

Implementing the family violence MARAM Framework in mental health and wellbeing services

Chief Psychiatrist's guideline

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We also acknowledge those who have sadly lost their lives to family violence and their loved ones, including children, and those who supported them and are impacted by their deaths.

It is for all of whom we undertake this work.

Key messages

Family violence and mental health

Family violence has many serious health and mental health impacts and is a violation of human rights. Receiving mental health services that respond to family violence is a human right recognised under the [MARAM Framework](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) <<https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management>>.

Family violence is a pattern of behaviour, rather than a one-off event. It includes many behaviours such as control, stalking and financial, emotional/psychological, physical, sexual, reproductive, child, cultural and spiritual abuse (State of Victoria, 2008/2020).

The impact of family violence is experienced by everyone: children, young people, adults, survivors and perpetrators. It is mostly, but not exclusively, experienced by women. Many consumers of mental health and wellbeing services have experienced family violence as a child or young person (Haslam et al., 2023). Others have or are using violence against a partner, child or family member (Department of Health and Human Services, 2018).

Family violence contributes to and exacerbates mental health problems (Khalifeh et al., 2015). An Australian study of child maltreatment, including family violence, found that people who have experienced abuse during their childhood are:

- 2.8 times more likely to experience mental illness
- 3.2 times more likely to have a major depressive disorder.

A Victorian study found that one-third of suicides are linked to family violence (MacIsaac et al., 2018). Another report into family violence and suicide found evidence of the intersection between family violence and other stressors including (Coroners Court of Victoria, 2024):

- diagnosed mental illness
- financial, legal and substance misuse

Also, mental illness may be weaponised as a way to control a person as part of family violence. Such controlling behaviours include (Allen + Clarke Consulting, 2023; Department of Health and Human Services, 2018; Warshaw & Tinnon, 2018a):

- threatening to get someone admitted to hospital
- threatening to get children removed
- controlling medication intake or appointments.

Mental health services are an integral part of the service system that needs to respond to family violence to protect and enhance safety for vulnerable Victorians.

MARAM and mental health and wellbeing services

The Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework was developed in response to Recommendation 1 of the Victorian Royal Commission into Family Violence.

MARAM comprises Pt 11 of the [Family Violence Protection Act 2008](https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/061) <<https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/061>>. This includes the [MARAM policy document, practice guides, guidance documents](#)

<<https://www.vic.gov.au/maram-practice-guides-and-resources>> and an online platform to host risk assessments and management (safety planning) tools and other resources.

The [Mental Health and Wellbeing Act 2022](https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/002) <<https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/002>> reflects the need for services to provide services that:

- are safe
- are responsive to any current experiences of family violence and trauma
- contribute to clients' safety and improve information sharing.

Key points from the MARAM Framework include the following:

- Inquiring and responding to family violence is an integral part of clinical mental health care.
- The MARAM Framework is a legislative instrument in line with s 189 of the Family Violence Protection Act.
- Designated mental health and wellbeing services have a statutory responsibility to comply with the MARAM Framework. This includes to:
 - implement policies and procedures to respond to family violence for consumers, families and carers and staff
 - ensure organisational leaders undertake MARAM training according to their roles, including high-level briefings on implementation
 - ensure staff undertake MARAM training to apply the MARAM Framework and undertake assessments
 - establish a mix of staff across all clinical roles who are trained in identification and screening and in intermediate assessment
 - establish processes to ensure medical staff fulfill their responsibility to enquire about, respond to and lead responses to family violence under MARAM
 - establish processes to support information sharing in keeping with the Family Violence Information Sharing Scheme and Child Information Sharing Scheme.

Introduction

Responding to family violence, increasing safety for victim survivors (including children) and holding those who use violence to account are priorities for Victoria's Chief Psychiatrist and for mental health and wellbeing services.

The Chief Psychiatrist has a statutory obligation to provide clinical leadership and guidance to promote continuous quality and safety improvement and promote human rights. This role is detailed in s 266 of the Mental Health and Wellbeing Act.

This guideline is for organisational leaders. It outlines their responsibilities for implementing and applying the MARAM Framework and tools.

MARAM aims

The aims of the MARAM Framework (Family Safety Victoria, 2018) are to:

- increase the safety of people experiencing family violence
- ensure a broad range of experiences across the spectrum of family violence risk are represented, including for Aboriginal and diverse communities, children, young people and older people, across identities and family and relationship types
- keep perpetrators in view and hold them to account for their actions and behaviours
- ensure alignment of practice across a broad range of organisations that have responsibilities to identify, assess and manage family violence risk
- ensure consistent use of the MARAM Framework across organisations and sectors.

MARAM principles

The MARAM principles establish the aims and objectives of the MARAM Framework. They are intended to guide the response to family violence (Family Safety Victoria, 2018). The principles are:

1. Family violence involves a spectrum of seriousness of risk and presentations, and is unacceptable in any form, across any community or culture.
2. Professionals should work collaboratively to provide coordinated and effective risk assessment and management responses, including early intervention when family violence first occurs to avoid escalation into crisis and additional harm.
3. Professionals should be aware, in their risk assessment and management practice, of the drivers of family violence, predominantly gender inequality, which also intersect with other forms of structural inequality and discrimination.
4. The agency, dignity and intrinsic empowerment of victim survivors must be respected by partnering with them as active decision-making participants in risk assessment and management, including being supported to access and participate in justice processes that enable fair and just outcomes.
5. Family violence may have serious impacts on the current and future physical, spiritual, psychological, developmental and emotional safety and wellbeing of children, who are directly or indirectly exposed to its effects, and should be recognised as victim survivors in their own right.

6. Services provided to child victim survivors should acknowledge their unique experiences, vulnerabilities and needs, including the effects of trauma and cumulative harm arising from family violence.
7. Services and responses provided to people from Aboriginal communities should be culturally responsive and safe, recognising Aboriginal understanding of family violence and rights to self-determination and self-management, and take account of their experiences of colonisation, systemic violence and discrimination and recognise the ongoing and present day impacts of historical events, policies and practices.
8. Services and responses provided to diverse communities and older people should be accessible, culturally responsive and safe, service-user centred, inclusive and non-discriminatory.
9. Perpetrators should be encouraged to acknowledge and take responsibility to end their violent, controlling and coercive behaviour, and service responses to perpetrators should be collaborative and coordinated through a system-wide approach that collectively and systematically creates opportunities for perpetrator accountability.
10. Family violence used by adolescents is a distinct form of family violence and requires a different response to family violence used by adults, because of their age and the possibility that they are also victim survivors of family violence.

MARAM implementation in mental health and wellbeing services

Family Safety Victoria has provided a range of [implementation documents and tools](https://www.vic.gov.au/maram-practice-guides-and-resources) <<https://www.vic.gov.au/maram-practice-guides-and-resources>> to help implement the MARAM Framework. A list of guidance documents is in the appendix of this document.

This section provides further guidance specifically for mental health and wellbeing services.

Executive responsibilities for mental health and wellbeing

The [MARAM Framework: summary for organisational leaders](https://www.vic.gov.au/maram-framework-summary-organisational-leaders) <<https://www.vic.gov.au/maram-framework-summary-organisational-leaders>> resource and associated documents is available to support rollout.

