

**MCH MARAM Practice Note**

**for Screening and Identification of family violence**

(Multi-Agency Risk Assessment and Management Framework)

December 2021

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| Maternal and Child Health (MCH) MARAM Practice Note |
| **for Screening and Identification of family violence practice**  **(Multi Agency Risk Assessment and Management Framework)** |
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**Purpose**

This practice note supports MCH nurses in their responsibilities under MARAM to support victim survivors to screen and identify for family violence. It provides an overview of the MARAM responsibilities for MCH, how to apply them in clinical practice and how to utilise the Client Development Information System (CDIS) to document activity.

MCH MARAM responsibilities for screening and identification of family violence risk include:

* knowing the identifying signs of family violence and the evidence-based risk factors’
* engaging respectfully, safely and sensitively and asking questions about family violence with confidence’
* recognising children as victim survivors in their own right,
* sharing risk relevant information,
* managing family violence risk through referral and basic safety planning, and
* keeping perpetrators accountable and in view at a systems level.

It is important MCH nurses and family violence professionals working within a MCH service are supported through their organisations’ policies and procedures, and responsibility for the management of family violence is not solely left to the clinician who identified the risk.

# **Background**

The Victorian Government established MARAM as a legislative framework under Part 11 of the Family Violence Protection Act 2008 to guide organisations, services and professionals in the sector response for the identification, assessment and management of family violence risk.

MARAM sets out a system-wide approach and shared responsibility to guide professionals across an integrated service system to identify, assess and manage family violence risk. It provides a shared understanding of family violence and outlines the roles and responsibilities of services and professionals in family violence identification and intervention. The MARAM works in combination with the Family Violence Information Sharing Scheme (FVISS) to support adult and child victim survivors to effectively identify, assess and manage family violence risk, and to hold perpetrators in view and accountable;

The MARAM also works in combination with the FVISS and Child Information Sharing Scheme (CISS) to promote child wellbeing and safety.

CISS complements and supports child and family service reforms of The Orange Door and other child safety legislation, including the Child Safe Standards and Reportable Conduct Scheme.

MCH were prescribed to apply MARAM, FVISS and CISS from September 2018.

**The objectives of the MARAM Framework are to:**

* Increase the safety of people experiencing family violence
* Ensure the broad range of experiences across the spectrum of seriousness and presentations of risk are represented, including for Aboriginal and diverse communities, children, young people and older people, across identities, and family and relationships types
* Keep perpetrators in view and hold them accountable for their actions and behaviours
* Guide alignment with the Framework for use across a broader range of organisations and sectors who will have responsibilities to identify, assess and respond to family violence risk
* Ensure consistent use of the Framework across these organisations and sectors.

# **Screening and Identification Responsibilities for MCH**

Practitioners hold different [responsibilities](https://www.vic.gov.au/maram-victim-survivor-practice-guides) under MARAM targeted to their role within a given organisation or service. MCH nurses are prescribed at the Screening and Identification level which is inclusive of Responsibilities One, Two, Five, Six, Nine and Ten.

* **RESPONSIBILITY One: Respectful, sensitive & safe engagement**
* **RESPONSIBILITY Two: Identification of family violence risk**
  + - * Observable signs of trauma
      * Screening and Identification Tool
      * Response options and safety planning
* **RESPONSIBILITY Five: Seek secondary consultation** for comprehensive risk assessment, risk management and referrals
* **RESPONSIBILITY Six: Contribute to information sharing**with prescribed services
* **RESPONSIBILITY Nine: Contribute to coordinated risk management**
* **RESPONSIBILITY Ten: Collaborate for ongoing risk assessment and risk management**

Some practitioners working in MCH services, based on their skills, experience, capacity and role, may choose to extend their responsibilities to the **Brief and Intermediate** level for Risk Assessment and Management under **Responsibilities Three and Four**. This is a decision for each MCH service and can be implemented with further MARAM training over time.

**Responsibilities Seven and Eight** are reserved for the**Comprehensive level** for family violence risk assessment and management for specialist family violence services.

# **The Structured Professional Judgement Model**

MARAM incorporates a Structured Professional Judgement Model to guide all professionalsin determining the level or seriousness of risk for family violence.

**There are four components of the Structured Professional Judgement Model**

1. **Victim Survivor Self-Assessment**

MARAM is led by a victim survivor’s self-assessed level of risk for fear and safety, a strong predictor of family violence risk. However, there are some occasions where a victim may underestimate their risk or minimise the violence they are experiencing. MCH nurses must balance the victim survivor's self-assessment with the identified risk factors present and their own professional judgement.

