



Model of Care

Supporting Recovery – a pilot program to provide trauma-informed recovery care for victim-survivors of family, domestic and sexual violence

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Dedication

This program will provide trauma-informed recovery care for people who have experienced family, domestic, and sexual violence (FDSV) and supports *the National Plan to End Violence against Women and Children 2022-2032* (the National Plan). The National Plan is dedicated to each and every victim and survivor of gender-based violence.

We thank the victim-survivors who have spoken out and shared their experiences and insights. Their work to reduce family, domestic and sexual violence (FDSV) continues to inspire us and drive us to do more.

We mourn those who have been murdered and the children we will not see grow up. We recognise those with lived experience who continue to recover from violence and manage the life-long impacts of trauma. We acknowledge the life-long disabilities and impairments that many live with as a direct result of violence.

Acknowledgement of Country

We acknowledge and pay respects to all Aboriginal and Torres Strait Islander peoples across Australia, who are the custodians of the land and of the oldest continuous living culture on Earth.

We honour Aboriginal and Torres Strait Islander peoples' ongoing connection to sea, waterways and Country.

We pay respects to Elders past, present and emerging.

Terminology

The Department of Health and Aged Care acknowledges there is no *'one size fits all'* when it comes to terminology that suits all situations and individuals. No exclusion or harm to individuals is intended in the terms used.

The Model of Care endeavours to use inclusive language, while acknowledging the evidence base and the experiences of women, girls, and females or women identifying and non-binary people.

The Model of Care uses the language 'violence against women' to acknowledge that the forms of violence it seeks to address is gendered in nature, being mostly perpetrated by men against women and children. The Model of Care also acknowledges that LGBTQIA+ communities, sexually and gender diverse people and intersex people are also impacted by violence with the same gendered drivers often in complex and intersecting ways.

The Model of Care acknowledges terminology around FDSV, gender-based violence, and violence against women is evolving and that this language does not work for all victim-survivors impacted by violence.

Introduction

The National Plan to End Violence against Women and Children 2022–2032

The National Plan is the Australian Government’s whole-of-society, 10-year policy framework to end violence against women and children. It outlines a vision of ending gender-based violence in one generation and what steps need to be undertaken to achieve it.

There are four domains in the National Plan that will help Australia achieve this vision of ending gender-based violence in one generation. They are prevention, early intervention, response, and recovery and healing. The pilot program supports the ‘recovery and healing’ domain of the National Plan.

The National Plan recognises there is more work to do and incorporates feedback from victim survivors, advocates, advisory groups, and family, domestic and sexual violence service providers.

Recovery and healing is an essential component of the National Plan and recognises that even after violence has ended, the effects on victim-survivors’ health and wellbeing continue. Victim-survivors often need life-long support to recover and heal from trauma.

Recovery is an ongoing process that enables victim-survivors to be safe, healthy and resilient and to have economic security and post-traumatic growth. Recovery includes addressing the short-term, long-term and lifelong health impacts for victim-survivors, which may include physical injuries, reproductive and sexual health issues and poor mental health. Recovery also relates to the rebuilding of a victim-survivor’s life, their ability to return to the workplace and community, as well as obtaining financial independence and economic security. However, it must be acknowledged that victim-survivors recover and heal in different ways, with some people being unable to return to work and requiring access to ongoing support.

The National Plan also recognises the need to support children as victim-survivors in their own right. Addressing the impacts of developmental trauma will help break future cycles of violence.

In cases of gender-based violence, the victim-survivor may still be in contact or live with the perpetrator. In these situations, the family, as a whole may need support to recover. Moreover, in some cases, people are both victim-survivors and perpetrators of violence – for example, some adolescents using violence. People in this situation must be supported to

both recover from their experiences of violence and address their own use of violence to prevent further harm.

Recovery from FDSV can be a difficult and long-term process. The National Plan recognises that trauma-informed and person-centred approaches are needed to address barriers to recovery and healing and to minimise the possibility that victim-survivors will be re-traumatised and harmed when using services and systems.

