting of family violence".⁷²

The unique access paramedics have into people's homes creates enormous potential for early intervention in family violence. The introduction of this training will enhance the capacity for paramedics to effectively intervene where they recognise the signs of family violence in a variety of situations. It will be important that the Ambulance Victoria family violence training and guidelines are integrated into a statewide approach to early intervention to contribute to the development of consistent best practice and standardised responses.

In summary, although limited in scope the interviews for this project reveal a diversity of responses in the level of understanding, training and capacity to undertake this work. In general, this project finds that better

⁷² Ambulance Victoria (2016) Continuing Professional Development Clinical Handbook p1

integration with specialist family violence services is essential for health professionals and services to strengthen their responses to family violence. The project revealed the need for more information about the family violence system generally, and specialist services in particular, in the primary health sector. As well as limiting referrals, a lack of understanding of the nature of family violence practice may lead some health practitioners to the view that they can ‘case-manage’ clients who are reluctant to be referred to specialist family violence services. With training and specialist support through secondary consultations, this can work well in cases where the family violence risk is low, however this approach is not appropriate where the risk is serious. In these cases, referral to services with expertise in the assessment and management of family violence risk is critical. This underlines the need for training and detailed practice guidelines informed by family violence expertise to clearly articulate services’ roles and responsibilities, as recommended for the revised CRAF.

Early childhood services

Family violence can have serious and long-term effects on children, with detrimental impacts on their neural, cognitive and psychosocial development, as well as their physical health and educational outcomes.⁷³ Supporting children and young people should be central to family violence policies, according to the RCFV.⁷⁴ The earlier in a child’s life that interventions can occur, including in utero, the greater the likelihood of mitigating the short and long-term effects of family violence. This makes schools and early childhood settings key locations for early intervention, however this project found that, consistent with the RCFV findings, these sectors are currently not well equipped to engage in this work.

Interviews were held with a range of service providers, peak bodies and representatives from the Department of Education and Training Victoria covering issues relating to schools, early childhood settings such as playgroups, and non-government childcare providers. In general, all these interviewees revealed a strong interest in building their organisation’s capacity to respond to family violence. The level of understanding and capacity varied significantly across individual organisations but one recurrent theme across these organisations was the lack of knowledge, understanding and links with the specialist family violence sector. As one interviewee notes,

“Most schools don’t know about family violence services. If they make referrals it would most likely be to GPs.”

Interviews with early childhood organisations illustrated the impact of the RCFV and an increased community awareness of family violence. Unlike the health sector, responding to family violence was largely new work for these organisations, and at the time of interview, they were all at the preliminary stage of assessing their role and requirements to develop the capacity of their workforce. With the exception of one national organisation,

⁷³ Campo, M., Kaspiw, R., Moore, S., & Tayton, S. (2014). Children affected by domestic and family violence: A review of domestic and family violence prevention, early intervention and response services. Melbourne: Australian Institute of Family Studies

⁷⁴ RCFV Summary and recommendations p8

Early Childhood Australia's Start Early project to develop online training tools, the interviews with early childhood organisations revealed a relatively limited knowledge of family violence, its impact on children, the specialist family violence service sector and the family violence system generally. The early childhood organisations revealed an 'appetite' to engage with the issue of family violence and to develop partnerships with the specialist family violence sector. They were principally interested in clarifying their role and accessing in the information, training and support required to prepare their staff to engage in this work.

Interviewees reported a mixed response to family violence across their workforces reflecting the pressing need for training. They want their staff to have detailed cues and directions to guide their responses to children, their mother and their father. In general, they considered their staff currently would be:

- 'too willing' to engage with a parent or child without training or knowledge of how to respond
- silent, lacking confidence to engage with a parent or child for fear of making things worse
- not comfortable asking questions about family violence, believing family violence to be a private matter and not their business; and
- not comfortable asking about Aboriginality (This is reported to be common across all service sectors).

Early childhood sector training has focused on mandatory reporting for child abuse and neglect.⁷⁵ This informs the early childhood services practice approach and has established professional relationships between early childhood providers and Child Protection. The response of an early childhood practitioner exemplifies this. When asked about her response to a child who showed signs of family violence (but no signs of physical or sexual abuse or neglect), the worker was unaware that specialist family violence services could provide a secondary consultation to support her response. As she said:

"I wasn't sure what to do about it so I called Child Protection to get advice. I didn't know who else to call."