In cases of extreme risk, MCH nurses may have to intervene where they have assessed the victim survivor is at the highest level of risk under MARAM for ‘lethality and harm’ at the level of **serious risk requiring immediate protection, (see table one - risk management, p 12 of this document).**

1. **Evidence-based risk factors**

The presence of family violence risk indicators does not necessarily mean family violence is occurring but does require the MCH nurse to ask prompting questions to find out more. The evidence-based risk factors are built into the **Screening and Identification Assessment Tool embedded in CDIS** to support identification of risk.

1. **Information Sharing**

The FVISS, makes it easier for professionals to request or share information, as authorised, about the risk factors present, observations and signs, or other relevant information which supports effective risk assessment and management. Professionals can also use the CISS to share information to support the broader wellbeing or safety of child victim survivors or adolescents using violence.

**4. Intersectional Analysis**

An intersectional analysis requires professionals toconsiders a persons’ unique identify and life experiences to respond safely and appropriately in clinical practice. Such considerations may include an individual’s age, identity,gender, sexual orientation, ethnicity, cultural background, language, religion, visa status, class, socioeconomic status, ability (including physical, neurological, cognitive, sensory, intellectual or psychosocial impairment and/or disability) and geographic location. An intersectional lens also requires putting aside personal biases and self-reflecting on practice.

In applying Structured Professional Judgement,consider whether the perpetrator’s use of violence is specifically targeting a victim’s identity, or whether there are structural inequalities or barriers.

[**MARAM Screening and Identification Practice Guide and Resources**](https://www.vic.gov.au/maram-practice-guides-and-resources/responsibility-2)

# **MARAM Screening and Identification for MCH**

MCH nurses play an important role in identifying family violence and providing information and support to mothers and their children. MCH nurses have the opportunity, through their clinical consultations, to observe women, their children and the physical environment for signs of family violence. These can include physical injury, poor emotional health and regulation, poor attachment with care givers, and developmental delays in infants and young children.

**Routine Universal Screening** is conducted at the four-week Key Age and Stage (KAS) consultation, where it is safe and appropriate to proceedusing the Screening and Identification questions in CDIS (see below ‘Opportunistic’ screening where not able to proceed at the four-week KAS consultation).

**Indicative Screening** occurs in any engagement wherever family violence indicators become suspected or identified, and where it is safe and appropriate to proceed.

Safe screening and identification takes place through observation and engagement with clients to identify family violence indicators and the MARAM evidence-based risk factors of family violence, and any changes in frequency or severity over time. MCH nurses have the unique opportunity to observe the family in their own home during the first KAS home visit and these observations are built upon with future client consultations.

**Safety and appropriateness to proceed** include the client being in a confidential space where they can respond to the screening without influence from another adult or older child that may restrict their answers to the questions raised.

Clients, where English is not their first language should always be assessed for their need for an interpreter. Family and friends **should never** be used to act in the role of an accredited interpreter as they:

* may not have the required language competence
* may lack impartiality
* are not bound by the same standards of conduct as accredited interpreters.

**In cases of family violence – using a family member to act in the role of an interpreter may further jeopardise the safety of the client.**

For further information on the **use of interpreters in clinical practice**, refer to the [Department of Health’s language services policy and guidelines](https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines).

**Opportunistic/Indicativescreening**

Although screening is conducted at the four-week KAS consultation, MCH nurses are able to offer support for family violence at any contact point with a client where family violence is suspected. If routine screening is unable to be performed or completed due to time constraints or safety and confidentiality issues, or if there are indicators of family violence, MCH nurses can utilise an additional family consultation to follow up with clients at a later stage. This ensures screening for family violence takes place and confidentiality and safety is adhered to.

MCH nurses should provide an additional family violence consultation to a client where any one of the following occurs:

inability to complete the family violence questions (e.g. at the four-week KAS consultation) because the partner or other family members were present

family violence has been disclosed or identified and more time is required for discussion or to complete a safety plan

the nurse suspects the family is experiencing family violence and requires additional time for exploration and discussion

the nurse or the family member/s require a joint consultation with a specialist family violence practitioner.

[**MCH Practice Note for the additional Family Violence consultation**](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/additional-family-violence-consultation)

# **Linking MARAM screening and identification to clinical practice and documentation**

Screening and identification of family violence for all MCH clients comes under MARAM [Responsibility 1 and 2](https://www.vic.gov.au/maram-practice-guides-and-resources). The following summarises how MCH nurses meetthese responsibilities, followed by CDIS process for documenting.

