FAIR WORK COMMISSION

Fair Work Act

Section 156 – 4 Yearly Review of Modern Awards

Family and Domestic Violence Leave (AM2015/1)

Witness Statement of Marilyn Beaumont

I, Marilyn Beaumont, Chairperson of the Australian Women Health Network of , in the State of say as follows:

1. I am the Chairperson of the Australian Women Health Networks National Board. I am authorised by the Australian Women's Health Network to make this statement on its behalf.

2. I make this statement to the best of my own knowledge. Where I make statements based on information provided by others, I believe such information to be true to the best of my knowledge and understanding.

Background and qualifications

3. I have over 30 years' experience in the health services sector, policy development, management and advocacy. Much of my policy work has focussed on the health impacts of violence against women. In the majority of my work over the years, I was often seeing the effects of domestic violence from a health practitioner's perspective.

4. In addition to having been CEO of various organisations, I have also served on, and chaired, various board committees including clinical governance, finance and audit, consumer participation, population health, strategy and fundraising.

5. I have been a member of various government advisory committees including Victorian Women's Prisons Advisory Committee and the Victorian Corrections Health Board. I am a current board member of a Victorian health board.

6. In 2007, I was inducted into the Victorian Honour Roll of Women for leadership and advocacy in improving women's health. I was also awarded the Australian Centenary of Federation Medal for significant services to women's health in 2003.

7. I commenced work as a student nurse in Sydney in 1968 and completed the requirement to become a registered general nurse in 1971. I am a qualified registered general and psychiatric nurse, but do not hold a current practising certificate.

8. A copy of my curriculum vitae is attached to this statement and marked **MB-1**.

Australian Women's Health Network

9. The Australian Women's Health Network (**AWHN**) is a national body that works closely with our members, partners and government to deliver change and to be the national voice for women's health. Our vision is for a healthy society. In a healthy society every citizen participates fully in cultural, social, environmental and economic life. We believe passionately in everyone's right to this participation. We know the result of this is a prosperous, dynamic, socially cohesive, thriving nation.

10. AWHN is a member-based organisation and has a diverse range of organisational and individual members with an interest in women's health and wellbeing, from across all states and territories in Australia. AWHN draws on the expertise of its members' and extensive network of external stakeholders to inform its work.

11. Gender based violence poses a significant risk to women's health and wellbeing. For this reason, it is a key AWHN work priority and its membership includes those with expertise in the prevention of violence against women and those with expertise in the provision of evidence based responses in support of women who have or are currently experiencing gender based violence, including family and domestic violence.

12. Although current legal definitions of family and domestic violence are not confined to violence by males against their female intimate partners, the majority of this reported violence falls into that category, and much of the research into it focuses on this form of gender based violence. As AWHN's expertise is women's health and wellbeing, the evidence provided in this witness statement refers to the impact of domestic violence on women.

Impact of domestic violence on health

13. For the purposes of this outline of evidence, I adopt the definition of family violence that is in the *Family Violence Protection Act 2008* (Vic). Section 5 of that Act defines family violence as:

> (1) (a) behaviour by a person towards a family member of that person if that behaviour —
>
> (i) is physically or sexually abusive; or
>
> (ii) is emotionally or psychologically abusive; or
>
> (iii) is economically abusive; or

(iv) is threatening; or

(v) is coercive; or

(vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety and wellbeing of that family member or another person.

(b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a).

(2) Family violence includes the following behaviours:

a) Assaulting or causing personal injury to a family member or threatening to do so;

b) Sexually assaulting a family member or engaging in another form of sexually coercive behaviour or threatening to engage in such behaviour;

c) Intentionally damaging a family member's property, or threatening to do so;

d) Unlawfully depriving a family member of the family member's liberty, or threatening to do so;

e) Causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the family member to whom the behaviour is directed so as to control, dominate or coerce the family member.

(3) To remove doubt, it is declared that behaviour may constitute family violence even if the behaviour would not constitute a criminal offence.'

