



Integrated public health responses to domestic and family violence

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Violence, abuse and neglect in Australia



Violence, abuse and neglect

'Violence, abuse and neglect' is used by NSW Health as an umbrella term for three types of interpersonal violence that are widespread in Australian communities:

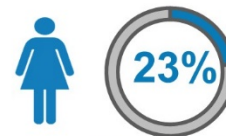
- domestic and family violence;
- sexual assault; and
- all forms of child abuse and neglect

Increasingly, children and young people with problematic or harmful sexual behaviour are presenting to NSW Health services. This group often also has personal experiences of abuse and neglect

Violence by intimate partner



1 in 6 people (16% or 2.9 million) experienced **violence**¹ by an **intimate partner**²



1 in 4 WOMEN
(2.2 million)



1 in 13 MEN
(703,000)

Sexual violence



1 in 9 people (11.7% or 2.2 million) experienced **sexual violence**³



1 in 5 WOMEN
(1.7 million)



1 in 20 MEN
(428,000)

Child abuse



1 in 8 people (13% or 2.5 million) 18 years and over experienced **child abuse**⁴



1 in 6 WOMEN
(1.5 million)



1 in 9 MEN
(991,600)

1. Physical and/or sexual violence since the age of 15. 2. Current and/or previous partner, girlfriend, boyfriend or date.

3. Sexual assault and sexual threat since the age of 15. 4. Physical and/or sexual abuse by an adult (18 years and over) before the age of 15.

Infographics: Costello & Backhouse, 2019a. Data source: *Personal Safety Survey 2016* (ABS, 2017).

Priority populations



Violence, abuse and neglect are experienced across all of Australia's communities. However, there is significant evidence that the following groups of people **can be more vulnerable to violence, abuse and neglect**, requiring targeted health responses and prevention efforts:



Women and girls



Aboriginal and
Torres Strait
Islander
people



Children and
young people



People with
disability

Additional priority populations identified in the evidence include:

- lesbian, gay, bisexual, transgender, queer and intersex people
- culturally and linguistically diverse people, migrants and refugees
- women in pregnancy and early motherhood
- people with a mental illness
- people living in regional, rural and remote areas
- incarcerated women
- older women





Definition of domestic and family violence

- ▶ The term “domestic violence” usually refers to violence against an intimate partner or ex-partner, while “family violence” may include violence perpetrated against children, older people, against parents by children, and other kin or family members. Many Aboriginal and Torres Strait Islander communities prefer the use of the term “family violence” to reflect broader family and kin relationships involved in violence.
- ▶ While there is no single definition, the central element of domestic and family violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal (COAG, 2011).



Gender differences in violence experienced

Men are more likely to experience **physical violence** of any type.

Women were much more likely to experience **sexual violence, violence by an intimate partner, stalking, sexual harassment** and **child abuse**:

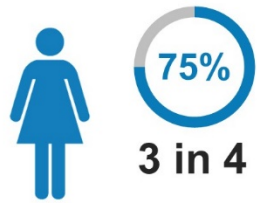
| | | | |
|--|--|-------------|--|
| Physical violence ¹ | | 1.3x | 31% or 2.9M women 41% or 3.7M men |
| Child abuse ² | | 1.5x | 16% or 1.5M women 11% or 991,600 men |
| Sexual harassment | | 2x | 53% or 5M women 25% or 2.2M men |
| Stalking | | 2.5x | 17% or 1.6M women 7% or 587,000 men |
| Violence by an intimate partner ³ | | 3x | 23% or 2.2M women 7.8% or 703,000 men |
| Sexual violence ⁴ | | 4x | 18% or 1.7M women 4.7% or 428,000 men |

1. Physical assault and physical threat by any type of perpetrator since the age of 15. 2. Before the age of 15.
3. Physical and sexual violence since the age of 15. 4. Sexual assault and threat since the age of 15.
Infographic: Costello & Backhouse, 2019a. Data source: *Personal Safety Survey 2016* ([ABS, 2017](https://www.abs.gov.au)).