### **Responsibility 1 - Respectful, sensitive & safe engagement**

Using a person-centred approach

Requesting victim survivor's consent to undertake Screening and Identification assessment (if safe to proceed)

A cultural safety lens is always applied

Recognising and addressing barriers that impact a person’s support and safety options

Facilitating an accessible, culturally responsive environment for safe disclosure of information

Responding sensitively, including tailoring engagement to individual needs and identity

Recognising and responding to patterns of family violence risk indicators and MARAM risk factors

Providing key messaging that family violence is never acceptable

Taking time to reflect upon and validate the victim survivor's experience

**Responsibility 2 - Identification of Family Violence risk**

* [**MARAM Observable signs of Trauma**](https://www.vic.gov.au/sites/default/files/2019-07/Responsibility-2-Attachment-1-Observable-%20signs-of-trauma.DOCX) **(Appendix 1)**

Requesting victim survivor's consent to undertake Screening and Identification assessment (if safe to proceed)

Being clear and transparent with reporting responsibilities prior to proceeding through MARAM Screening and Identification questions

Clinical assessment with consent, includes assessment of client, infants and children for observable signs of trauma, and documented in CDIS.

Use of screening and identification tools to assess family violence, safety and emotional wellbeing, including the MARAM family violence screening and safety plan, parent/care giver psychological assessment, and the parent child interaction scale –infant toddler (Brigance 111).

Utilising the Structured Professional Judgment model to assess the level of seriousness of risk incorporating the nurses experience, skills and knowledge.

Educating the victim survivor on their level of risk

Respecting the victim survivor’s decision on how to proceed. The exception to this would be where the victim survivor is assessed at MARAM's highest level of risk or where there are children at risk: **Serious risk and requires immediate protection**

Connecting victim survivors with relevant services and options for their safety

Documenting the clients reported experience of any type of family violence in CDIS including utilising assessment tools, documenting all referrals internal and external and noting any other health care professionals involved in care to date, and noting all persons present at consultation

Identification of all family members who are impacted.

# **MARAM screening and identification assessment and recording in CDIS**

The following chart describes how Responsibility 1 and 2 of the MARAM screening and assessment are recorded in CDIS.

| # | Description | CDIS view |
| --- | --- | --- |
| **1** | **Complete Family Violence Assessment (MARAM)**  To be completed (where safe and appropriate to proceed):   * at the four-week KAS. * at any KAS or additional consultation * as part of the Consultation type - Family Consultation * anytime when family violence is suspected   If 'Yes' - all other Q's become mandatory  If 'No' - remaining fields are not mandatory (however advised to continue through questions if safe to do so)  Option to add relevant attachments  Add Comments  Add any further relevant details, including   * any identified risk factors * if session was interrupted record why in the Comments box, and follow up actions moving forward * If a secondary MCH family consultation is set up for follow up   Click Save | Graphical user interface, application  Description automatically generated |
| **2** | Consultation Type:  - Family Consultation  (MARAM assessment can be made in any consultation)  Select Reason:  - No prior opportunity to ask about FV  - Previous disclosure of FV  - Previous suspicion of FV  Allocate:  - Site / Centre  - Family present  - Other professionals present | Graphical user interface, text, application  Description automatically generated |
| **3** | Assessment / Intervention  - Family Violence Assessment (MARAM)  - Safety Plan (MARAM)  - Parent and Carers psychological assessment  - Parent-child interactions scale-Infant and toddler (Brigance III) | Graphical user interface, text, application  Description automatically generated |

### **Risk assessment and management of clients where family violence may be present.**

Where family violence is identified, MCH nurses work in partnership with the victim survivor/s to actively address immediate risk and safety concerns and undertake risk management through safety planning, sharing of information and referral. **This falls under** [**MARAM Responsibilities 5, 6, 9 & 10**](https://www.vic.gov.au/maram-practice-guides-and-resources)**.**

It is important to note that while intervention is made to lower risk for lethality and harm, it can also raise risk when the victim survivor attempts to leave the perpetrator, as the perpetrator believes their power and control over the victim survivor is threatened.

MCH nurses should take this into consideration particularly when identifying victim survivor's at MARAM's highest level of risk, i.e. Serious risk requiring immediate protection, whether immediate intervention is required, or whether it is safer for the victim survivor's circumstances to implement a strong safety plan and risk management strategies to prevent serious lethality and harm, and to identify a safer time for the victim survivor to separate from the perpetrator.

### **Responsibility 5. Seek secondary consultation for comprehensive risk assessment, risk management and referrals**

### Seekinternal supervision and consult with family violence specialists to collaborate on risk assessments and make active referrals for comprehensive specialist assessment where indicated.

* Referral of the victim survivor and children to services such as, but not limited to family services, family violence agencies, medical and allied health practitioners, counselling and emotional health support services, legal and protective services, housing and other relevant aid services and organisations in the local areas.

### **Responsibility 6 - Contribute to information sharing**

### 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 (ISEs) such as Victoria Police, Child Protection and state funded family violence specialists under the FVISS.Information relevant to risk assessment and management can also be shared with both prescribed and non-prescribed services using other permissions such as privacy laws. Information should also be shared under the CISS where relevant to promoting the broader wellbeing or safety of a child.