Executives need to oversee the implementation of the MARAM Framework. They must ensure:

- strategic plans spell out MARAM implementation
- they promote and support all aspects of MARAM implementation
- medical staff understand that they operate under the MARAM Framework
- organisational policies include a family violence staff policy describing support structures available and provided to all staff (these includes family violence leave entitlements and processes to both record family violence and maintain confidentiality)
- organisational support and supervision is available for staff to manage the impact of working with family violence, as well as the impact of such work on those who feel triggered or otherwise impacted due to their own experiences.

Medical staff responsibilities

- Medical staff of all levels have a responsibility to enquire about, assess and respond to family violence in keeping with the MARAM Framework.
- Senior medical staff (for example, directors of clinical services, consultant psychiatrists and senior registrars) have a responsibility to co-lead the organisational and practice implementation of the MARAM Framework for their organisation.
- Medical staff need to undertake training in MARAM assessment and information sharing.
- Medical staff are responsible for clinical oversight of information sharing.

Specialist family violence advisor roles

- Specialist family violence advisors (SFVAs) perform a range of important roles in mental health and wellbeing services including:
 - building capacity and capability
 - supporting collaboration
 - providing secondary consultation
 - supporting MARAM alignment and embedding
 - engaging with the statewide SFVA program.
- SFVAs need to be members of clinical risk meetings and incident review committees (alongside other specialist roles) to ensure family violence is considered, assessed and responded to.

- Organisations have a responsibility to provide adequate structures and support for SFVAs through a range of mechanisms including:
 - reporting structures that reflect the scope of their work (for example, director of operations)
 - direct access and collaboration with the Executive (ideally, they are part of the Executive)
 - direct access and collaboration with medical leaders and Family Violence Champions (FV Champions)
 - providing supervision that matches their role and responsibilities.

For more on the role of SFVAs and the role of organisations to support SFVAs, refer to the [Specialist Family Violence Adviser guideline](https://www.health.vic.gov.au/specialist-family-violence-advisor-guidelines-and-reporting-template) <https://www.health.vic.gov.au/specialist-family-violence-advisor-guidelines-and-reporting-template>.

Implementation structures

SFVAs and organisational leaders and the Executive team must work together to enable MARAM implementation.

Implementation committees

Organisations need to create MARAM (or family violence) implementation committees. Membership needs to include:

- medical staff
- SFVAs
- lived and living experience (LLE) representation
- a range of staff across the organisation.

The committees need to:

- develop an implementation plan and track implementation over time
- oversee the development and review of MARAM-related policies and procedures
- work with People and Culture teams to develop and review a family violence policy for staff
- oversee the development of support structures for LLE staff and their roles in responding to family violence.

Implementation change agents

The clinical work of implementing MARAM must be carried by a number of staff including:

- managers
- medical and other clinical staff
- SFVAs
- team leaders
- FV Champions.

FV Champion roles¹ need to be developed in each team. Their roles include:

- providing secondary consultation to colleagues
- assisting in a range of family violence-related enquiries within their teams.

¹ Refer to the appendices for examples of FV Champion roles.

Role descriptions need to describe the requirements and scope.

Having undergone intermediate MARAM training, FV Champions will come together:

- for advanced training
- for reflective practice
- to support implementation at the clinical level.

Medical staff need to be involved in MARAM on several levels including:

- taking part on the implementation committee
- orientating new medical staff
- supervising and supporting junior medical staff who are responding to family violence.

Practice structures and opportunities

Organisations need to develop and ensure participation is enabled to continuously enhance family violence responses by the service and its staff. The following are examples of internal and external mechanisms to continue a focus on family violence and work towards continuous improvement.

Family violence clinical leadership

Family violence clinical leadership needs to be provided in a variety of ways:

- Staff orientation processes should include information and a session with the SFVA, FV Champions and clinical family violence leadership. This will cover an overview of the SFVA role, the family violence program, approach, responsibilities, policies, and procedures and training requirements.
- Position descriptions should include the need for knowledge and skills in family violence and MARAM or that these are obtained within the probation period.
- Clinical review meetings should include a focus on family violence and include FV Champions and the SFVA.
- Capability building and monitoring should include the following:
 - Professional development and training requirements are clearly stated for all roles. Intermediate MARAM training is mandated, monitored and repeated annually/biannually.
 - Professional development sessions are provided for specific teams. Sessions are tailored to respond to clinical need and focus on:
 - aspects of MARAM (for example, short-term engagement such as crisis teams, inpatient settings)
 - information sharing schemes
 - responding to family violence for both victim survivors and those using violence.
 - Ongoing professional development and case scenario discussions and reviews as part of medical and other professional development opportunities are provided across the organisation and/or in teams.

Family Violence Clinical Leadership Group

This is an organisation-wide internal group that focuses on current consumers and family violence risk. This group can hold monthly meetings to provide a structured opportunity for senior clinical leaders to discuss family violence and safety issues and maintain a view of people using family violence to increase safety for victim survivors.² It enhances skills for senior clinicians in providing supervision that includes MARAM responsibilities.

MARAM assessment tools

Family Safety Victoria provides MARAM assessment tools; these are available online (refer to the appendices). These tools need to be integrated into electronic information and assessment management systems.

² Refer to the appendices for an example of the terms of reference for such a group.

Embedding identification and screening questions into an initial assessment can ensure they are responded to before completing the full clinical assessment.

Information sharing

Mental health and wellbeing services must establish information sharing processes in keeping with Victoria's [Family Violence Information Sharing Scheme \(FVISS\)](https://www.vic.gov.au/family-violence-information-sharing-scheme) <https://www.vic.gov.au/family-violence-information-sharing-scheme> and [Child Information Sharing Scheme \(CISS\)](https://www.vic.gov.au/child-information-sharing-scheme) <https://www.vic.gov.au/child-information-sharing-scheme>.

FVISS enables relevant information to be shared between authorised services to assess or manage family violence risk. It is designed to manage victim survivor safety and hold perpetrators to account. CISS is designed to enable better assessment of risks and needs and facilitate service collaboration and earlier intervention. Together, these schemes aim to increase safety and decrease risk for victim survivors.

In line with both schemes, organisations prescribed as 'Information Sharing Entities' (ISEs), including mental health and wellbeing services, are legally obliged to:

- respond to information sharing requests
- share information proactively
- share information on request.

The Mental Health and Wellbeing Act put in place [new information sharing principles and obligations](https://www.health.vic.gov.au/mental-health-and-wellbeing-act) <https://www.health.vic.gov.au/mental-health-and-wellbeing-act> to share with the consent of the consumer. These principles and obligations clarify expectations for information sharing for mental health and wellbeing providers.

Organisations should include guidance on information sharing in their policies and procedures to support clinical practice.

Guidance on information sharing

Organisations must follow the *Family violence information sharing guidelines* (State Government of Victoria, 2018). The guidelines have details on information sharing, including documentation.

When information is shared as part of FVISS or CISS about any individual, either voluntarily or in response to a request, an ISE must document:

- what information was requested, who requested it and the date
- what information was shared, who with and the date
- a relevant family violence risk assessment and safety plan for the victim survivor about who the information relates, and any other family members at risk of family violence.

When sharing information about adult victim survivors and third parties, ISEs must also record:

- if consent was provided, a record of consent whether written, verbal or implied
- if information is shared without their consent:
 - the reason why consent was not obtained
 - whether it sought and obtained the views of the person and, if not, the reason why
 - whether the individual was informed that their information was shared without their consent.

