Government of **Western Australia**
North Metropolitan Health Service

Family and Domestic Violence Framework 2021–2026


Image: Keating Photography

Contents

Scope 6

What is family and domestic violence? 7

Family and domestic violence snapshot 9

Groups at higher risk of FDV 10

Vision 12

Governance 13

Preventing family and domestic violence 14

Early intervention for high risk groups 15

Service response 16

Workforce capability and system accountability 18

Supporting staff at risk of FDV 19

Next steps 20

Appendices 21

Appendix A: Related policies and strategies 21

Appendix B: Glossary of terms 22

Appendix C: Resources 23

References 24

Message from the Chief Executive

Family and domestic violence (FDV) is a major public health issue associated with many serious physical and mental health impacts for victims, children and perpetrators. Whilst FDV is a complex issue which requires a whole of community response, NMHS recognises the valuable role we can play in contributing to improving the safety of our patients, consumers and staff. We know that health care providers are often the first, and sometimes only, point of contact for people who have experienced abuse. We also know that women who have experienced FDV use health services more frequently than women who have not.

This is why we have developed the NMHS Family and Domestic Violence Framework 2021-2026. We recognise the important role NMHS can play in prevention, early intervention and supporting our community to prevent or reduce family and domestic violence. The framework identifies clear strategies we will undertake to improve our capacity and effectiveness in responding to both victims/ survivors and perpetrators of FDV.

Given our predominantly female workforce, coupled with the knowledge that FDV disproportionately affects women, I am pleased this framework recognises improving the safety and support for our staff who may be at risk of FDV as a key priority area.

Improving the safety and wellbeing of both our consumers and staff requires active engagement from all levels of government, the community and within our health service. I am confident that all NMHS staff will welcome and support this framework. By working together to implement the many actions outlined, we will continue to work towards improving, promoting and protecting the health and wellbeing of our consumers, staff and community.

Tony Dolan
Chief Executive
North Metropolitan Health Service

Dedication

In memory of Jessica Bairnsfather-Scott. A much loved granddaughter, daughter, sister, aunty, cousin, friend and health worker whose life was stolen by family and domestic violence at only 32 years old. The devastating loss of Jessica reminds all of us that this pervasive violence not only happens to our patients but also to our colleagues, families, and friends. Jessica was an employee of North Metropolitan Health Service and was to be a member of the NMHS working group that guided the development of this framework.

Jessica's professional and personal work assisting victims will not be forgotten and is a constant reminder that keeping people safe is everyone's business.

A note on terminology

In line with Western Australia's Strategy to Reduce Family and Domestic Violence 2020-2030, this document refers to 'victim' and 'perpetrator' in recognition that these are the terms most widely used in the community. See *Appendix B: Glossary of Terms* for definitions of these terms.

Whilst the scope of this framework encompasses all victims (including male victims), we acknowledge that FDV is deeply gendered where overwhelmingly the majority of perpetrators are men and victims are women and children[1].

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

This document uses the term 'consumer', which encompasses health consumers, in-patients, out-patients, clients and all service users of the North Metropolitan Health Service. The term 'staff' encompasses paid and non-paid workers (including volunteers, students and contractors).

Scope

The Family and Domestic Violence Framework 2021-2026 has been developed to provide strategic direction, leadership and best practice for North Metropolitan Health Service (NMHS) in response to the public health issue of family and domestic violence (FDV). The framework addresses patients, consumers, and staff members who are victims of FDV.

The framework applies to the following North Metropolitan health services:

- Sir Charles Gairdner Osborne Park Health Care Group
- Mental Health, Public Health and Dental Services
- Women and Newborn Health Services (including King Edward Memorial Hospital and Osborne Park Hospital)
- Joondalup Health Campus
- NMHS Workforce Development

FDV is a complex issue which requires a whole of community response. In Western Australia, the Department of Communities is the lead agency for the coordination of a response to FDV; however, all state government agencies, including health services, have a role in responding to FDV[2].

The framework progresses the implementation of WA Health, State and National strategic priorities for the family and domestic violence sector, and is one of the actions that WA Health committed to as part of the Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence, 2020-2030.

In addition, the implementation of the framework will facilitate progress towards conformance with the following key documents:

- National Plan to Reduce Violence Against Women and their Children 2010-2022
- NMHS Strategic Plan 2020 – 2025
- NMHS Our People Strategy 2019-2024
- NMHS Wellbeing Framework
- The State Public Health Plan
- WA Health Promotion Strategic Framework 2017-2021

The framework builds on the established clinical processes within NMHS to identify and support FDV victims to optimise their safety and wellbeing.

What is family and domestic violence?

NMHS adopts the Western Australian Government definition of FDV, that is:

> An ongoing pattern of behaviours intended to coerce, control or create fear within a family or intimate relationship. This includes physical harm or threats of physical harm, financial, emotional and psychological abuse, sexual violence or any other behaviour which causes the victim to live in fear”[3].

Whilst FDV is often thought of as violence between partners, it extends to abuse within extended families and families defined through kinship and other relationship forms such as parent-child relationships, siblings, and relatives through blood, marriage or culture.

Whilst both men and women can perpetrate FDV, most victims of FDV are women and children and the majority of perpetrators are men. FDV occurs most often in intimate partner relationships; however, it can occur in all family (and kinship) relationships. Within Australia, 25% of women and 8% of men are, or have been, victims of violence from a current or former partner[5].

