

Chief Psychiatrist's guideline and practice resource: family violence

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Summary

This guideline outlines the Chief Psychiatrist's expectations of Victorian public mental health services regarding family violence. It provides guidance for services about responding to people who experience family violence and improving the way they work with people who perpetrate family violence.

The guideline is part of the Victorian Government's response to the recommendations of the Royal Commission into Family Violence.¹ The royal commission highlighted the unique opportunities of health and mental health professionals to identify and intervene in family violence. It specifically recommended that the Chief Psychiatrist issue a guideline relating to family violence.

Key messages

Family violence is a fundamental violation of human rights and is unacceptable in any form.

Mental health services have a responsibility to address family violence. Mental health clinicians are expected to become skilled in recognising, understanding, enquiring about and responding to family violence. They are not expected to become family violence specialists.

Mental health services can identify and respond to family violence by:

- supporting those experiencing family violence
- facilitating safety and protection, especially of children
- holding those who perpetrate violence accountable.

Effective responses to the needs of women, children and others experiencing family violence should be integrated into usual mental health care. Equally, responding to people who perpetrate violence must be part of mental health care.

Members of mental health services' leadership groups have a responsibility to:

- undertake introductory training on family violence
- ensure family violence training and supervision is accessible to all clinicians
- create an authorising environment and provide leadership
- develop effective organisational policies and procedures for identifying and responding to family violence
- proactively support collaboration and partnerships with other service providers
- ensure the organisation follows the new Family Violence Information Sharing Scheme, the Child Information Sharing Scheme and the updated Family Violence Risk Assessment and Risk Management Framework ('FV framework') (from September 2018)
- ensure the organisation supports staff who are experiencing family violence.

Mental health clinicians have a responsibility to:

- undertake necessary family violence training and professional development appropriate to their level and role (including changes to be introduced under new information-sharing schemes and the new FV framework)
- identify and respond to people who experience and those who perpetrate violence
- actively consult senior clinicians, supervisors or specialist family violence services to optimise their response.

Introduction

Every year, tens of thousands of Victorians are the victims of violence in their homes

Family violence takes many forms and covers a wide spectrum of behaviour. It includes physical, sexual, psychological, financial and emotional abuse or coercion, and other behaviours that hurt, frighten, intimidate, humiliate or isolate another person. Appendix 1 contains a full definition of family violence from the Family Violence Protection Act 2008 (Vic).

Examples of family violence include stalking, neglect and abuse of children, cruelty to pets, damage to property, financial abuse and preventing a person from interacting with others.

Perpetrators' attempts to exercise power and control over another person can escalate over time. Although every experience is unique, family violence is not a one-off incident for most victims/survivors. Family violence is understood as a pattern of repeated and coercive control, aiming to control another person's thoughts, feelings and actions.

While family violence remains one of the most underreported crimes, police data show alarmingly high rates of violence. Victoria Police recorded 76,497 family violence incidents in 2016–17, with women comprising three-quarters of the victims. Family violence accounts for 17.5 per cent of all crime in Victoria.

Family violence is a major public health problem across the world and is associated with many serious physical and mental health impacts.

Most victims of family violence are women and children and most perpetrators are men. However, both men and women can be perpetrators or victims of family violence (see the box on the following page). The most common and pervasive instances of family violence occur in intimate partner relationships. Gender inequality has been identified as the leading cause of family violence, particularly intimate partner violence.

However, violence can occur in all types of families, kinship networks and intergenerational relationships. Lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people experience violence in their relationships. Family violence can be perpetrated by young people against their parents or siblings, or by adult children against their elderly parents (elder abuse). Some family members and non-family carers perpetrate violence against people they care for, and violence is sometimes perpetrated against carers.

Certain people or communities are at higher risk of experiencing family violence. They are also more likely to experience barriers to accessing services or to receiving an appropriate response. The section on 'diversity and intersectionality' in this guideline provides further information.

Note

This guideline has been developed at a time of significant change following the royal commission's report and recommendations.

Some of the most significant changes relate to the Family Violence Risk Assessment and Management Framework ('FV framework', commonly referred to as 'CRAF' (*Crisis risk assessment framework*)), the Family Violence Information Sharing Scheme and the Child Information Sharing Scheme.

Changes to information sharing has a focus on increasing the safety of victims/survivors and removes certain consent requirements if safety is at risk, especially children's safety.

While new legislation was introduced in February 2018, mental health services will be 'prescribed' to follow these changes by September 2018.

Information about changes, training, roles and responsibilities will be provided by Family Safety Victoria and the Centre for Workforce Excellence.

The gendered nature of family violence

Family violence is predominately perpetrated by men against women and children.²

In Australia, one in four women has experienced violence from an intimate partner.³

On average, at least one woman dies at the hands of a current or former partner every week.⁴

One in five women has experienced sexual violence, and 92 per cent of women who are physically assaulted by a male know the perpetrator – commonly (41 per cent of cases) this is a former partner.³

One in four children experiences family violence.⁵

While women are more likely to experience violence by a known person rather than a stranger, the reverse is true for men.⁶

Women are eight times more likely to experience sexual violence by a partner than men.³

Around 95 per cent of victims of all types of violence – whether women or men – experience violence from a male perpetrator.⁷

Three out of four affected family members (victims) are female, while one in four is male.⁸

One in 12 men in Australia (694,100 or 8 per cent) has experienced violence by a female intimate partner.⁶

Intimate partner violence contributes to more death, disability and illness in women aged 15–44 than any other preventable risk factor, including smoking and obesity.⁹

There are times when women and their children are at greater risk of intimate partner violence. For example, young women (18–24 years) experience significantly higher rates of physical and sexual violence than women in older age groups³ and women are at higher risk of intimate partner violence during pregnancy and shortly after birth.¹⁰

Women with disabilities or long-term health conditions are more likely to experience violence.⁶

Women with mental illness experience higher rates of violence than those without mental illness.¹¹

About this guideline

The guideline outlines expectations of mental health services managers and clinicians regarding their roles in responding to family violence.

Language

The term 'victim/survivor' is used to refer to those who experience family violence, reflecting the advice of the Victorian Government's Victim Survivors' Advisory Council.

The term 'perpetrator' is used to describe people who use family violence.

In this document, the word 'family' encompasses and acknowledges the variety of relationships and structures that can make up a family unit and the range of ways family violence can be experienced, including through family-like or carer relationships.

The term 'Aboriginal' is used to refer to both Aboriginal and Torres Strait Islander people.

The term 'clinician' is used to describe all who are involved in a person's mental health care. It is acknowledged that lived experience staff do generally not identify as clinicians. They are, however, included under the umbrella term 'clinician' in this document.

Appendix 1 provides further definitions of terms used in this document.

Scope and focus

The guideline applies to publicly funded clinical mental health services in Victoria, including all service settings (mental health inpatient units, community teams, subacute services, residential services, emergency departments and general hospital inpatient units) and services delivered in people's own homes. The document may also be used by private mental health services and mental health community support services; however, the Chief Psychiatrist does not direct these services.

The guideline focuses predominately, but not exclusively, on women and children as the main victims/survivors. Other forms of family violence are recognised, and the guideline provides information and practice suggestions to work with diverse groups, including men who use violence.

Sections

While the guideline can be read in its entirety, it has been organised into different sections that can be lifted out, copied and used in practice as prompts. The key messages, for example, could be copied and displayed to remind all clinicians of their responsibilities.

Section title	Focus	Greatest relevance
Summary	Short summary of the document's purpose and key messages	Management and clinicians
Introduction	Background information about family violence and introduction to the document	Management and clinicians
Guiding principles	Principles underpinning the guidelines	Management and clinicians
Organisational responsibilities	Responsibilities of the service's leadership group, including management, family violence sponsors and senior clinicians	Management
Clinical practice	Guidance and expectations of mental health service provision for clinicians, including practical examples and advice.	Clinicians
Appendices	Abbreviations and definitions; organisational checklist; key policies, guidelines and initiatives; practice resources; clinical checklist; myths about family violence	Management and clinicians

The Royal Commission into Family Violence

The Royal Commission into Family Violence report 2016¹ outlines 227 recommendations addressing a wide range of gaps across Victoria's service system. This guideline responds specifically to recommendation 97, which states that:

'The Chief Psychiatrist issue a guideline relating to family violence – including that family violence risk should be assessed when considering discharging or transferring care of a person receiving mental health services and when consulting with families or carers in relation to treatment planning.'

The guideline is also connected to recommendation 102, which states that 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. Findings from the project to develop this guideline will inform understanding of training needs in the mental health sector.

The guideline is just one component of the Victorian Government's response to the royal commission's report. The government's *Ending family violence: Victoria's plan for change*¹² outlines a vision of a Victoria free from family violence and a commitment to implementing all the royal commission's recommendations. Key reforms being progressed as part of this 10-year plan include:

- establishing 'Support and Safety Hubs' ('The Orange Door')
- the new Family Violence Information Sharing Scheme and Child Information Sharing Scheme
- reviewing and redeveloping Victoria's FV framework
- introducing routine antenatal screening for family violence
- an integrated model of care for responding to suspected elder abuse
- establishing the Centre for Workforce Excellence (within Family Safety Victoria), the *Family violence 10-year industry plan* and the *Responding to family violence capability framework*
- implementing the Strengthening Hospital Responses to Family Violence initiative across the state
- establishing family violence advisor roles in mental health services and alcohol and other drug (AoD) services
- introducing a broader range of interventions targeting perpetrators.

The impact of family violence on infants, children and young people

Approximately one in four children experiences family violence.³ Recent data reflects that more than half of the women who experience violence had children in their care when the violence occurred, with more than three-quarters of children witnessing the violence.³

Children can be direct and indirect victims of family violence. The terms 'living with' and 'experiencing' family violence best describe the circumstances for a child in this environment.

Experiences of family violence include:

- suffering physical harm; for example, if a mother is holding a child when she is attacked; if a child is trying to protect his or her mother; or the child is the target of the violence
- feeling scared of those who they love
- seeing the consequences of physical violence
- having belongings destroyed
- distress caused by harm to a pet or threats that their pet will be harmed
- not being allowed to bring friends home or being unwilling to bring friends home because of shame they will witness family violence
- isolation from extended family
- feeling responsible for the violence
- disruptive schooling because of absences or changing schools
- having a parent who is struggling in their parenting role due to experiencing violence.

Some perpetrators use children or young people to maintain power and control. For example, a father who is perpetrating family violence might:

- use the child as a means of ensuring the mother returns home
- force the child to watch or participate in assaults
- interrogate or involve the child in spying on their mother
- undermine the mother by encouraging the child to have negative opinions of her.^{1,13}

Family violence trauma can disrupt child development and healthy attachment and compromise brain development.¹⁴ The notion of children 'being too young to understand' has been challenged in the research literature on the impacts of family violence trauma. Children do not need to understand or have language to feel the impact of violence. Even if it is experienced before birth (during pregnancy), family violence has enduring detrimental impacts and significantly increases the risk of mental health disorders at all stages of life.¹⁵

Manifestations of this trauma include regression – for example, a child wetting the bed after previously having bladder control, developing sleep problems, withdrawing, being anxious or becoming aggressive. Some children develop chronic somatic problems. Older children and young people might engage with risk-taking behaviours such as using drugs or alcohol or experience suicidal ideation or other mental health difficulties.

Experiencing childhood trauma, especially severe trauma, is likely to have many effects on a person, including long-term effects on their mental health. Many people, especially women, who receive a diagnosis of borderline personality disorder have experienced childhood trauma. Complex trauma-related disorders such as borderline personality disorders are frequently not well understood within a trauma framework. This can lead to women with such a diagnosis to move between mental health, sexual assault and family violence services without coordinated support that assists with the impact of early childhood trauma.¹⁶

Family violence and mental illness

Experiencing family violence has a detrimental effect on mental health

Current and/or previous family violence, including childhood sexual abuse, can cause or exacerbate mental health problems and mental illness.^{11, 17} The following studies are part of a large body of evidence showing a relationship between family violence and poorer mental health outcomes:

- An Australian study found that ‘women who had experienced gender-based violence are more likely to experience mental illness over the course of their lifetime’. The study also found that ‘approximately 77 per cent of women who have experienced three or four types of gender-based violence had anxiety disorders, 56 per cent had post-traumatic stress disorder and 35 per cent had made suicide attempts’.¹⁸
- A Victorian study found that one-third of people who suicided in Victoria had a history of ‘exposure to IPV [interpersonal violence], present in almost half of female suicides and in one third of male suicides’. Women are more likely to be victims/survivors and men are more likely to be perpetrators of family violence. A larger proportion of the 517 women who died ($n = 219$, 42.4 per cent) had experienced violence than men ($n = 554$, 33.9 per cent).¹⁹

The main mental health impacts on people who experience family violence are depression, anxiety, post-traumatic stress and suicidal ideation.²⁰ Almost 60 per cent of the health impact relates to anxiety and depression, with women who experience family violence almost twice as likely to be depressed, anxious or use alcohol.²¹ (Conversely, depressive symptoms can increase the risk of experiencing intimate partner violence.) There is also a link between intimate partner violence and postnatal depression.¹⁶ Additionally, many people with other types of diagnoses, including bipolar disorder, psychosis, schizophrenia¹⁶ and eating disorders, have experienced high levels of violence.²² Many people who have experienced trauma, especially during early childhood, hear voices (this can include ‘hearing the perpetrator’, defending themselves or internalised shame). While within a mental health service context the existence of voices is generally seen as a symptom of psychosis, hearing voices can also be the effect of abuse (or a combination of psychosis and voices connected to abuse).²³

Being abused during childhood increases the likelihood of experiencing abuse as an adult. The cumulative effect of different types of abuse over a lifetime increases the likelihood of health and mental health problems and mental illness.

