Avoiding the 3 ‘M’s

Accurate use of violence, abuse and neglect statistics and research to avoid myths, mistakes and misinformation

A resource for NSW Health workers

A collaboration between the NSW Health Education Centre Against Violence (ECAV) and Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit, Ministry of Health

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Acknowledgements

NSW Health recognises Aboriginal and Torres Strait Islander people as the First Nations People of Australia, whose lands on which we now live and work, and winds and waters we now all share. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging. We value Aboriginal and Torres Strait Islander history, culture and knowledge and the many ways it enriches the life of our nation and communities.

Data representing violence, abuse and neglect tell us a particular story. At times, the numbers may seem de-personalised. When engaging with this resource, it is important to remember the individual lived experiences of victims and survivors, and the stories of resilience, courage, hope and resistance to violence that underpin the statistics and research. Our understanding of how to prevent and appropriately respond to violence, abuse and neglect is deeply enriched because of the bravery and strength of all victims, survivors and their families who have sought support and trusted services and researchers with their stories.

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All resources from the Integrated Violence, Abuse and Neglect Statistics and Research Project including this publication are available for download at: http://www.ecav.health.nsw.gov.au/van-statistics-and-research/
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There are significant differences in men and women’s experiences of violence. Men are more likely to experience physical violence by any type of perpetrator while women and girls are more likely to experience violence, abuse and neglect (sexual assault, domestic and family violence, and child abuse), sexual harassment and stalking.

Violence prevalence

2 in 5 people (39% or 7.2 million) aged 18 years and over experienced violence¹

This included:

- 37% of WOMEN (3.4 million) and 42% of MEN (3.8 million)

Violence, abuse and neglect

1 in 6 people (16% or 2.9M) experienced violence² by an intimate partner

1 in 6 MEN (703,000)

1 in 9 WOMEN (2.2 million)

Violence by an intimate partner

1 in 9 people (11.7% or 2.2M) experienced sexual violence³

1 in 20 MEN (428,000)

1 in 5 WOMEN (1.7 million)

Sexual violence

1 in 8 people (13% or 2.5M) 18 years and over experienced child abuse³

1 in 9 MEN (991,600)

1 in 6 WOMEN (1.5 million)

Child abuse

1 in 4 WOMEN (2.2 million)

1 in 5 MEN (703,000)

1 in 13 MEN (587,000)

1 in 2 WOMEN (1.1 million)

Physical violence²

1.3x

31% or 2.9M women

41% or 3.7M men

Child abuse³

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 partner⁴

3x

23% or 2.2M women

7.8% or 703,000 men

Sexual violence⁵

3x

18% or 1.7M women

4.7% or 428,000 men


1. Physical and/or sexual violence since the age of 15. 2. Physical assault and physical threat by any type of perpetrator since the age of 15. 3. Physical or sexual abuse before the age of 15. 4. Physical and sexual violence since the age of 15 by an intimate partner. 5. Sexual assault and threat since the age of 15.

‘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 have personal experiences of abuse and neglect.

Violence, abuse and neglect 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 outcomes of violence, abuse and neglect

Extensive research indicates violence, abuse and neglect has serious outcomes for women, children, and men’s health. These health and wellbeing outcomes are cumulative and may be incrementally worse for victims experiencing multiple types of abuse.

- Physical injuries
- Mental health
- Death
- Physical health
- Chronic disease
- Sexual and reproductive health
- Behaviours associated with risk

Contributes an estimated 5.1% of the BURDEN OF DISEASE (impact of illness, disability, premature death) for women aged 18-44 years.

Intimate partner violence

This is more than any other risk factor, including alcohol, tobacco use and obesity

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

$22 billion
This includes $1.4 billion to the HEALTH SYSTEM

Estimated cost of child abuse and neglect in 2007:

$10.7 billion
This includes $6.7 billion for BURDEN OF DISEASE & 381 million to the HEALTH SYSTEM

Violence, abuse and neglect 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, and outcomes are cumulative.

“Violence, abuse and neglect” is 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 have personal experiences of abuse and neglect. Infographics: Costello & Backhouse, 2019a. Data sources: Costello & Backhouse, 2019b; Webster, 2016; KPMG, 2016 & Access Economics et al, 2008.
Health responses to violence, abuse and neglect

Violence, abuse and neglect can be prevented, and its negative health outcomes reduced.

The World Health Organisation promotes a public health approach to preventing and responding to violence and abuse built on the socio-ecological model. Like other public health concerns, such as infectious diseases, violence, abuse and neglect can be prevented by addressing the underlying individual, relationship, social, cultural and environmental factors (WHO, 2013). Adopting a public health approach involves focusing on both prevention and early intervention.

Violence, abuse and neglect is core business for health workers and services.

It must be addressed through an integrated public health response.

Primary prevention

- Preventing health consequences

Early intervention

- With individuals and groups at high risk of perpetrating violence, abuse and neglect

Response

- Preventing recurring violence, abuse and neglect

Supporting recovery

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.

Foundations
1.1 Introduction

As an issue of increasing concern for communities and governments in recent years, interventions and investments to prevent and respond to the incidence and impact of violence, abuse and neglect are important. This is particularly the case given the increasing recognition of the social, health, and financial costs of this violence to the Australian community as well as to individuals (National Council to Reduce Violence against Women and their Children, 2009, pp.36-47).

In 1996 the World Health Assembly declared violence a major public health issue and in 2002 released the first World Report on Violence and Health, stating:

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 efforts in this area with its focus on prevention, scientific approach, potential to coordinate multidisciplinary and multi-sectoral efforts, and role in assuring the availability of services for victims (Krug, Mercy, Dahlberg, & Zwi, 2002, p. 1083).

The World Health Organisation recognises that violence results in both immediate and long-term negative health consequences to the individual, their family and the community. They argue the effects of violence are serious, continue long after the abuse has ended and, for many victims, are life-long. People who have experienced violence, abuse and neglect have a greater risk of developing a range of poorer health outcomes, report poorer physical health overall, are more likely to engage in practices that are harmful to their health, and experience difficulties accessing the appropriate health service (World Health Organisation (WHO), 2002).

“Violence, abuse and neglect” is used in this paper as an umbrella term for three types of interpersonal violence that are widespread in the Australian community: all forms of child abuse and neglect; domestic and family violence; and sexual assault. While the dynamics in each sub-group can differ, there is a high degree of connection and overlap in the experience of, and responses to, these issues. There is also a substantial connection and overlap between violence, abuse and neglect and children and young people with problematic or harmful sexual behaviour and so this issue is also addressed in this paper.

Women, men, children and young people may enter the NSW Health system with issues that are either a direct or indirect consequence of violence, abuse and neglect. Prevention and response therefore need to be widespread across the health system and need to be based on accurate understandings of the issue to help ensure our efforts are effective and resources are targeted appropriately.

The statistics and research concerning violence, abuse and neglect are complicated and, in our experience in direct service, policy, research and politics, even experienced practitioners, trainers, researchers, and policy-makers commonly make mistakes in citing them accurately. Some of the most common myths, mistakes and misinformation concern gender with two prominent inaccurate claims being that “1 in 3 women are victims of domestic violence” and “1 in 3 victims of domestic violence are men”. This second claim in particular sits alongside other inaccurate claims and misinformation about “gender symmetry” such as: the rates of domestic violence perpetrated by men and women are approximately equal; most domestic violence is “mutual” (i.e. perpetrated by both partners); or a significant minority of victims of domestic violence are men. Such claims are both dangerous for the safety, health and wellbeing of people affected by violence, abuse and neglect and for the appropriate allocation of resources to where they are needed most.
In response to both the need for accurate understandings of violence, abuse and neglect and to dispel widespread myths, mistakes and misinformation concerning them, the Integrated Violence, Abuse and Neglect Statistics and Research Project (the Project) was developed as a joint initiative of NSW Health’s Education Centre Against Violence and the Prevention and Response to Violence, Abuse and Neglect Unit in the NSW Ministry of Health, with the support of The Program Delivery Office (PDO) NSW Ministry of Health. The Project has developed infographics and fact sheets to help NSW Health workers understand and communicate relevant violence, abuse and neglect statistics and research accurately and succinctly and to dispel myths, mistakes and misinformation about them. This current document was produced as part of the Project to be a companion resource providing a detailed breakdown of the statistics and additional research information used in the infographics provided in the form of a PowerPoint presentation titled *Avoiding the 3 ‘M’s: Myths, mistakes and misinformation in violence, abuse and neglect statistics and research* (Costello & Backhouse, 2019a) as well as the Project’s accompanying fact sheets (available from: http://www.ecav.health.nsw.gov.au/van-statistics-and-research/).

The Project recognises that NSW Health workers, in taking a public health approach to violence, abuse and neglect, have a broad scope of work in prevention and response which includes clinical work, service planning and management, local and statewide policy, education and training, professional development and support, and community development and prevention. In response, the Project has developed resources for NSW Health workers with clear, accurate, accessible and relevant statistics and research from authoritative and trustworthy sources for use in contexts such as:

- Education and training.
- Professional consultation, development and support.
- Presentations.
- Community education, engagement and prevention work.
- Submissions e.g. funding submissions and parliamentary inquiries.
- Service planning and development.

All violence, abuse and neglect is wrong and all victims deserve a compassionate and appropriate response regardless of their gender or that of the person who has perpetrated violence against them. Nevertheless, there are distinct gendered patterns in both the nature and impact of all types of interpersonal violence. This includes in victimisation, which is predominantly against women and girls, and perpetration, which is predominantly by men. It is important that Health workers are aware of these gendered dynamics and the myths, mistakes and misinformation that surround gender and structure our prevention and response efforts to violence, abuse and neglect accordingly. This resource therefore pays particular attention to this issue by comparing men and women’s different experiences of violence, abuse and neglect and identifying and dispelling the most common myths, mistakes and misinformation about gender.
1.2 Nature and structure of this resource

This resource aligns with, complements and is intended to support the various system design, policy and practice change and violence, abuse and neglect integration efforts underway across NSW Health statewide and locally. This includes the VAN Redesign Program and accompanying strategic documents: The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health (NSW Health, 2019b) and the Integrated Violence, Abuse and Neglect Prevention and Response Framework (NSW Health, 2019c) as well as the development of various NSW Health policy and procedures such as for New Street Services, Child Protection Counselling Services, Sexual Assault Services, and the Joint Child Protection Response Program. To achieve this alignment, elements of these publications have been incorporated into and adapted for this resource.

This resource is intended to be a companion resource and reference document supporting the other resources in the Project by outlining the statistics, research and sources on which the Project is based and to demonstrate the rigour underpinning it. This resource is structured in three main parts:

1. **Foundations** – This first section outlines the nature of this resource and provides an overview of the types of statistics and research available and those that are recommended for use due to their reliability and representativeness.

2. **Statistics and research on violence abuse and neglect** – The second section provides accurate statistics and research on violence, abuse and neglect focussed on the needs of Health workers. The section is divided into three parts: what is violence, abuse and neglect including definitions, prevalence and key features; why should we intervene including the health, social and economic impacts; and how should we intervene including understanding gender, causes, and the broad spectrum of prevention and response to violence, abuse and neglect. The section is structured to provide the key infographics developed or collated for the Project¹ followed by the statistics and research underpinning the infographics, including in some cases additional information about and/or from that source. The section also includes tips for helping to cite statistics and research accurately.

3. **The 3 ‘M’s – myths, mistakes and misinformation** – The third section addresses the most common myths, mistakes and misinformation concerning violence, abuse and neglect. It identifies the myth, mistake or misinformation and then provides infographics to dispel these alongside a discussion of where these have come from and strategies for effectively dispelling them.

Guide to key symbols and abbreviations in this resource

- **Key statistic**
- **PSS** Personal Safety Survey
- **Tip**
- **Other research**
- **Other representations of key statistic**

¹ Larger format versions of the infographics for use in presentations are provided in the Master PowerPoint Avoiding the 3 ‘M’s: Myths, mistakes and misinformation in violence, abuse and neglect statistics and research (Costello & Backhouse, 2019a).
1.3 Types of statistics and research and their strengths and limitations

A brief outline of the key types of statistics and research as well as their strengths and limitations is provided below followed by a profile of one of the key sources of statistics for the Project, the Australian Bureau of Statistics’ (ABS) Personal Safety Survey (ABS, 2017). To help understand the nature, relevance, strengths and limitations of violence, abuse and neglect statistics it is useful to first define and understand two key research concepts; prevalence and incidence.

### Statistics and research evidence – prevalence and incidence

- **Prevalence**: number or proportion of people in a population or sub-population who have experienced a phenomenon or condition (e.g. violence).

- **Incidence**: the frequency, number of incidents or events of a phenomenon (e.g. number of assaults) that may (or may not) be represented as the number per person.

#### 1.3.1 Prevalence and incidence

**Prevalence**

Prevalence is the number or proportion of people in a population or sub-population who have experienced a phenomenon or condition (e.g. violence). That is, prevalence refers to a unique number of individuals in a population or sub-population who have experienced a phenomenon without regard to the frequency they have experienced it. For example, 1 in 5 Australian women have experienced sexual assault is a sub-population prevalence statistic (i.e. sub-population is women, prevalence is 20% who have had at least one incident of sexual assault but we don’t know how many times each woman has been sexually assaulted in total).

Prevalence data may be expressed as the proportion of people who have experienced violence as part of the total population (i.e. all Australians), the total sub-population (e.g. all Australian women) or the total population of people ‘at risk’ (e.g. estimates of violence by an intimate partner may be presented as a proportion of the population of ever-partnered people) (UNFPA, 2016a).

Prevalence is usually collected in two timeframes; lifetime (over a whole lifetime or since a particular age such as 15, 16 or 18) and recently (e.g. last 12 months). The former is best to use when making general claims about a phenomenon (e.g. to understand the extent of the problem) and the latter is of use for service planning, understanding trends over time and effectiveness of interventions (because...
lifetime prevalence takes so long to shift, it is best to use 12 months data for this).

The best purpose or use to put prevalence statistics to include: general understanding of an issue; and service planning for longer term services for people who have ever experienced violence (e.g. counselling).

**Incidence**

Incidence is the frequency, number of incidents or events of a phenomenon (e.g. number of assaults) that may (or may not) be represented as the number per person. That is, incidence refers to the unique number of events and frequency with or without necessarily referencing or referring to an individual. For example, police statistics saying there were 1,252 domestic assaults in an area in a specified time period is incidence data. This tells us how many assaults there are without reference to how many actual victims experienced these assaults (i.e. more than one incident may have been against the same victim).

Incidence data is helpful in service planning for crisis services (e.g. approximately how many incidents or call outs will a crisis service need to respond to in any given year regardless of the number of unique victims who present. It is also useful for providing an understanding of the potential severity of the impact of the violence due to the fact the impact of violence is cumulative.

A simple example to demonstrate the difference between prevalence and incidence is that if a single woman experienced sexual assault twice in her lifetime, a prevalence survey would record this as 1 (i.e. one individual experienced sexual assault regardless of how many times) and an incidence survey would record the incidence (or frequency) as 2 (there were two sexual assaults regardless of whether these were perpetrated against one or two individuals).

### 1.3.2 Statistics and research - key types

#### Statistics and research evidence – types of data

1. **Population-based / prevalence / crime victimisation surveys**  
   (e.g. ABS Personal Safety Survey).

2. **Administrative by-product**  
   (e.g. police reports, court data, Health service usage data).

3. **Qualitative research and targeted surveys**  
   (e.g. particular victim group interviews, self-referred snow-balled sample).
There are three main types of statistics and research identified for this Project.

a) Prevalence / population-based / crime victimisation surveys

Prevalence surveys (e.g. ABS’ Personal Safety Survey), which may also be called crime victimisation surveys, or population-based surveys. Prevalence surveys usually involve interviewing a large, representative sample of people using a well-designed questionnaire and specially trained interviewers that is either a dedicated survey to the issue being considered or a module or modules within a larger survey on a different topic (UNFPA, 2016a & 2016b). “These ‘population-based’ surveys are the only way to achieve reliable and comprehensive statistics that represent the magnitude of the problem in the general population...” (UNFPA, 2016a, p.2). Although the focus of these surveys is on prevalence, they often also have frequency or incidence-related questions for respondents.

The nature of these types of surveys involving large population samples means that their key strength is accuracy (being replicable) and representativeness. These types of surveys are therefore the best evidence to use to make population-based claims about something (e.g. how many people in a population have experienced violence).

The limitations of these types of surveys is that: the sample size means these are often expensive surveys to run; the information collected tends to be broad (not deep); they rely on incident based definitions of violence and find it hard to capture context, meaning or impact; they rely on participants recollection of events; and they offer limited capacity to understand perpetration as, because the focus is on experiences of victimisation, their only insights into perpetration are from the perspective of the victim.

b) Administrative data

Administrative data, which may also be called Administrative by-product, service, or service-use data, is data from public data systems and administrative records, such as health management information systems, police records, social services records, and court files (UNFPA, 2016a).

The strengths of administrative data include that is can be valuable monitoring and informing agency practice including the effectiveness of particular interventions (UNFPA, 2016a), and in understanding the characteristics of people using the service and/or the circumstances which led them to using the service. It is therefore particularly valuable for service planning needs.

The limitations of administrative data is that it only reflects those people actually using particular services, and therefore cannot help measure the extent or patterns of violence in a population. For example, police data on domestic assault does not tell us how many people have experienced domestic assault in a population or the total number of incidents of domestic assault there were, it only records those that have come to the attention of the police. Data from these sources therefore cannot be used to make population or sub-population-based claims beyond the number of people accessing a service. A further limitation is that data is often collected inconsistently as the service provision is, appropriately, the first focus and data is secondary. These types of data often have significant inconsistencies as they rely on practitioners to both know and input in the data collection system all the relevant data fields consistently.

c) Qualitative research and targeted surveys

Qualitative research and targeted surveys (e.g. particular victim group interviews, self-referred snow-
balled sample) offer the third type of research relevant to this Project and refer to the extensive range of qualitative and quantitative research methods and approaches that produce research data and information on various aspects of violence, abuse and neglect. Research in this category may include multi-method approaches which incorporate at least one of the data collection methods identified above.

The strengths of these other types of research is that they provide a deeper, more detailed, in-depth, and contextualised insights and understandings of violence, abuse and neglect than is possible from statistics alone. This includes the context, nature, dynamics and impact of the violence. Consequently, these types of research are particularly valuable in understanding the causes and impacts of violence, abuse and neglect and providing more detailed information and guidance on how services can most effectively respond.

The limitations of these other types of research is that they are not representative and therefore cannot make claims about a phenomenon concerning whole populations or sub-populations.

1.3.3 The Australian Bureau of Statistics’ Personal Safety Survey

The first part of Section 2 of this resource focusses on the ‘what’ of violence, abuse and neglect, particularly what we know about prevalence and provides a large body of new infographics created for this Project. This part of Section 2 draws heavily, although not exclusively, on the ABS’ Personal Safety Survey (PSS), especially the most recent survey administered in 2016 (ABS, 2017), for this purpose. The PSS, which is a population-based, crime victimisation survey, is the most comprehensive and robust quantitative survey of interpersonal violence in Australia (Cox, 2016, p.2). In 2016-17, over 21,000 people completed the survey in face-to-face interviews in their homes. The PSS is administered every four years (ABS, 2017).

Although statistics in the PSS are indicative rather than definitive, the findings of this survey provide Australia’s only reliable prevalence estimates for various types of violence including physical violence, sexual violence, violence by a partner, sexual harassment, stalking and child abuse (Cox, 2016) and therefore offers the best source of data for this resource. The data produced by the PSS is of particular value to provide insights on prevalence because responses to the PSS are weighted to reflect the demographics of the Australian community and it is therefore representative. This can mean, however, that estimates for small sub-populations are unreliable (Cox, 2016, p.9).

The strengths and limitations of the PSS, both in terms of those that specifically relate to the survey itself (Cox 2016) and those it shares with other crime victimisation surveys (Kimmel, 2002; Flood, 2006), include: (see next page)
## Strengths and Limitations of the Personal Safety Survey

### Strengths
- Uses a large sample size and robust methodology.
- Uses standardised definitions of violence.
- Includes a wide range of types of violence.
- Is repeated over time so that temporal comparisons can be made.
- Includes current and former partners.
- Explores [to a limited extent] severity and frequency of violence.
- Data is weighted so that it is representative of a diverse population.

### Limitations
- Relies on single act-based reports of violence so does not account for patterns of violence.
- Provides limited data on the context in which the violence occurs.
- It is not a measure of ‘domestic violence’ and does not adequately record certain characteristics of domestic violence including:
  - multiple experiences of different types of violence;
  - coercion and intimidation used to maintain power and control without resorting to violence, and
  - some forms of domestic violence such as spiritual abuse and some types of emotional abuse.
- Relies upon participants’ retrospection, accurate recall of events, and willingness to report.
- Has limited capacity to understand perpetration of violence as the focus is explicitly on people’s experiences of victimisation.

Of note here for the purpose of this resource is that one of the key limitations of the PSS is that it does not ask questions about domestic violence. Rather, it focuses on single act-based reports of violence and so does not adequately account for key elements that are identified in definitions of domestic violence commonly used in policy and practice such as: patterns of violence; intent; fear; power, and coercive control.

To illustrate this limitation; in the survey an incident of coercive control physical violence against a victim of domestic violence, and that same victim using physical violence in self-defence against a domestic violence perpetrator, would both be counted in the PSS as an incident of violence by a partner if both partners were interviewed. The ABS has taken several steps to ask broader questions about the nature, context and impact of violence (e.g. frequency of violence; anxiety and fear as a result of violence; reporting and help-seeking actions; whether children were present, and so on). While these changes enhance the scope of information on violence in intimate relationships, they cannot entirely overcome the challenges in using PSS data to better understand the nature and extent of domestic violence. This means that although the PSS provides some insights into domestic violence and is the best source of data to make population claims, special care also needs to be taken in reporting PSS findings very precisely to prevent inaccurately making claims about domestic violence as opposed to violence by a partner.

A second issue of note here is the type of data from prevalence surveys that is most appropriate to use for specific purposes. The PSS collects data on both prevalence since the age of 15, and for the 12 months prior to the survey. The best data set to use depends on the purpose it is being used for. PSS prevalence data since the age of 15 is the best data to use when the purpose is to understand the extent of the problem, since this provides information about lifetime prevalence (i.e. the number of people in the Australian population who have experienced a particular form of violence). This data is of particular use for policy, research, and service planning for responding to the impact and longer-term effects of violence and should be the basis for broader claims about reported experiences of violence. Data on experiences of violence in the 12 months prior to the survey is of value for service planning in crisis services such as hospitals and police agencies, as it provides a better indication of...
the likely presentation to those services in any given period. Given both of these types of data are of value to Health services, both will be provided in the following section of the resource, however given the focus on identifying the extent of the problem, more comprehensive statistics for lifetime prevalence since the age of 15 are cited.

1.3.4 Key tips for using statistics and research accurately

Below is a short list of key tips for using statistics and research accurately that are helpful to avoid some of the most common myths, mistakes and misinformation in violence, abuse and neglect statistics. These tips have been developed based on our extensive experience in research, policy and practice concerning violence, abuse and neglect and seeing and sometimes making these errors ourselves. In addition to the general tips provided below, throughout this resource we will provide tips specific to particular data or research. Where these specific tips are provided, they will be indicated with a lightbulb icon (💡).

Use authoritative sources of data

It is preferable to use data from research with a rigorous, clearly explained, and replicable research methodology and from reputable institutions who use peer review and other forms of quality control in their studies and analysis. Examples of organisations who use these approaches include: the Australian Bureau of Statistics, Australian Institute of Health and Welfare, OurWatch, Australia’s National Research Organisation for Women’s Safety (ANROWS), Australian Institute of Criminology, Australian Institute of Family Studies, VicHealth, the World Health Organisation, and the UNFPA’s kNOwVAWdata project.

Some organisations use a grading system for sources e.g. with systematic reviews, meta-evaluations, and randomised controlled trials near the top down through to comparative studies and case studies at the bottom. While this may be of some value, care should be taken with such a system as it tends to favour a scientific and positivist world view that isn’t always a good fit for the study of violence, abuse...
and neglect (Goodman, Epstein and Sullivan, 2017). For example, it may be unethical to conduct
a ‘gold standard’ randomised controlled trial where the choice would be for one group of abused
children to receive an intervention while the other group of abused children receives no intervention.