As illustrated in the focus group responses, the relationship between family violence and child protection services must be a nuanced one. The fear of an intervention by Child Protection services prevents many women from disclosing family violence, thereby increasing the risks to herself and her children. Building a better understanding of family violence and access to secondary consultations with specialist family violence services will support early childhood workers to be able to respond effectively to disclosures or when signs of family violence are identified.

⁷⁵ RCFV Vol 2: 131-2

These interviews highlight the pressing need for specialist family violence training to prepare this sector. Like the paramedics, the early childhood services interviewed were initially concerned about the level of engagement expected of their workforce and wanted assurance that they would not be expected to be experts in family violence. The interviewees identified the need for clarification of their role and detailed practice guidelines and referral protocols so workers can be confident to undertake this work. They had limited knowledge of the specialist family violence system and services. The introduction of a family violence lens into the practice of early childhood providers will require training in the complex nature and dynamics of family violence, the safety risks to both mother and child, and the impacts of family violence on children. It should also provide information about specialist family violence services and support connections between these services at the local level to facilitate referrals and secondary consultations. These services are acutely aware that inadequate training and poor guidelines could result in interventions that are detrimental to a woman's safety.

Early childhood organisations revealed an 'appetite' to engage with the issue of family violence and to develop partnerships with the specialist family violence sector.

The training capacity for workers in the early childhood sector is limited. The current standards and training requirements for early childhood workers under the Australian Government's National Quality Framework for early childhood education and care⁷⁶ and the Early Years Learning Framework mean that the resources and capacity of services for additional training and skills development are already stretched. As one interviewee noted, because most childcare services are privately owned the sector is fragmented and competitive making it less likely to take a collaborative approach to building family violence capacity across its workforce.

Disability sector

Interviews with this sector suggest that there is work to do to develop the capacity of workers in the disability sector to recognise and respond to family violence. Women with disability are at a heightened risk of family violence from family members and disability support workers, and they experience significant barriers to disclosing it. Failure to recognise family violence substantially increases the risks for women with disabilities.⁷⁷ The common assumption that family is the safest place is an obstacle to identifying family violence against people with disabilities. Due to a lack of external supports, family (including intimate partners) are often the providers of assistance with daily living for such crucial things as communication, financial and physical supports. Additionally, disability discrimination means that when women with disabilities do disclose family violence, they are not believed and receive no support.⁷⁸ A growing body of evidence finds that disability

⁷⁶ <http://acecqa.gov.au/national-quality-framework/explaining-the-national-quality-framework>

⁷⁷ Woodlock D, Healey L, Howe K, McGuire M, Geddes V and Granek S (2014) *Voices Against Violence Paper One: Summary Report and Recommendations* (Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria. <http://wdv.org.au/voicesagainstviolence.html#DownloadtheReports>

⁷⁸ See *Voices Against Violence Papers 1 & 6*

discrimination combined with gender discrimination compounds the risks of violence against women with disabilities.⁷⁹ This makes it even more important that disability workers, other community services and broader community understand family violence and are trained to recognise the signs and respond appropriately, including how to build referral pathways with specialist services.

Disability workers are well placed to practice early interventions for family violence against people with disabilities with the right skill set and approach, but it is equally important for universal service providers generally to have these skills. Training that is underpinned by an understanding of the gendered power dynamics of family violence and the intersection of gender and disability is crucial to building an effective early intervention response for women with disabilities. Currently, the primary focus of professional development in disability sector is on the Zero Tolerance framework that addresses the risks to people with disability posed by workers. While clearly important, the framework does not specifically address the risks of family violence to people with disability or its gendered nature. However, there are other important initiatives in Victoria that provide the sector with resources to strengthen responses to family violence. The disability service, Scope has recently launched toolkit, *Speak up and be safe from abuse* toolkit⁸⁰ to help workers to identify violence and

A woman's experience of family violence is not linear; interventions work when women receive the right response at the right time for them.

abuse against people with communication difficulties. This valuable resource, which includes the statewide family violence crisis support line, is a positive step towards highlighting family violence against people with disabilities and enabling effective interventions to support them. Additionally, the CRAF review recommends the inclusion of specific risk factors and specific and targeted questions for people with disabilities.⁸¹

Women with Disabilities deliver Victoria's Workforce Development Program on Gender and Disability that is designed to be an organisational change program for disability services promoting gender equity to clients, workers and executives. It models cross sector collaboration and respectful relationships through co-facilitation by women's violence prevention and response services alongside women with disabilities.⁸² Approaches such as this facilitate stronger relationships between disability support services and the specialist family violence sector and build capacity and understanding across both sectors. The development of these skills and relationships will become more important as the National Disability Insurance Scheme is rolled out, and the family members of people with disabilities are more likely to manage their support plans and deliver paid support services.

