Mapping hospital and health services' workforce for MARAM Alignment

Workforce mapping against the 10 MARAM responsibilities

Introduction

The purpose of this resource is to propose a methodology that hospitals and health services can follow to map their workforce against the 10 MARAM responsibilities for identification, risk assessment and risk management to respond to family violence. This mapping process is a framework requirement for alignment to Pillar 3 in the MARAM Framework.

This resource should not be viewed as prescriptive, as mapping workforces and achieving MARAM alignment may differ across the sector depending on a variety of factors, including which clinical services each hospital and health service delivers and the workforce structure within. Hospital and health services' have the discretion to lead and tailor the alignment and mapping process to their specific context and clinical operating environment, with the final decision for the endorsement of where workforces are mapped against the 10 MARAM responsibilities sitting with each services' Chief Executive Officer and senior executives.

This resource also outlines the practice expectations related to the 10 MARAM responsibilities which have been tailored to the health non-clinical and clinical operating environment.

Where hospitals and health services map their workforce and the associated practice expectations will inform decisions on how to train and resource the workforce, amend clinical practice guides and associated systems and actions outlined in the *MARAM Alignment Action Plan*.

The *Workforce Mapping* document in Appendix A is an example that has been populated from workforce mapping undertaken at the Royal Women's Hospital. A *Workforce Mapping* template can also be found in the MARAM Organisational Embedding Guide due for release in mid-2020.

Terminology

Reference to hospitals and health services throughout this document refers to public hospitals and health services that are/to be prescribed under MARAM.
The term 'department' has been used to refer to clinical and non-clinical departments, teams and services within a hospital or health service.
The term 'staff groups' has been used to refer to clinical and non-clinical workforce groups or particular classifications of staff that work within a department of a hospital or health service.

Alignment requirements for Pillar 3

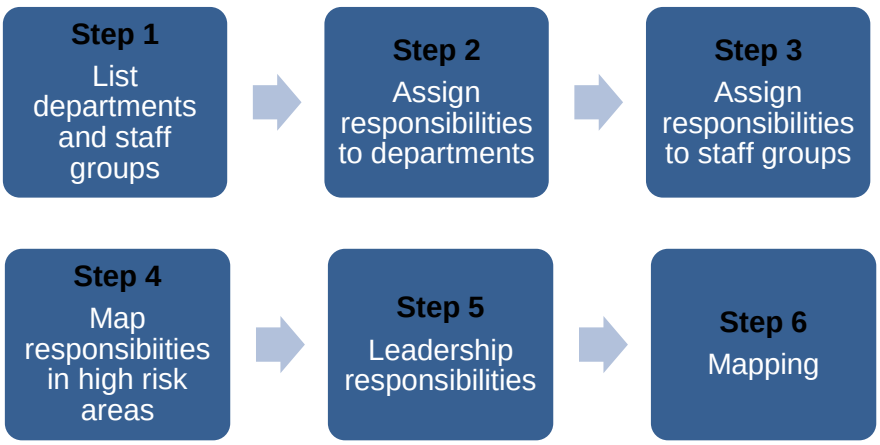
Pillar 3 of the MARAM Framework identifies 10 responsibilities which combine to create an effective response to family violence across the integrated service system. The responsibilities are supported by MARAM practice guidance and cover all aspects of effective response from sensitive and safe engagement, early identification, screening, risk assessment and management, information sharing, to safety planning and collaborative practice. Alignment to these responsibilities supports consistency of practice across the service system, and sets out minimum requirements for organisations. The MARAM Practice Guides can be found on the Victorian Government website.

In order to meet the alignment requirements for Pillar 3, hospitals and health services need to understand their responsibilities in risk assessment and management, assign responsibilities to their workforce and enable their workforce to implement the responsibilities in practice. MARAM responsibilities are set at an organisational level, meaning that it is for the organisation to ensure the responsibilities can be met by their workforce in practice by putting into place the appropriate policies, procedures, practice guidance and tools and associated systems to facilitate their practical application.

It is important to note that while the MARAM Framework outlines responsibilities for working with perpetrators, current alignment requirements focus on working with victim survivors. Practice guides and resources to support how organisations should work with and respond to perpetrators are in development by Family Safety Victoria and are expected to be release in late 2020. For this reason, this document only refers to the practice expectations and capabilities related to working with victim survivors. Practice guidance for working with adolescents is also in development, with dates for release still to be confirmed.

Methodology for mapping the health workforces against the 10 MARAM responsibilities

The methodology used in this guide involves a series of steps that draw on a range of information and considerations that respond to the complexity of this process with the intent to support informed decision making.



These steps have been informed by the MARAM Framework, MARAM responsibilities: Decision guide for organisational leaders and MARAM Practice Guides (each MARAM responsibility has an accompanying practice guide) and contextualised within a health setting. Please note that the methodology has been tailored specifically for clinical and non-clinical operating environments within the health sector and endorsed by Family Safety Victoria. The five steps are explained in detail below.

Determining where workforces are mapped requires executive oversight and input from leaders across the organisation. Workforce mapping should be a collaborative process undertaken with executive directors, directors, managers and leadership within all departments of a hospital and health service. Further details about engaging leadership and consultation to support a collaborative process to workforce mapping can be found in the *MARAM Alignment for hospital and health services* document.

Step 1: List departments and staff groups within the hospital or health service's workforce

The first step is to gather a list of your hospital or health service's clinical and non-clinical workforces that includes the discrete departments and staff groups that work within them. This list needs to include staff at all levels of the organisation, management, permanent and casual staff, patient facing and non-patient facing staff, as well as those who work after-hours. Human Resources can provide you with this information. See Appendix A for an example of a list of departments and staff groups.

Step 2: Assign responsibilities to departments with the hospital or health service

The next step is to assign a broad level response to all departments within the hospital or health service. MARAM refers to three broad levels of response to family violence within the integrated service system:

i) Identification and Screening ii) Intermediate and iii) Comprehensive.

Each broad level corresponds to a different combination of the ten MARAM responsibilities for risk assessment and management that an organisation is required to meet. Assigning these levels to each department will set clear expectations within and between organisations, indicate the level of family violence risk that the organisation is required to hold and manage, and establish what responsibilities need to be assigned between staff groups.

Note: Within the Identification and Screening level there are three levels of response: Foundational Practice, Sensitive Practice and Screening. These distinctions are specific to the operating environment within hospitals and health services and are further on the next page.