When sharing information about a child victim survivor, ISEs must also record:

- whether it sought and obtained the views of the child or their parent (who is not an alleged perpetrator or a perpetrator), and if not, the reason why
- whether the child victim survivor or their parent (who is not an alleged perpetrator or a perpetrator) was informed that the information was disclosed.

Communication with family and carers

When assessing risk, if sharing information may increase the risk of a consumer or any family member being subjected to family violence, mental health and wellbeing services must not share information, even with the consumer's consent. While this will limit the information that is shared directly with the people experiencing family violence, there may be risk management planning opportunities that clinicians and MARAM champions can undertake to mitigate risk. Practice guidance can be found in the [MARAM practice guides and resources](https://www.vic.gov.au/maram-practice-guides-and-resources) <<https://www.vic.gov.au/maram-practice-guides-and-resources>>.

The Mental Health and Wellbeing Act requires services to disclose information about a consumer in certain circumstances, such as to their carer or nominated support person. But Pt 1.6 (s 31) outlines that information must not be disclosed if there is a risk that someone may be subjected to family violence or other serious harm.

Part 1.6 (s 31) applies regardless of whether the consumer has consented to the disclosure of their information (Department of Health, 2023a) (State Government of Victoria, 2022).

Organisations and clinicians must take care to ensure that disclosing documentation about the person using violence or victim survivor does not increase the risk to victim survivor(s), including children. This includes disclosure to family members.

Information about freedom of information requests and information sharing under the FVISS and CISS can be found in the [Ministerial Guidelines](https://www.vic.gov.au/family-violence-information-sharing-scheme) <<https://www.vic.gov.au/family-violence-information-sharing-scheme>>.

Documentation

MARAM aims to create a system-wide understanding of family violence and family violence risk. It guides practitioners across the continuum from generic services to specialist family violence services. MARAM also seeks to increase safety and decrease risk where possible through a range of actions by professionals.

Documenting family violence in clinical files needs to occur with careful consideration and within a shared understanding of family violence and family violence risk. It should contribute to reducing risk and increasing safety.

This means that organisations need to develop clear guidance on how, what and where to record family violence information. It will also depend on who the information has been provided by, whether the provider is:

- the victim survivor who is also the consumer
- the victim survivor who is a partner or family member of the consumer
- the consumer who is perpetrating family violence.

Organisations need to clearly outline where information is stored (such as in a clinical file or specific section). Using MARAM language and the MARAM risk factors, organisational procedures need to outline appropriate documentation of family violence in clinical files.

Using MARAM language and terminology assists in communication and collaboration across sectors. Clinical notes need to reflect MARAM language; for example, language around behaviour needs to be guided by the risk factors.

More detailed information is included in a MARAM intermediate risk assessment. If this is undertaken, it needs to be filed securely and easy to locate. Refer to documentation examples in the appendix.

Specific clinical situations and considerations

The MARAM Framework and its application applies throughout clinical care. But a number of clinical situations are pivotal to ensuring family violence and family violence risk is attended to appropriately. Examples include the following.

Clinical reviews and critical reviews

Clinical and critical reviews both need to include staff with a depth of subject matter expertise of family violence and MARAM. This helps ensure family violence is considered for both victim survivors and people using family violence. It's important to consider this in all reviews so family violence is included even when it has not previously been clinically identified. Include FV Champions (including medical staff), SFVAs and others.

Nominated person, primary carer, decision-maker, support person

In the mental health and wellbeing sector, the nominated support person may be the person using family violence.

It is essential to check in with consumers about changing the nominated support person when family violence is identified. This supports the consumer's agency and their safety. Helping them to change the nominated support person is part of good mental health care that incorporates an understanding of family violence. All care needs to be taken to ensure the consumer is well supported, no matter whether they continue to be living or staying in a relationship with the person perpetrating family violence. No information that increases risk to the consumer can be shared with the person who uses family violence, no matter if they are the nominated support person, a carer or other. Follow information sharing principles and seek secondary consultations internally with family violence experts such as SFVAs or externally with specialist family violence services.

Assessing suicidality

There is a strong link between experiencing and perpetrating family violence and suicidality (Fitzpatrick et al., 2022; MacIsaac et al., 2018). Some population groups are at higher risk of suicide due to additional societal factors. This includes LGBTQIA+ people, especially transgender people, young people and Aboriginal people.

Threatening suicide may also be part of controlling behaviour. Clinicians need to understand both the links and the potential for controlling behaviour.

Risk Assessment and Management Panels

These are formal monthly meeting of agencies and organisations that contribute to the safety of children, young people and adults at serious risk from family violence. Risk Assessment and Management Panels (RAMPs) aim to reduce the risk posed by adults using family violence. Each

RAMP is co-chaired by a specialist family violence service and Victoria Police. Mental health and wellbeing services have been part of RAMPs for some years.

Mental health and wellbeing services need to ensure they are represented on RAMPs by senior clinicians, medical staff or FV Champions where capacity is appropriate. Safe and Equal has more information on [RAMPS](https://safeandequal.org.au/working-in-family-violence/assessing-managing-risk/ramps/) <https://safeandequal.org.au/working-in-family-violence/assessing-managing-risk/ramps/>.

Workforce and workforce development

Mental health and wellbeing services are prescribed under MARAM. This means they align their policies and procedures with MARAM and ensure they follow legal requirements. Implementing the workforce framework needs to link with professional development and training in line with MARAM.

All position descriptions need to include statements about family violence and the required (or to be acquired) skills relating to family violence and the MARAM Framework.

More information is available in the [Our workforce, our future framework](https://www.health.vic.gov.au/our-workforce-our-future) <<https://www.health.vic.gov.au/our-workforce-our-future>>.

Training and ongoing professional development

Training

MARAM training must be mandated for all staff according to their level of responsibility.

- Training attendance needs to be monitored and form part of annual reviews. Training participation includes:
 - all clinical staff
 - senior management
 - LLE staff
 - executive staff
 - administrative staff.
- Health information officers involved in information sharing schemes need to undertake intermediate MARAM training to understand risk factors, safety planning and documentation.
- FV Champions need to attend intermediate MARAM training (at a minimum).

Reflective practice

Organisations need to create opportunities for clinicians to come together to take part in:

- reflective practice and (group) supervision regarding family violence and MARAM (such as community of practice)
- clinical review
- supervision groups
- family violence specialist supervision.

Ongoing professional development for clinicians

After introducing the MARAM assessment, especially the intermediate level, create opportunities for staff to increase their knowledge and ability to undertake holistic assessments that include family violence.

A 5-year review of MARAM found that MARAM questions are frequently used like a tick-box exercise, rather than a conversation (Allen + Clarke Consulting, 2023). Ongoing professional development and reflective practice can help embed a more conversational approach to assessments, reducing barriers to asking questions and building a stronger engagement. In turn, ensuring assessments are conversational enhances connection and will help increase safety.

Training and support for lived and living experience staff

LLE staff, particularly peer workers, are highly likely to receive family violence disclosures by virtue of their roles and trusting relationships with consumers. Organisations need to develop guidance and support for LLE staff to be skilled in:

- family violence identification and response (MARAM training needs to be mandatory)
- managing role boundaries
- dealing with the impact of family violence disclosures.

