family safety victoria

ORIMA RESEARCH

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2019-20

Census of Workforces that Intersect with Family Violence

Survey Findings Report:
Specialist Family Violence Response Workforce

VICTORIA State Government

Census of Workforces that Intersect with Family Violence **2019-20**

Survey Findings Report: Specialist Family Violence Response Workforce

This project was conducted in accordance with the international quality standard ISO 20252, and complies with the Australian Privacy Principles contained in the Privacy Act 1988. ORIMA Research also adheres to the Privacy (Market and Social Research) Code 2014.

Acknowledgement of Aboriginal Victoria

We pay our respects to Aboriginal and Torres Strait Islander peoples past and present, their cultures and traditions and acknowledge their continuing connection to land, sea and community.

Contents

1 Introduction

Background

In March 2016, the Royal Commission into Family Violence (RCFV) delivered a multi-volume report with 227 recommendations directed at improving the foundations of the system, seizing opportunities to transform the way that the Victorian Government responds to family violence, and building the structures that will guide and oversee a long-term reform program that deals with all aspects of family violence.

The recommendations of the RCFV highlighted the lack of detailed knowledge and systematic collection of data about family violence and related workforces in Victoria, which has made effective industry and workforce planning challenging. The RCFV recommendations also confirmed the important role that these workforces play in identifying and addressing family violence.

In response to these findings, a commitment was made to undertake a family violence workforce census (the Census) every two years in a continued effort to address this gap. The first Census was conducted in 2017, and in July 2019, Family Safety Victoria (FSV) commissioned ORIMA Research to design and deliver the 2019-20 Census.

Research objectives

The overarching aim of the 2019-20 Census was to assist in deepening the Victorian Government's understanding of a range of issues in the context of reforms recommended by the RCFV.

More specifically, the Census aimed to:

- provide an evidence base for the analysis required to inform the Victorian Government's decisions relating to industry planning and associated workforce reforms; and
- enable a more nuanced understanding of specialist family violence and primary prevention workforces through targeted consultation, surveying and regional analyses of these workforces.

The findings of this Census will help the Victorian Government to better understand the breadth and nature of workforces that come into contact with family violence; identify opportunities to build on knowledge, support and capability; as well as build on what is known in order to maintain its commitment to keep improving family violence prevention and response in Victoria.

Three target groups (workforces) were identified for the Census, as detailed in Table 1 overleaf. This report presents the 2019-20 Census findings for the first target group listed – those who completed the Census in a specialist family violence response capacity[1].

1. Where respondents indicated that they held paid roles across multiple workforces, the initial screening questions directed them to complete the Census in the capacity of only one of these workforces. Please see Appendix A for the full questionnaire, including screening / routing rules.

Table 1: Target groups for the Census (workforces)	
Workforce	**Definition and example roles**
Specialist family violence services	– Those who work directly with victim survivors, perpetrators, or cases of family violence as a family violence response specialist; or – Those who work directly with family violence response specialists as a manager, supervisor or trainer; or in a capacity building, policy or practice development role. *Example roles: family violence or justice case manager, family violence outreach, refuge worker, counsellor / phone support, crisis worker, men's behaviour change practitioner or case manager, RAMP Coordinator, intake or enhanced intake, sexual assault worker, family violence court practitioner or family violence court registrar, etc.*
Primary prevention of family violence	– Those who work to prevent family violence through systemic / organisational / community-level initiatives. *Example roles: family violence primary prevention officer or practitioner, family violence or respectful relationships educator, gender equity officer, prevention of violence against women officer, family violence health promotion officer, manager or trainer of primary prevention officers or practitioners, etc.*
Broader workforce that intersects with family violence	– Those who are sometimes in contact with victim survivors or perpetrators of family violence and required to deal with the impacts of family violence, despite this not being a significant focus of their role. – This includes all types of workforces who work with women, families and children (or the broader community) as part of their day-to-day role even though it is not directly related to family violence. *Example roles: police officer, court registrar, ambulance officer, teacher, nurse, disability services worker, community services or social worker, prison officer, youth worker, residential home worker, developmental support officer, student support, Child & Family Wellbeing / Integrated Family Services worker, etc.*

Project development

Questionnaire development and sector consultation

The questionnaire (see Appendix A) was developed by ORIMA Research and the FSV project team, with content informed by the previous Census. The questionnaire was designed as a single instrument, with screening questions at the start to categorise respondents into one of the three workforces and route them through to the applicable survey questions.

Learnings from the 2017 Census led to the following changes being implemented in the current Census:

- Changes to workforce definition to improve data quality.
  - In 2017, respondents were categorised into four "tiers". For the 2019-20 Census, this approach was carefully revised and replaced with the three workforce categories outlined earlier in Table 1.
  - It should be noted that the current Census results for the specialist family violence response workforce are unable to be benchmarked against results from the 2017 Census, due to the substantial changes in the way workforces were defined in 2019-20.
- Extensive consultation with the sector to accurately inform the design and development of the questionnaire.
  - ORIMA Research and FSV conducted a series of consultative workshops, meetings and interviews with representatives from the target workforces between August and October 2019 (see Appendix B for a list of the stakeholders consulted).
  - The survey dissemination method and elements of the survey design, including the initial screening questions, were tested amongst the target workforces and iteratively refined.
  - A consultation summary report was prepared in November 2019, summarising participants' feedback and recommendations regarding survey communication, design and dissemination.
  - Sector consultation was made possible with the assistance of the Victorian Council of Social Services, Domestic Violence Victoria and No to Violence.

Research approvals

Ethics approval was granted for this project by the ORIMA Research Human Research Ethics Committee on Thursday 31 October 2019 (Approval Number: 0112019). Research approvals were also granted by the Victoria Police Research Committee and the Victorian Department of Education and Training Research in Victorian Government Schools and Early Childhood settings committee, to conduct research with their staff.

Pilot survey

The survey was administered using an online self-completion methodology. As part of the questionnaire finalisation process, a pilot was conducted between Monday 11 November and Friday 15 November 2019, to assess the suitability of survey design and content, and to test the online system and survey length.

Pilot participants were volunteers recruited by the FSV project team, and included individuals representing each of the three workforces. A total of n=16 individuals completed the pilot survey, from a pilot contact list of N=30.

Participants were asked to provide feedback via email. Comments made within the survey were also analysed and feedback was clarified directly with participants as required. Overall, the pilot was assessed as being successful as there were no substantial difficulties raised or improvement suggestions provided in relation to any aspect or question of the survey, and no critical survey issues were uncovered. A pilot testing outcome

summary was provided to the FSV project team which detailed some suggestions for improvement primarily in relation to optimising the clarity of some response options. Some valuable feedback was also provided in relation to accessibility, and some programming changes were made prior to full launch to optimise accessibility of the survey.

Following the pilot survey, the online survey was revised to incorporate pilot feedback, and was finalised in consultation with the FSV project team in preparation for the main fieldwork phase. The online survey underwent comprehensive internal testing by the ORIMA project team, as well as User Acceptance Testing by the FSV project team, prior to launch.

Main survey

The main survey was conducted between Monday 18 November 2019 and Friday 28 February 2020. A small extension was also granted for certain workforces until Friday 13 March 2020 in order to boost final response numbers. Participation in the survey was voluntary, and responses to the survey were private and confidential.

Survey dissemination (via Survey Coordinators)

The Victorian workforce intersecting with family violence is vast, and there is no central or reliable record of contact details for all individuals employed in this sector. Therefore, in order to conduct the Census, ORIMA Research and the FSV project team relied on sector, departmental, and organisational (or similar) representatives to assist in a controlled dissemination of a generic Census survey link.

These representatives, known as Survey Coordinators, were carefully recruited to ensure good coverage of all areas of the workforces that intersect with family violence in Victoria. Coordinators were asked to either email the survey link directly to their contacts, or act as an intermediary, by asking their contacts to share the link to relevant cohorts within their extended network.

A total of 22 Survey Coordinators assisted in promoting and disseminating the Census across the three workforces. Coordinators were provided with support materials to assist them in both identifying in-scope workforces and participants, and to share with these individuals. This ensured that a consistent and clear invitation and message was communicated across the sector.

Pre-registration

Prior to the main survey period, a Census pre-registration page was set up by ORIMA Research to support survey dissemination. This page allowed individuals to voluntarily register their email address to receive an invitation to the survey upon launch.

Response rate

In advance of fieldwork, the FSV project team undertook an extensive data collection exercise to estimate the population size for each of the relevant workforces for this project. Figures were collated via consultation with various organisational representatives across the sector. Estimated headcounts and/or full-time equivalent (FTE) figures were provided by key occupation groups. These figures were used to monitor response rates and are the basis for response rate figures below. Potential limitations regarding these estimates are outlined on the following page.

Overall, a total of 5,021 responses were received for the Census, including 1,575 from the specialist family violence response workforce (see Table 2).

Table 2: Response rate breakdown (based on population estimates)			
Workforce	**Population size (approximate)**	**Number of responses**	**Response rate**
Specialist family violence response	2,491	1,575	63%
Primary prevention of family violence	352	517	147%
Broader workforce that intersects with family violence	222,070	2,929	1%
TOTAL	**224,913**	**5,021**	**2%**

Response numbers were monitored by area throughout the fieldwork period to ensure good coverage was achieved across the state. Targeted communications were utilised as necessary to boost numbers in areas with fewer responses.

Population estimates

The following should be noted regarding the population size used to calculate the overall response rate:

- **Population figures that were used to calculate response rates are estimates of the true population size.** These figures were collated by the FSV project team in consultation with other government departments and workforce contacts. These estimates do not represent the estimated overall headcount at a single point in time (as different workforce contacts provided figures at different points over 2019) and do not consider vacancy rates. Although the available population figures are assumed to provide a good estimate of the size of the workforce, in the absence of any single and reliable source of data it cannot be known how closely these figures mirror that of the true population.
  - A key consideration regarding the estimated figures is that there is likely to have been some employee turnover or restructuring of roles / organisations since this estimate was collated. There is also a small risk that the original estimates may not have covered all in-scope areas of the workforce (though it should be noted that the FSV project team undertook a substantial amount of work to ensure all areas of the workforce were covered).
- **Respondents were responsible for classifying themselves into the correct survey** (by answering the screening questions), hence there is a risk that incorrect self-classification may have occurred for some. The project teams very carefully designed the screening questions in collaboration with the sector and provided a range of key roles as examples to assist respondents in classifying themselves correctly. The risk of incorrect self-classification was further mitigated where possible at the data processing stage, with any respondents who were identified as clearly answering the wrong survey (through their role and organisation type) were allocated back to the correct cohort.
  - It should be noted that respondents' interpretation of their own role may also be misaligned to FSV's understanding / classification. Role examples were provided to mitigate this however some respondents may have disagreed with their classification.

Statistical precision

As this survey was an attempted census of the specialist family violence workforce within Victoria (i.e. all those in scope for the survey were assumed to have been invited to participate, via either a personalised or generic survey link), the survey results are not subject to sampling error.

However, the survey is subject to potential non-sampling error, including coverage error and non-response error. Unlike sampling error, non-sampling error is generally not mathematically measurable. ORIMA Research uses several strategies to address sources of non-sampling error to the extent possible, including careful questionnaire construction and data processing quality control.

Presentation of results

Percentages in this report are based on the total number of valid responses made to the particular question being reported on. In most cases, results reflect those participants who expressed a view and for whom the questions were applicable. 'Don't know / can't say' and 'prefer not to answer' responses are included only where they aid in the interpretation of results. Results presented as percentages throughout the report may not add up to 100% (particularly where displayed in chart form) due to rounding, or where participants were able to select more than one response.

Results for demographic cohorts

This report presents the results for the specialist family violence response workorce at an aggregate / overall level.

A snapshot of results for key questions are provided for the following demographic cohorts:

- **Organisation type** – presented in tabular format in the body of the report; and
- **Location** – presented in tabular format in Appendix D.

In order to succinctly report the findings, results for other demographic cohorts (e.g. age, gender, years of experience, organisation size, etc.) are only presented in the body of this report where notable differences are observed.

Suppression rules have been implemented throughout this report whereby groups of individuals with fewer than 10 respondents have not been reported on to protect respondent confidentiality.

Please note that all results are self-reported by respondents and have not been verified against any external secondary data.

2 Executive summary

Role requirements

The Census identified the diversity of activities undertaken by the specialist family violence response workforce, and the varying frequencies at which these activities were conducted. The family violence response-specific activities most frequently undertaken by this workforce included identifying and screening for family violence risk, and monitoring on-going risk / changes in risk for a client.

Employment conditions

The results indicated that the roles held within the specialist family violence response workforce were highly varied in terms of working hours and contract conditions. Most employees reported that the number of hours they were employed to work was equivalent to the number of hours they ideally wanted to be employed. Over half also worked additional unpaid hours at least 'sometimes'.

Supervision

The specialist family violence response workforce was satisfied with the quality of support provided to them by their supervisor or direct manager. Having the opportunity to regularly discuss their professional development, or their work more generally, were key drivers of this satisfaction.

Training and confidence

While the specialist family violence response workforce had completed training across a range of topic areas, overall confidence in their level of training and experience was moderate. The findings highlighted MARAM (Multi-Agency Risk Assessment and Management) as a priority area for further / improved training and professional development.

Health and wellbeing

Overall, the results suggested that many within this workforce had experienced stress due to high workload. Despite this, few were dissatisfied in their current role and most felt that they made a difference to people affected by family violence.

Career and future intentions

The results showed that respondents were predominantly motivated to work in the specialist family violence response workforce due to a strong commitment to preventing / responding to family violence.

When asked about their future intentions, four-in-ten reported that they had plans to leave their current role in the next 12 months. The main reasons cited related to career prospects and lack of advancement opportunities, and stress or other negative influences on their health and wellbeing.

3 Profile of respondents

SPECIALIST FAMILY VIOLENCE RESPONSE WORKERS

work directly with victim survivors, perpetrators or cases of family violence as a family violence response specialist; or work directly with family violence response specialists as a manager, supervisor or trainer; or in a capacity building, policy or practice development role

Where do specialists work?

They work across **a range of different organisation types**, the top 10 being:

- 43% Specialist Family Violence Victim Survivor Services
- 9% Men's Behaviour Change
- 9% Legal Services
- 9% Specialist Family Violence Perpetrator Services (other than Men's Behaviour Change)
- 8% Community Health
- 6% Courts and Court Services
- 6% Hospital
- 6% Sexual Assault Services
- 4% Housing / Social Housing / Homelessness
- 3% Peak Body

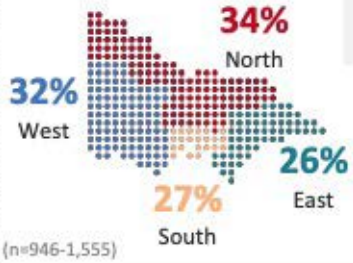
(n=1,400)

They work for both **large** and **small** organisations ...