Trauma, complex trauma and trauma informed care and practice

Awareness of the prevalence and impact of trauma has increased greatly in society and within health care over recent years. Trauma can have been defined as ‘overwhelming stress. Interpersonal trauma includes sexual abuse, physical and emotional abuse, community and family violence as well as neglect.’²²

Trauma can affect many areas of a person’s life, in particular if it happened during childhood, if the person was not believed or did not receive appropriate support, or if the violence occurred at pre-verbal age. Having experienced trauma, a (perceived) threat can

be enough for a person to feel unsafe or threatened. While the initial experience lies in the past, its effects can be felt as if there was immediate danger (this is called being 'triggered').

Complex trauma is 'cumulative, underlying, and often interpersonally generated'.²⁴ Understanding the long-term impacts of trauma, in particular the cumulative effects of trauma experienced by many people who access mental health services, forms the foundation of becoming trauma-informed.

Trauma-informed care and practice (TICP) involves a shift to understanding the impact of trauma on a person's life, their health and mental health. TICP has five principles: safety, trustworthiness, collaboration, choice and empowerment. Organisations that apply a TICP framework ensure that these principles are applied throughout policy and mental health care. While this document does not allow for an in-depth look at TICP, organisations are advised to follow current best practice models (such as that provided by the Blue Knot Foundation <<http://www.blueknot.org.au>>).

People with mental illness as perpetrators of violence – myths and facts

*People with mental illness are more likely to be victims
than perpetrators of violence and crime*

The belief that people with mental illness are likely to perpetrate violent crime is steeped in stigma and discrimination rather than facts.

Population-based studies of the relationship between mental illness and acts of violence have reported mixed findings. While most mental disorders are not related to violence, some studies have found an increased risk of violence by patients with schizophrenia compared with the general population.²⁵ However, systematic reviews of published research have concluded that most, if not all, of this increased risk is associated with comorbid substance abuse rather than the mental illness per se.²⁶ Without substance abuse, a person with mental illness is only as likely as anybody else in society to be violent.²⁷ Mental illness carries far less weight as a predictor of violence than variables such as gender, age and history of offending.²⁸

People with a mental illness are more likely to be the victim of violence than to perpetrate violence. Women and men with all types of mental illness diagnoses report higher rates of family violence experiences than those without mental illness. As in the general population, women who use mental health services are more likely to experience family violence than male consumers. Among female consumers, studies report prevalence rates between 23 and 70 per cent, depending on the service setting and the type of abuse experienced. When childhood abuse (including sexual abuse) is considered, prevalence rates are up to 90 per cent for women with mental illness who access acute mental health services.²⁹

Even though women are more likely to tell health professionals than others about intimate partner violence, it is rare that such disclosure occurs spontaneously. As discussed in the clinical practice section of this guideline, mental health clinicians must be open to the possibility of family violence, otherwise it is likely to be missed.

Families of people with mental illness

While mental illness is not a strong predictor of violent behaviour, some family members and other carers experience violence from the person with mental illness. Study findings suggest that between 10 and 34 per cent of family members have experienced physical assault by a family member with mental illness.^{30,31} In some cases, the violence is directly related to the person's mental illness – for example, when individuals act on delusions such as voices telling them to harm someone. In these cases, addressing the symptoms of mental illness is likely to reduce the risk of violence. For others, the violence is not related to their mental health problems, and they are abusive or violent to their partner or family member irrespective of their mental state.

Conversely, families and other carers might perpetrate violence against the person with mental illness. Data on violence by family members, including carers, against people with mental illness are scarce, except for intimate partner violence (refer to 'the gendered nature of family violence').

In clinical practice, dealing with these forms of violence can be challenging, particularly when family members are involved in the person's care. Balancing the inclusion of family members (as part of good mental health practice) with the fact that family violence is present requires careful consideration of all family members and their safety. The safety of victims/survivors has to be the first priority, ensuring consent is sought and the wishes of the person affected by violence are adhered to.

Guiding principles

Five key principles underpin this guideline:

- responding to family violence
- trauma-informed care and practice
- working with families
- diversity and intersectionality
- collaboration.

Responding to family violence

Responding to family violence is a core element of good mental health practice. Mental health clinicians have a responsibility to enquire about safety and respond to the impacts of current and past family violence on individuals and their children and families. Equally, enquiring about violence and responding to individuals who perpetrate family violence are integral to good mental health practice.

The safety of individuals, whether consumers or family members, who are subject to or at risk of violence must be the first concern when family violence is identified. Ensuring the safety of children affected by violence is paramount, as reflected in the principles of the *Mental Health Act 2014*, the *Children, Youth and Families Act 2005*, the *Family Violence Protection Act 2008* and *Family Violence Protection Act Amendment 2017*.

Trauma informed care and practice

Trauma-informed care and practice creates an environment that is culturally safe and supportive, and which facilitates disclosure of family violence

The TICP approach acknowledges that most people who use mental health services have experienced abuse or other trauma and recognises the impact trauma has had on the person. It provides a way to understand past and current stressors and links these with the person's current level of distress and mental ill-health.

On an organisational level, it means adopting 'cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches'.³² Trauma-informed organisations ensure all staff (clinicians and others) are well supported to provide trauma-sensitive care and create safer environments for consumers and family members to talk about all forms of abuse, including family violence.

Many people who have experienced trauma can be triggered through a range of circumstances and behaviours. Inpatient units and bed-based services in particular can be spaces that can be re-traumatising for people. A TICP approach includes understanding a person's potential triggers and providing sensitive support when this occurs.

It is acknowledged that consumers can find compulsory treatment under the Mental Health Act re-traumatising.

Even if organisations have not implemented TICP on a system-wide level, elements of TICP can be incorporated into clinical care by individuals and teams.^{16, 33}

Working with families

Victoria's mental health legislative and policy frameworks emphasise that engaging and working with consumers' families and carers is part of good mental health practice. The Chief Psychiatrist expects mental health services to:

- in collaboration with the consumer, identify family members and carers and involve them in assessment, treatment and recovery
- be clear about privacy, confidentiality and information-sharing protocols
- respond to the needs of families and carers
- include families and carers in organisational governance
- have clear support and referral pathways (also see the Chief Psychiatrist guideline *Working with families and carers*).³⁴

However, in situations where family violence has occurred, or is at risk of occurring, working with affected consumers can be challenging for clinicians. Adhering to principles of family involvement needs to be balanced with the safety of consumers, their children and/or other family members.

If family violence is occurring, clinicians need to respect the victim/survivor's wishes about the involvement of family members. The safety of victims/survivors and their children is paramount and trumps family involvement requirements if this is deemed unsafe by the person experiencing family violence.

If a person with mental illness is, or has been, violent towards their partner or other family members, the safety of family members should be central to decision making. Discharge planning needs to assess levels of safety and risk to family members (refer to 'Discharge planning and transfer of care' in the 'Expectations at different stages of the care pathway' section). Safety concerns expressed by family members need to be taken seriously and their wishes respected.

Experienced clinicians are often able to balance these tensions, while others will require assistance from more senior colleagues (such as their supervisor or manager) and/or consultation with a specialist family violence service.

Diversity and intersectionality

Victoria is made up of many diverse communities. Practising within a diversity framework requires an appreciation of difference beyond the obvious characteristics of an individual.

Although family violence is not part of any culture or unique to any community, people from 'diverse' communities are often confronted with intersecting and compounding risks relating to family violence. Family Safety Victoria's *Diversity and intersectionality framework* states:

Intersectionality describes how diversity characteristics such as gender ethnicity and cultural background, language, socio-economic status, disability, sexual orientation, religion, age, geographic location or visa status and mental illness can interact on multiple levels to compound risk, create overlapping forms of discrimination and amplify service barriers.³⁵

Intersectionality recognises the various ways people can face heightened risks and increased barriers (including systemic barriers) to getting support.³⁵ An intersectional approach means taking all characteristics or 'identities' of a person into account, including how the person experiences family violence.

Collaboration

*'The most beneficial responses to people with special/diverse needs are provided when there are strong, collaborative, cross-sectoral partnerships which promote a sharing of expertise between specialist and other services to build capacity'*³⁶

An effective response to family violence requires that mental health services work collaboratively with other services such as police, child protection, sexual assault and legal services.

Clinicians should also actively seek out specialist family violence services with specialised family violence knowledge and expertise for consultation, referral and co-working (for example, joint case management).

As well as supporting clinicians' collaborative relationships with other practitioners, mental health services should build relationships with other relevant organisations at a service-to-service level and as part of agency networks addressing family violence.

Organisational responsibilities

Mental health services are expected to have leadership and governance arrangements that enable effective responses to family violence

This section provides information and advice to help mental health services build a 'whole-of-organisation approach' to family violence, as recommended by the Royal Commission into Family Violence. It is targeted to the service's leadership group.

Mental health services are expected to develop their own policies and processes consistent with the broad guidelines provided here and in the *Family Violence Risk Assessment and Risk Management Framework* ('FV framework). These should be incorporated in planning and quality assurance mechanisms, including strategic and business plans. The Strengthening Hospital Responses to Family Violence resources, developed by the Royal Women's Hospital and Bendigo Health, provide more detailed guidance to support this work.³⁷ Appendix 2 contains a checklist that summarises organisational requirements.

Organisational policies and processes must comply with relevant legislation and Victorian Government policies (see Appendix 3) and be kept up to date with initiatives implemented as part of the government's response to the royal commission's recommendations.

Ideally, members of the leadership group will undertake the appropriate level of induction training delivered through the redeveloped FV framework (due for release in September 2018). In the interim, management may wish to use the one-hour modules of the Strengthening Hospital Responses to Family Violence resources³⁷ or training provided by the Domestic Violence Resource Centre.

Family violence roles

The new FV framework will outline roles and responsibilities regarding family violence. Consult the framework from September 2018 to clarify these and align with organisational policies and responsibilities outlined here.

Executive sponsor

The mental health service should identify a family violence executive sponsor from within the leadership group. This role is responsible for the organisation's response to family violence in collaboration with the members of the family violence committee.

Family violence committee

The executive sponsor will establish a family violence committee to oversee the implementation of this guideline and develop an organisational project plan and local implementation plans. The executive sponsor and the committee are responsible for aligning organisational policies and procedures with the most current FV framework and tools. The committee should include representatives of all clinical disciplines and people with lived experience (consumers and carers).

Reflective questions

- Have you thought of involving the specialist family violence advisor and the Families where a Parent has a Mental Illness (FaPMI) coordinator on your family violence committee? Have you involved or do you have a plan for involving people with lived experience in this work and on the committee?
- How and when will the committee report to the service's main executive committee?
- What authority do the executive sponsor and the family violence committee have, and where are ultimate decisions made?
- How does this committee relate to lived experience committees?
- Do you have the right combination of people on the committee?
- How will you communicate with the rest of the organisation about this work?

Clinical family violence champions

Mental health services are strongly encouraged to identify clinical family violence champions from a range of different programs and disciplines. Ideally, each team will have at least one clinical family violence champion.

The role of clinical champions is to support and assist other clinicians to identify and respond to family violence. Clinical champions should have sound knowledge of family violence issues and practices, and capacity to support others. Their family violence roles and responsibilities should be written into their position descriptions and performance plans.

Family violence policy

Mental health services are expected to develop a family violence policy or revise their existing policy to ensure consistency with this Chief Psychiatrist guideline and align with the FV framework. In developing or updating policies, it could be helpful to consider other mental health services' policies and/or the Strengthening Hospital Responses to Family Violence sample policy.³⁸

Collaboration and partnerships

Collaboration provides both mental health and specialist family violence services with increased access to each other's expertise. Collaboration may also extend to services that are not specialist family violence services but provide family violence specific programs (such as community health services' and services for specific communities). The new Family Violence Information Sharing Scheme and the Child Information Sharing Scheme will provide guidance regarding information sharing between organisations.