* Information can be shared with another ISE under the **FVISS** for a:
  + 1. **Family violence assessment purpose:** to share information with a **Risk Assessment Entity** to establish whether family violence risk is present, to correctly identify a perpetrator, and to assess the level of risk the perpetrator poses to the victim survivor.
    2. **Family violence protection purpose:**to share information to manage the risk of the perpetrator committing family violence, or the risk of the victim survivor(s) being subjected to family violence, including for ongoing risk assessment and management.Nurses can also share perpetrator information with the victim survivor to manage a risk to safety (without consent).
* TheCISS enables information to be shared to promote the wellbeing or safety of a child or group of children; and supports existing child safety legislation including the Child Safe Standards and Reportable Conduct Scheme 2018, Child Wellbeing and Safety Act (2005) and the Best Interests Framework.
* Nurses can share relevant information with non-prescribed organisations / workforces using other existing permissions to share, i.e. privacy laws with consent or without consent for the primary purpose or secondary related purpose it was collected and to lessen or prevent a serious threat.

[**See OVIC website for guidance**](https://ovic.vic.gov.au/book/ipp-2-use-and-disclosure/)

[**Guidance on sharing health information under Commonwealth laws**](https://www.oaic.gov.au/privacy/guidance-and-advice/guide-to-health-privacy/chapter-3-using-or-disclosing-health-information/)

* Record in CDIS all internal and external referrals in the management of the client experiencing family violence, completeall clinical notes and use appropriate assessment tools foruse across the MCH service.

### **Responsibility 9. Contribute to co-ordinated risk management**

* Engage with other services to provide co-ordinated risk management, to be led by a specialist family violence service if engaged with the family.
* Share information, report changes in circumstances, respond to requests for information.

### **Responsibility 10. Collaborate for ongoing risk assessment and management**

* Collaborate with other services to provide on-going risk management; this is likely to be led by a specialist family violence service if engaged with the family.
* Plan for ongoing risks through collaboratively monitoring, assessing and managing risk over time. This will identify changes in levels of risk and ensure risk management through the ongoing family violence assessments and screening tools, safety plans, parent care giver psychological assessment and parent child interaction scale - infant toddler (Brigance 111).

Table 1 –Risk Management - Levels of Risk

| MARAM level of Risk | Description | Response |
| --- | --- | --- |
| At Risk | High risk factors are not present.  Some recognised family violence risk factors are present, but protective factors and risk management strategies, such as advocacy, information sharing and victim survivor support and referral are in place to manage risk from the perpetrator.  Victim survivor self-assessed level of fear and risk is low, and safety is medium-high. | Not in immediate danger, but **unwilling** to receive further assistance:   * If children are involved, consider their wellbeing and safety and if further intervention is required, and any reporting requirements  * provide information about help and support available  * consider sharing information proactively * let the client know that they should seek assistance if their circumstances change * Complete [**Mandatory Reporting**](https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/mandatory-reporting) to Child Protection   <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/mandatory-reporting>  Not in immediate danger, and is **willing** to receive assistance   * If children are involved, consider their wellbeing and safety and if further intervention is required, and any reporting requirements * Create a safety plan noting services and options tailored for the victim survivor, including support to make a report to VicPol   + Refer and collaborate with a specialist family violence service for a comprehensive assessment |
| Elevated Risk | A number of risk factors are present, including some high-risk factors that are likely to continue without intervention.  The likelihood of a serious outcome is not high, however the impact of risk from the perpetrator is affecting the victim survivor’s day-to-day functioning.  Victim survivor self-assessed level of fear and risk is elevated, and safety is medium. |
| Serious Risk | A number of high-risk factors linked to lethality or serious injury are present. Risk factors may have changed / escalated in frequency.  Serious outcomes from current actions by the perpetrator has occurred, or is likely to continue imminently.  Immediate risk management is required to reduce risk or prevent a serious outcome from the identified threat posed by the perpetrator.  Statutory and non-statutory services response and coordinated and collaborative risk management is required.  Victim survivor self-assessed level of fear and risk is high - extremely high and safety is low. |
| Serious Risk Requiring Immediate Protection | This is an **additional sub-category within Serious Risk**where the victim survivor also requires a different response for **immediate protection**.  **At this level previous strategies for risk management have been unsuccessful.** Escalation of frequency of violence has occurred / is likely to occur.  Formally structured coordination and collaboration with statutory and non-statutory crisis response services for risk assessment and management, planning and intervention to lessen or remove serious risk that is likely to result in lethality or serious harm.  Victim survivor self-assessed level of fear and risk is high-extremely high and safety is extremely low.  In some cases, serious risk requires formally convened crisis responses, such as referral for a RAMP (Risk Assessment and Management Panel) response.it may be necessary to supersede privacy and consent as per information sharing legislation.  MCH nurses are supported by councils, and guided by ethics and principles of victim survivor agency. | In immediate danger or a crime has been committed, or is about to be committed:   * Direct victim survivor to call police with your support, or call the police on their behalf. In this category it may be necessary to supersede the victim survivor's wishes for their own safety, or of their children. * Seek support of a family violence crisis service, including to conduct a comprehensive assessment * Create a safety plan noting services and options tailored for the victim survivor, including support to make a report to VicPol * If children are involved, consider their wellbeing and safety and if further intervention is required, and any reporting requirements including a Child Protection report and * Complete [**Mandatory Reporting**](https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/mandatory-reporting) to Child Protection   <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/mandatory-reporting> |