The Department of Health and Aged Care is leading the implementation of three programs that support victim-survivors of FDSV under the National Plan, including:

- \$48.7 million to support victims and survivors of FDSV and child sex abuse to navigate the health system, through Primary Health Networks (PHNs),
- \$67.2 million to pilot a new model of trauma-informed recovery care, through six PHNs, to improve coordination and access to trauma-informed recovery services for victim-survivors who have experienced FDSV; and,
- \$25.0 million to support the Illawarra Women's Health Centre to establish a Women's Trauma Recovery Centre.

Issue

Evidence suggests adults and children who experience FDSV, often experience significant mental health conditions as a result, including anxiety, depression, post-traumatic stress disorder (PTSD) and complex PTSD. These can last for many years with recovery requiring an extensive range of supports, including a focus on mental health supports.

Recovery is often dependent on addressing legal, financial and security concerns resulting from FDSV, as well as on services being delivered from a trauma-informed perspective, ensuring they do not exacerbate the impact on the person's mental health. Recognising the gendered nature of these types of violence are enabled by existing gendered inequality, women's housing, financial, and personal security is often more significantly impacted and harder to restore after experiencing abuse.

In Australia, the FDSV support landscape remains fragmented and complex to navigate. Existing FDSV services are often focused on crisis supports, rather than on longer-term recovery and healing services.

The department has made progress in facilitating trauma-informed care and integrating different service systems by:

- Funding the PHN Family and Domestic Violence pilot program to support training for the primary care workforce to better recognise and support victim-survivors of family

and domestic violence and improve system integration and health system navigation for victim-survivors. A key component of this is through the establishment of system integrators as a link between specialist support services, primary health care services and local health systems; and,

- funding the Illawarra Women’s Health Centre to establish a Women’s Trauma Recovery Centre.

However, gaps remain in providing integrated, comprehensive, and appropriate trauma-informed care. This presents an opportunity for the Australian Government to deliver a new pilot program that is individualised, trauma-informed and recovery focused.

Supporting Recovery from Family, Domestic and Sexual Violence – a pilot program

Supporting Recovery from Family, Domestic and Sexual Violence (the Pilot Program), is a pilot program that will provide trauma-informed care across the FDSV service provision and provide access to trauma-informed mental health care to victim-survivors as part of their longer-term recovery. The Pilot Program focuses on the recovery aspects of care and embeds mental health capabilities within existing local services.

The Pilot Program aims to bring together the diverse FDSV service landscape and ensure that supports are delivered appropriately, effectively and consistently to those that need it most.

Key components of the Pilot Program include:

- **Local Care Teams:**
 - embedded in an existing service to provide individual case and care management to each victim-survivor.
 - Consist of professionals appropriately trained in FDSV-specific trauma informed care.
 - provide warm referrals to trauma-informed and trained service providers to deliver support specific to the needs of the victim-survivor.
- Commissioning by PHNs of new trauma-informed mental health services including providing access to free, long term and trauma-informed mental health care.
- An independent evaluation.

The Pilot Program is not intended to replace or duplicate other FDSV supports available, including shorter term and crisis supports already in place. The Pilot Program is intended to complement and extend existing programs.

In scope

The following support services are in scope for the Pilot Program:

- Recovery services – the Pilot Program is intended for victim-survivors in the recovery and healing stages of their journey. The Pilot Program acknowledges that recovery is not linear and it will support victim-survivors in a longer-term approach over the course of their journey.
- Trauma-informed mental health care – the Pilot Program intends to provide trauma-informed services to victim-survivors.
- Local variability – the Pilot Program intends to ensure local variability by embedding Local Care Teams within existing local services.
- Person-centred and integrated care models – the Pilot Program provides referrals to trauma-informed and trained service providers to deliver support specific to victim-survivors' needs.

Out of scope

As this program has a focus on recovery, the following support services are out of scope for the Pilot Program:

- Crisis support services - the Pilot Program is designed for victim-survivors in the recovery and healing stages of their journey and are not intended to be used as crisis supports. Crisis FDSV services generally focus on safety, affordable and secure housing and financial security. The Pilot Program is not designed to take on new clients in crisis situations, but may continue to support existing clients if they find themselves in crisis situations throughout their recovery journey. This may include connecting clients with appropriate crisis supports. This is in recognition that recovery is not linear and that victim-survivors may continue to experience different forms of violence after receiving support.