A list of some of the best and most trustworthy sources of data on violence, abuse and neglect from
Australia and internationally is provided in 1.4 below.

Understand there may be variations in data reportedly about the same thing

Variations in data reportedly about the same phenomena can be explained by various factors and
it is important to explore these to determine whether two pieces of data are indeed about the same
thing and so can be compared or are actually not comparable.

The first consideration in this context is the definition used and whether the definitions in two separate
studies align. Taking child sexual abuse as an example, you should consider:

- Does the definition include or exclude contact or non-contact offences; and for contact
  offences there is often a distinction between penetration (i.e. sexual assault) and non-
  penetration contact (i.e. indecent assault) and so are both included or just one?
- Has the definition included or excluded particular age groups? For example, some surveys
  define “child” as under 18, some under 16, some under 15.
- Who has the research defined as a perpetrator; is it anyone of any age, or an “adult” which
  may be someone over the age of 18, or is it someone over the age of 16 given the age of
  consent.
- Is prevalence being confused of conflated with incidence?

A second consideration in this context is research scope. For example, are particular populations
excluded either intentionally (e.g. exclusion of complex trauma or multiple experiences of abuse to
give a ‘clean’ sample) or unintentionally (e.g. not having survey methods adapted for disability or not
accessing people who reside in institutions or remote communities). Or are a particular age group or
gender or ethnicity included or excluded from the scope?

Finally, it is also important to consider epistemology and method to understand how research about
the same phenomenon can vary. For example, consider questions such as how the researchers frame
and ask questions about violence (as considering it as conflict rather than coercive control will lead
to very different questions and very different outcomes); what method is used; what is the sampling
strategy and so on.

Be precise with terminology and concepts and use the right statistics for the purpose

It is extremely important to take care in repeating terminology and concepts as close as possible
to the original source of research and to use the correct data for the purpose. One of the key
examples of mistakes and misinformation related to this is in recognising the difference between
statistics and research on domestic violence versus those on violence by a partner. One of the best
examples of this is the claim is the statement “one in three victims of domestic violence are men”,
citing for support the ABS PSS statistics on violence by a partner in the last 12 months. Not only
is this using the wrong type of data as the lifetime prevalence data should be used when making
claims like this about a population or sub-population (and the lifetime prevalence data is 1 in 4),
but it is also a statistic on “violence by a partner” and not “domestic violence” so the terminology is
also incorrect. The correct way to say the statistics from that source is “1 in 3 victims of violence by a
partner in the 12 months preceding the survey were men”.

It is important to take care to compare like with like when dealing with statistics; whether it be data from the same source or ensuring we are using comparative data about the same phenomenon. For example, the PSS asks questions about both “intimate partners” and “partners” as well as “current partner” and “former partner”. We need to be careful that we don’t, for example, compare statistics on current violence by a partner for women against statistics on former partner for men and so on.

**Quote percentages along with actual numbers where possible**

This provides a more accurate understanding of an issue and may help determine where resources are best placed. For example, using a statistic from the PSS, let’s compare men and women’s police reporting following violence by a partner. An estimated 97% of men compared to 82% of women who experienced violence by a current partner never contacted the police (ABS, 2017). If we look at percentages alone, the message we could take from these percentages is that the most urgent priority is for us to work with men to increase their reporting. Let’s now add in the numbers, however, to demonstrate how this changes things. Because women experience violence by a partner at much higher rates than men, this 97% is 146,100 men whereas the 82% for women is 225,700 which shows we have far many more women who are not reporting to the Police which may then influence us changing our priorities for intervention.

**Take care in adding statistics in tables together**

Unless you are familiar with the data sources, this is one of the easiest ways to make mistakes. Sometimes the numbers don’t or can’t add up. For example, simply adding the people who have experienced sexual violence with the people who have experienced violence by a partner may not give the correct total number who have experienced violence as some people may have experienced both and therefore will be counted twice. Further, the numbers in tables have sometimes been manipulated to anonymise the data or for other reasons like to ensure representativeness which may also mean they can’t simply be added together.
1.4 Key sources of statistics and research used in this resource

The following key publications and sources are predominantly drawn on for this resource as they are some of the strongest sources of statistics, research and data analysis for an Australian and international context in terms of: trustworthiness (from reputable institutions); rigour (a clearly articulated and replicable methodology); representativeness; clarity in the presentation of the information; and so on. Additional statistics and research sources cited throughout this Resource are also provided in the reference list at the end of this document.

1.4.1 Primary data sources and research


Domestic violence statistics for NSW (Bureau of Crime Statistics and Research [BOCSAR], 2018)

National Homicide Monitoring Program (Australian Institute of Criminology [AIC]).


Examination of the burden of disease of intimate partner violence against women in 2011: Final report (AIHW, 2016) and A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions (Webster, 2016).

The cost of violence against women and their children in Australia Final Report (KPMG, 2016)

Australians’ attitudes to violence against women and gender equality. Findings from the 2017 National Community Attitudes towards Violence against Women Survey (NCAS) (Webster et al., 2018).

1.4.2 Secondary sources and analysis

Family, domestic and sexual violence in Australia, 2018 (AIHW, 2018a)


National Risk Assessment Principles for domestic and family violence and companion resources (Toivonen & Backhouse, 2018).

Change the story: A shared framework for the primary prevention of violence against women and their children (OurWatch, VicHealth & ANROWS, 2015); Changing the picture: preventing violence against Aboriginal and Torres Strait Islander women (OurWatch, 2018); and Counting on change: A guide to prevention monitoring (OurWatch & ANROWS, 2017); and accompanying resources (e.g. Webster and Flood, 2015; OurWatch, ANROWS & VicHealth, 2015).
Violence and Injury Prevention, World Health Organisation [WHO], especially:

- World report on violence and health (WHO, 2002).

The KNOwVAWdata Project (measuring prevalence of violence against women in asia-pacific) (UNFPA, 2016a & 2016b).

The economic costs of child abuse and neglect CFCA Fact Sheet (Australian Institute of Family Studies [AIFS]).
Statistics and research on violence, abuse and neglect
THE WHAT

2.1 What do we mean by violence, abuse and neglect

‘Violence, abuse and neglect’ (VAN) is used in the Project as an umbrella term for three types of interpersonal violence that are widespread in the Australian community: sexual assault; domestic and family violence; and all forms of child abuse and neglect. While the dynamics in each sub-group can differ, there is a high degree of connection and overlap in the experience of, and responses to, these issues. For this reason, some of the statistics below are repeated in different categories (for example, child sexual assault is identified in both sexual assault and child abuse) to allow for each part to be used separately without referring back to other types of violence. There is also a substantial connection and overlap between violence, abuse and neglect and children and young people who use problematic or harmful sexual behaviour, however the statistics on this latter issue are not as robust as those for the other forms of violence and so this is addressed in the section on the overlaps between the forms of violence, abuse and neglect.

2.2 Violence in the Australian Community

To make sense of violence, abuse and neglect, it is important to contextualise it within the broader experiences of violence in the Australian community particularly to help understand the differences and similarities between men and women’s experiences.

Violence prevalence

2 in 5 people (39% or 7.2 million) aged 18 years and over experienced violence¹

This included:

37% of WOMEN (3.4 million) and
42% of MEN (3.8 million)

¹ Physical and/or sexual violence since the age of 15.


Violence is very common in the Australian community:

There are quantitative and qualitative differences between men and women in their experiences of violence. From a quantitative perspective, men are more likely to experience physical violence by any type of perpetrator while women and girls are more likely to experience: violence, abuse and neglect; sexual harassment and stalking as illustrated in the figures below:
### 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**:

<table>
<thead>
<tr>
<th>Violence Type</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence†</td>
<td>1.3x 31% or 2.9M women</td>
</tr>
<tr>
<td>Child abuse‡</td>
<td>1.5x 16% or 1.5M women</td>
</tr>
<tr>
<td>Sexual harassment</td>
<td>2x 53% or 5M women</td>
</tr>
<tr>
<td>Stalking</td>
<td>2.5x 17% or 1.6M women</td>
</tr>
<tr>
<td>Violence by an intimate partner†</td>
<td>3x 23% or 2.2M women</td>
</tr>
<tr>
<td>Sexual violence‡</td>
<td>4x 18% or 1.7M women</td>
</tr>
</tbody>
</table>

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.

---

<table>
<thead>
<tr>
<th>Incident</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 in 10 women</td>
<td>(31% or 2.9 million) experienced <strong>physical violence</strong> by any type of perpetrator since the age of 15.</td>
</tr>
<tr>
<td>1 in 6 women</td>
<td>(16% or 1.5 million) experienced <strong>child abuse</strong> before the age of 15.</td>
</tr>
<tr>
<td>1 in 2 women</td>
<td>(53% or 5 million) experienced <strong>sexual harassment</strong> during their lifetime.</td>
</tr>
<tr>
<td>1 in 6 women</td>
<td>(17% or 1.6 million) experienced <strong>stalking</strong> since the age of 15.</td>
</tr>
<tr>
<td>1 in 4 women</td>
<td>(25% or 2.2 million) experienced <strong>sexual harassment</strong> during their lifetime.</td>
</tr>
<tr>
<td>1 in 15 men</td>
<td>(7% or 587,000) experienced <strong>stalking</strong> since the age of 15.</td>
</tr>
<tr>
<td>1 in 4 women</td>
<td>(23% or 2.2 million) experienced <strong>violence by an intimate partner</strong> since the age of 15.</td>
</tr>
<tr>
<td>1 in 13 men</td>
<td>(7.8% or 703,000) experienced <strong>violence by an intimate partner</strong> since the age of 15.</td>
</tr>
<tr>
<td>1 in 5 women</td>
<td>(18% or 1.7 million) experienced <strong>sexual violence</strong> since the age of 15.</td>
</tr>
<tr>
<td>1 in 20 men</td>
<td>(4.7% or 428,000) experienced <strong>sexual violence</strong> since the age of 15.</td>
</tr>
</tbody>
</table>

Source: PSS 2016 (ABS, 2017)
Physical violence by any type of perpetrator

3 in 10 WOMEN (31% or 2.9 million) and 4 in 10 MEN (41% or 3.7 million) experienced physical violence from any type of perpetrator\(^1\)

Child abuse before the age of 15 in Australia

1 in 6 WOMEN (16% or 1.5 million) and 1 in 9 MEN (11% or 991,600) aged 18 years and over experienced child abuse\(^1\)

Sexual harassment

1 in 2 WOMEN (53% or 5 million) and 1 in 4 MEN (25% or 2.2 million) experienced sexual harassment\(^1\)

Stalking

1 in 6 WOMEN (17% or 1.6 million) and 1 in 15 MEN (7% or 597,000) experienced stalking\(^1\)

Violence by an intimate partner

1 in 4 WOMEN (23% or 2.2 million) and 1 in 13 MEN (7% or 703,000) experienced violence\(^1\) by an intimate partner

Sexual violence

1 in 5 WOMEN (18% or 1.7 million) and 1 in 20 MEN (4.7% or 428,000) experienced sexual violence\(^1\)

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\(^1\) Based on Australian Bureau of Statistics

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AVOIDING THE 3 M’S | 23
From a qualitative perspective, men and women’s experiences of the same type of violence had both differences and similarities as illustrated in the infographics below concerning the most common experience of violence for women and men; which was physical assault by any type of male perpetrator.

**Physical assault by a male gender differences**
The most common experience of violence was physical assault by a male, however men and women experienced this violence differently.
In the most recent physical assault by a male in the last 10 years:

**WOMEN** were most likely to be assaulted by a male they knew (92% or 977,600) and the location was most likely their home (65% or 689,800).

**MEN** were most likely to be assaulted by a male stranger (66% or 873,100) and the location was most likely a place of entertainment or recreation venue (28% or 370,700) or outside location (28% or 370,500).


**Physical assault by a male gender similarities**
The most common experience of violence for men and women was physical assault by a male. In the most recent physical assault by a male in the last 10 years:

- **APPROXIMATELY HALF** (49% or 519,700) of the **women** victimised perceived alcohol or another substance to be a contributing factor to the most recent incident.
- **APPROXIMATELY TWO-THIRDS** (69% or 734,500) of the **women** victimised did not contact the police.
- **ALMOST TWO-THIRDS** (61% or 804,000) of the **men** victimised perceived alcohol or another substance to be a contributing factor to the most recent incident.
- **APPROXIMATELY TWO-THIRDS** (69% or 908,100) of the **men** victimised did not contact the police.

Characteristics of physical assault by any perpetrator type

The most common experience of violence for men and women was physical assault by a male. Men were much more likely to experience physical assault from a male stranger in a place of entertainment/recreation or outside location and women were much more likely to experience physical assault from a male they knew in their home:

<table>
<thead>
<tr>
<th>In the most recent physical assault by a female in the last 10 years ...</th>
<th>In the most recent physical assault by a male in the last 10 years...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women were most likely to be physically assaulted by a female they knew (74% or 240,900)</td>
<td>Men were most likely to be physically assaulted by a male they knew (92% or 977,600)</td>
</tr>
<tr>
<td>The location of the incident was most likely to be the woman’s home (30% or 98,700)</td>
<td>The location of the incident was most likely to be the man’s home (55% or 286,200)</td>
</tr>
<tr>
<td>Just under half (45% or 144,600) of all women who experienced physical assault by a female perceived alcohol or another substance to be a contributing factor to the most recent incident.</td>
<td>Just under half (46% or 240,900) of men who experienced physical assault by a male perceived alcohol or another substance to be a contributing factor to the most recent incident.</td>
</tr>
<tr>
<td>Of the women who experienced a physical assault by a female in the last 10 years, 44% (144,000) were physically injured. Of these 144,000 women, 20% (29,100) contacted a doctor or occupational health professional about these injuries.</td>
<td>Of the men who experienced a physical assault by a male in the last 10 years, 51% (539,900) were physically injured. Of these 539,900 women, 31% (169,200) contacted a doctor or occupational health professional about these injuries.</td>
</tr>
<tr>
<td>Three-quarters (75% or 243,800) of women who experienced physical assault by a female did not contact the police about their most recent incident.</td>
<td>Approximately two-thirds (69% or 734,500) of men who experienced physical assault by a male did not contact the police.</td>
</tr>
<tr>
<td>Table continues next page.</td>
<td>Table continues next page.</td>
</tr>
</tbody>
</table>

Table continues next page.
In the most recent physical assault by a female in the last 10 years...

Approximately two in three (67% or 352,700) men who experienced physical assault by a female had sought advice or support about the most recent incident.

Of these men, they sought advice and support from:
- 63% (217,500) a friend or family member
- 28% (186,700) Counsellor, support worker or telephone helpline.
- 25% (167,899) Police
- 19% (124,700) Other health professional (except GP)
- 10% (68,300) Work colleague or boss
- 9% (61,500) Other
- 9% (59,300) Legal service
- 3% (18,500) Refuge or shelter

Approximately one-third (36% or 116,100) of women who were physically assaulted by a female experienced anxiety or fear in the 12 months after their most recent incident.

Of these women, they sought advice and support from:
- 63% (71,500) a friend or family member
- 28% (186,700) Counsellor, support worker or telephone helpline.
- 25% (167,899) Police
- 19% (124,700) Other health professional (except GP)
- 10% (68,300) Work colleague or boss
- 9% (61,500) Other
- 9% (59,300) Legal service
- 3% (18,500) Refuge or shelter

In the most recent physical assault by a male in the last 10 years...

Approximately three-fifths (59% or 623,600) of women who experienced physical assault by a male had experienced anxiety or fear in the 12 months after their most recent incident.

Of these women, they sought advice and support from:
- 63% (417,500) a friend or family member
- 28% (186,700) Counsellor, support worker or telephone helpline.
- 25% (167,899) Police
- 19% (124,700) Other health professional (except GP)
- 10% (68,300) Work colleague or boss
- 9% (61,500) Other
- 9% (59,300) Legal service
- 3% (18,500) Refuge or shelter

Approximately one-quarter (24% or 316,600) of men who experienced physical assault by a male had experienced anxiety or fear after their most recent incident.

Of the 37% (486,400) of men who had sought support, they sought advice and support from:
- 47% (228,800) a friend or family member
- 36% (175,100) Counsellor, support worker or telephone helpline.
- 7% (37,400) Police
- 15% (71,500) Work colleague or boss
- 14% (69,600) Other health professional (except GP)
- 3% (18,500) Legal service
- 5% (23,800) Other

Approximately one in three (62% or 659,000) of women who experienced physical assault by a male had sought advice or support about the most recent incident.

Of these women, they sought advice and support from:
- 54% (363,500) a friend or family member
- 22% (145,400) Counsellor, support worker or telephone helpline.
- 21% (137,400) Police
- 16% (104,700) Work colleague or boss
- 15% (98,800) Other health professional (except GP)
- 11% (73,800) Other
- 7% (47,700) Legal service
- 3% (20,900) Refuge or shelter

Approximately two in three (63% or 840,100) of men who experienced physical assault by a male had sought advice or support about the most recent incident.

Of the 37% (486,400) of men who had sought support, they sought advice and support from:
- 47% (228,800) a friend or family member
- 36% (175,100) General Practitioner
- 33% (158,900) Police
- 16% (76,600) Work colleague or boss
- 15% (71,500) Counsellor, support worker or telephone helpline.
- 14% (69,600) Other health professional (except GP)
- 8% (40,500) Legal service
- 5% (26,700) Other
- 5% (23,800) Other services

* estimate has a relative standard error of 25% to 50% and should be used with caution.

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use. Source: PSS 2016 (ABS, 2017 & ABS, 2017 Tables 10, 11, 15 and 16)
Similarities and differences were also evident more broadly in differences and similarities in experiences of women and men in terms of the perpetrator of physical and sexual violence against them.

Men were approximately 3 times more likely to have experienced violence from a stranger than women.

### Relationship to perpetrator

**Men** were approximately **3x** more likely than **women** to have experienced **violence** from a stranger:

- **1 in 10 WOMEN** (9.4% or 880,000) experienced violence by a stranger
- **1 in 4 MEN** (27% or 2.5 million) experienced violence by a stranger

1. Since the age of 15.


The Personal Safety Survey is a crime victimisation survey that seeks respondents’ experience of victimisation (not perpetration). Care therefore needs to be taken when making general claims about perpetration as one perpetrator may have victimised more than one respondent. Claims about perpetration only relate to the victims’ experiences and it is recommended to directly quote these statistics in the way presented here to avoid errors.

Source: PSS 2016 (ABS, 2017, Table 3.1)
The most common type of perpetrator of violence against both men and women was male:

- 27% of victims of violence (1 in 4 victims or 2 million) had experienced at least one incident of violence by a female perpetrator.
- 92% of victims of violence (9 in 10 victims or 6.7 million people) had experienced at least one incident by a male perpetrator.
- 1 in 10 Australians (11% or 2 million) had experienced violence by a female perpetrator.
- 1 in 3 Australians (36% or 6.7 million) had experienced violence by a male perpetrator.

Source: PSS 2016 (ABS, 2017 & ABS, 2017 Table 3.1)
## Violence, abuse and neglect in Australia

### Violence by intimate partner

- **1 in 6 people** (16% or 2.9M) experienced violence by an intimate partner.
  - 23% of women (2.2 million)
  - 7.8% of men (703,000)

### Child abuse

- **1 in 8 people** (13% or 2.5M) 18 years and over experienced child abuse.
  - 16% of women (1.5 million)
  - 11% of men (991,600)

### Sexual violence

- **1 in 9 people** (11.7% or 2.2M) experienced sexual violence.
  - 18% of women (1.7 million)
  - 4.7% of men (428,000)

### Emotional abuse by partner

- **1 in 5 people** (19% or 3.6M) experienced emotional abuse by a partner.
  - 23% of women (2.2 million)
  - 16% of men (1.4 million)

### Witness violence to parent

- **1 in 9 AUSTRALIANS** (2M) witnessed violence towards their mother by a partner.
  - 11%
- **1 in 22 AUSTRALIANS** (819,000) witnessed violence towards their father by a partner.
  - 4.5%

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*‘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.

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1. Physical and/or sexual violence since the age of 15. 2. Current and/or previous partner, girlfriend, boyfriend or date. 3. Since the age of 15. 4. Current and/or previous partner (lived with). 5. Sexual assault and sexual threat since the age of 15. 6. Physical and/or sexual abuse by an adult (18 years and over) before the age of 15. 7. Physical assault only witnessed before the age of 15.


2.3 Sexual assault and sexual abuse (adult and child)

Sexual assault is a broad term used to describe when a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities. The exact definition of sexual assault varies between jurisdictions and often between agencies within the same jurisdiction. In NSW, the Crimes Act 1900 Part 3, Division 10 sets out offences of a sexual nature including sexual assault, indecent assault, sexual intercourse with a child under 16, and grooming a child under 16 for unlawful sexual activity. In addition, the Child Wellbeing and Child Protection Policies and Procedures for NSW Health (NSW Health, 2013, p.38) defines sexual abuse with regard to children and young people as:

Sexual abuse is sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person. Sexual activity includes the following: sexual acts; exposure to sexually explicit material; inducing or coercing the child or young person to engage in, or assist any other person to engage in, sexually explicit conduct for any reason and exposing the child or young person to circumstances where there is risk that they may be sexually abused.

The Personal Safety Survey 2016 (PSS) (ABS, 2017) defines sexual violence as the occurrence, attempt or threat of sexual assault experienced by a person since the age of 15. There are two components of sexual violence in the PSS:

- Sexual assault: an act of a sexual nature carried out against a person’s will through the use of physical force, intimidation or coercion, including any attempts to do this. This includes rape, attempted rape, aggravated sexual assault (assault with a weapon), indecent assault, penetration by objects, forced sexual activity that did not end in penetration and attempts to force a person into sexual activity. Incidents so defined would be an offence under state and territory criminal law.
- Sexual threat: the threat of acts of a sexual nature that were made face-to-face where the person believed it was able to and likely to be carried out.

The PSS also asks respondents of experiences of sexual abuse before the age of 15. The PSS defines sexual abuse as any act by an adult involving a child (under the age of 15 years) in sexual activity beyond their understanding or contrary to currently accepted community standards. It excludes emotional abuse and sexual abuse by someone under the age of 18.

Data on child sexual abuse from the PSS is likely to be a significant under-presentation compared with surveys that define child as under the age of 18 and involve perpetrators under the age of 18, especially because we know:

- The group most at risk of sexual assault are 15-19 year old women and for men this age group has the second highest risk of sexual assault for males (AIHW, 2018a, p.52).
- A significant amount of child sexual abuse is perpetrated by children and young people against their peers, for example:
  - Sibling sexual abuse is more prevalent than other types of intra-familial sexual abuse (Tapara, 2012; Welfare, 2008; Cafardo, 2013).
  - 30-60% of childhood sexual abuse is carried out by children and young people (El-Murr, 2017).
2.3.1 Adult sexual violence and sexual assault

Since the age of 15, women were much more likely to experience sexual violence than men:

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

1 in 5 women (18% or 1.7 million) experienced sexual violence.

1 in 20 men (4.7% or 428,000) experienced sexual violence.

Source: PSS 2016 [ABS, 2017]

Both women and men were more likely to experience sexual violence by a known person than a stranger:

<table>
<thead>
<tr>
<th>Relationship to perpetrator of sexual violence</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced sexual violence by a known person</td>
<td>1 in 6 WOMEN (19% or 1.8 million)</td>
<td>1 in 27 MEN (3.7% or 330,000)</td>
</tr>
<tr>
<td>Experienced sexual violence by a stranger</td>
<td>1 in 22 WOMEN (4.6% or 433,000)</td>
<td>1 in 71 MEN (1.4% or 128,300)</td>
</tr>
</tbody>
</table>

Women were much more likely to experience sexual violence by a male than a female perpetrator. Men were almost as likely to experience sexual violence by a male as a female perpetrator.

### Gender of perpetrator of sexual violence

Women were much more likely to experience sexual violence by a male than a female perpetrator. Men were almost as likely to experience sexual violence by a male as a female perpetrator:

- **Almost all** WOMEN VICTIMS (98% or 1.7 million) experienced sexual violence by a male perpetrator (51% or 291,000).
- **1 in 24** WOMEN VICTIMS (4.2% or 72,200) experienced sexual violence by a female perpetrator (55% or 33,900).
- **1 in 2** MEN VICTIMS (51% or 291,000) experienced sexual violence by a male perpetrator.
- **1 in 2** MEN VICTIMS (55% or 237,900) experienced sexual violence by a female perpetrator.