## Create safety plan - recording in CDIS

| # | Description | CDIS view |
| --- | --- | --- |
| **4** | **Create Safety Plan (MARAM) under Assessment dropdown**  One Safety Plan for each victim survivor, including for each child  Select Intervention  - Safety Plan (MARAM)  Complete details for:  (\*indicates mandatory fields)  - Safe place to go:  - Emergency Contacts:  - System Intervention: (perpetrator detail)  - Safe Communication  - Transport:  - Items to take with you:  - Financial access:  Add any relevant attachments and general comments  Click Save | Graphical user interface, text, application  Description automatically generated  Graphical user interface, text, application  Description automatically generated |
| **5** | Topics Discussed:  - Select Family Violence, and any other relevant fields | Table  Description automatically generated with low confidence |
| **6** | **Making an External Referral**  See [**Child Development Information System External Referral Process**](https://www2.health.vic.gov.au/primary-and-community-health/maternal-child-health/child-development-information-system)  Ensure you add the Referral Reason by using the + button (this is how referral are counted for the annual report) | Graphical user interface  Description automatically generated  Graphical user interface, text, application  Description automatically generatedGraphical user interface, text, application  Description automatically generated |

# **CDIS- recording in the EMCH integrated program**

When working in CDIS for the EMCH program, CDIS is working on the capabilities of an integrated program. The following showsa walkthrough of recording family violence and MARAM activities in CDIS.

| # | Description | CDIS view |
| --- | --- | --- |
| **1** | Consultation List - select Enhanced MCH hyperlink  Option to open lead client's (mother) case file to **view Case Summary**  (or any member of the Enhanced case).  Add any other family who should be included in this case  Case summary screen is completed | A screenshot of a computer  Description automatically generated  Graphical user interface, application  Description automatically generated  Graphical user interface, application  Description automatically generated |
| **2** | Assessment / Interventions:  Select:  - FV Assessment (MARAM)  - Safety Plan (MARAM) | Graphical user interface, text  Description automatically generatedGraphical user interface, text, application, chat or text message  Description automatically generated |
|  | **Complete Family Violence Assessment (MARAM)**  Select client (mother) and add the required record-keeping action for each family member linked to the case.  Case notes, flags can be added separately to relevant family members that may not be part of the case, for example a sibling living in a different home.  If '**Yes**' - all other Q's become mandatory  If '**No**' - remaining fields are not mandatory (however advised to continue through questions if safe to do so)  Also an option to add any relevant attachments if relevant.  Comments:  (Note that any comments added here will be linked to the family members selected above.)  Add any further relevant details, including  - any identified risk factors  - if session was interrupted record why in the Comments box, and follow up actions moving forward  Click Save | Graphical user interface, text, application  Description automatically generated  Graphical user interface, text, application  Description automatically generated |
| **3** | Actions and Interventions  Update this field to reflect the actions taken following completion of assessments  Under Parent/family health, wellbeing and safety, select from:  - Family Violence Risk Assessment and Risk Management, including Safety Planning  - Referral to Child FIRST  - Referral to Orange Door | Graphical user interface, application  Description automatically generated |

# **Family violence MARAM case scenario for best practice**

This scenario may potentially cause distress or concern. Please access the Employee Assistance Program at your organisation, the Nurse and Midwife support service and clinical supervision if you require additional support to that offered by the Coordinator/Team Leader of the MCH Service.

**Setting the scene:**

**This case outlines a scenario occurring over time in relation to interactions with the MCH Service and has been developed from a combination of several case scenarios:**

* Family have not previously been seen by the Victorian MCH service.
* Family have moved from interstate where the previous children were born.
* Birth Notice received from delivering hospital
* Home visit organised as part of standard MCH practice
* Delivery by Caesarean Section – mother discharged herself stating that she had to get home to look after the other children.
* MCH obstetric discharge summary given to mother for the MCHN to receive at home-visit

**Best Practice:**

* Obstetric discharge summary provided to MCH service on discharge from hospital.

**KAS Home visit:**

Visit to new Mother with 7-day old newborn baby.

**Present in home:** birth mother, birth father, newborn baby ,18-month-old child, 3-year-old child (4-and-a-half-year-old child is at kindergarten).