Misinformation: Women and men are equally violent in relationships ('gender symmetry')



Violence by an intimate partner is overwhelmingly perpetrated by men against women, and women are much more likely to be killed by their intimate partner than men:



3 in 4

VICTIMS

(75% or 2.1 million)
of **violence by an intimate partner** since the age of 15



were **women** who experienced violence from a **male perpetrator** ¹



3 in 4

VICTIMS

(75% or 488)
of intimate partner homicides



In Australia between 2002-2012 were **women** killed by **men** ²

The **violence women** experience from their intimate partners is **more frequent, more severe**, and more likely to result in **serious injury or death** than for **men**.

Women are much more likely than **men** to experience:³



Coercion and control



Anxiety and fear



Sexual violence by an Intimate partner



Homelessness



Hospitalisation



Interruptions to employment



Restraining order against perpetrator



Police charging perpetrator

Misinformation: Men are excluded from domestic and family violence and sexual assault services



Everyone has the right to a **life that is safe and free from violence**, and to have **access to appropriate services**.



Most responses to domestic and family violence and sexual assault are **provided by mainstream services** including hospitals, and health, welfare, police and justice services, which are **whole-of-population, gender neutral services**.¹

However, as the **prevalence, nature and impacts** of domestic, family and sexual violence are **gendered**, **there is a need for some specialist services** and **targeted** prevention and response **initiatives**.

For example:



WOMEN ARE

8x

more likely than men to experience **sexual violence by a partner**²

High-risk factors for domestic and family violence



Many factors contribute to risk and no one factor is singularly causal. However, the presence of certain evidence-based risk factors can indicate **severe or lethal violence** by men against their female intimate partners:



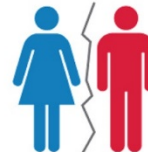
Intimate partner sexual violence



History of violence



Non-lethal strangulation (or choking)



Separation



Stalking



Escalation (frequency and/or severity)



Coercive control



Threats to kill



Misuse of drugs or alcohol



Pregnancy and early motherhood



Court orders and parenting proceedings



Victim's self-perception of risk



Perpetrator's access to or use of weapons



Suicide threats and attempts (perpetrator)