The mental health service's leadership group, family violence executive sponsor and family violence committee members are responsible for establishing mechanisms for cross-sector collaboration. Over time, the mental health service will develop more formal agreements about referral pathways and secondary consultation arrangements between services. Liaison with Victoria Police forms part of organisational responsibilities.

If not already established, good working relationships with police need to be established through structured meetings with local police to ensure clear referral pathways and engagement regarding family violence.

Collaboration and partnering with other organisations can also occur by nominating mental health service representatives to cross-service regional family violence committees.

Active participation in Risk Assessment and Management Panels

In line with recommendation 98 of the Royal Commission on Family Violence, mental health services are required to be active participants of their regional Risk Assessment and Management Panel (RAMP). The RAMP is a formally convened meeting of key agencies and organisations that contribute to the safety of victims/survivors (including children) experiencing serious and imminent threat from family violence.

The management leadership group, and ultimately the mental health service's operational manager, is responsible for ensuring continuing participation in the RAMP, including key actions assigned to the mental health service. The family violence committee should receive regular updates on how contributing to the RAMP benefits other organisations, consumers and carers of the mental health service. This also provides an opportunity to review systemic issues highlighted by the RAMP.

Professional development, supervision and support

Mental health clinicians should be trained and supported to integrate family violence enquiry and response into their practice

Training and skills development

Position descriptions for clinical mental health roles need to convey an expectation that incumbents will have or acquire family violence skills and knowledge.

Training on family violence and related organisational policies should be part of induction training for new clinicians, and all clinicians should receive family violence training suited to their level of skill and experience. Senior clinicians are expected to have advanced knowledge and skills in this area. Family Safety Victoria's Centre for Workforce Excellence is central point of information on workforce development.ⁱ

Mental health services can access training through a variety of means and for different levels of competency. They might decide to access training from an external provider (for example, the Domestic Violence Resource Centre Victoria), an internal health service training unit, the mental health training clusters or the new Centre for Mental Health Workforce Development.

Training will also be provided regarding the new FV framework from September 2018. Staff are expected to participate in training as directed by their organisation.

ⁱ For more information regarding the Centre for Workforce Excellence, see the Family Safety Victoria website <<https://www.vic.gov.au/familyviolence/family-safety-victoria/the-centre-for-workforce-excellence.html>>.

Clinical supervision

All clinicians, including the lived experience workforce, must have access to discipline-specific supervision. The clinician's usual supervisor is expected to provide supervision that develops skills and confidence in responding to family violence. Organisations need to provide clear expectations of staff about when and how to escalate a family violence situation to a senior staff member, including how to respond to high-risk situations. It is expected that such guidance will form part of an updated family violence policy and guideline. A clinician should not be left holding family violence risk on their own.

Consultation can also be obtained from internal specialist family violence advisors (as available), specialist family violence services or (once established) a Support and Safety Hub ('The Orange Door').ⁱⁱ

Support for staff affected by family violence

Prevalence rates of family violence in the general community suggest that many clinicians and other staff will have personal experience of family violence.

The family violence executive sponsor, members of the service's family violence committee and senior clinicians should be familiar with the organisation's policy on supporting staff who experience family violence.

Physical environment

The design of facilities and spaces can support disclosure of family violence. Where possible, the leadership group should make any changes needed to provide safe, private and friendly physical environments. Creating women-only corridors is one example of working towards improving safety for women in psychiatric inpatient units.

Staff need to be sensitive to the fact that the environment, in particular that of inpatient units, can be re-traumatising for many patients. Applying a Trauma Informed Care and Practice framework assists with understanding that people can be triggered through a range of situations and behaviours by others including staff, patients and visitors. Good clinical mental health care includes an awareness of and sensitivity to these issues and strategies to support patients who experience re-traumatisation.

ii For more information about the Support and Safety Hubs, see the Family Safety Victoria website <<https://www.vic.gov.au/familyviolence/support-and-safety-hubs.html>>.

Clinical practice

This section outlines expectations of clinicians when responding to suspected or identified family violence by:

- describing key practice approaches and steps
- discussing specific clinical situations and considerations at different points in the pathway of care
- highlighting issues relevant to diverse communities
- giving advice on overcoming common barriers to effective family violence responses.

Appendix 4 provides links to further resources to help clinicians respond appropriately to family violence.

Key practice stepsⁱⁱⁱ

Enquiring about and responding to family violence should be part of each mental health clinician's routine practice when assessing or treating people with a mental illness, and when planning and transferring their care.

Clinicians' responses to family violence will vary according to the person's circumstances, wishes, and level of risk, as well as the type of violence and whether a child is at risk. However, the practice steps described are applicable to all types of response.

While described as discrete entities, the steps can occur simultaneously or in overlapping or non-linear ways. In some circumstances, such as a triage assessment, not all the steps will be undertaken due to the brevity of the interaction.

Appendix 5 contains a checklist for easy reference to the main messages, which are to **enquire, support, assess risk, plan for safety, follow-up, consult, refer** and **collaborate**.

ⁱⁱⁱ Family Safety Victoria is in the process of developing guidance on risk assessment. A suite of tools will be available online and training will be provided. The new risk assessment framework and tools will override this information once available.

Enquire

*'Women are more likely to disclose domestic [family] violence to a healthcare professional than to the police'*³⁹

Routine mental health assessments and risk assessments include enquiring about family, partners, family relationships and dependent children. Given the high prevalence of family violence experienced by mental health consumers, questions that enable disclosure must form part of these assessments. The clinical picture is incomplete if the treating clinician does not know about current or previous family violence, including childhood abuse. A comprehensive mental health assessment has to address family violence.

Even though women are more likely to disclose family violence to a health or mental health professional, they are not likely to disclose *unless they are asked*.¹ Similarly, someone who uses violence against their partner or family member is unlikely to disclose this spontaneously. Initial and ongoing interactions with consumers should include questions about how they experience their family relationships, including any problems, concerns or conflict (see practice points 'enquiring about a partner and family relationships' and 'asking questions if family violence is suspected').

Enquiries that could lead to a disclosure of family violence should not occur in the company of the person's partner or other family members because this can increase risk to the person. While it is relatively unlikely that a person who perpetrates violence will disclose their behaviour, family members might discuss such violence with clinicians. If this has occurred, develop safe ways to check in with family members and to follow risk assessment and risk management protocols as outlined later in this guideline. Particular attention needs to be paid to such risk if the person perpetrating the violence is to be discharged into their family's care (also see later section on 'Expectations at different stages of the care pathways').

Practice points

Enquiring about a partner and family relationships

Start with broad questions such as 'How are things at home?' or 'How are you and your partner/teenage son/daughter getting on?'.¹

If appropriate, questions can become more direct, such as 'Do you feel safe' or 'Are you afraid (of your partner, family member)?'.¹

Following the intake and initial assessment processes, questions about (potential) family violence need to be revisited over time. Initially, consumers might suggest that things are not quite right with their partner but not be ready to say more. Over time, you should check in regularly about how significant relationships are going and whether the consumer would like to talk about anything.

Further information on 'asking questions' is available in the following publications:

- *Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook*⁴⁰
- *Abuse and violence: working with our patients in general practice*¹³
- *Supporting patients experiencing family violence: a resource for medical practitioners*⁴¹
- *Can I ask...? An alcohol and drug clinician's guide to addressing family and domestic violence.*⁴²

Practice points

Asking questions if family violence is suspected^{iv}

If family violence has been disclosed or is suspected, questions about family violence should be introduced by providing the context for asking such personal questions. For example:

- 'I am a little concerned about you because [of what you just told me] or [you say your relationship hasn't been good] or [you said your partner won't let you go anywhere on your own].'

More direct questions can then be asked, as appropriate. For example:

- 'Has someone in your family (your partner) done something that made you or your children feel unsafe or afraid?'
- 'Have they controlled your day-to-day living or humiliated you?'

[Prompt: controlled who you see, where you go, how much money you can have, when you can eat]

- 'Have they threatened to hurt you in any way?'

[Prompt: threats include to harm you, your children or other family members or pets or threat to kill]

- 'Have you been hit, slapped, kicked or otherwise physically hurt by them?'
- 'Do you feel safe when you leave here?'
- 'Are you worried about your children?'
- 'Do you have any immediate concerns about the safety of your children or someone else in your family?'

Why someone might not disclose family violence (even if asked)

There are many reasons why people do not feel comfortable or ready to disclose intimate partner or other forms of family violence. For example, a woman might:

- not be ready
- not identify her experience as violence
- have had negative experiences when disclosing it in the past
- be scared that the perpetrator will find out that she has talked to you
- be concerned about cultural profiling
- be worried that her children will be taken away
- be worried about judgement if she is in a same-sex relationship
- be worried that a disclosure is interpreted as evidence of mental illness
- be worried that professionals won't believe her.

Reflective questions

- Which questions about family violence do you feel most and least comfortable with? What might be the reasons for that?
- Who do you feel most comfortable or least comfortable asking these kinds of questions to? Think about why that is so.
- What would assist you to get more comfortable and confident in enquiring sensitively about family violence risk?

^{iv} The FV framework (due September 2018) will provide the most up-to-date questions.

Support

The clinicians' first response to (initial) disclosure should be conveyed through active listening and non-judgemental support.²⁰ This response will influence the person's level of comfort and trust in the clinician and the service, and whether they are likely to raise the issue again.

It takes a lot of courage to disclose something so personal and that is often associated with shame, blame and judgement. It is unacceptable that disclosures are shut down or brushed aside as 'delusions' of mental illness. Dismissive responses can exacerbate the victim/survivor's feelings of distress and isolation and could mean that the person continues to experience violence.

The clinician's response to disclosure of family violence, whether immediate or ongoing, will vary depending on the circumstances and level of risk identified (also see the 'Assess risk' section). Existing guidelines for other services' responses to disclosures of family violence encourage clinicians to 'listen, validate, believe, and respond'⁴³ or to 'listen, enquire about needs and concerns, validate, enhance safety and support'.⁴⁰

Support can also include making sure the person receives the necessary information to make informed decisions. You might have access to some of the information or you might need to consult or refer to another organisation. Relevant information will vary and may include intervention orders, legal rights, child protection and specialist family violence support services. The fact that no intervention order exists (or the person does not want to take out an order) does not mean that family violence is not occurring.

The practice points below offer some specific ideas about how to validate and support people who have disclosed family violence.¹³

Practice points

Responding to disclosures of family violence

If a person has disclosed family violence to you, you are the best person to provide an initial supportive response. This can be as simple as listening and validating someone's experience or agreeing to talk in more depth when the person is ready (provided there is no immediate risk of harm to them or others, especially children).

The New Zealand Ministry of Health offers the following advice for validating people's disclosures of family violence:

- Let them know you believe them.
- Let them know you're glad they told you.
- Let them know you're sorry it happened.
- Let them know it's not their fault.
- Let them know you'll help.
- Don't overreact. A first disclosure is a critical moment. The person will monitor every reaction and might be frightened if the abuser has threatened them not to disclose the violence or has told them that no-one will believe them.⁴⁴

Specific responses to a disclosure might include statements along the following lines.

- 'Everyone deserves to feel safe at home [in their relationships].'
- 'You don't deserve to be hit [or hurt or humiliated].'
- 'I am concerned about your safety and wellbeing.'
- 'You are not alone, I [we] will be with you through this. I support you.'
- 'You are not to blame; abuse is unfortunately common and happens in all types of relationships.'

You can express support by:

- being patient and taking time to listen
- responding in a non-judgemental way, with compassion and belief of experiences
- validating experiences and challenging incorrect assumptions (such as 'I deserve this')
- providing encouragement
- acknowledging the complexity of the issue
- respecting the safety concerns of the person and any dependent children, even if you have not met the person who is violent ('keeping the perpetrator in view')
- providing information on specialist family violence services if appropriate
- assisting the person to make their own decisions.¹³

Reflective questions

- Are there situations when you feel somewhat judgemental? If yes, when do you feel judgemental? Do you know what lies behind your judgement? What would assist you in becoming more understanding?
- Imagine a colleague dismisses a disclosure as being part of a woman's delusions. How would you go about increasing support for the woman and respectfully disagreeing with your colleague?

Assess risk

*Assessing risks to self or others is a core mental health practice
Assessing family violence risk needs to become part of good mental health practice*

Each disclosure of family violence should be met with an assessment of risk to the safety of those experiencing violence.

The Family Violence Risk Assessment and Risk Management framework (FV framework) is the standard family violence risk framework in Victoria. An updated version of the framework will be published in 2018 and associated training will be publicised through the Centre for Workforce Excellence (Family Safety Victoria). The updated version will include roles and responsibilities regarding family violence risk assessment.

Mental health clinicians are encouraged to use the current FV framework to assess family violence risks. Clinicians not yet trained in using the framework are advised to collaborate with colleagues or a specialist family violence service.

