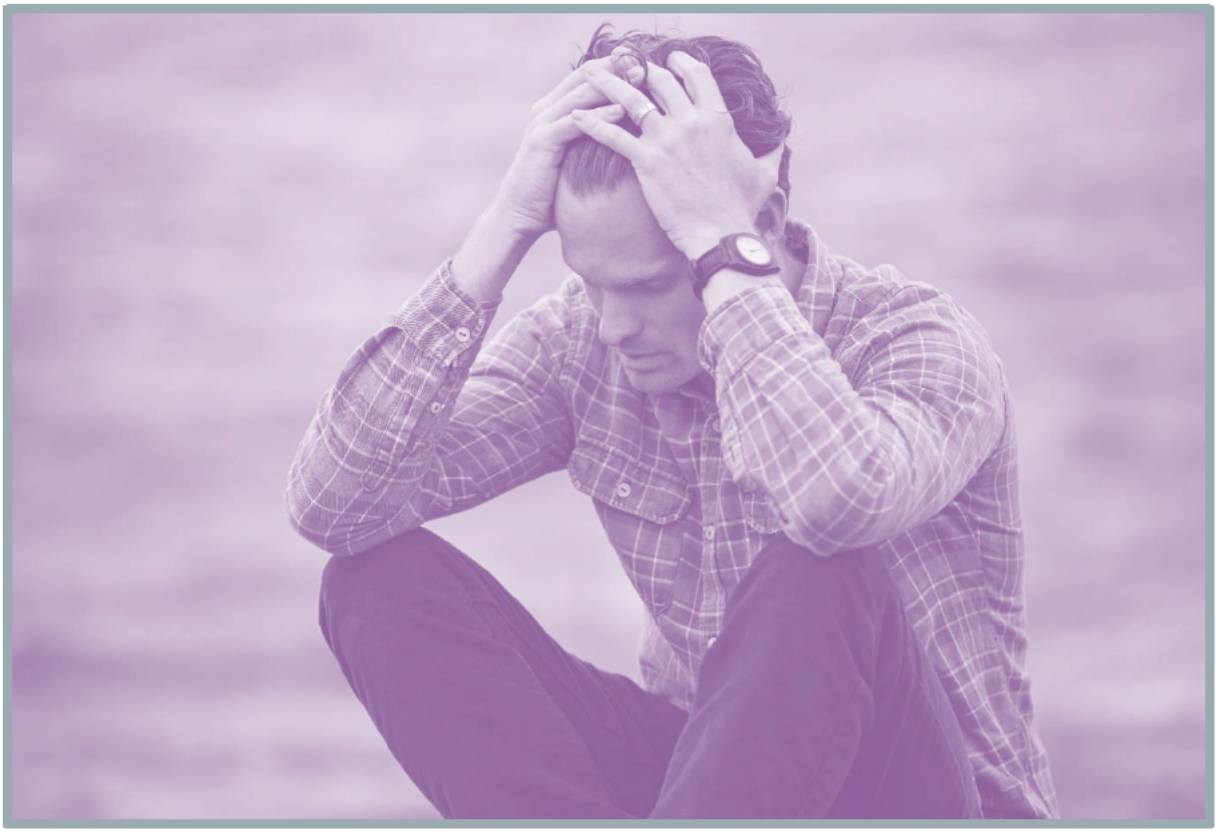
No to Violence

Leading the change to end male family violence in Australia

Submission to:
The Family Violence Reform Implementation Monitor

Review of family violence information sharing and risk management



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Section 1: The Family Violence Information Sharing Scheme and Central Information Point

Question 1:
Are the legal requirements in the Act sufficiently clear? NO

In responding to this question, please consider whether you feel the Act is sufficiently clear in relation to the meanings of key terms (such as person of concern, primary person, confidential information and excluded information), the circumstances in which confidential information can be requested or disclosed, record-keeping requirements and any other matter.

If no, how do you think they could be made clearer?