Assumptions underpinning the pilot program

- Local Care Teams are embedded within existing services to increase integration and wrap around supports and will not be a new stand-alone service.
- Services will be provided for the duration of the pilot program and will focus on the recovery of victim-survivors who have had their mental health affected because of FDSV.
- Equitable and inclusive – a no cost, welcoming, compassionate, culturally safe environment that is inclusive of all who present, including First Nations peoples, people with disability, members of LGBTQIA+ communities and people from Culturally and Linguistically Diverse (CALD) backgrounds.
- Local Care Teams and services must adhere to the principles of the Gayaa Dhuwi (Proud Spirit) Declaration and the National Agreement on Closing the Gap in the development and delivery of services to ensure culturally safe services for First Nations people are included as part of the broader Program.

Eligibility criteria

The Pilot Program will operate under a no wrong door approach. Any person who presents to the Local Care Team as a victim-survivor of FDSV, regardless of age or gender, including victim-survivors of child sexual abuse, will be assessed by the LCT who will assist with coordination to relevant local services, including new trauma-informed services commissioned by the PHN, if appropriate. People who are not Australian citizens, including permanent residents and those on temporary visas, are also eligible for the Pilot Program, provided they currently reside in Australia. People currently engaged with the judicial system are also eligible to access services.

The Pilot Program recognises children and young people as victim-survivors of violence in their own right. The Pilot Program will establish appropriate supports and services that will meet their safety and recovery needs

While the Pilot Program is not designed to take on new clients in crisis situations, it will continue to support existing clients if they find themselves in crisis situations throughout their recovery and healing journey. This may include connecting clients with appropriate specialist and crisis supports including ongoing/other services. This is in recognition that recovery is not linear and that victim-survivors may continue to experience different forms of violence after receiving support.

Key principles

The Pilot Program has been designed to improve coordination and access to FDSV trauma-informed recovery services for victim-survivors who have experienced FDSV and ensure supports are delivered appropriately, effectively and consistently. The Pilot Program is designed to reduce touchpoints and ensure victim-survivors have access to integrated and coordinated services to ensure safety and ability to engage in FDSV trauma-informed mental health therapies to enable a sustainable recovery.

Core components

1. **Local Care Teams** embedded into existing service locations undertake intake and referral (including care coordination and case management).
2. **Trauma-informed services** are commissioned by PHNs to support mental health of victim-survivors.
3. **Independent evaluation** of the Pilot Program.

Guiding principles

1. **Safety:** A place where victim-survivors and staff are culturally, emotionally, and physically safe.
2. **Choice:** Each victim-survivor has the power of choice and control over their recovery journey.
3. **Collaboration:** Shared decision making with the victim-survivors and not on behalf of them. Active support will be provided to support decisions the victim-survivors has made regarding their recovery journey.
4. **Trustworthiness:** Transparency and trustworthiness are foundational to all relationships. The dignity, integrity and lived expertise of every victim-survivors receiving care is respected.
5. **Empowerment:** An atmosphere that allows each victim-survivor to be validated and affirmed at each and every contact with staff. The setting fosters recovery and healing.
6. **FDSV and trauma-informed approaches:** A focus on FDSV trauma-informed services that put mental health at the heart of recovery for adults and children who have experienced FDSV.
7. **Person-centred coordination and integration:** The Pilot Program embeds mental health capabilities within existing services that are needed in an ongoing way as victim-survivors recover from FDSV. To increase integration and wrap around supports, this will not be a new stand-alone service.