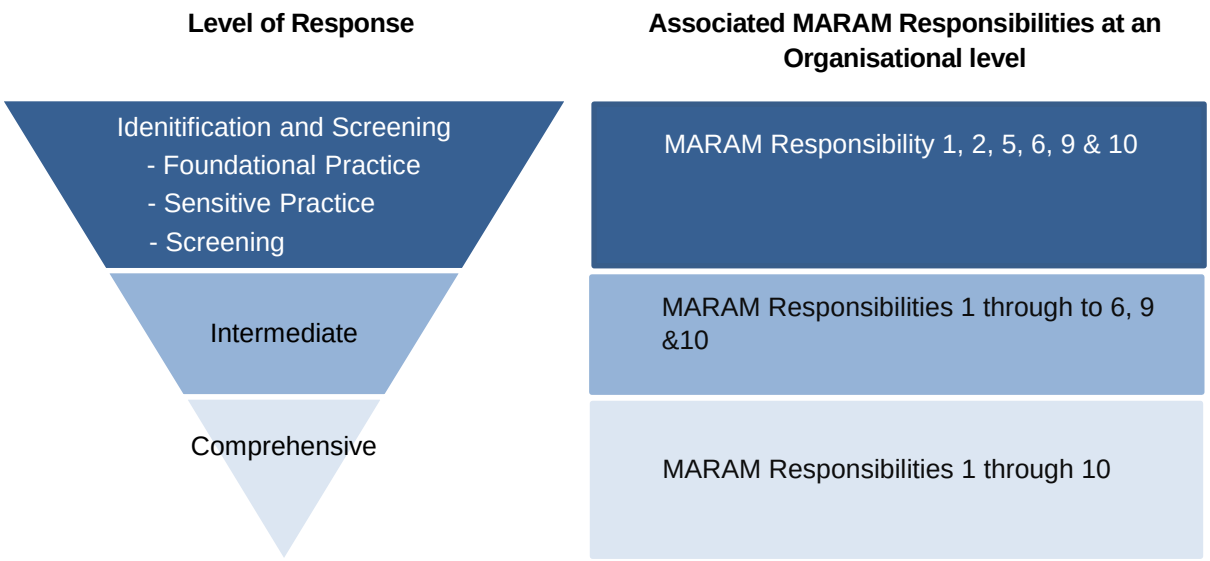


Illustration: Level of Response

Identification and Screening

Hospitals and health services main function within the service system is to provide health care and a first line response to screen, identify and respond to family violence victim survivors including referring to specialist support services, where appropriate. These functions are in line with MARAM Identification and Screening level of response. This means all hospital and health services have an obligation to ensure they meet MARAM Responsibilities 1, 2, 5, 6, 9 & 10 as an organisation.

To meet these responsibilities it is recommended that within hospitals and health services:

- At a minimum non-clinical departments are assigned **Foundation Practice**.
- At a minimum clinical departments are assigned **Sensitive Practice** and where appropriate **Screening** (see box below). It is also recommended that non-clinical departments responsible for the Workplace Support Program and departments with specific clinical support roles that work with at-risk cohorts, such as Aboriginal Health departments are assigned Sensitive Practice.

Distinction between Sensitive Practice and Screening

Sensitive Practice refers to using the opportunity of a clinical encounter to check for family violence and associated health problems should a clinician observe signs of family violence (or risk factors) or a disclosure of family violence is made with the use of an evidence-based identification tool.

Screening in a hospital or health setting refers to the consistent use of a validated set of short questions to detect family violence in all patients.

The World Health Organisation (2013) does not recommend universal screening for family violence in all settings, although acknowledges that in antenatal care there may be enough evidence for screening. A Cochrane screening review (O'Doherty , Hegarty, Ramsay et al, 2015) reinforced current evidence that suggests overall screening and initial response by a health professional increases identification, but does not have a clear effect on increases in referrals or changes in women's experience of violence or wellbeing.

Intermediate

Hospital and health services may also identify particular departments within their organisation where it is appropriate and necessary to align to an Intermediate level of response. This assessment should be informed by an understanding of the government funding agreements, the clinical service provided, and whether patient cohorts are at-risk of family violence or present in family violence related crisis, as well as the infrastructure, resources and capabilities required to competently hold and manage the associated level of risk.

An **Intermediate** level of response are appropriate for hospitals and health services departments that:

- Respond to family violence as part of their role, but are not focused on this risk alone
- Engage with people in crisis situations or cohorts who are at-risk of experiencing family violence
- Provide therapeutic interventions, a crisis service, case management support or broader needs assessment and management.

An Intermediate level of response requires organisations to ensure these departments can meet MARAM Responsibilities 1 through 6, 9 &10 (in particular Responsibility 3 & 4).

At-risk cohorts

Family violence is a gendered crime as the prevalence and experience of family violence disproportionally affects women and children, and overwhelmingly perpetrators are men. In addition, at-risk cohorts refers to groups that have been identified, through evidence, as being at higher risk of experiencing or being exposed to family violence such as:

- Aboriginal people
- People from culturally and linguistically diverse and faith communities
- People from lesbian, gay, bisexual, transgender, intersex, queer or questioning (LGBTIQ+) communities
- People with a disability
- People who experience mental health issues or mental illness
- Older people
- Rural and remote communities
- Women in or exiting prison
- Children and young people

These groups experience family violence at higher rates than the general population. This is not because violence is more inherent in these communities, but because of the structural inequalities and discrimination these communities experience, and community attitudes that create the conditions for increased rates of violence towards these communities to be normalised, tolerated and excused.

Further information about at-risk cohorts can be found on pages 33-36 of the MARAM Framework and pages 43-56 of MARAM Practice Guides: Foundation Knowledge.

Comprehensive

A **Comprehensive** level of response is appropriate for hospitals and health departments that:

- Work with victim survivors of family violence in a specialist capacity
- Are mandated or funded to provide specialist family violence case management, crisis support or family violence therapeutic interventions
- Their core role is directly related to increasing victim survivor safety

A Comprehensive level of response is appropriate for hospitals or health services that are funded by the Victorian Government to provide specialist family violence case management. There is no expectation for services not funded to provide specialist family violence services to align to a comprehensive level of response.

A Comprehensive level of response requires organisations to ensure these departments can meet MARAM Responsibilities 1 through 10 (in particular Responsibility 7 & 8).

Mapping the level of response to departments

To support mapping their workforce, hospitals and health services should assign a broad level of response to each department within their organisation. Appendix A demonstrates how this could be presented.

Responding to the Family Violence Capability Framework (RFVCF)

The RFVCF refers to four workforce tiers spanning specialist family violence services, core support services and professionals, mainstream/social support services and universal services. It also outlines five capabilities (as well as foundational knowledge) and details the level of knowledge and skills each tier should have within each capability.

The MARAM Embedding Guides refers to these tiers to support organisations to determine where they may sit within the family violence service system.

These four tiers do not address the complexity and diversity of staff roles and departments within specific services and sectors prescribed under MARAM. It is therefore recommended that hospitals and health services assign responsibilities to departments and staff groups through the methodology used in this document that is informed by the MARAM Framework and supporting resources.

Step 3: Assign responsibilities to staff groups

The next step is to assign responsibilities to staff groups. To meet their MARAM responsibilities at an organisational level, hospitals and health services need to ensure the practice expectations associated with each responsibility assigned to the department's level of response can be met within their organisation. The MARAM practice guides sets out the practice expectations and key capabilities for each of the 10 MARAM responsibilities.

Different staff groups will contribute to the organisation meeting their MARAM obligations in various ways. To reflect this in the mapping document, a distinction has been made between staff groups assigned to perform and fulfil, and staff groups who contribute to a responsibility. This distinction is specific to the operating environment within hospitals and health services, and recognises the ways in which collaborative practice functions across the organisation. The distinction is as follows:

- Staff groups who are **assigned** or mapped against a MARAM responsibility must be able to **perform and fulfil** this responsibility in their everyday practice. This requires them to be able to competently perform the practice expectation and all the key capabilities associated with the assigned MARAM responsibility
- Staff groups who **contribute to** a MARAM responsibility are required to have an understanding and awareness of this responsibility and play a role in enabling others in the organisation to effectively perform and fulfil this responsibility.

For example, under Responsibility 6, all staff groups have a responsibility to share information about family violence to promote risk assessment and management. For some staff groups this may require contributing to this responsibility through sharing relevant information with a manager or the social work department. For other staff groups, they will be required to have a responsibility to respond to external requests for information sharing and proactively share information externally, and therefore are assigned to perform and fulfil this responsibility. Both of these roles help the organisation meet its obligations under Responsibility 6, but the operation of the responsibility varies by staff group.