- 68% work in organisations with **fewer than 100** individuals
- 31% work in organisations with **100 or more** individuals
- 1% are **self-employed** or have **'other'** circumstances

(n=1,549)

And **provide services all over Victoria**



(n=946-1,555)

- 22% State-wide / National
- 55% Metropolitan
- 46% Regional

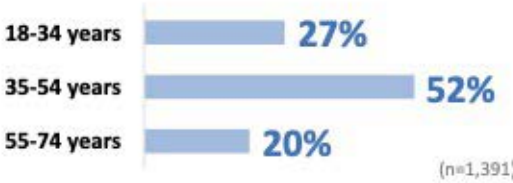
Who are the individuals in this workforce?

This is a predominantly **female** workforce

- 87% of the workforce identify as **female**
- 12% identify as **male**
- <1% self-described

(n=1,374)

Over half are **aged between 35 and 54**

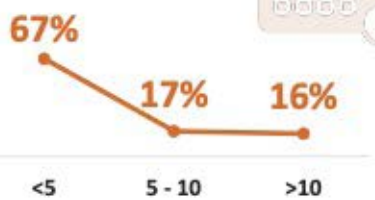


(n=1,391)

7% experience **difficulties or restrictions** which affect their participation in work activities

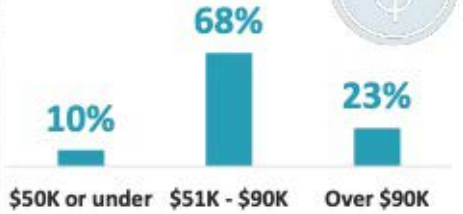
(n=1,336)

Most are fairly **new** to their current role, while others have been working in their current role for **a number of years**



Years of experience in current role (n=1,395)

The annual (individual) **income** for this workforce is varied, with the majority earning between $51K and $90K a year



Annual (individual) income (n=1,334)

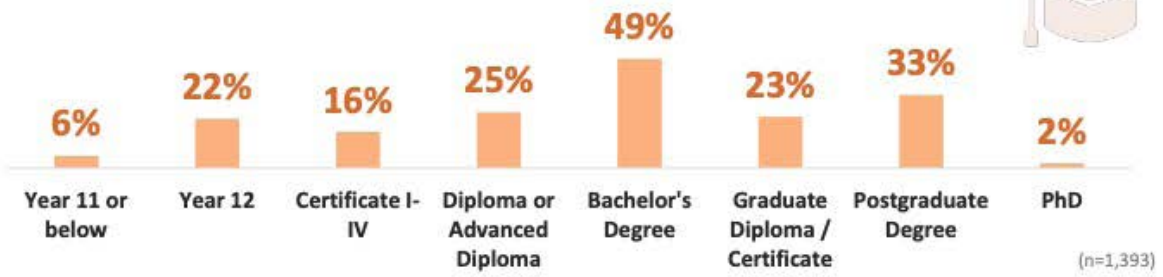
What level of education does this workforce hold?

This workforce has completed study in **various fields**, the top 10 being:

38%	Social Work	10%	Social Science
20%	Community Services	8%	Law
15%	Counselling	7%	Community Development
15%	Psychology	6%	Men's Behaviour Change
13%	Arts / Humanities	5%	Criminology / Legal Studies

(n= 1,365)

They most commonly hold a **Bachelor's Degree** or a **Postgraduate Degree**



(n=1,393)

What is the cultural diversity of this workforce?

The majority were **born in Australia** ...

Top 3 places of birth:

80%	6%	2%
Australia	United Kingdom	New Zealand

(n=1,363)

And **identify as Australian**

Top 3 cultural backgrounds / ethnicities:

70%	9%	4%
Australian	English	Irish

(n=1,347)

40% use their **cultural or faith-based knowledge and experience** in undertaking their work

(n=1,196)

93% speak English **at home**

1% also speak Mandarin, Spanish or Arabic at home

(n=1,384)

99% use English **to carry out their role**

1% also use at least one of the following to carry out their role: Mandarin, Hindi, Italian, Punjabi, or Spanish

(n=1,376)

3% identify as **Aboriginal or Torres Strait Islander**

(n=1,375)

4 Role requirements

Individuals within the specialist family violence response workforce:

- work directly with victim survivors, perpetrators or cases of family violence as a family violence response specialist; or
- work directly with family violence response specialists as a manager, supervisor or trainer; or in a capacity building, policy or practice development role.

This chapter summarises the role requirements of this workforce both generally and as they relate to family violence.

Overall, the Census results identified the diversity of activities undertaken by this workforce, and the varying frequencies at which these activities are conducted. Respondents were more likely to report that they frequently undertook family violence response-specific activities (such as identifying and screening for family violence risk), and worked on other non-response related activities relatively less frequently (particularly those related to the provision of clinical supervision and facilitation of group work / communities of practice).

Family violence response-specific activities

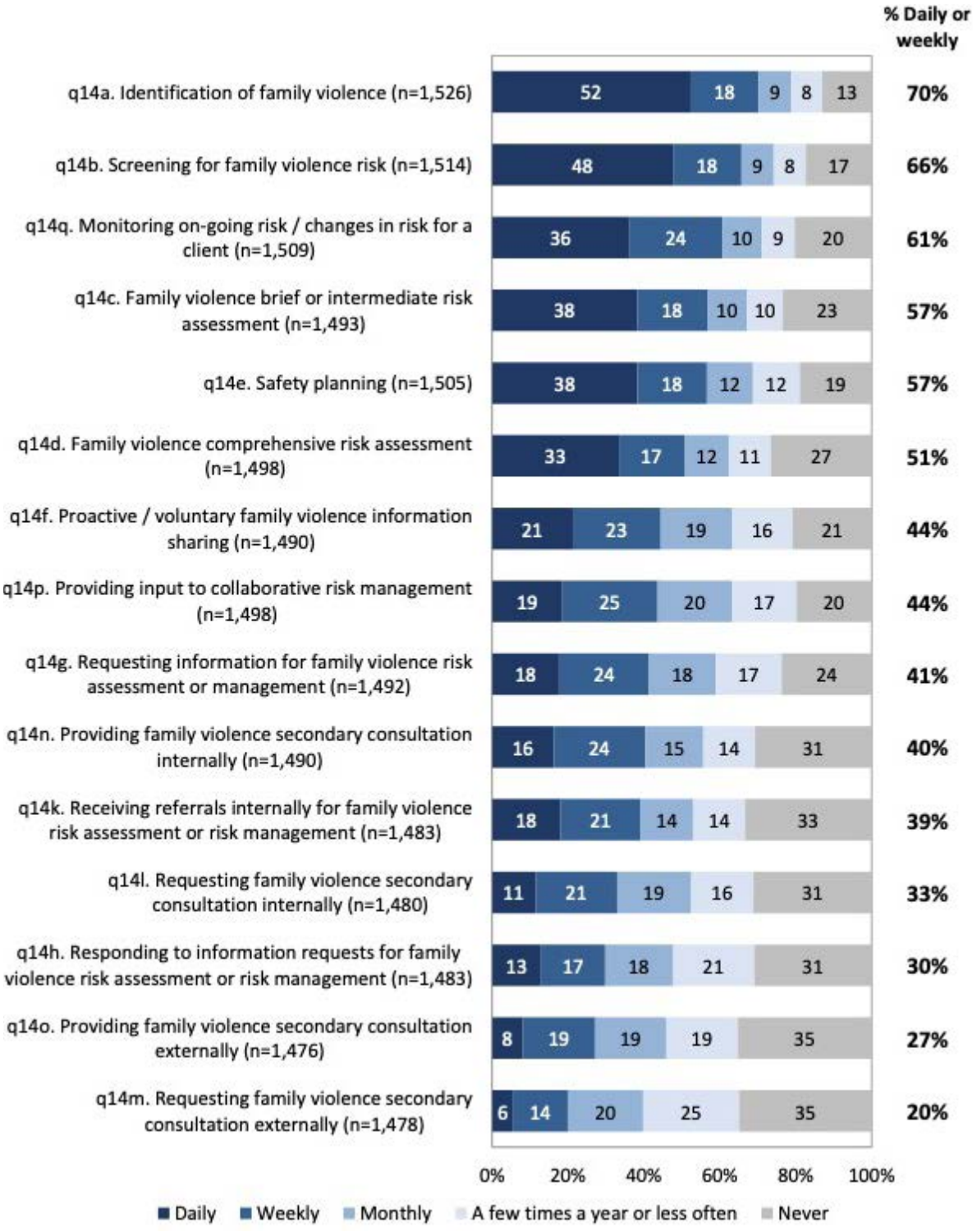
Respondents were asked about the frequency with which they worked on a number of family violence response related activities as part of their role. As shown in Figure 1 overleaf, overall, respondents undertook these activities more frequently (20%-70% daily or weekly) compared to the 'other' non-response related activities discussed later in this chapter (8%-54% daily or weekly).

Over three-in-five respondents reported that they frequently conducted the following activities at least weekly:

- identification of family violence (70%);
- screening for family violence risk (66%); and
- monitoring on-going risk / changes in risk for a client (61%).

Conversely, over one-third of respondents (35%) indicated that they never worked on activities related to providing or requesting family violence secondary consultation externally.

Figure 1: Role requirements – Family violence response-specific
Base: All respondents



Q14. Overall, how frequently do you work on the following activities?

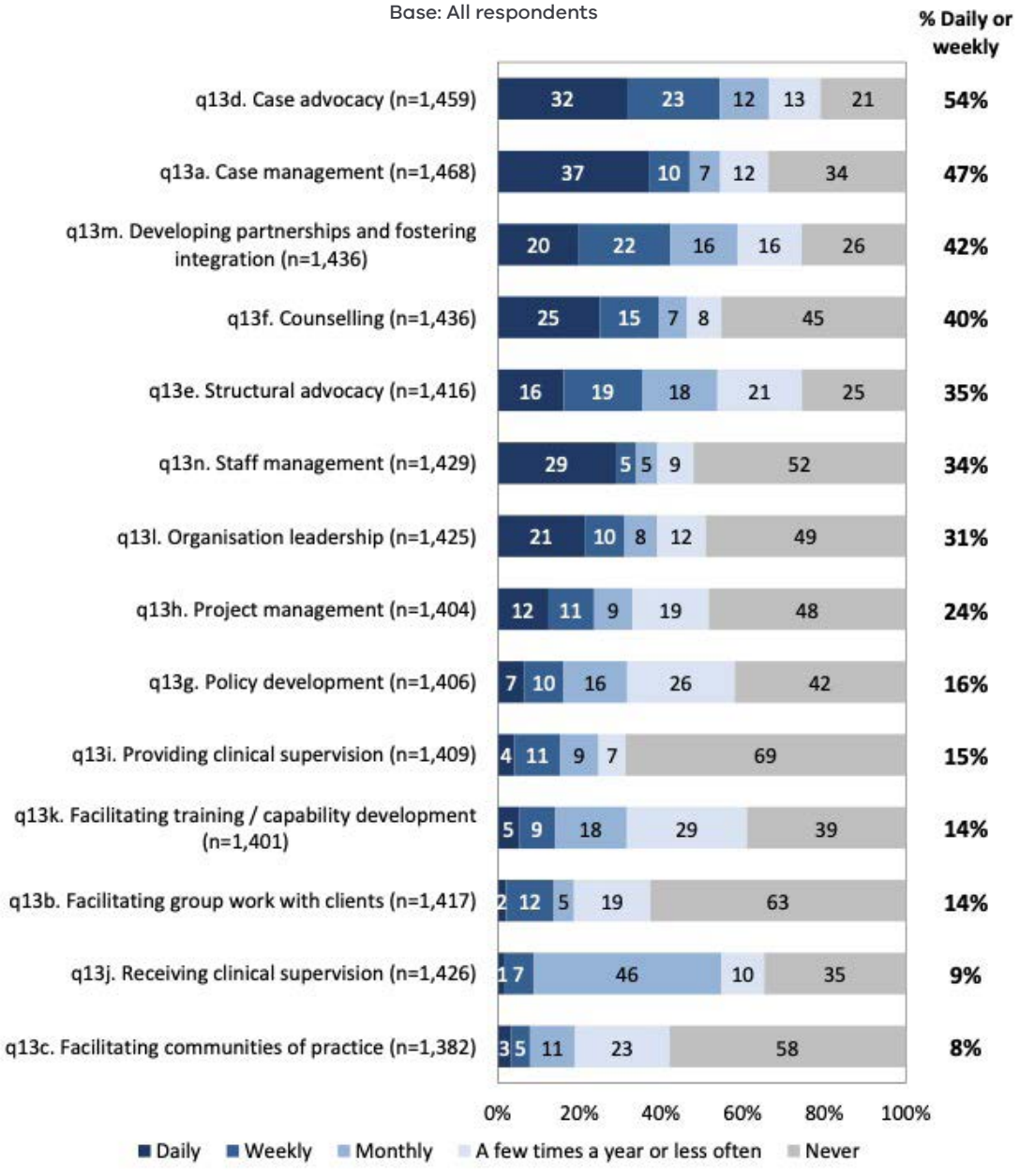
Other activities

Figure 2 illustrates the frequency with which family violence response specialists reported that they undertook various other activities as part of their role. Respondents most frequently worked on case-related activities, including case advocacy (54% indicated that they worked on this at least weekly) and case management (47%). At least two-in-five also indicated that they frequently developed partnerships and fostered integration (42%) and provided counselling services (40%).

In contrast, respondents were most likely to report that they never undertook the following:

- provide clinical supervision (69%);
- facilitate group work with clients (63%); and
- facilitate communities of practice (58%).

Figure 2: Role requirements – Other
Base: All respondents



Q13. Overall, how frequently do you work on the following activities?

5 Employment conditions

This chapter details the employment conditions of the specialist family violence response workforce. This includes the nature of contracts held (full-time, part-time, casual or other; ongoing versus fixed-term), average number of hours and days worked, and amount of unpaid work undertaken.

Exploring these conditions can assist in understanding any challenges this workforce may face in undertaking their work, and aid in the interpretation of subsequent results throughout this report.

Overall, the Census results indicated that the roles held within the specialist family violence response workforce were highly varied in terms of working hours and contract conditions (i.e. ongoing versus fixed-term). Most employees reported that the number of hours they were employed to work was equivalent to the number of hours they ideally wanted to be employed. Over half also worked additional unpaid hours at least 'sometimes'.

Figure 3 illustrates that respondents were most commonly employed on a full-time basis (58%), while 38% were employed on a part-time basis, and just 3% were casual or sessional employees.

