Strengthening hospital responses to family violence

Project overview

August 2016
Introduction

The hospital system is an early contact point for many people who have experienced family violence. As such, hospitals are in a unique position to routinely make early identification for the benefit of patients experiencing family violence.

With appropriate education and support, health professionals can reduce the barriers for patients to disclose their concerns and be a catalyst for action. An empathetic and professional response from a trusted doctor, nurse, midwife or other health provider can reinforce a patient’s understanding that they are entitled to healthy relationships and a life free from violence. By respecting the decisions of patients and offering a range of options, health care providers have a vital role in ensuring that health needs are met, inclusive of a patient’s safety. Such interventions have the potential to not only empower people affected by family violence but to also contribute to enhanced health outcomes and to potentially save lives.

For these reasons, and as a priority, hospitals need to invest in a service model that equips and supports staff to respond to family violence drawing on evaluated approaches in Victoria and elsewhere.

To assist hospitals to undertake this work, the Victorian government funded the Royal Women’s Hospital (the Women’s) and Bendigo Health to develop the Strengthening Hospital Responses to Family Violence (SHRFV) service model in 2014 and 2015. This first stage of the SHRFV project was evaluated by Our Watch and can be accessed at www.ourwatch.org.au.

The result of this work is a service model which is based on the work undertaken by the Women’s, Bendigo Health, international best practice, and in particular the work of Kaiser Permanente in northern California. The SHRFV Project Management Guide outlines an approach to introduce the service model and discusses how your hospital might identify priority areas for rollout of this project and associated training.

The scope of this project has limited the SHRFV service model to a particular focus on violence against women, and substantially on intimate partner violence (IPV). Clearly, all violence is wrong and anyone can be a victim or perpetrator of family violence but Australian statistics indicate it is predominantly committed by men against women, children and other vulnerable individuals.

The Women’s and Bendigo Health have now used their experience to produce a Tool Kit to assist Victorian public hospitals to implement a system wide approach for responding to family violence.

The SHRFV Tool Kit contains:
- an overview of the SHRFV service model
- SHRFV Project Management Guide – a practical guide for establishing and implementing the service model
- SHRFV Service Model Training Package – a practical guide for facilitators tasked with delivering the SHRFV training modules that includes presentations and facilitators’ notes with modules of training aimed at improving the ability of staff to identify and respond to family violence
- an internal briefing presentation and notes to build executive and leadership engagement
- a suite of tools to assist your service to implement the service model
- print-ready files for promotional and awareness raising materials targeting staff and patients and their families in a format that will enable hospitals to insert a local brand and contact details.

The SHRFV service model and project management approach detailed in the Guide maps out the process that the Women’s and Bendigo Health developed, and continue to implement, to improve how they respond to family violence. It is not prescriptive and can be adapted to suit different hospital environments and the communities they serve.
Defining family violence

The Act defines family violence as ‘including a range of behaviours such as physical and sexual abuse; emotional or psychological abuse; economic abuse; or behaviour that is threatening, coercive, or in any way controls or dominates that person or causes them to feel fear. The definition also refers to any behaviours that cause a child to witness or hear or otherwise be exposed to the effects of family violence.’

As described by the Royal Commission into Family Violence 2016 (Victoria), family violence ‘may involve partners, siblings, parents, children and people who are related in other ways. It includes violence in many family contexts, including violence by a same sex partner, violence by young people against parents or siblings, elder abuse, and violence by carers in a domestic setting against those for whom they are responsible.’

Family violence incidence data highlights that the experience of family violence is often gendered, and is most frequently and most severely perpetrated by men against women.

Our Watch www.ourwatch.org.au use the following statistics to demonstrate the severity of such violence, its prevalence, and the groups most vulnerable to experiencing it:

- On average, at least one woman dies at the hands of a current or former partner every week in Australia.
- One woman in three has experienced physical violence, since the age of 15.
- One woman in five has experienced sexual violence.
- One woman in four has experienced emotional abuse by a current or former partner.
- Women in Australia are at least three times more likely than men to experience violence at the hands of a partner.
- More than half of the women who experienced violence had children in their care when the violence occurred.
- Young women (18–24 years) experience significantly higher rates of physical and sexual violence than women in older age groups.
- There is growing evidence that women with a disability are more likely to experience violence. For example, 90% of Australian women with an intellectual disability have been subjected to sexual abuse.
- Aboriginal and Torres Strait Islander women experience disproportionately high levels of family violence and more severe forms of violence compared to other women.
- Aboriginal and Torres Strait Islander women are 34 times more likely to be hospitalised due to family violence related assaults than non-Indigenous people.