Hospitals and health services must decide which staff groups or staff members within their departments or organisation are best placed to be assigned to **perform and fulfil** a responsibility and how other staff groups will **contribute** to meeting their obligations at an organisational level. Later in this section the practice

expectation and key capabilities of each responsibility are outlined, and recommendations for how staff groups can contribute to the organisation meeting the obligations under that responsibility. In summary, it is recommended that:

- **Foundation Practice**: All staff groups within departments with a Foundational Practice level of response

  Have a responsibility to respond respectfully, sensitively and safely to a disclosure of family violence or indicator of family violence and know where to refer a victim survivor internally for support AND be aware of and contribute to the organisation's responsibility to share information, refer for specialist support and collaborate at a multi-agency level.
  This can be mapped by assigning these staff groups to perform and fulfil Responsibility 1 and contribute to Responsibilities 2, 5, 6, 9 and 10

- **Sensitive Practice:** Staff groups within departments with a Sensitive Practice level of response

  Have a responsibility to engage respectfully, sensitively and safely AND undertake sensitive enquiries of patients to identify if family violence is occurring in order to refer for support AND be aware of and contribute to the organisation's responsibility to share information, refer for specialist support and collaborate at a multi-agency level
  This can be mapped by assigning these staff groups to perform and fulfil Responsibility 1 & 2 and contribute to Responsibilities 5, 6, 9 and 10

- **Screening:** Staff groups within departments with a Screening level of response

  Have a responsibility to engage respectfully, sensitively and safely AND undertake sensitive enquiries of patients to identify if family violence is occurring through use of a screening tool in order to refer for support AND be aware of and contribute to the organisation's responsibility to share information, refer for specialist support and collaborate at a multi-agency level
  This can be mapped by assigning these staff groups to perform and fulfil Responsibility 1 & 2 and contribute to Responsibilities 5, 6, 9 and 10

- **Intermediate Practice**: Staff groups within departments with an Intermediate level of response

  Have a responsibility is to engage respectfully, sensitively and safely AND undertake intermediate risk assessment and management AND undertake information sharing proactively and on request AND collaborate at a multi-agency level
  This can be mapped by assigning these staff groups to perform and fulfil Responsibility 1 through 6, 9 and 10

- **Comprehensive Practice**: Staff groups within departments with a Comprehensive level of response

  Have a responsibility is to engage respectfully, sensitively and safely AND undertake comprehensive risk assessment and management AND undertake information sharing proactively and on request AND collaborate and lead at a multi-agency level
  This can be mapped by assigning these staff groups to perform and fulfil Responsibility 1 through 10

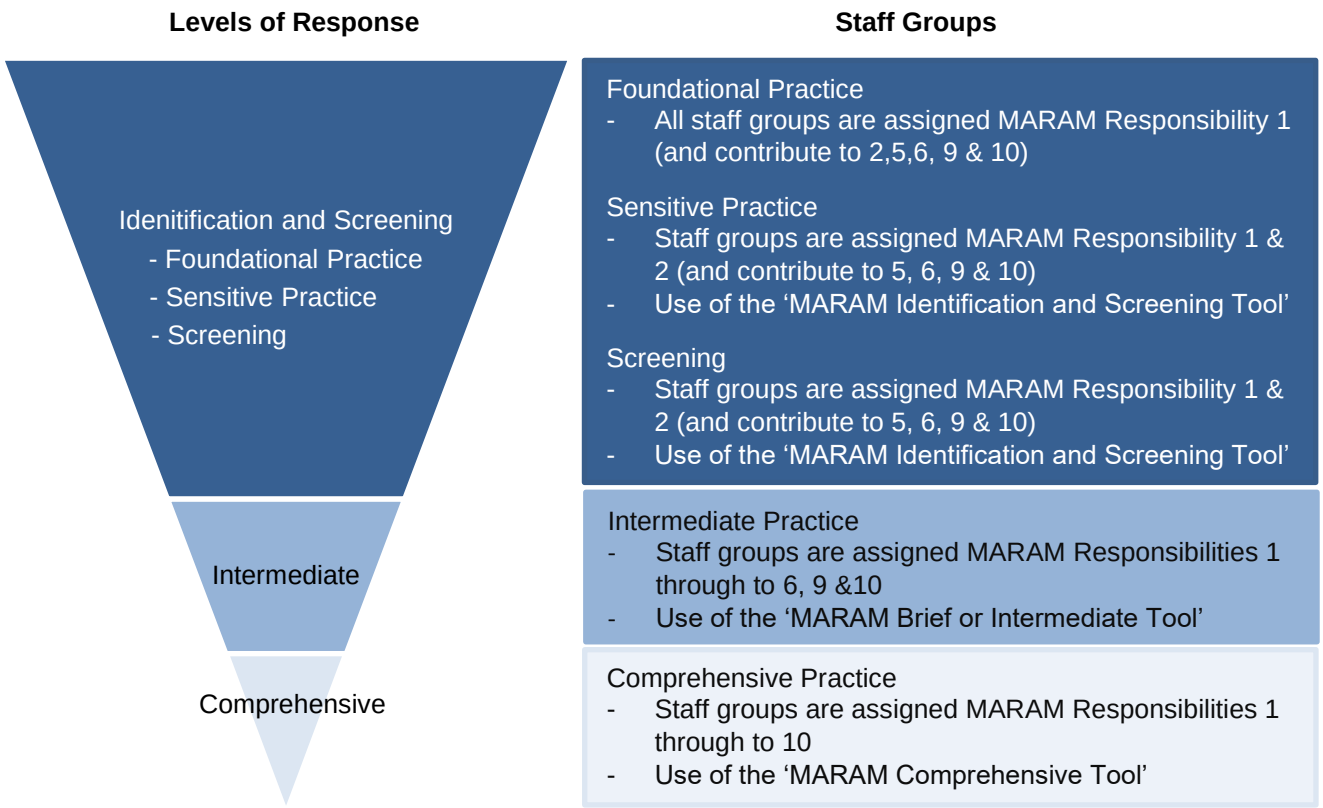


Illustration: Practice expectations for staff groups

The contributing practice expectations that are outlined above and further detailed later in this section recognise that within hospitals and larger health services, the social work departments, other departments assigned Intermediate or Comprehensive level of response or particular staff members or staff groups, can be referred to or consulted with to fulfil and perform particular capabilities related to a responsibilities.

For example, it is recommended that staff groups within departments assigned Foundational Practice or Sensitive Practice are not required to contact specialised family violence services. If this is required, this can be undertaken by the social work department. However, for smaller health services or departments without access to a social work department or departments with Intermediate or Comprehensive level of response to refer to, they will need to ensure a staff group or staff member is assigned to perform and fulfil the responsibilities set at an organisational level (see box below).

Note: In addition to the practice expectations outlined above, specific staff groups or staff members may be required to be assigned to perform and fulfil Responsibility 6, 9 or 10 because of their particular expertise or functions. This will be explored later in this section.

The ways in which staff groups are expected to perform and contribute to the 10 MARAM responsibilities must be clearly defined in organisational policies, procedures, family violence training, clinical practice and position descriptions. The recommended practice expectations for Foundational Practice and Sensitive Practice outlined in this document are covered in the corresponding MARAM aligned policy, procedures and training modules in the SHRFV toolkit.

Mapping Smaller Health Services

By following the methodology outlined above, some smaller health services may have assigned their departments to only Foundation or Sensitive Practice or Screening. In this case, to meet their obligations at an organisation level a health services will need to ensure that there is a staff group or a staff member within their organisation assigned to perform and fulfil Responsibility 5, 6, 9 & 10.