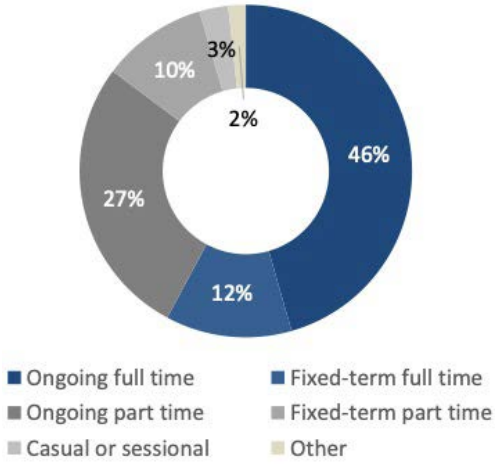
Furthermore, almost three-in-four respondents indicated that they were employed in an ongoing capacity (73%), while 23% held fixed-term roles.

Just over one-in-ten reported that they held at least one additional paid role outside of the specialist family violence response workforce (12%), and 7% held more than one paid role within this workforce.

As shown in Figure 4 overleaf, the majority of the workforce (73%) reported that in the past fortnight, the number of hours they were employed to work was equivalent to the number of hours they ideally wanted to be employed to work in this role. Those who reported that their hours worked were not ideal were slightly more likely to indicate that they worked in excess of their ideal hours (17%), compared to below their ideal hours (10%).

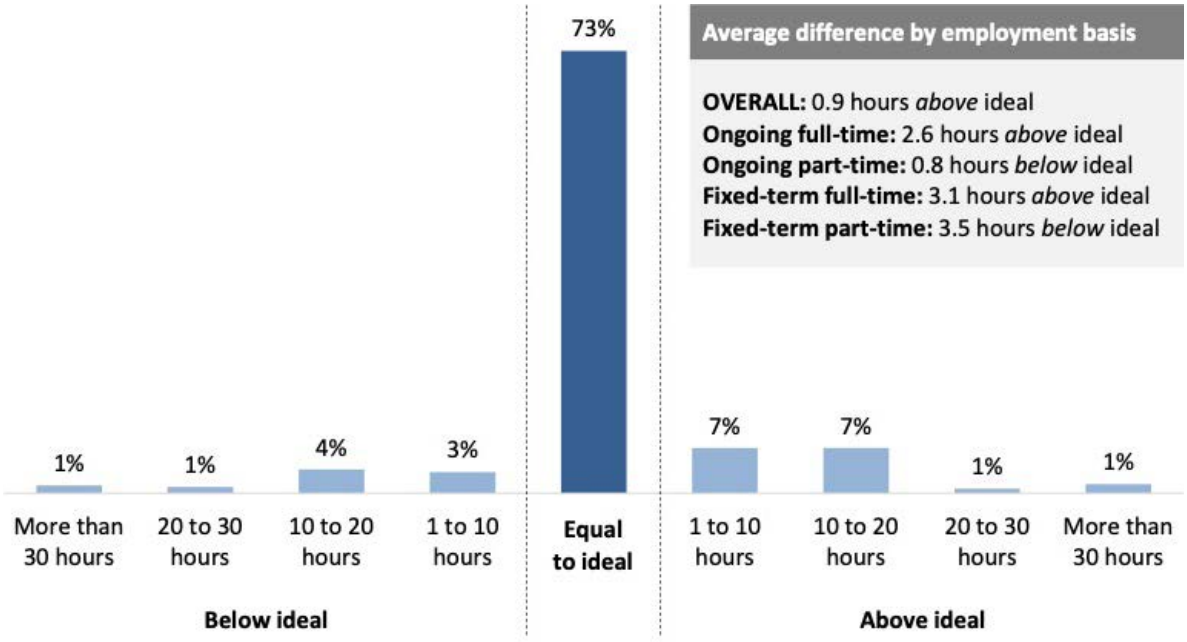
The difference between actual and ideal hours worked naturally varied by basis of employment, with part-time employees (particularly those in fixed-term roles) being generally more likely than full-time employees to report a desire to have been employed for a greater number of hours in the last fortnight.

Figure 3: Basis of employment
Base: All respondents (n=1,532)



Q16. On what basis are you employed in this role?

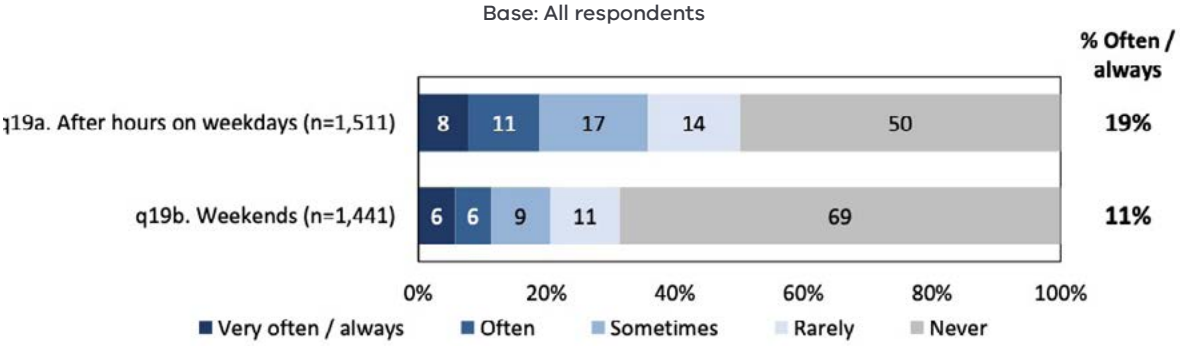
Figure 4: Difference between respondents' actual and ideal* hours worked in the past fortnight
Base: All respondents (n=1,486)



*Q17 / Q18. In the past fortnight, how many hours were you employed / did you ideally want to be employed to work in this role? (Note: only those who entered a positive numeric response for both questions are included in this analysis) *'Ideal' refers to the respondents' preferred number of hours that they would like to have been employed to work.*

The majority of respondents were generally paid to undertake their work during normal business hours. Around one-in-five reported that they were frequently[2] paid to undertake their work after hours on weekdays (19%), while 11% were frequently paid to work on weekends (see Figure 5).

Figure 5: Paid work outside of normal business hours
Base: All respondents



Q19a/b. How often are you paid to work outside of normal business hours (e.g. shift work / after hours or weekends), if at all?

Furthermore, respondents were also asked to provide comment about any unpaid work that they undertook. Overall, fewer than one-in-three respondents indicated that they frequently worked additional unpaid hours (17% often and 14% very often / always), though a further 26% reported that they sometimes did.

2. 'Often' or 'Very often / always'

Employment conditions differed by some demographic cohorts, as follows:

- **Age** – compared to the overall workforce, younger respondents aged under 35 were more likely to hold full-time roles (64% versus 58%), and less likely to report that they often worked additional unpaid hours (24% versus 31%).
- **Gender** – although a small proportion of the overall workforce (12%), males were substantially more likely to be employed on a full-time basis (73% versus 58% overall). Furthermore, while males were more likely to report that they were often paid to work after hours on weekdays (27% versus 19%), they were less likely to indicate that they often worked additional unpaid hours (24% versus 31%).
  - It should be noted that males were also most likely to work in perpetrator services / men's behaviour change, and the work undertaken in such roles often occurs after hours (see below).
- **Organisation type**
  - Full-time roles (58% overall) were most likely to be held by those working in courts and court services (81%), Aboriginal Community Controlled Organisations (73%), and multicultural or settlement services (71%).
  - Fixed-term contracts (23% overall) were most likely to be held by those employed in LGBTIQ services (60%) and peak bodies (48%).
  - Paid work outside of normal business hours (often undertaken by 11%-19% overall) was most frequently reported by those working in sexual assault services (24%-25%). Furthermore, those specialising in perpetrator services / men's behaviour change also reported that they were often paid to work after hours on weekdays (29%), and those employed in specialist family violence victim survivor services were frequently paid to work on weekends (18%).
  - Additional unpaid work (often undertaken by 31% overall) was most frequently reported by those working in women's health (43%), family safety contact (42%) and community health (40%).

3. Those working in child protection also reported that they frequently undertook paid work outside of normal business hours (20%-33%), however these results should be treated with caution due to the low sample size (n=15).
4. Practitioner responsible for partner and family contact responsibilities as part of a Men's Behaviour Change Program.

6 Supervision

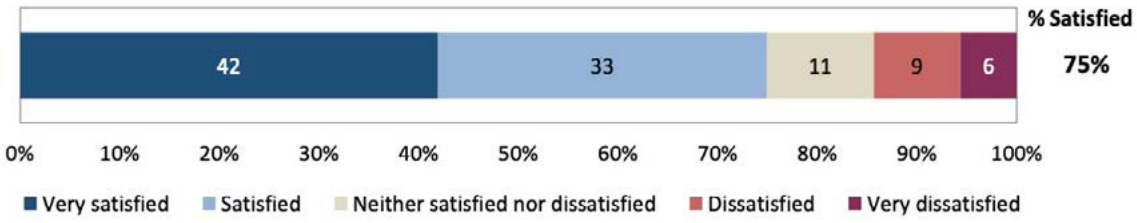
This chapter explores the extent to which the specialist family violence response workforce felt satisfied with both the quality of support provided by their supervisors and managers, and the quality of professional supervision provided to them by internal and external supervisors.

Overall, the results indicated that workers in the specialist family violence response workforce were **satisfied with the quality of support** provided to them by their supervisor or direct manager, and that having the opportunity to regularly discuss both their work and their professional development were key drivers of this satisfaction.

Additionally, this workforce was also broadly satisfied with the quality of professional supervision that they received, particularly with external supervisors (from outside of their organisation).

As illustrated in Figure 6, three-quarters of the specialist family violence response workforce reported that they were satisfied with the quality of supervision provided by their supervisor or manager (75%). Few were dissatisfied (14%).

Figure 6: Overall satisfaction with support provided by supervisor / manager
Base: All respondents (n=1,500)



Q22. Overall, how satisfied are you with the quality of support provided to you by your supervisor / direct manager?

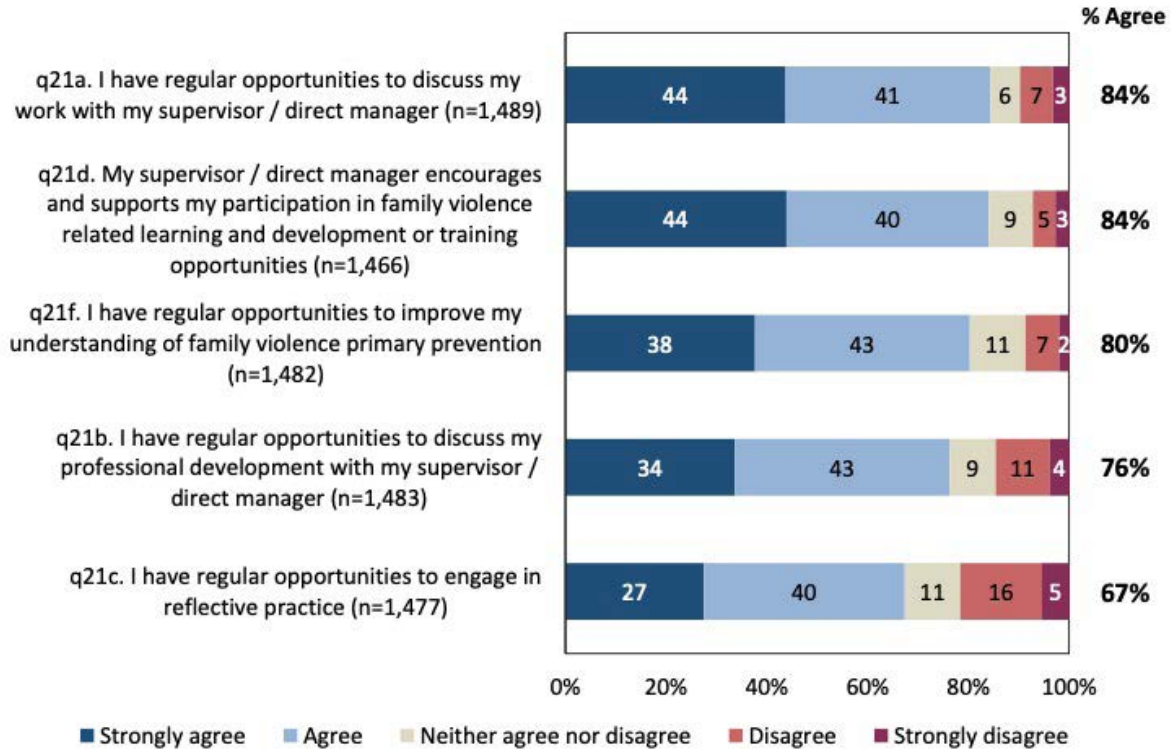
Additionally, many respondents agreed that:

- they have regular opportunities to discuss their work with their supervisor / direct manager (84%, see Figure 7); and
- their supervisor / direct manager encourages and supports their participation in family violence related learning and development or training opportunities (84%).

Though still fairly high, specialists were less likely to feel that they had regular opportunities to engage in reflective practice[5], with 67% agreeing that this was the case.

5. Reflective practice, also referred to as critical reflection or reflexivity, is a process of self-examination by a practitioner about their own work; becoming self-aware, considering their thoughts, feelings and assumptions, and examining how these impact upon their work.

Figure 7: Support / opportunity provided by manager
Base: All respondents



Q21. Please indicate the extent to which you agree or disagree with the following statements about the level of support and opportunity provided by your supervisor or manager. (Note Q21e not asked of this audience).

To determine what was most important in influencing the overall levels of satisfaction with support provided by supervisors / managers amongst this workforce, regression analysis was undertaken. The results suggest that the most influential drivers of satisfaction were having regular opportunities to discuss both their work generally, and their professional development.

Satisfaction with the quality of supervisory / managerial support differed by some demographic cohorts:

- **Age** – younger members of the workforce (aged under 35) were generally more satisfied with the quality of support provided by their supervisor or direct manager than their colleagues aged 35 years or older (77% versus 68%-75% of those aged 35-54 and 55+).
- A similar trend was reflected in relation to years of experience, with a general reduction in overall satisfaction reported as years of experience in their current role increased.
- **Organisation type** –see Table 3 (on page 23) for details.

Professional supervision

For the purposes of the Census, professional supervision is defined as:

> **supervision aimed at developing a practitioner's clinical awareness and skills in recognising and managing personal responses, value clashes and ethical dilemmas**

69% of the specialist family violence response workforce reported that they receive professional supervision in their current role; and

26% indicated that they were responsible for providing such supervision.[6]

Providing supervision

Professional supervision was most commonly provided by this workforce through individual / one-on-one sessions (70% of those who provided supervision did so in this way), while 28% provided both individual and group supervision. Just 2% provided supervision for groups only.