**Source:** PSS 2016 (ABS, 2017)

TIP

The statistics on sexual violence (sexual assault + sexual threat) are useful for understanding the broader social dynamics of this issue and to inform prevention efforts. The nature and dynamics of sexual assault alone are, however, of significant interest for NSW Health workers in terms of service planning and response. The remainder of this section therefore focuses on sexual assault.
Since the age of 15, women were much more likely to experience sexual assault than men:

1 in 6 women (16.9% or 1.6 million) experienced sexual assault.

1 in 23 men (4.3% or 384,800) experienced sexual assault.

Source: PSS 2016 [ABS, 2017]

In the 12 months prior to the survey:

1.6% or 148,100 Australian women experienced sexual assault.

0.6% or 57,200 Australian men experienced sexual assault.

Source: PSS 2016 [ABS, 2017]

1.1% or 33,700* women in NSW experienced sexual assault.

Comparative data is not available for men’s experience of sexual assault as the data is not reliable enough to report due to the much lower prevalence and higher associated error.

* estimate has a relative standard error of 25% to 50% so should be used with caution.

Source: PSS 2016 [ABS, 2017; NSW Table 1.1]
Administrative and survey data relating to crime result in different statistics than prevalence surveys. For example, statistics from police records are different from those reported in household or population-based surveys because not all incidents are reported to the police (ABS, 2017). However as outlined in Section 1, while administrative crime data cannot provide a reliable measure of the extent of violence in a population, it can be valuable to inform agency priorities and to assess the effectiveness of violence prevention initiatives and service interventions.

In NSW in the 12 months from July 2017-June 2018:

| 89% or 1026 victims of recorded sexual assault recorded were women | 10.9% or 121 victims of recorded sexual assault were men |


2.3.2 Characteristics of sexual assault

Despite some of its limitations as a crime victimisation survey, the PSS can provide insights into some of the characteristics of sexual assault which may help to understand the nature of the violence experienced and the interventions necessary as a result.

**Characteristics of sexual assault**

In the most recent sexual assault of a female* by a male in the last 10 years:

- **RELATIONSHIP**: These women were most likely to be sexually assaulted by a male they knew (87% or 553,700).
- **LOCATION**: The location was most likely to be the woman’s home (40% or 252,400) or perpetrator’s home (17% or 109,400).
- **INJURY**: 23% (144,100) of these women were physically injured; of which 33% (48,200) contacted a doctor or health professional about these injuries.
- **POLICE**: Approximately nine out of ten (87% or 553,900) of these women did not contact the police.
- **HELP & SUPPORT**: Half (50% or 316,900) of these women sought advice or support about the most recent incident.
- **ANXIETY & FEAR**: Over half (57% or 365,700) of these women felt anxiety or fear for their personal safety in the 12 months after the incident.

* Comparative data is not available for men’s experiences of sexual assault by a male or female or women’s experience of sexual assault by a female as the data for these types of violence are not reliable enough to report due to their low prevalence.

Infographic: Costello & Backhouse, 2019a.

In the most recent sexual assault by a male in the last 10 years...

Women were most likely to experience sexual assault by a male they knew (87% or 553,700).

The location of the sexual assault was most likely to be the woman’s home (40% or 252,400) or the perpetrator’s home (17% or 109,400).

Of the women who experienced a sexual assault by a male in the last 10 years, 23% (144,100) were physically injured. Of these 144,100 women, 33% (48,200) contacted a doctor or occupational health professional about these injuries.

Approximately nine out of ten (87% or 553,900) women who experienced sexual assault by a male did not contact the police about the most recent incident. Reasons for not contacting the police included feeling like they could deal with it themselves (34% or 189,400) and not regarding the incident as a serious offence (34% or 187,400).

Of the 85,700 women, who did contact the police, approximately one quarter advised that the perpetrator was charged (27% or 23,500).

Women who experienced sexual assault by a male were more likely to perceive the most recent incident as wrong but not a crime (42% or 268,000), compared with something that just happens (22% or 138,900) or as a crime (26% or 165,600).

Half (50% or 316,900) of all women who experienced sexual assault by a male sought advice or support about the most recent incident. Of these women, they sought advice and support from:

- 71% (224,500) a friend or family member.
- 27% (84,200) a counsellor, support worker or telephone helpline.
- 21% (65,200) a general practitioner.
- 18% (57,200) another health professional.
- 17% (53,700) the police.
- 7% (21,100)* a legal service.
- 6% (20,100) a work colleague or boss.
- 6% (20,100)* other.
- 2% (7,800)* a refuge or shelter.

Over half (57% or 365,700) of women who experienced sexual assault by a male felt anxiety or fear for their personal safety in the 12 months after the most recent incident.

Comparative data is not available for men’s experience of sexual assault by a male or female or women’s experience of sexual assault by a female as the data for these types of violence are not reliable enough to report due to their lower prevalence and higher associated error.

* estimate has a relative standard error of 25% to 50% and should be used with caution

Source: PSS 2016 (ABS, 2017 & ABS, 2017 Tables 10.1 and 15.1)
Gender of perpetrator of sexual assault

Australians were almost **6X more likely** to experience sexual assault by a male perpetrator than a female perpetrator:

- **1 in 62 AUSTRALIANS** (1.6% or 298,600) experienced sexual assault by a female perpetrator.
- **1 in 11 AUSTRALIANS** (9.4% or 1.7 million) experienced sexual assault by a male perpetrator.

Women were much more likely to experience sexual assault by a male perpetrator than a female perpetrator, whereas men were almost as likely to experience sexual assault by a male perpetrator as a female perpetrator:

- **1 in 6 WOMEN** (16.5% or 1.5 million) experienced sexual assault by a male perpetrator.
- **1 in 140 WOMEN** (0.7% or 67,000) experienced sexual assault by a female perpetrator.

Source: PSS 2016 (ABS, 2017, Table 3)
Age at most risk of sexual assault

Children and young people are more likely to experience sexual assault, particularly young women and girls.

15-19 years old

Young women aged 15-19 had the highest rates of reported sexual assault (661.9 victims per 100,000 women).

10-14 years old

Boys aged 10-14 had the highest rates of reported sexual assault for males (112.3 victims per 100,000 boys).

10-14 years old

Girls aged 10-14 had the second highest rates of reported sexual assault (542.8 per 100,000 girls).

15-19 years old

Young men aged 15-19 had the second highest rate of reported sexual assault for males (82.2 victims per 100,000 males).

Crime data collected by the ABS shows that children and young people are disproportionately victims of sexual assault, however there are significantly higher numbers of young women and girls affected compared to young men and boys:

Young women aged 15–19 had the highest rates of reported sexual assault of any age and sex group, with 661.9 victims per 100,000 women in this age group.

Boys aged 10–14 had the highest reported sexual assault rates for males, with police recording 112.3 victims per 100,000 boys in this age group.

Girls aged 10–14 had the second highest reported rate of sexual assault victimisation of any age and sex group (542.8 per 100,000 females aged 10-14).

Young men aged 1–19 had the second highest rate of reported sexual assault for males (82.2 victims per 100,000 males aged 15–19).

Sexual assault and the justice system

Research has established that only a small proportion of sexual assaults enter the criminal justice system, and those that do face a range of barriers and filtering mechanisms, which means that few result in a charge, prosecution, or conviction (Australian Law Reform Commission, nd).

**TIP**

These statistics are just provided as an example to demonstrate the point of what is often termed the ‘criminal justice funnel’ or sexual assault justice system attrition rates. It is important to note that these statistics are not from a single study that follows through one cohort from incident to conviction and therefore are not directly reliable data.

There is also no reliable data on men’s experience of prevalence in NSW for a 12-month period to make these directly relatable. Care should therefore be taken when using these statistics and the audience should be advised that they are illustrative only.
1. **Prevalence**  
(Number of people who had experienced sexual assault.)

In the 12 months prior to the survey (approximately 2016), 1.1% or 33,700** women in NSW experienced sexual assault (Personal Safety Survey 2016, ABS, 2017)*.

2. **Report to Police**

Between January – December 2016, there were 8,795 reported incidents of sexual assault recorded by the NSW Police Force (this is both male and female victims) (Recorded Crime – Victims 2016, ABS, 2017b, Table 10).

3. **Criminal proceedings**

Of the 8,795 reported incidents of sexual assault in NSW in 2016, 10.6% (or 933) had the investigation finalised and an offender proceeded against at 30 days after report (1,775 had investigation finalised and no offender proceeded against and 6,087 investigation not finalised) (Recorded Crime – Victims 2016, ABS, 2017b, Table 10). This is consistent with Australian research that found that, among all sexual offences reported to police, criminal proceedings are initiated in only 15% of incidents involving child victims and 19% of incidents involving adult victims (Fitzgerald, 2006 cited in Australian Law Reform Commission, nd).

4. **Conviction**

NSW research (Fitzgerald, 2006 cited in Australian Law Reform Commission, nd) found that 44% of persons prosecuted for a sexual offence against a child, and 42% of persons prosecuted for a sexual offence against an adult, were found guilty on at least one count. Applying this percentage to the 2016 statistics above, this means approximately 390 people would have been found guilty of an offence. This would equate to less than 1% of the estimated women who experienced sexual assault in the 12-month period. Note, if a reliable estimate of men’s experience of sexual assault were available, the conviction rate as a percentage of prevalence would be even lower.

* estimate has a relative standard error of 25% to 50% and should be used with caution.
** Comparative data not available for men’s experience of sexual assault as data too unreliable to use due to much lower prevalence and higher associated error.
2.3.3 Child sexual abuse before the age of 15

Before the age of 15, women were much more likely to have experienced sexual abuse as children than men:

1 in 13 Australians (7.7% or 1.4 million) experienced sexual abuse, which includes:

1 in 9 women (10.7% or 1 million) and
1 in 22 men (4.6% or 411,800)

Source: PSS 2016 (ABS, 2017, Table 31)
2.3.4 Characteristics of child sexual abuse

Relationship to perpetrator of child sexual abuse

Both men and women were significantly more likely to have experienced child sexual abuse\(^1\) by a known adult perpetrator.

Of people who experienced child sexual abuse by an adult before the age of 15:

- **91%** of these **WOMEN** (91% or 907,300) reported experiencing child sexual abuse by someone known to them.
- **83%** of these **MEN** (83% or 343,700) reported experiencing child sexual abuse by someone known to them.

1. Sexual abuse perpetrated by an adult (over 18 years) before the age of 15.
   Infographic: Costello & Backhouse, 2019a.

---

Relationship to perpetrator of child sexual abuse

Of the people who had experienced child sexual abuse\(^1\):

- **For women** the most common perpetrator types in order were:
  - Non-familial known person 47% (or 468,400)
  - Other relative or in-law 29% (or 294,000)
  - Parent 17% (or 173,600)
  - Stranger 12% (or 115,500)
  - Sibling\(^*\) 7.9% (or 79,000)
  - Relationship to perpetrator not known 1.2% (or 12,100)

- **For men** the most common perpetrator types in order were:
  - Non-familial known person 65% (or 268,500)
  - Other relative or in-law 15% (or 62,900)
  - Stranger 15% (or 62,100)
  - Parent 4% (or 16,700)
  - Sibling\(^*\) 4% (or 16,700)
  - Relationship to perpetrator not known 1.2% (or 4,800)

\(^*\) estimate has a relative standard error of 25% to 50% and should be used with caution.
\(^{**}\) estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

1. Sexual abuse perpetrated by an adult (over 18 years) before the age of 15.
   Infographic: Costello & Backhouse, 2019a.
Of the people who had experienced sexual abuse before the age of 15:

<table>
<thead>
<tr>
<th>Women who experienced sexual abuse by an adult before the age of 15 reported that the most common perpetrator types (in order) were:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-familial known person (i.e. a known person that wasn’t a family member/relative/in-law), for just under half of sexually abused women (47% or 468,400).</td>
</tr>
<tr>
<td>2. Other relative or in-law 29% (294,000).</td>
</tr>
<tr>
<td>3. Parent 17% (173,600); of which 99% (171,500) was a father/step-father.</td>
</tr>
<tr>
<td>4. Stranger 12% (115,500).</td>
</tr>
<tr>
<td>5. Sibling 7.9% (79,000).</td>
</tr>
<tr>
<td>6. Relationship to perpetrator not known for 1.2% (12,100)* of victims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Men who experienced sexual abuse by an adult before the age of 15 reported that the most common perpetrator types (in order) were:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-familial known person (i.e. a known person that wasn’t a family member/relative/in-law), for nearly two-thirds of sexually abused men (65% or 268,500).</td>
</tr>
<tr>
<td>2. Other relative or in-law 15% (62,900).</td>
</tr>
<tr>
<td>3. Stranger 15% (62,100).</td>
</tr>
<tr>
<td>4. Parent 4% (16,700)*; of which 100% (16,700) were abused by a father/step-father. and (equal)</td>
</tr>
<tr>
<td>5. Sibling 4% (16,700)*.</td>
</tr>
<tr>
<td>6. Relationship to perpetrator not known for 1.2% (4,800)** of victims.</td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution
** estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: PSS 2016 (ABS, 2017, Table 31)
The gender of the perpetrator of sexual abuse before the age of 15 is not recorded in the published data from the PSS 2016 (ABS, 2017) except concerning parents.

Victims of sexual abuse by a parent before the age of 15 were 15 times more likely to experience that abuse from their father/step-father than their mother/step-mother:

<table>
<thead>
<tr>
<th>Gender of Perpetrator</th>
<th>1 in 1521 Australians (0.1%* or 12,100)</th>
<th>1 in 97 Australians (1% or 189,300)</th>
</tr>
</thead>
<tbody>
<tr>
<td>experienced sexual abuse from their mother/step-mother.</td>
<td>experienced sexual abuse from their father/step-father.</td>
<td></td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: PSS 2016 (ABS 2017, Table 3.1)

Women were much more likely than men to have experienced sexual abuse before the age of 15 by either parent, but particularly by a father/step-father:

<table>
<thead>
<tr>
<th>Gender</th>
<th>1 in 55 women (1.8% or 171,500)</th>
<th>1 in 500 men (0.2%* or 16,700)</th>
</tr>
</thead>
<tbody>
<tr>
<td>experienced sexual abuse by their father/step-father.</td>
<td>experienced sexual abuse by their father/step-father.</td>
<td></td>
</tr>
<tr>
<td>1 in 1000 women (0.1%* or 9,500)</td>
<td>No men (0% or 0)</td>
<td></td>
</tr>
<tr>
<td>experienced sexual abuse by their mother/step-mother.</td>
<td>experienced sexual abuse by their mother/step-mother.</td>
<td></td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: PSS 2016 (ABS 2017, Table 3.1)
2.3.5 Other research on child sexual abuse

- An analysis of 5 contemporary and comprehensive Australian studies on the prevalence of child sexual abuse found that females had prevalence rates of 4-12% for penetrative abuse and 14-26.8% for non-penetrative abuse, and males had prevalence rates of 1.4-8% for penetrative abuse and 5.7-16% for non-penetrative abuse (Child Family Community Australia, 2017).

- Fergusson & Mullen (1999) conducted a meta-analysis of the prevalence of child sexual abuse reported in studies in the 1990’s, using both community samples and studies of convenience (i.e. university students, clients accessing welfare services etc.). Studies that were based on less than 100 subjects were excluded. The studies included had a range of definitions of child sexual abuse and a range of ages to define childhood (including one as low as 12 years old). This meta-study found prevalence rates of:
  - For girls between 15-30% (1 in 6 up to 1 in 3). If a broad definition of sexual abuse was used, rates varied between 8% to 62% and if definitions included only sexual acts that involved penetration then it was between 1.3% and 28.7%.
  - For boys between 3-15% (1 in 6 at the upper range). If a broad definition of sexual abuse was used, rates varied between 3% to 29% and if definitions included only sexual acts that involved penetration then it was 1.1% to 14.1%.

- In Australian recorded crime data, young women aged 15-19 years had the highest victimisation rate for sexual assault of all female victims and this is more than four times that of the overall female rate of sexual assault (ABS 2012 cited in Tarczon & Quadara, 2012).

- There are specific contexts in which children and young people are more at risk of sexual assault, namely:
  - Children and young people with intellectual disabilities, psychiatric disabilities or complex communication disabilities (Mitra-Kahn, Newbigin & Hardefeldt, 2016).
  - Young people in correctional or juvenile justice settings (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a).

TIP

Prevalence rates of child sexual abuse can vary dramatically based on a range of factors including, but not limited to:

- The definition of abuse used both in terms of the acts considered (e.g. penetrative or non-penetrative) and who the perpetrator is (e.g. the PSS limits the perpetrator to an adult over 18 years old).
- Definition of childhood (e.g. under 15, 16 or 18 years old).
- The data on which it is based (e.g. crime victimisation survey or administrative by-product data such as reported crime data).
- The sampling strategy including whether the sample is representative of the population.
- The way questions are formed.
- Disclosure rates as some people believe some survivors of child sexual abuse will opt out of general population studies.
• Both men and women report experiencing sexual abuse as a child by someone known to them. However, women are more likely to have reported being sexually abused in all other settings including by family members and in the community where the majority of child sexual abuse occurs, while the majority of victims of sexual abuse in institutions, particularly religious institutions, were male (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

• The sexual abuse of boys is far more common than generally believed and, in comparison to girls, boys are more likely to be assaulted by siblings or other boys (Cashmore & Shackel, 2013; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

• Sibling sexual abuse is more prevalent than other types of intra-familial sexual abuse (Tapara, 2012; Welfare, 2008; Caffaro, 2013).

• Australian studies find that 30 to 60 per cent of childhood sexual abuse is carried out by children and young people, and ‘most young people target younger children or peers, and know their victim’ (Department of Health and Human Services, 2012; Hunter, 1999; KPMG, 2014, p. 22; Weinrott, 1996 as cited in El-Murr, 2017).

• The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) heard from 7,981 survivors of child sexual abuse in institutional contexts in 8,013 private sessions. Of these:
  ▶ Most survivors were male (64.3%) and 35.7% were female.
  ▶ The vast majority of survivors (93.3%) were abused by one or more male adult perpetrator or child with harmful sexual behaviours. 10.7% were abused by one or more female adult perpetrator or child with harmful sexual behaviours.
  ▶ Of those survivors that provided information about the age of the perpetrator, most were abused by an adult perpetrator (85.2%), and 23.4% were abused by a child with harmful sexual behaviours (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).
2.4 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. More information about family violence in Aboriginal communities is provided in Section 2.6.3. Family violence is often connected to violence by an intimate partner, with women and children continuing to experience its most profound effects and women continuing to be most at risk of harm from their intimate partners (Toivonen & Backhouse, 2018).

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).

In NSW, the definition of domestic and family violence commonly used by NSW Government agencies is “any behaviour in a domestic relationship, which is violent, threatening, coercive or controlling and causing a person to fear for their own or someone else’s safety. It is usually manifested as part of a pattern of controlling or coercive behaviour” (NSW Government, 2014). The behaviours that may constitute domestic and family violence include (adapted from NSW Government, 2014):

- physical violence including physical assault or abuse;
- sexual assault and other sexually abusive or coercive behaviour;
- emotional or psychological abuse including verbal abuse and threats of violence;
- economic abuse, for example denying a person reasonable financial autonomy or financial support;
- stalking, for example harassment, intimidation or coercion of the other person’s family in order to cause fear or ongoing harassment;
- kidnapping or deprivation of liberty, as well as unreasonably preventing the other person from making or keeping connections with her or his family or kin, friends, faith or culture;
- damage to property irrespective of whether the victim owns the property;
- spiritual violence, including but not limited to ridiculing or preventing victim survivors’ practice of faith or culture and/or manipulating religious and spiritual teachings or cultural traditions to excuse the violence;
- technology-facilitated abuse, including but not limited to the use of text, email, phone to abuse, monitor, humiliate or punish, or threats such as to distribute private photos/videos of victim-survivors of a sexual nature; and
- causing injury or death to an animal irrespective of whether the victim owns the animal.

The PSS (ABS 2017) includes in the definition of violence by an intimate partner both physical violence and sexual violence from two types of partners:

- A Partner (current or previous) is defined as a person the respondent lives with, or lived with at some point, in a married or de facto relationship.
An intimate partner is defined as a current or previous partner with whom the respondent has lived, or current or previous boyfriend, girlfriend or date with whom the respondent did not live.

Emotional abuse by a partner is considered separately in the Personal Safety Survey in its own category (and not included as a part of violence by an intimate partner). No composite data is provided in the findings of the PSS which reports the combined totals for physical violence, sexual violence and emotional abuse by a partner.

Information about other forms of violence (e.g. spiritual and financial abuse) are not collected.

As noted in Section 1.3.3, one of the key limitations of the Personal Safety Survey (PSS) (ABS 2017) is that it does not ask questions about domestic and family violence. Despite this limitation, the PSS can provide insights into domestic and family violence in the questions it asks about violence by a partner and the nature, context and impact of this violence. Care needs to be taken, however, with terminology and particularly in representing and referring to the data from the PSS as “violence by a partner” and not “domestic and family violence”.

Care is needed when using the terms “violence by an intimate partner” and “intimate partner violence”. The World Health Organisation uses the term “intimate partner violence” to refer to what is more closely (although not totally) aligned to definitions of domestic violence in this resource. The WHO (2012) states: “Intimate partner violence [IPV] is one of the most common forms of violence against women and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner” and “IPV refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship”. Despite this definition, the WHO tends to measure “intimate partner violence” through crime victimisation surveys that use incident-based definitions of violence and which do not necessarily capture the ongoing pattern of behaviour, control, fear and safety elements of common definitions of domestic violence.

In comparison, the PSS (ABS 2017) uses an incident-based definition limited to physical and sexual violence by an intimate partner as already discussed. The PSS does not include psychological or emotional abuse in their definition of violence by a partner (although emotional abuse by a partner is collected as a separate category) and also does not capture the ongoing pattern of behaviour, control, fear and safety elements of common definitions of domestic violence.

When referring to the PSS in this resource we use the term “violence by an intimate partner” and “violence by a partner”, however when referencing other sources, we use their terminology to ensure consistency with the original source (e.g. the burden of disease study referenced later on uses the term “intimate partner violence”).
2.4.1 Prevalence of violence and emotional abuse by a partner

Since the age of 15, women were much more likely to experience all forms of violence from an intimate partner than men:

1 in 6 Australians (16% or 2.9 million) experienced violence by an intimate partner.

- 1 in 4 women (23% or 2.2 million) experienced violence by an intimate partner.
- 1 in 13 men (7.8% or 703,000) experienced violence by an intimate partner.

- 1 in 5 women (19% or 1.8 million) experienced physical violence by an intimate partner.
- 1 in 14 men (7.1% or 654,200) experienced physical violence by an intimate partner.

- 1 in 11 women (9.2% or 864,000) experienced sexual violence by an intimate partner.
- 1 in 83 men (1.2% or 104,800) experienced sexual violence by an intimate partner.

Source: PSS 2016 (ABS 2017 & Table 3)
Avoiding the 3 ‘M’s

1. Physical and/or sexual violence since the age of 15. 2. Current and/or previous partner (lived with).


This included:

1 in 6 WOMEN (17% or 1.6 million) and
1 in 16 MEN (6.1% or 547,600)

experienced violence\(^1\) by a partner\(^2\)

---

**Physical violence by a partner**

Women were **3x** more likely to experience physical violence by a partner than men:

1 in 6 WOMEN (16% or 1.5 million) experienced physical violence\(^1\) by a partner\(^2\)
1 in 17 MEN (5.9% or $28,000) experienced physical violence\(^1\) by a partner\(^2\)

---

\(^1\) Physical and/or sexual violence since the age of 15. \(^2\) Current and/or previous partner (lived with).
Since the age of 15, women were much more likely to experience all forms of violence from a partner than men:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Violence Type</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>experienced sexual violence by a partner</td>
<td>5.1%</td>
<td>480,200</td>
</tr>
<tr>
<td>Men</td>
<td>experienced sexual violence by a partner</td>
<td>0.6%</td>
<td>53,000</td>
</tr>
<tr>
<td>Women</td>
<td>physical violence by a partner</td>
<td>16%</td>
<td>1.5 million</td>
</tr>
<tr>
<td>Men</td>
<td>physical violence by a partner</td>
<td>5.9%</td>
<td>528,000</td>
</tr>
<tr>
<td>Women</td>
<td>sexual violence by a partner</td>
<td>5.1%</td>
<td>480,200</td>
</tr>
<tr>
<td>Men</td>
<td>sexual violence by a partner</td>
<td>0.6%</td>
<td>53,000</td>
</tr>
</tbody>
</table>

Source: PSS 2016 (ABS 2017 & Table 3)

TIP

- An **Intimate partner** in the PSS 2016 is a current or previous partner with whom the respondent has lived, or current or previous boyfriend, girlfriend or date with whom the respondent did not live.
- A **Partner** (current or previous) in the PSS 2016 is a person the respondent lives with, or lived with at some point, in a married or defacto relationship.
1 in 5 Australians (19% or 3.6 million) experienced emotional abuse by a partner.