LLE staff need to be supported to respond to family violence, enabling them to escalate a response (including a MARAM assessment) to a clinician with responsibility to undertake MARAM assessments. While not responsible for safety planning, LLE staff might be involved in safety planning if appropriate.

Providing guidance on confidentiality and limited confidentiality in the parameters of the information sharing schemes will assist LLE staff in balancing both safety and the wellbeing of consumers, as well as their own professional responsibilities. Clarifying duty of care obligations through organisational policies, training and reflective practice opportunities will support the roles of LLE staff. LLE staff may encounter situations where a consumer invites them to collude or discloses family violence, requesting that this information is kept confidential. Such situations can create great pressure for LLE staff. Organisational procedures can support staff to maintain professional boundaries while being empathetic and transparent about their duty of care.

Supervision must include exploring family violence work within role boundaries and support to manage such situations.

Self-assessment

Organisations can use the [MARAM self-assessment tools](https://www.vic.gov.au/maram-practice-guides-and-resources) <<https://www.vic.gov.au/maram-practice-guides-and-resources>> for an initial assessment of organisational readiness and to check progress.

Appendices

Appendix 1: Abbreviations

Abbreviation	Meaning
CISS	Child Information Sharing Scheme
FVISS	Family Violence Information Sharing Scheme
ISE	Information Sharing Entity
LLE	Lived and living experience
MARAM Framework	Family Violence Multi-Agency Risk Assessment and Management Framework
RAMP	Risk Assessment and Management Panel
SFVA	Specialist family violence advisor

Appendix 2: Documentation and risk practice examples

Documentation examples

Preamble

Attaching family violence–related documents in clinical files can support victim survivors. Documents that can be an important source of information include intervention order applications, court proceedings and reporting to police. This also helps in keeping perpetrators in view and ensures their behaviour and impact is visible in case notes.

Some points to consider:

- Using MARAM language, indicators or risk factors of family violence need to be stated and described.
- Think of a victim survivor accessing their file in a few years' time. Consider how they might feel when reading their file. Using their language to describe what has occurred shows respect and understanding of family violence. Avoid using judgemental language.
- Under both information sharing schemes, information must be shared appropriately. Consider how your notes reflect the consumer's situation and experience respectfully. This applies to victim survivors and perpetrators.

Not MARAM aligned	MARAM aligned
Consumer is homeless for the third time in 6 months. Discussed importance of holding on to housing to support mental health stabilisation.	Consumer is homeless. She has had to move 3 times in the past 6 months due to her ex-partner's attempts to locate her in breach of intervention order. Discussed stressfulness of having to move and lack of safety. Updated safety plan [note where the safety plan is located in the file].
Consumer has missed another appointment, even though we discussed the need for regular attendance in support of her mental health.	Consumer could not attend her appointment. This is out of character and has occurred a couple of times of late. Writer is concerned about her wellbeing due to ongoing coercive control by partner, who keeps her from attending appointments. Will continue to try to contact her to find ways of supporting her to attend next appointment.
Parent of consumer reports difficulties at home, son gets loud and yells at them when becoming unwell. Discussed ways to manage these situations.	Parent of consumer reports verbal abuse and threats by son when he became unwell recently. Parent is fearful and concerned about their safety. Unsure if son will carry out threats of suicide if they don't lend him money. Discussed situation with colleague who provided support to parent (to provide separate support person). Undertook a MARAM assessment and developed a safety plan. Note: The organisation needs to establish whether a separate health record is opened for the parent and how to link with the consumer's file.

Risk practice example

Consumer has mentioned several serious family violence risk factors during a conversation. These include that their partner has threatened to harm their dog, is using coercive control by not allowing her to see her family and is emotionally abusive by calling her names and telling her that she is a bad mother because she has mental ill-health.

Decreasing family violence risk (increasing safety)	Increasing family violence risk
<p>Clinician is aware that the consumer mentioned several risk and serious family violence risk factors. Enquires sensitively and suggests undertaking a MARAM risk assessment.</p>	<p>Clinician is unaware that threatening to harm an animal is a family violence risk factor. Thinks that not being able to see family is not great, and supports her in her mothering role by telling her she is a good mum.</p>
<p>Clinician contributes towards increasing safety by checking with the consumer (as agreed) on their safety plan, adjusting the safety plan and ensuring she knows she can contact clinician between appointments if needed. Clinician has provided contact details for after-hours support services.</p>	<p>Clinician does not undertake a MARAM assessment, does not use MARAM language when documenting these issues and does not undertake safety planning.</p>

Appendix 3: Definitions

Adolescent violence in the home Any behaviour used by an adolescent in the family to control, dominate, threaten or coerce a parent, sibling or other family member.

Advance care directive A document that sets out a person's binding instructions or preferences and values for medical treatment in the event they do not have decision-making capacity for the medical treatment (s 12(1) of the *Medical Treatment Planning and Decisions Act 2016*). An advance care directive has no effect while a person is a patient under the Act (as per s 48(1)).

Advance statement of preferences A document that sets out a person's preferences for their treatment, care and support if they become a patient under the Mental Health and Wellbeing Act 2022 (s 57).

Authorised psychiatrist A psychiatrist appointed by a designated mental health service under s 328 of the Mental Health and Wellbeing Act 2022 to carry out the functions and exercise the powers conferred on an authorised psychiatrist under the Act or any other Act and support the chief psychiatrist to perform the chief psychiatrist's functions under the Act. An authorised psychiatrist can delegate a function or power to certain people under s 329 of the Act.

Carer A person, including a person under the age of 18 years, who provides care to another person with whom they are in a care relationship (per s 3 of the *Carers Recognition Act 2012*). It does not include a parent if the person to whom care is provided is under the age of 16 years (per s 3(1) of the Act).

Child A person who is under the age of 18 years, including infants and toddlers (s 4 of the *Family Violence Protection Act 2008*).

Child Information Sharing Scheme Scheme that enables information sharing between authorised organisations to promote a child's safety.

Clinical accountability Used in this guideline to identify the service or service provider that is responsible for justifying or explaining the clinical decision making that has occurred.

Clinical mental health service provider A designated mental health service or a mental health and wellbeing service provided in a custodial setting.

Coercive control Control that can be exerted through any combination of the MARAM evidence-based risk factors. It is often demonstrated through patterns of behaviours of emotional or financial abuse and isolation, stalking (including using technology), controlling behaviours, choking/strangulation and sexual and physical violence. The behaviour is intended to harm, punish, frighten, dominate, isolate, degrade, monitor/stalk, regulate or subordinate a victim survivor.

Consumer A person who has or is receiving mental health and wellbeing services or was assessed by an authorised psychiatrist and is not receiving treatment or sought or is seeking mental health and wellbeing services and was not or is not provided with those services.

Consumer Any person receiving or seeking mental health and wellbeing services regardless of their legal status.

Designated mental health service A prescribed public hospital, public health service, denominational hospital, privately operated hospital or private hospital that is registered as a health service establishment under the *Mental Health and Wellbeing Act 2022*, the Victorian Institute of Forensic Mental Health, a service temporarily declared to be a designated mental health service or a declared operator (per s 3(1) of the Act).