25%
of women

8%
of men

victims of violence from a current or former partner[5].

A major public health issue

FDV is a major public health issue associated with many serious physical and mental health impacts for both victims and perpetrators. It is the number one contributing factor to the burden of disease for Australian women aged 18-44 years[6]. Examples of adverse health outcomes for women include depression and anxiety, self-harm, suicide, sexually transmitted infections and problematic alcohol and substance use[7,8,9]. Pregnant women can experience a higher risk of miscarriage, preterm birth and low-birth weight babies. Children and young people exposed to FDV experience a range of psychological, behavioural, social and academic consequences, which also adversely impact their future interpersonal relationships[10].

FDV exerts a substantial financial burden on our health system. In Western Australia, the cost to WA Health for people admitted to hospital for assault related injuries caused by FDV was placed at $51.9 million between 2009–2015[11].

Evidence suggests that women who have been subjected to violence seek health care more often than non-abused women, even if they do not disclose violence. Therefore, health care providers are often the first point of contact for people who have experienced FDV. Women also identify health care providers as the professionals they would most trust with disclosure of abuse[12].

While many health care professionals will see women at crisis presentation stages – for example, during visits to emergency departments – health professionals also interact with women over their life, making health services key settings for opportunistic identification and interventions. These interventions enable women to be empowered in their relationships and seek care and support early to prevent or reduce future harm.

While safety and assistance to victims is the priority, perpetrators of FDV also suffer adverse health consequences. Providing appropriate support and referrals for perpetrators can assist in improvement of their mental and physical health and facilitate behaviour change, consequently impacting the wellbeing of victim/s[13].

A recent, preliminary Australian study found that 45.2% of surveyed female nurses, doctors and allied health professionals reported experiencing violence by an intimate partner or family member, compared to the national, general population average of 25%[14]. Therefore, it is imperative health services have robust and responsive systems in place that support both consumer and staff victims.

COST OF FAMILY AND DOMESTIC VIOLENCE

$51,900,000

between 2009–2015[11]

Family and domestic violence snapshot 2020

National statistics

Partner violence is responsible for more preventable ill-health and premature death in women under 45 than any other risk factor, including obesity and smoking[a].

1 in 4 Australian women have experienced violence by an intimate partner[b].

Family and domestic violence (FDV) in WA statistics

1 in 5 **Western Australian women reported experiencing partner violence since the age of 15[c].**

70% did not report violence or assault from a partner to police[d]. **34.4%** noted that this violence occurred during pregnancy[e].

10min

On average **WA police respond** to an episode of FDV every **10 minutes**, totalling over 54,000 incidents p.a.[f].

61%

61% of all recorded assaults in WA were family-violence related[g].

71%

of all female victims murdered were victims of FDV[h].

1/3

1/3 of sexual assault offences were FDV related[i].

Hospitalisations due to FDV statistics

While at least **54%** of all women who present to an emergency department have experienced FDV at some point in their lives, only **5%** are identified by health care professionals[j].

In Australia, almost **1 in 3** hospitalisations due to assault injuries were a result of family and domestic violence[k].

In Australia, on average **8 women and 2 men are hospitalised** each day after being assaulted by their spouse or partner[l].

Aboriginal women are 32 times more likely to be hospitalised due to family violence-assaults as non-Indigenous women[m].

FDV in NMHS

$4.6M

The cost of FDV related hospitalisations for NMHS between 2009 – 2015[n].

93%

of all people hospitalised due to assault injuries by an intimate partner in NMHS **were women**.

76%

of the NMHS workforce **are female**.

Research into patients identified as at risk of FDV at KEMH, OPH and SCGH indicated longer and more frequent stays in hospital, and **2.2 times more presentations** to Emergency Departments[o].

References

a. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia. Canberra: AIHW; 2018. b. Personal Safety Survey, 2016, Australian Bureau of Statistics. c. Women's Report Card, 2019. d. Women's Report Card, 2019. e. Women's Report Card, 2019. f. Department of Communities. (2018). 2017-18 Annual Report. Government of Western Australia. g. Australia Bureau of Statistics 2016, Recorded Crime, Canberra 2017 no 4510.0 h and i. ibid. j. Intimate partner violence screening in emergency department: A rapid review of the literature. Journal of Clinical Nursing, 26(21-22), 3271–3285. k. AIHW National Hospital Morbidity Database.
Reference: https://www.aihw.gov.au/reports-data/behaviours-risk-factors/domestic-violence/about. l. Family, domestic and sexual violence in Australia 2018. Cat. No FDV 2. AIHW. m. Women's Report Card, 2019. n. Reference: AIHW 2018. Family, domestic and sexual violence in Australia 2018. Cat. no FDV 2. Canberra: AIHW. o. W.A. Health Costs associated with FDV – a Snapshot, 2017.