Additional considerations for mapping Foundation Practice to staff groups

Having allocated a level of practice to a department, hospitals and health services then need to consider the nuances when assigning practice levels to staff groups within each department.

For example, a General Medical department with a Sensitive Practice level of response, at a minimum should be able to fulfil MARAM responsibilities 1 and 2, and contribute to 5, 6, 9 and 10. This does not mean that every staff group within this department will need to be assigned Sensitive Practice.

Clinical staff who engage closely with patients should be assigned to Sensitive Practice. It is likely that non-clinical staff (e.g. Clerical staff) in this department are assigned to Foundational Practice and are expected to engage with patients in a respectful, sensitive and safe way and refer to other staff members within the department if a disclosure is made. There may also be some clinical staff also assigned to Foundation Practice, such as PSAs, orderlies and Pharmacists.

This recognises that:

- Within a department, patients will come into contact with or can be referred to other staff groups with higher responsibilities (such as nurse, midwives and doctors) and who are more appropriate to engage with victim survivors of family violence, meaning that not every staff member within the department has be to trained to the department's overall highest responsibility
- The significant investment required to train, resource and support staff groups to competently undertake higher responsibilities is beyond what is realistic and feasible
- Not all staff groups are not in a position to identify, screen or assess for family violence risk in the course of their work, or is not within their scope of practice or position description

Distinction between assigning responsibilities and increasing capabilities through training

MARAM responsibilities set minimum requirements for organisations. It is recommended that organisations only assign higher responsibilities if the organisation has the infrastructure, resources, and capabilities to competently hold and manage the associated level of family violence risk and can provide consistent responses to all patients.

A hospital or health service may decide to increase staff capabilities through training without assigning higher responsibilities to support a more sophisticated approach to contributing to the organisation effectively executing their responsibilities, to enhance family violence literacy and increase the capability of the service to support victim survivors who do not wish to access support from a specialist family violence service. For example, some Emergency Department clinicians assigned Sensitive Practice responsibilities may be trained to an Intermediate Practice level, or sexual assault counsellors who are assigned Intermediate Practice may be trained at a Comprehensive Practice level. Another example is staff in roles who are responsible for operationalising information sharing obligations but who do not provide patient care such as legal counsel or senior health information staff are also trained in Intermediate

or Comprehensive risk assessment and management to provide further context and insight into the work and build capacity to support safe and ethical application of the Family Violence Information Sharing Scheme.

Indicating this distinction on the Workforce Mapping document is important, as it impacts the recommendations put forward in the *MARAM Alignment Action Plan* and the communications to staff about their role and responsibilities in family violence risk assessment and management.

Appendix A indicates this distinction by using the asterisk symbol * where the recommendation is for staff groups to be trained at a level higher than their assigned responsibilities.

Practice Expectations

The MARAM Practice Guides explore in depth the practice expectations and required capabilities of each responsibility and should be used by organisations to support decisions about what responsibilities staff groups are assigned to or contribute to.

Staff leading this work must be able to facilitate a consultation process that support staff groups to be appropriately mapped and make an assessment of whether recommendations put forth by leaders and staff align with the responsibilities outlined in the MARAM Practice Guides. Staff leading this work must also be able to articulate the rationale for how decisions were made and make recommendations that are ultimately endorsed by the hospital or health service's senior leaders.

Detailed below are the practice expectations and key capabilities associated with each MARAM responsibility, and recommendations for which staff groups or staff members should be assigned to preform and fulfil or contribute to the responsibility. Also outlined are the recommended practice expectations associated with contributing to each responsibility at the different level of responses.

Responsibility 1: Respectful, sensitive and safe engagement

Practice expectations	Ensure staff understand the nature and dynamics of family violence, facilitate an appropriate, accessible, culturally responsive environment for safe disclosure of information by service users, and respond to disclosures sensitively.
Key capabilities	Understand • The gendered nature and dynamics of family violence • Creating a safe environment to ask about family violence • Respectful, sensitive and safe engagement as part of Structured Professional Judgement • How to facilitate an accessible, culturally responsive environment for safe disclosure of information. • How to respond to disclosures sensitively and priorities the safety of victim survivors • How to tailor engagement with adults, children and young people, including Aboriginal people and people from diverse communities • The importance of using a person-centred approach • Recognising and addressing barriers that impact a person's support and safety options

Which roles does it apply to?

It is recommended that all hospital and health service staff groups are assigned Responsibility 1 and can perform and fulfil the key capabilities.

This is to ensure that at any point in a patient's journey they feel safe to make a disclosure, and if a disclosure is made or family violence is suspected staff feel confident to respond respectfully, sensitively and safely.

Foundational Practice Expectations

It is recommended that the practice expectations for staff groups with Foundational Practice to perform and fulfil Responsibility 1 are to understand:

- The gendered nature and dynamics of family violence
- Respectful, sensitive and safe engagement
- How to respond to disclosures sensitively and prioritise the safety of victim survivors
- Recognising and addressing barriers that impact a person's support and safety options

Responsibility 2: Identification of family violence risk

Practice expectations	Ensure staff use information gained through engagement with service users and other providers (and in some cases, through use of screening tools to aid identification/ or routine screening of all clients) to identify indicators of family violence risk and potentially affected family members.
Key capabilities	• Awareness of the evidence-based family violence risk factors and explanations • Being familiar with questions to identify family violence, observable signs and indicators, using the Screening and Identification Tool and how-to-ask identification questions • Using information gathered through engagement with victim survivors and other providers via information sharing to identify signs and indicators of family violence (for adults, children and young people) and potentially identifying victim survivors • Know how to respond if family violence is not occurring • Know how to respond if family violence is occurring • Know what to do if an immediate risk management response is required • Discuss support options and provide information to support informed decision making • Support connection to relevant internal and external services • Support the victim survivor to make a basic safety plan

Which roles does it apply to?

It is recommended that Responsibility 2 is assigned to staff groups with Sensitive, Screening, Intermediate and Comprehensive Practice. And staff groups with Foundation Practice are required to contribute to enabling the organisation to effectively executive this responsibility.

It is recommended that the practice expectations for staff groups assigned Sensitive Practice and Screening cover all key capabilities except that relating to routinely gathering information through engagement with other providers via information sharing unless supported by the organisation's information sharing procedures.

Contributing Practice Expectations

It is recommended that the practice expectations for staff groups undertaking Foundational Practice and who contribute to Responsibility 2 are to:

- Have an awareness of the evidence-based family violence risk factors
- Be familiar with observable signs and indicators
- Know who to refer a victim survivor internally to if they disclosure of family violence. There is no expectation that a staff member with Foundational Practice will engage in a conversation to gather further information, only to respond respectfully and sensitively and offer a referral to a staff member with higher responsibilities
- Know who to share information with if they observe a sign or indicator of family violence, or a victim survivor does not want a referral after a disclosure

Responsibility 3 and 4: Intermediate risk assessment and management

Responsibility 3: Intermediate risk assessment	**Responsibility 4: Intermediate risk management**
Practice expectations Ensure staff can competently and confidently conduct intermediate risk assessment of adult and child victim survivors using structured professional judgement and appropriate tools, including the Brief and Intermediate Assessment tools.	***Practice expectations*** Ensure staff actively address immediate risk and safety concerns relating to adult and child victim survivors, and undertake intermediate risk management, including safety planning.
Key capabilities • Ask questions about risk factors • Understanding the evidence-base of how questions link to the level of risk • Using the process of Structured Professional Judgement in practice • Using intersectional analysis and inclusive practice • Using the Brief or Intermediate Assessment Tools • Forming a professional judgement to determine seriousness of risk, including levels 'at risk 'elevated risk' or 'serious risk'	***Key capabilities*** • Working with victim survivors (adults, children and young people) to develop an appropriate risk management response based on their unique experience of risk and assessed level of risk • Understand the different elements of intermediate risk management • Responding to serious and immediate risk • Consider mandatory reporting obligations • Discussing staying at home or leaving and talking to victim survivors about options • Safety planning with an adult victim survivor • Developing safety plans for children and young people, working with a parent/carer (usually the mother) who is not a perpetrator (who may also be a victim survivor), and/or working directly with the child or young person. • Connect to relevant services • Documenting evidence of family violence • Developing risk management strategies where there are multiple victim survivors, including children

Which roles does it apply to?