⁷⁹ Krnjacki, L. Emerson, E. Llewellyn, G. and Kavanagh, AM. (2016) Prevalence and risk of violence against people with and without disabilities: findings from an Australian population-based study *Australian New Zealand Journal of Public Health* 40(1) pp16-21; Voices Against Violence Paper 1 Stop the Violence' 2014 by WWDA and UNSW

⁸⁰ <http://www.speakupandbesafe.com.au/>

⁸¹ http://www.dhs.vic.gov.au/_data/assets/pdf_file/0004/974551/Review-of-the-Family-Violence-Risk-Assessment-and-Risk-Management-Framework-CRAF-Final-Report.pdf p105-6

⁸² <http://www.wdv.org.au/documents/Evaluation%20Summary%20%20WDV%20Workforce%20Development%20Program%20on%20G&D%20October%202015.pdf>

Early intervention in family violence within organisations

Organisations undertaking an enhanced role in early intervention of family violence will have to respond appropriately to family violence within their own workforce. Organisation-wide family violence training to build skills and capacity for early interventions will increase the likelihood of disclosures, particularly for services with highly feminised workforces, such as early childhood services, hospitals and MCHN services. Workplaces will need to develop workplace policies and procedures to ensure that staff disclosures are treated appropriately; supports are in place for those staff members and information and referral pathways are available. A number of the organisations interviewed for this project recognised the need for specialist advice on the development of these policy frameworks and protocols.

Workplace-based programs for the primary prevention of violence against women are well established in Victoria. The *Take A Stand Against Domestic Violence* program developed by Women’s Health Victoria began in 2007 and continues to provide businesses with the foundations to implement organisational training and policies to respond to staff members experiencing family violence.⁸³ Our Watch, the national organisation for the prevention of violence against women, is currently conducting a workplace-based project to assist organisations to develop quality standards for the prevention of violence against women in the workplace.⁸⁴ An important component of *The Victorian Workplace Equality and Respect Project* is to provide training for key staff, such as managers, HR personnel and staff leaders, so that they understand the impact of family violence on individuals and workplaces and ensure that policies and procedures are in place to respond to disclosures by staff members. The findings from this project, as well as work conducted by Women’s Health Victoria should inform the development of statewide policy and procedural framework for organisational responses to family violence.

Managing the risk of vicarious trauma in staff should be built into workplace occupational health and safety policies.

Vicarious trauma and staff support

Another important consideration is the impact of vicarious trauma on the increased numbers of workers who will be responding to family violence, either in their own workplace or when engaging in early interventions with their service users. Vicarious trauma is described as “a normal response to repeated exposure and empathetic engagement with traumatic material.”⁸⁵ Working in family violence with traumatised clients carries a high risk of vicarious trauma. The work is by nature stressful, emotional and fatiguing. Many specialist family violence workers bring an extra investment to their work through a commitment to address violence against women,

⁸³ <http://whv.org.au/what-we-do/take-a-stand-against-domestic-violence>

⁸⁴ <http://www.ourwatch.org.au/What-We-Do/%E2%80%8BVictorian-Workplace-Equality-and-Respect-Project>

⁸⁵ Morrison, Z. (2007) "Feeling heavy" Vicarious trauma and other issues facing those who work in the sexual assault field Australian Institute of Family Studies, Melbourne <https://aifs.gov.au/publications/feeling-heavy/what-vicarious-trauma>

often based on personal experience. This, and the systemic lack of funding across the family violence system and support services, compounds the stresses and increases the risk of worker burn-out and vicarious trauma.⁸⁶

While this phenomenon is well recognised in specialist family violence services, it will become increasingly common in other workplaces as family violence awareness and training is rolled out. It will be essential that workplace management is cognisant of potential vicarious trauma for staff who engage with clients about family violence, and also for staff, such as HR staff or workplace ‘champions’ who lead the family violence response within organisations. Managing the risk of vicarious trauma in staff should be built into workplace occupational health and safety policies.