14. I have used this definition because I consider it is important to acknowledge that domestic violence is not always physical violence. It is important that we also recognise emotional abuse and economic abuse as family violence.

15. It is now well recognised that domestic violence has many adverse impacts on the health of women and potentially, their children.

16. The body of evidence on the health impact of violence has been analysed in recent years through the work of Women's Health Victoria, VicHealth, AWHN, the Australian National Research Organisation for Women's Safety and the Victorian Royal Commission into Family Violence 2016. All of these sources, whilst drawing heavily from ground-breaking work in Victoria, also drew together national data.

17. I am familiar with this research, particularly the 2004 VicHealth report 'The Health Costs of Violence: Measuring the burden of disease caused by intimate partner violence' as I was the Women's Health Victoria CEO at the time and involved in it's development. This report acknowledges women's health advocates and women's health services, in particular Women's Health Victoria, whose advocacy about the health costs of intimate partner violence and the need for them to be considered in health impact assessments, and in particular Victorian burden of disease estimates, provided the impetus for this study.

18. It was the result of 3 years advocacy, which challenged the World Health Organisation (and subsequently the Victorian Department of Health) analysis of data to generate an understanding of health impact and the burden of disease (BOD). Burden of disease is a modelling technique that combines multiple data sources to count and compare the total fatal and non-fatal health loss from diseases and injuries in a population, and its attribution to specific risk factors.

19. WHV asserted that to use BOD to allocate funding to areas of high BOD would disadvantage certain population groups, particularly women, as much of women's experience of health is not collected in data feeding into the BOD data sources. The WHV 2002 'Victorian burden of disease, women's health and gender' discussion paper was prepared to clarify what the key issues were and inform a think tank on Gender in Health which shortly followed. As a result of the think tank the Victorian Government recognised that its BOD study could be questioned on the basis of its ability to measure the disease burden of specific groups, particularly the health impact of violence against women, and consequently contributed to the VicHealth research.

20. The health impact of violence against women is not new. What is new is the research and collection of evidence and our translation of this into policy and practise across a wide range of jurisdictions.

21. AWHN's 'Health and the Primary Prevention of Violence Against Women Position Paper 2014', found that *"The direct health consequences of gender based violence (GBV) to women, include depression, anxiety and phobias, suicidal behaviours, physical injury, a range of somatic disorders and a variety of reproductive health problems (Victorian Health Promotion Foundation, 2008). Women who have been exposed to violence report poorer overall physical health than those who have not, and there is evidence that the health impact of violence can persist long after the abuse has stopped (Victorian Health Promotion Foundation, 2004, García-Moreno et al., 2013)".*

22. The common health consequences of domestic violence themes from this research include physical injury – bruising, broken teeth and bones and head injuries, depression, anxiety and phobias, and isolation, homelessness and reduced socio-economic status.

23. These health impacts are consistent with my experience, both as a health practitioner and as an advocate for women's health. The longer the violence goes on and the more severe it is the higher the impact. These impacts contribute to the direct and indirect, short and long-term health consequences on women and their children. Family violence can have long-term effects on a victim's health and well-being. In addition to obtaining and maintaining housing, financial security, education and employment, the ability of victims to regain their health and sense of wellbeing after family violence is an essential part of the recovery process.

Physical injuries

24. In my work in hospital emergency departments many women who presented with physical injuries, when asked in confidence, would disclose they had been beaten by their husband, or the police and ambulance staff would notify hospital staff that the injuries requiring the woman to be brought to the hospital arose from a 'domestic' (which it was called at the time I was working as a registered nurse). These injuries included bone fractures and injuries to the head (including eyes and teeth).