It is recommended that Responsibilities 3 and 4 are assigned to staff groups with Intermediate and Comprehensive Practice and who are either primarily responsible for the healthcare needs of that patient within their department or are collaborating with another department because of their expertise in family violence. For example: Social work positions, drug and alcohol clinicians, counsellors, psychiatrists and psychologists.

It is expected that staff groups who hold Responsibility 3 will also hold Responsibility 4. If a professional engages in a conversation with a victim survivor to assess risk, they need to ensure they are in a position to manage the risk that is disclosed. If they are not, then the victim survivor should be referred to an appropriate department or service internally or externally with this capability, so that the victim survivor do not have to repeat their story, which can be discouraging, disempowering and re-traumatising and risk is managed competently and a timely manner.

Responsibility 5: Seek consultation for comprehensive risk assessment, risk management and referrals

Practice expectations	Ensure staff seek internal supervision and further consult with family violence specialists to collaborate on risk assessment and risk management for adult and child victim survivors and perpetrators, and make active referrals for comprehensive specialist responses, if appropriate.
Key capabilities	• Seek internal supervision through their service or organisation • Consult with family violence specialists to collaborate on risk assessment and risk management for adult and child victim survivors and perpetrators • Make active referrals for comprehensive specialist responses, if appropriate.

Which roles does it apply to?

It is recommended that staff groups with Foundational Practice, Sensitive Practice and Screening are expected to contribute to the organisation meeting the requirements of Responsibility 5. This means seeking secondary consultations internally and sharing information to relevant staff members who can make referrals.

It is recommended that seeking external secondary consultations and making external referrals under Responsibility 5 is assigned to staff groups within Intermediate or Comprehensive Practice or who through the normal course of their work interface with external family violence specialists. For example, social work positions, drug and alcohol clinicians, counsellors, and psychologists.

Hospitals and health services need to also consider situations where internal collaboration is not available, for example in smaller health services with no social work department or during after-hours. In these situations, a hospital or health service needs to consider which staff group or staff member can be assigned this responsibility, such as a manager, after-hours coordinator or admitting officer.

Supervision in a non-clinical or clinical environment is likely to refer to the practice of seeking support /consultation with a manger or supervisor within their department or organisation for assistance when responding to family violence.

To meet the requirements of Responsibility 5, hospitals and health services also need to ensure all staff can access internal supervision. Consequently hospitals need to consider who is best placed within their organisation to perform and fulfil this requirement and assign this responsibility accordingly along with

ensuring they receive the appropriate training, resources and support, and how staff can access internal supervision is reflected in policies and procedures.

Contributing Practice Expectations:

Foundational Practice

It is recommended that the practice expectations for staff groups undertaking Foundational Practice and who contribute to Responsibility 5 are to:

- Ensure they have an understanding of the organisation's family violence policy and procedure to guide active internal referrals of patients who disclose family violence
- Seek internal support/consultation when a disclosure of family violence is made or when they observe a sign or indicator of family violence

Sensitive Practice and Screening

It is recommended that the practice expectations for staff groups undertaking Sensitive Practice and Screening and who contribute to Responsibility 5 are to:

- Ensure they have an understanding of the organisation's family violence policy and procedure to guide active internal referrals of patients who disclose family violence
- Provide information about external specialist family violence services to patients, and in some cases they may also assist a patient to call a specialist family violence service
- Seek information, guidance, support and consultation from another colleague who holds a higher responsibility and has greater family violence literacy and specialisation. Staff undertaking Sensitive Practice and Screening are not required to routinely consult with external family violence specialists to collaborate on risk assessment and management.
- Seek internal support/consultation when a disclosure of family violence is made or when they observe a sign or indicator of family violence

Responsibility 6: Contribute to information sharing with other services (as authorised by legislation)

Practice expectations	Ensure staff proactively share information relevant to the assessment and management of family violence risk and respond to requests to share information from other information sharing entities under the Family Violence Information Sharing Scheme, privacy law or other legislative authorisation.
Key capabilities	• Proactively share information relevant for the assessment and management of family violence risk, including under the Family Violence Information Sharing Scheme, privacy legislations or other legislations • Proactively share information relevant to broader safety and wellbeing issues for children using the Child Information Sharing Scheme and other relevant legislations • Respond to requests to share information from other services.

Which roles does it apply to?

All hospital and health services' staff groups are expected to contribute to Responsibility 6. It is recommended that only staff groups with expertise relating to information sharing, family violence and/or the safety and wellbeing of children be assigned to perform and fulfil the requirements of Responsibility 6. Examples include,

staff groups undertaking Intermediate Practice and Comprehensive Practice, legal counsel, senior health information staff and some management roles.

Hospital and health services need to ensure that information sharing policies and procedures support both responding to requests for information sharing and facilitate proactive sharing or risk relevant information to other prescribed services.

Practice Expectations:

Foundational Practice

It is recommended that the practice expectations for staff groups undertaking Foundational Practice and who contribute to Responsibility 6 are to:

- Have an awareness of relevant information sharing, child safety and privacy legislations and relevant organisational policies and procedures
- Understand that the organisation has a legal obligation regarding information sharing and they contribute to this though proactively sharing information about a disclosure, observed sign of family violence or the safety or wellbeing of a child with the appropriate professional within their organisation as per their organisation's information sharing policies and procedures.

Sensitive Practice and Screening

It is recommended that the practice expectations for staff groups undertaking Sensitive Practice and Screening and who contribute to Responsibility 6 are to:

- Have an awareness of relevant information sharing, child safety and privacy legislations and relevant organisational policies and procedures relating to information sharing
- Ensuring patients are informed about the limits of confidentiality in relation to these legislations
- Ensure that patient records are up-to-date
- In line with their policies and procedures, know when and how to trigger internal processes for sharing information proactively, know who to refer to when a request for information is received and seek appropriate consent/views as required for information sharing

Intermediate Practice, Comprehensive Practice and Staff Assigned to fulfil and perform Responsibility 6

It is recommended that the practice expectations for staff groups assigned to Responsibility 6 are to be:

- Responsible for enacting and having oversight of relevant information sharing, child safety and privacy legislations in line with the organisations policies and procedures.
- Responsible for receiving, assessing and responding to requests for information and sharing information proactively via Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS)

Staff who hold this responsibility require a strong understanding of the legislation, family violence risk, and the broader safety and wellbeing needs of children, as this underpin the safe and ethical application of FVISS and CISS. Further information on the schemes can be found at https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework

Responsibility 7 and 8: Comprehensive risk assessment and management

Responsibility 7: Comprehensive risk assessment	Responsibility 8: Comprehensive risk management and safety planning
Practice expectations Ensure staff in specialist family violence positions are trained to comprehensively assess the risks, needs and protective factors for adult and child victim survivors.	***Practice expectations*** Ensure staff in specialist family violence positions are trained to undertake comprehensive risk management through development, monitoring and actioning of safety plans (including ongoing risk assessment), in partnership with the adult or child victim survivor and support agencies.
Key capabilities • Comprehensively assess the family violence risks, needs and protective factors for victim survivors (adults, children and young people) • Use the comprehensive family violence risk assessment tool • Use structured professional judgement to determine the seriousness of risk • Determine the predominant aggressor • Use inclusive practice and apply an intersectional lens when assessing risk	***Key capabilities*** • Confidently and competently plan and undertake a range of risk management activities with victim survivors (adults, children and young people) including comprehensive safety planning • Actively monitor family violence risk and respond to changes in risk levels through adjusting risk management activities and safety plans. • Proactively share and gather information on family violence risk including building a shared understanding of a person's family violence risk with other support agencies. • Manage risk with an intersectional lens • Lead coordinated multi-agency risk management activities

Which roles do these apply to?