- The Act presumes and expects that organisations and clinicians understand the law. Often, as an ISE you will not have access to all the information.
- Within the Act, 'excluded information' requires a more detailed explanation. It would be important to note examples of what meets the criteria for excluded information. Currently, the lack of clarity creates anxiety for clinicians. The legal terminology of 'Good Faith' needs to be linked to the excluded information section to ensure that information is shared in good faith to ensure victim-survivors are safe and the person using violence are kept in view and accountable.
- The Act needs be more explicit outlining the difference between the Act and family court requirements. The Family Safety Victoria Guidance is a tool in which advisors use to determine the difference between the two, however it would be useful to have this within the Act.
- The language within the Act i.e. Person of concern and primary person is not aligned to the Multi Agency Risk Assessment and Management (MARAM) framework. Legislation needs to align and be consistent across sectors, for example, police use Affected Family Member and Subject/Defendant/Alleged offender whereas MARAM uses victim-survivor and person using violence.
- The Act needs to specify that it does not go across jurisdictions and that the information sharing schemes do not apply across states and territories. Assumptions have been made as to where the Act can be applied.
- An explanation of Record keeping requirements needs to be noted in the Act. For example, medical records i.e. how do medical records sit within the record keeping requirements.
- An explanation Victorian legislation falls under the National DVO Act.

Question 2:
The Act outlines principles, and requires the Minister to issue guidelines, to guide decision-making in relation to the collection, use or disclosure of confidential information.

a) To what extent are the principles reflected in your organisation's policies, procedures, practice guidance and tools? MOSTLY

- Some larger organisations are challenged aligning to MARAM as there is still some resistance and there is a need for further education on the principles.
- Most policies, procedures and tools are in place however what this looks like in practice can vary. This can decrease visibility.
- The impacts of COVID, staffing issues, workload and lack of time can make it challenging to ensure all staff are aware of the policies, procedures, practice guidance and tools.
- Due to workforce change management, the policies, procedures, practice guidance/tools may not always be applied appropriately or not as often and with a standard as required. This is a workforce/sector wide issue.
- Organisations and clinicians can be confused between Freedom of Information and Information sharing legislation and requirements.
- Reviews of policies, procedures, practice guidance and tools are undertaken frequently and sometimes not in the scope of the SFVA role.
- Some organisations require an increase in capacity to ensure risk assessment tools are adapted to specific teams and clinicians. This will ensure that the tools are useful to the team/clinician to identify and respond to family violence. This then needs to be reflected in policies, procedures, and practice guidance.
- Some policies, procedures and practice guidance do not refer to the Act. The nuances between Acts are not made explicit in the policies, procedures, and practice guidance.
- There can be confusion on where to store MARAM tools and sensitive information particularly if clinicians are working with a person using violence. The Act does not specify how to do this, in terms of hospital records and can be challenging to note in policies and procedures.

How could this be improved?

- More collaboration and capacity building for staff around the Act and MARAM.
- Education is the key for staff, ensuring induction for new staff include the Act and MARAM. A standardised presentation on MARAM and the Act to build capability.
- Examples on The Act should be integrated in practice.
- There needs to be additional clinical champions of family violence within organisations.

b) Do the principles and guidelines support you to make decisions under the Act? YES & NO

YES:

- If there is resistance to information sharing, the Act is used to inform decision making for clinicians.
- The Act is simpler than MARAM to explain to clinicians.
- Promoting the Act to further the safety of victim-survivors and increases accountability for the person using violence.
- The ability to use 'having a reasonable belief' – supports with managing clinician's anxiety around the difference between confidentiality and information sharing.

NO:

- The hierarchy within organisations can impact the ability to make decisions even with indicating the Act. Education on the Act and MARAM needs to be mandated for those who hold governance.
- Furthering the point above, the lack of education within psychiatry teams impacts the ability to make change. The Act should outline that ISE Organizations and people in governance roles need to comply with the Act and education associated.
- The reference of other Acts is often used to support information sharing to increase safety and accountability, for example the *Mental Health Act.*
- There is a belief that privacy and medical privilege may be violated if information is shared. The threshold for voluntarily sharing information is varied. Decision making can be attributed to cultural resistance and requires a shift that safety of the victim-survivor is at the centre of the work.

Question 3:
Does the Act provide sufficient scope and authority for you to collect, request, use or disclose all information you feel is needed to effectively establish, assess, and manage risks of family violence? YES

Where are the gaps?