The updated FV framework will be implemented from September 2018. From this time, mental health services will need to comply with new legislation and undertake family violence risk assessments according to the new framework (as they will be 'prescribed' – follow the latest information and expectations as outlined by Family Safety Victoria).

Routine mental health assessment processes ('risk to self or others') provide an opportunity to determine whether the person with mental illness is likely to perpetrate violence and, if so, to identify people at risk. If the person at risk of violence is a partner or family member, then this constitutes family violence or the potential for family violence and this needs to be assessed, following contemporary family violence risk assessment procedures.

It is important to find out whether there is an intervention order protecting the person with mental illness or against that person because this provides information about the severity and nature of the risk. A copy of the intervention order, if one exists, should be requested and kept in the case file.

Assessing family violence risk

Family Violence Risk Assessment and Risk Management:

- is the process of identifying the presence of risk factors and determining the likelihood of an adverse event occurring, its consequences and its timing
- allows for an informed, tailored and proactive response and interventions that can help reduce the risk that a person will be harmed
- considers the victim/survivor's self-assessment or risk, presence of risk indicators, and professional judgement to determine the level of risk.⁴⁵

Understanding the relationship between likelihood, consequence and timing will promote structured decision making during risk assessment.

Plan for safety

Safety planning is part of routine family violence work in specialist services. Mental health clinicians can also undertake safety planning with people who experience family violence. The current FV framework needs to be used to undertake safety planning and utilise current evidence.

A safety plan can be formulated by taking the following into account:^v

- Safety planning is the process of identifying and documenting the steps required to optimise a state of safety for all victims/survivors in a family.
- Safety planning can refer to any aspect of physical, social, emotional, financial or psychological safety. It typically involves planning to avoid serious injury, to escape violence (crisis management) and to ensure safety of children.
- Often a safety plan will be developed with the adult victim/survivor, and the child victim/survivor will be involved so far as their involvement will assist in increasing their safety.

Practice points

Developing a safety plan

Use the current *Victorian FV framework*.

If uncertain, discuss safety planning with a colleague trained in the framework, a family violence advisor (if available at your organisation) or a specialist family violence service.

The risk assessment framework advises that a safety plan should identify:

- emergency telephone numbers
- a safe place for the victim/survivor and any children to go to in an emergency, and how they will get there
- supportive family, friends or neighbours willing to assist
- people or organisations who can care for pets, if applicable
- all family members affected by the violence, where possible
- an available source of money
- a place to store valuables and important documents together
- a plan for exiting their home and where they can go to (at least initially)
- any specific needs or resources relating to diversity and intersectionality.

The safety of children is paramount. Referrals to Child First, Support and Safety Hubs ('The Orange Door') or child protection services should be made according to organisational policies and procedures and the relevant legislation.

The Child Information Sharing Scheme provides clarity of what and when information can and needs to be shared about children at risk of harm (refer to earlier section). Mental health services will be prescribed from September 2018.

Reflective questions

- What do you need to consider before raising the idea of a safety plan with a consumer?
- What could you ask a colleague or specialist family violence staff member before discussing safety planning with your consumer?

Follow-up

Clinicians are expected to provide ongoing support following the initial responses to family violence disclosure. This can be done by enquiring often about the person's relationships and asking if there are any new concerns or support needs. Where children are involved, the clinician should enquire about each child in the family and their needs.

Risk assessments should be updated at regular intervals and whenever risk factors change, either for better or worse.

Reflective question

- What would assist you to stay engaged about family violence while providing other clinical care to the consumer?

Consult

Consultation with other practitioners is important, even for the most senior mental health clinicians. It not only helps the clinician provide good treatment and care in challenging situations but also supports the clinician's own wellbeing.

As a first step, clinicians will often consult people within their service – for example, an immediate supervisor, senior colleague or discipline leader, a clinical family violence champion, or the service's family violence advisor.

Families where a Parent has a Mental Illness (FaPMI) coordinators, who are available in all area mental health services, can assist mental health clinicians and partner agencies respond to family violence involving a parent with a mental illness. FaPMI coordinators can provide secondary consultation or suggest other services that can provide secondary consultation in cases involving parental mental illness.

Depending on the situation, supports available within the mental health service and their own expertise, clinicians will collaborate with other organisations to optimise their response and support for individuals and families affected by family violence. Relevant organisations include Support and Safety Hubs, Victoria Police, child protection services, Centres Against Sexual Assault or the Men's Referral Service. It can also be helpful to consult with other specialist services, such as Aboriginal, LGBTIQ, disability or youth services or organisations supporting culturally and linguistically diverse (CALD) communities.

Reflective question

- What specific support do you need from a consultation? It is helpful to write down some points before you seek advice from colleagues or others service providers.

Refer

Mental health clinicians are not expected to become family violence specialists and should engage specialist services, where necessary, as part of providing good clinical care.

All clinicians should have access to information about specialist family violence services available to people in their area.

Concerns regarding a child need to be responded to as per organisational policies, guidelines and current legislation. This may include referrals to Child First (to be integrated into Support and Safety Hubs) and reports to Child Protection.

Practice points

Referral to another service

If a person has disclosed family violence to you, you might be the best person to provide support in relation to this.

Before making a referral, consider what you or your service can provide. Clarify which information you can share according to current information-sharing schemes and legislation. Decide if a referral is necessary or if it might be better to consult with the specialist service provider.

If a referral is warranted, reach an agreement with the other service about what it can provide and what you will continue to provide. Refer to inter-organisational agreements if available.

Make sure you discuss the referral with the consumer and give information about what the other service will provide. Enquire about any specific service the consumer wishes to be referred to (including Aboriginal or LGBTIQ specialists).

If you will continue to be involved in the person's care, give reassurance that you will continue to provide support.

Reflective questions

- Reflect on your abilities, skills and experience in this area of work. Do you need a secondary consultation with a specialised service? Do you need to make a referral? Reflect on what assists you in making this decision or if you wish to discuss it with the specialist service.

Collaborate

Over time, mental health services will develop more formal relationships with the agencies they consult about family violence, including those that accept client referrals for providing specialist services.

Future collaboration between organisations and sectors will need to reflect changes in information-sharing legislation as it is introduced across Victoria between 2018 and 2020.⁴⁶ This is discussed further in the next section.

Reflective question

- How would you approach collaboration with a worker from a different sector? What has assisted in the past?

Sensitive practice

The Victorian Government funded the Royal Women's Hospital to collaborate with Bendigo Health in developing tools and resources to help Victorian hospitals to strengthen their response to family violence. The resulting Strengthening Hospital Responses to Family Violence toolkit describes sensitive practice as 'an approach to engage with [patients and] consumers in a way that increases or elicits their feelings of safety, respect and control'.⁴⁷

The principles of sensitive practice are summarised below.

Respect the person and their experience, wishes and needs.

Take time to enquire, to listen and to respond.

Build and maintain rapport.

Share information. Let the person know what supports are available.

Stay supportive.

Engage respectfully. Convey respect in interactions and conversations.

Create a sense of control. Avoid 'doing to' or pushing one's own ideas onto the other person ('This is so bad, why don't you leave?').

Sensitive and appropriate practice requires that clinicians have non-judgemental attitudes and accurate information about family violence and its impacts. Appendix 6 outlines common societal myths that can shape people's attitudes to family violence.

Documenting and sharing information

Training for Victoria's new information-sharing legislation is being progressively introduced throughout 2018 and 2019

When family violence has been identified or is suspected, sharing information with family members should be considered very carefully. Clinicians should seek direction from the victim/survivor and secondary consultation as required. Information that could increase risk to the consumer should not be provided to the person who is violent, even if the consumer has previously identified the perpetrator as a 'nominated person' under the *Mental Health Act 2014*. In such situations, the consumer may wish to change their nominated person to someone else or limit which information can be provided. It is unacceptable that a consumer's wish is negated due to their current mental state. The consumer's safety is paramount and needs to take priority over a previous arrangements regarding a nominated person.

Information can be shared about the person perpetrating the violence, the adult victim/survivor, children and third parties if consent requirements are met and the information relates to assessing or managing a family violence risk (see the latest legislation on information-sharing schemes to be introduced in September 2018).

In a situation where a family member has disclosed that the consumer perpetrates family violence, file notes can be made, reflecting the family member's disclosure. At the same time, as a disclosure increases potential risk to the family member, information sharing (as with any third-party information) can be restricted by following the usual processes. The information can be marked as exempt from freedom of information laws and therefore will not be accessible to the consumer.

Victoria's new Family Violence Information Sharing Scheme and the Child Information Sharing Scheme⁴⁶ mean that information about victims/survivors and children at risk will be shared differently than in the past.^{vi} These changes will be introduced over time, and organisations will be progressively 'prescribed' to comply with the new requirements. Family Safety Victoria is in the process of developing a training strategy for Victoria. Regular updates will be available on its website and through the Centre for Workforce Excellence (Family Safety Victoria).

^{vi} These changes will include that consent is not required to share information if there is serious threat to someone's safety (follow newly introduced information-sharing schemes as prescribed). Discuss with senior staff if uncertain.

Practice points

Case documentation

Information about family violence should be recorded and passed on at each stage of the care pathway, from triage to other internal and external services, through to discharge.

Follow the health service's policy about documenting patient information, privacy and confidentiality, and for storing notes.

Document disclosures of family violence or intimate partner violence in the consumer's file. Be factual and succinct.

Document any risks, evidence of injuries, treatment provided, referrals made and any information the person has disclosed about the violence.

(Separate) documentation needs to occur for the person who experiences violence and the person who perpetrates violence.

In situations where a parent is the perpetrator of family violence or child abuse, consider the parent's access to the child or young person's file. Follow organisational procedures and consult senior clinicians and management to ensure that documentation requirements are met in a way that does not jeopardise the safety of children and young people.

The Royal Women's Hospital has adopted the following as standard for documenting family violence disclosure. It is suggested that mental health services adopt a similar, if not the same, standard for documenting family violence:

- date
- clinician's name
- person's name
- suspected family violence
- clinician's observations
- clinician's actions, including secondary consultation
- follow up – what actions need to be taken?

Expectations at different stages of the care pathway

The guidance provided in the preceding discussion of key practice steps applies generally to all types care that consumers experience in mental health services. Table 1 lists some expectations applicable to specific components of the care pathway.

Table 1: Expectations at different stages of the care pathway

Service component	Expectation
Mental health triage	<p>If the person is not referred for further mental health services, and family violence has been identified, the consumer (or carer or other referrer) is to receive information about family violence support services and referral to these services following discussion and consent by the person.</p> <p>If the person is accepted for further assessment and/or treatment, any information about family violence is to be documented as part of the notes on the triage assessment. The clinical team receiving the referral from triage should be alerted to the need for further enquiry about and response to the violence.</p> <p>Regardless of whether the person is accepted by the mental health service, any immediate family violence safety concerns are to be referred to a specialist service or the police, depending on the circumstances and severity of the situation.</p>
Stays in bed-based services	<p>If information about family violence was obtained as part of previous service provision, it should be checked and updated.</p> <p>If family violence has been disclosed or is suspected, a treating clinician should find out if intervention orders are in place and alert other staff to any people who are not allowed to visit the patient.</p> <p>If no intervention order is in place, consider discussing the possibility of getting an intervention order with the person.</p>
Community mental health treatment	<p>Given the likelihood of longer engagement with consumers and carers in community-based services, clinicians have opportunities to enquire about and revisit family violence issues over time. If the consumer has disclosed family violence, the clinician should provide ongoing support to the consumer (or family) and involve specialist family violence services as needed.</p>
Discharge planning and transfer of care	<p>A revised risk assessment is to be conducted and documented as part of discharge planning. It is unacceptable that a person is knowingly discharged into a situation where their safety is at serious risk (follow the FV framework). All efforts should be made to discuss safety concerns with the consumer and seek alternatives to the person returning to the violent situation.</p> <p>If a person is discharged into a situation of family violence, this fact has to be documented on the case file and any discharge notes sent to other service providers, along with details of the safety assessment, safety concerns raised by clinicians or family members and any referrals made to specialist family violence services.</p> <p>If the consumer has perpetrated violence towards a family member, discharge planning needs to include a discussion with affected family members. While respecting family members' wishes, including their acceptance of the person back into the family, safety concerns need to be addressed.</p> <p>This can also be a good time discuss concerns about violent behaviour with the consumer (and their family if safe to do so), provided such discussions have started earlier in the episode of care.</p> <p>If the person who has perpetrated violence is discharged back into a family situation, the relevant documentation is to include information on the reasons for this decision, actions taken to respond to the behaviour, referrals to other services, and copies of intervention orders. Communication regarding discharge and safety planning with family, a partner and carers before the person is discharged needs to reflect family, partner and carer preferences and concerns.</p>

Specific clinical situations

When a woman's mental illness is used as family violence 'technique'

While family violence looks similar across any group in society, there are additional issues confronting women with mental illness. Some perpetrators (most likely intimate partners) use the woman's mental illness against her as part of perpetrating abuse, making it even harder for women to seek assistance. Techniques can include:

- telling her nobody will believe her because she has a mental illness or 'because she is mad'
- telling other people that she is 'crazy' and makes things up
- threatening to tell others (for example, in her workplace) that she has a mental illness
- withholding medication or controlling when she takes it
- controlling appointments, always accompanying her, and dominating conversations (to prevent disclosure)
- threatening to have her 'locked up'
- changing things in the house, denying having done so and telling her she it is part of her delusional thinking (also known as 'gaslighting')
- threatening to have the children taken away because she is a 'bad mother'
- turning the children against her by inflating how 'sick' she is
- lying to mental health professionals about how unwell she is (for example, making out that she is suicidal, has tried to harm herself or is not taking her medication) when this is not true.

