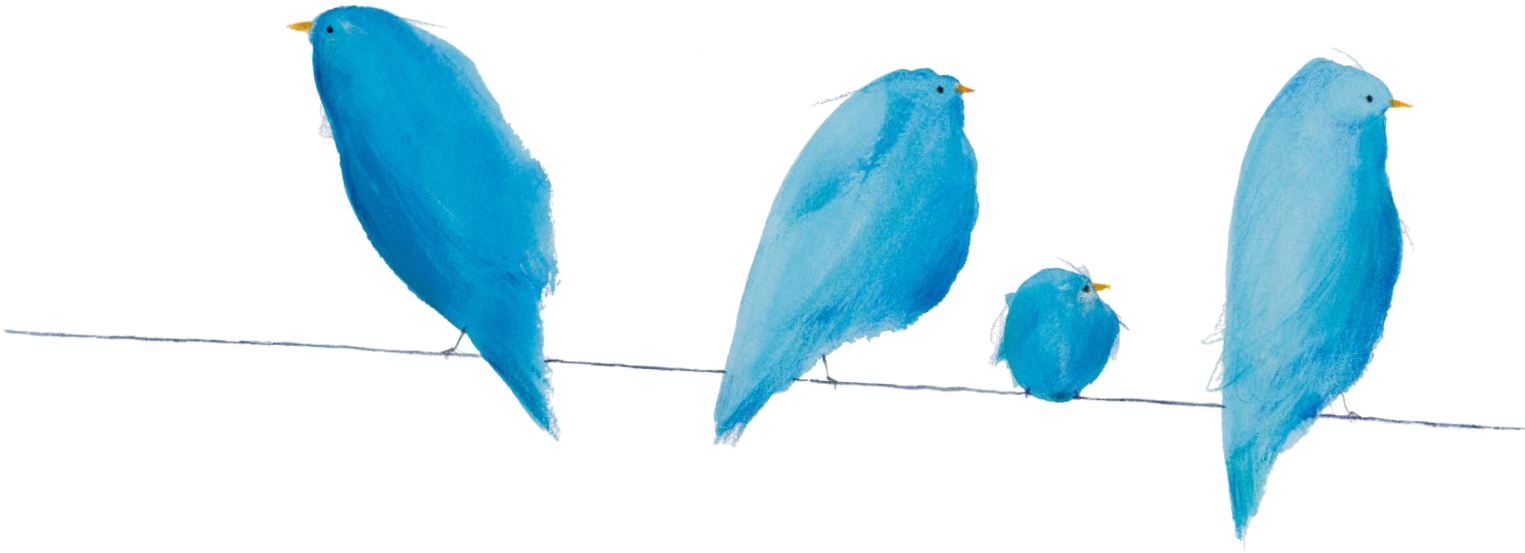

Submission to Family Violence Monitor:

Strengthening Hospital Responses to Family Violence (SHRFV) Program

22 July 2020

the women's
the royal women's hospital
victoria australia

How has the family violence service system changed since the Royal Commission?

Overview of SHRFV development

The **Strengthening Hospital Responses to Family Violence** (SHRFV) service model is currently in its sixth stage of development.

In 2014 and 2015 the Victorian Government funded the Royal Women's Hospital (the Women's) and Bendigo Health to develop and implement a framework for embedding the practice of identifying and responding to family violence. This was the first stage of creating the **Strengthening Hospital Responses to Family Violence** (SHRFV) service model as a guide to a whole of organisation and system-wide approach. Two training modules to support the model were designed to build on the existing capabilities of hospital staff.

In stage two, the SHRFV model was expanded and the training modules were incorporated into the first edition of the **SHRFV Toolkit** which also offered resources and communication materials to support transferability and guide other acute health services in the implementation of the model. Two metropolitan and two regional health services joined the project as demonstration sites and with mentoring and leadership from the Women's and Bendigo Health, began implementing and adapting the service model to their health care settings.