1 in 4 women (23% or 2.2 million) experienced emotional abuse by a partner.

1 in 6 men (16% or 1.4 million) experienced emotional abuse by a partner.

Source: PSS 2016 [ABS 2017]
2.4.2 Characteristics of violence by a partner

Both women and men were more likely to have experienced violence by a previous partner than a current partner, however women were five times more likely to have experienced violence from a previous partner while men were three times more likely to have experienced violence from a previous partner:

**Women were five times more likely to have experiences violence from a previous partner than a current partner.**
- 1 in 7 women (14.6% or 1.4 million) experienced violence by a previous partner.
- 1 in 34 women (2.9% 275,000) experienced violence by a current partner.

**Men were three times more likely to have experienced violence from a previous partner than a current partner.**
- 1 in 22 men (4.4% or 397,300) experienced violence by a previous partner.
- 1 in 59 men (1.7% or 150,300) experienced violence by a current partner.

Source: PSS 2016 (ABS 2017, Tables 17 & 18)

**Women make up a much greater proportion of victims of violence by a partner:**

**Women** were 3 in 4 of the respondents who experienced violence by a partner since the age of 15 (17% of women or 1.6 million women experienced violence by a partner).

**Men** were 1 in 4 of the respondents who experienced violence by a partner since the age of 15 (6.1% of men or 547,600 men experienced violence by a partner).

Source: PSS 2016 (ABS 2017, Table 3)

**Most violence by an intimate partner is experienced by women in co-habiting de-facto relationships or marriages. In the 12 months prior to the survey:**

**2.3% or 211,700 Australian women experienced violence by an intimate partner** which includes
- **1.7% or 155,900 Australian women** who experienced violence by a partner.

**1.3% or 113,900 Australian men** experienced violence by an intimate partner which includes
- **0.8% or 75,500 Australian men** who experienced violence by a partner.

**2.2% or 66,400 women in NSW experienced violence by an intimate partner.** which includes
- **1.6% or 48,700 women in NSW** who experienced violence by a partner.

**1.4% or 39,900* men in NSW experienced violence by an intimate partner.** Comparative data is not available for NSW for men’s experience of violence by a partner as the data is not reliable enough to report due to the much lower prevalence and higher associated error.

* estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: PSS 2016 (ABS 2017, Table 5 and NSW Table 5)
The NSW Bureau of Crime Statistics and Research (BOCSAR) provides data on domestic violence related assaults that are reported to, or detected by, the NSW Police Force (BOCSAR, 2018).

In NSW in the 12 months from July 2017-June 2018:

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>67.9% or 21,002 victims</td>
<td>32% or 9,912 victims</td>
</tr>
<tr>
<td>of recorded domestic</td>
<td>of recorded domestic</td>
</tr>
<tr>
<td>violence related assaults</td>
<td>violence related assaults</td>
</tr>
<tr>
<td>were women</td>
<td>were men</td>
</tr>
</tbody>
</table>


2.4.3 How much are experiences of violence by a partner like domestic violence?

Although not a measure of domestic violence per se as discussed above, the Personal Safety Survey and other data sources demonstrate women are more likely than men to experience characteristics of violence by a partner that are more like domestic violence in terms of impact and severity.

The impact data above and below is predominantly related to violence by a partner as it is mostly from the PSS. It is intended to demonstrate using a large-scale population based study (i.e. the PSS) the ways that violence by a partner is more like domestic violence for women than men. To demonstrate the impact of domestic violence alone, it would be better to use a smaller qualitative study that explores this specific topic with a sample of victims of domestic violence because crime victimisation studies effectively dilute the impact of domestic violence (e.g. we’d expect each of the impacts to be much higher for a sample of domestic violence victims only compared to a sample like this of all violence by a partner victims).
### Anxiety and fear due to violence and abuse since the age of 15:

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 2 women who experienced violence by a current partner felt anxiety or fear due to the violence (46% or 126,100).</td>
<td>1 in 3 men who experienced violence by a current partner felt anxiety or fear due to the violence (32% or 47,300)*.</td>
</tr>
<tr>
<td>2 in 3 women who experienced violence by a previous partner felt anxiety or fear due to the violence (65% or 887,900).</td>
<td>1 in 3 men who experienced violence by a previous partner felt anxiety or fear due to the violence (29% or 116,000)*.</td>
</tr>
<tr>
<td>6 in 10 women who experienced emotional abuse by a current partner experienced anxiety or fear due to the emotional abuse (59% or 338,100).</td>
<td>4 in 10 men who experienced emotional abuse by a current partner experienced anxiety or fear due to the emotional abuse (41% or 196,200).</td>
</tr>
<tr>
<td>7 in 10 women who experienced emotional abuse by a previous partner experienced anxiety or fear due to the emotional abuse (72% or 1.2 million).</td>
<td>4 in 10 men who experienced emotional abuse by a previous partner experienced anxiety or fear due to the emotional abuse (43% or 452,200).</td>
</tr>
</tbody>
</table>

*estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: PSS 2016 ([ABS 2017](#))

### Experience of post-separation violence by a partner since the age of 15.

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost 2 in 5 women (39% or 153,000) who temporarily separated from a violent previous partner experienced violence during the separation.</td>
<td>Almost 1 in 3 men (35% or 38,700) who temporarily separated from a violent previous partner experienced violence during the separation.</td>
</tr>
</tbody>
</table>

Source: PSS 2016 ([AIHW, 2018a](#), p.38)

Of people who had been temporarily separated, the percentage of people who experienced violence from a former partner during temporary separation was approximately equal, however the total number of women affected was much higher given the higher prevalence of violence by a partner generally for women:

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.9% (152,500) of women experienced violence from a former partner while temporarily separated.</td>
<td>35.1%* (38,700*) of men experienced violence from a former partner while temporarily separated.</td>
</tr>
<tr>
<td>14.3% (56,300) of women experienced violence from a former partner for the first time while temporarily separated.</td>
<td>13.2%# (14,600*) of men experienced violence from a former partner for the first time while temporarily separated.</td>
</tr>
<tr>
<td>For 13.6% (53,300) of women violence from a former partner increased while temporarily separated.</td>
<td>For 13.6%* (15,000*) of men violence from a former partner increased while temporarily separated.</td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution.

# proportion has a margin of error >10 percentage points or proportion ± margin of error <0% or >100%, which should be considered when using this information.

Source: PSS 2016 ([ABS 2017, Tables 22 & 23](#))
Women were eight times more likely to experience sexual violence by a partner than men. This is especially significant as it is a form of violence that could not have any other mitigating factor (e.g. unlike physical violence it cannot be a form of self-defence) and cannot be misconstrued or misinterpreted in the way that, for example, emotional abuse might.

Sexual assault that is perpetrated by men against women in the context of domestic violence, or ‘intimate partner sexual violence (IPSV)’, is also an indicator of high-risk of severe or lethal future violence, particularly if the woman is also being physically abused (Campbell et al., 2003; and see Section 2.4.4).

1 in 20 Australian women (5.1% or 480,200) experienced sexual violence by a partner since the age of 15.

1 in 167 Australian men (0.6% or 53,000) experienced sexual violence by a partner since the age of 15.

Impact on employment - women and men are more likely to take time off work after violence by a previous partner and women were more likely than men to have taken time off work as a result of violence by a partner:

1 in 11 (9.6%, or 26,500) women who have experienced violence from a current partner had taken time off work as a result.

1 in 25 (4.0% or 6,000) men who have experienced violence from a current partner had taken time off work as a result.

1 in 5 (20%, or 270,000) women who have experienced violence from a previous partner had taken time off work as a result.

1 in 6 (17% or 66,200) men who have experienced violence from a previous partner had taken time off work as a result.

Both women and men were highly unlikely to contact the police concerning violence by a partner. A higher percentage of women who had experienced violence by a partner contacted the police than men who had experienced violence by a partner. It is unclear whether this was due to the severity of the violence, reluctance to report, or some other factor. It is notable, however, that for a substantially higher proportion of women (compared to men) who had contacted the police about a former partner their partner was charged.

An estimated 82% of women (225,700) who experienced violence by a current partner never contacted the police.

An estimated 97% of men (146,100) who experienced violence by a current partner never contacted the police.

An estimated 65% of women (888,100) who experienced violence by a previous partner never contacted the police.

An estimated 76% of men (299,900) who experienced violence by a previous partner never contacted the police.

Of the estimated 485,800 women who had contacted the police, approximately half (56% or 271,900) reported that their partner was not charged.

Of the estimated 99,100 men who had contacted the police, approximately three quarters (73% or 72,300) reported that their partner was not charged.

Source: PSS 2016 [ABS 2017 Table 3.1]
Women who had experienced violence by a previous partner were more than twice as likely than men who had experienced violence by a previous partner to have a restraining order issued against their partner:

1 in 4 women (24% or 329,500) who experienced violence by a previous partner had a restraining order issued against their partner.  
1 in 10 men (10% of 41,100) who experienced violence by a previous partner had a restraining order issued against their partner.

Source: PSS 2016 (ABS 2017)

Domestic violence is the leading reason for seeking assistance from specialist homelessness services, particularly for women and children.

In 2016-17, 2 in 5 people (40% or 114,757) who were assisted by specialist homelessness services reported that domestic and family violence contributed to, or was the reason for, their homelessness*. Of these clients:

- 3 in 4 (77% or 88,360) were female and 1 in 4 (23% or 26,560) were male
- 9 in 10 adults (18+) were female (91% or 68,000)
- 1 in 5 (22% or 25,400) were children aged 0-9 years
- 1 in 3 (35% or 40,000) were children or young people under 18 years old

* While specialist homelessness services mostly assist people who are victims of domestic and family violence, they may also assist perpetrators who seek homelessness services. SHSC data does not separately identify these clients.

Source: Specialist Homelessness Services Collection (SHSC) 2016–17 (AIHW 2017, Table DV.1 and CLIENT.14)

On average, 8 women are hospitalised every day after being assaulted by their spouse or partner:

For 8 in 20 hospitalisations for female assault victims (45% or 2,800), a spouse or domestic partner was the perpetrator (where the perpetrator was identified).

1 in 20 hospitalisations for male assault victims (4.4% or 563), a spouse or domestic partner was the perpetrator (where the perpetrator was identified).

Source: National Hospital Morbidity Database 2014-15 (AIHW, 2018a, pp.55-56)
Women are much more likely to be killed by an intimate partner than men

In the 4 years from mid-2010 to mid-2014, there were 152 intimate partner homicides in Australia that followed an identifiable history of domestic violence. Of these:

- 18.4% of victims were men killed by a female partner (18.4% or 28)
- 79.6% of victims were women killed by a male partner (79.6% or 121)
- 2% of victims were men killed by a male partner (2% or 3)

Women are much more likely than men to be killed by their intimate partners:

- 4 in 5 (79% or 99) victims of intimate partner homicide were female in the 2 years from mid-2010 to mid-2014.
- 1 in 5 (21% or 27) victims of intimate partner homicide were male in the 2 years from mid-2010 to mid-2014.
- 3 in 4 (75% or 488) victims of intimate partner homicide were female in the 10 years from mid-2002 to mid-2012.
- 1 in 4 (25% or 166) victims of intimate partner homicide were male in the 10 years from mid-2002 to mid-2012.

Source: National Homicide Monitoring Program (NHMP) (Bryant and Bricknell 2017, table 8; Cussen & Bryant 2015, table 3)
Most intimate partner homicides in Australia involve patterns of abuse perpetrated by men against a female partner before the homicide, no matter which partner is killed. In the 4 years from mid-2010 to mid-2014, there were 152 intimate partner homicides in Australia that followed an identifiable history of domestic violence.* Of these:

- **4 in 5 (79.6% or 121) victims** of intimate partner homicide were women killed by a male partner. No women were killed by a female partner.
- **1 in 4 (24% or 29) women** who were killed by a male partner, were protected under a Domestic Violence Order naming the male homicide offender as the respondent (domestic abuser).
- **1 in 4 (25% or 7) female intimate partner homicide offenders** were protected under Domestic Violence Orders naming the male victim as the respondent (primary domestic abuser) at the time of death.
- **1 in 7 (14.3% or 4) men** who were killed by a female partner, were protected under a Domestic Violence Order naming the female homicide offender as the respondent (domestic abuser).
- **1 in 5 (18.4% or 28) victims** of intimate partner homicide were men killed by a female partner. 3 [2%] of victims of intimate partner homicide were men killed by a male partner.
- **1 in 7 (14.3% or 4) men** who were killed by a female partner, were protected under a Domestic Violence Order naming the female homicide offender as the respondent (domestic abuser).
- **1 in 5 (24% or 29) women** who were killed by a male partner, were protected under a Domestic Violence Order naming the male homicide offender as the respondent (domestic abuser).
- **1 in 7 (14.3% or 4) men** who were killed by a female partner, were protected under a Domestic Violence Order naming the female homicide offender as the respondent (domestic abuser).
- **1 in 121 (0.8% or 1) male intimate partner homicide offenders** were protected under Domestic Violence Orders naming the male victim as the respondent (primary domestic abuser) at the time of death.
- **1 in 121 (0.8% or 1) male intimate partner homicide offenders** were protected under a cross-Domestic Violence Order naming the male victim under a cross-Domestic Violence Order.

* All homicides were identified as being preceded by either police reported and/or anecdotal histories of domestic violence.

Source: National Minimum Dataset

(Australian Domestic and Family Violence Death Review Network, 2018)
2.4.4 High-risk factors for severe or lethal domestic and family violence

Australian and international lethality studies including research by domestic and family violence death review committees and Coroner’s Courts, provide evidence of behavioural and situational risk factors that are associated with a higher likelihood of violence re-occurring, serious injury or death, in the context of violence by an intimate partner by men against women. In many fatal cases, there have been ongoing patterns of abuse prior to the homicide, as well as identifiable indicators of severe harm. While men can be victims, women are much more likely to be killed by an intimate partner than men, and analyses of homicide data produce statistics on high-risk factors that reflect the disproportionate risk to women of lethal violence by a male partner.

High-risk factors for domestic and family violence identified through quantitative methods are consistent with findings from qualitative studies and clinical literature. The relationship between these factors and the risk of re-assault or death is often complex and none can be considered singularly “causal”. However, identification through the evidence of common factors and patterns of behaviour preceding intimate partner homicide, is valuable to inform: proportionate and appropriate risk assessment and safety management responses with victims; violence prevention initiatives; and policy and resourcing priorities.

The below evidence-based risk factors can indicate high risk of lethality and/or severe harm, and/or risk of re-assault, when mediated by other risk factors, or an individual’s situation and conditions of vulnerability. Emerging research suggests that the presence of any of these factors may indicate risk of serious violence, and when used to guide professionals’ risk assessment and safety planning processes through a structured professional judgement approach, collaboratively with victim-survivors, may lead to a reduction in the risk of violence or its impacts (Australian Domestic and Family Violence...
The key task in risk assessment processes is to evaluate how risk changes over time, rather than assuming that assessments made at a particular point in time will remain valid indefinitely. By identifying dynamic risk factors that can be altered through health and other service interventions, pathways for changing perpetrators’ behaviours emerge, and safety planning and risk management strategies to support and protect victims can be identified (Toivonen & Backhouse, 2018).

It is important to note that risk factors identified through empirical research are almost exclusively based on data from heterosexual, intimate partner samples. The applicability of these risk factors to people in non-heterosexual LGBTQI relationships, or for violence occurring more broadly within families, remains unclear. Qualitative studies, practice-based research and clinical data indicate that these factors may also indicate high-risk of violence in LGBTQI relationships, but that there may also be unique factors that should be considered. Risk assessment practices and tools should be adapted as emerging research determines how well the existing evidence-base applies to people in non-heterosexual intimate partner relationships and people experiencing broader family violence.

Building a shared understanding of risk and safety through common reference to evidence-based risk factors in clinical tools, practice guidance and policy frameworks, is an important component of integrated and multi-agency service responses to clients who have experienced domestic and family violence.

**TIP - Data types that assist in understanding lethal and repeat violence**

**Domestic, family and child death reviews and Coroners’ Courts reports** identify factors and behaviours that precede the most severe outcome of violence - death - and identify gaps in service and system responses to help prevent future homicides.

**Homicide and lethality data** provide statistics on prevalence and characteristics of deaths due to violence.

**Recidivism and crime data** from police records, provide evidence of factors that indicate high-risk of re-offending or repeat victimisation. Recidivism data is typically used to predict whether violence will happen again, not how severe or lethal future violence will be.

Further research and practice and implementation guidance to support evidence-based risk assessment and safety management with victim-survivors and perpetrators of violence, as well as the development and review of tools and frameworks, can be found in the National Risk Assessment Principles for domestic and family violence: Companion resource. A summary of the evidence-base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence (Backhouse & Toivonen, 2018).

The table below has been adapted and updated from The National Risk Assessment Principles for domestic and family violence (Toivonen & Backhouse, 2018).
Some forms of abuse and situational factors indicate a high-risk of severe or lethal violence by men against their female intimate partners:

<table>
<thead>
<tr>
<th>High-risk / lethality factor</th>
<th>Characteristics and statistics</th>
</tr>
</thead>
</table>
| History of violence         | Homicide is rarely a random act and often occurs after repeated patterns of coercive and controlling behaviours, including physical and sexual abuse. Risk of re-assault, injury or death is high where there is a history of domestic violence and when the violence increases in frequency or severity.  
  - Of a sample of 105 male domestic violence abusers who killed female victims in Australia between 2000-2014, 76.2% (80) of those males had previously used physical violence against the female they killed (The Network).  
  - In Campbell et al.’s (2003) widely validated 11-city US femicide study, 72% of intimate partner femicides were preceded by physical violence by the male perpetrator. When there was an escalation in frequency or severity of physical violence over time, abused women were 5-times more likely than other abused women to be killed. |
| Intimate partner sexual violence (IPSV) | Sexual violence perpetrated by a partner is a particularly dangerous form of exerting power and control with significant health consequences. More so than other factors, IPSV is under-disclosed by victims. Shame and stigma around discussing sex and sexual assault within relationships are significant barriers to seeking help for IPSV.  
  - In Campbell et al.’s (2003) study, physically abused women who also experienced forced sexual activity or rape, were 7-times more likely than other abused women to be killed by their partner; and IPSV was the strongest indicator of escalating frequency and severity of violence, more so than stalking, strangulation and abuse during pregnancy (Campbell et al., 2003).  
  - In Australia, 1 in 11 (9.2% or 858,100) women have experienced sexual violence (sexual assault or threat) by an intimate partner since the age of 15, and half of all female victims of sexual assault by a male since the age of 15, are sexually assaulted by an intimate partner (51% or 787,900) (ABS, 2017, table 3.1). |

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2 This figure is based on data collected from NSW, VIC, QLD, SA and NT death review processes between July 2000 and June 2014 and is a more intensive case review sample of the Network’s dataset. 109 cases involved a primary abuser of domestic violence killing the person they had historically used violence against. This number includes 105 cases in which a male domestic violence abuser killed a female domestic violence victim (The Network, p.41).

3 This 11-city US study sought to identify risk factors for femicide in abusive relationships. Proxies of 220 intimate partner femicide victims identified from police or medical examiner records were interviewed, along with 343 abused control women. Pre-incident risk factors associated with increased risk of intimate partner femicide included: perpetrator’s access to a gun and previous threat with a weapon; perpetrator’s stepchild in the home; and estrangement, especially from a controlling partner. Significant incident factors included the victim having left for another partner and the perpetrator’s use of a gun (Campbell et al., 2003; 2009; Glass et al., 2008).
<table>
<thead>
<tr>
<th>High-risk / lethality factor</th>
<th>Characteristics and statistics</th>
</tr>
</thead>
</table>
| Non-lethal strangulation (or choking) | Strangulation is one of the most lethal forms of violence by an intimate partner. Minimal visibility of physical injury means the seriousness of strangulation or choking as an indicator of lethality is often misidentified or not responded to proportionately.  
  - Women whose partner had tried to strangle or choke them were over 7-times more likely than other abused women to be killed by their partner, whether by repeat strangulation or another violent act (Glass et al., 2008).  
  - In 1 in 4 (26% or 20) intimate partner homicides in NSW that occurred in contexts of domestic violence between 10 March 2008 and 30 June 2014, there were indications that the abuser had strangled the domestic violence victim prior to the fatal assault (NSW DVDRT, 2017). |
| Separation | Women are most at risk of being killed or severely harmed during and/or immediately after separation. Children are also at heightened risk of harm during and post-separation.  
  - Two-thirds (65% or 60) of women killed by a former intimate partner in NSW between 1 July 2000 and 30 June 2014, had ended their relationship within three months of the homicide (NSW DVDRT, 2017).  
  - In over a third (41% or 42) of cases where women were killed by current partners (63% or 102) in NSW between 1 July 2000 and 30 June 2014, either the victim and/or the perpetrator had indicated an intention to leave the relationship within three months of the homicide (NSW DVDRT, 2017).  
  - Nationally, actual or intended separation was a characteristic in 55.4% (67) of cases where males killed a female intimate partner between 2010-2014 (the Network, 2018). |
| Stalking | Many men who kill their female partners stalk them prior to the homicide. Repeated, persistent and unwanted behaviours including surveillance, cyber-harassment and interference with property, increases risk of severe or lethal harm.  
  - 36.2% of women who were killed by a male intimate partner in Australia between July 2010 and June 2014 were stalked by the offender prior to the homicide (The Network, 2018).  
  - Stalking by the male homicide offender was a factor in 85% of attempted femicides in a case control sample of 821 women in 10 US cities, and for 76% of femicide victims. Women who were “followed or spied on” in the 12 months prior to the attempted/actual homicide, were over 2-times more likely than other abused women to be killed (McFarlane et al., 1999).  
  - For women, perpetrators of stalking are much more likely to be intimate partners of the victim (45% or 662,100) than a stranger (25% or 365,400) or other known person (31% or 452,200) (ABS, 2017, table 35.1). |
### High-risk / lethality factor

#### Characteristics and statistics

<table>
<thead>
<tr>
<th>Threats to kill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats to kill or harm are a severe form of psychological abuse. Perpetrators who threaten to kill their partner or former partner, themselves, or others including children, pose a high risk of lethal harm.</td>
<td></td>
</tr>
<tr>
<td>- Campbell et al. (2003) found that women whose partners threatened to kill them, were 15-times more likely than other abused women to be killed.</td>
<td></td>
</tr>
<tr>
<td>- Actual attempts to kill are difficult to separate from serious physical and sexual abuse and choking or attempted strangulation are of significant concern given the prevalence of femicide through strangulation (Humphreys, 2007).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perpetrator’s access to or use of weapons</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of a weapon (any tool that could injure, kill or destroy property) indicates high risk of severe or lethal harm, particularly if used in the most recent incident of violence.</td>
<td></td>
</tr>
<tr>
<td>- Campbell et al. (2003) found that women who are threatened or assaulted with a gun or other weapon are 20-times more likely than other abused women to be killed. The severity of non-lethal violence is significantly higher when weapons are involved.</td>
<td></td>
</tr>
<tr>
<td>- While the availability of firearms in Australia is more limited than in the US, there is evidence that in Australia the use of weapons is a common characteristic of physical abuse perpetrated by male domestic violence homicide offenders against their female intimate partners prior to the homicide (the Network, 2018).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Escalation (frequency and/or severity)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escalation in frequency or severity of violence over time is linked to lethality, and often occurs when there are shifts in dynamic (changeable) risk or situational factors, such as attempts by the victim to leave the relationship. Transition points such as separation require re-assessment of level of risk and should be treated with great caution.</td>
<td></td>
</tr>
<tr>
<td>- Dwyer and Miller (2014) found that police investigations and family, criminal or civil court proceedings can trigger an escalation in aggressive and violent behaviour by the perpetrator towards their partner or ex-partner and children.</td>
<td></td>
</tr>
<tr>
<td>- Campbell et al. (2003) found that when there is an escalation in either frequency or severity of violence over time, abused women are more than 5-times more likely to be killed than other abused women.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coercive control</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All domestic and family violence can be understood as coercive control, characterised by behaviours that exploit power imbalances and are intended to instil fear and compliance.</td>
<td></td>
</tr>
<tr>
<td>- Reports from death reviews and Coroners’ Courts highlight the prevalence of patterns of coercive and controlling behaviours prior to male-perpetrated intimate partner homicide, including verbal and financial abuse, psychologically controlling acts and social isolation (NSW DVRT, 2017; the Network, 2018).</td>
<td></td>
</tr>
<tr>
<td>- Through a synthesis of key empirical research, Elliot (2017) shows that coercive control is a gendered pattern of abuse, and that men’s violence against women is rarely experienced as a single incident, it is ongoing, cumulative, chronic and routine.</td>
<td></td>
</tr>
<tr>
<td>- Coercive and controlling behaviours are particularly dangerous and can heighten the risk of lethality in contexts where other high-risk factors are present such as attempts by the victim to leave the relationship (Campbell et al., 2003).</td>
<td></td>
</tr>
<tr>
<td>High-risk / lethality factor</td>
<td>Characteristics and statistics</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
</tbody>
</table>

**Pregnancy, termination and new birth**

Violence perpetrated against pregnant women is a significant indicator of future harm to the woman and child. Violence often begins when women are pregnant and, where previously occurring, often escalates in frequency or severity.