Most respondents who indicated that they provide professional supervision had been trained to provide such supervision (80%), though one-in-five had not received such training (20%). Furthermore, the majority provided supervision to either 1-5 staff (56%) or 6-10 staff (32%). A relatively small but notable proportion provided supervision to over 11 staff (12%).

Receiving supervision

Professional supervision was most commonly received by this workforce via a line manager (73%), though several also received professional supervision from an individual other than their line manager, with:

- 37% indicating that they received supervision from an external supervisor from outside their organisation; and
- 27% indicating that they received supervision from another internal supervisor.

Responses also suggested that all three supervisor cohorts were most likely to provide supervision through individual / one-on-one sessions (62%-98%), though external supervisors from outside of the organisation were more likely than internal supervisors to provide group sessions (55% of external supervisors, versus 14%-36% of line managers and other internal supervisors).

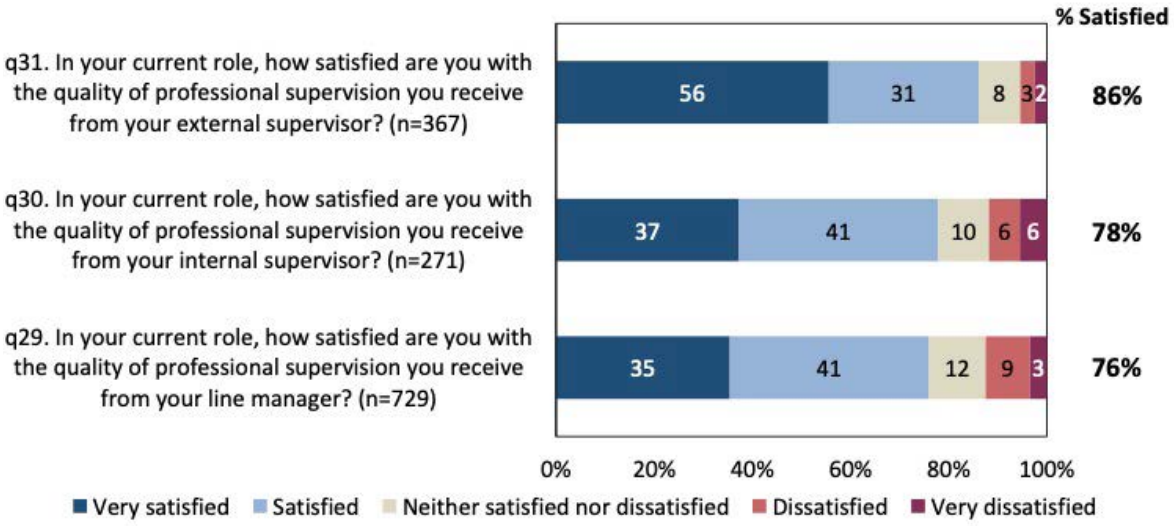
When asked about how often they received professional supervision, most indicated that this occurred at least every 2 months (93%).

- Respondents were most likely to report that this occurred between once a fortnight and once a month (41%) or between once a month and once every two months (36%). Thirteen percent also received supervision weekly to fortnightly.

As illustrated in Figure 8, this workforce was most satisfied with the quality of professional supervision provided by external supervisors (from outside of their organisation). However, it should be noted that satisfaction with internal supervisors was also high for many respondents (76%-78% were satisfied with line managers or other internal supervisors).

6. Q23. In your current role, do you provide or receive professional supervision? Multiple responses accepted (n=1,475)

Figure 8: Satisfaction with quality of professional supervision received
Base: Respondents who had received professional supervision from a line manager / internal supervisor / external supervisor



Results differed by years of experience – was the case regarding satisfaction with their direct supervisor / manager, there was a general reduction in overall satisfaction with professional supervision as years of experience in respondents' current role increased.

Key results by organisation type are shown in Table 3 below.

Table 3: Chapter 6 – Key results by organisation type				
	% Satisfied with the quality of...			
Organisation type	Overall support provided by **supervisor / direct manager** (Q22)	Professional supervision provided by **line manager** (Q29)	Professional supervision provided by **internal supervisor** (Q30)	Professional supervision provided by **internal supervisor** (Q30)
Overall workforce (n=271-1,500)*	75%	76%	78%	86%
Specialist family violence victim survivor services (n=94-576)	75%	77%	82%	86%
Specialist family violence perpetrator services / Men's behaviour change (n=48-195)	73%	76%	75%	83%
Aboriginal Community Controlled Organisation (n=6-38)	63%	67%	^	^
Alcohol or other drug services (n=9-41)	83%	75%	^	86%
Victims assistance (n=7-37)	73%	56%	^	60%
Peak body (n=3-45)	76%	88%	^	88%
Women's health (n=4-37)	70%	75%	^	88%
Child protection (n=4-14)	86%	^	^	^
Community health (n=17-110)	70%	67%	94%	93%
Courts and court services (n=17-84)	69%	79%	71%	71%
Family safety contact (n=6-37)	70%	82%	^	^
Hospital (n=9-71)	77%	64%	93%	^
Housing / Social housing / Homelessness (n=6-54)	78%	84%	^	^
Legal services (n=18-116)	74%	68%	61%	79%
LGBTIQ services (n=4-25)	68%	82%	^	90%
Mental health services (n=11-44)	70%	62%	100%	92%
Multicultural or settlement services (n=1-16)	63%	^	^	^
Older people (including elder abuse) services (n=1-15)	87%	^	^	^
Education and training provider (family violence) (n=6-37)	76%	73%	^	91%
Sexual assault services (n=20-72)	81%	78%	80%	90%
Regional integration (n=0-14)	93%	^	^	^

*n= indicates the range of the sample sizes across the four key questions. ^Result suppressed due to low sample size (n<10).

7 Training and confidence

This chapter discusses the extent to which respondents within the specialist family violence response workforce were confident in their role, as well as any training or professional development they had undertaken in a range of skill and capability areas, generally, and as they relate to family violence.

The Census results demonstrated that while the specialist family violence response workforce had completed training across a range of topic areas, overall confidence in their level of training and experience was moderate. The findings highlighted **MARAM** (Multi-Agency Risk Assessment and Management) as a priority area for further / improved training and professional development.

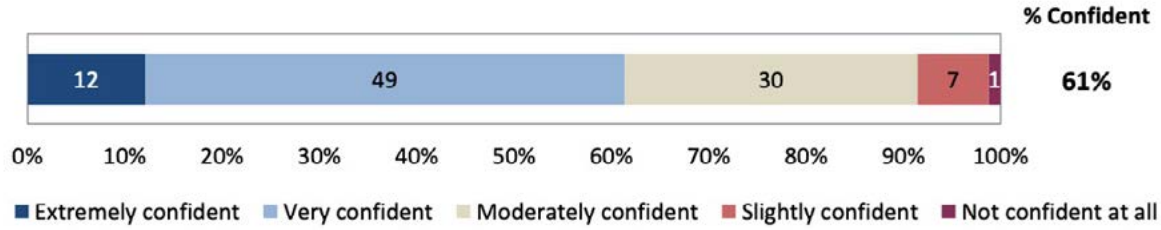
Furthermore, this workforce generally believed that **collaborative forms of additional support** (i.e. collaboration with other service providers, community of practice for specialist response workers) would be most useful in increasing their confidence in performing their role(s).

In terms of barriers to accessing further training and development, lack of time was the most commonly reported barrier, followed by cost of study and location of training facility.

Confidence

As illustrated in Figure 9, overall, around three-in-five respondents within the specialist family violence response workforce indicated that they were 'extremely' or 'very' confident that they have had enough training and experience to perform their role(s) effectively (61%). In contrast, just 9% reported that they were 'slightly' or 'not at all' confident.

Figure 9: Confidence in level of training and experience
Base: All respondents (n=1,486)



Q37. In relation to family violence response, how confident are you that you have had enough training and experience to perform your role(s) effectively?

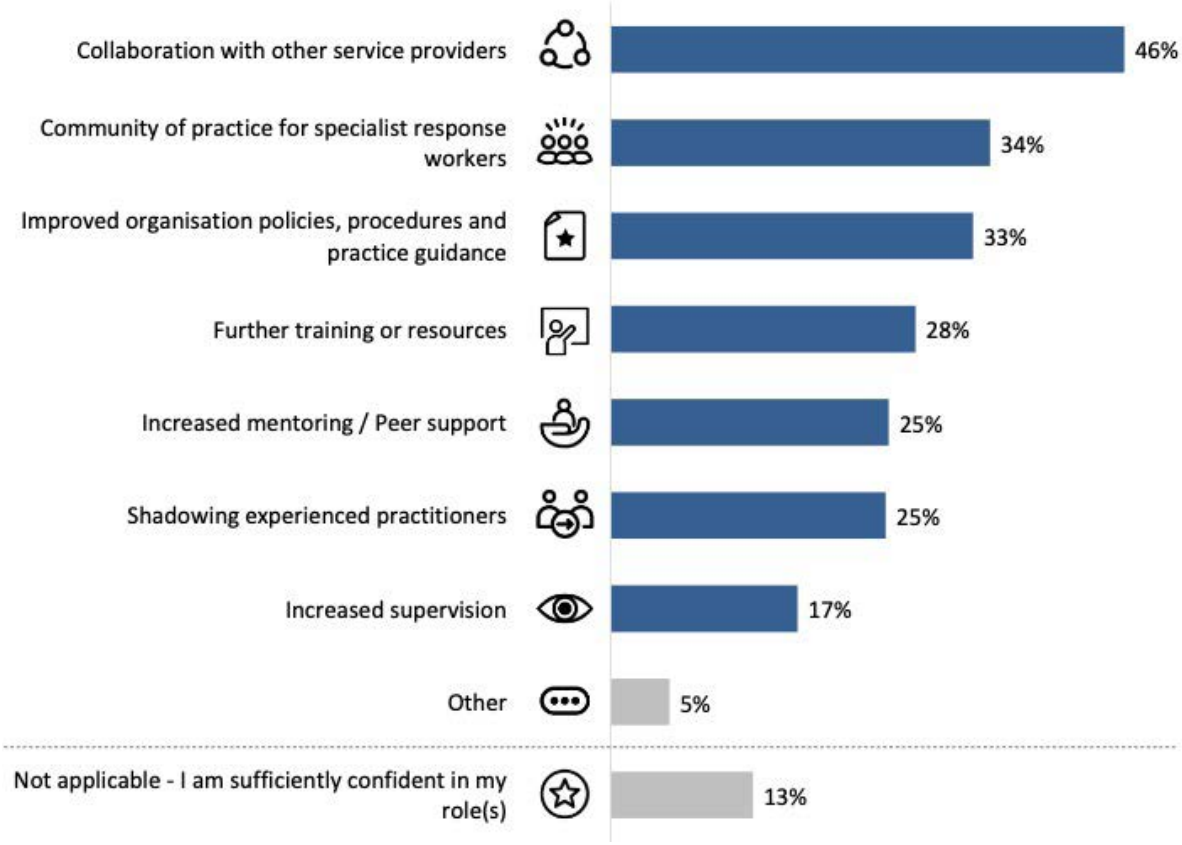
Confidence levels varied across some demographic cohorts, including:

- **Age** – confidence increased with age (59% for those aged under 35, 62% for those aged 35-54, and 66% for those aged 55+).
- **Years of Experience** – a similar trend was found in relation to years of experience. Respondents with 1 year of experience or less were substantially less confident than those with more experience.
- **Gender** – although a small proportion of the overall workforce (12%), males were considerably less confident compared to females (49% versus 63%).
- **Organisation type** – see Table 4 (on page 28) for details.

Respondents within the specialist family violence response workforce felt that the following additional support would be most useful in increasing their confidence in performing their role(s) (see Figure 10):

- collaboration with other service providers (46%);
- community of practice for specialist response workers (34%); and
- improved organisation policies, procedures and practice guidance (33%).

Figure 10: Additional support required to increase confidence
Base: All respondents (n=1,484); multiple responses accepted



Q38. In relation to family violence response, what additional support would increase your confidence in performing your role(s)?

Conversely, fewer than one-in-three respondents indicated that further training, increased mentoring / supervision or shadowing would be beneficial in this context. Furthermore, 13% reported that they felt sufficiently confident in their role, and therefore did not require additional support.

Results differed by **age** – younger respondents aged under 35 were considerably more likely than older respondents aged over 55 to report that they would benefit from shadowing experienced practitioners (41% versus 17%), improved organisation policies, procedures and practice guidance (47% versus 32%), and increased supervision (28% versus 15%).

MARAM

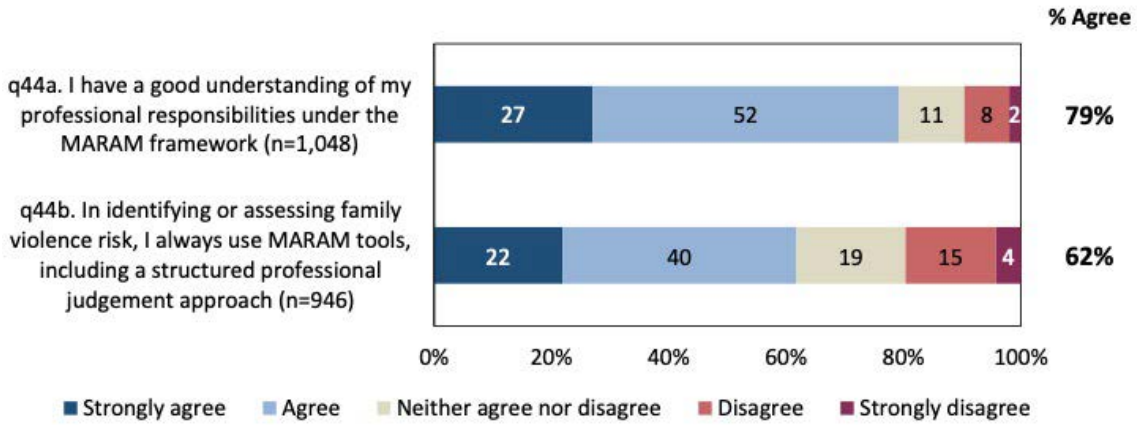
The family violence Multi-Agency Risk Assessment and Management (MARAM) framework provides guidance to organisations prescribed under regulations that have responsibilities in assessing and managing family violence risk. The framework is designed to ensure services are effectively identifying, assessing and managing family violence risk. A range of organisations were prescribed under MARAM in September 2018. Further information about the scope and timeline of MARAM reforms is available at **www.vic.gov.au/about-information-sharing-schemes-and-risk-management-framework.**

92% of respondents within the specialist family violence response workforce indicated that they had heard of the MARAM framework[8]; and of these,

81% understood that the organisation that they currently worked for was prescribed to align with the MARAM framework[9].