Sources:
Why a service model for hospitals?

Research shows that family violence and broader violence against women, has major health impacts and accounts for substantial repeat presentations in hospitals.

For example, a South Australian trial* found that in one hospital emergency department people experiencing family violence used services up to a third more often than those who had not been victims.

The National Plan to Reduce Violence against Women and their Children 2010–22 also indicates that women experiencing family violence commonly disclose to health professionals and that their first response is pivotal to their safety and support.

Doctors, nurses, midwives, social workers and other health professionals working in a hospital setting are therefore uniquely placed to help people respond to family violence.

An empathetic, sensitive and inclusive first response has further importance when working with individuals from diverse and vulnerable populations who may be reluctant to disclose due to concerns of judgement, dismissal, and discrimination.

Surveys of front-line clinicians prior to training indicate that the majority of staff recognise the importance of identifying and responding to family violence, but lack the confidence to do so.

The implementation and adaptation of the SHRFV service model provides hospitals with a model to address these barriers to identifying and responding to family violence. It also offers non-clinical staff, for example administrative and security staff, an introductory training session designed to raise awareness and improve their understanding of the issue, promoting a whole of organisation response.

Hospitals and health care providers are large employers with predominantly female workforces and a broad reach into the community through both patients and staff. With one woman in three having experienced physical violence since the age of 15, it is likely that a number of hospital staff will have experienced violence or been indirectly impacted by it. The SHRFV service model includes actions and activities that hospitals can undertake to ensure that their own staff who may be impacted by family violence are supported to stay safe, along with their managers and colleagues.

About the service model

The SHRFV service model is the implementation framework recommended for strengthening hospital responses to family violence in Victoria.

The service model aims to:
- introduce practices in hospitals which will make people affected by family violence more inclined to disclose and seek help
- ensure clinical staff feel confident, and have the capacity, to provide the necessary support and referrals.

The model involves two overarching principles and six key elements of work to ensure successful implementation and a strengthened response to family violence across the hospital.
Overarching principles

PRINCIPLE 1
Respect and gender equity

This fundamental principle recognises that family violence is a serious health issue, determined and reinforced by gender inequality and adherence to rigid gender roles and stereotypes. This has implications in a hospital environment in terms of leading change across policy, planning, and service delivery.

By promoting respect and addressing gender inequity, hospitals can contribute to:
- better health and social wellbeing
- improving organisational performance
- prevention of family violence.

The SHRFV service model identifies a number of strategies and activities that can be undertaken to create an environment where patients feel safe and supported in disclosing their experiences and to build an inclusive and fair environment for all employees.

The SHRFV Tool Kit includes awareness raising materials targeting both patients and staff.

PRINCIPLE 2
Sensitive practice

Sensitive practice enhances person-centred care by providing health professionals with a practice framework that increases a patient’s sense of safety, respect and control regardless of whether they choose to disclose violence or not.

Sensitive inquiry is an aspect of sensitive practice involving a six steps approach to routinely asking patients about their experience(s) of family violence where specific risk factors are identified such as pregnancy, mental health, isolation, separation or plans for separation.

Sensitive inquiry is different to universal screening where every patient is asked about their experiences of family violence. In sensitive inquiry (or case finding) a patient is asked only if a risk factor/s are identified.