It is recommended that Responsibility 7 & 8 only sit with staff groups who are specifically funded to provide specialist family violence support. For example: Specialist family violence case managers.

There is no expectation that staff groups who are not funded to provide specialist family violence services will hold these responsibilities, nor would it be appropriate. Staff groups with these responsibilities are required to have considerable family violence expertise, and be able to undertake this work as their primary activity and lead work in the delivery of services for victim survivors. These responsibilities are only appropriate for staff groups that are trained, have access to resources and whose organisation has the infrastructure to competently undertake these capabilities.

Responsibility 9 and 10: Contribute to coordinated and collaborative risk management including ongoing risk assessment

Responsibility 9: Contribute to coordinated risk management	***Responsibility 10: Collaborate for ongoing risk assessment and risk management***
Practice expectations Ensure staff contribute to coordinated risk management, as part of integrated, multi-	***Practice expectations*** Ensure staff are equipped to play an ongoing role in collaboratively monitoring, assessing and

disciplinary and multiagency approach, including information sharing, referrals, action planning, coordination of responses and collaborative action acquittal.	managing risk over time to identify changes in assessed level of risk and ensure risk management and safety plans are responsive to changed circumstances, including escalation. Ensure safety plans are enacted.

Key capabilities

- Contribute to coordinated risk management as part of a multi-disciplinary and multi-agency approach. This includes proactively requesting and sharing relevant information to facilitate coordinated risk management
- Have an ongoing role in collaboratively monitoring, assessing and managing risk over time including identifying any changes in the assessed level of risk. This includes ensuring risk management and safety plans are responsive to escalation of risk and changed circumstances
- Participate in joint action planning, coordination of responses and collaborative action including enacting and monitoring safety plans

Which roles do they apply to?

It is recommended that staff groups with Foundational Practice, Sensitive Practice and Screening contribute to Responsibility 9 & 10 and staff groups with Intermediate Practice and Comprehensive Practice are assigned to perform and fulfil Responsibility 9 & 10. It should be noted that specialist family violence practitioners holding Responsibilities 7 and 8 may be required to lead multi-agency collaborative practice.

Health services without departments assigned either an Intermediate or Comprehensive level of response, will need to consider who is best placed within their organisation to be assigned these responsibilities in order to meet their organisational responsibilities.

It is also recommended that all hospitals and health services assign these responsibilities to key leadership roles within their organisation, who are responsible for coordinating and leading risk management responses in high risk cases both internally and as part of a multi-disciplinary and multi-agency approach, such as the Director of Access or Emergency Department.

Contributing Practice Expectations:

Foundational Practice

It is recommended that the practice expectations for staff groups undertaking Foundational Practice and who contribute to Responsibility 9 & 10 are to:

- Have an awareness of MARAM and the health sectors role in an effective system wide response to family violence
- Understand that they play a role in this by ensuring they refer a victim survivor internally if they disclosure family violence and share information with the appropriate person if they observe a sign of family violence, or a victim survivor does not want a referral after a disclosure.
- Ensure they follow the organisation's family violence procedure (or the appropriate clinical governance structure in their work unit or area).

Sensitive Practice and Screening

It is recommended that the practice expectations for staff groups undertaking Sensitive Practice and Screening and who contribute to Responsibility 9 & 10 are to:

- Have an awareness of MARAM
- Understanding how their role and organisation contributes to an integrated service system response to family violence.
- Ensure patient records are up-to-date

- Follow the organisation's family violence procedure (or the appropriate clinical governance structure in their work unit or area).
- Enact their organisations escalation process to support staff with higher responsibilities to undertake risk assessment and coordinated risk management as part of a multi-disciplinary and multi-agency approach

Mapping responsibilities according to staff groups

Hospitals and health services should map what responsibilities each staff group within each department are assigned to perform and fulfil or contribute to. Appendix A demonstrates how this could be presented.

At this step, it is important to ensure there are staff groups within each department (or organisation) that match the broad level of response. That is, if in Step 2 a department determined their appropriate level of response was at an Intermediate level, then through the process outlined in this step at least one staff group or in some cases at least one staff member within that department (or organisation) should be assigned the corresponding MARAM Responsibilities of 1 through 6, 9 & 10.

What to do if there is a difference of opinion when mapping workforce responsibilities

It is likely that there will be different opinions as to where certain workforces should be mapped in relation to the 10 MARAM responsibilities. This can occur for a range of reasons such as staff having varying levels of awareness of MARAM and current practice, staff overestimating their skills and abilities or concern about the resources required to train large numbers of staff. It is important that a consensus is reached through a collaborative approach. If a difference of opinion occurs, consider the following actions:

- Facilitating a collaborative workshop with all relevant parties to reach agreement
- Seek more detailed information about the department and its staff groups to better understand the day-to-day practice
- Provide detailed advice on the 10 MARAM responsibilities, capabilities and alignment requirements
- Provide informed advice about best practice under MARAM and benchmark this against capabilities, resources and the capacity of departments and staff groups
- Suggest a staged approach where lower responsibilities are assigned until experience and literacy have increased
- Leave the final decision to the relevant directors and executive directors
- Ensure you demonstrate the benefits to staff and patients of a consistent and collaborative approach to family violence
- Benchmark against mapping results at other similarly sized and resourced hospitals and health services

Step 4: Map responsibilities in high risk areas

The next step is to review high risk areas within the hospital or health service. Most departments that provide services to patient cohorts' at-risk of family violence will have been identified in Step 2 and 3 and the appropriate MARAM responsibilities will have been assigned. However, there may be other high risk areas where further exploration of responsibilities are required due to particular operational constraints or when patients have complex needs.

High risk areas could relate to situations such as:

- When a response requiring higher responsibilities is required by an out-patient service within a hospital and these services are not able to access support from the social work department
- Changes in operating procedures at particular times of day such as the transition from business hours to after-hours. For example in Emergency Departments during after-hours. Usual practice during business hours in an Emergency Department may include collaboration with social work who have higher MARAM responsibilities for risk assessment and management. However, this support may not be available after-hours so hospitals may need to consider how high risk situations are managed during this time
- In smaller rural and regional health services where staff roles are assigned to Foundation Practice, Sensitive Practice and Screening, services may need to consider how high risk situations are managed if a victim survivor declines a referral to a specialist family violence service
- Services that work with at-risk cohorts who face barriers to accessing services (see note below)
- When a patient experiencing family violence has significant care needs after they are discharged.