Groups at higher risk of FDV

Aboriginal women

Women in pregnancy and early motherhood

Young women and adolescents

Women with mental illness and /or significant drug or alcohol dependency

Women with disabilities

LGBTQI+ people

Migrant, refugee and culturally and linguistically diverse women

Women in regional, rural and remote areas


Curtin University
MIDWIFERY MATTERS
DIET

Vision

Principles

The following principles underpin the framework:

1. Family and domestic violence is a fundamental violation of human rights that overwhelmingly impacts women and children.
2. NMHS does not condone any form of violence or abuse, or any justification for its use.
3. The safety of consumers and staff is the first priority.
4. NMHS strives to create an environment where consumers and staff feel safe and supported in disclosing their experiences of FDV.
5. Staff have a key role to play in identification, intervention and support for victims of FDV.
6. Responding to FDV requires sensitivity and awareness of individual needs of staff and consumers.
7. NMHS acknowledges the complex and multiple factors that contribute to FDV and aims to support consumers and staff in flexible, trauma-informed and culturally safe responses.
8. NMHS recognises the impacts of colonialism, inter-generational trauma, structural disadvantage, the destruction of culture, loss of cultural identity and the pervasion of racism and normalisation of systemic disadvantage faced by Aboriginal people as a driver of and context for their experience of violence.
9. Collaboration with other departments and non-government organisations to improve consumer safety is essential.
10. Perpetrators are solely responsible for their choice to use violence and must be accountable for their behaviours, and supported to cease their violent behaviour.
11. NMHS can participate in FDV prevention through addressing gender inequality in the workplace.

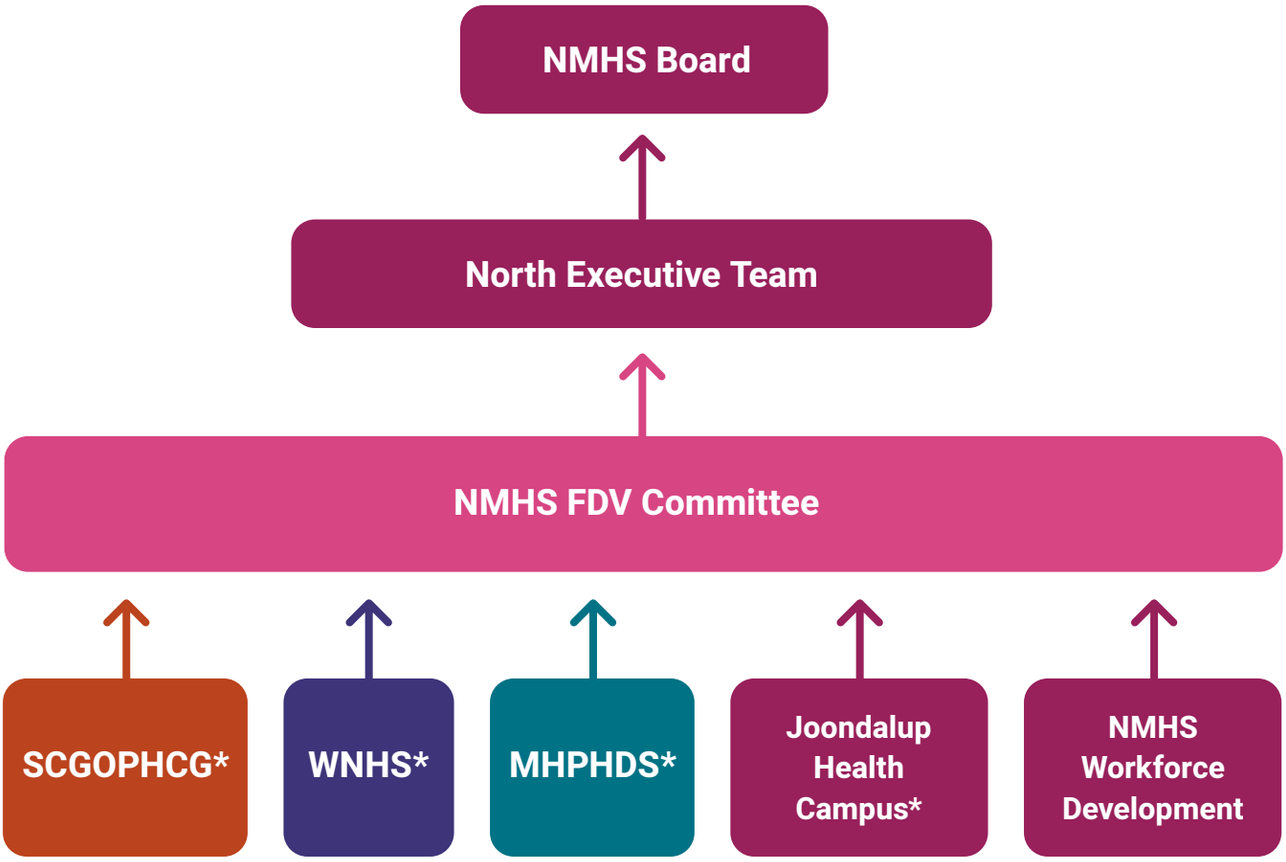
Focus areas

- **Preventing FDV**
- **Early intervention for high risk groups**
- **Service response**
- **Workforce capability and system accountability**
- **Staff at risk of FDV**

Governance

The NMHS Board, Executives and Managers will lead the management of the FDV framework through effective governance and oversight approaches. An NMHS FDV Committee will be established with representatives from all main health services to support the implementation and monitoring of the framework.

Effective oversight of the framework will be through regular Board, Executive and Services reports. This structure will ensure a solid foundation to successfully implement, monitor, evaluate, review and resource the framework.