Of those who worked for organisations prescribed to align with the MARAM framework, understanding of one's professional responsibilities under the framework was widespread (79% – see Figure 11). Additionally, a majority (62%) consistently used MARAM tools (including a structured professional judgement approach) in identifying or assessing family violence risk.

Figure 11: Understanding of MARAM responsibilities and use of MARAM tools
Base: Respondents working for organisations prescribed to align with the MARAM framework



Q44. It is understood that not all MARAM tools have been released to date. However, please answer the following in relation to identifying risk for victim survivors by indicating the extent to which you agree or disagree with the following.

Understanding and usage levels differed across certain demographic cohorts, including:

- **Organisation size** – those working in large organisations (200 or more employees) generally reported lower understanding and usage compare to those working in small (1-49 employees) or medium (50-199) sized organisations.
- **Level of remoteness** – those working in regional locations reported higher usage of MARAM tools in identifying or assessing family violence risk, compared to those in metropolitan locations.
- **Organisation type** – see Table 4 (on page 28) for details.

7. https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management
8. Q42. Before today, had you heard of the Multi-Agency Risk Assessment and Management (MARAM) framework? (n=1,482)
9. Q43. Is the organisation that you work for in your current role prescribed to align with the Multi-Agency Risk Assessment and Management (MARAM) framework? (n=1,356)

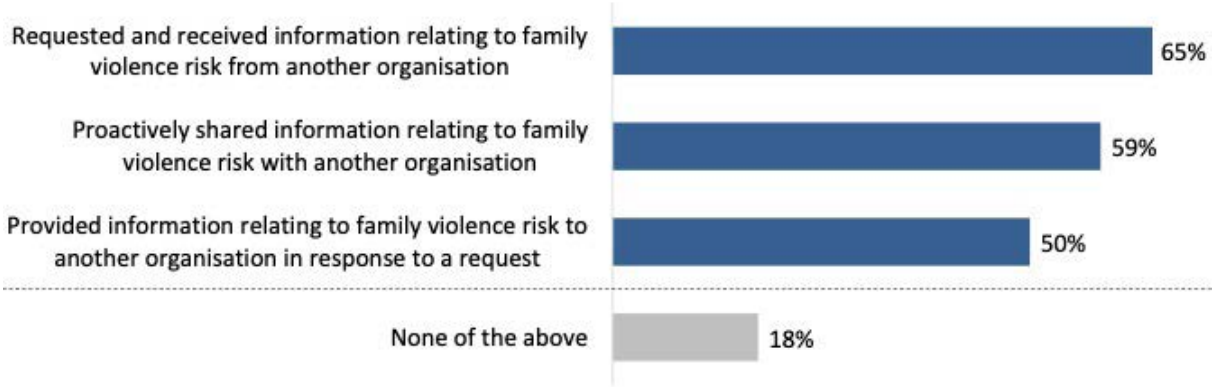
81% of respondents within the specialist family violence response workforce felt that they had a 'good' or 'very good' understanding of their responsibilities to share information relating to family violence risk under relevant Information Sharing Schemes and privacy law.[10]

Reported understanding of information sharing responsibilities did not vary substantially across most demographic cohorts, but did differ slightly by organisation type (see Table 4 on page 28 for details).

Figure 12 shows that conduct of information sharing activities under the Family Violence Information Sharing Scheme (FVISS) was moderate, with:

- the most common activity undertaken in the past year being the request and receipt of information relating to family violence risk from another organisation (65%); and
- just under one-in-five indicating that they had not undertaken any information sharing activities under the FVISS in the past year (18%).

Figure 12: Information sharing relating to family violence risk
Base: Respondents who were responsible for sharing information relating to family violence risk under relevant Information Sharing Schemes and privacy law as part of their role (n=1,159); multiple responses accepted



Q47. In the past year, which of the following have you done (under the FVISS)?

By organisation type[11], the level of information sharing activity was:

- **highest** among those working in specialist family violence victim survivor services (89% had undertaken at least one activity in the past year), and courts and court services (88%)[12]; and
- **lowest** among those employed in legal services (43% had not conducted any of the listed activities in the past year), and hospitals (40%).

Results also differed by employment basis – those holding ongoing full-time roles reported higher levels of information sharing activity (85% undertook at least one activity in the past year), while those in casual or sessional roles reported the lowest activity (69%).

10. Q46. Please rate your understanding of your responsibilities to share information relating to family violence risk under the Family Violence Information Sharing Scheme (FVISS), Child Information Sharing Scheme (CISS) and relevant privacy law. (n=1,343)
11. FVISS enables prescribed Information Sharing Entities (ISEs) to share information with each other to assess and manage of family violence risk to children and adults. Some ISEs are prescribed for specific services, rather than the entire organisation. Further detail on the FVISS is available at www.vic.gov.au/about-information-sharing-schemes-and-risk-management-framework
12. Those working in child protection also reported a high level of information sharing activity (90%), however this result should be treated with caution due to the low sample size (n=10).

Key results by organisation type are shown in Table 4 below.

Table 4: Chapter 7 – Key results by organisation type				
Organisation type	**Confidence** in level of training and experience (% confident at Q37)	Understanding of **responsibilities under MARAM** (% agree at Q44a)	Usage of **MARAM tools** (% agree at Q44b)	Understanding of **information sharing responsibilities** (% good at Q46)
Overall workforce (n=946-1,486)*	61%	79%	62%	81%
Specialist family violence victim survivor services (n=448-570)	72%	82%	64%	87%
Specialist family violence perpetrator services / Men's behaviour change (n=142-190)	59%	86%	65%	86%
Aboriginal Community Controlled Organisation (n=27-36)	58%	96%	74%	85%
Alcohol or other drug services (n=33-40)	45%	76%	58%	85%
Victims assistance (n=26-38)	53%	67%	58%	71%
Peak body (n=13-46)	57%	87%	62%	65%
Women's health (n=13-36)	61%	78%	54%	66%
Child protection (n=9-14)	79%	91%	^	93%
Community health (n=70-108)	50%	80%	64%	79%
Courts and court services (n=50-84)	57%	63%	32%	80%
Family safety contact (n=31-37)	70%	84%	65%	88%
Hospital (n=24-70)	59%	57%	38%	66%
Housing / Social housing / Homelessness (n=38-53)	58%	79%	50%	73%
Legal services (n=16-110)	55%	75%	50%	65%
LGBTIQ services (n=13-23)	61%	86%	85%	86%
Mental health services (n=27-42)	52%	67%	48%	70%
Multicultural or settlement services (n=10-16)	31%	80%	70%	64%
Older people (including elder abuse) services (n=5-15)	60%	^	^	75%
Education and training provider (family violence) (n=16-38)	71%	78%	69%	75%
Sexual assault services (n=55-72)	57%	81%	55%	80%
Regional integration (n=8-13)	77%	82%	^	90%

*n= indicates the range of the sample sizes across the four key questions. ^Result suppressed due to low sample size (n<10).

Training

The specialist family violence response workforce was asked to identify both the family violence prevention and response topics that they had completed training in, and those they would like further training in.

As illustrated in Figure 13 overleaf, at least two-in-three respondents had completed training in relation to:

- family violence risk assessment and risk management (CRAF – 73%);
- identifying and screening family violence (69%); and
- trauma-informed practice (67%).

The topics which respondents felt they required further training in were generally those with lower completion rates, including training related to:

- working with people with disabilities (25% had completed training, 50% desired further training);
- working with adolescents (25% had completed training, 48% desired further training);
- sexual assault in family violence (31% had completed training, 48% desired further training); and
- RAMP (19% had completed training, 47% desired further training).

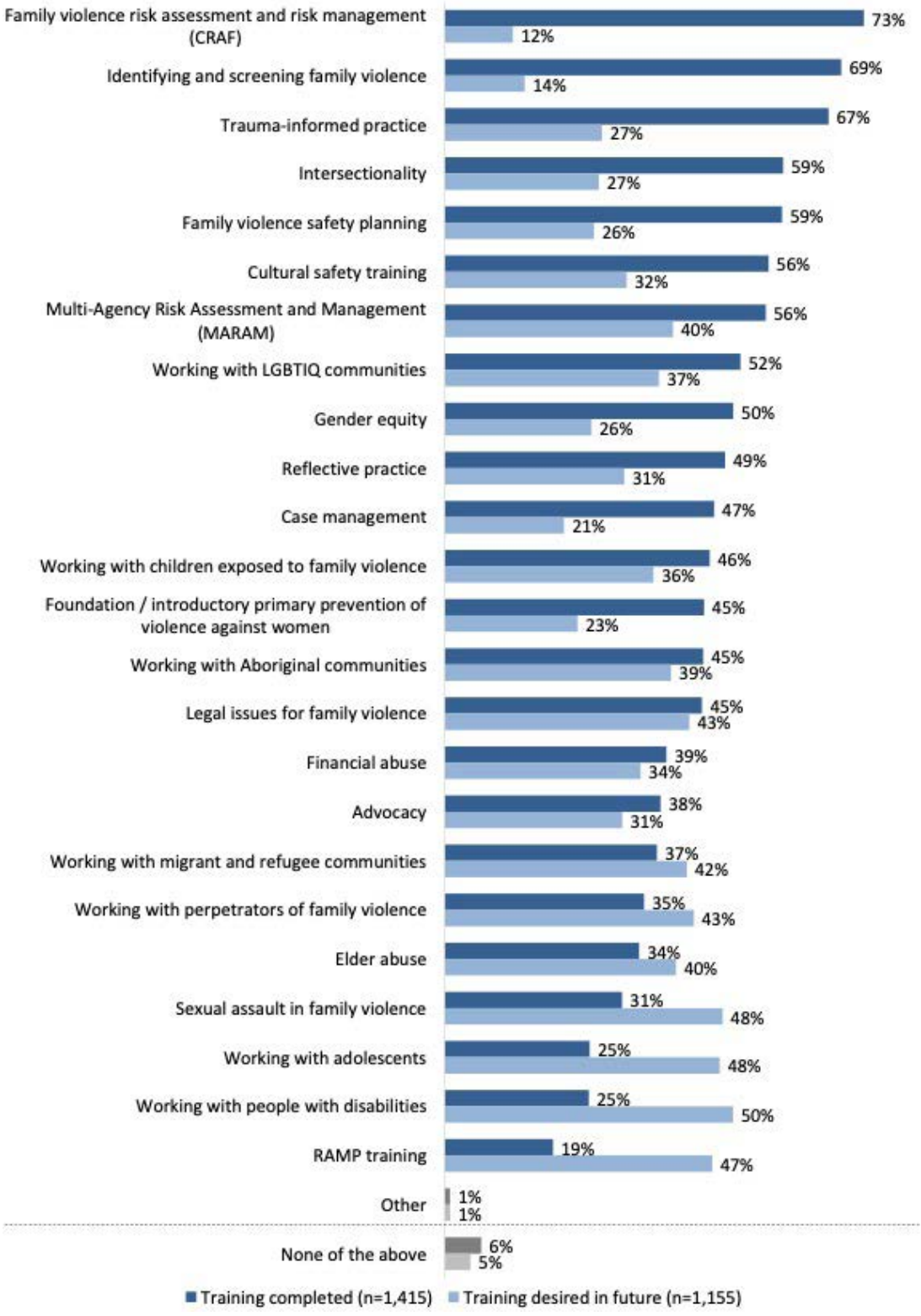
Those who had completed training in each topic area were then asked to assess the degree to which they believed the training had assisted them in undertaking their work more effectively. Figure 14 (see page 31) shows that perceived helpfulness was high across most topic areas, and was highest in relation to training in:

- trauma-informed practice (88% found training in this topic to be 'extremely' or 'very' helpful);
- working with children exposed to family violence (85% felt this was 'extremely' or 'very' helpful);
- identifying and screening family violence (82% felt this was 'extremely' or 'very' helpful); and
- sexual assault in family violence (82% felt this was 'extremely' or 'very' helpful).

In contrast, although the proportions were not particularly low (still greater than half), respondents were least likely to feel that training undertaken in the following topics was helpful, suggesting that there is an opportunity to review and improve training in these areas:

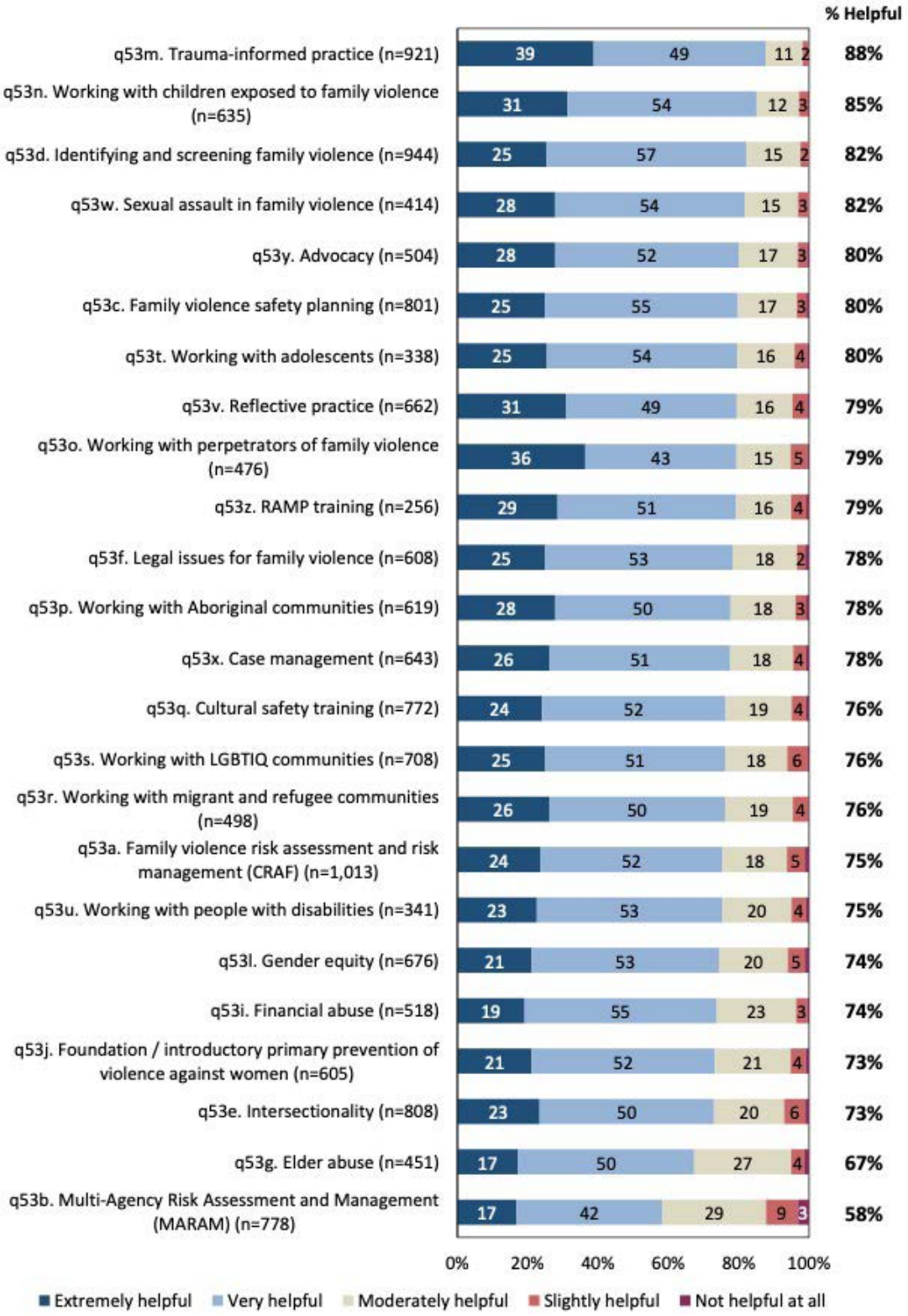
- MARAM (58% felt this was 'extremely' or 'very' helpful); and
- elder abuse (67% felt this was 'extremely' or 'very' helpful).