8. **Services:** Provided for the duration of the pilot program and will focus on the recovery and healing of victim-survivors who have had their mental health affected due to FDSV.
9. **Equitable and inclusive:** A no cost, welcoming, compassionate, culturally safe and appropriate environment that is inclusive for all victim-survivors accessing services and supports.
10. **Evidence-informed best practice and continuous quality evaluation:** Using data, evidence, research and lived experience of care and feedback indicators to create a continuous feedback loop between research, clinical practice and the outcomes for victim-survivors.
11. **Clinical governance and accountability:** Appropriate governance to ensure quality standards and clinical competence, and reporting requirements are maintained and responded to.
12. **Flexible and responsive:** LCTs and PHNs have the ability to respond to the needs of the victim-survivor and the local region.
13. **Cultural responsiveness and safety:** A commitment to culturally informed and safe practices that align with the National Agreement on Closing the Gap.
14. **Recovery and healing:** Services are focused on the recovery and healing of victim-survivors.
15. **Embedding the lived-experience of victim survivors:** Lived-experience and advice provided by victim-survivors will be acknowledged and embedded into the design of the Pilot Program to ensure outcomes are achieved for victim-survivors accessing care.

Key requirements

1. FDSV trained, trauma-informed and culturally safe mental health care staff.
2. Accessible locations embedded within existing service locations.
3. Partnerships with mental health professionals and local services to facilitate service integration and linkages.

Core components

All pilot sites will be commissioned by PHNs. While allowing for local flexibility, there are core services that all pilot sites would be expected to provide. Individual sites will need to consider the mode of delivery to best meet the population requirements including in-house (at the site), out-reach and telehealth services.

A diagram outlining pathways to recovery is provided at [Attachment A](#).

1. Intake and referral

It is intended that victim-survivors requiring trauma-informed recovery care as a result of FDSV can access the Local Care Teams in a number of ways. The primary referral pathway will be via the Head to Health Assessment and Referral Phone Service. This service is localised, and the call will be answered by someone in the local PHN area. The person on the phone line will direct the victim-survivor to the trial site if they are in the same region. Warm referrals, from the phone line to the Local Care Team, will be provided.

This referral approach reflects the limited pilot locations available to offer the service and the ability of the phone service staff to seamlessly connect callers with local multidisciplinary teams operating within their jurisdiction.

In addition to the national phone service, victim-survivors may also be referred to the service through:

- walk-ins from the setting that Local Care Teams are embedded within the RRR pilot, where services provided in the Pilot Program are being provided near a RRR site
- the 1800 RESPECT phone line.

Referrals may also be made beyond primary care settings, for example, family court, community legal assistance services or other FDSV programs. The pilot program will operate on a 'no wrong door' approach, where victim-survivors presenting to Local Care Teams for assistance will not be turned away if they have been referred through a method not referred to above.

2. Initial assessment

Following referral, an initial assessment with a member of the Local Care Team will be undertaken to assess the mental health and other support needs of the victim-survivor.

The initial assessment is focused on information gathering to assign a level of care and is not seeking to make a diagnosis or replace a comprehensive mental health assessment.

Professionals conducting the initial assessment will be FDSV trained, trauma-informed and culturally safe, to ensure this process is not traumatising for victim-survivors.

Outcomes of the assessment will inform the development of an integrated recovery care plan tailored to each victim-survivor, including up to two years of mental health support.

Interventions including treatment, care and support required from within the service (if appropriate) or through a supported warm referral to other trauma-informed support services or social services will be outlined.

The Pilot Program does not require victim-survivors to tell their story unless they choose to. It is understood that some victim-survivors will choose not to tell their story at all. An initial

assessment of need will be undertaken. However, the priority of the initial meeting is to build rapport and establish a relationship between the victim-survivor and the Local Care Team.

An initial assessment of need will vary across locations and may include family and other supports, and engagement and motivation.

3. Care coordination and case management

A member of the Local Care Team will play a care coordination and case management role. They will stay with the victim-survivor throughout their journey as a single point of contact to the Local Care Team. The case manager will provide a warm referral to a mental health service who will deliver individualised FDSV trauma-informed therapies. Where a child presents as a victim-survivor, referrals to child-specific services will be provided.

The case manager will develop an integrated recovery care plan based off the initial assessment. Each victim-survivor will receive up to two years of subsidised support, including mental health treatments, support from the Local Care Team/case manager or via referrals to other trauma-informed services, e.g., legal, financial or housing support.