- Nearly half (48% or 325,900) of women who have experienced violence by a previous partner and who were pregnant during that relationship, experienced violence from their partner while pregnant (ABS, 2017).
- Violence against pregnant women is considered ‘double-intentioned’, and perpetrators may aim physical violence at their partner’s abdomen, genitals or breasts, so that abuse is against both the mother and child (Humphreys, 2007).
- In multiple cases reviewed by the NSW DVIRT (2017), women who had been pregnant or terminated a pregnancy while in a relationship with the man that killed her, had been abused by the homicide offender while pregnant or seeking an abortion, and coercive and controlling behaviours often escalated during these times.

**Victim’s self-perception of risk**

A victim-survivor led approach to risk assessment recognises that clients have intimate knowledge of their lived experiences of violence, and when appropriately supported, are best-placed to provide information that will assist in managing their health and safety and in identifying pathways for perpetrator interventions.

- A study by Heckert & Gondolf (2004) showed that women’s perceptions of risk were around as accurate in predicting re-assault by their partner as key international risk assessment tools which have undergone predictive validity testing (the SARA, K-SID & DAS). This study also found that the best prediction of repeated re-assault was obtained using evidence-based risk indicators alongside women’s own perceptions and experiences of safety to assess risk.
- There is also evidence that certain perceptions and beliefs lead some women to minimise or underestimate risk of harm, including: desensitisation to the seriousness of abuse; fear of retaliation, judgement, or of not being believed; and low self-esteem. Empowering victims to understand the dangers of being in an abusive relationship, is a key role for professionals responding to domestic and family violence (Murray et al., 2015).

**Suicide threats and attempts**

Threatened and attempted suicide in the context of domestic and family violence are strategies used by some perpetrators to exert control over victims.

- Hart’s (1998) study found that the combination of attempts, threats or fantasies of suicide, availability of weapons, obsessiveness, perpetrator isolation and drug and alcohol consumption indicate high risk of severe or lethal violence.
- A quarter of all men (24% or 41) who killed an intimate partner in NSW between 1 July 2000 and 30 June 2014, suicided following the murder (DVIRT, 2017).
### High-risk / lethality factor

<table>
<thead>
<tr>
<th>Characteristics and statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Court orders and parenting proceedings</strong></td>
</tr>
<tr>
<td>Domestic and family violence is common and often escalates when parents are separating. Perpetrators may use their parenting role or judicial options as a way of exercising control over a former partner.</td>
</tr>
<tr>
<td>• In their review of the Victorian Common Risk Assessment Framework (CRAF), McCulloch et al. (2016) found that from their experience, victims and survivors considered family law proceedings and intervention orders a critical and often overlooked indicator of domestic and family violence risk.</td>
</tr>
<tr>
<td><strong>Misuse of drugs or excessive alcohol consumption</strong></td>
</tr>
<tr>
<td>Excessive alcohol consumption and drug misuse are often exacerbating or moderating factors that can increase the dangerousness of perpetrators.</td>
</tr>
<tr>
<td>• Of 121 male homicide offenders who killed a female victim in Australia between 2010-2014, almost half were using alcohol at the time of the fatal episode (48.8% or 59), and 30.6% (37) were using other substances (including pharmaceutical or other non-therapeutic drugs) at the time of the fatal episode (the Network, 2018).</td>
</tr>
<tr>
<td>• Recent cessation of drug or alcohol addiction without active involvement and support from recovery and rehabilitation services can also escalate violent behaviour.</td>
</tr>
<tr>
<td><strong>Isolation and barriers to help-seeking</strong></td>
</tr>
<tr>
<td>Isolation, including limiting interactions with family, friends, social supports and community support programs is a control strategy used by some perpetrators, and a victim is at increased risk of future violence if she has had no prior engagement with services.</td>
</tr>
<tr>
<td>• A systematic review by Capaldi et al. (2012) found that social support and tangible help are protective against both perpetration and victimisation and that a lack of support is a significant risk factor for victims.</td>
</tr>
<tr>
<td>• Some population groups may experience institutional disadvantages and barriers to seeking support and if presenting at a service for the first time may be at risk of serious harm. For example, there is evidence that immigrant and refugee women tend to seek help only after enduring years of abuse, and are prompted by escalating frequency and severity, and fears for the impact on their children (Segrave, 2017; Vaughan et al., 2016). Fear of child removal continues to influence the decisions women make about disclosing violence, particularly for Aboriginal women (SNAICC et al., 2017).</td>
</tr>
<tr>
<td><strong>Abuse of pets and other animals</strong></td>
</tr>
<tr>
<td>Cruelty and harm directed to pets and other animals can indicate risk of future or more severe violence and are often used as a control tactic by perpetrators. Having to leave pets behind is a recognised barrier to victim-survivors leaving their violent partners.</td>
</tr>
<tr>
<td>• In one Victorian study, 52.9% of domestic violence survivors said their partner had hurt or killed one of their pets, and women whose partners had threatened to harm a pet were 5-times more likely than other women to experience violence by an intimate partner (Volant, et al., 2008).</td>
</tr>
</tbody>
</table>
2.5 Child abuse and neglect

The term “child abuse and neglect” describes different types of maltreatment of a child. Various forms of child abuse and neglect can be a criminal offence under the [Crimes Act (1900)]. Child abuse and neglect usually occurs within the context of adult-child/young person relationships where the child or young person trusts the adult and relies on them for basic needs.

Child abuse is a term commonly used to refer to different types of maltreatment inflicted on a child or young person. It includes physical harm, assault (including sexual assault), ill treatment and exposing the child or young person to behaviour that might cause psychological harm. Child abuse is an offence under Section 227 of the [Children and Young Persons (Care and Protection) Act 1998].

Neglect, as distinct from abuse, refers to the failure by a parent or caregiver to provide a child (where they are able to do so) with the conditions that are culturally accepted in a society as being essential for their physical and emotional development and wellbeing (Broadbent & Bentley, 1997; Bromfield, 2005; Scott, 2014). Neglectful behaviours can be divided into different sub-categories, which include:

- supervisory neglect: characterised by absence or inattention and can lead to physical harm or injury, sexual abuse or, in an older child, permitting criminal behaviour;
- physical neglect: characterised by the caregiver’s failure to provide basic physical necessities, such as safe, clean and adequate clothing, housing, food and health care;
- medical neglect: characterised by a caregiver’s failure to provide appropriate medical care. This could occur through a failure to acknowledge the seriousness of an illness or condition, or the deliberate withholding of appropriate care;
- emotional neglect: characterised by a lack of caregiver warmth, nurturance, encouragement and support (emotional neglect is sometimes considered a form of emotional maltreatment);
- educational neglect: characterised by a caregiver’s failure to provide an education and the tools required to participate in the education system; and
- abandonment: when a caregiver leaves a child alone for more than a reasonable period and does not provide for the presence of alternative age-appropriate care (where the substitute carer is capable of caring for the child) (Scott, 2014).

There has been limited research into the various forms of child abuse, neglect and other childhood adversity in Australia that can be considered representative of the general population or provide reliable prevalence data (Matthews et al., 2016). However, a number of recent studies have either measured one or two maltreatment types in detail or have superficially measured all individual maltreatment types as part of a larger study (Rosier, 2017). Despite the difficulties involved in measuring the extent of child maltreatment in the wider population, it is very clear that it occurs at significant levels in the Australian context (Rosier, 2017).

The Personal Safety Survey (ABS, 2017) collects information about physical and sexual abuse experienced before the age of 15 by any adult (male or female) where:

- Sexual abuse is defined as any act involving a child (under the age of 15) in sexual activity beyond their understanding or contrary to currently accepted community standards. This excludes emotional abuse and sexual abuse by someone under the age of 18.
• Physical abuse is defined as any deliberate physical injury (including bruises) inflicted upon a child (under the age of 15 years) by an adult. This excludes discipline that accidentally resulted in injury, emotional abuse, and physical abuse by someone under the age of 18.

The Personal Safety Survey (ABS, 2017) also collects information about whether respondent’s witnessed violence by a parent towards a partner before the age of 15, however violence in this context only refers to physical assault which is defined as any incident that involved the use of physical force with the intent to harm or frighten a person (ABS, 2017).

**TIP**

The definitions of child abuse and witnessing violence towards a parent in the Personal Safety Survey 2016 (ABS 2017) mean these figures likely are an under-representation of child abuse, in particular considering:

- Age is under 15 years (not under 18).
- Perpetrator is over 18 years old only.
- Information about emotional abuse/psychological harm and neglect are not collected.
- Witnessing violence against a parent is limited to physical assault only.
- The survey relies on respondents being able to accurately recall experiences of being abused as a child when they are adults (over the age of 18) and to identify what they experienced as abuse.
Physical and sexual abuse of children (before the age of 15) is prevalent in Australia and girls are more likely to be abused than boys:

1 in 8 Australians (13% or 2.5 million) experienced child abuse, which includes:

- 1 in 6 women (16% or 1.5 million)
- 1 in 9 men (11% or 991,600)

Source: PSS 2016 (ABS 2017)
2.5.1 Child physical abuse before the age of 15

1 in 11 people (8.5% or 1.6 million) aged 18 years and over experienced physical abuse¹

This included:
1 in 11 WOMEN (18.8% or 828,200) and
1 in 12 MEN (48.1% or 727,700)

2.5.2 Child sexual abuse before the age of 15

Before the age of 15, women were more than 2 times more likely to have experienced child sexual abuse as children than men:

1 in 13 Australians (7.7% or 1.4 million) experienced sexual abuse, which includes:

| 1 in 9 women (10.7% or 1 million) | 1 in 22 men (4.6% or 411,800) |

Source: PSS 2016 (ABS, 2017, Table 31)
2.5.3 Characteristics of child abuse

Relationship to perpetrator of child abuse

94% of VICTIMS OF CHILD ABUSE

experienced that abuse by someone known to them.

94% of VICTIMS OF CHILD ABUSE


Of the people who had experienced abuse before the age of 15:

<table>
<thead>
<tr>
<th>Women who experienced sexual abuse before the age of 15 reported that the most common perpetrator types (in order) were:</th>
<th>Men who experienced sexual abuse before the age of 15 reported that the most common perpetrator types (in order) were:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-familial known person 47% (468,400) (i.e. a known person that wasn’t a family member/relative/in-law).</td>
<td>1. Non-familial known person 65% (268,500) (i.e. a known person that wasn’t a family member/relative/in-law).</td>
</tr>
<tr>
<td>2. Other relative or in-law 29% (294,000)</td>
<td>2. Other relative or in-law 15% (67,900).</td>
</tr>
<tr>
<td>3. Parent 17% (171,500), of which 99% (171,500) were abused by a father/step-father.</td>
<td>4. Parent 4% (16,700)*, of which 100% (16,700) were abused by a father/step-father and (equal).</td>
</tr>
<tr>
<td>4. Stranger 12% (115,500)</td>
<td>5. Sibling 4% (16,700)*</td>
</tr>
<tr>
<td>5. Sibling 8% (79,000)</td>
<td>6. Relationship to perpetrator not known for 1% (4,800)** of victims.</td>
</tr>
<tr>
<td>6. Relationship to perpetrator not known for 1% (12,100)* of victims.</td>
<td>6. Relationship to perpetrator not known for 1% (5,200) of victims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women who experienced physical abuse before the age of 15 reported that the most common perpetrator types (in order) were:</th>
<th>Men who experienced physical abuse before the age of 15 reported that the most common perpetrator types (in order) were:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parent (including step parents), 80% (654,600), of which 73% (478,700) were abused by a father/step-father.</td>
<td>1. Parent (including step parents), 73% (534,100), of which 86% (463,600) were abused by a father/step-father.</td>
</tr>
<tr>
<td>2. Other known person 16% (132,100)</td>
<td>2. Other known person 29% (211,800).</td>
</tr>
<tr>
<td>3. Other relative or in-law 8% (67,900).</td>
<td>3. Stranger 15% (62,100).</td>
</tr>
<tr>
<td>4. Sibling 6% (49,500)</td>
<td>4. Other relative or in-law 5% (32,300)*</td>
</tr>
<tr>
<td>5. Stranger 3% (27,600).</td>
<td>5. Sibling 4% (30,700)*</td>
</tr>
<tr>
<td>6. Relationship to perpetrator not known for 1% (6,000)** of victims.</td>
<td>6. Relationship to perpetrator not known for 1% (5,200) of victims.</td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution  
** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

Source: PSS 2016 (ABS, 2017, Table 31)
WOMEN AGED 18 YEARS AND OVER WHO EXPERIENCE ABUSE BEFORE AGE OF 15, Type of abuse by relationship to perpetrator(s)(a)

MEN AGED 18 YEARS AND OVER WHO EXPERIENCE ABUSE BEFORE AGE OF 15, Type of abuse by relationship to perpetrator(s)(a)
Abuse by a parent

Considering the dynamics of abuse by a parent is significant for Health workers to understand the context of child abuse and nature of risk for the people and families they are working with. Parents are also the only category within the perpetrator of child abuse components of the Personal Safety Survey 2016 (ABS, 2017) which identify the gender of the perpetrator (as they breakdown the category of parent into mother and father) and thus give us insight into the gendered nature of the perpetration of child abuse.

There is a gender disparity in perpetration of child abuse by a parent which shows that fathers/step-fathers are much more likely to be the perpetrators of child abuse than mothers/step-mothers. This disparity is especially significant due to gendered differences in caring and expectations of mothers. “Given that fathers provide, on the whole substantially less direct child care than mothers ... [the high] proportions of father and possible father surrogates as perpetrators of severe child abuse appear as rather startling” (Guterman & Lee, 2005, p. 136).

Abuse by a parent

Victims of abuse\(^1\) by a parent were **15x** more likely to experience sexual abuse and almost **2x** times more likely to experience physical abuse by their father/step-father than their mother/step-mother.

1 in 35 AUSTRALIANS (2.9% or 524,700) experienced child abuse\(^1\) from their mother/step-mother

1 in 18 AUSTRALIANS (5.6% or 1 million) experienced child abuse\(^1\) from their father/step-father

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\(^1\) Physical and/or sexual abuse by an adult (18 years and over) before the age of 15.


Physical abuse by a parent

Victims of physical abuse\(^1\) by a parent were almost 2x times more likely to experience physical abuse by their father/step-father than their mother/step-mother.

- 2.8% experienced physical abuse from their mother/step-mother (1 in 35 Australians, 2.8% or 520,300).
- 5.1% experienced physical abuse from their father/step-father (1 in 20 Australians, 5.1% or 940,200).

1. Before the age of 15.


---

Sexual abuse by a parent

Victims of sexual abuse\(^1\) by a parent were 15x more likely to experience sexual abuse from their father/step-father than their mother/step-mother:

- 0.1% experienced sexual abuse from their mother/step-mother (1 in 1521 Australians, 0.1% or 12,100*).
- 1% experienced sexual abuse from their father/step-father (1 in 100 Australians, 1% or 189,300).

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

1. Before the age of 15.

Victims of abuse by a parent before the age of 15 were 10 times more likely to experience sexual abuse and almost 2 times more likely to experience physical violence by their father/step-father than their mother/step-mother:

<table>
<thead>
<tr>
<th>1 in 35 Australians (2.9% or 524,700) experienced abuse before the age of 15 from their mother/step-mother.</th>
<th>1 in 18 Australians (5.6% or 1M) experienced abuse before the age of 15 from their father/step-father.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 1521 Australians (0.1%* or 12,100) experienced sexual abuse from their mother/step-mother.</td>
<td>1 in 100 Australians (1% or 189,300) experienced sexual abuse from their father/step-father.</td>
</tr>
<tr>
<td>1 in 35 Australians (2.8% or 520,300) experienced physical abuse from their mother/step-mother.</td>
<td>1 in 20 Australians (5.1% or 940,200) experienced physical abuse from their father/step-father.</td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution

Source: PSS 2016 (ABS 2017, Table 31)

There were some gendered differences in the experience of abuse by a parent:

<table>
<thead>
<tr>
<th>1 in 16 women (6.1% or 568,200) experienced abuse from their father/step-father.</th>
<th>1 in 19 men (5.2% or 468,300) experienced abuse from their father/step-father.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 55 women (1.8% or 171,500) experienced sexual abuse by their father/step-father.</td>
<td>1 in 20 women (5.1% or 478,700) experienced physical abuse by their father/step-father.</td>
</tr>
<tr>
<td>1 in 27 women (3.7% or 345,300) experienced abuse from their mother/step-mother.</td>
<td>1 in 50 men (2% or 181,900) experienced abuse from their mother/step-mother.</td>
</tr>
<tr>
<td>1 in 1000 women (0.1%* or 9,500) experienced sexual abuse by their mother/step-mother.</td>
<td>1 in 28 women (3.6% or 340,300) experienced physical abuse by their mother/step-mother.</td>
</tr>
<tr>
<td>No men (0% or 0) experienced sexual abuse by their mother/step-mother.</td>
<td>1 in 50 men (2% or 181,900) experienced physical abuse by their mother/step-mother.</td>
</tr>
</tbody>
</table>

* estimate has a relative standard error of 25% to 50% and should be used with caution

Source: PSS 2016 (ABS 2017, Table 31)

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4 This is the only perpetrator type for this abuse type in the published data where gender can be identified.
2.5.4 Witnessing violence towards a parent by a partner

The NSW Government recognises that children’s exposure to domestic and family violence constitutes maltreatment, even if they are not a direct victim of the violence. Exposure to domestic and family violence poses a risk to a child’s physical, emotional and psychological safety. The harmful effects on the developmental and emotional wellbeing of exposure to domestic and family violence are clear and there is increasing attention on children as victim-survivors of family violence in their own right, with their own unique risks and service needs (Fitz-Gibbon, Maher, McCulloch, & Segrave, 2018; Laing, Heward-Belle, & Toivonen, 2018).

**TIP**

As previously advised, it is important to remember that:

1. Domestic violence and violence by a partner (or in this case witnessing violence towards a parent by a partner) are not necessarily the same thing.
2. The definition of witnessing violence towards a parent by a partner in the Personal Safety Survey 2016 (ABS, 2017) is limited to physical assault only and witnessed before the age of 15 and so these figures a likely a significant under-estimation.

**Witnessing violence towards a parent before the age of 15**

1 in 9 AUSTRALIANS (16.9% or 1.6 million) witnessed violence towards their mother by a partner

1 in 22 AUSTRALIANS (4.5% or 819,000) witnessed violence towards their father by a partner

1. Violence includes physical assault only witnessed before the age of 15.

Before the age of 15, Australians were almost 2.5 times more likely to have witnessed violence (physical assault) towards their mother by a partner than towards their father by a partner and this violence witnessed towards their mother by a partner was more frequent than towards a father:

<table>
<thead>
<tr>
<th>1 in 9 Australians (11% or 2 million) witnessed violence (physical assault) towards their mother by a partner before the age of 15.</th>
<th>1 in 22 Australians (4.5% or 819,800) witnessed violence (physical assault) towards their father by a partner before the age of 15.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 8 women (13% or 1.2 million) witnessed violence towards their mother by a partner before the age of 15.</td>
<td>1 in 10 men (10% or 896,700) witnessed violence towards their mother by a partner before the age of 15.</td>
</tr>
<tr>
<td>1 in 20 women (4.7% or 440,900) witnessed violence towards their father by a partner before the age of 15.</td>
<td>1 in 25 men (4.2% or 380,000) witnessed violence towards their father by a partner before the age of 15.</td>
</tr>
</tbody>
</table>

An estimated 71% of people (1.5 million) who witnessed violence (physical assault) towards their mother by a partner witnessed this violence more than twice compared to an estimated 29% (589,800) who witnessed it once or twice.

An estimated 62.5% of people (514,200) who witnessed violence (physical assault) towards their father by a partner witnessed this violence more than twice compared to an estimated 37.5% (307,000) who witnessed it once or twice.

Source: PSS 2016 (ABS 2017 & Table 30)

Men and women were equally likely to have children in their care at the time of experiencing violence by a partner, however there were a substantially higher number of women who experienced violence by a partner and had children in their care.

An estimated 50% of women (60,300) who had children in their care when they experienced violence by a current partner reported that the children had seen or heard the violence.

ABS advised the estimate has a relative standard error greater than 50% [as the numbers are too low] and is considered too unreliable for general use.

An estimated 68% of women (418,200) who had children in their care when they experienced violence by a previous partner reported that the children had seen or heard the violence.

An estimated 60% of men (92,200) who had children in their care when they experienced violence by a previous partner reported that the children had seen or heard the violence.

An estimated two-thirds (68% or 187,800) of women who experienced violence by a current partner were pregnant at some point during the relationship. Of these women, nearly one in five (18% or 34,500) experienced violence during their pregnancy.

An estimated 686,400 women who experienced violence by a previous partner were pregnant at some point during the relationship. Of these women, nearly half (48% or 325,900) experienced violence during their pregnancy.

Source: PSS 2016 | [ABS, 2017 & AIHW, 2018a]
2.5.5 Other research on child abuse and neglect

Although providing insights into child abuse, there are substantial limitations to the Personal Safety Survey (PSS) data in this context as identified above. It is therefore of value to supplement the information provided from the PSS from other sources of data. The best currently available evidence (Price-Robertson et al., 2010) in Australia suggests the following prevalence rates for child abuse and neglect using broader definitions such as those provided at the beginning of this topic:

- neglect is 12%
- emotional abuse is 11%
- witnessing domestic and family violence is 12-23%
- penetrative sexual abuse for females is 7–12% and males is 4–8%
- non-penetrative sexual abuse for females is 23–36% and males is 12–16%.

Other research argues it is widely recognised that neglect is the most common form of child maltreatment in the western world with one source estimating prevalence of child neglect in Australia as 2.4 per cent overall (using more narrow definitions than those above) (NSW Family and Community Services, 2017). This source argues research suggests neglect is the second most common form of maltreatment substantiated by child protection authorities in Australia, following emotional abuse.

In addition, the incidence of child abuse and neglect reported to the child protection system in 2016-2017 is identified as follows:

- 379,459 notifications of suspected child abuse and neglect were made to state and territory authorities (a rate of 34.0 notifications per 1,000 Australian children) (Australian Institute of Health and Welfare [AIHW], 2018b).
- NSW recorded a total number of 18,919 substantiations of notifications (confirmed cases of child abuse and neglect) and 66,689 children were receiving child protection services (AIHW, 2018b).
- In NSW 20,453 children were on care and protection orders and 17,879 children were living in out of home care (AIHW, 2018b).

Except for child sexual abuse, children are most likely to be abused or neglected by parents and/or caregivers (May-Chahal & Cawson, 2005; Sedlak et al., 2010). Research suggests that child sexual abuse is perpetrated by a wider group of people, including parents, other relatives, siblings, friends, or others known to the child (e.g., sports coach, teacher, priest). It is difficult to ascertain if mothers or fathers are more likely to abuse and neglect children (Scott, 2014).