Figure 13: Training completed / desired
Base: All respondents; multiple responses accepted



Q52. In relation to family violence prevention and response, which topics have you completed training in, and which topics would you like further training in?

Figure 14: Perceived helpfulness of training
Base: Respondents who had completed training in each topic area



Q53. In general, how helpful has the training in each of these topics or areas been in assisting you to undertake your work more effectively?

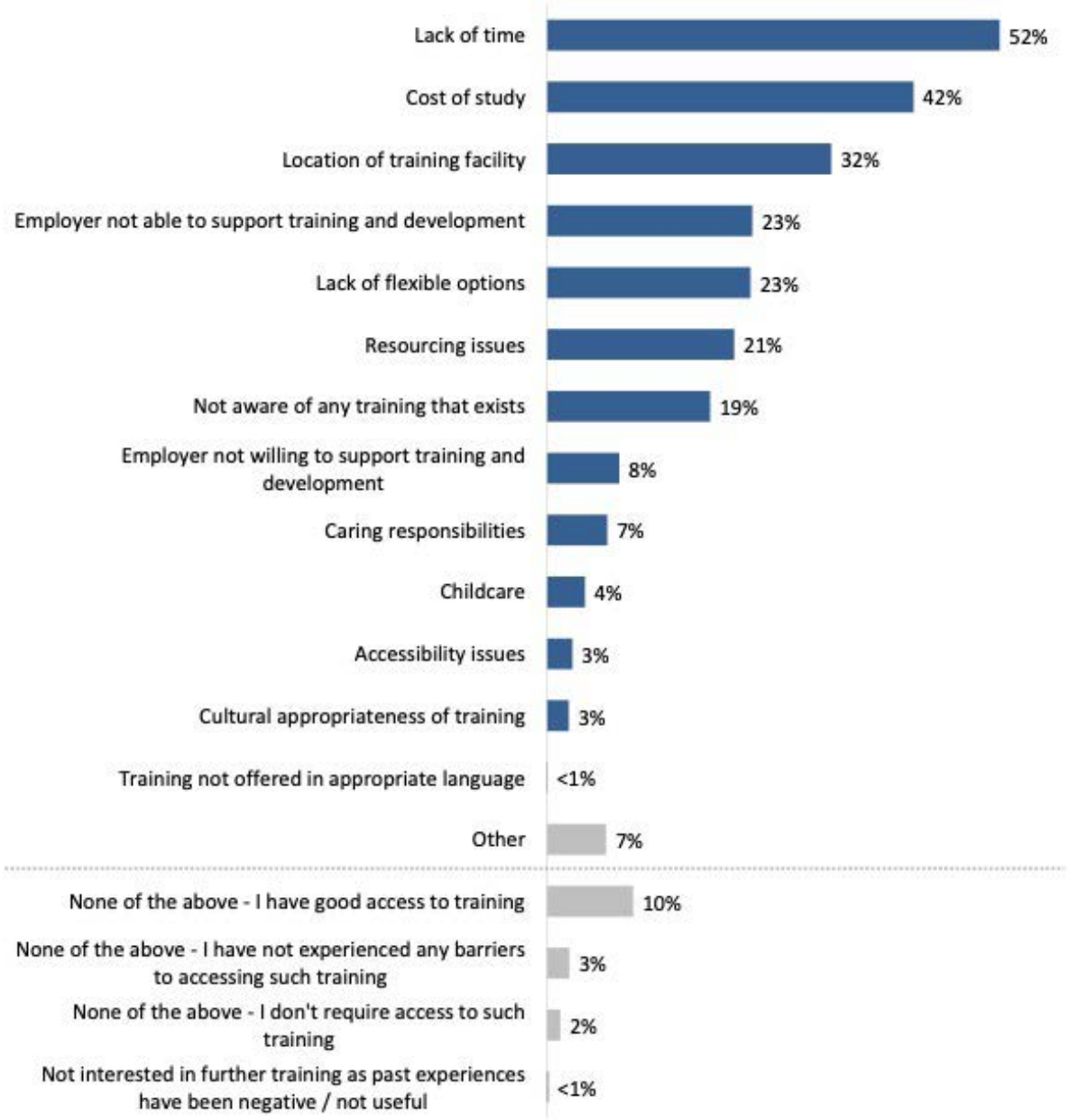
Table 5: Top 3 training needs by organisation type	
Organisation type	**Top 3 training needs**
Specialist family violence victim survivor services (n=436)	– Working with people with disabilities (55%) – Working with adolescents (54%) – Sexual assault in family violence (53%)
Specialist family violence perpetrator services / Men's behaviour change (n=146)	– Sexual assault in family violence (49%) – Working with people with disabilities (48%) – RAMP training (47%)
Aboriginal Community Controlled Organisation (n=27)	– RAMP training (70%) – Working with perpetrators of family violence / Intersectionality (52% each) – Working with migrant and refugee communities / Working with people with disabilities / Elder abuse / Advocacy (44% each)
Alcohol or other drug services (n=27)	– MARAM / Working with Aboriginal communities (53% each) – Legal issues for family violence / Working with perpetrators of family violence (50% each) – Working with adolescents (47%)
Victims assistance (n=30)	– Legal issues for family violence (63%) – Elder abuse / Working with perpetrators of family violence / Working with Aboriginal communities / Working with migrant and refugee communities / Working with adolescents / Sexual assault in family violence (43% each) – RAMP training (40%)
Peak body (n=37)	– Working with people with disabilities (54%) – Trauma-informed practice / Working with LGBTIQ communities (49% each) – Working with perpetrators of family violence / Working with Aboriginal communities / Working with adolescents (43% each)
Women's health (n=27)	– MARAM / Working with migrant and refugee communities (56% each) – Working with LGBTIQ communities / Working with people with disabilities (52% each) – Working with perpetrators of family violence / Working with adolescents / Advocacy (48% each)
Child protection (n=10)	– Working with perpetrators of family violence / Working with people with disabilities / Sexual assault in family violence (50% each) – MARAM / Elder abuse / Working with adolescents / Reflective practice / Advocacy / RAMP training (40% each) – Family violence risk assessment and risk management (CRAF) / Legal issues for family violence / Working with Aboriginal communities / Working with migrant and refugee communities (30% each)
Community health (n=83)	– Sexual assault in family violence (60%) – Legal issues for family violence (54%) – Working with people with disabilities (53%)
Courts and court services (n=64)	– MARAM (56%) – Working with people with disabilities (45%) – Elder abuse / Reflective practice (36% each)
Family safety contact (n=30)	– Working with Aboriginal communities (57%) – Working with migrant and refugee communities (53%) – Working with adolescents / Working with people with disabilities / RAMP training (50% each)

Table 5: Top 3 training needs by organisation type	
Organisation type	**Top 3 training needs**
Hospital (n=46)	– MARAM (65%) – Working with perpetrators of family violence (63%) – RAMP training (59%)
Housing / Social housing / Homelessness (n=41)	– Working with perpetrators of family violence (61%) – Legal issues for family violence (59%) – Working with migrant and refugee communities / Sexual assault in family violence (54% each)
Legal services (n=88)	– Working with LGBTIQ communities (56%) – Working with adolescents (51%) – MARAM (50%)
LGBTIQ services (n=17)	– RAMP training (65%) – Working with Aboriginal communities / Working with migrant and refugee communities / Working with people with disabilities (47% each) – MARAM / Legal issues for family violence / Elder abuse / Working with adolescents / Sexual assault in family violence (35% each)
Mental health services (n=31)	– Working with perpetrators of family violence (68%) – Working with migrant and refugee communities / Working with LGBTIQ communities / RAMP training (65% each) – Sexual assault in family violence (61%)
Multicultural or settlement services (n=10)	– MARAM / Working with perpetrators of family violence (60% each) – Trauma-informed practice / Working with children exposed to family violence / Working with adolescents / Working with people with disabilities (50% each) – Family violence safety planning / Intersectionality / Working with Aboriginal communities / Working with LGBTIQ communities / Sexual assault in family violence / RAMP training (40% each)
Older people (including elder abuse) services (n=10)	– MARAM / Working with perpetrators of family violence / Working with LGBTIQ communities (60% each) – Working with migrant and refugee communities (50%) – Financial abuse / Working with children exposed to family violence / Working with Aboriginal communities / Cultural safety training / Case management / Advocacy / RAMP training (40% each)
Education and training provider (family violence) (n=25)	– Working with people with disabilities (56%) – Working with perpetrators of family violence / Working with LGBTIQ communities (52% each) – Trauma-informed practice / Cultural safety training / Sexual assault in family violence (48% each)
Sexual assault services (n=50)	– Legal issues for family violence (52%) – Working with Aboriginal communities / Working with perpetrators of family violence (48% each) – Working with LGBTIQ communities / Working with people with disabilities (42% each)
Regional integration (n=11)	– Working with adolescents / Working with people with disabilities (64% each) – Working with children exposed to family violence / Working with Aboriginal communities / Sexual assault in family violence (55% each) – MARAM / Working with perpetrators of family violence / Cultural safety training / Working with migrant and refugee communities / Working with LGBTIQ communities (45% each)

When asked about barriers to accessing further training and development in relation to family violence response or prevention, the three main barriers identified by respondents were:

- lack of time (52%);
- cost of study (42%); and
- location of training facility (32% – see Figure 15).

Figure 15: Barriers to accessing further training and development
Base: All respondents (n=1,457); multiple responses accepted



Q54. Overall, what are the main barriers for you in accessing further training and development in relation to family violence response or prevention?

Reported barriers differed across certain demographic cohorts, including:

- **Age** – respondents aged under 35 were more likely than older respondents to indicate that they were unable to access further training and development due to lack of time, lack of awareness about the training available, and resourcing issues.
- **Gender** – female respondents were more likely than male respondents to identify cost of study as a barrier, while males were more likely than females to indicate that they were not aware of any training that exists.
- **Level of remoteness** – those working in regional locations were substantially more likely than those in metropolitan locations to indicate that location of training facility was a barrier (45% versus 15%).

8 Health and wellbeing

This chapter explores the impacts of the work that the specialist family violence response workforce undertakes on their health and wellbeing. Given the various work-related stressors that this group may encounter, this information is important to understand and may be used to assist in identifying any specific areas of focus to inform plans, processes or strategies to support its workers.

Overall, the results suggested that many within this workforce had experienced stress due to **high workload,** with over three-quarters reporting that they experienced at least moderate stress in their role. Of this group, many cited a high volume of work or high demands of their role as a primary reason for their stress (84%). Over two-in-five also reported that vicarious trauma was a cause of stress for them when undertaking their work.

Positively, around two-thirds of this workforce felt that their work made a significant difference to people affected by family violence. Additionally, most were satisfied in their current role (75%).

Workplace stressors

Work-related stress is an important consideration when exploring the health and wellbeing of staff, and there are various elements of an individual's role that may contribute to such stress.

78% of the specialist family violence response workforce reported that they experienced at least moderate work-related stress, and 33% experienced high, very high or severe levels.[13]

84% of those who experienced at least high levels of stress reported that this was due to a high volume of work / high demands of their role, whilst 48% also cited poor management or organisational issues.[14]

Figure 16 overleaf illustrates the frequency at which this workforce had experienced a range of factors that may contribute to workplace stress. Positively, over eight-in-ten respondents indicated that they:

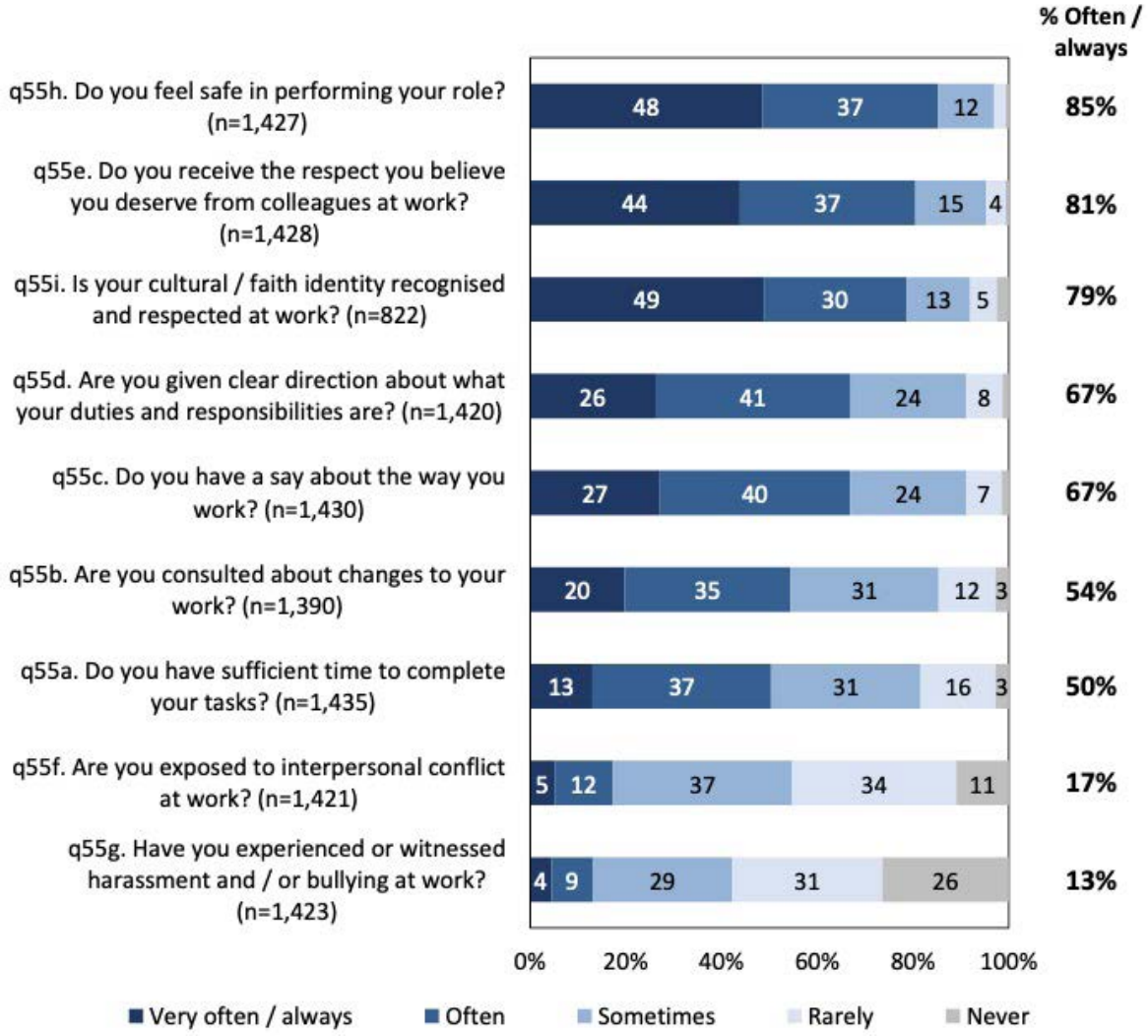
- felt safe in performing their role (85% always or often); and
- received the respect they believed they deserved from colleagues at work (81%).