Elder abuse Any harm or mistreatment of an older person that is committed by someone with who the older person has a relationship of trust. In the context of family violence, this may be by any person who is a family member (such as their partner, adult children or grandchildren) or carer. Elder abuse may take any form defined under ‘family violence’.

Family Family of origin or family of choice.

Families, carers and supporters The network of people that supports consumers with their mental health and wellbeing. This support must always be with the consent of the consumer or aligned to the information sharing principles of the *Mental Health and Wellbeing Act 2022*.

Family violence Any behaviour towards a family member (including a domestic or intimate partner) that is physically, sexually, emotionally, psychologically or economically abusive, that is threatening or coercive or is in any other way controlling that causes a person to live in fear for their safety or wellbeing or that of another person.

In relation to children, family violence is also defined as behaviour by any person that causes a child to hear or witness or otherwise be exposed to the effects of the above behaviour.

This definition includes violence within a broader family context such as extended families, kinship networks and communities and other family-like relationships (as set out in s 5 of the *Family Violence Protection Act 2022*).

Family Violence Information Sharing Scheme Scheme that enables information to be shared between authorised organisations to assess and manage family violence risk.

Family Violence Protection Act 2008 Victoria’s Act that aims to promote safety for people who have experienced family violence, reduce its prevalence, and increase accountability of family violence perpetrators.

Instructional directive An expressed statement in an advance care directive of a person’s medical treatment decisions. It takes effect as if the person who gave it has consented to, or refused, the commencement or continuation of, medical treatment as the case may be (s 6(1) of the *Medical Treatment Planning and Decisions Act 2016*).

LGBTIQ+ Lesbian, gay, bisexual, transgender and gender diverse, intersex and queer/questioning. For comprehensive definitions refer to the [LGBTIQ inclusive language guide](https://www.vic.gov.au/inclusive-language-guide) <<https://www.vic.gov.au/inclusive-language-guide>>.

Lived and living experience workforce Staff of mental health and wellbeing services who are employed because of their lived or living experience, and which is an essential criterion of their job. They are also expected to have knowledge of lived and living experience perspectives. They are employed across a range of mental health services in direct practice and support and through operational management, leadership, consultation, education, training, research, advocacy and representation.

Medical treatment decision-maker Where the person is not a ‘patient’, a medical treatment decision-maker is someone appointed by a person to make medical treatment decisions if the appointee is reasonably available and willing and able to make the medical treatment decision. If someone is not appointed as described above, it is a guardian appointed by the Victorian Civil and Administrative Tribunal under the *Guardianship and Administration Act 2019* who has the power to make treatment decisions on behalf of a person under the appointment and is reasonably available and willing and able to make the medical treatment decision. If no-one has been appointed, it is the first person in the statutory list of people provided in s 55(3) who has a close and continuing relationship with the person and who is reasonably available and willing and able to make a medical treatment decision, (s 48 and s 55 of the *Medical Treatment Planning and Decisions Act 2016*).

Mental health and wellbeing service A service performed for the primary purpose of improving or supporting a person's mental health and wellbeing; assessing or providing treatment, care or support to a person for mental illness or psychological distress; or providing care or support to a family member, carer or supporter of a person with mental illness or psychological distress.

Multi-Agency Risk Assessment and Management Framework (MARAM) Victoria's evidence-based framework for assessing family violence risk.

Nominated support person A person nominated by a patient under Pt 2.6 of the Mental Health and Wellbeing Act 2022 to support them, to advocate for them and receive information and be consulted about them in line with the Act.

Parent Under s 3(1) of the Mental Health and Wellbeing Act 2022 a parent, in relation to a person under the age of 18 years, includes the following:

- a person who has custody or daily care and control of the person
- a person who has all of the duties, powers, responsibilities and authority (whether conferred by a court or otherwise) which by law parents have in relation to their children
- any other person who has the legal right to make decisions about medical treatment of the person.

Patient A person who is subject to an assessment order, court assessment order, temporary treatment order or treatment order, or a security or forensic patient, under s 3(1) of the Mental Health and Wellbeing Act 2022.

Perpetrator Term used as a legal and police term in Victoria. It has the same meaning as the words 'person of concern' in s 144B of the *Family Violence Protection Act 2008*. The Act says an individual is a person of concern if an Information Sharing Entity reasonably believes that there is a risk that they may commit family violence.

Person using violence A term that is frequently used as the preferred term to describe someone's behaviour because it emphasises a person's agency for change.

Risk assessment In the family violence context, this means the process of applying the model of Structured Professional Judgement to determine the level of family violence risk.

Risk Assessment Entity Has the same meaning as set out in the *Family Violence Protection Act 2008*, being an Information Sharing Entity that is prescribed to belong to the category of a risk assessment entity. Risk Assessment Entities can request and voluntarily receive information from Information Sharing Entities for a family violence assessment purpose. Mental health and wellbeing services are Risk Assessment Entities and are prescribed under MARAM.

Risk factors In the family violence context, refers to the evidence-based risk factors associated with the likelihood of family violence occurring or the severity of the risk of family violence.

Risk management In the family violence context, refers to any action or intervention taken to reduce the level of risk presented to a victim and to hold perpetrators to account. Actions taken and interventions that are implemented must be appropriate to the level of risk identified in the assessment stage. Risk management includes supports or interventions that promote stabilisation and recovery from family violence for victim survivors. Risk management includes responding to circumstances and presenting needs of perpetrators that reduce the likelihood of using related risk behaviour.

Safety planning In the family violence context, involves a conversation by a professional who is working with an adult or child victim survivor, or a person using violence, about actions they can take to respond to family violence risk of the person using violence. Safety planning is part of a

MARAM risk assessment and includes safely documenting the safety plan in a consumer's file and, if safe to do so, for the consumer to keep a copy. The MARAM practice guides provide further guidance.

Serious risk In the family violence context, risk factors are associated with the increased likelihood of the victim survivor being killed or nearly killed.

Support person Someone (including a child) who supports a person to make, communicate and give effect to that person's treatment decisions and represents the interests of the person in respect of the person's medical treatment. This includes when the person does not have decision-making capacity for medical treatment decisions (s 32(1) of the *Medical Treatment Planning and Decisions Act 2016*). A person can only appoint one support person (s 31(2) of the Act). The support person acting in the capacity of a support person does not have the power to make the person's medical treatment decisions (s 32(2)).

Values directive A statement in an advance care directive of a person's preferences and values as the basis on which the person would like any medical treatment decisions to be made on their behalf. This includes, but is not limited to, a statement of medical treatment outcomes that the person finds acceptable (s 6 of the *Medical Treatment Planning and Decisions Act 2016*).

Victim survivor Describes an individual, including children, young people, adults and elderly people, who has experienced family or sexual violence.

Young patient A patient who is under the age of 18 years (s 3(1) of the Mental Health and Wellbeing Act 2022).

Young person A person who is under the age of 18 years.