Although types of child abuse and neglect rarely occur in isolation (see also Section 2.7 of this resource on integration), and many children may experience chronic and multiple types of abuse and neglect, research data regarding perpetrators of child abuse and neglect tend to isolate incidents into one form of abuse so it is difficult to make conclusions about whether mothers or fathers are those who are more likely to abuse children (Scott, 2014). Nevertheless, “[g]iven that fathers provide, on the whole substantially less direct child care than mothers... [the high] proportions of father and possible father surrogates as perpetrators of severe child abuse appear as rather startling” (Guterman and Lee, 2005, p.136). Further, the gendered nature of domestic and family violence indicates that perpetrators of domestic and family violence are predominantly male and may be the child’s father, step-father, or carer.
2.6 Gender, diversity and vulnerability

2.6.1 Priority populations

Violence, abuse and neglect are experienced by individuals and families across all of Australia’s communities. There is sufficient evidence to suggest, however, that particular groups of people experience multiple challenges that may heighten the likelihood, impact or severity of violence, as well as experiencing additional barriers to seeking support and securing safety (AIHW, 2018a; Royal Commission into Institutional Responses to Child Sexual Abuse, 2018b).

It is clear from the statistics and research that violence by an intimate partner, sexual assault and, to a lesser extent, child abuse and neglect, are gendered crimes disproportionately experienced by women and girls and overwhelmingly perpetrated by men. In addition to gender, there is evidence particularly from service and administrative data and qualitative research, that other factors can contribute to greater vulnerability to violence and abuse, including age and developmental stage, disability, sexual orientation, cultural background and identity, migration and visa status, religion, economic and geographic status (Mitra-Kahn et al., 2016).

Qualitative research, program evaluations, service and other administrative data, and people’s own descriptions of their lived experience, provide evidence of increased vulnerability to violence, abuse and neglect for some groups of people. However, there are significant gaps in quantitative data for these priority population groups, and further research is needed to provide a comprehensive picture of the extent and impacts of violence, abuse and neglect across all of Australia’s communities. Robust and disaggregated data on prevalence and characteristics is also important to inform the design and delivery of integrated public health approaches to prevention and response to violence, abuse and neglect.

‘Priority population’ is a term used to refer to diverse groups for whom there is significant evidence of heightened vulnerability to violence, both in frequency and severity, and who may encounter a range of specific barriers to seeking support and securing safety, related to intersecting identity-based and situational factors and experiences of discrimination. While a range of terminology is used by, and to describe, these groups, ‘priority population’ is consistent with NSW and national policy landscapes and practice settings (Council of Australian Governments, 2011; Centre for Epidemiology and Evidence, 2018).
There are four population groups identified through analysis of research on the experiences of sexual assault, domestic and family violence and child abuse and neglect (see Sections 2.6.3-2.6.7), of particular note for health workers because they form the largest proportion of potential clients for NSW Health Violence, Abuse and Neglect services. There is also evidence that these groups are more likely to experience multiple forms of violence, abuse and neglect, either co-occurring, or across their lifetime, thus requiring targeted and integrated prevention and response initiatives.

Priority populations identified through the available evidence that are more likely to experience one or more type of violence, abuse and neglect, include:

- Women and girls
- Aboriginal and Torres Strait Islander people
- Children and young people
- People with disability

Sections 2.3-2.5 provide statistics and research demonstrating the disproportionate prevalence and impacts of violence, abuse and neglect among women, girls, children and young people. Sections 2.6.3 and 2.6.4 outline key statistics and research on experiences of violence and abuse for Aboriginal and Torres Strait Islander people, and people with disabilities.

Research on individual types of interpersonal violence shows that in addition to the four priority population groups identified above, there are other groups of people whose unique and often competing needs should be specifically considered and appropriately responded to, and for whom targeted prevention efforts including outreach and community development may be required.

Additional priority populations identified in the available 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 mental illness
- People living in rural and remote areas
- Older women
- Incarcerated women

Due to the limited data and research in Australia on experiences of violence for people from priority population groups, including on the nature and extent of co-occurrence and re-victimisation, Sections 2.6.5-2.6.7 provide a summary of evidence on sexual assault, domestic and family violence, and child abuse and neglect, separately. The information in these sections is not exhaustive, and violence, abuse and neglect prevention and response efforts should be adapted and updated as emerging
evidence on the experiences of priority population groups becomes available.

Challenges and limitations of Australian data on priority populations’ experiences of violence:

- Quantitative evidence on prevalence and perpetration of violence is limited.
- General population surveys like the ABS Personal Safety Survey provide very limited evidence, as they measure the prevalence of violence in the general population, and to disaggregate data on different groups - for example, by ethnicity or sexuality - would produce small and unreliable sample sizes.
- A key limitation of the PSS is that the ABS has difficulty accessing and surveying a statically valid sample of people from communities of interest, including women with disabilities, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.
- Specific and complex forms of violence not adequately considered.
- Barriers to reporting and access to appropriate services due to multiple, intersecting challenges, including experiences of discrimination and disadvantage.
- Design and methodological gaps in data sources.
- Lack of consistent definitions across sources and definition complexities within data sources.
- Gaps in leveraging and linking existing data to generate new information.
- Poor data quality, including gaps in recording and reporting data (Cox, 2016; Mitra-Kahn et al., 2016).

Actions to improve data on experiences of violence for people from diverse groups:

- Additional analysis of existing data. For example, disaggregating data to local geographic levels.
- Share and make accessible existing and unpublished data across agencies (while maintaining individuals’ privacy).
- Develop common definitions and conceptual understanding across data sets to improve identification and measurement.
- Address the specificity of diverse experiences of violence and improve contextual understanding of this violence by considering data alongside evidence from qualitative research.
- Augment and enhance existing surveys and administrative data collection, to better understand people at risk and the services they need and use.
- Increase data linkage and longitudinal surveys to understand pathways and outcomes for victims and survivors (AIHW, 2018a; Mitra-Kahn et al., 2016).
2.6.2 Intersectionality: framework for understanding diversity data

The term “intersectionality” was coined by Kimberlé Crenshaw in 1989 in her paper Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, to help understand and resist bias and violence against African American women. ‘Intersectionality’ is sometimes confused with ‘diversity’. However, while diversity is used to describe the different cultural and identity-based groups that are part of any society, intersectionality is about identifying and questioning unequal interpersonal relationships and institutional and social abuses of power, and seeking to address the additional impacts of discrimination and disadvantage on individuals from different population groups (Multicultural Centre for Women’s Health, 2017).

Used in the context of prevention and response to violence, abuse and neglect, intersectionality refers to the conceptual framework that seeks to understand the dynamics of different identity-based and situational factors experienced by individuals from diverse communities, and the unique safety risks and sometimes competing needs these factors contribute to (The Equality Institute, 2017).

Further, taking an intersectional approach in practice, means recognising that the barriers to seeking support and the particular forms of violence and fears that victim-survivors from some groups experience are not only driven by sexism and gender inequality, but also by experiences of other forms of discrimination including racism, ableism and homophobia (Chen, 2017).

Applied to the use of statistics and research on experiences of sexual assault, domestic and family violence, child abuse and neglect, and on children and young people with harmful or problematic sexual behaviours, an intersectional approach means recognising that individual statistics considered in isolation provide only a limited, or partial, picture of a person’s experience and life circumstances, and are not sufficient by themselves to inform evidence-based policy and practice.

Research on the application of intersectionality to both quantitative and qualitative methods, highlight important considerations in analysis of data and evidence aiming to understand people’s experiences of a particular phenomenon. These are:

- Considering how statistics relate to, or differ from, evidence in qualitative research, practice-based literature and victims’ and survivors’ stories of lived experience, to understand the context in which the data should be interpreted.
- Recognition of the interactive and dynamic nature of the impacts of intersecting challenges on people’s lives. Statistics reflect the experience of people at a particular point in time, and people’s relationship to inequality and disadvantage changes across time and place.
- Analysis that accounts for changes over time, is also important to help identify protective factors, as well as to provide evidence of victims’ resilience and resistance to discrimination and abuse and its impacts on safety.
- Reflecting the evidence that ‘one size fits all’ and ‘universal’ approaches are inadequate to describe and understand the experiences and needs of victims and survivors.
- Questioning claims of objectivity, or ‘positivist’ approaches, by considering the different ways, and contexts in which, knowledge is produced, used and translated into policy and practice (Etherington & Baker, 2018; Malbon et al., 2018; Scott & Siltanen, 2017).
Violence against women begins with gender inequality.

**Drivers of violence against women**

- **Essential actions to prevent violence against women**
  - Condoning violence against women:
    - Challenge condoning of violence against women.
  - Men's control of decision-making and limits to women's decision-making and independence in public and private life:
    - Promote women's independence and decision-making in public life and relationships.
  - Rigid gender roles and stereotyped constructions of masculinity and femininity:
    - Foster positive personal identities and challenge gender stereotypes and roles.
  - Male peer relations that emphasise aggression and disrespect towards women:
    - Strengthen positive, equal and respectful relations between and among women and men, girls and boys.

**Putting the prevention of violence against women into practice:**

- **How to Change the story**
  - **Key principle**
    - The key principle for the prevention of violence against women is to transform norms, structures and practices for a gender equal society, whilst addressing other forms of social inequality and discrimination to create gender equality for all women.

**Good practice approaches to prevention work**

- be inclusive and responsive to diversity
- work in partnership
- challenge masculinity and engage men and boys while empowering women and girls
- develop and maintain a reflective practice.

**Infographic: Our Watch, 2017**

**Infographic: Canadian Research Institute for the Advancement of Women**

(in Gender Equality Network Canada, 2018)

**A Human Rights Framework**

A human rights framework recognizes that basic human rights are a necessary pre-condition to equality. Key international human rights agreements define that all people have civil, political, economic, social and cultural rights, including having rights to food, shelter, property, reproductive choice, social security, health care, work, political and religious freedom of expression, access to education, and the civil rights to life, freedom from torture, cruel, inhuman and degrading treatment and punishment and free, active and meaningful participation.

Women's rights are human rights and human rights are women's rights.

Hillary Clinton
2.6.3 Violence, abuse and neglect in Aboriginal communities

Aboriginal and Torres Strait Islander people’s experiences of violence, abuse and neglect

Data on Indigenous people’s experiences of family violence is limited, and must be understood with recognition of the impacts of colonisation, systemic disadvantage, forced removal of children, land dispossession, racism and discrimination, and the intergenerational trauma that these factors have significantly contributed to.

Indigenous women are 32x more likely than non-Indigenous women to be hospitalised due to family violence injuries.

1 in 5 WOMEN killed by a male partner identified as Aboriginal (22.3% or 27)

* of 121 female victims of intimate partner homicide in Australia between 2010-2014

Up to 90% of Aboriginal and Torres Strait Islander women in prisons are survivors of domestic, family, and/or sexual violence.

Indigenous children were 7-times more likely than non-Indigenous children to have child protection reports substantiated in 2015–17.

Aboriginal and Torres Strait Islander women’s experiences of domestic and family violence

Most Aboriginal and Torres Strait Islander women trust their doctors and health workers have an important role to play in prevention and early intervention of domestic and family violence through collaborative and integrated service provision.

8 in 10 Aboriginal and Torres Strait Islander WOMEN agreed or strongly agreed that they could trust their own doctor

This includes:

- 77% Aboriginal and Torres Strait Islander women who had experienced domestic and family violence
- 83% Aboriginal and Torres Strait Islander women who had not experienced any physical violence

Compared to women who had not experienced physical violence, Aboriginal and Torres Strait Islander women who had experienced domestic and family violence*, were:

More likely to report high or very high psychological stress (69% compared with 34%)

More likely to have a mental health condition (53% compared with 31%)

More likely to have experienced homelessness (55% compared with 28%)

Less likely to trust local police (44% compared with 62%)

* Domestic and family violence measure is based on 12-month physical violence incident data only.

Infographic: Costello & Bachhouse, 2019a.


Health
Statistics and research about the experiences and perpetration of violence, abuse and neglect by and against Aboriginal people must be understood within, and responded to with, recognition of the contexts of colonisation, systemic disadvantage, forced removal of children, land dispossession, racism and discrimination, and the intergenerational trauma that these factors significantly contribute to (Blagg, Bluett-Boyd, & Williams, 2015; Cripps & Adams, 2014; Laing & Greer, 2001, all cited in Backhouse & Toivonen, 2018; NSW Health, 2012).

The term ‘family violence’ in often preferred in an Indigenous context to describe the range of violence that takes place in Indigenous communities including physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that may be perpetrated within a family. The term also recognises the broader impacts of violence on extended families, kinship networks and community relationships. It has also been used in the past decade to encompass acts of self-harm and suicide and has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms (Gordon et al. 2002; Robertson 1999; Wild & Anderson 2007, all cited in Cripps & Davis, 2012).

When using statistics and research to represent the experiences of Aboriginal and Torres Strait Islander people and when working to prevent and respond to violence, abuse and neglect in Aboriginal communities, it is important to consider the broader evidence that identifies resilience and cultural strength as essential to positive health and wellbeing outcomes, and to challenge deficit-based thinking and representation that tends to focus on dysfunction (SNAICC et al., 2017).

Deficit statistics, that systematically compare Aboriginal and Torres Strait Islander Australians to non-Indigenous Australians, such as the methodology used in Closing the Gap reports, consistently represent Indigenous people as ‘falling short’ or ‘failing’ to meet national norms (Lowitja Institute, 2018). Focusing on deficit metrics is sometimes useful to draw attention to and address inequalities. However, focus on disparities between and within population groups can also minimise and reduce attention to the reasons underlying these differences, and to the often complex causes of more prevalent and severe violence (Lowitja Institute, 2018; SNAICC et al., 2017).

Care must also be taken not to make assumptions about perpetrator characteristics and motivations, including ethnic and cultural identity. Most quantitative research, administrative and service data and population-based surveys, including the PSS, do not collect information on the ethnicity of perpetrators. This is particularly important in the context of violence against Aboriginal and Torres Strait Islander women and children, as inaccurate representations of Indigenous men as more violent than non-Indigenous men can lead to inappropriate and disproportionate interventions and undermine community-led prevention of violence efforts (Chen, 2017; Longbottom, 2019).

Despite these limitations, there are a range of sources that provide evidence of the disproportionate prevalence and impacts of violence, abuse and neglect for Aboriginal and Torres Strait Islander people, including Indigenous-specific population data such as the ABS National Aboriginal and Torres Strait Islander Social Survey (NATSIS), as well as general population research and administrative data such as hospital, homelessness and crime collections (AIHW, 2018a).

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5 The terms “Indigenous” and “non-Indigenous” are sometimes used to categorise data relating to Australia’s First Peoples and all other Australians, respectively. In NSW and this paper, “Aboriginal” or “Aboriginal and/or Torres Strait Islander” are most commonly used, reflecting that “Indigenous” can detract from the preferred identities of individuals or groups as well as minimise the differences in culture, tradition, beliefs, language, protocols, histories and contexts between Aboriginal and Torres Strait Islander people, families and communities (NSW Health, 2019b).
Data limitations that should be considered when using statistics on Aboriginal and Torres Strait Islander people’s experiences of violence include:

- More prevalent under-reporting than non-Indigenous people, in part because of distrust of certain institutions and authorities and fear of discrimination.
- Lack of appropriate screening and identification of intimate partner and family violence incidents by service providers.
- Incomplete identification of gender and Indigenous status in many data collections.
- Lack of nationally comparable data on family violence from police, courts, health and welfare sources.
- Inability to disaggregate data from population-based surveys to show localised geographical variation.
- The ABS Personal Safety Survey (PSS) does not collect information on Indigenous status and therefore produces no statistics on Aboriginal and Torres Strait Islander people’s experiences of violence.
- The ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS) collects information on incidents of physical violence experienced in the 12 months prior to the survey only and does not include information on sexual violence or violence experienced across the respondent’s lifetime.
- Neither the NATSISS or the PSS collect information on the ethnicity or Indigenous status of perpetrators of violence, therefore care should be taken not to assume the cultural identity of perpetrators of violence against Aboriginal and Torres Strait Islander people. (ABS, 2019; AIHW, 2018a; Longbottom, 2019.)

The NATSISS is a six-yearly multidimensional social survey, which provides broad, self-reported information across key health and social areas. The NATSISS was first undertaken in 1994 in response to recommendations from the Royal Commission into Aboriginal Deaths in Custody. The latest survey in 2014-15, includes a sample of approximately 11,000 Aboriginal and Torres Strait Islander people surveyed face-to-face, and is considered representative of Aboriginal and Torres Strait Islander people in Australia (AIHW, 2018a).

Results from the NATSISS are not easily comparable to the ABS PSS, particularly as the information from the NATSISS is limited to incidents of physical violence that occurred in the 12 months prior to the survey (ABS, 2016). In contrast, the PSS captures data on experiences of physical and sexual violence since the age of 15, as well as a range of data on the characteristics and impacts of violence by an intimate partner.

Prevalence of violence by an intimate partner among Indigenous women

The need for further research and data on the extent and characteristics of Aboriginal and Torres Strait Islander people’s experiences of domestic, family and sexual violence is widely recognised. One analysis by Ayre et al. (2016) has produced an estimate of the prevalence of violence by an intimate partner experienced by Indigenous women.
Through application of a "rate ratio" to the ABS 2012 Personal Safety Survey national prevalence rates for violence by an intimate partner violence, it was estimated that 2 in 5 (39%) Indigenous women experienced physical or sexual violence perpetrated by a former or current co-habiting partner in a 12-month period (Ayre et al., 2016). When current and ex-boyfriends, girlfriends and dates that women had not lived with were included, prevalence rates increased, indicating that 3 in 5 (65%) Indigenous women experienced physical or sexual violence in a 12-month period (Ayre et al., 2016).

It is important to be cautious when making claims based on these statistics, due to the different survey methodologies and definitions of violence in the NATSISS, PSS and General Safety Survey. However, despite these limitations, it is clear that Aboriginal and Torres Strait Islander people experience higher rates of intimate partner violence than the general population, which show that since the age of 15, 1 in 6 (17%) women in Australia have experienced physical and/or sexual violence by a current or former cohabiting partner, and 1 in 4 (23%) women have experienced violence by an intimate partner (ABS, 2017).

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6 Using data from the ABS’ 2008 NATSISS and 2006 General Safety Survey, it was estimated that Indigenous women were 2.5 times more likely than non-Indigenous women to have experienced physical or sexual violence over a 12-month period (Ayre et al., 2016).
### Findings from the ABS 2014-15 National Aboriginal and Torres Strait Islander Social Survey, show that in the last 12 months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>The majority (90%) of Aboriginal and Torres Strait Islander people aged 15 years and over who had experienced physical violence, knew the perpetrator of the most recent incident (96% of females and 83% of males) (ABS, 2016)</td>
<td>2 in 3 Indigenous women (63%) and 1 in 3 Indigenous men (35%) who had experienced physical violence reported that the perpetrator in the most recent incident was a family member, including a current or previous partner (ABS, 2016).</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander females aged 15 years and over who were 2-times as likely as males to have experienced violence by an intimate partner or family member (ABS, 2019).</td>
<td>1 in 7 (14%) Indigenous women had experienced physical violence. Of these, 1 in 4 (28%) indicated that the most recent incident was perpetrated by a cohabiting partner.</td>
</tr>
<tr>
<td>8 in 10 (77%) women who had experienced physical violence by a partner or family member, agreed or strongly agreed with the statement that they could trust their doctor (ABS, 2019).</td>
<td>Indigenous women who had experienced physical violence, were 4-times as likely as Indigenous men to have reported that their current or previous partner was the perpetrator in the most recent incident (ABS, 2016).</td>
</tr>
</tbody>
</table>

### Compared to women who had not experienced physical violence, Aboriginal and Torres Strait Islander women who had experienced domestic and family violence*, were:

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>More likely to report high or very high psychological stress (69% compared with 34%) (ABS, 2019).</td>
<td>More likely to have a mental health condition (53% compared with 31%) (ABS, 2019).</td>
</tr>
<tr>
<td>More likely to have experienced homelessness (55% compared with 26%) (ABS, 2019).</td>
<td>Less likely to trust local police (44% compared with 62%) (ABS, 2019).</td>
</tr>
<tr>
<td>Equally as likely to have strong social networks outside the household, reporting ability to get general support (86% compared with 91%); get support in a time of crisis (88% compared with 92%) and to confide in family and friends (77% compared with 84%) (ABS, 2019).</td>
<td>More likely to have been diagnosed with at least one long-term health condition (79% compared with 68%); and to have experienced one or more personal stressors (e.g. illness, accident, disability, pregnancy, discrimination, death of someone close) (88% compared with 67%) (ABS, 2019).</td>
</tr>
</tbody>
</table>
Putting the statistics in context: challenging misconceptions about violence against Aboriginal and Torres Strait Islander women.

Violence is not part of traditional Aboriginal or Torres Strait Islander cultures

Violence against Aboriginal and Torres Strait Islander women is not a part of traditional culture. When violence occurred prior to colonisation, it was regulated and controlled, and bore no resemblance to the kinds of violence and abuse seen today. Many aspects of traditional culture and customary law were respectful and protective of women. As custodians of some of the longest surviving cultures in the world, Aboriginal and Torres Strait Islander people successfully managed interpersonal, family and community relationships for over 60,000 years prior to colonisation.

Violence against Aboriginal and Torres Strait Islander women is perpetrated by Indigenous and non-Indigenous men

Public debate and media reporting frequently imply that this violence is always perpetrated by Aboriginal or Torres Strait Islander men, when this is not the case. Violence against Aboriginal and Torres Strait Islander women is perpetrated by men from many cultural backgrounds. Anecdotal evidence suggests that non-Indigenous men make up a significant proportion of perpetrators. For intimate partner violence, this reflects data showing the majority of partnered Indigenous women have non-Indigenous partners, especially in capital cities. Perpetration patterns vary geographically, with this data suggesting violence against women in remote areas more likely to be perpetrated by Indigenous men, and violence in urban areas more likely to be perpetrated by non-Indigenous men.

Alcohol is a contributing factor, and often a trigger for violence, but it is not the ‘cause’

Across Australia, for both Indigenous and non-Indigenous people, alcohol can increase the frequency or severity of violence. However, on its own, alcohol doesn’t explain violence. It can’t be simplistically seen as a ‘cause’ of violence against Aboriginal and Torres Strait Islander women, both because violence occurs where alcohol is not involved and because many people consume alcohol but are never violent.

Where there is a correlation between alcohol and violence in some Aboriginal and Torres Strait Islander communities, this needs to be understood in context. Colonisation introduced alcohol to disrupted, displaced and traumatised communities, resulting in high rates of harmful alcohol use in some contexts as a coping mechanism or a self-medicating behaviour. This means strategies need to address the underlying reasons for harmful alcohol use.

We also need to understand alcohol in relation to social norms and practices that condone violence against women generally, and violence against Aboriginal and Torres Strait Islander women in particular. Prevention strategies need to address drinking cultures among all groups of men that emphasise aggression and disrespect for women, as well as drinking cultures among non-Indigenous men that involve racism and disrespect towards Aboriginal and Torres Strait Islander women. Reducing harmful alcohol use is a useful supporting strategy, which delivers many positive outcomes, and which may also help reduce the severity or frequency of violence. However, this needs to occur not in isolation but in addition to addressing the deeper drivers of violence against Aboriginal and Torres Strait Islander women.

Infographic: Our Watch, 2018
Additional data and research show Aboriginal and Torres Strait Islander women, children and families experience violence, abuse and neglect at higher rates than non-Indigenous people, and that its impacts can be severe and long-lasting.

Effective prevention and response of Indigenous family violence is community-led, trauma-informed, and built on principles that promote cultural healing in partnership with Aboriginal and Torres Strait Islander people and organisations (Healing Foundation, 2017; SNAICC et al., 2017).

In 2014–15, Aboriginal women were 32-times more likely than non-Indigenous women to be hospitalised due to family violence (AIHW, 2018a).