However, it should be noted that 15% also reported that they only felt safe sometimes, or less often, and 19% felt that they received the respect they deserved only sometimes, or less often.

In contrast, only half of this workforce (50%) reported that they usually had sufficient time to complete their tasks (consistent with the high volume of work / role demands noted earlier).

13. Q56. On average, how would you rate your level of work-related stress? (n=1,443)
14. Q57. What is the primary cause(s) of your work-related stress? Multiple responses accepted (n=482)

Figure 16: Frequency of various workplace wellbeing metrics
Base: All respondents



Q55. In performing your duties for this role, how often:

Support for negative encounters

As outlined earlier, although high volume of work and poor management were the most cited causes of workplace stress, 43% of those who experienced at least high levels of stress also mentioned vicarious trauma.

For the purposes of the Census, vicarious trauma is defined as:

> **The experience of trauma that stems from indirectly living the experiences, thoughts, and emotions of those undergoing or recounting traumatic events.**

59% understood that their organisation had processes or policies and procedures in place to recognise and manage vicarious trauma.[15]

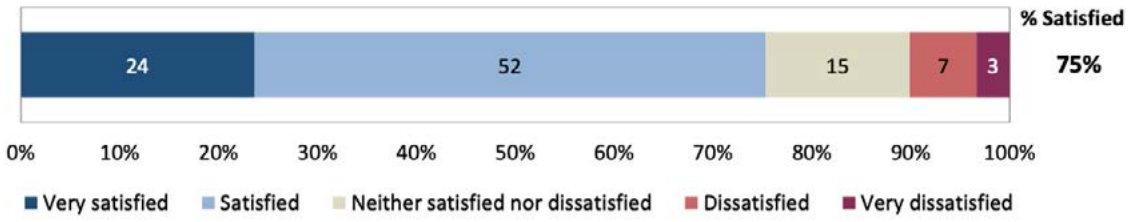
35% felt that these measures were very or extremely effective in assisting them to recognise that they are experiencing vicarious trauma. A further 47% felt that they were moderately effective.[16]

31% felt that these measures were very or extremely effective in assisting them to manage vicarious trauma. Again, 47% felt that they were moderately effective.[17]

Satisfaction with role

Overall, three-quarters of the specialist family violence response workforce indicated that they were satisfied in their current role (75% – see Figure 17). Positively, only a minority expressed dissatisfaction (10%), whilst 15% were neither satisfied nor dissatisfied in their role.

Figure 17: Overall satisfaction with current role
Base: All respondents (n=1,406)



Q66. Overall, how satisfied are you in your current role in the specialst family violence response workforce?

15. Additionally, 18% believed that their organisation did not have such measures in place, and 23% were unsure. Q58. Does your organisation have processes in place or policies and procedures to recognise and manage vicarious trauma? (n=1,436)
16. Q59. Overall, how effective are these processes, policies and / or procedures in assisting you to recognise that you are experiencing vicarious trauma? (n=744)
17. Q60. Overall, how effective are these processes, policies and / or procedures in assisting you to manage vicarious trauma? (n=731)

Overall satisfaction did not differ substantially by various demographic cohorts such as age, gender, number of roles held, organisation size or tenure. Results split by organisation type are presented in Table 6 overleaf.

Respondents were additionally asked to comment on how much difference they believe their work makes to people affected by family violence.

indicated that they felt that their work makes a significant difference to people affected by family violence, whilst 32% felt their work makes a moderate difference[18]

There was not a strong correlation between overall role satisfaction and whether one felt that their role made a positive difference to people affected by family violence, suggesting that differences in satisfaction levels were driven by other factors.

Perceptions of the difference their work made differed by some demographic cohorts, as follows:

- **Gender** – Females were more likely than males to feel as though their work made a significant difference to people affected by family violence (68% versus 53% of males).
- **Organisation size** – perceptions that their work made a significant difference to people affected by family violence reduced as organisation size increased: 69% of those in smaller organisations (1-49 staff) indicated that they felt this way, compared to 57% of staff in organisation with more than 200 staff.
- **Organisation type** – see Table 6 overleaf for details.

18. Q67. How much difference do you think your work makes to people affected by family violence? (n=1,352)

Key results by organisation type are shown in Table 6 below.

Table 6: Chapter 8 - Key results by organisation type			
Organisation type	Experienced **workplace stress** (% at least moderate at Q56)	**Satisfied** with current role (% satisfied at Q66)	Work makes a **significant difference** (% significant difference at Q67)
Overall workforce (n=1,352-1,443)*	78%	75%	66%
Specialist family violence victim survivor services (n=527-555)	77%	76%	77%
Specialist family violence perpetrator services / Men's behaviour change (n=171-187)	73%	79%	56%
Aboriginal Community Controlled Organisation (n=34-37)	68%	83%	65%
Alcohol or other drug services (n=38-40)	80%	72%	58%
Victims assistance (n=37-38)	71%	76%	51%
Peak body (n=39-46)	78%	80%	59%
Women's health (n=35-38)	76%	78%	71%
Child protection (n=13-14)	57%	85%	77%
Community health (n=100-106)	73%	73%	65%
Courts and court services (n=74-81)	85%	69%	57%
Family safety contact (n=34-37)	81%	81%	59%
Hospital (n=59-67)	81%	74%	64%
Housing / Social housing / Homelessness (n=48-51)	82%	73%	73%
Legal services (n=99-107)	82%	76%	73%
LGBTIQ services (n=22)	77%	77%	59%
Mental health services (n=36-40)	85%	78%	53%
Multicultural or settlement services (n=14-15)	80%	71%	71%
Older people (including elder abuse) services (n=10-13)	69%	69%	80%
Education and training provider (family violence) (n=32-37)	68%	71%	59%
Sexual assault services (n=66-69)	81%	81%	82%
Regional integration (n=12-14)	57%	93%	67%

*n= indicates the range of the sample sizes across the four key questions.

When asked about various elements of their roles, the results suggested that the specialist family violence workforce were most satisfied with the nature of the work that they perform and working conditions (87% and 80% respectively – see Figure 18).

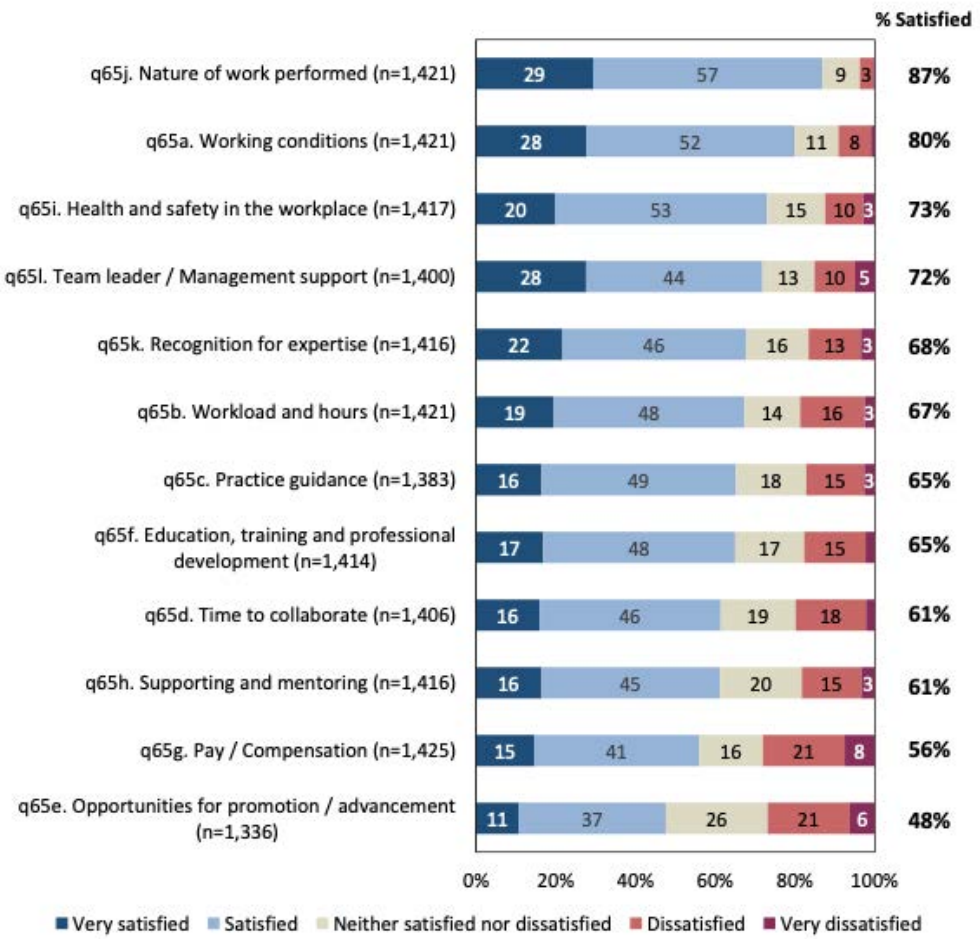
In contrast, the main areas for improvement where respondents indicated that they were least satisfied included:

- opportunities for advancement (48% satisfied, 27% dissatisfied);
- pay / compensation (56% satisfied, 28% dissatisfied); and
- support and mentoring (61% satisfied, 18% dissatisfied).

In order to determine what was most important in influencing overall levels of role satisfaction, regression analysis was undertaken. The results suggest that the key drivers were having positive perceptions of:

- team leader / management support;
- the nature of the work performed;
- recognition for expertise;
- working conditions; and
- workload and hours.

Figure 18: Satisfaction with various elements of role
Base: All respondents

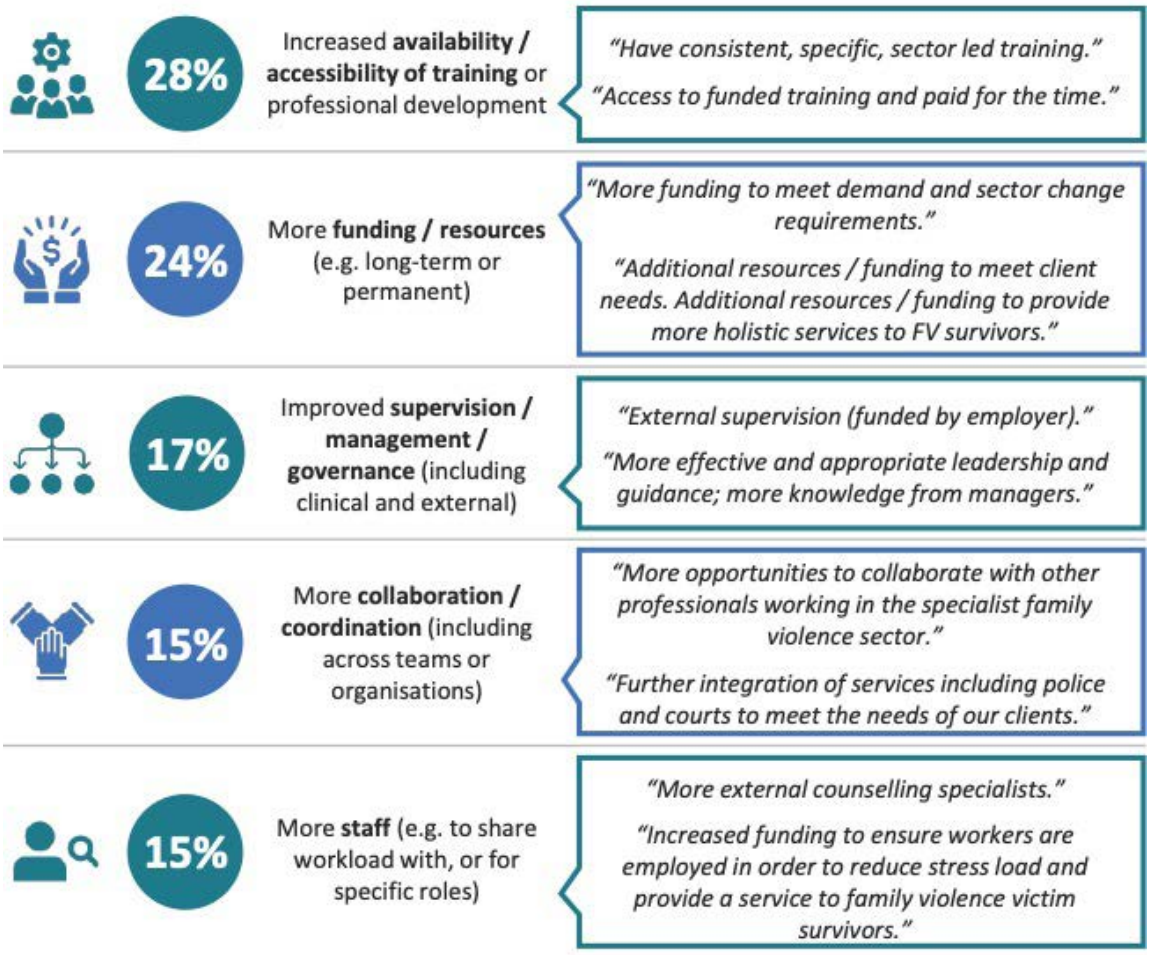


Q65. How satisfied are you with the following elements of your role?