Reflective questions

- What might assist you in identifying these behaviours?
- How might you begin to address controlling behaviour, if the partner is always in attendance?

Adolescent violence

Adolescent violence in the home is confronting and many parents are ashamed to talk about it.⁴⁸ It challenges the expectation that parents have more power and authority than the young person⁴⁹

Victoria Police records show that 6.7 per cent of those who perpetrated family violence in 2016–17 were aged 17 and under; 64 per cent of these incidents involved a parent/guardian as the affected family member. The average age of the young person was 14.8 years.⁵⁰ The real incidence of this type of family violence is likely to be much higher.

Adolescent violence has many similarities to other forms of family violence, but there are some key differences.⁵¹ The affected parent, sibling or family member *wants the violence to stop*, as in other forms of family violence, but usually does not want to consider separation from the child. The decision to involve police can be very difficult for parents, even if a police response is warranted. Taking out an intervention order against one's own child is even more challenging. Most parents do not want their child to get a police record, become involved with the youth justice system, or be removed. The situation is more complex still if the young person has an emerging mental illness.

Other points to note about adolescent violence are that it is:

- not the same as challenging behaviour, a single isolated incident or a strong reaction
- most often perpetrated by male adolescents against their mothers (and is more common in families led by single mothers); however, young women also perpetrate violence and fathers and siblings can also be the victim of such violence
- frequently connected to the child's own experience of family violence.

Parents typically do not seek help for adolescent violence until the behaviour has occurred over a long period and has escalated. Therefore, intervention should be offered as soon as possible. Interventions that involve the young person and their parent(s) can significantly improve family relationships and result in better outcomes for the young person.

Reflective questions

- What might assist you in identifying adolescent violence?
- How might you begin to address such behaviour when you work with a young person?

Elder abuse

*'Incidents of violence and abuse of older people are sometimes dismissed as being the result of "caregiver stress"... [but] there is never an excuse for abusing another person, regardless of how much stress a caregiver is experiencing'*⁵²

It is estimated that between 2 and 10 per cent of Australians aged 65 or older are experiencing or are at risk of abuse by someone they know or should be able to trust such as a partner, family member or carer.⁵³

While women experience higher rates of elder abuse, men can also be victims. Perpetration of elder abuse is not as gendered as other forms of family violence (where men are the main perpetrators); both men and women are known to perpetrate abuse towards elderly family members.

Elder abuse is a growing problem due to the ageing population, increased longevity and increased numbers of people with dementia. The most common forms of elder abuse are financial or psychological mistreatment,⁵⁴ although the abuse can be physical, social and sexual.

Elder abuse has similar risk factors to other forms of family violence and include family conflict, the victim/survivor's dependency on the perpetrator, social isolation and disability. Like other forms of family violence, it is underreported due to feelings of shame, fear and family responsibilities.

Practice points

Identifying elder abuse

What are the inter-generational relationships like in the family?

Does the son/daughter seem to make all the decisions for the elderly person or unnecessarily restrict the parent's autonomy?

Does the elderly person seem frightened, less certain or intimidated when a certain family member is present?

When both people attend a mental health service as consumers

It occasionally occurs that both the person experiencing violence and the person perpetrating violence attend the same service. The practice points below suggest ways that the organisation can respond in these situations to increase the victim/survivor's safety and hold the person using violence accountable.

Practice points

Managing situations where both the perpetrator and the victim/survivor use your service

The needs of the victim/survivor and those of the perpetrator of violence should be addressed independently.

Separate clinicians need to be allocated to each individual.

Each person needs to be admitted to a separate inpatient unit.

Do not discuss suspected or confirmed abuse with the perpetrating partner unless the victim/survivor has consented to this.

Note: Disclosure of family violence is a time of increased danger for victims/survivors. Even if the victim has given consent, highest caution is warranted – seek advice from a men's service before you take this step. Specialist workers are ideally the ones to discuss violence with a perpetrator. While a referral or their involvement might not be possible, seek advice first. The victim/survivor's safety must be the highest priority (the new FV framework will provide further clarity).

If such conversation is to occur, a safety plan needs to be in place.

Ensure a 'team approach' – make good use of clinical review processes to increase safety and decrease risk.

Follow usual procedures regarding the safety and care of children.

Violence during pregnancy and early parenting

Pregnancy is a high-risk period for intimate partner violence. Violence sometimes begins or becomes more severe during pregnancy,¹⁰ often because the pregnant woman's partner feels jealous or abandoned when she focuses on her pregnancy and baby.

Factors that pose an increased risk of intimate partner violence during pregnancy include:⁵⁵

- violence prior to pregnancy
- young maternal age (women aged 18–24 years are at higher risk of family violence during pregnancy)
- unintended pregnancy, including pregnancies that occur in family violence contexts through rape or reproductive control (restricting reproductive autonomy).

Family violence during pregnancy is associated with several negative health and mental health outcomes for the fetus, mother and child,⁵⁶ including low birthweight, heightened stress for the fetus and newborn, and high levels of perinatal depression, anxiety and post-traumatic stress disorder among mothers.⁵⁷

Practice points

Working with women who are pregnant or who have young children

Pregnancy can provide an opportunity to provide extra support if family violence has been identified previously.

Family violence can disrupt the maternal–child bond and the child's attachment to the mother. Approaches that foster mother–infant bonding, based on relational trauma and attachment theory, are helpful.

Consider co-working with the practitioners providing pregnancy care such as (enhanced) maternal and child health nurses, general practitioners and others.

Where possible, consider consulting with child mental health specialists such as staff of the Parent Infant Mental Health Initiative⁵⁸ or a FaPMI coordinator.

Consider the 'parenting after violence' programs provided by specialist family violence services, referral to or consultation with experts at the Royal Children's Hospital or the Royal Women's Hospital programs addressing family violence and mothering.

Men who perpetrate family violence

*'Perpetrators of family violence ... often require a long journey to start to take some responsibility for their behaviour. It might take several significant events or "crises" stemming from their behaviour, over a period of months or years, before they develop some internal motivation to change'*⁵⁹

Prevalence rates and patterns of family violence indicate that clinicians will work with men who use violence against their partner, children or other family members.

Mental health clinicians are well placed to identify and respond to men who use violence and are encouraged to undertake training and other professional development activities to increase their skills in responding to family violence perpetrators. However, clinicians are not expected to work with men specifically on their violence, as this is the work of specialist services.

Each interaction with a service, including a mental health service, by a person who uses violence provides an opportunity to intervene to change the person's behaviour. This can be done while continuing a therapeutic relationship through respectful enquiry, support and mental health care.

While disclosure by a person perpetrating violence is rare, it might happen. If this is the case a referral to the Men's Referral Service might be appropriate, in particular if the person is ready to address their behaviour.

If family violence perpetration is suspected or has been identified, the highest priority is the safety of women, children and other affected family members. Support needs should be identified without jeopardising their safety. Where family members of a mental health consumer are at risk, someone other than the perpetrator's treating clinician (for example, another mental health clinician or a specialist family violence service provider) should develop the safety plan.

Questions that aid identification of family violence perpetration should be part of the service's routine intake, mental health assessment and risk assessment processes, which include questions about relationships. The practice points below provide specific advice.

It is appropriate for clinicians to respectfully encourage perpetrators to take responsibility for their actions. One way of doing this is through discussing the impact the perpetrator's behaviour has on partners and children and their role as a parent. Discussing the violence in this way keeps the focus on the problematic behaviour, the safety (or lack of) of partners, children and other family members.⁴⁷ Seek expert advice prior to discussion with person who perpetrates violence.

Work on responding to perpetrators and 'holding perpetrators accountable' is underway across the service system as part of the Victorian Government's current Family Violence Reform agenda. Staff of mental health services are advised to familiarise themselves with new publications and resources on working with perpetrators as they become available on the Family Safety Victoria website <<https://www.vic.gov.au/familyviolence/family-safety-victoria.html>>.

Practice points:

Working with men who perpetrate family violence

Questions about family violence should not be asked with the victim/survivor present if disclosure by the person perpetrating the violence has not occurred or if you have heard about the violence third hand.

Use open-ended questions that start broad such as 'How are things at home?', 'How is your relationship?' and 'What are the best and worst things about your relationship?'.⁶⁰

You might need to put aside your own reactions to the behaviour and feelings of a need to 'intervene'⁴⁷ to protect the safety of the perpetrator's partner, children or family members – which must always be the highest priority.

Continuing a collaborative response is important when working with someone who perpetrates violence. Continue to be curious, respectful and invitational. Meet the person 'where they are at', approach the 'truth' as subjective and don't focus on the behaviour of the victim/survivor (perpetrators will often use the victim's behaviour as excuse – 'She didn't have the kids ready').

Examples to ensure you stay engaged while balancing safety of those affected include:

- Develop rapport, be interested in the person.
- Focus on the choice of violent behaviour, not judging the individual.
- Keep a check on your own emotional responses ('What is going on for me?')
- Use a safe preamble – 'May I ask you a hard question?'

If concerns for children's safety have been identified, follow organisational procedures and professional requirements regarding mandatory reporting of child abuse to child protection services. Ensure you follow the new Child Information Sharing Scheme and the Family Violence Information Sharing Scheme (from September 2018).

People who use violence will often try to minimise, excuse, explain and not take responsibility for the violence, and use strategies to seek sympathy from others. Avoid colluding with the perpetrator – for example:⁴⁰

- saying nothing when violence is disclosed or minimising the violence ('You were upset', 'At least you didn't...')
- focusing on the narrow view of violence (physical) and not picking up on other forms of abuse (emotional, verbal, financial)
- not challenging his stories and language used to minimise their behaviour or responsibility.

Make good use of supervision and secondary consultation. It can be hard to work with someone who perpetrates violence and to stay engaged with them. Ensure you have the professional support needed to discuss your concerns, reactions and needs.

Secondary consultation is strongly advised and can be obtained by phoning the Men's Referral Service (see Appendix 4).

Alcohol and other drugs

'A perpetrator of family violence can be more dangerous when they are under the influence of alcohol or other drugs. However, not all people who use alcohol or drugs become violent and not all people who are violent use drugs or alcohol' ⁴²

The relationships between AoD use, mental illness and family violence is complex.

Victoria Police reports that 22 per cent of family violence incidents involved alcohol use by the perpetrator, the victim, or both.⁴³ While there is a high co-occurrence of problematic AoD use and family violence,⁶¹ alcohol and other drugs do not *cause* family violence.⁵⁶ The use of substances by a perpetrator can, however, greatly increase the severity of violence.

While people who perpetrate family violence might misuse drugs or alcohol, they are generally also violent when not using substances. Some victims/survivors use alcohol or drugs as coping strategy to deal with the impact of current violence and to manage flashbacks to previous violence.

AoD use can become part of violence perpetration – for example, if the perpetrator:

- forces the victim/survivor to take part in drug dealing or AoD consumption
- threatens to expose AoD use to services as part of threats to have children removed
- sabotages the victim/survivor's attempts to give up alcohol or drugs.

Practice points

Responding to family violence where perpetrators or victims/survivors abuse alcohol or other drugs

Focus on the safety of the woman and her children, taking AoD use into account.

Make sure you know about AoD harm minimisation strategies.

Consult with specialist AoD services as necessary.

Reflective questions

- How do you feel about working with someone who perpetrates violence?
- How could you talk to consumers and their families about your observations in situations where the consumer's mental illness contributes to their violent behaviour?
- Are you clear about your role in responding to someone who discloses that they perpetrate family violence? What would you need to do to hold the person accountable while still providing a mental health service to them and ensuring the safety of the victim(s)/survivor(s)?
- What supports do you need to provide good clinical care in responding to men who perpetrate violence?
- What does your organisation offer to support you in this work?
- Do you have a 'limit' when it comes to working with someone who perpetrates violence (for example, a type of violence or its severity)? What is it?

Working with diverse communities

While family violence affects all types of families, victims/survivors from diverse communities can face specific issues and/or barriers to getting help. Some perpetrators will, for example, use a person's characteristics or life circumstances against them as part of perpetrating violence, while discriminatory attitudes can hinder effective responses to victims/survivors.