- A cultural lens is needed within the Act however advisors are using other acts to support, manage and assess risk.
- There is confusion about what meets the threshold for information sharing and there are discrepancies on clinician's responsibilities, for example, do they complete a MARAM assessment or complete a referral to a specialist family violence service.
- The practice of sharing information can be problematic, it varies between clinician to clinician for example, there is sometimes not enough analysis of what information should be shared – this is a practice issue. Further upskilling of information sharing is required.

Question 4:
Have you been able to obtain consolidated and up-to-date information from the CIP about perpetrators of family violence to support your organisation to assess and manage risks of family violence? YES & NO

YES:

- Can vary from region to region.
- CIP reports are useful when victim-survivors are disclosing family violence. This ensures that the victim-survivor is supported and believed rather than pathologized as a medical diagnosis. which impacts outcomes and safety planning.

NO:

- There needs to be universality of CIPs across the state. The Orange Door have refused CIP access.
- CIP information needs to be analysed before sharing to ensure it is risk relevant.
- Time frames are often lengthy which in turn places the management of risk onto organisations, whereby they often must involve police.
- There can be 'fishing of information'. The need for systems and services to have access to each other's information for example, CIP or TOD having access to CMI system.

Question 5:
Have you observed an increase in the level of information sharing, including: YES & NO

YES:

- There has been an increase in sharing of information and asking for information across some of the SFVA's organisations.
- SFVAs have advised that practitioners use Mental Health services to gather information.
- SFVAs are requesting more information than receiving requests, however AOD SFVA requests are low.

NO:

- There is an absence of governance for information sharing. There is large amount of information sharing requests coming to the SFVA rather than clinicians.
- The FVIS has limited the networking between organisations and timeliness of information sharing due to having to complete request rather than a phone call.
- Information sharing can be impacted by staff shortages, this in turn can decrease cross sector collaboration.

- Responsibilities of Information Sharing can vary in organisations, for example, Information Sharing goes to managers rather than clinicians.
- There needs to be a shift in culture around information sharing, whether that is through a request or voluntary i.e. via phone to clinician. The capacity of clinicians is varied on sharing information, this can sometimes be re-allocated to SFVAs.
- The limited amount of information sharing that child protection undertakes can be an issue and is mostly always a verbal request rather than an FVISS request. This poses risks to the victim-survivor and does not always hold the person using violence in view and accountable.

a) information being disclosed voluntarily? MOSTLY

If no, what were the barriers or challenges?

- Some clinicians are not actively sharing information voluntarily, there is more emphasis placed on information sharing requests rather than voluntarily.

b) information being disclosed on request? YES

- There are no issues if a SFVA is requesting information.

Question 6:
Have you observed an increase in the level of collaboration between organisations to support the delivery of coordinated services? YES & NO

YES:

- Yes, however COVID has impacted the ability to connect and build collaborative relationships and visibility of the SFVA role. In saying that, online platforms have made it easier to collaborate especially in regional areas.
- The PSA role has been supportive in building collaboration and there is an increase in the AOD sector's collaborative practice.

NO:

- Establishment of The Orange Door has made it difficult to collaborate as there has been an influx in staff, increase in demand, lack of funding. There is medical collaboration occurring, however Family Violence specific collaboration does not occur as frequently.
- There are differences between practitioner skill set i.e. child protection, how well individuals collaborate. This is impacted by workload and FTE.

Question 7: Have you experienced any legal barriers or challenges in:

a) collecting, requesting, using, or disclosing information?

- Excluded information i.e. Judicial proceeding report Act 1958 and the spent convictions Act have posed barriers to SFVAs as this is unclear as to what can and cannot be excluded, specifically in relation to the Mental Health and AOD sector.
- The Magistrates court want to know additional information regarding the victim-survivor before responding to an IVO request, however organisations do not have consent to release this information. This can increase risk to the victim-survivor.
- When the person using violence has power of attorney.
- Storage of sensitive information, the information is not always protected.
- When clients are discharged into private care, clinicians in private practice are not required to share information under FVIS and CIS.

b) collaborating with other organisations to deliver coordinated services?

n/a

c) complying with the Act's requirements?