The case manager will ensure referrals to FDSV trained and trauma-informed mental health care are accessible and affordable. Where possible, there should be minimal changes to the composition of a victim-survivor's care team. When changes are necessary this should be reflected in the victim-survivor's recovery plan.

Regular communication or meeting sessions with the victim-survivor and members of their care team will be offered. Frequency of these sessions will be dependent on the complexity of the victim-survivor's needs during their recovery journey. Sessions with members of the care team will be fully subsidised.

The Local Care Team may also link victim-survivors to a range of other social services dependent on need. Local Care Teams will provide warm referrals to other services, and take on the referral burden, so the victim-survivor does not need to tell their story more than once. Other types of services that might be suggested include (but not limited to):

- primary health care
- legal supports
- housing support
- financial advocacy.

Local Care Teams will include professionals appropriately trained in FDSV-specific trauma informed care. Each pilot site will have two full-time equivalents (FTE) in its local care team. FTE will be accessible in part-time units, as required at each local site. Teams may include:

- psychologists
- counsellors
- mental health nurses
- mental health occupational therapists
- social workers
- general practitioners
- mental health peer support workers
- FDSV peer support workers, if appropriate/relevant for the local region
- Aboriginal Health Practitioners, if appropriate/relevant for the local region.

Peer support should be offered. Peer support workers should be available to assist either by their inclusion in the care team or provided separately.

4. Trauma-informed mental health therapies

Treatments and therapies will play a key role in the Pilot Program. It is integral that the mental health service providing therapies is fully trained in FDSV specific trauma-informed care in order to ensure that re-traumatisation does not occur.

Local Care Teams will provide warm referrals to mental health services that will support the victim-survivor with FDSV trauma-informed therapies. Telehealth options to receive services will be available as mental health professionals may not be locally accessible to each victim-survivor.

New FDSV trauma-informed therapeutic services will be commissioned per PHN, to provide up to two years of ongoing mental health support. These services could be existing services that have been enhanced, or they can be new and not from an existing provider. Mental health services would not be based in the facility housing the Local Care Teams. PHNs are likely to be needed to undergo a process to select a provider per region or location.

Psychological therapies will be fully subsidised for a period of up to two years for each victim-survivor.

Holistic treatment and therapies may include:

- Cognitive Behavioral Therapy (CBT)/Dialectical Behaviour Therapy (DBT)
- Cognitive Processing Therapy (CPT)
- Hoping to Overcome PTSD through Empowerment (HOPE) Intervention Model

- Family therapies/Narrative therapy
- Occupational therapies
- Eye Movement Desensitization and Reprocessing (EMDR) Therapy
- Somatic Therapy
- Mindfulness
- Other appropriate wellbeing and social interventions.

Services will also be holistic, culturally informed and include traditional healing, where appropriate to the victim-survivor.

5. Services are embedded into existing locations

To ensure services are not fragmented and allow for integration across different sectors, it is essential that Local Care Teams are embedded into existing local services.

PHNs will commission the Local Care Teams and will play a key role in embedding them into existing local services. Local Care Teams will be managed on a day-to-day basis by the service in which they are embedded (host service). PHNs will provide funding to the host service for this management service.

The service in which the Local Care Team is located will differ across each trial site and PHN regions dependent on availability. The Pilot Program will seek to trial a variety of service locations to determine which type of site(s) prove to be most effective.

For example, Local Care Teams may be embedded into one of the following services:

- a Head to Health Adult Mental Health Centre
- a Women's Health Centre
- a Women's Legal Centre, or other appropriate legal assistance service
- an Aboriginal Community Controlled Health Organisation (ACCHO)
- an Aboriginal Community Controlled Organisation (ACCO)
- a state-run service (e.g., a maternity ward at a state-run hospital)
- a primary care location
- community health centres
- a RRR location
- a Maternal and Child Health Clinic
- a GP or medical centre
- other existing FDSV services.

Workforce – a multidisciplinary team approach

To deliver the core functions of the Pilot Program, it is expected that PHNs will establish Local Care Teams, supported by appropriate clinical governance. Services provided will need to be recovery focused, FDSV trauma-informed, family, community, culture and person-centered.