Organisational support is critical to building workforce resilience and preventing vicarious trauma for staff working with family violence. The essential elements of a workplace response are manageable and diversified workloads, effective supervision, a supportive workplace culture and access to specialist counselling.⁸⁷ For specialist family violence services, these policies and supervision of staff are located in a gendered framework. The database of psychologists and counsellors with family violence expertise, recommended by the RCFV, will be important for access to appropriate support. The National Sexual Assault, Domestic and Family Violence Counselling Line, 1800 RESPECT also provides counselling for workers experiencing work-induced trauma.⁸⁸ With the expansion of family violence early interventions across universal services, the demand on this resource is likely to increase significantly, requiring greater funding for this service to meet this demand.

Consistent, standardised specialist family violence training

In the current climate of urgency for family violence to incorporate family violence responses into workplace, there has already been an escalation in the number of organisations, some with no experience of family violence or links to the family violence sector, stepping into ‘the market place’ of training and organisational policy and practice development. There is great potential for this to increase in the coming years as the expectation of cross-sectoral workplace ‘family violence readiness’ grows. Without regulation, this approach will inevitably result in inconsistent practice as new sectors become engaged in family violence.

As the women who told their stories for this project demonstrate, family violence is complex and multi-dimensional; an interplay of individual and cultural beliefs, values and practices, including fear and love, responsibility, and gender inequality and financial dependence. A woman’s experience of family violence is not linear; interventions work when women receive the right response at the right time for them. This project illustrates that interventions in family violence that improve the lives of women and children must be sensitive and nuanced, and informed by an understanding of this complex dynamic.

⁸⁶ DV Vic (2015) Specialist family violence services: the heart of an effective system: Submission to the RCFV <http://www.dvic.org.au/images/DV%20Vic%20Submission%20to%20the%20Royal%20Commission%20-%20Specialisation.pdf>

⁸⁷ Morrison (2007)

⁸⁸ <https://www.1800respect.org.au/workers/fact-sheets/workplace-issues-for-services-dealing-with-dvf-and-sexual-assault/work-induced-or-vicarious-trauma/>

For this reason it is essential that workers across universal services receive family violence training that is delivered by specialist practitioners, with expertise and a comprehensive understanding of these complex dynamics. It is anticipated that the revised CRAF will provide a consistent, expert-informed framework for family violence training. The CRAF training provided by family violence experts should be promoted as the optimum program to build capacity in the new workforces. Timing and resourcing will make achieving this a challenge, with many organisations in this sector keen to get on with this work now and specialist family violence training organisations struggling to meet demand.

The Centre for Workforce Excellence, a key plank of the Victorian Government's ten-year plan, *Ending Family Violence: Victoria's Plan for Change*, could take leading role in the implementation and regulation of consistent, high quality early intervention training. According to the Plan, its purpose is to:

*"...lead initiatives designed to boost the capabilities of specialist family violence, primary prevention and social services workforces. The Centre will play a key role in research, identifying core skills and capabilities across workforces, promoting best practice and contributing to the development of formal workforce training."*⁸⁹

Driven by specialist family violence expertise and practice, this Centre will potentially provide the vehicle for a statewide approach to best practice in family violence early interventions.

⁸⁹ State Government of Victoria, (2016) Ending Family Violence Victoria's Plan For Change <http://vic.gov.au/familyviolenceplan>

Conclusion

The project identified a number of findings in relation to specialist family violence services and early intervention work. A key finding from research evidence is that to be effective, services engaging in early intervention in family violence must be supported by, and work with, specialist family violence services. A specialist family violence approach must underpin all aspects of early intervention work. This means that:

- The safety and well-being of the woman and her children is always the first priority
- The woman's understanding of her own situation and agency to make decisions is central
- Policy and practice is informed by an analysis of the gendered nature of family violence
- Perpetrators are held accountable and responsible for their violence.

Without this, interventions can increase the risks for everyone, including workers. This project found many examples of effective partnerships between universal services and specialist family violence services, and identified opportunities for collaborations in a variety of settings.

Specialist family violence practitioners consider their role in early intervention to be: engaging with women in their first contact to 'plant the seed', particularly in response to police incident reports; supporting universal services through outreach and secondary consultations; and group work with women and children in diverse settings. Each of these activities requires a specialist response. Currently, the funding for these activities is either through short-term project grants or resourced through the organisation's core funding. The specialist family violence sector is keen to build their capacity for this work and to engage with universal services to support better outcomes for women and children. This includes producing and promoting information about family violence and the specialist family violence service system.