- The Mental Health Tribunal can be a barrier, for example 'least restrictive care' can be used to override victim-survivor safety. There are assumptions on whose rights (victim-survivor or the person using violence) clinicians are prioritising. For example, a person using violence having rights to have extended leave within a mental health setting is not considering victim-survivor safety.
- There are concerns and barriers around what information is stored within the Mental Health Tribunal and that this information may be shared with the person using violence.
- Legislation can be used to minimise behaviour.

Question 8:
Are you aware of any instances of the unauthorised use or disclosure of confidential information under the FVISS or CIP provisions?

- Fishing for information occurs across organisations. There are victim-survivor services seeking information on person using violence's mental health presentation as the victim-survivor has mentioned this in disclosure. This information is then used in legal matters.
- The Orange Door requesting discharge summary and clinicians providing whole files rather than redacting information. This highlights the need for more capacity building.
- Limited places to store sensitive information relating to risk.
- Forensic Information Sharing requests can be used to support a forensic report, however this does not fall under the Information Sharing Scheme.

Section 2: Family Violence Risk Assessment and Risk Management Framework

Please reflect on your experience in aligning your organisation's policies, procedures, practice guidance and tools with the MARAM Framework when responding to the following questions.

Question 9:
Are the legal requirements under the Act sufficiently clear, including in relation to the meaning of framework organisation and section 191 agency?

Yes, individually as an organisation under the act, however as a program this is not relevant.

Question 10:
Have you observed greater consistency in organisations' approaches to family violence risk identification, assessment, and management?

YES & NO

YES:

- Organisations are getting better at this, there has been improvement, for example, there has been a high visibility of family violence in conversation and the recognition of family violence in clinical review settings.

NO:

- Consistency has been impacted by COVID and staffing issues.
- There is a gap between approach and practice – MARAM fatigue.

General Questions

Question 11:
Have you observed any adverse effects of the provisions for groups, such as children and young people, adolescents who use violence in the home, or members of the Aboriginal community?

Yes - Adolescents, Children, and the Aboriginal community.

What types of adverse effects have you observed?

- *Adolescents:*
  There are issues with confidentiality of documents and what can and should be shared, the response in which practitioners are responding to family violence in a family context. There are concerns around the amount of training clinicians must adequately provide a whole of family approach to family violence.
- *Children:*
  There is a concern about how children's files are being used in court. The person using violence is requesting Mental Health records of the child to withhold consent of treatment as a tact of coercive control over the victim-survivor, aggression toward staff if the person using violence is having to access information if the IVO states, they cannot contact the victim-survivor.
- *Aboriginal community:*
  There are assumptions being made of what referral pathways are required, for example, whether the service user is wanting an indigenous service or mainstream service. There is limited consultation and agency provided to service user whereby the service user may not be consulted on what service they would prefer to engage with. Advisors have noted there is a need for stronger collaboration between mainstream and indigenous services. FVISS and CISS schemes are impacting on engagement, due to impacts of colonisation and these schemes increases fear within the aboriginal community.

Question 12:
Do the provisions sufficiently provide for the needs and characteristics of diverse communities? NO

- Choice needs to be provided to the service user.
- The Family Violence Sector does not have capacity to support parents of adult mental health clients, especially when these clients do not sit within the elder abuse programs/support.
- The abstinence policy within the Family Violence Sector limits engagement if the victim-survivor or person using violence has AOD presentations. The victim-survivor's use of substances should be included in MARAM tools.
- Coercive substance use is not currently listed in MARAM.
- Marginalised communities do not fit within our 'boxes'/provisions. It is a heteronormative framework; it is understood that family violence has gender drivers however does not cater to marginalised communities.

Question 13:
Do you have any other comments about the operation of the provisions, including any suggestions for improvement?

- Set up a FVIS/CIS enquiry line.
- Due to capacity issues across the sector, there is a large volume of information. Could a 1-page document be created to share most risk relevant information to reduce administrative workload.
- The MARAM website is challenging to navigate, could be more user friendly.
- Additional resourcing to respond to FVIS and CISS, a dedicated role within organisations to complete this.