<table>
<thead>
<tr>
<th>Additional Information</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2016–17, Aboriginal and Torres Strait Islander children were 7-times as likely as non-Indigenous children to have received child protection services (AIHW 2018a).</td>
<td>Between 2012–13 and 2016–17, the rate of children receiving child protection services rose for Indigenous children (from 126.9 to 164.3 per 1,000) (AIHW 2018a).</td>
</tr>
<tr>
<td>Sexual assault of Aboriginal children is widespread and under-reported (NSW Aboriginal Child Sexual Assault Taskforce, 2006; NSW Ombudsman, 2012).</td>
<td>Of all NSW sexual abuse victims aged 15 years and younger, 9.8% were Aboriginal while Aboriginal children make up only 4% of children in NSW (NSW Ombudsman, 2012).</td>
</tr>
<tr>
<td>The burden of disease due to intimate partner violence (which is the largest contributor to premature illness, disability and death for all women aged 18-44), is 6.3 times higher for Indigenous women than non-Indigenous women aged 18-44 years (Webster, 2016).</td>
<td>Existing data indicate that the prevalence and severity of violence affecting Aboriginal and Torres Strait Islander people increases as geographic remoteness increases (AIHW, 2018a).</td>
</tr>
<tr>
<td>Up to 90% of Aboriginal and Torres Strait Islander women imprisoned in Australia are survivors of domestic, family and/or sexual violence (Australian Law Reform Commission, 2018).</td>
<td>The recorded rate of victimisation for sexual assault and child sexual assault is 3-times higher for Aboriginal people than the total population (ACSAT, 2006).</td>
</tr>
<tr>
<td>The recorded rate of victimisation for domestic violence related assault is 6-times higher for Aboriginal people than the total population (ACSAT, 2006).</td>
<td>3-times as many Indigenous women will experience an incident of sexual violence compared to non-indigenous women (12% compared to 4%) (Mouzos &amp; Makkai, 2004).</td>
</tr>
</tbody>
</table>
2.6.4 People with disabilities experiences of violence and personal safety

There is a significant need for robust data and research on prevalence of violence, abuse and neglect for people with disabilities in Australia, to provide a comprehensive picture of the incidence, nature, causes and impacts of people with disabilities’ experiences of interpersonal violence and personal safety in Australia. However, there is some data to suggest that the rates of violence against people with disabilities may be significantly higher than for people with no disabilities, in a range of settings, and by a range of perpetrators (Dowse et al., 2013; Frohmader & Sands, 2015; Frohmader, 2019).

Reliable and accurate data is limited, however available Australian and international research indicates that violence, abuse and neglect are experienced by many people with disabilities:

Compared to their peers, women with disability experience significantly higher levels of all forms of violence more intensely and frequently and are subjected to such violence by a greater number of perpetrators. Their experiences of violence last over a longer period of time, and more severe injuries result from the violence (WWDA, 2007 & Dowse et al., 2013 in Frohmader, 2019).

Violence experienced by women with disabilities is not sufficiently captured by commonly-used terminology such as ‘domestic and family violence’. However, research shows women with disabilities may be 40% more likely than women without disabilities to experience intimate partner violence (ALRC, 2010 in Frohmader et al., 2015).

Data from the 2008 NATSISS showed that 3 in 5 Aboriginal and Torres Strait Islander men (55%) and women (60%) who had experienced physical violence in the 12 months prior to interview, reported that they experience a disability or long-term health condition (ABS, 2008 in Frohmader, 2019).

Women with intellectual disabilities and cognitive impairments are particularly at risk of experiencing violence. Research suggests that up to 90% of women with intellectual disabilities have experienced sexual violence, two-thirds of whom were sexually abused before they were 18 years old (Dowse et al., 2013).
Research suggests more than 70% of women with disabilities may have been victims of sexual violence in their lives (Frohmader et al., 2015). Between 2000-2003 in Victoria, a quarter of rape cases reported by women were perpetrated against women with disabilities (Heenan & Murray, 2006 in Frohmader et al., 2015).

Intimate partner, domestic and family violence is a significant contributor to acquired injuries and disabilities. For example, every week in Australia, more than 3 women are hospitalised with a brain injury as a direct result of family violence (Brain Injury Australia, 2015 in Frohmader et al., 2015).

**Key findings from the ABS 2016 Personal Safety Survey on experiences of physical and sexual violence, sexual harassment, stalking and safety for people with disability or a long-term health condition:**

<table>
<thead>
<tr>
<th>Of people with disability or a long-term health condition, the highest rates of violence were among people with psychological disability (14.8% or 132,500 people), and intellectual disability (14.3% or 67,900 people) with around one in seven people reporting violence. Of people with physical disability, one in twenty (5.0% or 196,300 people) reported having experienced violence during the same time period.</th>
<th>Women with disability or a long-term health condition were more likely to have experienced violence in the preceding 12 months than women without disability or a long-term health condition (5.9% or 172,800 women with disability or long-term health condition and 4.3% or 274,400 of women without disability or a long-term health condition).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men with disability or a long-term health condition were equally likely to experience violence in the last 12 months as men without disability or a long-term health condition (5.6% or 158,100 compared to 6.2% or 383,200).</td>
<td>A higher proportion of people with disability or a long-term health condition experienced physical violence compared with people without disability or a long-term health condition (5.0% or 288,700 people and 4.2% or 531,300 people respectively).</td>
</tr>
<tr>
<td>2.2% of women with a disability or a long-term health condition (63,900 women) reported experiencing sexual violence in the previous 12 months. There was no statistical difference when compared with women with no disability or long-term health condition (1.6% or 105,300 women).</td>
<td>Two in five people (43.3% or 172,400) with disability or a long-term health condition in the 18-24 age group reported experiencing sexual harassment in 2016. This was almost double the proportion of people without disability or a long-term health condition in the same age group (23.6% or 433,000 people) (ABS, 2018).</td>
</tr>
</tbody>
</table>

**TIP**

Limitations that should be considered when using disability data from the Personal Safety Survey include:

- Disability status is determined based on the respondent’s conditions at the time of the interview.
- The PSS does not indicate whether the respondent had a disability or long-term health condition at the time of an incident of violence or harassment.
- The ABS only interviews people living in private dwellings; this population excludes people with disability who live in non-private dwellings, such as care facilities.
- Proxy interviews (when the person selected for the interview cannot answer for themselves due to illness, injury or language difficulties, and requires another person to answer on their behalf) do not include sensitive content, including questions of violence. People with a severe or profound communication disability are therefore under-represented in PSS data about experiences of violence. (ABS, 2018.)
2.6.5 Sexual assault: priority population considerations

This table provides a summary of statistics on the prevalence and characteristics of sexual assault for some groups of people for whom there is evidence of increased barriers to help-seeking, vulnerability to sexual assault, or for whom the impacts of sexual assault may be more severe and long-lasting.

No one factor is singularly causal for violence and abuse and, in practice, all people who have experienced sexual assault should be assessed and responded to on an individual basis, no matter which community they belong to, or how they identify. Further, target groups for violence prevention initiatives will be specific to local contexts. However, developing a shared understanding of the additional barriers and unique experiences some people may face is important to inform appropriate integrated responses, allocation of resources and targeted outreach activities.

### Some people are more vulnerable to sexual assault or its impacts

<table>
<thead>
<tr>
<th>Women</th>
<th>Young women and girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 5 women (18% or 1.7 million) and 1 in 20 men (4.7% or 428,800) have experienced sexual violence since the age of 15 (ABS, 2017).</td>
<td>Women aged between 18-34 years are 3-times more likely to experience sexual violence than men aged 18-34 years or women aged 35 years and over (ABS, 2017).</td>
</tr>
<tr>
<td>1 in 20 (5.1% or 480,200) Australian women compared to 1 in 167 (0.6% or 53,000) Australian men experienced sexual violence by a partner since the age of 15. This means women are 8-times more likely to experience sexual violence by a partner than men (ABS, 2017).</td>
<td>Before the age of 15, almost 1 in 10 women (10.7% or 1.0 million) experienced sexual abuse compared to almost 1 in 22 men (4.6% or 411,800) (ABS, 2017).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aboriginal women</th>
<th>Aboriginal children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-times as many Indigenous women (12%) experience sexual violence as non-Indigenous women (4%) (Mouzos &amp; Makkai, 2004).</td>
<td>Of all sexual abuse victims in NSW aged 15 years and younger, 9.8% are Aboriginal, while Aboriginal children make up 4% of children in NSW (NSW Ombudsman, 2012).</td>
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<td>Of 6,875 survivors of child sexual abuse who spoke in a private session, 14.3% were Aboriginal or Torres Strait Islander people (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017d).</td>
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<tr>
<th>Experience of child sexual assault</th>
<th>Lesbian, gay, bisexual, transgender, queer and intersex people</th>
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<tr>
<td>Several studies have found that people who have been sexually abused as children are 2 to 3-times more likely to be sexually re-victimised in adolescence and/or adulthood than people not sexually abused as children (Strathopoulos, 2014).</td>
<td>1 in 3 LGBTQI Australians have reported experiencing abuse in a relationship, including 65% of transgender males and 43% of intersex females. Lesbian, gay and bisexual people are at greater risk of experiencing sexual coercion than heterosexual females (in O’Halloran, 2015).</td>
</tr>
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</table>
**Women with disabilities**

International research indicates that up to 70% of women with disabilities have been victim-survivors of sexual violence; and that up to 90% of women with an intellectual disability have experienced sexual abuse, more than two-thirds (68%) before they were 18 years of age (Australian Law Reform Commission 2010, in Frohmader, Dowse, & Didi, 2015).

More than a quarter of rape cases reported by women in Victoria between 2000-2003, were perpetrated against women with disabilities (Heenan & Murray, 2006, in Frohmader et al., 2015).

**Children and young people with problematic or harmful sexual behaviours**

Australian studies show that 30-60% of childhood sexual abuse is carried out by children and young people, and most young people know their victim and target younger children or peers (Department of Human Services, 2012; Hunter 1999; KPMG, 2014, p. 22; Weinrott, 1996 – all cited in El-Murr, 2017).

Of survivors of institutional child sexual abuse that provided information in a private session to a Commissioner about the age of the perpetrator, most were abused by an adult perpetrator (85.2%), and 23.4% were abused by a child with harmful sexual behaviours (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

**People in correctional facilities**

People in correctional and juvenile justice settings often have histories of sexual victimisation (Clark & Fileborn, 2011; Crome, 2006; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a).

**Older women**

In Australia, 344 reports of ‘alleged or suspected unlawful sexual contact’ were made in residential aged care during 2011-2012 (Mann, Horsley, Barrett, & Tinney, 2014).

**Women experiencing domestic and family violence**

Since the age of 15, 5.1% (1 in 20 or 480,000) Australian women have experienced sexual violence (sexual assault or threat) by a partner they have lived with; and half of all female victims of sexual assault by a male since the age of 15, were sexually assaulted by an intimate partner (51% or 787,900) (ABS 2017).

International research shows that physically abused women who also experienced forced sexual activity or rape, were 7-times more likely than other abused women to be killed by their partner; and that sexual assault by a partner was the strongest indicator of escalating frequency and severity of violence, more so than stalking, strangulation and abuse during pregnancy (Campbell et al., 2003).
### 2.6.6 Domestic and family violence: priority population considerations

This table provides a summary of statistics on the prevalence and characteristics of domestic and family violence for some groups of people for whom there is evidence of increased barriers to help-seeking, vulnerability to domestic and family violence, or for whom the impacts of domestic and family violence may be more severe and long-lasting.

No one factor is singularly causal for violence and abuse, and in practice, all people who have experienced domestic and family violence should be assessed and responded to on an individual basis, no matter which community they belong to, or how they identify. Further, target groups for violence prevention initiatives will be specific to local contexts. However, developing a shared understanding of the additional barriers and unique experiences some people may face is important to inform appropriate integrated responses, allocation of resources and targeted outreach activities.

#### Some people are more vulnerable to domestic and family violence or its impacts

<table>
<thead>
<tr>
<th>Women</th>
<th>Aboriginal women</th>
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<tbody>
<tr>
<td>1 in 4 women (23% or 2.2 million) compared to 1 in 13 men (78% or 703,000) have experienced physical and/or sexual violence by an intimate partner since the age of 15 (ABS, 2017).</td>
<td>Of 121 female victims of intimate partner homicide in Australia in the 4 years between July 2010-June 2014, 1 in 5 women (22.3% or 27) killed by a male partner, identified as Aboriginal (The Network, 2018).</td>
</tr>
<tr>
<td>3 in 4 (75% or 488) victims of intimate partner homicide in Australia in the 10 years from mid-2002 to mid-2012, were female (AIC National Homicide Monitoring Program, in Bryant and Bricknell 2017).</td>
<td>Indigenous women experience intimate partner homicide at 2-times the rate of Indigenous men (AIHW, 2018a).</td>
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<tr>
<td>Women are 8-times more likely than men to experience sexual violence by a partner since the age of 15 (ABS, 2017).</td>
<td>Aboriginal women were 2-times as likely as men to have experienced domestic and family violence in the 12 months preceding the 2014-15 NATSISS (ABS, 2019).</td>
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<th>Women with mental illness</th>
<th>Women in pregnancy and early motherhood</th>
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<tr>
<td>In 2011, domestic and family violence contributed to more burden of disease (the impact of illness, disability and premature death) than any other risk factor for women aged 25–44. Mental health conditions are the largest contributor to the burden of physical/sexual intimate partner violence, with anxiety disorders making up the greatest proportion (35%), followed by depressive disorders (32%) (Ayre et al. 2016).</td>
<td>During pregnancy, domestic violence can become particularly dangerous, causing premature birth, serious injury or death to the baby, while also impacting the mother’s mental and physical health (Keeling, 2012; Manzolli et al., 2009; O’Reilly, 2007; Oweis, Gharabeh &amp; Alhaurani, 2009 - all cited in Cooper, 2013).</td>
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<tr>
<th>Women with disabilities</th>
<th>Lesbian, gay, bisexual, transgender, queer and intersex people</th>
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<tr>
<td>Studies show women with disabilities are 40% more likely to experience domestic and family violence than other women (Australian Law Reform Commission 2010, in Frohmader, Dowse, &amp; Didi, 2015).</td>
<td>1 in 3 LGBTQI Australians have reported experiencing abuse in a relationship, including 65% of transgender males and 43% of intersex females (in O’Halloran, 2015).</td>
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<tr>
<td>Every week in Australia, 3 women are hospitalised with a brain injury as a direct result of family violence (Brain Injury Australia, 2015 in Frohmader et al., 2015).</td>
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<tr>
<td><strong>Migrants, refugees and people who are culturally and linguistically diverse</strong></td>
<td><strong>Experience of child abuse</strong></td>
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<tr>
<td>Immigrant and refugee women tend to seek help only after enduring years of abuse and are prompted by escalating frequency and severity and fears for the impact on their children (Segrave, 2017).</td>
<td>1 in 3 women (36% or 535,800) and 1 in 6 men (15% or 152,600) who have experienced abuse before the age of 15, have also experienced violence by a partner as an adult (ABS, 2017).</td>
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<tr>
<th><strong>Older women</strong></th>
<th><strong>Women in regional, rural and remote areas</strong></th>
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<tr>
<td>International evidence suggests women aged over 50 who are victims of domestic violence are suffering in silence because the problem is ignored by professionals and policy makers (Lazenbatt &amp; Devaney, 2014).</td>
<td>Women living in regional and remote areas are more likely to have experienced violence since the age of 15 years than those living in major cities (Webster &amp; Flood 2015).</td>
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<tr>
<th><strong>Women experiencing sexual violence</strong></th>
<th><strong>Young women and adolescents</strong></th>
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<tr>
<td>Half of all female victims of sexual assault by a male since the age of 15, were sexually assaulted by an intimate partner (51% or 787,900) 5.1% (1 in 20 or 480,000) Australian women have experienced sexual violence (sexual assault or threat) by a partner since the age of 15 (ABS 2017).</td>
<td>Global prevalence of partner violence is 29% among young women aged 15–19, indicating that violence can occur in women’s earliest relationships (AIHW, 2018a).</td>
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2.6.7 Child abuse and neglect: priority population considerations

<table>
<thead>
<tr>
<th>Younger children</th>
<th>Aboriginal and Torres Strait Islander children</th>
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<td>Infants (children aged less than 1 year) were most likely to be the subject of a child protection substantiation* (16.1 per 1,000 infants), followed by children aged 1-4 years (9.0 per 1,000 children aged 1-4) (AIHW, 2018b).</td>
<td>Nationally, Aboriginal and Torres Strait Islander children were almost 7-times more likely to be the subject of substantiated reports than non-Indigenous children (with rates of 43.6 per 1,000 children compared with 6.4 per 1,000 respectively) (AIHW, 2018b).</td>
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<tr>
<th>Children living in remote areas</th>
<th>Children living in lower socio-economic areas</th>
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<tr>
<td>Children from remote and very remote areas were most likely to be the subject of a substantiation* (16.2 per 1000 and 23.5 per 1000 respectively) compared with children in major cities (6.2 per 1000) (AIHW, 2018b).</td>
<td>Children in lower socio-economic areas were more likely to be the subject of substantiation* than children in higher socio-economic areas, with 6.9% of substantiations occurring in the highest socio-economic areas compared with 35.7% in the lowest socio-economic areas (AIHW, 2018b).</td>
</tr>
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* ‘Substantiation’ typically means that there is sufficient reason (after an investigation of a child protection notification) to believe that a child has been, or is, at risk of abuse and/or neglect (AIHW, 2018b). Terminology used to describe assessment and identification of risk of significant harm to children varies between jurisdictions. In NSW, the Department of Family and Community Services (FACS) refers to the secondary assessments of risk of harm undertaken after a report has been made, that enable a caseworker to determine or ‘substantiate’ whether actual harm to a child or young person has occurred.
2.7 Tangled interactions: overlaps between violence, abuse and neglect

Although practitioners and policy makers often talk about sexual assault and sexual abuse, domestic and family violence, and child abuse and neglect as separate and quite distinct types of violence, the evidence strongly suggests that these concepts are intrinsically linked and connected. This is evident, for example, in statistics from the Personal Safety Survey (PSS) cited above including on sexual assault by a partner and children witnessing violence towards a parent by a partner. It is therefore difficult to separate and respond to each single issue or type of violence, abuse and neglect. One type of abuse rarely occurs in isolation of others, and a single abusive incident is often the exception rather than the norm (Cox, 2015; Laing, 2018; Laing, Heward-Belle, & Toivonen, 2018). Nevertheless, much of the emerging statistics and research on integration are not available from large-scale population studies such as the PSS due to the inherent limitations of that methodology, and so our knowledge of these intersections instead relies on other forms of statistics and research. This section explores two main topics in the context of the interactions, intersections, integration of different forms of violence, abuse and neglect:

1. The overlap between different forms of violence, abuse and neglect.
2. Children and young people with problematic or harmful sexual behaviours.

2.7.1 Overlaps between different forms of violence, abuse and neglect
For domestic and family violence, child abuse and neglect, and sexual assault it is difficult to separate out and respond to one single issue at a time. Many people’s experiences of different types of abuse are intertwined and occur across their life span (Herman, 1997). This is consistent with what families entering the health system for support to address its effects tell us about how the different forms of violence, abuse and neglect are interconnected in their lives. The research and literature also provide evidence of the significant co-occurrence of forms of violence, abuse and neglect as well as their relationship to children and young people with problematic or harmful sexual behaviour. The health and other impacts of different types and multiple episodes of abuse is also cumulative and health consequences may be incrementally worse for victims experiencing multiple types of abuse, either co-occurring, or compounding over a lifetime (Golding, 1999; Laing, 2018; Taft, 2003; WHO, 2002).

Some examples of the overlaps between forms of violence, abuse and neglect include:

- **Co-occurrence**: different forms of violence experienced by women and their children at the hands of the same perpetrator, for example domestic violence and child abuse perpetrated by the same man. At least 50% of men who are violent to their partners also abuse their children (Antle et al., 2007).

- **Re-victimisation**: different experiences of violence by the same victim-survivor by different perpetrators, for example a woman who experienced childhood sexual assault, then experienced adult sexual assault and domestic violence in her adult life. Women who experienced childhood sexual assault are 2.44 times more likely to experience psychological abuse by a partner in adulthood and 2.75 times more likely to experience physical abuse by a partner in adulthood (Cox, 2015).

- A child who has experienced sexual assault, domestic violence and chronic neglect who then displays problematic sexualised behaviours.
The research and literature provide substantial evidence on the significant co-occurrence of forms of violence, abuse and neglect and their impact. For example:

- 1 in 3 women (36% or 535,800) and 1 in 6 men (15% or 152,600) who have experienced abuse before the age of 15, have also experienced violence by a partner as an adult (ABS, 2017).
- In Australia, 1 in 11 (9.2% or 858,100) women have experienced sexual violence (sexual assault or threat) by an intimate partner since the age of 15, and half of all female victims of sexual assault by a male since the age of 15, are sexually assaulted by an intimate partner (51% or 787,900) (ABS, 2017, Table 3.1).
- About 1 in 3 women who experience physical violence are also raped by violent partners (Campbell et al., 2003).
- Sexual abuse and domestic violence frequently co-exist. In one study 40-55% of children who experienced sexual abuse were also exposed to domestic violence (Kellogg & Mellard, 2003). Sexual abuse of children by men who perpetrate family and domestic violence is also likely to be under-reported as children are often too frightened to disclose (Harne 2011 cited in Department for Child Protection, 2013).
- A meta-analysis of 80 studies (12,252 survivors) found a mean prevalence of sexual revictimization across studies was 47.9%; that is almost half of child sexual abuse survivors are also sexually victimized in the future (Walker et al., 2017).
- Children living with domestic violence are at increased risk of experiencing emotional, physical and sexual abuse, with the rate of co-occurrence of domestic violence and child abuse estimated at rates between 45-70% (Holt et al., 2008).
- More than half (56.8%) of children and young people aged 10-17 years surveyed who had witnessed domestic violence had also been maltreated (Hamby et al., 2010).
- Approximately 60 per cent of physical abuse occurs in homes where there is family and domestic violence (Moloney et al., 2007). This includes children who are harmed during an assault against the non-abusive adult victim (for example, when the child is being held or tries to intervene in the violence) and harmed intentionally as a means to punish the adult victim (scapegoating) (Department for Child Protection, 2013, p.24).
- The co-occurrence of domestic violence and child sexual abuse is under-studied, however rates of 12-70% have been found, with higher rates found in clinical samples (Bidarra, Lessard, & Dumont, 2016).
- Between 35-50% of children under 10 with problematic or harmful sexual behaviours have experienced sexual abuse and between 35-50% have experienced physical or emotional abuse, neglect and/or have witnessed domestic violence (Evertsz & Miller, 2012).
- While experiencing sexual assault is associated with increased risk of young people sexually harming (Aebi et al., 2015), this is not the sole causal factor. Other contributing factors in the development of harmful sexual behaviours include: exposure to domestic violence; chronic, long-term neglect; and inappropriately witnessing sexual activity (Pratt et al., 2010).
- Girls with harmful sexual behaviours are more likely than boys to have a more severe history of victimisation (Thibaut et al., 2016).
- There is a correlation between neglect and domestic violence, whereby “the more severe the violence the greater the lack of supervision and neglect of children in the family” (Laing, Humphreys and Kavanagh, 2013).
• In 2016, police recorded a large number of sexual assaults against children that were related to family and domestic violence, with 1 in 5 (20%, or 1,665) victims aged between 10 and 14 and just under 1 in 5 (19%, or 1,532) aged between 0 and 9. For females, the largest proportion of sexual assault victims related to family and domestic violence were aged 15–19 (22%, or 1,535 female victims). For males, the largest proportion of victims were aged 0–9 (42%, or 523) (AIHW, 2018a, p.52).

Notwithstanding the links between the forms of violence noted above, it is important to also acknowledge evidence about the intergenerational transmission of violence. While there are limitations to this evidence, it does suggest that experiencing violence as a child may increase the risk of perpetrating violence in later life but it is not inevitable and that the vast majority of people who have been abused in childhood do not go on to perpetrate abuse in adulthood and the link is complex and mediated by other social and situational factors:

• “It is widely believed that children who have been maltreated are more likely to become abusive toward their own children as adults, continuing an intergenerational transmission of abuse. Some individuals who have been abused or neglected as children will go on to abuse or neglect their own children, however, from the limited evidence available it is important to note that most people who have been abused or neglected do not become abusive or neglectful. … Although certain studies have found associations between past histories of abuse and neglect and perpetrating abuse and neglect in adulthood, research into intergenerational transmission of abuse and neglect is limited.” (CFCA, 2014).

• “Exposure to family violence is not a prerequisite for future abuse, and as Heise (1998: 267) also notes, some studies find that significant proportions of wife abusers have neither witnessed nor experienced physical aggression as children. In turn, most boys who were abused as children do not grow up to be abusers. While many studies have supported a link between child abuse and the adult or adolescent perpetration of violence (Carr and Vandeusen 2002: 634-635), some studies find no such link (Lichter and McCloskey 2004; Sellers et al. 2005)” (Flood and Pease, 2006, p.35).