The project found that primary health organisations, particularly community health services, viewed family violence interventions as an expansion of their existing work. Health services reported that clients experiencing family violence commonly resist referral to specialist services, driving them to develop internal family violence case management responses. The level of interaction between primary health and family violence services varied. Primary health providers were more likely than other services to know about the specialist family violence service system but also expressed more concern about its capacity to respond to their clients. There was less recognition of the specialist nature of family violence work in this sector. The relatively low referral levels to specialist services from this sector, including GPs, identified in this report could be a reflection of this, highlighting the need for greater collaboration between these sectors.

The early childhood services, which have not previously engaged with family violence, were primarily concerned about clarifying expectations about their role in responding to family violence. They identified the urgent need for their staff to receive family violence training that articulates their role and provides guidelines so they can act with confidence that they would do no harm. The organisations interviewed were reassured that their role would be limited to recognising (the signs of family violence); and responding (know how to ask, know how to

respond to disclosure and know where to refer). They were keen to collaborate with specialist family violence services to develop their skills and understanding and form partnerships to support their staff and clients.

This report referred to a number of family violence projects initiated by universal services that include the development of internal training, policy and procedures and production of materials. It is likely more universal services will look to develop their own organisational responses to family violence, as their awareness of the problem grows. While this increased responsiveness is positive, it is concerning that such a localised approach will result in continued fragmented and ad hoc responses with no quality control mechanism, minimum standards and integration. Similarly, in the current environment of urgency to incorporate family violence responses into workplaces, there is a serious risk that organisations with no experience or links to the family violence sector will step into the 'market place' of training and organisational policy development.

The project findings reinforce the need for a statewide framework for early intervention in family violence that provides the practical guidance, policies and procedures required by organisations. In addition to practice guidelines for workers to recognise the signs of family violence and know how to respond to it, the framework will need to include guidelines on organisational structures and policies to support staff in this work. For example, policies for supervisory support and access to counselling to build resilience and reduce the risk of vicarious trauma to workers, as well as internal policies to support staff who may be living with family violence themselves. There is a pressing need for this material, and the training that accompanies it, to be made available as soon as possible. This should be a priority consideration for the Family Violence Industry Taskforce.

Family violence training is central to building the skills and capability for workforces across all universal services. As documented in the report, the revised CRAF will provide a detailed practice guide tailored to address the roles, responsibilities and practice of service providers across the community. The CRAF is based on the specialist family violence practice approach and understanding of the complex nature and dynamics of family violence, including the often subtle, covert use of coercive and controlling behaviours. It is critical that the CRAF is promoted as the recommended practice guide and that all training is delivered by trainers with family violence expertise and based on the use of the CRAF. There is overwhelming evidence that family violence training must be ongoing – included in staff induction with refresher courses for all staff on a regular basis. Without this, skills and knowledge are lost when staff turnover, and family violence practice becomes stale and outdated. Clearly, the training model will need to take account of the practical constraints of organisations, including time availability, staff size, workloads and capacity, and resourcing.

Significant work will be required to implement effective, high quality and sustainable early interventions in family violence. The goal is a co-ordinated, statewide approach that incorporates cross-sectoral training for consistent, best practice responses. This presents considerable challenges. It will require a significant increase in dedicated and recurrent funding to build and maintain an early intervention workforce across all sectors.

Recommendations

Recommendation 1

The Industry Taskforce should develop a Statewide Framework for Early Intervention in Family Violence as a priority. The framework should:

- be based on the revised Family Violence Risk Assessment and Risk Management Framework (the CRAF), and its delineated roles and responsibilities for different service sectors
- include detailed practice procedures and protocols, including secondary consultation information and referral pathways
- outline best practice organisational structures and policies to respond to the effects of family violence in the workplace, including supervisory support structures for staff (drawing on of the workplace programs of Our Watch, Women's Health Victoria, Women with Disabilities Victoria and InTouch Multicultural Centre Against Family Violence Service)
- recommend organisational training requirements, including continuous professional development.

Recommendation 2

The Centre for Workplace Excellence (announced in the ten year plan) should have oversight and administrative responsibility for the Statewide Framework for Early Intervention in Family Violence, with support from the specialist family violence peak bodies, such as Domestic Violence Victoria and No to Violence.