* FDV added into a relevant existing committee within their Health Service.

Preventing family and domestic violence

Intimate partner violence has been found to contribute more to the total burden of disease for Australian women aged 18–44 years than alcohol and tobacco use, illicit drug use, and being overweight or obese[15]. Preventing FDV can have a significant impact, not only on improving a person's overall health, but also on decreasing the burden on our health system. In 2016, approximately one in four Australian women had experienced intimate partner violence, with an estimated annual cost to the national economy of $12.6 billion. Some $617.2 million of that was specifically on health costs[16].

Strategies to support the prevention of FDV include addressing the underlying determinants and risk factors that contribute to the perpetration of FDV[17]. The North Metropolitan Health Service can assist in FDV prevention by raising awareness of the attitudes, behaviours and social norms that contribute to FDV, campaigns to raise awareness of FDV as a public health problem, upholding gender equality as a norm, and promoting zero tolerance of violence in any form[18]. In addition, by partnering and collaborating across government, NMHS can encourage agencies to take action and share resources.

The workplace also plays an important role in primary prevention. Workplace structures and cultures have an impact on gender inequality, through reinforcing or challenging norms and practices. NMHS works towards prevention of FDV through addressing inequalities and negative gender attitudes within the workplace, ensuring workplace conditions (policies and procedures) support equality, and by taking steps to ensure the workplace is a safe space for staff to discuss inequality, discrimination or violence without fear of negative treatment.

NMHS is an integral part of the community response to improving the safety of families experiencing FDV.

Objectives

- Partner and collaborate across Government and the sector to increase awareness of FDV as a public health issue
- Explore and implement workforce initiatives that address gender inequality
- Work with families, to advocate for and support healthy relationships and gender equality

Measures of success

- An increase in the number of cross-government collaborations and campaigns
- An FDV position statement is developed, endorsed and promoted across all health services
- FDV is considered in the development of workforce policies
- Respectful relationships content included in antenatal education programs

Early intervention for high risk groups

Early intervention of FDV involves the detection of at-risk individuals and those exhibiting early signs of experiencing or perpetrating abuse. Early intervention seeks to prevent escalation and address issues arising from FDV. Early interventions typically target individuals or groups in the population that are more vulnerable to becoming victims of violence, such as pregnant women, people with a disability, women from refugee and migrant backgrounds, Aboriginal women, mental health consumers, frequent emergency department attendees, women with significant drug and alcohol dependency, and women with young children.

In line with most Australian states, NMHS staff screen for FDV in antenatal, postnatal and mental health settings due to the higher likelihood of violence victimisation among these populations[19,20]. In addition to these settings, emergency department presentations have been identified as a key (and sometimes the only) point of contact for victims of FDV[21]. For example, research indicates women experiencing FDV seek care from hospital emergency departments three times more often than non-abused women. Research also indicates that many victims of FDV are seen in emergency departments in the year prior to their death[22]. However, FDV can go undetected in emergency settings due to women's reluctance to disclose, inadequate training/awareness of staff and limited time and resources[23].

Through targeted screening in high risk groups, NMHS can facilitate the disclosure of abuse and provide pathways to support consumers.

NMHS is a health service where victims and perpetrators of abuse are supported and provided with early intervention.

Objectives

- Strengthen NMHS screening and response for women attending high risk settings such as antenatal, postnatal, mental health, emergency departments and drug & alcohol services
- Develop culturally appropriate resources and responses for Aboriginal women and women from refugee and migrant backgrounds

Measures of success

- 80% of women are screened for FDV in the identified high risk settings
- All staff who screen for FDV have completed the FDV E-learning package and training in responding to Culturally and Linguistically Diverse (CaLD) and Aboriginal consumers experiencing FDV
- Staff report high competence in knowledge of FDV procedures and referral pathways within their health service
- Aboriginal and CaLD consumers report feeling safe and supported when screened for FDV
- Health services demonstrate they have resources on FDV available in other languages

Service response

Given the high likelihood that victims of FDV have experienced trauma, it is important for staff to respond in a trauma-informed way. Trauma-informed care seeks to create safety for consumers by understanding the effects of trauma and its close links to health and behaviour. A trauma informed health service includes incorporating trauma-informed policies such as allowing sufficient time (length of session) and continuity of care to engage with a consumer, spaces to have private and confidential discussions, and if possible, decisions made in collaboration and respectful of a consumer's choice[24]. It also requires clear roles for staff and referral pathways both internally and externally.

A key factor in supporting a consumer who discloses FDV is to provide them with information and support in response to their needs. Responses need to be culturally appropriate, culturally secure, and flexible to better meet the needs of consumers.

Whilst historically, the response to FDV in health services has focused on identifying and supporting victims, we acknowledge that victims can only be kept safe if perpetrators change their actions.

Just as victims access health services due to the health impacts of FDV, so too do perpetrators of abuse. Health workers have an opportunity therefore, based on their engagement with perpetrators, to assist in perpetrator accountability. Examples of perpetrator visibility and accountability can include not colluding with a person who is minimising, justifying, or blaming their family members for their behaviour. Increased perpetrator visibility also relies on coordination and information sharing between FDV support services. Health services can form part of this 'visibility' web.