By stage three, the total number of health services participating in the SHRFV program rose to 15, including 11 metropolitan and 4 regional services. Regional Coordinator roles were established at regional lead health services to support the smaller rural health services to implement the SHRFV service model. As a result of the Royal Commission into Family Violence, recommendation 95, every Victorian public hospital was required to strengthen its response to Family Violence in its Statement of Priorities. The Victorian government announced an investment of $38.4 million from 2017 to 2020 to support hospitals with this work.

The key outcomes in stage 3 related to:

1. Creating cross hospital leadership and momentum: Executive commitment, resource investment, strong governance structures, an engaged and committed workforce, leadership across the sector.
2. Laying a foundation through policy, procedure and guidelines: Embedding best practice guidelines and procedures to ensure a holistic and supportive response to patients experiencing family violence.
3. Changing culture: Building capacity for change, raising awareness, promoting understanding, celebrating achievements.
4. Building capacity and capability: Staff training, measuring staff confidence to identify and respond, expanding the education modules, implementing quality improvement processes.
5. Building partnerships and connections with the wider community and the family violence sector: Positioning hospitals as an essential part of the integrated family violence sector, supporting consumer participation and consultation
6. Building the Evidence Base: Data capture, auditing, barriers to enquiry, establishment of the Women's Centre for Family Violence Prevention,

By stage 4, in 2017-18 all Victorian hospitals were in receipt of SHRFV funding and the model had evolved to include the workplace support program targeting staff who had experienced family violence. In 2018-19, stages 5 and 6, the SHRFV state-wide reports indicated that the successes and key enablers have included the delivery of the Family Violence Workplace Support Program, strong executive leadership engagement, access to and use of the SHRFV toolkit, and the sector-led approach that focuses on ensuring that hospitals have the infrastructure and capabilities to lead the

cultural change, structures, and processes needed to embed and sustain a whole-of-hospital response to family violence.

The SHRFV project is scheduled to conclude in June 2021.

SHRFV model explained
A range of evidence-informed resources and tools have been developed to support 87 Victorian public hospitals to implement the SHRFV model. The Victorian government investment of $38.4m to the SHRFV project recognizes the particular role of acute health services in being the first, and sometimes the only contact with the public health system that has capacity to enable children, women and men affected by family violence to gain access to necessary support, care and advocacy.

The SHRFV model is staff and patient centered and has 5 key elements:

1. Engaging leadership and decision makers to confirm commitment, as well as appoint staff, establish reference groups, and develop a communications plan.

2. Adapting and developing policies, service mapping, identifying opportunities and barriers to successful implementation of the model.

3. Raising awareness across the hospital so that all staff better understand family violence and its drivers. This includes training and building the core capabilities of clinical staff, managers and enables the continuous improvement of systems and procedures.

4. Building partnerships with the wider community and the family violence sector to ensure appropriate referral pathways.

5. Evaluating and researching the model.

Antenatal screening: a high risk group of women
The significance of routine identification and screening for family violence in all public antenatal settings was articulated in Recommendation 96 of the RCFV, and the SHRFV project has recently been engaged to lead this work with the 53 hospital sites and 14 Koori maternity services across Victoria.

Family Violence Workplace Support: a supported workforce
This program has trained thousands of managers and practitioners across the state, and supported 87 Victorian hospitals to respond to staff impacted by family violence. This program developed specialist human resource and industrial relations practice tools including the development of policies, procedures and industrial instruments, training for managers and family violence contact officers, sector partnership development, capacity building and secondary-consultation.