It is important to keep in mind that many people belong to more than one 'group'. Applying an intersectionality lens (see the 'Diversity and intersectionality' section) can assist clinicians to appreciate multiple layers of discrimination and barriers to accessing services.

The following section provides brief summaries of some issues relevant to specific communities or groups.

Aboriginal and/or Torres Strait Islander people

Aboriginal people, and particularly Aboriginal women and children, experience significantly higher rates of family violence than other Victorians. In 2013–14 Aboriginal people were 7.3 times more likely than non-Aboriginal people to experience family violence.¹

Aboriginal communities' understanding of family violence takes broader family and kinship networks into account. Family violence can occur outside the home and can involve several people.¹

The Royal Commission into Family Violence reported a 'clear connection between the high rates of family violence and the high numbers of Aboriginal children in out-of-home care.'¹ The royal commission recognised the 'importance of understanding family violence in Aboriginal communities within the historical context and impact'. This includes the following impacts associated with white settlement:

- dispossession of land and traditional culture
- breakdown of community kinship systems and Aboriginal lore
- racism and vilification
- economic exclusion and entrenched poverty
- the effects of institutionalism and historical child removal policies
- inherited grief and trauma'.¹

Practice points

Engage in a way that demonstrates cultural awareness, respect and recognition.⁶²

Consider whether it is culturally safe for an Aboriginal woman to disclose violence in your organisation and think about what you could do to make her feel safer.

Ask if the person wants an Aboriginal service to be involved or if they want to be referred to an Aboriginal service (but do not assume).

Consider what disclosure will mean to the person's connection with her or his family or broader community.

Recognise that violence can involve the broader family or kinship networks. Are you aware who is involved?

Understand the traumatic connection of family violence with past child removal practice while balancing safety concerns for children.

Culturally and linguistically diverse communities

CALD communities are not homogenous. The way family violence manifests or is experienced or perpetrated depends on many factors such as immigration status, level of English proficiency and access to culturally and linguistically appropriate services.

The Australian National Research Organisation for Women's Safety has identified four key types of barriers to responding to family violence and sexual assault among CALD communities:

- personal (such as isolation from family, feelings of shame and dishonour)
- cultural (such as fear of community rejection)
- information and language (such as inability to read or write in English)
- institutional (such as limited access to interpreters or lack of culturally sensitive services).

Practice points

Working with cultural and linguistic diversity

Consider what a disclosure will mean for the person in relation to their community. What is at stake? Do they believe that they will 'lose face' or 'bring shame' to their community?

Find out about the person's immigration status. Is he or she worried about being deported? If they are not proficient in English, use interpreters. DO NOT use family members to interpret.

Reflective questions

- What might be some of the barriers that keep people from diverse backgrounds from disclosing family violence?
- What could you or your service do to increase opportunities to have conversations about family violence?

Women with disabilities

*Women with disabilities experience higher rates of family violence than those without a disability. Women with intellectual disabilities are at particularly high risk. When violence against women with disabilities occurs, it is likely to be more frequent, severe and longer lasting*⁶³

While many women with disabilities experience the same kind of violence as other women, they also experience 'disability-based violence', such as when the perpetrator uses a woman's disability to control her.⁶³ If the perpetrator of family violence has a role as the person's carer, and in particular if it is her partner, the victim/survivor is likely to experience violence and control that entraps and isolates her further.

Examples of types of abuse include:⁵⁵

- controlling when medication can be taken
- breaking or removing physical aids, such as wheelchairs, crutches and reading aids
- withdrawing care or not assisting with daily activities or physical care
- not letting the person do things they are capable of and want to do, such as looking after children.
- abusing a power of attorney.

Practice points

Working with people who have disabilities

Ask the victim/survivor about their support needs; don't make assumptions about what they need.

Ensure that information is communicated in an appropriate and accessible format. Find out if written or verbal information is preferred.

Engage an Auslan interpreter if required.

Recognise the family-like or interdependent relationships a victim/survivor may have with carers and other support people.

Allow for privacy and create opportunities for the person to disclose information without a carer or support worker present.

Consider the broad range of perpetrators who might use violence against victims/survivors with disabilities, including co-residents in care facilities who have a family-like relationship with the victim/survivor.

If the person has a National Disability Insurance Scheme plan, work with their support coordinator or local area coordinator.

Ask questions about whether perpetrator behaviours specifically affect the disability.

If the person has caring responsibilities for children, consider how the violence might affect them and their relationship with the victim/survivor.

Be aware that children with disabilities may also be victims/survivors in a family, with their own special needs.

Lesbian, gay, bisexual, transgender, intersex and queer people

People in LGBTIQ communities experience family violence at or above the same rate as non-LGBTIQ people. They face additional barriers to identifying, reporting and accessing safe and appropriate supports. These include the impact of past experiences of discrimination, the lack of visibility of LGBTIQ people in family violence discourse and the lack of LGBTI-specific services.

It is important to understand the historical and current context of discrimination against LGBTIQ people. This includes acts of public harassment and violence, social isolation and oppression, and legal discrimination that may deny LGBTIQ people some of the rights, protections and freedoms enjoyed by others.

Societal discrimination against LGBTIQ people can affect familial attitudes towards LGBTIQ family members, LGBTIQ people's own sense of their personal worth, and the perceived worth of their intimate relationships.⁶⁴

While many experiences of coercion and control are like those in heterosexual and cisgendered relationships, there are some differences. The Victorian Office for Prevention and Women's Equality has identified the following forms of violence specific to LGBTIQ people:

- threats to 'out' or reveal the victim/survivor's sexual orientation, gender or biological sex
- exploiting the stigma that still surrounds violence in non-heterosexual relationships
- withholding or threatening to restrict access to hormones, medications, medical treatment or support services
- ridiculing or disrespecting gender identity or intersex status
- threatening the non-biological parent regarding custody of, or relationship with, their child
- young people being forced to leave home when they 'come out' about their sexuality or gender identity.

LGBTIQ victims/survivors

LGBTIQ people might mistrust mainstream services or be concerned about the response they would receive if they disclosed family or intimate partner violence. They may have previously had a negative response to their relationship or gender status.

The person may feel uncomfortable about their sexuality, which could compound their reluctance to disclose family violence.

Family and intimate partner violence against LGBTIQ people is often not well understood by others. For example, if a young person has been made homeless due to their sexuality, then that is family violence.

It might be difficult for police to distinguish between a victim/survivor and a perpetrator when attending a same-sex family violence incident.

People living in poverty

While family violence occurs in any socioeconomic group, lack of access to money can significantly limit victims'/survivors' opportunities to gain support or to leave the violent situation. Catching a taxi to safety, renting a hotel room, moving or paying for counselling is not possible for many people on low incomes.

Many women, in particular, experience loss of income as a result of family and intimate partner violence. A woman might need to take time off or lose employment because of the violence, she might need to attend court hearings or medical appointments, or be forced to move out of her home to be safe.

Rural, regional and remote communities

Victoria Police records show that the highest rates of family violence per 100,000 population are outside of metropolitan Melbourne.¹

People living in these areas experience barriers to disclosing, reporting, seeking help and receiving appropriate services following family violence. The Royal Commission into Family Violence highlighted factors that influence the experience of family violence in these areas, namely social and geographic isolation, economic vulnerability and dependence, cultural norms, the position or reputation of the perpetrator in the community and access to firearms. Victims/survivors may be reluctant to seek help due to feelings of shame and social embarrassment within a small community.¹ Access to services is more challenging than in metropolitan areas. Informal supports play a vital role in women's decisions to seek help.⁶⁵

Overcoming barriers

Table 2 lists some of the reasons why mental health clinicians may feel unable or unwilling to respond to family violence. The 'comments' in the right-hand column challenge clinicians to revise unhelpful attitudes and to try to address any barriers they experience in responding appropriately to family violence.

Table 2: Barriers to effective clinical responses to family violence

Barrier	Comment
High workload and lack of time	Not engaging may increase risk to a person and ultimately increase your workload.
'More pressing issues to deal with'	Family violence has major mental health impacts. It is pressing.
'Not part of my job'	It is part of your job.
Not being alert to the signs and risks of family violence	Increase your understanding of family violence through training and professional development, including online learning.
Being worried about placing the victim/survivor at risk	Sensitive enquiry includes understanding how and when to ask and when not to ask.
Feeling helpless about providing solutions	Supporting someone takes many forms. You may not need to provide any solutions. Sometimes victims/survivors just want someone to listen. Follow TICP guidelines. If you are really stuck, you can consult other practitioners.
Not knowing what to do or how to respond	This guideline gives you some ideas. Consult the suggested resources or speak with a colleague.
Not knowing how and where to refer for a specialist family violence response	Easy! Find out how to refer to the local specialist family violence service or the Support and Safety Hub. Colleagues might be able to help you.
Not feeling supported by the organisation, colleagues or supervisor	This guideline directs mental health services to support clinicians in responding to family violence. Access specialist family violence services for secondary consultation if necessary.

Appendices

Appendix 1: Abbreviations and terms used in this guide

Abbreviations

AoD	Alcohol and other drugs
CALD	Culturally and linguistically diverse (communities or people)
FaPMI	Families where a Parent Has a Mental Illness (program)
FV framework	Family Violence Risk Assessment and Management Framework
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, queer
RAMP	Risk Assessment and Management Panel
TICP	Trauma Informed Care and Practice

Definitions of terms

Carer	<p>'Carer' is used to describe someone who is actively supporting, assisting or providing unpaid care to a consumer. A carer may or may not live with the consumer. A carer may be a family member, friend or other person, including a child or young person who has a significant role in the life of the consumer.</p> <p>'Means a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship.'⁶⁶</p>
Cisgender	<p>Cisgender is a term for people whose gender identity matches the sex that they were assigned at birth.</p>
Disability	<p>'Disability' in relation to a person means— (a) a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which— (i) is, or is likely to be, permanent; and (ii) causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and (iii) requires significant ongoing or long term episodic support; and (iv) is not related to ageing; or (b) an intellectual disability; or (c) a developmental delay.⁶⁷</p> <p>Disability is a social construct and stems from the interaction of a person's functional impairment with a disabling environment. Disabling environments create structural, attitudinal and behavioural barriers – for example, by preventing people with functional impairments from accessing housing, education, work opportunities or transport. A specific type of disability arises from the interaction of a specific impairment with an environment that creates barriers.⁶³</p>

Economic abuse	This includes restricting or controlling access to money for essential needs (to pay bills, buy groceries), stealing from the other person, using their money without their consent and illegally taking, misusing or concealing funds, property or assets.
Emotional abuse	This occurs when a person is subjected to behaviours or actions that are aimed at preventing or controlling their behaviour with the intent to cause them emotional harm or fear. ¹⁷
Family member	<p>The Family Violence Protection Act 2008 defines 'family member' as:</p> <ul style="list-style-type: none"> (a) a person who is, or has been, the relevant person's spouse or domestic partner; or (b) a person who has, or has had, an intimate personal relationship with the relevant person; or (c) a person who is, or has been, a relative of the relevant person; or (d) a child who normally or regularly resides with the relevant person or has previously resided with the relevant person on a normal or regular basis; or (e) a child of a person who has, or has had, an intimate personal. <p>The Act further outlines that the relationships can be of a sexual or non-sexual nature. It further states that the term includes any other person who the person regards as being like a family member (find further details relating to this last section in the Family Violence Protection Act, section 8).</p> <p>For definitions of 'domestic partner' and 'relative', see section 9 in the Act.</p>
Family Safety Victoria	Family Safety Victoria was established in July 2017 to drive key elements of Victoria's family violence strategy and to coordinate support for families to help them care for children and young people.
Family violence	<p>The Family Violence Protection Act 2008 defines family violence as behaviour by a person towards a family member of that person if that behaviour—</p> <ul style="list-style-type: none"> is physically or sexually abusive; or is emotionally or psychologically abusive; or is economically abusive; or is threatening; or is coercive; or in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or causes a child to hear or witness, or otherwise be exposed to the effects of [that] behaviour ...