Father remains with mother throughout the visit and is observed to loudly yell at the older children who are sitting in the room where the visit is being conducted. Children appear to withdraw and become quiet when father yells. The MCHN did not observe obvious actions by the children precipitating the yelling. Mother does not respond to the children or the yelling. Mother focuses completely on the baby and is gentle and attentive to the baby’s needs.

Home is spotlessly clean with no toys or books or entertainment present for the children.

Mother appears withdrawn and responds with simple yes/no answers to questions asked.

During the visit, the mother and MCHN go to the bedroom and shut the door to exam Mother’s LUSCS wound. MCHN attempts to ask mother whether she feels safe and supported but father enters the room without knocking.

**Best Practice:**

* The MCHN should record her observations about each family member, including ‘whether mother is free to meet with the MCHN on her own’, **p20 MCHS practice guidelines.** <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/maternal-child-health-service-practice-guideline>> link doesn’t work
* The observations and inability for the MCHN to ask the MARAM screening questions of the mother alone flags for the MCHN to plan an additional family violence consultation (CDIS consultation type – family consultation) follow up when safe to do so.
* Safety of the mother and children must be considered when the father is present
* Add a flag to mother and children’s histories e.g. Risk – Family/Parental factors – Family conflict or violence (add to the comments box relating to this)
* MCHN reviews the children’s reactions to their father’s yelling using a MERTIL trauma informed lens.

**Notes:**

* Case notes to highlight any observed family violence risk indicators and name any MARAM risk factors for client and relevant family members.
* Baby – KAS consultation notes are completed on the baby/Child, including a note about the interaction between the parents and the baby. All assessments relevant to the consultation are completed on this history, including the inability to complete the MARAM screening
* Mother – Any sensitive notes in relation to the observations, interactions, add to the mother’s history as an additional note. Reference to the observations made of the mother in relation to the father yelling at the children should also be made here.
* Father - Any sensitive notes in relation to the observations, interactions, add to the father’s history as an additional note.
* Other children – Notes about the reactions of the children to the yelling should be documented, if anything specific is noted for the other children as they are all under school age a note can be added to their histories.
* **[MARAM Observable signs of Trauma](https://www.vic.gov.au/sites/default/files/2019-07/Responsibility-2-Attachment-1-Observable-%20signs-of-trauma.DOCX) (2019)**

**2-week KAS Visit:**

Mother and father attend MCH Centre with their three children (the 4-and-a-half-year-old is at kindergarten). Children appear well dressed and two older children sit down at the small table where there are puzzles and books. Father answers many of the questions about the baby. When mother is asked questions, she glances at her husband before answering (appearing to gain permission to answer).

The 3-year-old child physically hits the 18-month-old child who starts to cry.

Father yells at the 18-month-old who attempts to come to her mother for comfort however the father roughly stops her from going to mother.

Father tells her not to be a sook. He tells his son, the 3-year-old not to play with the girly toys but to be a man.Mother does not intervene in any comforting of her 18-month-old child or to say anything to the husband about his behaviour to the children.

When mother is undressing baby, she appears flat and disengaged with the baby. When the baby cries, she does not comfort the baby but otherwise is gentle in her care of the baby.

Mother states that the baby is bottle fed as her husband did not think she had enough milk. The husband says that he is a boy, and he needs to be big and strong, and formula is better than his mother fussing over him.

Mother appears to have some difficulty getting up out of the chair at the end of the consultation and when the MCHN asks if she is feeling ok the husband says she is just lazy and not to worry about her.

There is no opportunity to ask the mother about how she is feeling and managing a newborn baby and her other children or about Family Violence.

When the husband is leaving, he says that she is not a good mother and that he has to do so much of the work to take care of the children. He refuses to elaborate further.

The MCHN reflects on the visit and the previous home visit and considers whether her observations about the mother and family may potentially identify risks to the mother and children of family violence.

**Best Practice:**

* The MCHN should record her observations about each family member
* The observations and inability for the MCHN to ask the MARAM screening questions of the mother alone flags for the MCHN to plan an additional family violence consultation (CDIS consultation type – family consultation) follow up when safe to do so.
* Safety of the mother and children must be considered when the father is present
* MCHN should discuss observations and concerns with MCH Coordinator/Team Leader, including information sharing options such as sharing concerning behaviour to a RAE

**Notes:**

* Case notes to highlight any observed family violence risk indicators and name any MARAM risk factors for client and relevant family members.
* Baby – KAS consultation notes are completed on the baby/child, including a note about the interaction between the parents and the baby. All assessments relevant to the consultation are completed on this history.
* Mother – Any sensitive notes in relation to the observations, interactions, add to the mother’s history as an additional note. A note about the inability of the mother to move freely should be included. The reaction of the mother to the attempt by the 18-month-old child to obtain comfort should also be noted.
* Father - Any sensitive notes in relation to the observations, interactions, add to the father’s history as an additional note.
* Other children – Observations in relation to the older children and interaction with their parents should be noted in their histories, if anything specific is noted for the other children as they are all under school age a note can be added to their histories.