Acknowledging the challenges of workforce availability, PHNs should consider innovative approaches to address workforce shortages and access. This may include shared employment or secondment arrangements, access to specialist clinicians through telehealth, training rotations with appropriate supervision incorporated into the Pilot Program and expanding the workforce scope broader than traditional mental health and health workforce where this is able to meet service needs.

Monitoring and evaluation

An independent evaluation framework for the Pilot Program is being developed, with assistance from an Expert Reference Group, to support monitoring the Pilot Program, review the effectiveness of the Pilot Program in achieving these outcomes, and to inform any future expansion of the Pilot Program.

In broad terms, the following outcomes for victim-survivors who have experienced trauma as the result of FDSV are expected from each site location:

- A Program that focuses on FDSV trauma-informed services and mental health as the focal point of recovery for a victim-survivor of FDSV.
- An uptake in the use of mental health services as a response to FDSV as a result of the trial.
- Victim-survivors affected by FDSV will continue to access more mental health support services as it will be affordable, accessible and offered to them as part of this trial.
- Victim-survivors are less likely to be re-traumatised through using the mental health system as services will be FDSV trauma-informed. This will encourage a quicker recovery and further encourage victim-survivors to participate in other FDSV services.
- Victim-survivors will have overall stronger mental health and wellbeing as a result of this trial.
- Victim-survivors will be able to access the particular mental health and related services they are assessed as needing through Local Care Teams.

- Victim-survivors will receive advice and care which will reduce their level of mental and emotional distress relating to FDSV.

Each pilot site will be required to collect qualitative and quantitative data to ensure outcomes are being achieved and help inform an iterative, ongoing evaluation of service effectiveness to ensure needs are being met. This includes ensuring data collection and reporting is consistent with the *Primary Mental Health Care Schedule Minimum Data Set (PMHS-MDS)* for all activities.

Types of data that can indicate if the Pilot Program is effective includes:

- Number of victim-survivors accessing care from the Local Care Teams at each pilot site.
- Number of referrals to mental health professionals.
- Number of mental health services accessed by victim-survivors.
- Instances of access to other trauma-informed services, such as legal, housing or financial referrals.
- Feedback from victim-survivors utilising services.

Flexibilities

While pilot sites will deliver services consistent with this Program, flexibilities will be allowed to address any local or jurisdictional requirements including:

- adjusting any service offering to ensure that the pilot site is complementing, not duplicating, existing services in the region
- addressing relevant cultural or community needs such as the needs of First Nations people, and the needs of victim-survivors from diverse communities within the region
- adapting or sharing the health workforce in areas of reduced availability, for example cross employment arrangements with state or territory government services
- exploring partnerships with other agencies to enhance development of innovative service options which complement the site's core functions.

Safety and quality

A comprehensive safety and quality framework will be required as part of the implementation of the Pilot Program. This should include the following:

- Compliance with relevant safety and quality standards, including the *National Standards for Mental Health Services 2010*.

- Implementing appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway to support quality care.
- Clinical governance to ensure that staff hold the appropriate credentials and are well supported and trained to provide care to those victim-survivors experiencing crisis. Protocols must be in place to guide review of the care provided and for responding to critical incidents and complaints.
- Consideration in general of safety and quality priorities outlined in the *Fifth National Mental Health and Suicide Prevention Plan*.
- Cultural safety considerations to ensure that First Nations people receive quality responses and equality of care.
- Culturally competent care for other diverse population groups including CALD people and LGBTQIA+ communities.
- Support for the appropriate use of the *Privacy Act 1988* and the Australian Privacy Principles so information can be shared by practitioners as part of effective collaboration with consumers and carers.
- [*The Family Violence Experts by Experience Framework*](#).
- Alignment with the National Agreement on Closing the Gap and the four Priority Reforms.

Partnerships and protocols

Close partnerships will be formed with the services described above, as appropriate, to enable an integrated approach to victim-survivors who may require transfer from one service to the other.

As many victim-survivors referred to the site may already be clients of other services, protocols for communicating with, and if appropriate, providing shared care with these services will also be important. Each site will need to have effective systems with other local providers for referral and coordination of care. It will be important that services are not duplicated, and that information is shared among providers (with consent) to minimise the need for repeated explanation by victim-survivors.