Abuse of pets and other animals

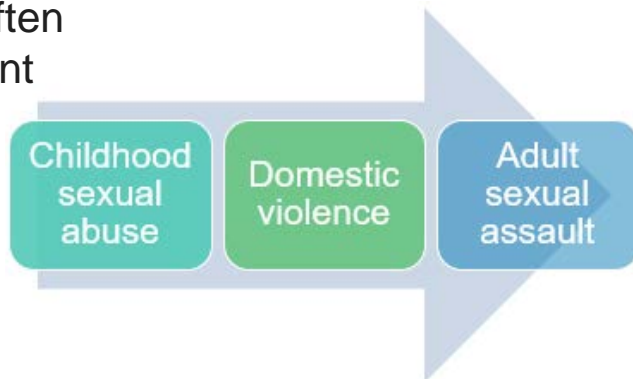
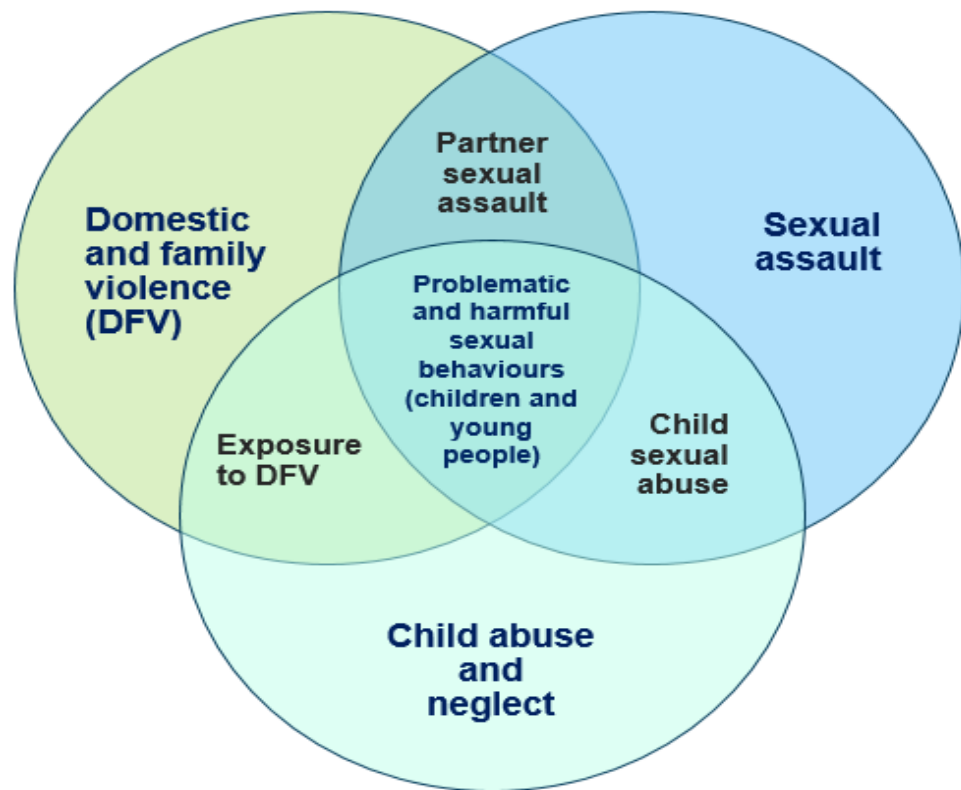


Isolation and barriers to help-seeking

Data sources and references: Australian and international domestic violence death reviews and lethality studies, Coroners' Courts reports, empirical research and practice-based literature.

The case for change: co-occurrence and re-victimisation have cumulative health impacts

- ▶ Violence and abuse is rarely experienced as a single incident
- ▶ Many people experience multiple forms of violence, abuse and neglect, either co-occurring or at different stages across their life
- ▶ Health and wellbeing consequences are cumulative and may be incrementally worse for victims experiencing multiple types of abuse
- ▶ Yet, the current health system is often siloed, fragmented, and inconsistent



The case for change: health outcomes



Physical injuries



Mental health



Death



Physical health




Chronic disease



Sexual and reproductive health



Behaviours associated with risk

▶ **Adverse Childhood Experiences (ACEs)**, especially traumas such as violence, abuse and neglect, significantly **increases the risk** of developing: 

- ▶ autoimmune diseases
- ▶ cancer
- ▶ chronic obstructive pulmonary disease
- ▶ diabetes
- ▶ heart disease
- ▶ liver disease
- ▶ mental health issues including suicide
- ▶ sexual and reproductive ill-health



▶ Only approximately **50% of this increased risk** is from increased **risk-related behaviours** (e.g. smoking, alcohol and drug use, and obesity)

50%



Child abuse & neglect

contributes an estimated

6.5%

of the **BURDEN OF DISEASE** (impact of illness, disability, premature death) for women aged 25-44 years.

This is the highest risk factor and more than any other risk factors including alcohol & other drugs and obesity



Intimate partner violence

contributes an estimated

4.1%

of the **BURDEN OF DISEASE** (impact of illness, disability, premature death) for women aged 25-44 years.