25. There are short and long term impacts of this type of injury. In the short term, repair of fractures and replacement of teeth can be achieved if the victim is able to access an affordable service. Loss of teeth (without repair) can cause long term impact on self esteem and eating. Multiple injuries to the head can cause acquired brain injury (**ABI**). ABI is long term and complex as the injury is not always obvious where there is a mild or moderate physical disability. However, it can result in significant restrictions on an individual's ability to participate fully in education, employment and other aspects of life. Relationships can be affected by personality and behavioural changes. It is a difficult area to quantify the impact as some people with acquired brain injury may report 'head injury/acquired brain damage' as their main condition, while others report a condition related to their ABI, or an unrelated condition. For example, many people with ABI report back problems and depression/mood affective disorders as their main condition.

26. I am unaware of any data collection about the connection between family violence and ABI, but I have seen many women with ABI in my work in psychiatric nursing, with homeless women, and with women in the corrections system. In each of these service systems there are significant numbers of women who have a history of family violence.

Mental harm

27. In my work in psychiatric nursing, homelessness services and women's health, depression, anxiety and phobias are evident in many women who have an experience of family violence. These become more manifest the longer the experience of violence goes on, particularly if it had started when the person was a child and continued into intimate adult relationships. These illnesses arise from living in a situation of constantly being on the alert to 'fault', or 'blame' which is then used as a catalyst by the perpetrator for a violent episode. There is no trust, with the victim having very poor self esteem or sense of self or self worth. The longer this goes on the more isolated the victim becomes the more profound the symptoms.

The role that work plays in improving health outcomes for victims, or minimising the adverse impact of domestic violence

28. The Victorian Royal Commission into Family Violence (2016) recognised that *"leaders in the economic, social and civic spheres of the community, as well as those who have experienced family violence, need to be engaged in building community awareness and determining the initiatives that are going to work for their community and how they should be pursued. These strategies should be targeted to all the places where people live, learn, work and play."* (Royal Commission report, Summary and Recommendations page 13).

29. My work in health promotion has utilised the workplace as a setting for action on health promotion, because people spend a significant amount of their time in the workplace. An example of my work in this area is a project I was involved in with Linfox. In 2007, when I was CEO, Women's Health Victoria obtained funding for one year for the *Working Together Against Violence* project as part of Phase I of VicHealth's *Respect, Responsibility & Equality: Preventing violence against women program.*

30. The funding was for a year-long pilot project at Linfox, a privately owned transport and logistics company with more than 18,000 employees in Australia and the Asia Pacific region.

31. In the first year of the pilot titled *Harm in the Home*, we worked with a Linfox Victorian worksite to develop and test a process to strengthen organizational capacity of a male dominated workplace to promote gender equality and non-violent norms.

32. This entailed Linfox Board and Executive leadership support and assigning a test site (which was self-selected). All employees at the test site were invited to come to training during work time. After the training, 86% of the trainees felt they were more likely to agree that the community should help those experiencing domestic violence and 94% agreed to some/great extent they had learnt some practical ways to help someone experiencing domestic violence.

33. In 2008, Women's Health Victoria secured further funding from VicHealth to 'scale up' the project over three years, expanding the pilot to other Linfox worksites in Victoria. Phase II aimed to further embed in Linfox the prevention of violence against women through activities such as training, workplace policy and the dissemination of key prevention messages. It included the development and modelling of a workplace program that could be implemented in other companies.

34. Between 2008-2011 a total of 615 employees at 11 Victorian Linfox worksites participated in the training, with many worksite managers making attendance mandatory. Evaluation demonstrated that training tools for workplace training helps both prevent violence before it occurs and to support staff who may be experiencing domestic violence. Employees are more

likely to challenge violence supportive attitudes and behaviours after completing workplace training thus contributing to primary prevention of violence.

35. The workplace program was originally named Stand Up: Domestic Violence is Everyone's Business, and was re-branded Take a Stand against Domestic Violence: It's Everyone's Business in 2011. It is now called Take a Stand and is being implemented in a wide variety of workplaces across Australia. Information about this program can be found in the *Working Together Against Violence Final Project Report* published by Women's Health Victoria on their website at http://whv.org.au/publications-resources/publications-resources-by-topic/post/working-together-against-violence-final-project-report/.