Glossary

In general, the terms used in this paper should be understood to align with definitions provided in the National Plan. The following terms are highlighted.

| Term | Definition |
|--------------------------------------|---|
| Alcohol and Other Drugs (AOD) | This term most often refers to excess use of alcohol and misuse of illicit or prescribed drugs. |
| Care navigator | A person who works collaboratively with consumers and carers to assist them in finding the most appropriate treatment, care or supports. |
| Clinical governance | Clinical governance is defined as the system by which the governing body (bodies), managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents. |
| Evidence-based | Models, approaches or practices found to be effective through evaluation or peer-reviewed research. Evidence is usually published and may be found in full or summarised in academic research documents, organisational reports, program evaluations, policy papers and submissions. There is a strong evidence base for strategies to prevent gender-based violence. As our understanding of what drives violence against women and children in different population groups and settings increases, the evidence base will continue to evolve. |
| Episode of care | The package of therapies and treatments provided by a Local Care Team. An episode of care is delivered by the Local Care Team over the duration of the recovery plan. |

| Term | Definition |
|---|--|
| <p>Family, Domestic and Sexual Violence (FDSV)</p> | <p>Family violence is violence between family members, such as between parents and children, siblings, and intimate partners.</p> <p>Domestic violence is a type of family violence that occurs between current or former intimate partners, sometimes referred to as intimate partner violence.</p> <p>Sexual violence includes sexual assault, sexual threat, sexual harassment, street-based sexual harassment and image-based abuse sexual harassment.</p> <p>Violence can be physical, sexual, emotional, psychological, social, cultural, spiritual, financial and technology-facilitated abuse (including image-based abuse), and stalking. Adults and children can experience multiple and intersecting forms of violence, harassment and abuse across the course of their lives and across a variety of settings.</p> <p>Children may witness domestic and family violence between other family members or be subjected to violence targeted at them by other family members that can have a range of impacts on their health, wellbeing, and social and emotional development.</p> |
| <p>Gendered drivers of violence</p> | <p>The underlying causes that are required to create the necessary conditions in which violence against women, children and LGBTIQ+ people occur. They relate to the particular structures, norms and practices arising from gender inequality in public and private life, but which must always be considered in the context of other forms of social discrimination and disadvantage.</p> |
| <p>Gender equality</p> | <p>Involves equality of opportunity and equality of results. It includes both the redistribution of resources and responsibilities between men and women and the transformation of the underlying causes and structures of gender inequality to achieve substantive equality.</p> |

| Term | Definition |
|---------------------------------------|--|
| Gender inequality | A social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity between them. It is the direct result of patriarchal systems which privilege the needs, interests and behaviours of men over women, and which permeate many aspects of Australian society and institutions. |
| LGBTQIA+ | <p>An acronym used to describe members of the lesbian, gay, bisexual, trans, queer, questioning, intersex, asexual community and more. These terms are used to describe a person's sexual orientation or gender identity. It is sometimes used to include allies or supporters of the LGBTQIA+ community. Other acronyms used to describe this community include LGBTIQ, or LGBTIQ+.</p> <p>There is no single LGBTQIA+ community. Though it may be referred to as a singular term, the LGBTQIA+ community is a highly diverse group of individuals from many different backgrounds with distinct histories and experiences.</p> |
| Local Hospital Networks (LHNs) | Entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being responsible for performance in a defined geographical area. LHNs also commonly manage other health services such as community-based health services. |
| Local Care Team | The Local Care Team is a multidisciplinary team that follows each victim-survivor through their care journey. |
| FDSV Peer Support Worker | Workers who have a lived experience of FDSV and who provide valuable contributions by sharing their lived experience with others. |