Perpetrators of FDV also suffer adverse health consequences such as mental health issues, alcohol and drug dependency, and trauma. Providing care and support to perpetrators can assist in improvement of their mental and physical health and consequently the wellbeing of their victim/s and children[25]. As such, NMHS will explore strategies to build staff capacity and opportunities to work with perpetrators in identified areas, with the safety of victims and staff always the priority.

Women experiencing FDV who access a health service in NMHS feel safe and supported.

Perpetrators who access NMHS are more visible and held accountable for their behaviour.

Objectives

- Health services demonstrate clear operational guidelines and responsibilities on responding to disclosures of FDV including for both consumers and staff
- Improve internal and external referral pathways for both victims and perpetrators of FDV
- Strengthen health workers' capacity to support all consumers in a culturally responsive, culturally secure and flexible way
- Enhance system responses within identified health areas to improve perpetrator visibility, accountability and access to support services
- Develop clear guidelines on information sharing between NMHS and external FDV services which facilitate the timely and safe sharing of consumer information, in line with the Children and Community Services Act (including appropriate delegation)

Measures of success

- All health services have protocols for identifying and responding to FDV (for both victims and perpetrators) and relevant frontline staff are aware of these
- Staff have privacy and safe space to conduct screening for FDV
- Endorsement of an appropriate delegation of authority to ensure the timely release of information in high risk FDV cases (as per S28b, Children and Community Services Act)
- Health Services can demonstrate they have clear processes on sharing information with external organisations as per Section 28b, Children Community Services Act, including the ability to securely transfer information (in line with the Information Access, Use and Disclosure Policy)
- Secure data transmission technology available to delegated authorities

Workforce capability and system accountability

Improving workforce capability for frontline health staff is vital to increase awareness of FDV as a public health issue. Providing staff with education and training opportunities will build their knowledge, skills and confidence to better respond to consumers who have experienced, or are experiencing, abuse and to improve the likelihood consumers feel safe and supported if they disclose FDV.

Research indicates that for FDV training to be effective, it should be mandatory, recurrent and ongoing for all hospital staff[26]. All frontline staff would benefit from training in the dynamics of FDV, types of abuse, coercive control and the health impacts of FDV. By educating all frontline staff, this will contribute to workforce capacity to provide a more trauma-informed response.

In addition, health professionals who directly work with high risk groups, such as in antenatal, mental health and emergency departments would benefit from additional training on how to respond to disclosures in a trauma-informed manner, knowledge of risk assessment and clear referral pathways.

Aboriginal women and children are significantly over-represented as victims of FDV in WA. Their experiences of violence are often exacerbated by a lack of culturally informed responses which can be compounded by deep mistrust of government authorities. We recognise that to genuinely address this we need to respond in ways that are culturally secure and responsive to the experiences and needs of Aboriginal people who access our health services.

Historically health services have not been able to collect data on FDV presentations in health services. Without this information, it is difficult to understand the complex work that health professionals are undertaking, the extent of FDV presentations and how this interrelates with presenting health issues. Improving the data collection of FDV presentations across the health areas will provide NMHS with more accurate information to inform staff resourcing, and funding, and ultimately to better respond to consumers' needs.

Front-line staff feel confident and competent to screen, identify and support consumers who are experiencing FDV and engaged with NMHS.

Objectives

- Ensure FDV training is incorporated into NMHS Learning Management Systems and is a mandatory requirement for frontline staff, including both face-to-face and e-learning options
- Develop competency training for health staff on responding appropriately and effectively with Aboriginal consumers, migrants and refugees, as well as people with a disability
- Develop a robust data set on FDV across NMHS

Measures of success

- 80% of frontline staff have completed training in FDV
- Training packages on working with Aboriginal consumers, migrants and refugees, and people with a disability developed and available for NMHS staff
- Minimum data-set established and endorsed. Regular reporting on the agreed data-set delivered to North Executive Team and Board

Supporting staff at risk of FDV

The gendered nature of FDV, coupled with a predominately female workforce (75%), indicates that it is highly likely that NMHS will have higher rates of victims of FDV among its health services staff compared to the general population. Further, research indicates that health professionals experience FDV at higher rates than the general population. For example, a study of FDV among Australian female doctors, nurses and allied health professionals found that in the last 12 months 11.5% of participants reported intimate partner violence[29]. Comparatively, this would equate to more than 1,000 female staff in NMHS currently experiencing FDV*[30].

FDV can affect a person's capacity to work, to get to work (due to physical restraint or injury, caring for children, and other health impacts), and their work retention. In addition, staff encountering FDV during their duties may in turn be triggered due to their own experience. Therefore, providing support for staff experiencing FDV can result in a range of benefits to an organisation, including staff retention, improved quality of service and economic benefits.

A National Domestic Violence and the Workplace Survey found that 45% of staff with a recent experience of FDV had discussed it with someone at work (more likely colleagues and friends than managers). It is imperative that we have clear processes to ensure staff experiencing FDV feel safe to disclose, and are supported by their colleagues and managers, including flexible working arrangements and access to support services (such as employee assistance programs and FDV support services).

NMHS is committed to providing workplace support measures to employees in situations of FDV by helping them to maintain their employment and participate safely in the workplace. This includes additional entitlements such as an additional 10 days FDV leave per calendar year (in line with the Premier's Circular 2017/07: Family and domestic violence – paid leave and workplace support), and other support measures for staff.