Toolkit development and review: a comprehensive and current resource
The SHRFV Toolkit was developed to support the model and has been revised and updated annually to reflect both the experience of health services and emerging government policy directions and

new legislation. The fifth and final edition is currently being updated and will include alignment with Multi Agency Risk Assessment and Management (MARAM) and the Family Violence and Child Information Sharing Schemes. The final edition of the Toolkit will include:

1. SHRFV Project Overview
2. MARAM Framework tailored to health settings
3. SHRFV Program Management Guide
4. SHRFV Mapping Partnerships and Connections
5. Family Violence Workplace Support Program Overview
6. Family Violence Workplace Support Program Resources
7. SHRFV Training Manual, Materials, Handouts, Videos
8. SHRFV Project Management Tools
9. SHRFV Train the Trainer
10. SHRFV Communication Materials

An indication of the successes across Victorian hospitals and health services reported in the June-December 2019 period are:

- 16,158 staff received SHRFV family violence training
- 66,162 staff, which equates to 57% of the Victorian hospital workforce, have received SHRFV training to effectively identify and respond to family violence since the project commenced
- 81% of health services now have senior leadership engagement to effectively respond to family violence

The key changes that have resulted from the SHRFV project are:

1. A robust infrastructure within and across hospitals for the implementation of a shared understanding and vision to guide the response to family violence in acute health settings;
2. Visible executive leadership and a network of support to promote evidence based and collaborative practice within and beyond acute health settings;
3. Consistency in policies and procedures across acute health settings;
4. A workforce development system that includes training, communities of practice and support for staff groups that are applicable to the demands of acute health settings;
5. Shared communication and information strategies to reduce duplication of effort

Case study 1: Family Violence Clinical Champions at the Women's *The Women's has established a network of Family Violence Clinical Champions that is inclusive of midwives, nurses and doctors. They are an engaged group that play an important role in sustaining family violence work across the organisation. The clinical champions are trained to assist, support, and resource clinical staff to be able to access evidence-based information about family violence in relation to the care of women and children throughout the hospital. Their role includes building staff capacity by guiding clinical practice in regards to family violence and leading reflective practice and case reviews at relevant staff, team and clinical meetings.*

Case study 2: Family Violence Workplace Support Officer at the Women's *The Women's is unique in establishing a Family Violence Workplace Support Officer role within its People, Culture and Wellbeing team. This role provides staff who experience family violence and those who support them with information and referral to specialist family violence services, workplace safety planning, family violence leave and altered work plans and advice to managers. The role is also responsible for upskilling and supporting Human Resources contact officers in managing family violence in their daily duties and in the delivery of Workplace Support Manager's training. The role contributes to hospital wide communications, relevant policy, procedure and intranet information updates and coordinates the 16 days of activism activities each year, incorporating primary prevention and early intervention activities during this time.*

Looking forward – what is still required in the family violence system.

The $38.4 million of SHRFV investment peaked in 2018-19, and there has been a significant reduction of funding for the project's final year, with significantly fewer staff working to embed the initiative.

This reduction in funding and staffing coincides with hospitals being prescribed under the Family Violence Protection Act to align their policies, procedures, and clinical practice to MARAM and the information sharing schemes. While the SHRFV project intends to align the SHRFV Toolkit to adapt and provide guidance and training to meet these increased responsibilities, there is no additional funding indicated to ensure that all hospitals have capacity to drive these changes to practice beyond June 2021.

The delayed publication of MARAM practice guidelines for working with children and perpetrators also presents a range of challenges for acute hospitals, both in terms of SHRFV capacity to build supporting materials and translate the guidelines to acute health settings. Hospitals will continue to need additional resourcing and support in order to embed these practices as the SHRFV resources diminish.

The SHRFV program has been monitored throughout the 4 years of funding by regularly reporting to the Department of Health and Human Services, however a comprehensive evaluation of its progress and achievements has not occurred.