Appendix 4: Legislation

[Charter of Human Rights and Responsibilities Act 2006](https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015) <https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015>

[Child information sharing ministerial guidelines](https://www.vic.gov.au/child-information-sharing-scheme-ministerial-guidelines) <https://www.vic.gov.au/child-information-sharing-scheme-ministerial-guidelines>

[Child Wellbeing and Safety Amendment \(Child Safe Standards\) Act 2015](https://www.legislation.vic.gov.au/as-made/acts/child-wellbeing-and-safety-amendment-child-safe-standards-act-2015)

<https://www.legislation.vic.gov.au/as-made/acts/child-wellbeing-and-safety-amendment-child-safe-standards-act-2015>

[Child Wellbeing and Safety Act 2005](https://www.legislation.vic.gov.au/in-force/acts/child-wellbeing-and-safety-act-2005/043) <https://www.legislation.vic.gov.au/in-force/acts/child-wellbeing-and-safety-act-2005/043>

[Child Wellbeing and Safety \(Child Safe Standards Compliance and Enforcement\) Amendment Act 2021](https://www.legislation.vic.gov.au/as-made/acts/child-wellbeing-and-safety-child-safe-standards-compliance-and-enforcement-amendment) <https://www.legislation.vic.gov.au/as-made/acts/child-wellbeing-and-safety-child-safe-standards-compliance-and-enforcement-amendment>

[Child Wellbeing and Safety Regulations 2017](https://www.legislation.vic.gov.au/in-force/statutory-rules/child-wellbeing-and-safety-regulations-2017/004) <https://www.legislation.vic.gov.au/in-force/statutory-rules/child-wellbeing-and-safety-regulations-2017/004>

[Children, Youth and Families Act 2005 \(Vic\)](https://www.legislation.vic.gov.au/in-force/acts/children-youth-and-families-act-2005/137) <https://www.legislation.vic.gov.au/in-force/acts/children-youth-and-families-act-2005/137>

[Family Violence Multi-Agency Risk Assessment and Management Framework](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) <https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management>

[Family Violence Information Sharing Scheme](https://www.vic.gov.au/family-violence-information-sharing-scheme) <https://www.vic.gov.au/family-violence-information-sharing-scheme>

[Family violence protection legislation](https://www.legislation.vic.gov.au/as-made/statutory-rules/family-violence-protection-regulations-2018) <https://www.legislation.vic.gov.au/as-made/statutory-rules/family-violence-protection-regulations-2018>

[Family Violence Protection Act 2008 \(Vic\)](https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/061) <https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/061>

[Health Records Act 2001 \(Vic\)](https://www.health.vic.gov.au/legislation/health-records-act) <https://www.health.vic.gov.au/legislation/health-records-act>

[Mental Health and Wellbeing Act 2002 \(Vic\)](https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/002) <https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/002>

[Privacy and Data Protection Act 2014](https://www.legislation.vic.gov.au/in-force/acts/privacy-and-data-protection-act-2014/030) <https://www.legislation.vic.gov.au/in-force/acts/privacy-and-data-protection-act-2014/030>

[Privacy Act 1988](https://www.legislation.gov.au/C2004A03712/latest/text) <https://www.legislation.gov.au/C2004A03712/latest/text>

Appendix 5: Related government guidelines

[Chief Psychiatrist's guideline and practice guide: family violence \(2018\)](https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/c/chief-psychiatrist-guideline-family-violence.pdf)

<<https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/c/chief-psychiatrist-guideline-family-violence.pdf>>

[Chief Psychiatrist's guideline on improving sexual safety in mental health and wellbeing services](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety)

<<https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>>

[Dhelk Dja: Safe our way 3-year action plan](https://www.vic.gov.au/dhelk-dja-3-year-action-plan) <<https://www.vic.gov.au/dhelk-dja-3-year-action-plan>>

[Physical health framework for specialist mental health services \(Equally Well in Victoria\)](https://www.vgls.vic.gov.au/client/en_AU/search/asset/1298074/0)

<https://www.vgls.vic.gov.au/client/en_AU/search/asset/1298074/0>

[Mental health and wellbeing workforce capability framework](https://www.health.vic.gov.au/our-workforce-our-future) <<https://www.health.vic.gov.au/our-workforce-our-future>>

[Nargneit Birrang-Aboriginal holistic healing framework for family violence](https://www.vic.gov.au/aboriginal-family-violence-reform)

<<https://www.vic.gov.au/aboriginal-family-violence-reform>>

[Working together with families and carers](https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers) <<https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers>>

Appendix 6: MARAM implementation tools

[MARAM practice guides](https://www.vic.gov.au/maram-practice-guides-and-resources) <https://www.vic.gov.au/maram-practice-guides-and-resources>

[MARAM Framework](https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management) <https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management>

[Information Sharing and MARAM](https://www.vic.gov.au/guides-templates-tools-for-information-sharing) <https://www.vic.gov.au/guides-templates-tools-for-information-sharing>

[Frequently asked questions about information sharing and MARAM](https://www.vic.gov.au/frequently-asked-questions-about-information-sharing-and-maram)
<https://www.vic.gov.au/frequently-asked-questions-about-information-sharing-and-maram>

[MARAM roleplay video series](https://www.vic.gov.au/maram-roleplay-video-series) <https://www.vic.gov.au/maram-roleplay-video-series>

[MARAM animation video series](https://www.vic.gov.au/maram-video-series) <https://www.vic.gov.au/maram-video-series>

Resources other sectors and organisations

The Centre for Mental Health Learning provides a range of resources and lists MARAM training

[Capability 7 - Understanding and responding to family violence](https://cmhl.org.au/learning-hub/capability-7-understanding-and-responding-family-violence) <https://cmhl.org.au/learning-hub/capability-7-understanding-and-responding-family-violence>

VAADA

VAADA provides a range of helpful tools, documents and flowcharts for the alcohol and other drugs sector

[MARAM Navigator](https://www.vaada.org.au/family-violence/maram/) <https://www.vaada.org.au/family-violence/maram/>

Training

[Centre for Mental Health Learning](https://cmhl.org.au/) <https://cmhl.org.au/>

[Safe and Equal](https://safeandequal.org.au/working-in-family-violence/assessing-managing-risk/ramps/) <https://safeandequal.org.au/working-in-family-violence/assessing-managing-risk/ramps/>

Regional women's health services

Some women's health services provide MARAM training. Visit the statewide website to locate your service and for more information.

[Victorian Women's Health Services Network](https://www.whsn.org.au/) <https://www.whsn.org.au/>

Appendix 7: Organisational MARAM-related documents – examples

While the implementation of MARAM will vary between mental health and wellbeing services, a range of documents, policies and procedures will be similar. The following is a list of document titles relevant to implementing MARAM that are expected to have been developed (or are in the process of being developed):

- family violence staff policy
- family violence workplace procedure
- MARAM Framework policy
- MARAM Framework procedure
- MARAM Child Intermediate Assessment Tool (integrate into electronic assessment)
- MARAM Victim Survivor Intermediate Assessment Tool (integrate into electronic assessment)
- MARAM Perpetrator Intermediate Assessment Tool (integrate into electronic assessment)
- FVISS procedure
- FVISS flow chart
- CISS procedure
- CISS flow chart
- MARAM identification and response procedure
- family violence FVISS and CISS record
- MARAM documentation procedure and practice guide
- MARAM risk management guide and procedure
- Information Sharing brochure (outlining the MARAM Framework, FVISS, CISS and the Family Violence Protection Act)
- outline of SFVA role and function (provide at staff orientation and via internal communications).