**Secondary Consultation and follow up:**

MCHN has concerns about potential family violence occurring against the mother and the wellbeing of the children and discusses the family with the MCH Coordinator/Team Leader and the Enhanced MCHN.

It is agreed that the kindergarten could be contacted to ascertain whether they have concerns about the 4-year-old child.

Using the CISS, the MCHN approaches the kindergarten and asks for any issues or concerns in relation to the 4-year-old child. The kindergarten state that the child easily bruises, and the father says that she is just clumsy. The child appears quiet and reacts to loud noises and appears scared when males are near her. The kindergarten staff have not made a notification to Child Protection as they consider that there are no grounds to do so.

**Best Practice:**

* Record the Information request in the Child’s history
* Record the information received in the Child’s history
* Proactively share information with the kindergarten staff
* Encourage kindergarten staff to make a notification based on their observations and additional information proactively shared

Following further discussion with the Coordinator/Team Leader, Child Protection are contacted however the information about the 4-year-old is considered hearsay and Child Protection are unable to act on it without a specific notification from the kindergarten. Although they listen to the report of the MCHN they are unable to undertake a welfare check due to the vague information without any specific incidents or evidence. They confirm that the family are known to Child Protection through a report from an anonymous source about the welfare of the children which was vague and non-specific. The unsubstantiated case was closed and referred onto The Orange Door where the family refused any supportive child and family services. The case is closed.

**Notes:**

* Case notes to highlight any observed family violence risk indicators and name any MARAM risk factors for client and relevant family members.
* Record the secondary consultation in the children and mother’s histories
* Record the notification as a referral to child protection in each child’s history (complete an external referral to child protection for each child)
* Add a note in the mother’s history

Following advice from the Enhanced MCHN it is agreed that VICPOL will be contacted for information about the family using FVISS. VICPOL respond there have been five L17 incidents however the father has refused to engage with services. VICPOL report that the mother had denied any concerns at each visit. VICPOL state that without a specific incident they are unable to attend the home.

**Notes:**

* Record the FVISS information request in each child’s and the mother’s history
* Record the information received in each child’s history, mother’s history, and father’s history

MCHN rings home ascertains the mother is alone and asks the mother if she is able to attend a special MCH Family Consultation visit but the mother refuses as her husband is at work, and he would not like her to attend without him. The mother is offered a home visit to which she replies that she would need to make the visit when her husband is home, he does not like people visiting when he is not there. The MCHN seeks permission to undertake MARAM screening, taking consideration to disclose reporting responsibilities, and commences asking the MARAM screening questions, the mother hesitantly answers the first two questions as no and when asked the third question says she has to go as the children need her and gets off the phone quickly.

**Notes:**

* Record as a Family consultation in the mother’s history mode telephone, including the MARAM assessment, note in the comments why all questions were not completed

MCHN remains concerned following this contact with the mother and makes another Child Protection notification. The MCHN shares the information obtained from VICPOL and what the mother stated in relation to not taking up the offered MCH consultation either in the centre or at home without the father being present including her hesitancy and reason for not completing all MARAM questions.

**Notes:**

* Record the notification as a referral to child protection in each child’s history (complete an external referral to child protection for each child)

**4-week KAS**

Mother and father attend MCH Centre with their three children, the 4-year-old is at kindergarten. Children are well dressed.

Father answers many of the questions about the baby.

Again, when questions are asked of the mother, she glances at her husband before answering (appearing to gain permission to answer).

The 3-year-old child says they need to go to the toilet and reluctantly the father takes the child to the toilet.

The MCHN quickly undertakes the MARAM screening which the mother answers by denying that there are any concerns.

The MCHN says that help is available if mother ever needs it and that she and the children should be treated well and be safe at all times. MCHN explains that there are many services available and if mother ever has any concerns for her or her children’s safety to ring Police on 000 and they will help. Mother says her sister helps her and the MCHN says to talk to her sister about what to do if she feels unsafe.Father returns and KAS visit is abruptly ceased by him.

**Best Practice:**

* Safety of the mother and children must be considered when the father is present.
* The MCHN should record her observations about each family member
* The MCHN should record her safety conversation with the mother

**Notes:**

* Case notes to highlight any observed family violence risk indicators and name any MARAM risk factors for client and relevant family members.
* Baby – KAS consultation notes are completed on the baby/child, note the incomplete consultation and why including a note about the interaction between the parents and the baby. All assessments relevant to the consultation are completed on this history, note if any of these were unable to be fully completed.
* Mother – Any sensitive notes in relation to the observations and interactions, add to the mother’s history as an additional note, ensure a detailed record of the safety conversation is included, note the incomplete consultation and why
* Father - Any sensitive notes in relation to the observations and interactions, add to the father’s history as an additional note.
* Other children – if anything specific is noted for the other children as they are all under school age a note can be added to their histories.