However, the Women's Centre for Family Violence Prevention, established in 2016 has played a critical role in leading research translation and evidence based practice across the health system. The Centre is currently leading the SAFE Project which is implementing a system audit across 18 Victorian hospitals and health services to evaluate the impact of SHRFV. This has been resourced through philanthropic funds. The SAFE Project will build the evidence base on how well Victorian health services are performing in implementing systems change to reduce the burden of ill health associated with family violence on both patients and hospital staff. This audit covers ten key patient, staff and organisational domains, detailed below:

Patient domain:

1. Identification first line response, and follow-up: A standard identification and screening protocol, and first line response approach, to guide appropriate assessment, referral (according to care pathways) and follow-up when responding to family violence across the lifespan.

Staff domains:

2. Staff education & training: Staff are educated and trained to have a shared understanding of family violence; specific training is tailored to clinical staff, specialist staff and managers.
3. Staff support: Practical support for all staff to undertake their work to address family violence.

Organisational domains:

4. Organisation policies, procedures & guidelines: Up-to-date policies, procedures and guidelines support family violence first identification and response for patients and staff using a lifespan approach.
5. Governance & Leadership: The health service demonstrates governance, leadership and investment in family violence program sustainability
6. Intersectionality & diversity: The program is inclusive and accessible for diverse communities including people with lived experiences of family violence.

7. Collaboration & service integration: Internal and external collaboration throughout family violence program and practice
8. Infrastructure – physical environment & financial resources: Infrastructure to support the FV program – attention to the physical environment signalling a safe and responsive environment in which to engage and seek help for family violence; and a fully funded and allocated program supporting dedicated staff and resources.
9. Organisational culture: Organisational cultural that demonstrates recognition of family violence and gender equity as an important issue for the health service.
10. Quality improvement & evaluation: Strategic and continuous monitoring with feedback to ensure service effectiveness is achieving its goal of systems change.

The final report of the SAFE project is not due until June 2021, but the preliminary findings indicate that the SHRFV project has improved the response to family violence in hospitals. However, these early results also indicate the need for quality improvement in both patient and staff domains. There are also indicators from the organisational domain that suggest that further enhancement to governance and leadership; intersectionality and diversity; infrastructure and quality improvement will be required to sustain the change that has been made across the acute health sector.

The SHRFV project has been highly successful in establishing a whole of organisation and whole of acute setting approach by leading:

1. A consistent evidence based approach to responding to family violence
2. A coordinated state-wide system that engages hospital leadership, supports systems growth, builds capacity and capability, encourages collaboration and contributes to the evidence base
3. A model that can be adapted to all acute health services in Victoria across the range in size, speciality and location while reducing duplication of effort

The investment in the SHRFV project has been considerable and the outcomes over a short period of time equally significant. However, sustainability and reach is reliant on additional ongoing funding to ensure that all hospitals are adequately supported to embed evidence based family violence response activity within their health service. This needs to be supported by consistent auditing of performance and quality improvement planning in order for hospitals to be the fully functioning organisational participants in the family violence response system that is required.

Impact of the COVID-19 pandemic

The Victorian hospital and health sector has been at the forefront of responding to COVID-19 since early 2020.

The global evidence that suggested that family violence could become more frequent and severe during periods of emergency like this current pandemic seems to have been borne out by local experience.

Our understanding of the extent of the impact of COVID-19 on the dynamics and prevalence of family violence is new and emerging, with many Victorian hospitals initially reporting a decrease followed by an increase in family violence identification and referral. This may be attributed to initial community reluctance to attend hospitals in combination with reduced face to face hospital services resulting from restrictions.

COVID 19 has limited the SHRFV and Workplace Support project in terms of:

- Delivery of face-to-face family violence training has been halted, replaced in part by online training
- Clinical Champions ongoing education programs have been limited
- The reach of SHRFV teams to hospital governance meetings and sector meetings has been curtailed due to postponements
- There has been a deployment of staff to COVID 19 responsibilities away from family violence related responsibilities.

Like other organisations, the SHRFV project has introduced webinars, online meetings and has pivoted towards e-learning as the platform for training. E-learning is now considered a priority for development to both manage COVID 19 restrictions and support the embedding of SHRFV training into hospital Learning Management Systems.