This is the 3rd highest risk factor



\$22 billion

Estimated cost of **violence against women** in 2015/16 (violence, abuse and stalking)

This includes \$1.4 billion for health



\$10.7 billion

Estimated cost* of **child abuse and neglect** in 2007

This includes \$6.7 billion for burden of disease and \$381 million for health



NSW Health

Infographics: [Costello & Backhouse, 2019a](#). * This is the lower estimate in the research – the upper estimate is \$30B

Data sources: Burke-Harris, 2018; [Costello & Backhouse, 2019b](#); [AIHW, 2019](#); [KPMG, 2016](#) & [Access Economics et al, 2008](#)

<http://www.ecav.health.nsw.gov.au/van-statistics-and-research/>

The case for change: health responses

NSW Health Services

NSW Health has 3 main service types responding to violence, abuse and neglect across the whole health system:

- ▶ **Violence, Abuse and Neglect (VAN) Services:** primary responsibility to respond to these issues.
- ▶ **Secondary / targeted responses:** respond to people at heightened risk (e.g. drug and alcohol services and mental health services).
- ▶ **Primary / universal responses:** help to reduce vulnerability or risk (e.g. maternity services and child health services).



Need for strengthened responses

Responses have historically been **siload, fragmented and disconnected** with negative consequences of inconsistent and uncoordinated service delivery on the health and wellbeing of people and their families.

Many skilled and dedicated teams provide timely, high quality, and holistic care, however challenges in delivering care and opportunities for improvement identified included: **governance; referral pathways; information sharing; consistent service models; availability of 24/7 integrated counselling, medical and forensic responses to all forms of VAN; and workforce support.**