The practice of sensitive inquiry adapted and piloted in the SHRFV project is based on the Victorian Family Violence Risk Assessment and Risk Management Framework (known as the Common Risk Assessment Framework or CRAF), and the key elements of sensitive practice are based on the lessons learned from working with victims and survivors of childhood sexual abuse in Canada. The practice of sensitive inquiry also aligns with the World Health Organization’s (WHO) recommendation that health care providers should ask about intimate partner violence when assessing clinical conditions associated with IPV, for example, depression, anxiety, repeat presentations, intrusive partner, unexplained chronic pain and unexplained reproductive symptoms.
Six key elements

The six key elements of work that underpin the SHRFV have been developed by the Women’s and Bendigo Health based on their experiences, and are informed by the internationally recognised Kaiser Permanente’s systems-model that aims to support family violence responses across the whole healthcare system. Kaiser Permanente is one of the largest not-for-profit, integrated health care delivery systems in the United States of America.

ELEMENT 1
Create cross hospital leadership and momentum
• Strategies to engage hospital personnel from top down

ELEMENT 2
Laying a foundation through policy, procedures and guidelines
• Adaptation or development of relevant policies, protocols and guidelines to identify and document consumers’ experiences of family violence and any subsequent referrals
• Relevant policies, procedures and guidelines to support staff experiencing violence, and those who may be perpetrators of violence
• Ensuring the hospital’s model complements and recognises the role of and expertise of local family violence services, and the need to integrate with the family violence system

ELEMENT 3
Changing culture
• Identifying the prevailing culture within the hospital and building capacity for change
• Partnerships with hospital consumers who have experienced violence
• Ensuring staff safety

ELEMENT 4
Building capacity and capability
• Increasing the competence of key staff within the hospital environment to better identify and respond to family violence
• Provision of clinical training aimed at improving the knowledge and ability of staff to identify and respond to family violence; and to increase understanding of risk assessment and family violence
• Providing ongoing support to clinicians to undertake this work

ELEMENT 5
Building partnerships and connections with the wider community and the family violence sector
• Supporting consumer participation and consultation in the process
• Building partnerships with the wider community and the family violence sector
• Increasing referrals of victim/survivors within the health service and to external services

ELEMENT 6
Building the evidence base
• Improving data collection on identification and responses to patients experiencing family violence
• Evaluating the implementation process and the success of the model
Training your workforce

The SHRFV training package recognises that all hospital staff need to have a basic understanding of the complexities of family violence.

Clinical staff need to be specifically trained to sensitively identify and respond to patients who disclose they are experiencing family violence. Managers need to be trained to have the necessary skills to support staff who provide direct support to patients experiencing violence, or who may be experiencing or perpetrating violence themselves.

While training your clinical workforce to build capacity and capability is a critical element of the SHRFV service model, it should also be the last component implemented. All other elements and supports of the service model need to be in place prior to any clinical training occurring. This will ensure your clinicians have the necessary support and structures around them to respond appropriately to family violence disclosures.

The SHRFV training modules have been designed so that they can be delivered in a range of formats and settings.

**MODULE 1**
A shared understanding
(for all hospital staff) covers the definitions and drivers of family violence, particularly intimate partner violence as a health issue and the gendered nature and impacts of violence.

**MODULE 2**
Identifying and responding
(for clinical staff only) covers clinical risk indicators, the six-step model of sensitive inquiry for responding to patients who disclose, professional responsibility and staff support.

**CONDENSED MODULE 1 & 2**
(for clinicians) where time is limited.

Conclusion

Hospitals are in a unique position to play a significant role in driving social change and helping to reduce the occurrence of family violence.

The SHRFV service model is based on the experience of the Women's and Bendigo Health embarking on their own change journey to strengthen their response to family violence. It has demonstrated there is no one size fits all approach and that it is not possible to effectively implement the SHRFV service model 'overnight'. The Women's and Bendigo Health have adapted the model to suit their environment and we expect other hospitals will do the same.

This work is vitally important for the benefit of both patients experiencing family violence and for clinical staff to feel supported to identify and respond appropriately. The commitment of a hospital Board and Executive, and a dedicated multidisciplinary Implementation Team is fundamental to successful implementation of the service model.

While undertaking this work can certainly present challenges in a health setting, the evidence tells us that for many women, a health care professional is often the first person they will talk to about family violence. Given this knowledge, the health sector must do all we can to better equip our staff to identify and respond to patients, drive social change and help reduce the occurrence of family violence in our communities.

The SHRFV service model is presented to guide hospitals in this work.