36. In my consulting work, I have also been a key consultant in the development of Gender Equity Quality Standards: Organisational Resource for Women's Health Lodden Mallee (2013) available at http://www.whlm.org.au/publications/gender-equity-quality-standards/.

37. This resource is designed to support organisations who seek to educate staff about gender equity. It includes work such as:

- Writing an effective sexual harassment policy
- Model policies, procedures and safety plans
- Working Together Against Violence
- Domestic and family violence clauses in EBAs

38. In my experience, which is supported by available evidence including the ANROWS paper outlined below, for women who are experiencing domestic violence, adverse impacts on their health and wellbeing can be minimised when they are in a supportive workplace.

39. Adverse impacts include the relationship between economic security and health and wellbeing. A supportive workplace will have a range of measures in place, including having access to paid family and domestic violence leave.

40. This evidence is outlined well in the Australian National Research Organisation for Women's Safety **(ANROWS**) paper titled *Building Effective Policies and Services to Promote Women's Economic Security following Domestic Violence*.

41. My views reflect the significant research about the experience of family violence. The violence is a tool used by the perpetrator to gain control over their victim. The abuser's need to maintain control and dominance lies at the core of every abusive relationship. This is grounded in the false belief that the abuser is entitled to control the victim and to use violence to achieve this. My understanding of controlling or coercive behaviour is that it does not relate to a single

incident, but is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another.

42. Some perpetrators do not allow their partners to work and in that way achieve financial independence. Others harass victims at their workplace, making it difficult for them to stay employed. In addition to the immediate financial problems this causes, this can affect women in later life because they have inadequate superannuation after retirement.

43. This behaviour includes using the full range of ways possible to gain access to information about the victim from their workplace. This includes using workplace contacts and connections (a particular problem in small communities with small workplaces) and using various technological means.

Domestic violence leave

44. A domestic violence leave clause in modern awards is important because it raises the profile of employment as a major policy area in preventing and addressing domestic violence.

45. It is important that the leave is dedicated paid leave, for two reasons.

46. Women disproportionately experience family violence. Women are also disproportionately the carers of children and sick or aged family members. They will use their paid sick and personal leave for this purpose. It is unfair for women to also carry the greater burden of needing time away from work to take action to secure their own and their children's lives free from family violence.

47. The second reason is that having a paid leave clause makes it more likely that organisations will build and develop broader workplace capacity, policies and procedures to support the implementation of domestic violence leave. This might include monitoring and reporting to the workplace leader or Board.

48. In my role as a Board Director, I have found that one way to assess costs, culture and the health of a workplace is through human resource reporting. The implementation of an entitlement to domestic violence leave would form part of the human resource reporting and allow organisations to properly assess the cost of domestic violence to their business, whereas currently that information is unable to be captured where women are taking other forms of leave, such as sick leave or annual leave, to deal with domestic violence.

49. In my view, domestic violence leave also improves access to the full range of services that are potentially needed for women currently in, or exiting or remaining safe or continuing to manage ongoing issues following, a violent relationship. These services may include health services, seeking new accommodation, and access to justice for women.

50. In addition, work is an important contributor to women's economic wellbeing, which in turn contributes to health.

Confidentiality and disclosure

51. We know that many women will not disclose their experience of domestic violence or might be reluctant to disclose the abuse that they are suffering. Fear and feeling unsafe is a significant contributor to women's mental health and wellbeing. It is therefore important that we provide assurance of a safe environment for women so that they feel comfortable to disclose their experiences, and that disclosing will not lead to the perpetrator using this for further violence, or even escalating the violence.

52. An important part of creating a safe environment is building trust with the woman, and giving her confidence so that she feels free to speak about her experiences. In my view, trust cannot be achieved unless the woman can be absolutely confident that her story will be kept confidential.