Staff feel safe and supported to disclose FDV to colleagues and Managers. Managers and staff feel confident to support colleagues at risk of FDV.

Objectives

- Increase staff awareness of how to support a colleague if they disclose FDV
- Strengthen workplace support measures to support staff who are experiencing FDV by the introduction of identified "Staff Support Ambassadors" at each health service
- Managers and supervisors to ensure employees are aware of workplace support measures in relation to FDV including the NMHS family and domestic violence leave procedure

Measures of success

- Managers attending the FDV for managers training
- Managers demonstrating competency in knowledge of workplace support measures in relation to FDV
- Introduction of Staff Support Ambassadors across all health services with specific training on supporting a colleague experiencing FDV (linked with the NMHS Wellbeing Framework)
- Staff feel supported by their colleagues and managers when disclosing FDV

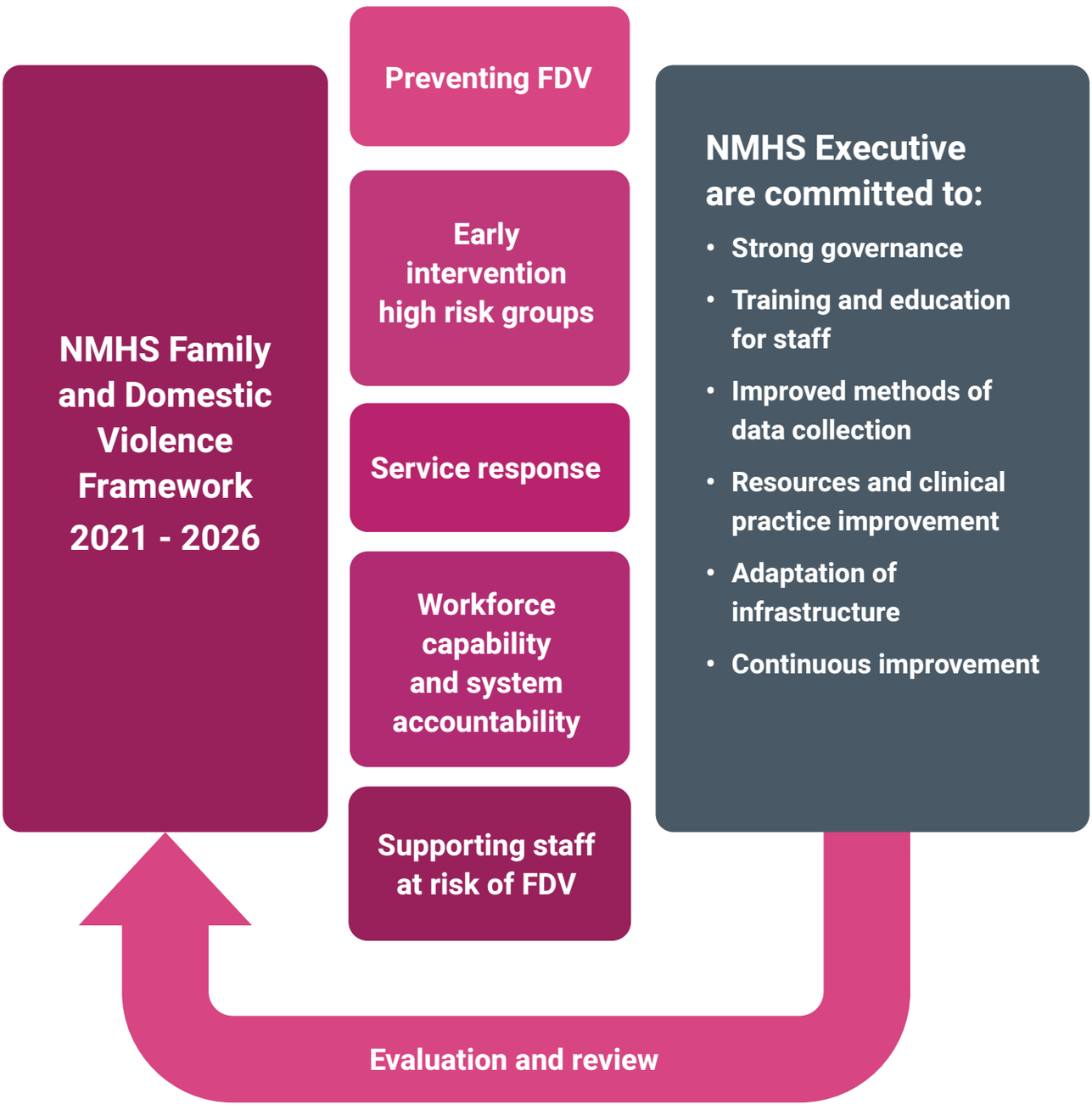
Next steps

Effective implementation of the NMHS Stop the Violence Strategy 2020 – 2025 will require collaborative efforts, active involvement and partnerships of all NMHS staff, stakeholders and consumers.

The implementation of the framework will also be supported through the formation of an NMHS FDV Committee with the aim of monitoring the progress of the implementation of the framework.

The Women's Health Strategy and Programs team, Women and Newborn Health Service will support the implementation of the framework with resources, training and strategic guidance.