Intimate partner violence	'Any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship'. ⁴⁰
Nominated person	A consumer can nominate a person to receive information and to provide them with support in the event they become unwell and require compulsory mental health treatment. ⁶⁸
Risk Assessment and Management Panels	RAMPs provide a response to victims/survivors (including children) at critical levels of risk, who require the development of a comprehensive, multi-agency risk assessment and management action plan (see 'Family Safety Victoria' for further information).
Rural Regional Remote	Rural: non-urban localities of less than 25,000 with reduced service accessibility. Regional: non-urban centres with a population more than 25,000 with relatively good access to services. Remote: communities of under 5,000 with restricted service access. ⁶⁹
Sexual assault and abuse	Sexual assault includes rape, child sexual abuse and unwanted sexual behaviour such as unwanted kissing and touching. It also includes behaviour that does not involve actual touching. For example, forcing someone to watch pornography or masturbation is also sexual assault. Sexual assault does not have to include physical harm. Sexual abuse is often part of a broader pattern of violence perpetrated as part of family violence.
Social abuse	Isolating the victim from family, friends or other community contacts.
Specialist family violence advisors	The Specialist Family Violence Advisor Capacity Building Initiative will include creating specialist family advisors in major mental health services. These roles will provide family violence expertise in clinical mental health services to lead system and practice change and build workforce capacity to increase services' response to family violence. These roles are being implemented from July 2018.
Specialist family violence services	Specialist family violence services are designed to support victims of family violence. There are also specialist family violence services that work with male perpetrators.
Strengthening Hospital Responses to Family Violence	This is a framework for embedding the practice of identifying and responding to family violence experienced by hospital inpatients. It is system-wide approach and is currently being implemented across Victoria (as part of implementing the royal commission's recommendations).
Support and Safety Hubs	Support and Safety Hubs form part of the implementation of the royal commission's recommendations. Also referred to as 'The Orange Door', Hubs will provide a regional response to family violence (see the 'Family Safety Victoria' website for further information).
Victim/survivor	Victim/survivor is the term used by the royal commission to describe someone who experiences family violence. This term also encompasses children experiencing violence.

Appendix 2: Organisational checklist

Task	Timeline
Family violence policy updated , incorporating: <ul style="list-style-type: none"> • victims/survivors (child/young person, adult) • unborn children (responsibilities regarding family violence perpetration against woman) • responding to perpetrators (including responsibilities of clinicians) • latest Family Violence Risk Assessment and Risk Management Framework (September 2018) 	
Family violence procedure updated in line with policy update , including: <ul style="list-style-type: none"> • ‘How to ask’ • ‘How to respond’ outline • responsibilities, documentation • discharge planning 	
Family violence executive sponsor identified: role description, including responsibilities clarified and documented	
Management ‘introduction to family violence’ training undertaken	
Family violence committee established: <ul style="list-style-type: none"> • terms of reference, scope, responsibilities, membership, reporting structures identified 	
Family violence advisor (if such role has been established): <ul style="list-style-type: none"> • departmental program guideline utilised • responsibilities and scope clarified • reporting structure clarified 	
Clinical family violence champions identified: <ul style="list-style-type: none"> • role description, including responsibilities, clarified 	
Family violence project plan developed	
Communication strategy developed	
Family violence workforce strategy identified: <ul style="list-style-type: none"> • decisions regarding introduction and advanced training • decisions regarding training for seniors/supervisors • opportunities for reflective practice created 	
Continuous review processes clarified: <ul style="list-style-type: none"> • business plan updated to include the family violence project • annual quality assurance process • data collection on family violence reviewed, clarified and implemented • documentation of family violence reviewed, clarified and communicated • consider a discrete alert system regarding family violence for clinical files 	
Risk Assessment and Management Panel: <ul style="list-style-type: none"> • participation clarified, clinician members’ role clarified • review processes in place 	
Health service’s family violence executive sponsor consulted on family violence policy for staff: <ul style="list-style-type: none"> • ensure that management members are familiar with the policy 	
Additional Items – add as required	

For further information (including project and organisational planning, role descriptions and committee terms of reference examples) visit the Have Your Say website <<http://haveyoursay.thewomens.org.au/shrfv-project>>.

Appendix 3: Key legislation and government policies

This guideline has been developed in the context of large changes and focus on family violence resulting from the Royal Commission into Family Violence. It is likely that changes will continue to occur beyond the publication of this guideline. The most up-to-date information can be found on the Family Safety Victoria website <<https://www.vic.gov.au/familyviolence/family-safety-victoria.html>>.

The following is a summary of legislation and policies that are most relevant at the time of writing.

Legislation

- *Children Legislation Amendment (Information Sharing) Act 2018*
- *Family Violence Protection Amendment (Information Sharing) Act 2017*
- *Mental Health Act 2014*
- *Carers Recognition Act 2012*
- *Family Violence Protection Act 2008*
- *Children, Youth and Families Act 2005*

Royal commission report and Victorian Government responses

- Family violence rolling action plan 2017–2020
- *Responding to family violence capability framework (2017)*
- *Free from violence – Victoria’s strategy to prevent family violence and all forms of violence against women (2017)*
- *Ending family violence – Victoria’s plan for change (2016)*
- *Royal Commission into Family Violence report and recommendations (2015)*
- Building from strength – 10-year industry plan for family violence prevention and response (2017)

Related state government policies and plans

- *Roadmap for reform: strong families, safe children*
- *Indigenous family violence 10-year plan – Strong culture, strong peoples, strong families: towards a safer future for Indigenous families and communities (2008)*
- *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*
- With respect to age – 2009 Victorian Government practice guidelines for health services and community agencies for preventing elder abuse

Mental health initiatives, guidelines and policies

In addition to the above, the following guidelines, policies and developments are relevant to this guideline.

- Centre for Mental Health Workforce Learning and Development (to commence 2018)
- Mental Health and Police response (MHaP)
- Department of Health and Human Services, Mental Health Branch: *Families where a Parent has a Mental Illness program guideline (2016)*
- Department of Health and Human Services–Victoria Police protocol for mental health. *A guide for clinicians and police (2016)*
- Victoria’s 10-year mental health plan (2015)
- Department of Health, Mental Health Branch: *Service guideline for gender sensitivity and safety (2011)*
- Department of Health and Human Services, Mental Health Branch: *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units. Chief Psychiatrist’s guideline (2009) – under review*
- Department of Health and Human Services, Mental Health Branch: *Working with families and other carers (2005) – under review.*

Appendix 4: Practice resources

Name of organisation or topic	Information / specific documents
<p>Aboriginal Family Violence Prevention and Legal Service Victoria <http://www.fvpls.org/index.php></p>	<p>An Aboriginal community-controlled organisation that provides assistance to Aboriginal and Torres Strait Islander victims/survivors of family violence and sexual assault and works with families and communities affected by violence</p>
<p>Adolescent violent towards parents <https://www.kildonan.org.au/programs-and-services/child-youth-and-family-support/family-violence/adolescent-violence/about-adolescent-violence/> <https://aifs.gov.au/cfca/2015/12/08/adolescent-violence-home-how-it-different-adult-family-violence></p>	<p>Information, practical ideas and links to helpful documents regarding adolescent violence</p>
<p>Australian Institute of Family Studies <https://aifs.gov.au/></p>	<p>Research and publications on a wide range of family violence topics</p>
<p>Alcohol and other drugs <http://nceta.flinders.edu.au/files/2713/6615/8232/EN488_2013_White.pdf></p>	<p><i>Can I ask...? An alcohol and drug clinician's guide to addressing family and domestic violence</i></p>
<p>Australian Medical Association <https://ama.com.au/sites/default/files/documents/AMA%20Supporting%20Patients%20Experiencing%20Family%20Violence%20Resource%20Corrected%2025Feb16.pdf></p>	<p>Supporting patients experiencing family violence: a resource for medical practitioners</p>
<p>Australian National Research Organisation for Women's Safety <https://anrows.org.au/></p>	<p>Latest research, publications and statistics</p>
<p>blue knot foundation <http://www.blueknot.org.au></p>	<p>National Centre of Excellence for Complex Trauma</p>
<p>Children and young people experiencing family violence <https://woah.org.au/></p>	<p>Information for children 10–13, 14–17 year olds and adult allies</p>
<p>Centres Against Sexual Violence <https://www.casa.org.au/></p>	<p>CASA forum – provides information and links to Victorian Centres Against Violence (CASAs)</p>
<p>Diversity and family violence <https://www.vic.gov.au/familyviolence/designing-for-diversity-and-intersectionality.html></p>	<p>Family Safety Victoria: Diversity Unit</p>
<p>Elder abuse <https://seniorsrights.org.au/your-rights/> <http://www.dvrcv.org.au/help-advice/elder-abuse-and-family-violence></p>	<p>Resources, information and links regarding elder abuse The Domestic Violence Resource Centre Victoria has practical suggestions and ideas of how to ask and what to do if elder abuse is suspected</p>
<p>Family Safety Victoria <https://www.vic.gov.au/familyviolence/family-safety-victoria.html></p>	<p>Information and the latest updates about family violence reform in Victoria</p>
<p>Family Violence Protection Act 2008 and Family Violence Protection Act Amendment 2017 <http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/C94BEB3E0B1834A3CA258122000DC2F0/\$FILE/17-019aa%20authorised.pdf></p>	<p>Outlines the legal definition of family violence in the State of Victoria</p>

Name of organisation or topic	Information / specific documents
Information sharing and risk management https://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.html	Information-sharing scheme – part of the family violence reform in Victoria
inTouch, the Multicultural Centre against Family Violence http://www.intouch.org.au/	A support and information service for migrant and refugee women experiencing family violence
LGBTIQ https://www.dvrcv.org.au/help-advice/lgbtiq	Domestic Violence Resource Centre Victoria
Male perpetrators http://www.ntvmrs.org.au/ http://www.ntv.org.au/about-family-violence/what-men-can-do/	Men’s Referral Service – support, information
Mental Health Act 2014 https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014	Legislation governing the assessment and treatment of people with mental illness within the public mental health system
National Sexual Assault, Domestic Family Violence Counselling Service https://www.1800respect.org.au/	Confidential counselling and support service Resources and training for professionals
Royal Australian College of General Practice https://www.racgp.org.au/publications/goodpractice/201704/abuse-and-violence/	<i>Abuse and violence: Working with our patients in general practice</i> (2014, 4th edition)
Royal Commission into Family Violence http://www.rcfv.com.au/Report-Recommendations	Report and recommendations
Strengthening Hospital Responses to Family Violence initiative https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/	Toolkit with a range of helpful information from project management to policy and practice
The Lookout https://www.thelookout.org.au/	A range of information on family violence for staff of all sectors (including family violence risk assessment and safety planning)
Women with Disabilities Victoria http://wdv.org.au/publications.htm#bte	A range of publications and resources regarding women with disabilities and family violence
World Health Organization http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/ http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf	<i>Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook</i> (2014) <i>Responding to intimate partner violence and sexual violence against women</i> , WHO clinical and policy guidelines
Working with families and carers https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers	<i>Working together with families and carers. Chief Psychiatrist’s guideline</i> (2005) – note this guideline is currently under review
Young people experiencing family violence https://woah.org.au/	Information for young people about healthy relationships
Women’s Mental Health Network Victoria https://wmhmv.org.au/	An advocacy, research and workforce-training network supporting and empowering women’s lived experience

Appendix 5: Clinical checklist

Use when:

- engaging with a new consumer
- family violence has been disclosed during ongoing clinical care
- reassessing family violence following initial disclosure.

Enquire	About family violence as part of intake processes
Support	Person disclosing experience of family violence Person disclosing using violence
Assess (use the current Victorian family violence risk assessment)	Level of risk for victim/survivor and their children (preliminary) Level of risk person using violence may pose to partner, children, family members and others
Provide ongoing support	Continue to support, check-in, reassess, safety plan
Safety plan	Victim/survivor and their children: review any change to previous risk, discuss safety plan(s), have copy on file Person using violence: 'risk to self and others' – take note if 'others' are family members, partner or children; and level of risk
Consult	With senior clinician, supervisor, clinician with family violence expertise Specialist family violence service, Support and Safety Hub, Child Protection, Centre Against Sexual Assault, Victoria Police (as appropriate)
Refer	To a specialist family violence service, Support and Safety Hub, Child Protection, Centre Against Sexual Assault, police
Collaborate	Provide clinical care with added expertise from family violence specialists or other relevant services

- Keep other family members, the partner, carers and particularly children in mind.
- Be concerned and enquire about their safety.
- If the perpetrator is the partner or another family member, keep them in mind even if you never meet them.
- Enquire about levels of risk or levels of safety as part of routine mental health care.

Appendix 6: Myths about family violence

Myths about family violence are just that – myths.

They minimise, distort and at worst excuse violence. They contribute to ‘victim blaming’ rather than put the responsibility for violence on the person perpetrating it.

The table below lists some common myths about family violence and the reality.

Myth about family violence	Reality
It is not a widespread problem	Family violence, especially intimate partner violence, is a widespread problem across the world
There are as many male victims as female victims	Women are at much greater risk of family violence than men
Family violence overwhelmingly occurs in certain groups, such as poor families	Family violence occurs in all types of communities
Alcohol causes intimate partner violence	Alcohol does not cause violence
People could just leave family violence situations if they wanted to	See below

‘Why doesn’t she just leave?’

People experiencing family violence, especially women, are often asked ‘Why don’t you just leave?’ when the question ought to be ‘Why doesn’t he stop the violence?’.

For example, as illustrated below, there are many reasons why a woman might remain with a partner or family member who is abusive.