**Secondary Consultation and follow up:**

MCHN should discuss observations and concerns with MCH Coordinator/Team Leader.

MCHN remains concerned – following this consultation and makes another notification to child protection.

MCHN seeks a secondary consultation with The Orange Door / Local Family Violence Service.

**Notes:**

* Record the notification as a referral to child protection in each child’s history (complete an external referral to child protection for each child)
* Add a note in the mother’s history
* Record the secondary consultations in the children and mother’s histories

**8-week KAS**

Family do not attend – MCHN attempts to contact family and mobile is not answered. Sends SMS by three, no response, Sends email / letter, no response. MCHN contacts kindergarten and 4-year-old child is still attending.

MCHN in conjunction with MCH Coordinator organises an Outreach visit to the kindergarten to offer MCH visits to family at the kindergarten.

Father brings 4-year-old to kindergarten and when approached by MCHN refuses to allow any of the children and his wife to engage with the MCH nurse, commenting that MCH service is no good for his family.

**Best Practice:**

* Child Protection notification made in relation to continued concerns and now disengagement with the MCH service.
* Discussion with MCH Coordinator/Team Leader (may include EMCH) about any additional actions which could be undertaken.
* Proactively share with VICPOL in relation to concerns for the mother and children’s safety considering the disengagement with the MCH service.
* Proactively share with The Orange Door / local Family Violence Service in relation to concerns for the mother and children’s safety considering the disengagement with the MCH service.

**Notes:**

* Record DNA from the CDIS calendar
* Record each separate follow up in CNP
* Record the contact with the kindergarten in the kindergarten child’s history
* Record the outreach visit and father’s response in the kindergarten child’s and father’s histories
* Record the secondary consultation in the children and mother’s histories
* Record the notification as a referral to child protection in each child’s history (complete an external referral to child protection for each child)
* Record Proactive sharing with VICPOL & Orange Door / Local Family Violence Service in the mother’s history using CNP and add a note to each child history

**Best Practice Note:**

To support staff through this process the provision of Clinical Supervision and the offering of EAP should be available and encouraged.

**Maternal and Child Health Program Standards p33**

4.3 (a)The Maternal and Child Health Service supports performance development of the maternal and child health workforce

* The maternal and child health workforce (with the exception of administration workers) is provided with appropriate clinical supervision, and supported by experienced and relevant workers and/or mentors.

# **MARAM Training and Resources**

[MARAM Training](https://www.vic.gov.au/training-for-information-sharing-and-maram)

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

[MCH Information Sharing Templates, with guidance on consent and sought views](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/maternal-and-child-health-resources#maramis)

[Victorian Government Information Sharing webpage](https://www.vic.gov.au/guides-templates-tools-for-information-sharing)

[List of Information Sharing Entities - a searchable database for ISE identification](https://iselist.www.vic.gov.au/ise/list/)

[Types of ISEs under FVISS and/ or CISS](https://www.vic.gov.au/ciss-and-fviss-who-can-share-information)

Information Sharing Enquiry Line: 1800 549 646

Family Violence Information Sharing Enquiry email: [CISandFVIS@education.vic.gov.au](mailto:CISandFVIS@education.vic.gov.au)

# **Flow Chart – Response options and safety plan**

Client in contact with MCH service

Signs and indicators of family violence present

Refer to guidance on Responsibility 2

MCH nurses are routinely screen all clients at the 4-week KAS visit

Yes

Ask screening& IdentificationQ's 1-7 to identify family violence.

Respect clients answers and provide information about help support available if they ever find themselves in a family violence situation

Is family violence occurring?

No

Yes

**IMMEDIATE DANGER**

(Adult and / or Child)

**NOT IN IMMEDIATE DANGER**

(Adult and/or Child)

If in immediate danger and person is willing to receive further assistance

* Call Police (000) if crime has been or likely to be committed
* Seek support of specialist family violence service
* Consider child wellbeing and safety and share information to provide if needed.

If not willing to receive assistance, particularly if children are affected consider referral and call Police (000)

If client is not in immediate danger and is willing to receive further assistance

* Note the services and options available to the victim survivor, including how to make a report to Victoria Police
* Consider child wellbeing and safety and share information to provide if needed.
* Refer and collaborate with a specialist family violence service for comprehensive assessment
* Undertake safety planning including for children

If client is not in immediate danger and is not willing to receive further assistance.

* Provide information about help and support that is available, including to make a report to Victoria Police, particularly if children are affected.
* Consider child wellbeing and safety and share information to provide if needed.
* Follow up with client to monitor closely