Pathways for prevention and management of FDV



Appendices

Appendix A: Related policies and strategies

This framework has been informed by a range of national, state and local policies and strategies that address FDV.

INTERNATIONAL

1. World Health Organization Responding to Intimate Partner Violence and Sexual Violence Against Women, Clinical Practice Guidelines
2. WPA International Competency-Based Curriculum for Mental Health Providers on Intimate Partner Violence and Sexual Violence Against Women

NATIONAL

- National Safety and Quality Health Service Standards 2019 (2nd Edn), Australian Commission on Safety and Quality in Health Care
- National Plan to Reduce Violence against Women and Children 2010-2022, Department of Social Security, Australian Government (Strategies 3.3 and 4.3)
- National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023
- National Women's Health Strategy: 2020-2030, Department of Health, Australian Government
- Australasian College for Emergency Medicine Policy on Domestic and Family Violence 2016
- RACGP Abuse and Violence - Working with Our Patients in General Practice Guideline
- Midwife Standards for Practice, Nursing and Midwifery Board, Australia
- Australian College of Midwives – Position Statement Domestic Violence - 2019
- National Standards for Mental Health Services (2010),
- Family Violence Prevention Programs in Indigenous Communities, Closing the Gap Report

WA GOVERNMENT

- Western Australia's Family and Domestic Violence Prevention Strategy to 2022
- Path to Safety: Western Australia's strategy to reduce family and domestic violence, First Action Plan 2020-2022
- Family and Domestic Violence paid leave and workplace support - Premier's Circular 2017/07
- Section 28b of the Children and Community Services Act 2004
- All Paths Lead to a Home: Western Australia's 10-Year Strategy on Homelessness 2020-2030

WA HEALTH

- Clinical Senate Responding to Interpersonal Violence: Are you Safe? 2017
- Sustainable Health Review
- Responding to the Abuse of Older People (Elder Abuse) Policy
- Western Australian Women's Health and Wellbeing Policy
- WA Aboriginal Health and Wellbeing Framework 2015-2030
- Guidelines for Protecting Children 2020,
- Procedure for Responding to a Recent Sexual Assault, Sexual Assault Resource Centre (SARC)

NORTH METROPOLITAN HEALTH SERVICE

- NMHS Strategic Plan 2020 - 2025
- NMHS Wellbeing Framework
- NMHS Aboriginal Health and Wellbeing Action Plan
- NMHS Stop the Violence Strategy 2020 – 2025
- NMHS Our People Strategy 2019-2024

Appendix B: Glossary of terms

This framework has been informed by a range of national, state and local policies and strategies that address FDV.

Diverse communities	Diverse communities include multiple groups: culturally and linguistically diverse; people with a disability; people experiencing mental health issues; lesbian, gay, bisexual, transgender and gender diverse, intersex and queer/questioning (LGBTIQ) people; women in or exiting prison or forensic institutions; people who work in the sex industry; people living in regional, remote and rural communities; male victims; older people and young people (12-25 years of age).
Perpetrator	The term perpetrator is used to refer to people who have used or are using violence in their relationships. The use of this terminology reflects the importance of holding the person to account for their choice to use violent behaviour and inflict harm. It is not intended to reflect a person's identity or capacity for change.
Risk factors	Evidence-based factors that are associated with the likelihood of family and domestic violence increasing in severity.
Social determinants of health	Social determinants of health are the conditions in which people are born, grow, live, work and age which are shaped by access to information, power and resources.
Trauma-informed	Trauma-informedcare involves understanding how trauma shapes a person's world view and functioning. Trauma-informed care will incorporate principles of safety, trust, collaboration and choice in service delivery.
Cultural security	Cultural security is the provision of programs and services offered by the health system that will not compromise the legitimate cultural rights, values and expectations of Aboriginal people.
Victim	The term is used to refer to people who have previously been or are currently being abused by a family member or intimate partner. This includes survivors and victim-survivors. The term aims to acknowledge the harm caused by FDV and in no way reflects the person's full identity.
Family	Relatives and family members as connected by blood or marriage, including current and past spousal relationships, relatives through kinship, cultural or religious grounds; and situations where people's lives have become enmeshed through the passage of time, trust and commitment, a level of intimacy, whether sexual or not; frequency of contact; or level of dependency, such as in informal care arrangements between people with disabilities and caregivers.[31]

Appendix C: Resources

- WNHS Family and Domestic Violence Toolbox
- Responding to Family and Domestic Violence Guideline
- NMHS Family and Domestic Violence Staff Support
- https://workplace.ourwatch.org.au/
- https://www.wgea.gov.au/topics/workplace-flexibility

If you or someone you know is experiencing FDV, you can contact the following 24hr helplines for assistance:

- **Women's Domestic Violence Helpline: 9223 1188 or 1800 007 339**
- **Men's Domestic Violence Helpline: 9223 1199 or 1800 000 599**
- **Crisis Care: 9223 1111**
- **1800RESPECT: 1800 737 732**
- **WA Police: 131 444**

In an emergency, call 000.

References

1. Australian Bureau of Statistics, Personal Safety Survey , 2016

2. Ombudsman Western Australia Annual Report, 2019-20.

3. Department of Communities (2020). First Action Plan 2020-2022. Path to safety. Western Australia's strategy to reduce family and domestic violence 2020-2030. Government of Western Australia, page 18.