In these situations, it will be important that hospitals and health services give additional consideration to how these cases are managed. Departments should consider opportunities to:

- Assign higher responsibilities to staff groups or leadership within these departments
- Ensure out-patient services can access support from the social work department or a department with higher responsibilities
- Establish or strengthen relationships with after-hours family violence crisis response services, if available. This will depend on the region
- Establish collaborative relationships with specialist culturally appropriate family violence services
- Establish and/or strengthen collaborative relationships with community based health services to provide follow up care needs
- Ensure services are accessible, inclusive and non-discriminatory
- Consider training staff to higher responsibilities to build internal capabilities to respond while not committing the hospital or health service to holding these higher responsibilities
- Ensure staff are supported to be clear about what their responsibilities are and are not, and that responsibilities are held at an organisational and system level, not with an individual staff member

Barriers to accessing appropriate support

Structural inequalities in our society such as sexism, ableism, racism, homophobia, transphobia, ageism, and mental health discrimination can lead to services being inaccessible to particular groups in society. This creates systemic barriers for these groups reporting experiences of family violence, finding appropriate and adequate support and responses that increase their safety.

How barriers manifest for an individual will be different, and will depend on their and their communities lived experience. Barriers may result from past experiences of inadequate system responses, experiences of services that haven't been accessible or responsive to their needs, shame, fear of not being believed,

language barriers, visa status, experiences of discrimination, historic and ongoing systemic oppression, fear of reprisals or ostracisation, and concerns about their safety.

Hospital and health services must have an understanding of and be responsive to barriers that at-risk cohorts face and take steps to ensure their services are accessible, inclusive and non-discriminatory to ensure equity of access and outcomes for all victim survivors.

Further information about high risk cohorts can be found on pages 33-36 of the MARAM Framework and pages 43-56 of MARAM Practice Guides: Foundation Knowledge

Step 5: Leadership responsibilities

Organisations should consider what responsibilities all leadership roles within their organisation should hold (including executives and the Chief Operating Officer). Leaders are required to ensure their organisation meets their MARAM responsibilities for risk assessment and management, have oversight of the level of risk the organisation is expected to hold and manage, and ensure staff groups are trained and supported to competently undertake their required MARAM responsibilities. Leaders and managers may also be called upon to provide secondary consultations for staff members on matters of family violence.

To facilitate appropriate application, it is recommended that operational leaders hold responsibilities to at least the highest responsibility of staff within their department.

Hospital and health services should also review their escalation processes when clinical high risk is identified to ensure all leadership roles that are consulted to make decisions in high risk cases and who have the authority to make decisions at an organisation level are mapped accordingly. This may include directors, executive directors and CEOs. It is recommended that these roles hold Responsibilities 1 through to 10.

Step 6: Mapping document

The final step is to populate a *Workforce Mapping* document based on the agreed recommendations and consensus made through the consultation process.

It is recommended that the *Workforce Mapping* document is reviewed by the appropriate strategic advisory and operations groups prior to being put forward to senior executives for their endorsement. Senior leaders should also be given the opportunity to be briefed individually before these documents are presented for final endorsement.

The final *Workforce Mapping* document, along with a briefing paper and *MARAM Alignment Action Plan* should be presented to the organisation's Chief Executive Officer and executive leaders for endorsement. Further details can be found in the Seek Endorsement section of the *MARAM Alignment for hospital and health services* document.

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Appendix A – Example Workforce Mapping document

Workforce Mapping

[This example has been adapted from the Royal Women's Hospital workforce mapping]

This document outlines the Royal Women's Hospital's workforce and puts forward recommendations for mapping each department and staff group according to the ten responsibilities for risk assessment and management under MARAM. A description of the ten responsibilities can be found below.

Key:

Levels of Response	
Foundational Practice	
Sensitive Practice	
Screening	
Intermediate	
Comprehensive	

Staff groups	
Full responsibility	
Contribute to responsibility	

Department	Roles	Responsibilities under MARAM										Comments
		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
OPERATIONS												
Allied Health and Clinical Support Services												
Social Work	Social Work Manager							*	*			*These specialist staff to be trained to a comprehensive level; however comprehensive assessment to be referred to specialist family violence services.
	Social Workers							*	*			
SACL	Counsellor/Advocate							*	*			
CASA House	Coordinator CASA House							*	*			
	Counsellor/Advocate							*	*			
Badjurr-Bulok Wilam	Aboriginal Health Liaison Coordinator			*	*							* Staff to hold Sensitive Practice and to receive intermediate training
	Aboriginal Health Liaison Officer			*	*							
Language Services	Interpreters – internal											Interpreter agencies to be provided with a MARAM guideline & included in service agreements as appropriate
	Interpreters - agency											
Genetic Services	Genetic Counsellors											
	Medical Staff											

PGWIC/ Radiology/ Ultrasound	Radiologists											
	Radiographers											
	Sonographers											
	Midwives											
	Nurses											
Pharmacy	Pharmacists											
	Pharmacy technicians											
Physiotherapy	Physiotherapists											
	Speech Pathologists											
	Occupational Therapists											
Pastoral Care	Pastoral Care Workers											
Infection Control	Nurses											
	Medical Staff											
Food Services	Menu Monitors											
	Food Services Assistants											
Clinical support services	Patient services assistance											
	Theatre techs											
	Per-natal autopsy											
Dietetics	Dietitians											
Pathology	Pathologists											
Family Accommodation	Family Accommodation Officer											
VPAS	Nurses											
Finance & Corporate Services												
Carlton/Cardigan site	Site Manager											
	PPP Contract Manager											
	General Handyman											
	Car Park Attendant											
Mail Room	Ward Clerks											
Finance	Accounts Payable/Receivable Clerks											
	Business Analyst											
	Cashier											
	Finance Officers											
	Patient Billing Clerks											
	Private Patient Liaison Officers											
Payroll	HRMIS Systems Administrator											
	Payroll Services Officers											
Business Performance & Reporting	Business Intelligence Officers											
	Business Analysts											
Clinical & IT Strategy/EMR	IT Staff											
	Project Managers											

	Credentialed Trainers											
	Connecting Care Staff											
Andrology	Medical Scientist											
Retail Precinct PRKV	Gift Shop Attendant											
Hospital Access & After Hours Management												
Access Centre	Access clerks											
Women's Bank (casual) & Pool (permanent staff)	Nurses											
	Midwives											Midwives working in Antenatal clinics will be required to undertake screening
	Instrument Technicians											
	Theatre Technicians											
	Allocations Officers											
	Ward clerk											
Maternity Services												
Maternity Services	Medical Staff											
	Midwives											
	Nurse Practitioner											
	Child birth education											
	Lactation Consultants											
	Diabetes Educators											
The Women's @ Sandringham	Medical Staff											
	Midwives											
	Nurse Practitioner											
	Child birth education											
	Lactation Consultants											
	Diabetes Educators											
The Women's Alcohol and Drug Service (WADS)	Medical Head/Addiction Specialist											*These specialist staff to be trained to a comprehensive level; however comprehensive assessment to be referred to specialist family violence services.
	Paediatrician											
	Manager - WADS							*	*			
	Social Workers (incl. Outreach)							*	*			
	Psychologist							*	*			
	Psychiatrist							*	*			
	Midwives											
	Pharmacist											
	Dietician											
	Administration Support											
Neonatal Services												
Neonatal Services	Medical Staff											
	Nurses											
	Midwives											