Reason for not leaving a family violence situation	Comments
Fear arising from perpetrator threats	The reality is that women are increasingly unsafe immediately after they leave because perpetrators experience a loss of power and control
Fear of losing children or having children removed	This is a real concern, especially if mental illness is present
Isolation from friends, family and community	Part of family violence perpetration is making the victim/survivor socially isolated. Reaching out for help is much harder for someone when they have lost contact with family and friends
Income and financial issues, including loss of income, job, home, pets, possessions	Many women and children are forced to leave their home
Hoping the violence stops / still loving the person	Perpetrators are not necessarily always violent; there can also be good times
A deep emotional attachment	Letting go of a person and relationship can be hard, even when violence occurs
Fear of being on one’s own	Getting used to being on one’s own can be difficult and being a single parent can be hard. Women with disabilities may rely on their partner for physical and other care and care for children
Negative impact on children through loss of connection to school and friends	Moving, often several times (for example, into a refuge, then into temporary accommodation before finding a place to live) creates instability when stability is most needed
Having grown up with violence can mean that violence is seen as part of relationships	When violence was part of growing up it can be hard to appreciate that violence does not have to be part of relationships
Isolation from community, judgement or being ostracised	While communities can be supportive, they can also be judgemental and find fault with the victim/survivor rather than holding the perpetrator to account (‘You’ve made your bed...’)
Immigration status and fear of deportation	Women may not know about their rights regarding their immigration status and family violence. ‘Having her deported’ may have become part of trapping a woman in a violent relationship
Having to relocate into a different area or interstate	Depending on the severity of the violence and previous experiences of leaving, some women and children are forced to move a long way from home
Feelings of guilt and shame	Victims/survivors often blame themselves and are often blamed by others – for the violence, for tolerating the violence, for not leaving, for leaving
Pressure from family community to stay	There are many societal, cultural, religious and other norms that promote staying in a relationship over separation, even if violence is present

References

- 1 State of Victoria 2016, *Royal Commission into Family Violence: report and recommendations*, Melbourne.
- 2 Family Safety Victoria 2017, *Responding to family violence capability framework*, State Government of Victoria, Melbourne.
- 3 Australian Bureau of Statistics 2017, *Personal Safety Survey 2016*, ABS, Canberra.
- 4 Bryant W, Cussen T 2015, *Homicide in Australia: 2010–11 to 2011–12: National Homicide Monitoring Program report*, Australian Institute of Criminology, Canberra.
- 5 Indermaur D, Harding R, Blagg H, Atkinson L, Coase P, Francas M, Zappelli R 2001, *Young people and domestic violence*, Commonwealth of Australia, Canberra.
- 6 Cox P 2015, *Violence Against Women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012*, ANROWS, Sydney.
- 7 Diemer K 2015, *ABS Personal Safety Survey: Additional analysis on relationship and sex of perpetrator*, University of Melbourne, Melbourne.
- 8 Crimes Statistics Agency 2016, Family Incidents, year ending 31 March 2016, viewed 9 February 2018, <<https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/family-incidents>>.
- 9 Vic Health 2004, *The health costs of violence. Measuring the burden of disease caused by intimate partner violence. A summary of findings*, VicHealth, Melbourne.
- 10 James L, Brody D, Hamilton Z 2013, Risk factors for domestic violence during pregnancy: a meta-analytic review, *Violence and Victims*, vol. 28, no. 3, pp. 359–380.
- 11 Campbell JC 2002, 'Health consequences of intimate partner violence', *The Lancet*, vol. 356, no. 9314, pp. 1331–1336.
- 12 State of Victoria 2016, *Ending Family Violence. Victoria's plan for change*, Department of Premier and Cabinet, Melbourne.
- 13 The Royal Australian College of General Practice 2014, *Abuse and violence: Working with our patients in general practice*, 4th edn, RANCGP, Melbourne.
- 14 The Lookout 2017, Working with children and young people, viewed 30 January 2018, <<http://www.thelookout.org.au/family-violence-workers/working-children-and-young-people>>.
- 15 Carpenter GL, Stacks AM 2009, 'Developmental effects of exposure to intimate partner violence in early childhood: a review of the literature', *Children and Youth Services Review*, no. 31, pp. 831–839.
- 16 Middleton W 2012, In: Kezelman C, Stavropoulos P. *The Last Frontier. Practice guidelines for treatment of complex trauma and trauma-informed care and service delivery*, p. x. Adults Surviving Child Abuse (now blue knot foundation), Sydney.
- 17 Lum On M, Ayre J, Webster K, Moon L 2016, *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper*, ANROWS, Sydney.
- 18 Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL, Slade T 2011, 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', *JAMA*, vol. 306, no. 5, pp. 513–521.
- 19 MacIsaac MB, Bugeja L, Weiland T, Dwyer J, Selvakumar K, Jelinek GA 2017, 'Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia', *Asia Pacific Journal of Public Health*, vol. 30, no. 1, pp. 36–44.

- 20 World Health Organization 2013, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, WHO, Geneva.
- 21 VicHealth 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence*, State Government of Victoria, Melbourne.
- 22 Khalihef H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, Osborn D, Johnson S, Howard LM, 2014, 'Domestic and sexual violence against patients with severe mental illness', *Psychological Medicine*, no. 45, pp. 875–886.
- 23 Kezelman C, Stavropoulos P 2018, *Talking about trauma. Guide to conversations and screening for health and other service providers*, blue knot foundation, Sydney.
- 24 Courtois C, Ford J 2009, *Treating complex traumatic stress disorders*, Guilford Press, New York, p. 13.
- 25 Kooyman I, Dean K, Harvey S, Walsh E 2007, 'Outcomes of public concern in schizophrenia', *The British Journal of Psychiatry*, vol. 191, no. 50, s29–s36.
- 26 Fazel S, Gulati G, Linsell L, Geddes JR, Grann M 2009, 'Schizophrenia and violence: systematic review and meta-analysis', *PLoS Medicine*, vol. 6, no. 8, p. e1000120.
- 27 Elbogen EB, Johnson SC 2009, 'The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions', *Archives of General Psychiatry*, vol. 66, no. 2, pp. 152–161.
- 28 Mullen P 2001, *A review of the relationship between mental disorders and offending behaviours on the management of mentally abnormal offenders in the health and criminal justice system*, Criminology Research Council, Canberra.
- 29 Department of Health 2011, *Service guideline on gender sensitivity and safety. Promoting a holistic approach to wellbeing*, State Government of Victoria, Melbourne.
- 30 Kageyama M, Yokoyama K, Nagata S, Kita S, Nakamura Y, Kobayashi S, Solomon P 2015, 'Rate of family violence among patients with schizophrenia in Japan', *Asia Pacific Journal of Public Health*, vol. 27, no. 6, pp. 652–660.
- 31 Labrum T, Solomon PL 2015, 'Rates of victimization of violence committed by relatives with psychiatric disorders', *Journal of Interpersonal Violence*, vol. 32, no. 9, pp. 2955–2974.
- 32 Quadara A, Hunter C 2016, *Principles of trauma-informed approaches to child sexual abuse: a discussion paper*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 6.
- 33 Bateman J, Henderson C 2013, *Towards a cultural shift in policy reform across mental health and human services in Australia. A national strategic direction*, Mental Health Coordinating Council, Sydney.
- 34 *Working together with families and carers*. Chief Psychiatrist Guideline (2008 – currently under review).
- 35 Family Safety Victoria 2017, *Diversity and intersectionality framework*, State Government of Victoria, Melbourne.
- 36 Twisleton L, Coleman D, Coorey L 2017, *Interrupting male violence with men who use domestic and family violence*, NSW Health Education Centre Against Violence, Parramatta.

- 37 Royal Women's Hospital 2017, *Strengthening responses to family violence*, RWH, Melbourne.
- 38 Royal Women's Hospital 2017, *Strengthening responses to family violence: Identifying and responding to family violence policy*, RWH, Melbourne.
- 39 Howard LM 2012, 'Domestic violence: its relevance to psychiatry', *Advances in Psychiatric Treatment*, vol. 19, no. 2, pp. 129–136.
- 40 World Health Organization 2014, *Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook*, WHO, Geneva.
- 41 Australian Medical Association 2016, AMA position statement family and domestic violence, viewed 23 January 2018, <<https://ama.com.au/position-statement/family-and-domestic-violence-2016>>.
- 42 White M, Roche AM, Long C, Nicholas R, Gruenert S, Battams S 2013, *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.
- 43 Australian Institute of Family Studies 2016, *Establishing the connection: guidelines for practitioners and clinicians in the sexual assault and alcohol and other drug sectors*, AIFS, Melbourne.
- 44 Fanslow JL, Kelly P, Ministry of Health 2016, *Family violence assessment and intervention guideline: child abuse and intimate partner violence* (2nd edn), Ministry of Health, Wellington.
- 45 Department of Human Services 2012, *Family violence risk assessment and risk management framework and practice guides 1–3*, State Government of Victoria, Melbourne.
- 46 Family Safety Victoria 2017, *Family violence information sharing guidelines: Guidance for Information Sharing Entities*, State Government of Victoria, Melbourne.
- 47 Royal Women's Hospital 2017, *Strengthening responses to family violence: project management guide*, RWH, Melbourne, p. 11.
- 48 Stewart M, Wilkes L, Jackson D, Mannix J 2006, 'Child-to-mother violence: a pilot study', *Contemporary Nurse*, vol. 21, no. 2, pp. 297–310.
- 49 Ibabe I, Jaureguizar J, Díaz Ó 2009, 'Adolescent violence against parents. Is it a consequence of gender inequality', *The European Journal of Psychology Applied to Legal Context*, vol. 1, no. 1, pp. 3–24.
- 50 Victoria Police 2017, Crime Statistics Agency, viewed 23 January 2018, <<https://www.crimestatistics.vic.gov.au/family-violence-data-portal/family-violence-data-dashboard/victoria-police>>.
- 51 Howard J 2011, *Adolescent violence in the home: the missing link in family violence prevention and response*, Australian Domestic, Family Violence Clearinghouse, University of New South Wales.
- 52 DVRCV 2017, Elder abuse and family violence, viewed 30 January 2018, <<http://www.dvrcv.org.au/help-advice/elder-abuse-and-family-violence>>.
- 53 Kaspiew R, Carson R, Rhoades H 2016, *Elder abuse: understanding issues, frameworks and responses*, Australian Institute of Family Studies, Melbourne.

- 54 Joosten M, Dow B, Blakey J 2016, *Profile of elder abuse in Victoria: analysis of data about people seeking help from Seniors Rights Victoria, final report*, National Aging Research Institute, Melbourne.
- 55 Frawlie P, Dyson S, Robinson S, Dixon J, 2015, *What does it take? Developing informed and effective tertiary responses to violence and abuse of women and girls with disabilities in Australia: State of knowledge paper*, ANROWS, Sydney.
- 56 Campo M 2015, *Domestic and family violence in pregnancy and early parenthood: CFCA practitioner resource*, Australian Institute of Family Studies, Melbourne, p. 4
- 57 Howard LM, Oram S, Galley H, Trevillion K, Feder G 2013, 'Domestic violence and perinatal mental disorders: a systematic review and meta-analysis', *PLoS Medicine*, vol. 10, no. 5, p. e1001452.
- 58 Austin Health 2018, Parent Infant Mental Health Initiative, viewed 6 April 2018, <<http://www.austin.org.au/page?ID=357>>.
- 59 INWMPCP 2017, Guideline for engaging people who cause family violence harm: policy guideline, viewed 23 January 2018, <<https://www.inwpcp.org.au>>.
- 60 Hegarty K, Forsdike-Young K, Tarzia L, Schweitzer R, Vlasis R 2016, 'Identifying and responding to men who use violence in their intimate relationships', *Australian Family Physician*, vol. 45, no. 4, p. 176.
- 61 Victoria Police 2017, *Policing harm, upholding the right: Victoria Police strategy for family violence, sexual offences and child abuse 2018–2023*, State of Victoria, Melbourne.
- 62 Department of Health and Human Services 2015, *Aboriginal family violence. Consultants' guideline*, State of Victoria, Melbourne.
- 63 Woodlock D, Healey L, Howe K, McGuire M, Geddes V, 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.
- 64 Family Safety Victoria (internal document), *Overview of LGBTI family violence 2018*, Diversity Unit, Victorian Government, Melbourne.
- 65 Wendt S, Chung D, Elder A, Bryant L 2015, *Seeking help for domestic violence: Exploring rural women's coping experiences*, ANROWS, Sydney, p. 1.
- 66 *Carer Recognition Act 2012* (Vic)
- 67 *Disability Act 2006* (Vic)
- 68 *Mental Health Act 2014* (Vic)
- 69 Roufeil L, Battye K 2008, *Effective regional, rural and remote family relationships service delivery, Australian Family Relationships Clearinghouse: Briefing No. 10*, Australian Family Relationships Clearinghouse, Melbourne.