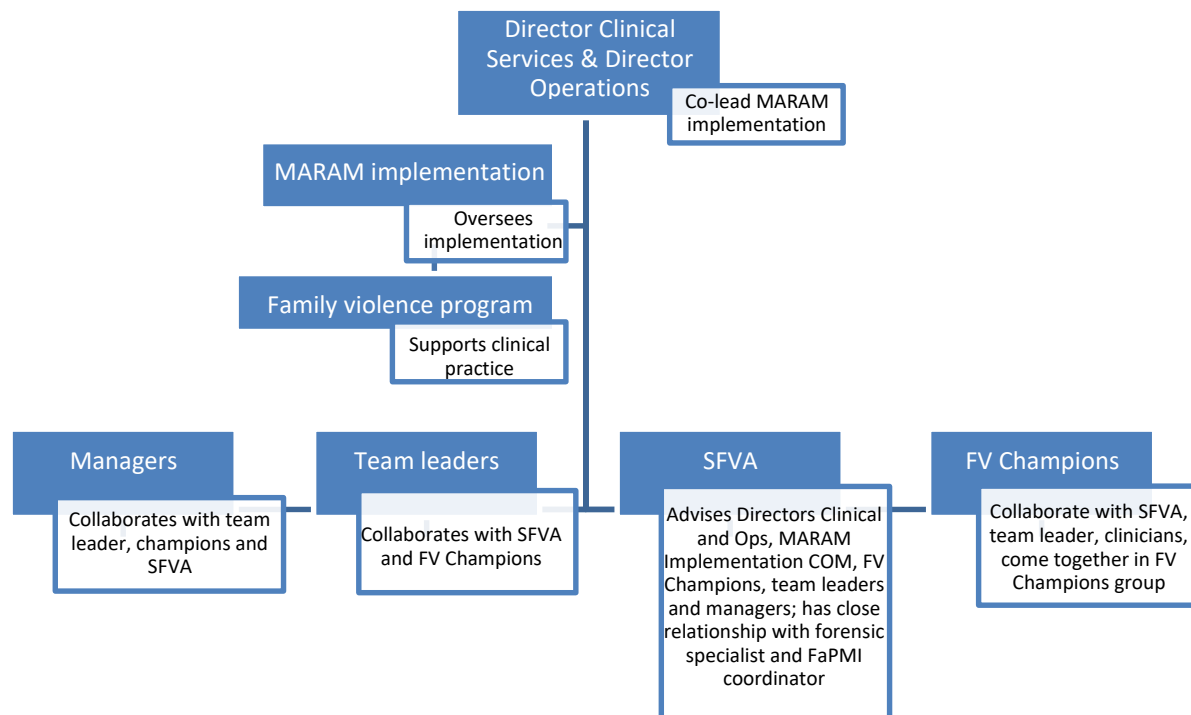
Appendix 8: Examples of implementation tools for mental health and wellbeing services

Structure

The following is an outline of an implementation structure that can assist in thinking through:

- the elements of MARAM implementation
- the level of responsibilities
- type of staff involved.

MARAM implementation is the responsibility of the organisational Executive, including the director of clinical services and other senior medical staff.



Accessible text version of the implementation structure outlined above:

- Director Clinical Services & Director Operations – Co-leads MARAM implementation
- MARAM implementation – oversees implementation
- Family violence program – supports clinical practice
- Managers – Collaborates with team leader, champions and SFVA
- Team leaders – Collaborates with SFVA and FV Champions
- SFVA – Advises Directors Clinical and Ops, MARAM Implementation COM, FV Champions, team leaders and managers; has close relationship with forensic specialist and FaPMI coordinator
- FV champions – Collaborate with SFVA, team leader, clinicians, come together in FV Champions group

MARAM Implementation and Monitoring Committee

There will be different phases of implementation and monitoring of implementation. Organisations might decide that they have implemented MARAM but the translation into clinical practice still needs further work.

Committees can be adapted and changed to accommodate this change. It is advisable to maintain oversight of MARAM to ensure ongoing quality improvement.

The following are some examples of both membership and terms of reference to help you establish or maintain such structures.

Membership

Clinical director, director of operations, seniors of discipline (allied health, nursing, medical), lived and living experience staff, managers, specialist family violence advisor, legal staff, human resources.

Terms of reference

The Family Violence/MARAM Implementation Committee is responsible to guide, support and actively work on implementing the MARAM Framework.

Responsibilities

Clearly outline the responsibilities.

Family Violence Clinical Leadership Group

Terms of reference

Purpose

The group aims to provide the opportunity for senior clinical leaders to:

- discuss family violence
- work towards increasing safety for victim survivors
- keep perpetrators in view.

It seeks to provide clinical leadership to manage identified family violence risk and to act as a resource for clinicians.

Responsibilities

- Contribute to clinical case discussions and safety planning.
- Identify gaps in practice areas and plan for quality improvement.
- Participate in and co-lead activities to improve coordination of best practice clinical care relating to family violence.
- Promote safety, accountability and information sharing.
- Promote uptake and upskilling in MARAM assessments.

Governance and clinical risk management

- Include statements about:
 - confidentiality, privacy and sensitive of content
 - adherence to patient confidentiality/privacy policies
 - family violence and child information sharing schemes.

Membership (as applicable)

Manager of the family violence program, chief/senior social worker, team leader of the family violence program, specialist family violence advisor, forensic clinical specialist, Families where a Parent has a Mental Illness (FaPMI) coordinator, senior family violence clinical champions, clinical directors of teams, team managers.

Family Violence Champion – role description

The following headings can be included in a role description:

- Statement of organisational commitment to family violence and MARAM
 - Clearly outline the organisation’s recognition of family violence as a health issue.
 - State the importance of the FV Champion roles.
 - Include a list of relevant policies and procedures.
- Organisational support provided to FV Champions
 - Outline support and training opportunities.
 - Clinical champions need to come together regularly to receive support for their roles, attend training and continuously develop their skills.
- Outline main responsibilities and functions
 - Promote awareness about family violence and the MARAM Framework.
 - Function as the ‘go to’ person for enquiries about family violence and MARAM that is beyond the scope or knowledge of clinicians.
 - Provide secondary consultation and guidance to team members, junior staff and others.
 - Take part in training to maintain their role and increase their skills.
 - Co-deliver orientation and training for other staff in collaboration with the specialist family violence advisor (SFVA), other FV Champions and medical staff.
 - Seek secondary consultation with the SFVA, their manager or specialist family violence services as appropriate.
 - Work with other FV Champions and other specialists (Families where a Parent has a Mental Illness [FaPMI] Coordinator, forensic specialist) through meetings, online forums, co-working and other opportunities.
 - Take part in relevant internal meetings to raise awareness of family violence and MARAM.
- Outline abilities and skills needed, including:
 - understanding of family violence and MARAM
 - ability and willingness to collaborate with and support other staff
 - acting with integrity and balancing a clinical role with this role
 - being able to commit to the role of FV Champion for a minimum of 12 months.

Family violence program

A family violence program can include a range of staff including the SFVA, FV Champions, senior clinicians and others.

Note: Depending on role descriptions and expectations, lived and living experience representatives might be involved in this program. This needs careful consideration due to the differences between clinical and non-clinical roles.

Psychiatrist in Family Violence Program – role description

A psychiatrist working in the family violence program collaborates with the program team. They supervise the Specialist Registrar in Family Violence Program role.

The following list provides ideas for a role description but is not exhaustive.

- Has a broad overview of the demand and type of work being undertaken with or related to registered consumers.