4. Australian Bureau of Statistics. (2017). Personal safety, Australia, 2016. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02016?OpenDocument

5. Australian Bureau of Statistics. (2017). Personal safety, Australia, 2016. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02016?OpenDocument

6. Ayre, J., On, M. L., Webster, K., Gourley, M., & Moon, L. (2016). Examination of the burden of disease of intimate partner violence against women in 2011. Australia's National Research Organisation for Women's Safety Limited (ANROWS).

7. Noonan, P., Taylor, A., & Burke, J. (2017). Links between alcohol consumption and domestic and sexual violence against women: Key findings and future directions. Compass, 8, ANROWS: Sydney.

8. Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., ... & Watts, C. H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. PLoS Med, 10(5), e1001439.

9. Tarzia, L., Thuraisingam, S., Novy, K., Valpied, J., Quake, R., & Hegarty, K. (2018). Exploring the relationship between sexual violence, mental health and perpetrator identity: a cross- sectional Australian primary care study. BMC

10. Harold, G. T., & Sellers, R. (2018). Annual Research Review: Interparental conflict and youth psychopathology: an evidence review and practice focused update. Journal of Child Psychology and Psychiatry, 59:4, 374-402.

11. Department of Health, Western Australia. (2017). WA Health costs associated with family and domestic violence – a snap shot. Perth: Women's Health Strategy and Programs, Women and Newborn Health Service, Department of Health, Western Australia.

12. World Health Organization (WHO). (2013b). Responding to intimate partner violence and sexual violence against women. World Health Organisation. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=F382938148D8468F4112EBB0E9991876?sequence=1

13. MacIsaac, M. B., Bugeja, L., Weiland, T., Dwyer, J., Selvakumar, K., & Jelinek, G. A. (2018). Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia. Asia Pacific Journal of Public Health, 30(1), 36-44.

14. McLindon, E., Humphreys, C., & Hegarty, K. (2018). "It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals. BMC women's health, 18(1), 113.

15. Webster, K. A preventable burden: measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women. Sydney (NSW), Australia's National Research Organisation for Women's Safety (ANROWS), 2016.

16. Pricewaterhouse Coopers Australia. A high price to pay: the economic case for preventing violence against women. Melbourne: Our Watch and VicHealth; 2015.

17. RESPECT women: Preventing violence against women. Geneva: World Health Organization; 2019 (WHO/RHR/18.19). Licence: CC BY-MC-SA 3.0 IGO

18. Respect Women: Preventing violence against women, Department of Reproductive Health and Research, World Health Organization, Switzerland, 2019

19. Family, C. P. (2018). Chief Psychiatrist's guidelines and practice resource: family violence. Melbourne: Victorian Government

20. Devries K, W. C. (2011). Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. Social science & medicine, 73(1), 79-86

21. Dawson, A. J., Rossiter, C., Doab, A., Romero, B., Fitzpatrick, L., & Fry, M. (2019). The emergency department response to women experiencing intimate partner violence: insights from interviews with clinicians in Australia. Academic emergency medicine, 26(9), 1052-1062

22. Brignone, L., & Gomez, A. M. (2017). Double jeopardy: Predictors of elevated lethality risk among intimate partner violence victims seen in emergency departments. Preventive medicine, 103, 20-25.

23. Dawson, A. J., Rossiter, C., Doab, A., Romero, B., Fitzpatrick, L., & Fry, M. (2019). The emergency department response to women experiencing intimate partner violence: insights from interviews with clinicians in Australia. Academic emergency medicine, 26(9), 1052-1062.

24. Hegarty, K., etal (2017). Women's Input into a Trauma-informed systems model of care in health settings (The WITH Study) Final report (ANROWS Horizons 02/2017). Sydney: ANROWS.

25. MacIsaac, M. B., Bugeja, L., Weiland, T., Dwyer, J., Selvakumar, K., & Jelinek, G. A. (2018). Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia. Asia Pacific Journal of Public Health, 30(1), 36-44.

26. Strengthening hospital responses to family violence, 4th edition, The Royal Women's Hospital, Victoria, 2018.

27. Workforce Planning, North Metropolitan Health Service, October 2020

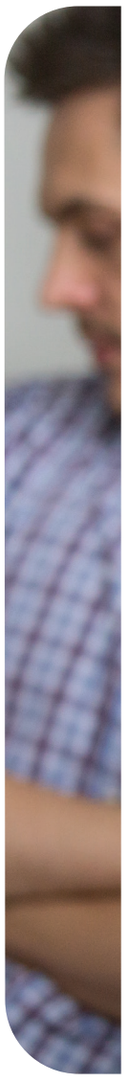
28. McLindon E., Humphreys C., Hegarty K., "It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals, BMC Women's Health,18, 113 (2018). https://doi.org/10.1186/s12905-018-0588-y

29. ibid

*30. 11.5% of the NMHS female workforce which totalled 9000 as at October 2020.

31. Australian Bureau of Statistics, Conceptual Framework for Family and Domestic Violence 2009, 4529.0

Notes



North Metropolitan Health Service
Hospital Ave, Nedlands WA 6009
(08) 6457 3333
KEMH.WomensHealthStrategyandPrograms@health.wa.gov.au
nmhs.health.wa.gov.au

This document can be made available in alternative formats on request.

NMHS1329_1021