The Centre for Women's Mental Health												
Women's Mental Health	Director Women's Mental Health							*	*			*These staff to be trained to a comprehensive level; however comprehensive assessment to be referred to specialist family violence services.
	Consultant Psychiatrist							*	*			
	Psychiatry Registrar							*	*			
	Psychologist											
	Psychiatric Nurse							*	*			
	Maternal Child Health Nurse											
	Mother Infant Registrar											
Women's Health Services												
Gynae & Cancer Services	Medical Staff											
	Nurses											
	Midwives											
Perioperative Services	Medical Staff											
	Nurses											
	Midwives											
	Theatre Technician											
	Instrument Technician											
	PSAs											
	Equipment Support Officers											
Women's Emergency Care	Associate Nurse Unit Manager			*	*							WEC staff to hold Sensitive Practice with their training to include brief risk assessment. *WEC Associate Nurse Unit Managers to receive intermediate training
	Medical Staff											
	Nurses											
	Midwives											
Breast Service	Senior Medical Staff											
Reproductive Services	Medical Staff											
	Fertility Nurses											
	Laboratory Technicians											
	Medical Scientists											
Sexual Health and Rapid Access Service	Sexual Health Nurse											
	Nurse Practitioner											
	Medical Staff											
Abortion & Contraception Service	Associate Nurse Unit Manager			*	*							Abortion & contraception staff to hold Sensitive Practice with their training to include brief risk assessment. Social workers to hold Intermediate Practice, and ANUM to receive intermediate training to support patients who decline social work referral
	Medical Staff											
	Nurse Coordinator											
	Nurses											
	Social Workers							*	*			
Early Pregnancy Assessment Service	Associate Nurse Unit Manager			*	*							Early Pregnancy Assessment Service staff to hold Sensitive Practice with ANUM to receive intermediate training to support patients who decline social work referral
	Medical Staff											
	Junior Medical Staff											
	Nurses											

Women's Cancer	Medical Staff											
	Nurse Practitioner											
	Midwives											
FARREP	Health Workers											
Outpatients	Nurses											
	Midwives											
Bookings Office	Nurse/Midwives											
Anaesthetics	Medical Staff											
	Nurses											
Human Resources												
Corporate Support services	Admin Staff											
	Facilities Management											
	Data performance											
	Security											
Non-employees												
	Security											
	Car parking attendants											
	ISS Cleaners											
	Pathologists											
MEDICAL SERVICES												
Medical Workforce												
	Medical staff have been mapped under individual teams in Operations											
Medical Education, Leadership Development & Professional Practice												
	Research Centres											
	Honoraries (medical)											
	Honoraries (research)											
NURSING & MIDWIFERY												
Nursing & Midwifery Professional Practice												
	Nurses and midwives have been mapped under individual teams in Operations											Midwives working in Antenatal clinics will be required to undertake screening
Nursing & Midwifery Education, Leadership Development & Professional Practice												
Clinical Education	Nurses											
	Midwives											
	Aboriginal Nurse and Midwife Cadets											

LEGAL												
	General Counsel		*	*	*	*				*	*	Legal to be trained to an intermediate level to support the provision of R6. Recommending 'Subject Matter Experts' receive intermediate or comprehensive training & are authorised to share information.
	Medico-Legal Manager		*	*	*	*				*	*	
CLINICAL EFFECTIVENESS												
Quality & Safety, Clinical Systems Improvement												
Patient Representative	Consumer Advocates											
Clinical Effectiveness	Quality Coordinators											
	Nurses											
COMMUNICATIONS												
Communications												
	Communications Staff											
PATIENT & CONSUMER												
Patient Experience – WWC												
	Customer Services Officer											
	Reception											
	Volunteers											
	Welcome Centre											
	Consumer Health Information Coordinator											
	Switchboard Operators											
OUR PEOPLE												
Leadership												
	Executive Directors											
	On call Directors/COO											
	After-hours Manager											
	Director Access											
Childcare Centre												
	Childcare Workers											
	Childhood Educators											
People, Cultural and Wellbeing, including the Family Violence Workplace Support Program												
	Family violence workplace support officer											
	Health Safety and Wellbeing Manager											
	Human Resources Director											
	Employee Relations Manager											
	FV Contact Officers											

	Other People, Culture & Wellbeing staff											
INFORMATION MANAGEMENT & TECHNOLOGY												
Information Management & technology												
Health Records	Admin Staff (including Library Technician)											
	Audio Typist											
	Ward Clerks											
	Health Information Managers			*	*			*	*			HIS Manager to lead technical application of R6 statutory framework requirements with support from Legal team Staff to be trained at a comprehensive level to facilitate safe and ethical application
	Clinical Coders/Managers											
Archives	Archivist											
Biomedical Engineering	Biomedical Engineer											
Information Communications (IT)	IT Staff											
	IT Support Staff											
STRATEGY, PLANNING & PERFORMANCE												
	Strategy, planning and performance staff & project staff											

MARAM Responsibilities

Risk Assessment and Management Responsibilities	Expectation of prescribed organisations
Responsibility 1: Respectful, sensitive and safe engagement	Ensure staff understand the nature and dynamics of family violence, facilitate an appropriate, accessible, culturally responsive environment for safe disclosure of information by service users, and respond to disclosures sensitively.
Responsibility 2: Identification of family violence	Ensure staff use information gained through engagement with service users and other providers (and in some cases, through use of screening tools to aid identification/ or routine screening of all clients) to identify indicators of family violence risk and potentially affected family members.
Responsibility 3: Intermediate risk assessment	Ensure staff can competently and confidently conduct intermediate risk assessment of adult and child victim survivors using structured professional judgement and appropriate tools, including the Brief and Intermediate Assessment tools.
Responsibility 4: Intermediate risk management	Ensure staff actively address immediate risk and safety concerns relating to adult and child victim survivors, and undertake intermediate risk management, including safety planning.

Responsibility 5: Seek consultation for comprehensive risk assessment, risk management and referrals	Ensure staff seek internal supervision and further consult with family violence specialists to collaborate on risk assessment and risk management for adult and child victim survivors and perpetrators, and make active referrals for comprehensive specialist responses, if appropriate.
Responsibility 6: Contribute to information sharing with other services (as authorised by legislation)	Ensure staff proactively share information relevant to the assessment and management of family violence risk and respond to requests to share information from other information sharing entities under the Family Violence Information Sharing Scheme, privacy law or other legislative authorisation.
Responsibility 7: Comprehensive assessment	Ensure staff in specialist family violence positions are trained to comprehensively assess the risks, needs and protective factors for adult and child victim survivors.
Responsibility 8: Comprehensive risk management and safety planning	Ensure staff in specialist family violence positions are trained to undertake comprehensive risk management through development, monitoring and actioning of safety plans (including ongoing risk assessment), in partnership with the adult or child victim survivor and support agencies.
Responsibility 9: Contribute to coordinated risk management	Ensure staff contribute to coordinated risk management, as part of integrated, multi-disciplinary and multiagency approaches, including information sharing, referrals, action planning, coordination of responses and collaborative action acquittal.
Responsibility 10: Collaborate for ongoing risk assessment and risk management	Ensure staff are equipped to play an ongoing role in collaboratively monitoring, assessing and managing risk over time to identify changes in assessed level of risk and ensure risk management and safety plans are responsive to changed circumstances, including escalation. Ensure safety plans are enacted.

** Please note that while the MARAM Framework outlines responsibilities for staff working with perpetrators, current alignment requirements focus on working with victim survivors. Practice guides and other supporting resources relating to how an organisation works with and responds to perpetrators of family violence are still in development. For this reason, this description only outlines capabilities relating to working with victim survivors.

Endnotes

1. O'Doherty L, Hegarty K, Ramsay J et al, 2015, Screening women for intimate partner violence in healthcare settings. Cochrane Database Syst Rev(7): CD007007.

2. World Health Organization, 2013, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: (http://apps.who.int/rhl/guidelines/9789241548595/en/ , accessed 13 May 2020.