53. In the health sector, training has been done with health providers to assist them in their understanding of domestic violence so that they can play a greater role in early and more effective intervention of domestic violence. Some of this training includes building capacity in sensitive practice to increase competence of health practitioners to better identify and respond to family violence, and to strengthen relationships between health service providers and the family violence system. This includes the importance of confidentiality.

54. Similarly to health services, workplaces have an important role to play in circumventing the patterns of power and control that characterise domestic violence, particularly when that conduct plays out in the workplace. Employers and workers need to have the same systems in place to build capacity and trust and confidence. These are skills that all people should learn. Confidentiality is not just about the woman's comfort, it is about her safety.

55. By encouraging women to disclose domestic violence, health providers and potentially employers have the opportunity to intervene early and for this intervention to be more effective earlier. I support the evidence that demonstrates that for women who are experiencing domestic violence, adverse impacts on their health and wellbeing can be minimised when they are in a supportive workplace.

56. The benefits of early intervention are well documented. In my view maintaining paid employment with an employer who ensures a supportive workplace for women experiencing (or seeking to leave) family violence is an important contributor to a woman's economic security and health and wellbeing.

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Marilyn Beaumont

Dated:

ATTACHMENT MB-1

Curriculum Vitae Marilyn Beaumont

Qualifications

- Diploma of Applied Science (Nursing Studies)
- SACAE, Sturt Campus, Adelaide South Australia, completed 1987
- Registered Psychiatric Nurse - Kenmore Hospital, Goulburn NSW, completed 1973
- Registered Nurse - Prince Henry Hospital, Sydney NSW, completed 1971

Work Experience

1972 - 1974	Psychiatric Nurse undertaking training to become a registered psychiatric nurse at Kenmore Psychiatric Hospital, Goulburn, NSW
1974 - 1975	Registered Psychiatric Nurse in the Psychiatric Unit of Sir Charles Gairdner Hospital, Perth, WA
1975 - 1976	Registered Nurse in the emergency department of Fremantle Hospital, Fremantle, WA
1976- 1980	Senior Nursing Officer - Haymarket Foundation Clinic for the Homeless, Sydney, NSW.
1980 -1981	Drug Counsellor – Alcohol and Drug Addicts Treatment Authority, Family Living, Adelaide, SA.
1981 - 1982	Appointed Liaison Officer, (then Royal) Australian Nursing Federation (SA Branch).
1982 - 1987	Elected ANF (SA Branch) State Secretary.
1987 - 1995	Elected to the position of ANF Federal Secretary. I held this position for two consecutive terms 1987 – 1995 and was based in Melbourne, Victoria. In addition, I was a member of a number of international (International Council of Nurses) and national bodies including Commonwealth Ministerial National AIDS Forum 1988 – 1990, HESTA (Health Employees Trust Australia) 1987-1995, ACTU Executive 1989 – 1995, Australian Nursing Council 1992 – 1995.
1995 - 2010	Women's Health Victoria CEO which is a statewide women's health information and advocacy service based in Melbourne, Victoria.

Boards and Government Advisory Committees

1995-2000	Commonwealth Health Insurance Commission Board of Commissioners (which administers Medicare and the Pharmaceutical Benefits Scheme)
2000 -2009	Melbourne Health Board (which includes Royal Melbourne Hospital)
2000 to 2006	Ministerial Advisory Committee on Gay, Lesbian Health
2000 to 2005	Hanover Welfare Services Board (a not for profit accommodation and support service for homeless men and women and families)
1996 – 1999, 2000 – 2002	Ministerial Advisory Committee on Women's Health and Wellbeing
2000 – 2008, 2008 to 2010	Victorian Department of Justice, Justice Health Clinical Advisory Committee
2003 to 2010	Victorian Women's Correctional Services Advisory Committee
2009 – 2015	Northern Health
2012 – 2015	Northern Melbourne Medicare Local
2015 to current	Bendigo Health Care Group