- Considers risks that include family violence but are not necessarily limited to family violence.
- Provides a point of clinical escalation and discussion for serious or complex family violence and mental health consumers.
- Provides specialist mental health expertise into the family violence program including service development and alignment with current governance structures.
- Attends Risk Assessment and Management Panel meetings as agreed.
- Provides feedback in Executive meetings about the program in collaboration with the SFVA and other representatives.
- Provides clinical expertise to external enquiries as appropriate.
- Ensures family violence and MARAM are part of the orientation program for new medical staff in collaboration with the SFVA.
- Promotes medical staff responsibilities in family violence and MARAM.
- Actively participates in family violence and MARAM implementation committees.
- Provides educational sessions to medical staff on family violence and MARAM in collaboration with members of the family violence program team.

Specialist Psychiatry Registrar in Family Violence Program – role description

A specialist psychiatry registrar working in the family violence program works with the program team. The Psychiatrist in the Family Violence Program supervises them. They might receive supervision or reflective practice from the SFVA.

The following list provides ideas for a role description but is not exhaustive.

- Has foundational knowledge of family violence.
- Is committed to increasing their knowledge and skills in working with family violence in mental health and wellbeing services.
- Undertakes reading in family violence and MARAM as outlined by the family violence program leads (Psychiatrist in Family Violence Program and the SFVA).
- Undertakes training in family violence and MARAM up to intermediate levels (via internal and external sources).
- Undertakes MARAM assessments (once training completed) with consumers and in collaboration with other clinical staff.
- Seeks secondary consultation from the SFVA or specialist family violence services as appropriate.
- Seeks clinical guidance from their supervising psychiatrist.
- Increasingly takes on a role of promoting medical staff responsibilities for family violence and MARAM.
- Spends time in partner agencies, such as specialist family violence services, to increase knowledge and contribute to cross-sector collaboration.
- Attends Risk Assessment and Management Panel meetings as appropriate.
- Provides feedback about the role and its function to contribute to continuous improvement of the program and the role.
- Contributes to medical staff orientation through delivering professional development and 'showcasing' specialist role.

Appendix 9: Documentation pointers

Organisations are likely to have developed guidelines about documentation. The following points can assist in guiding staff and can be adapted as necessary.

Regarding information sharing (FVISS), the consumer's notes need to include:

- whether information is shared with or information is sought from other organisations
- the process followed
- clarity about legal obligations
- what consent has been sought or needed for information sharing
- who sought information
- what information was shared
- who you consulted with
- who gave approval for any decision or action taken
- what the outcome was.

Disclosures of family violence

- Whenever possible make notes in the presence of the person. Double-check by feeding back to the person what you have heard and then write it down.
- The record of the disclosure should be in the victim survivor's own language.
- Follow MARAM and the organisation's frameworks guiding case notes and reporting of disclosures.
- Note:
 - concerns, risks and safety concerns
 - protective factors and supports
 - who you consulted with, decisions made, actions taken
 - rationale for decisions.

Case notes terminology and definitions to use under MARAM

- Use the MARAM Framework relating to family violence language, terminology and definitions to ensure consistency across services.
- MARAM uses 'adult or child victim survivor' (when referring to someone experiencing family violence). VACCA has released a [video on 'person experiencing violence'](https://youtu.be/Ba_iD7L9R8Q?si=7i7r--gNMiVmEHwA) <https://youtu.be/Ba_iD7L9R8Q?si=7i7r--gNMiVmEHwA> being the preferred term, as Aboriginal women find this less stigmatising.
- MARAM uses 'person who uses family violence' rather than 'someone who perpetrates family violence'.
- Aboriginal communities prefer the term 'person who uses violence' to 'perpetrator'.
- Men's behaviour change programs use the term 'men who use violence' rather than 'perpetrator'.
- Family violence towards an older person is called 'elder abuse'.
- The actions of a young person or adolescent using family violence is referred to as 'adolescent violence in the home'.

What not to put in case notes

Do not include:

- personal bias, your attitude towards the consumer or family, assumptions, stereotypical comments
- judgement statements (*'She should have left when she could'*)
- third-hand information unless it is relevant.

Examples

MARAM risk factor	Don't write	Do write
Imminence	Person X is being discharged from hospital soon.	Person X is being discharged in 2 days; this increases the risk to his partner. Safety plan has been adjusted (see updated safety plan) and victim survivor has been notified.
Controlling behaviours	Person X's partner has mentioned they are not allowed to see their family, which isn't supportive of them anyway.	Person X's partner says they are being controlled in several ways: has been kept from seeing their family, has to account for time spent when doing grocery shopping and account for all money spent.
Escalation	Person X's partner has mentioned they are not only not allowed to see family but also not to talk with neighbours or go to their walking group.	Controlling behaviour has escalated (MARAM risk factor) in severity and frequency. The victim survivor now is also prevented from speaking to neighbours or going to their walking group. The neighbour and walking group have been supportive to the person. Safety plan and risk management plan has been updated [note in file where safety plan can be located].
Has ever threatened to harm pets or other animals	Person X has threatened to kick the dog but has never done so in the past when using that threat.	Person X has threatened to hurt the dog if his partner doesn't advocate for his early discharge from hospital. His partner believes he will carry out this threat because he killed a dog in a previous relationship.

Appendix 10: Coercion and control related to mental illness in the context of family violence

Growing research evidence highlights the specific ways that mental illness is used and weaponised as part of perpetrating family violence (State of Victoria, 2018; Warshaw & Tinnon, 2018b). Equally, those perpetrating family violence often target a person's identity or specific circumstances, in particular people who are marginalised in society. This includes, but is not limited to, Aboriginal people, women with disabilities, women with mental illness diagnoses, refugees, migrants and LGBTQIA+ people (Allen + Clarke Consulting, 2023).

The following provides an overview of the ways mental illness is used to control a person in a family violence context.

Mental health coercion has been defined as (Warshaw & Tinnon, 2018b):

Abusive tactics targeted towards a partner's mental health as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include deliberately attempting to undermine a survivor's sanity, preventing a survivor from accessing treatment, controlling a survivor's medication, using a survivor's mental health to discredit them with sources of protection and support, leveraging a survivor's mental health to manipulate police or influence child custody decisions, and/or engaging mental health stigma to make a survivor think no one will believe them (p. 5).

Other examples of coercion in this context include (Department of Health and Human Services, 2018; Warshaw & Tinnon, 2018b; Warshaw & Zapata-Alma, 2020):

- telling someone that nobody will believe them because they are 'mad'
- undermining or stopping them from accessing mental health support
- forcing them to get mental health support against their will
- threatening to get them admitted into a psychiatric inpatient unit or calling the crisis team
- being pressured into taking medication when it suits the person using violence, rather than when appropriate (such as making them drowsy early in the day/evening)
- undermining their credibility with authorities, mental health services
- undermining their credibility with family, friends, neighbours or anybody who supports them
- deliberately 'playing into' someone's experience of delusions (such as moving furniture around and denying having done so)
- gaslighting: twisting situations to make the person feel 'crazy' and uncertain
- telling friends, family, work colleagues or mental health professionals that the person is 'unstable'
- using a mental health diagnosis to make false accusations
- continuously 'diagnosing' a person to destabilise them
- withholding medication or forcing (too much) medication
- turning children against her by inflating 'how sick she is'.

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