| Term | Definition |
|--|--|
| Mental Health Peer support worker | Workers who have a lived experience of mental illness and/or suicide and who provide valuable contributions by sharing their experience of mental illness and/or suicide and recovery with others. Peer workers may have lived experience as a consumer or as a carer. |
| Primary Health Networks (PHNs) | Commonwealth funded independent organisations that coordinate primary health care in their region. PHNs assess the needs of their community and commission health services so that people in their region can get coordinated health care where and when they need it. |
| Recovery | <p>Recovery is an ongoing process that enables victim-survivors to be safe, healthy and resilient and to have economic security and post-traumatic growth. Victim-survivors require support to recover from the financial, social, psychological, emotional and physical impacts of violence.</p> <p>Recovery also includes addressing the short-term, long-term and lifelong health impacts for victim-survivors, which may include physical injuries, reproductive and sexual health issues and poor mental health.</p> <p>Recovery also relates to the rebuilding of a victim-survivor's life, their ability to return to the workplace and community, as well as obtaining financial independence and economic security.</p> <p>However, it must be acknowledged that victim-survivors recover and heal in different ways, with some people being unable to return to work and requiring access to ongoing support.</p> <p>In cases of gender-based violence, the victim-survivor may still be in contact or live with the perpetrator. In these situations, the family as a whole may need support to recover. Moreover, in some cases, people are both victim-survivors and perpetrators of violence – for example, some adolescents using violence.</p> |

| Term | Definition |
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| <p>Recognise, Respond and Refer (RRR) Pilot Program</p> | <p>The RRR Pilot Program trains primary care staff to enhance their capacity to support DFSV affected people. Training is delivered by system integrator positions that act as a conduit between primary care and FDSV services to improve coordination between the primary care and FDSV sectors. Each PHN is implementing a tailored model developed in response to local need.</p> <p>The RRR is currently being expanded into new locations and to trial new locally integrated models of FDSV identification, response and referral activities to better support people experiencing FDSV.</p> |

| Term | Definition |
|----------------------|--|
| <p>Trauma</p> | <p>Trauma is a typical emotional, psychological and physical response to abuse. Trauma can occur immediately after an event, or many years later. Within the context of gender-based violence, victim-survivors often experience multiple traumatic events over time. This can result in complex trauma and the mental, emotional and physical impacts can extend over the long-term.</p> <p>For children and young people, witnessing or being exposed to domestic, family and sexual violence can affect their physical and mental wellbeing, development and schooling. Children’s exposure to multiple types of violence increases the likelihood that they will experience post-traumatic stress disorder.</p> <p>Trauma can also be experienced by people supporting others who have experienced violence or abuse, including other family members who may experience direct or indirect forms of violence, coercive control or witness violence occurring.</p> <p>Some victim-survivors may clearly display trauma response behaviours, while others may have delayed responses to trauma. Underlying trauma can go unrecognised and unidentified, which can result in long-term impacts on the person’s physical and mental health. The impacts of trauma, whether acknowledged or not, may surface at any time, and affect people’s ability to connect, study, work and live. While these impacts are significant, they can be managed with the right support and access to culturally responsive and trauma-informed response and recovery services.</p> <p>Victim-survivors of violence who continue to experience the impacts of trauma may pass on their trauma to further generations. In Australia, intergenerational trauma particularly affects Aboriginal and Torres Strait Islander peoples, especially the children, grandchildren and future generations of the Stolen Generations.</p> |

| Term | Definition |
|-----------------------------|---|
| Trauma-informed care | <p>Trauma-informed care and practice recognises the prevalence of trauma and its impacts on emotional, psychological and social wellbeing of people and communities.</p> <p>Trauma-informed practice means integrating an understanding of past and current experiences of violence and trauma in all aspects of service delivery. The goal of trauma-informed systems is to avoid re-traumatising individuals and support safety, choice and control to promote healing.</p> |
| Warm referrals | <p>A warm referral involves contacting a service for or with the client, rather than just providing the client with a provider’s contact information and recommending they contact the service directly.</p> |
| Victim-survivors | <p>People who have experienced family and domestic violence or gender-based violence. This term is understood to acknowledge the strength and resilience shown by people who have experienced or are currently living with violence. People who have experienced violence have different preferences about how they would like to be identified and may choose to use victim or survivor separately, or another term altogether. Some people prefer to use ‘people who experience, or are at risk of experiencing, violence’.</p> |

Attachment A – Pathways to Care flowchart