Recommendation 3

The Family Violence Industry Plan should require that family violence training for 'prescribed organisations' be aligned with the revised Family Violence Risk Assessment and Risk Management Framework (the CRAF) and recommended for all other universal services.

Recommendation 4

The Family Violence Industry Plan should require accreditation for organisations providing family violence training (to be delivered by the Centre for Workplace Excellence) that is:

- Delivered by trainers with family violence expertise
- CRAF-aligned
- Informed by a gendered analysis of family violence
- Standardised in content and delivery modules that conform to service roles and responsibilities defined by the CRAF and the Statewide Framework for Early Intervention in Family Violence
- Supported by organisational processes and procedures to respond to staff experiencing family violence.

Recommendation 5

The Centre of Workplace Excellence should establish and maintain a mechanism for continuous monitoring and oversight of CRAF training.

Recommendation 6

The Centre for Workplace Excellence or relevant body should maintain a central register for all CRAF-aligned training tools and resources (as recommended by the CRAF review).

Recommendation 7

The Victorian Government should establish a standing Women's Family Violence Advisory Group, with a membership of women from diverse backgrounds with experience of family violence, as a formal and ongoing mechanism to provide advice on family violence policy development, service delivery and training.

Recommendation 8

The Family Violence Industry Plan should recognise the expert role of specialist family violence services in providing early interventions through individual contacts, universal service outreach and secondary consultations, and working with groups and allocate/recommend funding to support and expand this work.

Recommendation 9

The Victorian Government should recognise the role of specialist family violence services in leading practice in early intervention, risk assessment and crisis responses to family violence and develop a Support and Safety Hubs model that is built around led by existing specialist family violence services.

Recommendation 10

The Victorian Government should commit additional, recurrent funding commensurate with building a statewide workforce response to family violence.

Recommendation 11

The Australian Government should increase funding for the National Sexual Assault, Domestic and Family Violence Counselling Service 1800 RESPECT to increase its capacity to provide early intervention responses to individuals, communities and service providers.

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Appendix A: List of Organisations and Individuals Interviewed

1. Aboriginal Family Violence Prevention and Legal Service
2. Northern Family and Domestic Violence Service - Berry Street
3. Boorndawan Willam Aboriginal Healing Service
4. Centre for Non-Violence, Bendigo
5. Eastern Domestic Violence Service (EDVOS)
6. Women with Disabilities Victoria
7. Good Shepherd Australia New Zealand
8. InTouch Multicultural Centre Against Family Violence
9. Minerva Community Services
10. Barwon Centre Against Sexual Assault
11. Quantum Support Services
12. Salvation Army Family Violence Family Violence Services
13. WAYSS Southern Women's Integrated Support Services (SWISS)
14. Regional Integration Co-ordinator, Eastern Metropolitan Region Regional Family Violence Partnership
15. Safe Futures Foundation
16. Women's Information and Referral (WIRE)
17. Women's Health West
18. CoHealth, Footscray
19. Relationships Australia Victoria
20. Ambulance Victoria
21. Centrelink, Family Safety
22. Commonwealth Bank
23. Victorian Principals Association
24. Mental Health Practitioners Network
25. AMA Victoria
26. Royal Australian College of General Practice
27. Australian Childcare Alliance Victoria
28. Angela Taft, Judith Lumley Centre, LaTrobe University
29. Maternal and Child Health Nurse
30. 1800RESPECT
31. Women's Health Victoria
32. Australian Psychological Society
33. Safe Futures Foundation
34. Victorian Department of Education and Training
35. Wesley Mission Homelessness and Support Services
36. Simon Sawyer, PhD candidate, Paramedic
37. Christine Craik, PhD Candidate & Lecturer, School of Global, Urban and Social Studies, RMIT
38. Neighbourhood Justice Centre, Collingwood
39. Royal Women's Hospital, Strengthening Hospitals Response to Family Violence project
40. Victorian Healthcare Alliance
41. Red Cross, Migration Support Program
42. Fitted for Work
43. Family Violence Project, Inner North West Primary Care Partnership
44. Multicultural Centre for Women's Health
45. Early Childhood Australia
46. Australian Association of Practice Managers
47. Australian Association of Social Workers
48. Scope Disability Services
49. National Disability Services
50. Playgroup Victoria
51. Primary Care Partnerships Forum
52. bestchance Child Family Care

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