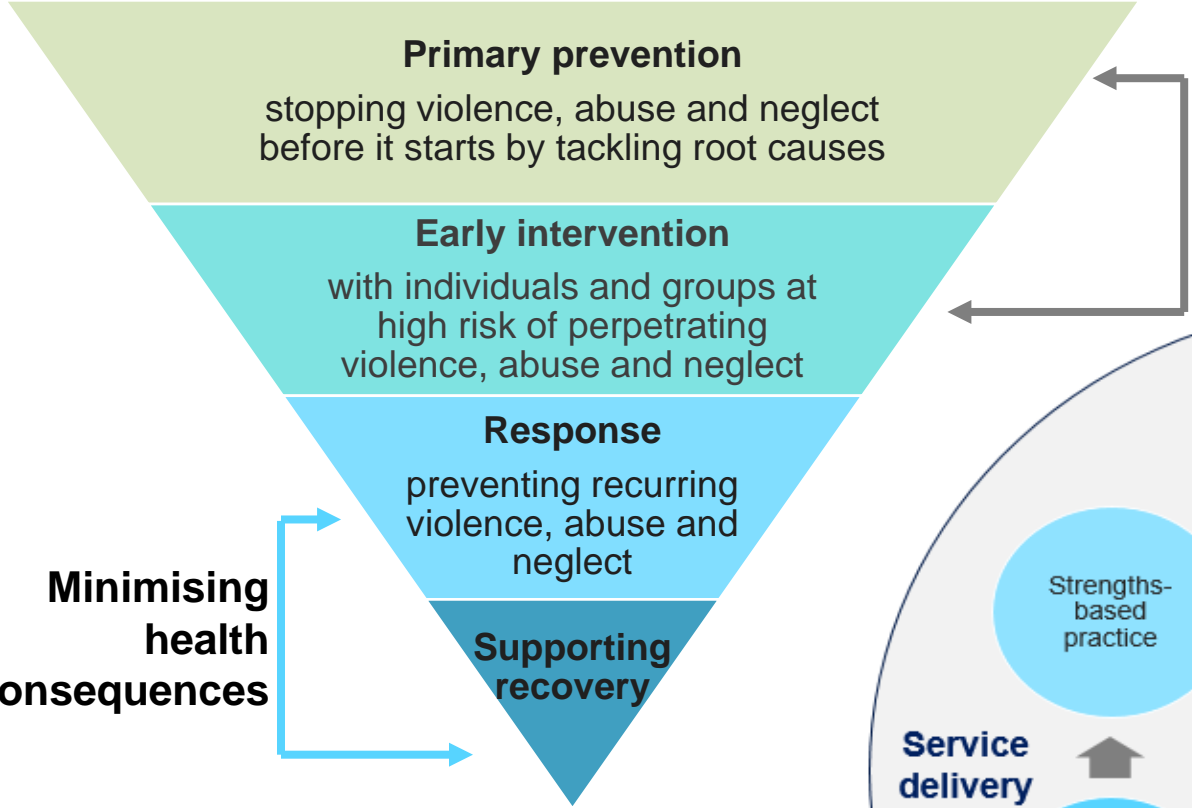
The role of the health sector



The public health sector is directly concerned with violence not only because of its huge effect on health and health services, but also because of the significant contributions that can and should be made by public health workers in reducing its consequences. Public health can benefit from efforts in this area with its focus on prevention, scientific approach, potential to coordinate multidisciplinary and multi-sectoral efforts, and role in assuming the availability of services for victims ([WHO, 2002](#), p. 1083).

Infographic: Costello & Backhouse, 2019a (adapted from [WHO, 2013](#))

The solution: an integrated public health response



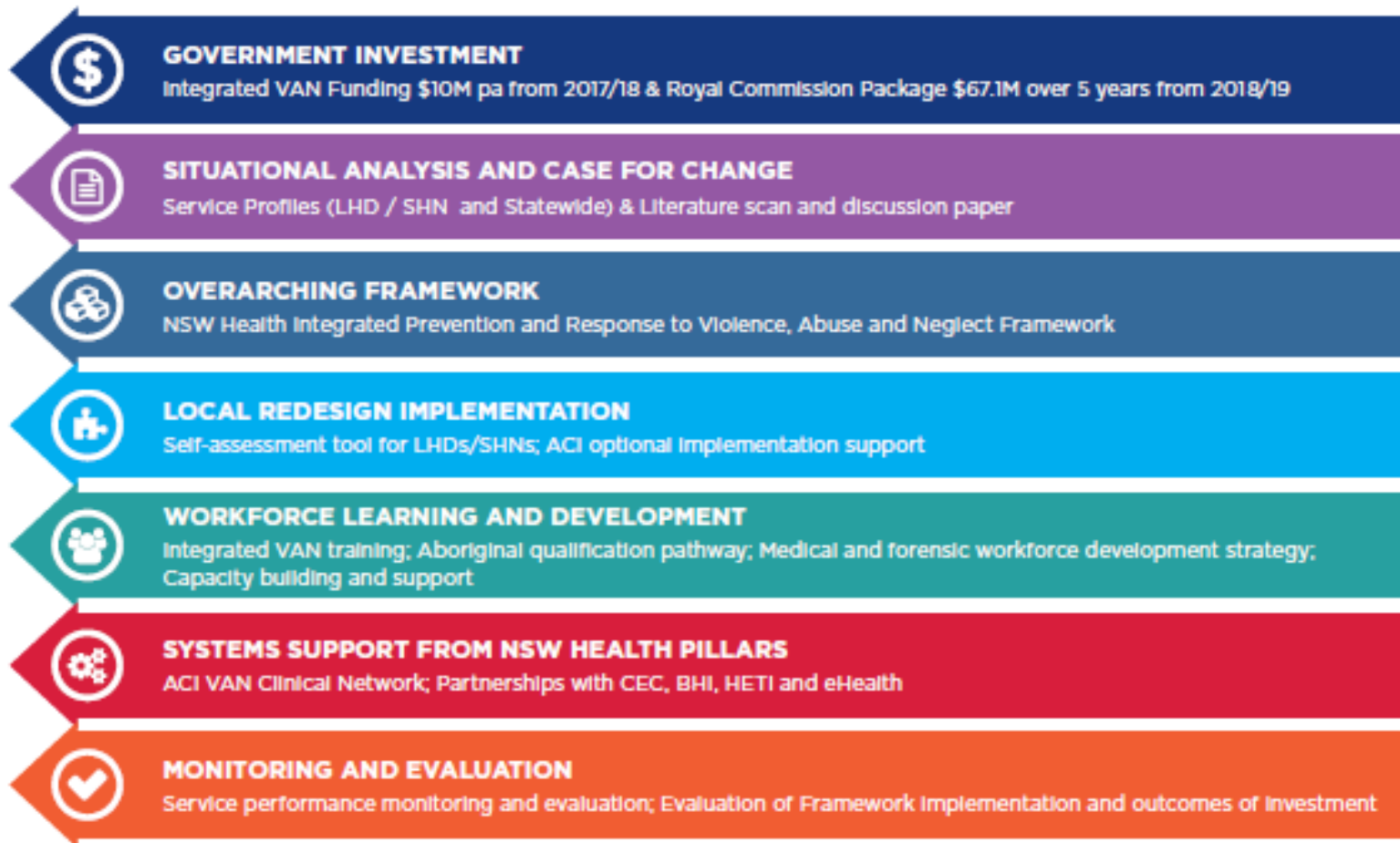
Infographic: Costello & Backhouse, 2019a adapted from [Webster, 2016](#)