Suggestions for improvement

Respondents were asked to explain what they felt to be the three most important changes that could be made to enable them to carry out their work more effectively. Free-text comments were coded into themes, with the main themes illustrated in Figure 19.

Figure 19: Suggestions for improvement (Top 5 themes identified in open-ended responses)
Base: All respondents



Q68. What are the top three most important changes that could be made to enable you to carry out your work more effectively?

9 Career and future intentions

This chapter outlines the key motivators for working in the specialist family violence response workforce and explores the future plans / intentions of this group. This information may be useful to inform recruitment and retention strategies.

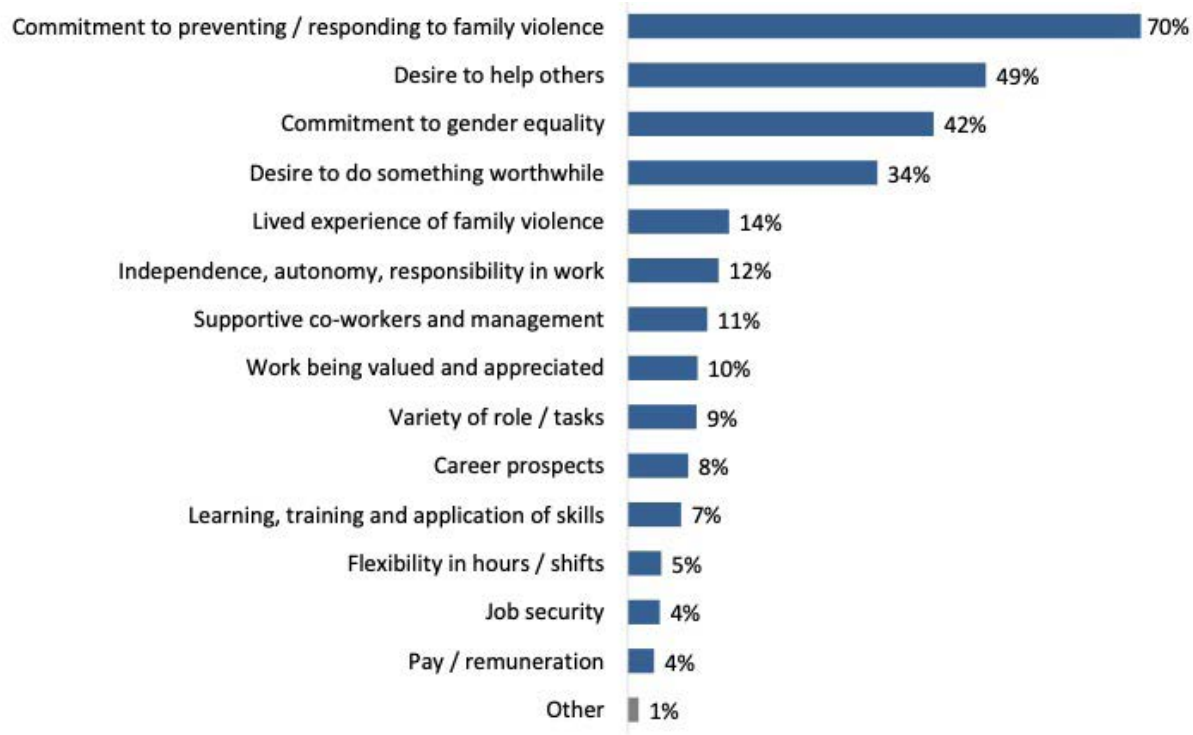
Overall, the results illustrated that the specialist family violence response workforce were highly motivated by a **commitment to preventing / responding** to family violence, and a desire to help others.

When asked about their future intentions, half this workforce reported that they did not have plans to **leave** their current role. Of the 40% who did hold such intentions, their reasons were predominantly due to career prospects and lack of advancement opportunities, stress or other negative influences on their health and wellbeing, or an end of contract.

The main motivator for working in a specialist family violence response role was reported to be a commitment to preventing and responding to family violence – with 70% citing this reason. Almost half of this workforce also indicated that they were motivated by a desire to help others (49%).

This workforce was least motivated by pay / remuneration and job security (4% each).

Figure 20: Motivators to working in family violence response
Base: All respondents (n=1,410); multiple responses accepted



Q69. Overall, what mainly motivates you to work in a role in family violence response?

When asked about their employment status prior to commencing their current role in the specialist family violence response workforce, a range of responses were provided. Overall, 41% indicated that they had held a role with another organisation or agency in the sector (within Victoria), 23% had been working in a related sector, 14% in an unrelated sector, and 13% had been studying.

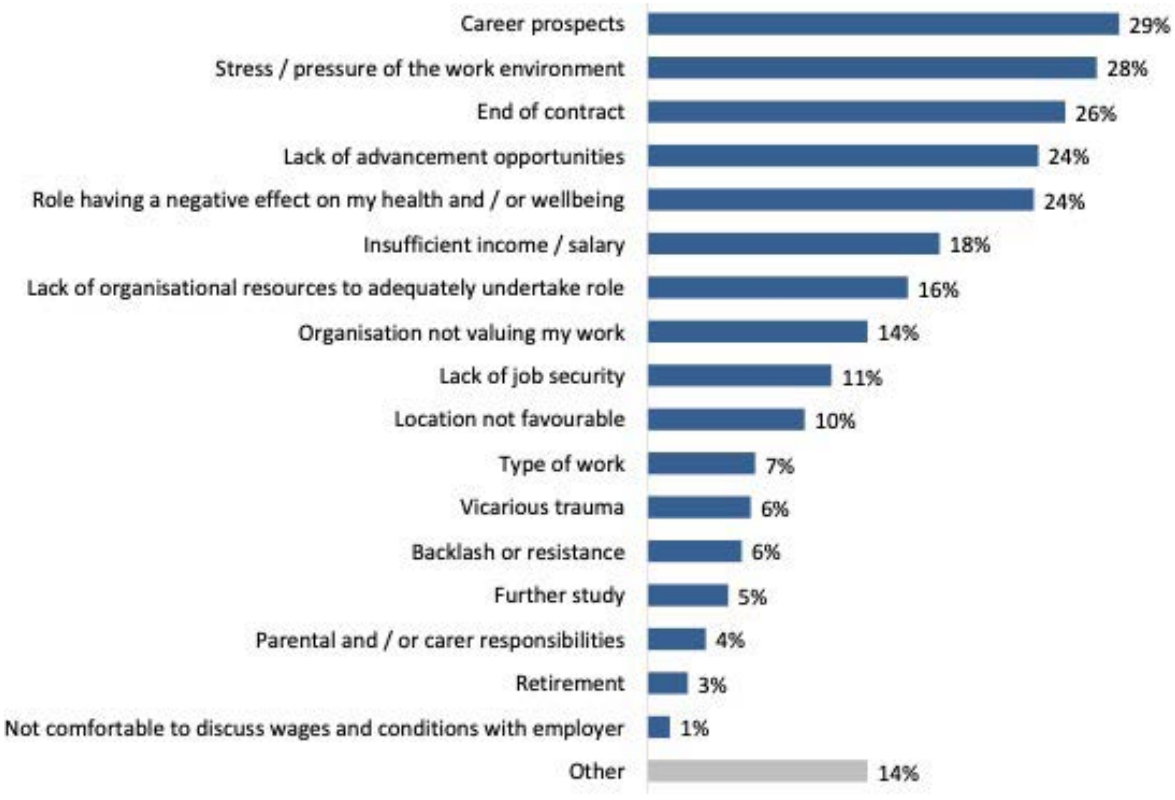
Future intentions

51% of respondents did not have plans to leave their current role at this stage, whilst 40% did have plans to leave their current role. A further 10% were unsure.[19]

Of those who did intend to leave their current role, 44% were planning to leave for another role within the specialist family violence response workforce. A similar proportion (40%) were planning to leave their current role for another role outside of this workforce.

Figure 21 illustrates the broad range of reasons that had driven respondents to consider leaving their role in the next 12 months. Although 26% cited an end of contract, other key reasons included career prospects or lack of advancement opportunities (24%- 29%); and stress / pressure or the role having a negative effect on respondents' health and wellbeing (24%-28%). On a positive note, few cited vicarious trauma or backlash / resistance.

Figure 21: Reasons for planning to leave current job
Base: Respondents planning to leave their role in the next 12 months (n=360); multiple responses accepted



Q74. What are your top 3 reasons for planning to leave your current job in the time frame indicated? 'Don't know' excluded

19. Q71. Thinking about your future, do you have plans to leave your current role? (n=1,409)

Furthermore, most specialist respondents indicated that they would consider taking on a role in the primary prevention of family violence workforce in the future (81%)[20], suggesting that there is an opportunity for shared resources across the specialist family violence response and primary prevention workforces.

Results differed by some demographic cohorts, as follows:

- **Age** – younger respondents (aged under 35) were more likely than their older colleagues to:
  - have plans to leave their current role (49% versus 38% of those aged 35-54, and 32% of those aged 55+); and
  - be open to a role in the primary prevention of family violence workforce (86% versus 80% of those aged 35-54, and 74% of those aged 55+).
- **Gender** – females were more likely than males to indicate that they would consider a role in the primary prevention workforce (82% versus 71%).
- **Years of experience** – those with fewer years' experience in their current role were more likely than those with greater experience to be open to considering a role in the primary prevention workforce (85% of those with 4 years' experience or less, versus 70-73% of those with 5-10 years or over 10 years' experience in their current role).
- **Level of remoteness** – those working in metropolitan locations were slightly more likely than those in regional locations to indicate that they had plans to leave their current role (44% versus 39%).
- **Organisation type** – see Table 7 overleaf for details.

20. Asked only of those who did not currently hold any roles in the primary prevention of family violence workforce.

Key results by organisation type are shown in Table 7 below.

Table 7: Chapter 9 - Key results by organisation type		
Organisation type	Plan to **leave current role** (Q71)	Would consider a role in the **primary prevention** workforce (Q75)
Overall workforce (n=1,017-1,409)*	40%	81%
Specialist family violence victim survivor services (n=408-547)	39%	88%
Specialist family violence perpetrator services / Men's behaviour change (n=121-183)	38%	86%
Aboriginal Community Controlled Organisation (n=25-36)	33%	84%
Alcohol or other drug services (n=28-39)	41%	82%
Victims assistance (n=27-35)	51%	67%
Peak body (n=33-46)	61%	94%
Women's health (n=22-37)	41%	64%
Child protection (n=9-13)	38%	^
Community health (n=74-102)	30%	80%
Courts and court services (n=61-80)	43%	62%
Family safety contact (n=23-36)	33%	87%
Hospital (n=41-65)	46%	71%
Housing / Social housing / Homelessness (n=34-50)	38%	74%
Legal services (n=70-104)	43%	71%
LGBTIQ services (n=14-22)	45%	64%
Mental health services (n=26-39)	49%	85%
Multicultural or settlement services (n=7-14)	36%	^
Older people (including elder abuse) services (n=4-12)	33%	^
Education and training provider (family violence) (n=23-35)	51%	70%
Sexual assault services (n=42-69)	29%	74%
Regional integration (n=11-14)	29%	82%

*n= indicates the range of the sample sizes across the four key questions. ^Result suppressed due to low sample size (n<10).

10 The Orange Door – Key findings

This chapter presents the key Census results for respondents who indicated that they currently worked in The Orange Door (10%; n=160). This cohort primarily comprised specialist family violence workers (29%), child and family services workers (14%), hub team leaders (10%), and men's family violence workers (9%).

Role requirements

Compared to other respondents, those who worked in The Orange Door were:

- more likely to hold full-time roles (66% versus 57% of those who did not work in the Orange Door), and be employed in an ongoing capacity (78% versus 72%);
- more likely to report that they worked in excess of their ideal hours in the past fortnight (21% versus 17%);
- less likely to indicate that they were often paid to work after hours on weekdays (9% versus 20%), and on weekends (2% versus 12%); and
- less likely to report that they often worked additional unpaid hours (24% versus 32%).

Supervision

Those who worked in The Orange Door were:

- more likely than others to be satisfied with the quality of support provided to them by their supervisor / direct manager (80%, compared to 74% of those who did not work in the Orange Door); and
- slightly more likely than others to be satisfied with the quality of professional supervision provided to them by external supervisors (94% versus 86%). Satisfaction did not vary in regard to the quality of internal supervisors.

Training and confidence

In relation to family violence response, 62% of respondents who worked in The Orange Door indicated that they were confident that they have had enough training and experience to perform their role(s) effectively (in line with 61% of those who did not work in the Orange Door).

Those who worked in The Orange Door reported:

- substantially higher usage of MARAM tools in identifying or assessing family violence risk, compared to those who did not work in the Orange Door (80% versus 59%); and
- considerably higher understanding of information sharing responsibilities (94% versus 80%).

This cohort also reported higher levels of information sharing activity – 94% had undertaken at least one activity in the past year, compared to 81% of those who did not work in the Orange Door.

The top three topics which respondents working in The Orange Door felt they required further training in were:

- legal issues for family violence (62%);
- working with people with disabilities (58%); and
- sexual assault in family violence (58%).

Training and confidence (continued)

The training topics completed by respondents working in The Orange Door and felt to be the most helpful were:

- RAMP (93%);
- trauma-informed practice (90%);
- identifying and screening family violence (89%); and
- working with adolescents (89%).

In terms of barriers to accessing further training and development, those who worked in The Orange Door were more likely than others to indicate that they were unable to access further training and development due to the location of the training facility (42% versus 31%), as well as a lack of flexible options (35% versus 22%). In contrast, they were less likely to identify cost of study as a barrier (32% versus 43%).

Health and wellbeing

Those who worked in The Orange Door reported a similar, though slightly higher, level of overall satisfaction with their current role than those who did not work in the Orange Door (79%, versus 75%). However, this cohort was less likely to feel that their work makes a significant difference to people affected by family violence (60%, compared to 67% of those who did not work in The Orange Door).

Career and future intentions

When asked about their future intentions, respondents working in The Orange Door were less likely than others to have plans to leave their current role (32%, compared to 40% of those who did not work in The Orange Door). This cohort was also more likely to indicate that they would consider a role in the primary prevention workforce in the future (92% versus 79%).

2019-20 Census of Workforces that Intersect with Family Violence

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