Infographic: Costello & Backhouse, 2019a. Data source: [NSW Health, 2019b](#)



VAN Redesign Program – key deliverables



The Framework – putting integration into practice

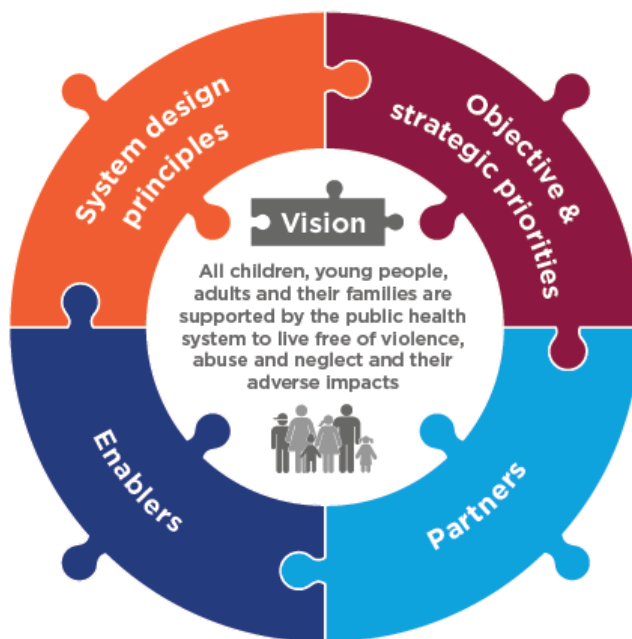
NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework

System design principles

- 1. Prevention and response to violence, abuse and neglect is a central role of NSW Health**
- 2. Person and family-centred, holistic and seamless care** is provided by NSW Health that prioritises the safety, well-being and unique needs and preferences of the person and their family
- 3. Minimising the impact of trauma and supporting recovery from trauma** are recognised and valued by NSW Health as primary outcomes of responses
- 4. Early intervention** is prioritised by NSW Health because it can change the long term trajectory of chronic disease and adverse health outcomes for people who have experienced violence, abuse or neglect
- 5. Equitable, accessible and consistent** service responses are provided by NSW Health
- 6. 'No wrong door'** – NSW Health workers will collaborate to support people and their families to access the most appropriate service responses
- 7. The best available** evidence is used to guide NSW Health's prevention of and response to violence, abuse and neglect

Enablers

- Learning & development
- Clinical networks & evidence-based models of service delivery
- Quality & safety
- Technology & infrastructure



Partners

- **Premier and Cabinet:** Aboriginal Affairs; Department of Premier and Cabinet; NSW Ombudsman
- **Treasury**
- **Education**
- **Primary Healthcare Networks**
- **Private health Sector**
- **Aboriginal Community Controlled Organisations**
- **NGO community-based services**

Stronger Communities:

- Child Protection; Coroner; Corrective Services; Courts; Housing; Juvenile Justice; Legal Aid; Multicultural NSW; NSW Police Force; Office of the Children's Guardian; Office of the Director of Public Prosecutions; Stronger Communities Investment Unit - Their Futures Matter; Victims Services; Witness Assistance Service; Women NSW

Objectives & strategic priorities

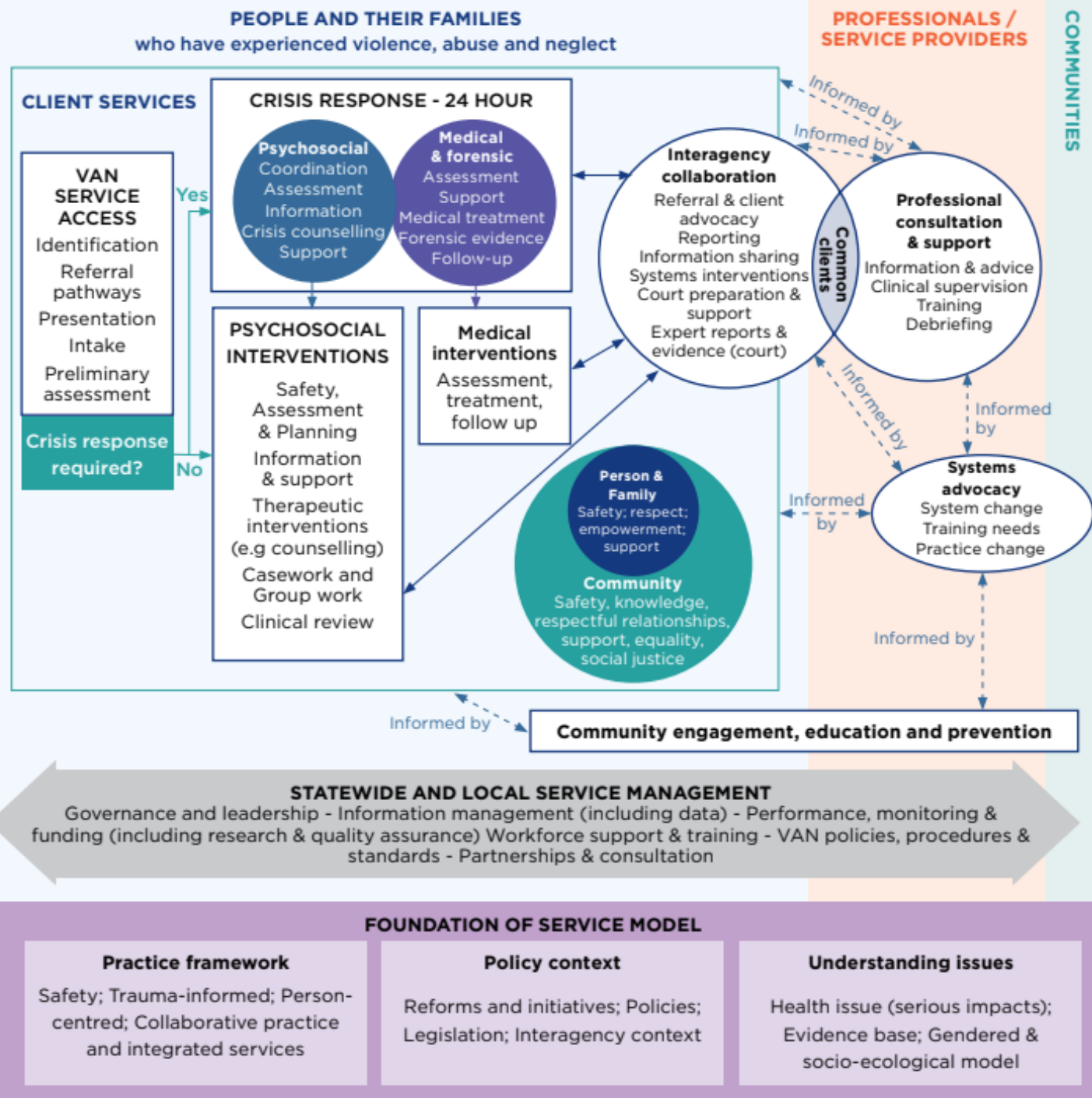
Making integrated prevention and response to violence, abuse and neglect happen in NSW Health:

| | |
|--|--|
| 1. Strengthen leadership, governance, and accountability | 2. Enhance the skills, capabilities and confidence of the NSW Health workforce |
| 1.1 Leadership driving NSW Health system reform and service improvement 1.2 Strong governance 1.3 Robust system for monitoring NSW Health service performance | 2.1 Increasing the workforce to meet demand 2.2 Education, training and professional development to equip NSW Health workers with the right knowledge, skills, attitudes and values 2.3 NSW Health workers receiving appropriate supervision and support |
| 3. Expand Violence, Abuse and Neglect (VAN) services to ensure they are coordinated, integrated and comprehensive | 4. Extend the foundations for integration across the whole NSW Health system |
| 3.1 Integrated VAN service models 3.2 Enhancement and expansion of VAN services 3.3 Improving VAN services quality and consistency, and reducing clinical variation across NSW 3.4 VAN services improving the patient journey and empowering people and families to be partners in their care | 4.1 System improvement - trauma-informed care and child safe organisations 4.2 Identification, response, referral and coordination 4.3 Integrated electronic clinical information systems |

Moving towards integrated prevention and response to violence, abuse and neglect across the NSW Health system

Enhanced service responses & improved client experiences and outcomes

VAN Services service model



Trauma-informed and trauma-specific care for NSW Health

TRAUMA-INFORMED CARE



Holistic, multi-agency,
non-stigmatising,
information sharing
among all
professionals

A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients

Trauma-Informed Care (TIC)

It's about asking what's happened to a person, not what's wrong with them.

TIC is a strengths-based framework, which recognises the complex nature and effects of trauma and promotes resilience and healing.

6 KEY PRINCIPLES:

SAFETY

Creating areas that promote a sense of safety.

TRUST

Providing clear and consistent information.

CHOICE

Providing options for treatment and care.

COLLABORATION

Maximising collaboration between health care staff, patients and their families.

EMPOWERMENT

Building upon a patient's strengths and experiences.

CULTURE

Providing culturally safe responses.

THE FOUR R'S OF TIC

REALISE

All people at all levels have a basic **realisation** about trauma, and how it can affect individuals, families, and communities

RESIST RE-TRAUMATISATION

Organisational practices may **compound trauma** unintentionally; trauma-informed organisations avoid this.

RECOGNISE

People within organisations are able to **recognise** the signs and symptoms of trauma

RESPOND

Programmes, organisations and communities **respond** by practising a trauma-informed approach

“ Trying to implement trauma-specific clinical practices without first implementing trauma-informed organisational culture change is like throwing seeds on dry land. ”

Sandra Bloom, Creator of the Sanctuary Model

www.70-30.org.uk
@7030Campaign



Questions?



Key contacts and resources

- ▶ **Lorna McNamara**, Director, Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit, lorna.mcnamara@health.nsw.gov.au
- ▶ **Dr Mayet Costello**, Manager, Violence, Abuse and Neglect (VAN) Integration, PARVAN, mayet.costello@health.nsw.gov.au
- ▶ **VAN Redesign Program (including *The Case for Change*):**
<https://www.health.nsw.gov.au/parvan/Pages/van-redesign-program.aspx>
- ▶ **Integrated Violence, Abuse and Neglect Statistics and Research Project:** <https://www.ecav.health.nsw.gov.au/Resources/Publications-Reports/the-integrated-violence-abuse-and-neglect-statistics-and-research-project>