• It appears that approximately 70% of people who experience domestic violence as children do not go on to perpetrate or be victims of domestic violence (Boyd, 2001).

• “Longitudinal, meta-analytic and population-based studies have consistently linked childhood exposure to domestic and family violence with future perpetration. There is, however, some debate on the question of whether exposure to domestic and family violence alone is a factor in future perpetration of violence. Not all children who experience abuse or family violence go on to become perpetrators or victims and, likewise, not all perpetrators have a history of childhood violence or abuse (Casey, Beadnell, & Lindhorst, 2009). Participants in studies where a correlation is established tend to have experienced childhoods characterised by several risk factors (such as socio-economic disadvantage, parental mental ill health, parental substance abuse and child abuse) (Fergusson, Boden, & Horwood, 2006; Fulu et al., 2013; Higgins, 2004; Temple et al., 2013). Moreover, gender roles and stereotypes and violence-supportive attitudes are important for understanding the correlation (Fulu et al., 2013). … Recent large multi-country population-based studies examining men and violence have found that gender inequality, rigid gender roles, and in particular harmful modes of masculinity, are important for understanding the correlation between childhood exposure and future perpetration (Barker et al., 2011; Fulu et al., 2013; Hagemann-White, Kavemann, Kindler, Meysen, & Puchert, 2010).” (Campo, 2015).
2.7.2 Children and young people displaying problematic or harmful sexual behaviours

**Children and young people with problematic or harmful sexual behaviours**

- Problematic and harmful sexual behaviour refers to behaviour of a sexual nature outside the range accepted as ‘normal’ for a child’s age and level of development, is detrimental to development and normal functioning, and may harm the child themselves, other children subjected to this behaviour, or place either child/ren at risk of harm.

- While no single causal factor can explain or predict sexual behaviour problems in children, the following are commonly associated with it:
  - sexual abuse (including sexual contact and exposure to sexually explicit material)
  - complex trauma histories including other forms of child maltreatment;
  - domestic and family violence;
  - problems in family functioning;
  - poverty;
  - loss; and
  - family stress

**Infographic: Costello & Backhouse, 2019a**
Sources: Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2014; KMPG, 2014

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**Children and young people displaying problematic or harmful sexual behaviour (PHSB) – the evidence**

Although not comprehensive, the evidence base suggests:

- **35-50%** of children under 10 with PHSB had experienced **sexual abuse** & **35-50%** had experienced **physical or emotional abuse, neglect** and/or had **witnessed domestic violence**.

- **30-60%** of **childhood sexual abuse** is by children and young people.

- **Sibling sexual abuse** is more prevalent than other types of **intra-familial sexual abuse**.

- **Sexually related offences** were recorded in Australian crime data for **1672** children and young people between the ages of **10-17** in 2015/16.

- Children engaging in **harmful sexual behaviours** are predominantly **male, older** than their victim and **known** by the victim.

**Sources:** Evertz & Miller, 2012; Tapara, 2012; Welfare, 2008; Caffaro, 2013; Cox, Ey & Bromfield, 2018, p.11; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017
Problematic and harmful sexual behaviour refers to behaviour of a sexual nature that is: outside the range accepted as ‘normal’ for a child’s age and level of development; detrimental to development and normal functioning; and may harm the child themselves, other children subjected to this behaviour, or place either child/ren at risk of harm. These behaviours may include “excessive self-stimulation, sexual approaches to adults, obsessive interests in pornography, and sexual overtures to other children that are excessive to developmental bounds. For some children, these [behaviours] are highly coercive and involve force; acts that would be described as ‘abusive’ were it not for the child’s age” (O’Brien 2010 cited in Evertsz & Miller, 2012, p.6). The use of the terms “problematic” and “harmful” rather than terms such as “sexually abusive” or “offending” behaviour reflects the fact that children under 10 cannot be held criminally responsible for their behaviour and are legally unable to consent to any sexual activity.

Problematic and harmful sexual behaviours overlap substantially with violence, abuse and neglect to such an extent for it to be necessary to address this issue as part of the NSW Health responses to violence, abuse and neglect. In particular, there is a strong link between problematic and harmful sexual behaviour and the child’s own experience of sexual abuse or other interpersonal violence. Vulnerability to developing problematic or harmful sexual behaviour arises from a complex interaction of factors related to the child, family and social environment (Gil & Shaw, 2014). While this means “no single causal factor can best explain or predict sexual behaviour problems in children” (Gil & Shaw, 2014, p.8), sexual abuse (including sexual contact and exposure to sexually explicit material) is recognised as a frequent precursor to it (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2014; KMPG, 2014). In addition to sexual abuse, other factors associated with problematic sexual behaviour in children include: complex trauma histories including other forms of child maltreatment, and domestic and family violence; problems in family functioning; poverty; loss; and family stress (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2014; KMPG, 2014).
Interventions with a child displaying problematic or harmful sexual behaviours offers opportunities to both prevent further sexual and other harm towards children who may be subjected to these behaviours and also to reduce the child’s own vulnerability. Children displaying problematic or harmful sexual behaviour can be at increased risk of:

- Being abused by others (e.g. as a result of poor boundaries and indiscriminate friendliness) (Chaffin et al., 2008).
- Unresolved child protection issues.
- Disruption to emotional and behavioural development (which affects social relationships and learning) (Silovsky & Niec, 2002).
- Identity issues and poor self-concept (Silovsky & Niec, 2002).
- Problematic or harmful sexual behaviour escalating and continuing into adolescence.

Problematic or harmful sexual behaviour can also have a significant impact on the development and long-term well-being of the child and those around them. Early and effective intervention is therefore imperative to both minimise the child’s vulnerability to abuse and preventing the ongoing health and social impacts of the child’s behaviour.

The evidence base about children under 10 with problematic and harmful sexual behaviours is limited, however key messages from what exists include:

- The prevalence of problematic and harmful sexual behaviour is difficult to determine particularly for children under 10 due to deficiencies in available data and methodological challenges in research including identification of age. Nevertheless, the Australian Bureau of Statistics’ Recorded Crime Offenders Report found that sexually related offences were recorded for 1,672 children and young people between the ages of 10-17 in 2015/16. No similar data was recorded for children under 10 due to them being below the age of criminal responsibility. In addition, these figures are likely an underestimation due to lack of reporting as well as variations in the data sources and the phenomena measured. (Cox, Ey & Bromfield, 2018, p.11.)
- Age appropriate and normal sexual behaviour needs to be distinguished from problematic, harmful or developmentally inappropriate behaviour (Kellogg & Committee on Child Abuse and Neglect, 2009).
- Children and young people who have demonstrated sexually harmful behaviours often have complex trauma histories including sexual assault in their histories (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2014, KMPG, 2014).
- Between 35-50% of children under 10 with problematic or harmful sexual behaviours have experienced sexual abuse and between 35-50% have experienced physical or emotional abuse, neglect and/or have witnessed domestic violence (Evertsz & Miller, 2012).
- Early intervention has been found to offer the best opportunity for preventing escalation of problematic or harmful sexual behaviour, negative impacts on social and emotional development and possible psychological and physical harm to other children (Lussier & Healey, 2010; valentine & Katz, 2007).
- The sexual abuse of boys is far more common than generally believed and, in comparison to girls, boys are more likely to be assaulted by siblings or other boys (Cashmore & Shackel, 2013; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).
- Sibling sexual abuse is more prevalent than other types of intra-familial sexual abuse (Tapara,
• “Australian studies find that 30-60% of childhood sexual abuse is carried out by children and young people, and “most young people target younger children or peers, and know their victim” ... However, accurate statistics are difficult to obtain” (Department of Health and Human Services, 2012; Hunter, 1999; KPMG, 2014, p. 22; Weinrott, 1996 as cited in El-Murr, 2017).

• Children with harmful sexual behaviours are predominantly male, older than their victim and known by the victim (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017c).

• A high proportion of clients of New Street (young people aged 10 to 17 who have demonstrated sexually harmful behaviours) have complex trauma histories. Ten per cent of New Street clients are girls who have significant prevalence of complex trauma, including sexual assault in their histories (KMPG, 2014).

• Although, similarly to adult offenders, the majority of children and young people with harmful sexual behaviours are male, international studies find that between 2.6-12% of children and young people with harmful sexual behaviours are female (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017c).
THE WHY

2.8 Health outcomes of violence, abuse and neglect

2.8.1 Research on health outcomes

It is clear that violence, abuse and neglect has serious impacts on an individual’s health, contributing to a range of negative outcomes, including poor mental health, problems during pregnancy and birth, alcohol and other drug use, suicide, injuries and homicide. Adversity, including traumatic experiences such as violence, abuse and neglect, is well-recognised as a social determinant of poor health outcomes. As paediatrician Dr Nadine Burke Harris wrote about childhood adversity:

Twenty years of medical research has shown that childhood adversity [especially traumas such as violence, abuse and neglect] literally gets under our skin, changing people in ways that can endure in their bodies for decades. It can tip a child’s developmental trajectory and affect physiology. It can trigger chronic inflammation and hormonal changes that can last a lifetime. It can alter the way DNA is read and how cells replicate, and it can dramatically increase the risk for heart disease, stroke, cancer, diabetes – even Alzheimer’s (Burke Harris, 2018)

Dr Burke Harris’ point is similarly applicable for those forms of violence, abuse and neglect experienced in adulthood such as domestic and family violence and sexual assault. A summary of some key pieces of research on the health consequences of violence for women, men and children is provided in the table below. As already noted, the co-occurrence between the different forms of violence, abuse and neglect and their cumulative impact on people’s health and well-being means that it is appropriate to identify these impacts all together.
Health outcomes of violence, abuse and neglect summary of key research

**Physical injuries**
- Repeated physical assaults (of adults or children) result in injuries and related health issues such as chronic pain, broken bones, arthritis, hearing or sight deficits, seizures or frequent headaches [Coker, Smith, Bethea, King, & McKeown, 2000].
- Children who experience physical violence are at risk of physical injury and death [Doherty, 2003].
- Australian research using hospital morbidity data has shown that almost a third of children admitted to hospital with an unintentional injury are known to child protection authorities [McKenzie, Scott, Fraser, & Dunne, 2012].
- A common form of abuse affecting the health of babies is shaken baby syndrome. Health problems resulting from shaken baby syndrome may include brain damage, spinal cord injuries, hearing loss, speech difficulties and even death [Child Welfare Information Gateway, 2008].
- Analysis of national databases reveal that Indigenous women are 32 times more likely to be hospitalised for injuries related to family violence assaults than non-Indigenous women [AIHW, 2018a].

**Death**
- Childhood abuse and household dysfunction contribute to the development, decades later, of the chronic diseases that are the most common causes of death and disability [Felitti et al., 1998] as well as to early mortality generally [Moore et al., 2017].
- Abuse and neglect, particularly in childhood, significantly increases the risk of suicidal ideation, attempted suicide and suicide [Dube et al. 2001; Hunter, 2014; Moore et al., 2017].
- Approximately three quarters of female homicides are classified as domestic homicides, involving victims who share a family or domestic relationship with the offender [NSW Government, 2014].
- The World Health Organization (WHO) estimated 31,000 homicide deaths of children aged 15 or younger around the world occur every year [WHO, 2010]. This is considered an underestimation as a large number of deaths caused by abuse and neglect go unreported due to being misattributed to other causes such as falls or insufficient investigations and a failure to run post-mortem examinations [Gilbert et al., 2009; WHO, 2010 cited in Hunter, 2014].
- Previous contact with child protection services, often with an intergenerational family history, feature as a common denominator in child deaths across Australia [Goldsworthy, 2017].
- Medical neglect (from failure to heed obvious signs of serious illness or failure to follow a physician’s instructions once medical advice has been sought for a child/young person) can be fatal in some cases or can lead to chronic disability [Jenny, 2007].

**Sexual and reproductive health**
- Violence, abuse and neglect is associated with sexually transmitted infections (including HIV/AIDS), unintended/unwanted pregnancies, gynaecological problems, induced abortions, and adverse pregnancy outcomes including miscarriage, premature birth, low birth weight and foetal death [Anda et al., 2006; Australian National Council to Reduce Violence Against Women and their Children, 2009; Burke Harris, 2018; Hillis et al., 2000; Hillis et al., 2004; WHO, 2002].
### Mental health

- Violence against women has been identified as a determinant of mental health and wellbeing (VicHealth, 2008).
- Violence and abuse and Adverse Childhood Experiences (ACEs) increase the risk of depression, post-traumatic stress disorder, sleep difficulties and insomnia, eating disorders, self-harm, suicidal thoughts, anxiety, suicide and emotional distress (Anda et al., 2002; Anda, Dube, & Felitti, 2003; Anda et al., 2006; Black et al., 2012; Campbell, 2002; Chapman et al., 2004; Cryan & Dinan, 2013; Edwards et al, 2003; Gunnar & Quevedo, 2007; Moore et al., 2015; Moore et al., 2017; Wekerle & Wolfe, 2003; Whitfield, et al., 2003).
- Childhood adversities including family violence, physical abuse and neglect are the strongest correlates of onset of adult psychiatric disorder (Green et al., 2010).
- Childhood exposure to violence increases children’s risk of mental health, behavioural difficulties, learning difficulties, and poor educational outcomes in the short-term and later in life (Campbell, 2002; Chapman et al., 2004; Cryan & Dinan, 2013; Edwards et al, 2003; Gunnar & Quevedo, 2007; Moore et al., 2015; Moore et al., 2017; Wekerle & Wolfe, 2003; Whitfield, et al., 2003).
- Childhood adversities including family violence, physical abuse and neglect are the strongest correlates of onset of adult psychiatric disorder (Green et al., 2010).
- Children and young people who have been neglected experience a myriad of mental health issues including: eating disorders, depression, anxiety disorders, psychosis, personality disorders, early onset bi-polar disorder, self-harm and suicidal ideation and behaviour (NSW Family and Community Services, 2017).

### Physical health and chronic disease

- A longitudinal study compared children with documented experiences of physical abuse, sexual abuse and/or neglect with non-maltreated children, following these cohorts over 30 years. The study found a number of medical problems in adulthood which were associated with childhood neglect and physical abuse, such as increased risk of diabetes, poor lung functioning, poor visual and oral health and high risk factors associated with heart disease (Widom, Czaja, Bentley, & Johnson, 2012).
- The Adverse Childhood Events (ACE) study involving more than 17,000 people identified ten categories of childhood experience that accurately predicted health concerns in adults. The more adversities a child experienced, the greater the number of health concerns they experienced. The numerous physical health problems in adulthood associated with these experiences as identified through the original ACE study and a number of follow up studies include increased likelihood of: autoimmune diseases (Dube et al., 2009); cancer (Brown et al., 2010; Brown et al., 2013; Moore et al., 2017); chronic obstructive pulmonary disease (Anda et al., 2008; Cunningham et al., 2014); diabetes (Moore et al., 2017); heart disease (Anda et al., 2008; Dong et al., 2003; Moore et al., 2017) and liver disease (Dong et al., 2003; Moore et al., 2017).
- Chronic health conditions that can be seen in victims of abuse indirectly through long term psychological stress include stomach ulcers, spastic colon, frequent indigestion, diarrhea, constipation, angina and hypertension (Coker et al., 2000).
- At a time of rapid neurological growth, an infant’s physical and emotional development may be compromised by exposure to ongoing violence, whether or not they are the target of the violence (Rossman, 2001).
- Women who have experienced sexual assault suffer ongoing physical problems such as chronic diseases, headaches, irritable bowel syndrome, eating disorders and gynaecological conditions (WHO, 2002).
Avoiding the 3 ‘M’s

Behaviours associated with risk

• Victims of abuse are much more likely to engage in activities that are seen to be linked to risk. These include smoking, poor nutrition, physical inactivity, unprotected sex and substance misuse. These actions may be adopted as coping strategies for the victim-survivor (Campbell, 2002; Coker et al., 2000; Taskforce on the Health Aspects of Violence against Women and Children, 2010).

• A person with 4 or more Adverse Childhood Experiences (ACEs) is two and a half times as likely to smoke, five and a half times as likely to be dependent on alcohol, and ten times as likely to use intravenous drugs as a person with zero ACEs (Burke Harris, 2018).

• Adverse Childhood Experiences (ACEs) are associated with increased: drug and alcohol misuse (Anda et al., 2002; Anda et al. 2006; Dube et al., 2002; Dube et al., 2003); obesity (Anda et al. 2006; Williamson et al., 2002); sexual behaviours associated with risk (e.g. early intercourse, adolescent pregnancy) (Anda et al., 2006; Hillis et al., 2001; Hillis et al., 2004); smoking (Anda et al., 2006; Ford et al., 2011); and social determinants of health including: cognitive and language difficulties, lower educational attainment, perpetration or experience of violence, unemployment, poverty, homelessness (Anda et al., 2006; Moore et al., 2017; Ports, Ford & Merrick, 2016; Whitfield et al., 2003). Significantly, however, only approximately 50% of the increased risk for a range of health impacts arising from ACEs (see physical health and chronic diseases above) is from risk-related behaviours (e.g. smoking, alcohol and drug use, and obesity) (Burke Harris, 2018).

• There is a link between exposure to adverse early experiences such as abuse and neglect, and increased likelihood of obesity, cognitive and language difficulties, lower educational attainment, unemployment, poverty, homelessness, becoming victims or perpetrators of violence in later life (Moore et al., 2017).

• Victims of abuse have higher levels of alcohol and drug misuse during both adolescence and adulthood (Fergusson & Lynskey, 1997; Harrison, Fulkerson, & Beebe, 1997; Perkins & Jones, 2004). Evidence suggests all types of child maltreatment are significantly related to higher levels of substance use (tobacco, alcohol and other drugs) (Moran, Vuchinich, & Holl, 2004).

• Some studies show the rates of child sexual assault amongst women in drug and alcohol programs is between 47%-74% (Jarvis & Copeland, 1997).

• Childhood experiences of violence and abuse are well-documented risk factors for a number of adverse psycho-social outcomes including: behavioural problems in childhood and adolescence (Campo, 2015; Ethier, Lemelin, & Lacharité, 2004; Mills, 2004; Shaffer, Huston, & Egeland, 2008) and attachment and interpersonal relationship issues and using violence themselves (Gilbert et al., 2009; Maas, Herrenkohl, & Sousa, 2008). This places the child or young person at risk of exposure to further violence from others (e.g. as a result of poor boundaries and indiscriminate friendliness) (Chaffin et al., 2008) or responding to their violent behaviour.

• Children with problematic or harmful sexual behaviour can be at increased risk of this behaviour escalating and continuing into adolescence (Silovsky & Niec, 2002).
2.8.2 Adverse Childhood Experiences (ACEs)

Some of the key pieces of research on the health impacts of violence, abuse and neglect identified in the table above are from Adverse Childhood Events (ACE) studies. The original ACE study is particularly significant given its size, the number of follow up studies and the significance and consistency of its findings demonstrating the negative health impacts of ACEs over time as summarised in this diagram. It is thus worth providing more detailed information about ACE studies.

The original landmark ACE study by medical doctors Vincent Felitti and Robert Anda and their colleagues (Felitti et al., 1998) was conducted in San Diego in the United States of America and involved 17,421 people; of which 70% were Caucasian and 70% were college-education. This composition of a high socio-economic population group was significant as it demonstrated that “adverse childhood experiences in and of themselves are a risk factor for many of the most common and serious disease in the United States (and worldwide), regardless of income or race or access to care” (Burke Harris, 2018, p.39).

The original ACE study and subsequent similar studies involve a questionnaire that collects information about 3 key areas of “adverse childhood experiences” – abuse, neglect and household challenges - which have evolved to include the following 10 categories, each of which counts as one point (Felitti et al., 1998; Burke Harris, 2018):

1. Psychological (or emotional) abuse (recurrent).
2. Physical abuse (recurrent).
3. Sexual abuse (any contact).
4. Physical neglect.
5. Emotional neglect.
6. Substance abuse in the household (e.g. living with a person with an alcohol or substance misuse problem).
7. Mental illness in the household (e.g. living with someone who is depressed or otherwise mentally ill or who has attempted suicide).
8. Mother (or step-mother) treated violently (domestic violence).
9. Divorce or parental separation.
10. Criminal behaviour in household (i.e. a household member has gone to prison).
Scores from the ACE questionnaires are then correlated to health risk behaviours and health outcomes and accurately predicted health concerns in adults. The key findings of these studies have been that ACE experiences are astoundingly common in the community and that there is a dose-response relationship (meaning the response varies based on levels of exposure) so that the more adversities a child experiences (that is the higher their ACE score), the greater the number of health concerns (Burke-Harris, 2018; Moore et al., 2017). For example, a person with 4 or more ACEs is: two times more like the develop heart disease and cancer, three and a half times more likely to develop chronic obstructive pulmonary disease than a person with zero ACEs (Burke Harris, 2018, p. 38).

The numerous health problems in adulthood associated with these experiences as identified through the original ACE study and numerous follow up studies identify increased likelihood of (in alphabetical order):
• autoimmune diseases (Dube et al., 2009);
• cancer (Brown et al., 2010; Brown et al., 2013; Moore et al., 2017);
• chronic obstructive pulmonary disease (Anda et al., 2008; Cunningham et al., 2014);
• diabetes (Moore et al., 2017)
• heart disease (Anda et al., 2008; Dong et al., 2003; Moore et al., 2017)
• liver disease (Dong et al., 2003; Moore et al., 2017);
• mental health issues (Anda et al., 2002; Anda et al., 2006; Chapman et al., 2004; Edwards et al., 2003);
• sexual and reproductive ill-health (e.g. sexual dissatisfaction, sexually transmitted infections, foetal death) (Anda et al., 2006; Hillis et al., 2000; Hillis et al. 2004); and
• suicidality and suicide (Dube et al. 2001; Moore et al., 2017).

In addition, ACE studies have identified that there are various health risk factors associated with childhood adversity including:

• drug and alcohol misuse (Anda et al., 2002; Anda et al. 2006; Dube et al., 2002; Dube et al., 2003);
• obesity (Anda et al. 2006; Williamson et al., 2002).
• sexual behaviours associated with risk (e.g. early intercourse, adolescent pregnancy) (Anda et al., 2006; Hillis et al., 2001; Hillis et al., 2004);
• smoking (Anda et al., 2006; Ford et al., 2011); and
• social determinants of health including cognitive and language difficulties, lower educational attainment, perpetration or experience of violence later in life, unemployment, poverty, homelessness (Anda et al., 2006; Moore et al., 2017; Ports, Ford & Merrick, 2016; Whitfield et al., 2003).

Significantly, however, additional analysis has identified that only approximately 50% of the increased risk for a range of health impacts arising from the ACEs listed above is from risk-related behaviours (e.g. smoking, alcohol and drug use, and obesity) (Burke Harris, 2018). Burke Harris argues that the other 50% of this risk comes from the impact of the adverse experiences themselves creating a dysregulated stress response where: “[h]igh doses of adversity affect not only the brain structure and function but also the developing immune system and hormonal systems, and even the way DNA is read and transcribed” (Burke Harris, 2018, p. 55).

This is consistent with the position taken by Moore et al. (2017, pp.34-35) in their The First 1000 Days: An Evidence Paper, where they argue that there are three key linking mechanisms through which sustained exposure to abuse and/or neglect increase the likelihood of ill (physical and mental) health and early mortality:

1. It disrupts the progression of critical developmental processes (namely the stress response and brain development).
2. It impacts the way in which children relate to and interpret the world around them.
3. It is likely to result in the development of negative risk behaviours in later life that lead to an increase in the likelihood of risk factors that undermine health and well-being outcomes.
For people (adults and children) who have experiences of childhood adversity, soothing their disrupted stress-response systems, managing their symptoms more effectively and reducing the risks associated with ACES, can be achieved by, based on the evidence (adapted from Burke Harris, 2018; WAVE Trust, 2018):

1. Supporting and enhancing the ability of care-givers to be buffers to toxic stress in children.
2. Developing the foundational skills of attachment, stress management and self-regulation through a focus on the key elements of:
   - Individual level - sleep, nutrition, exercise, and mindfulness.
   - Relationship level – establishing safety, healthy relationships, the quality of social responses, and integrated mental health services that are trauma and violence-informed.

It is important to note, however, that a public health response to ACEs also needs to both pay attention to these key elements within a practice context that is trauma-informed and to seek to prevent the adversity occurring in the first place. As Jarvis (2018) argues: “the ultimate aim for ACEs informed practice is to create a society in which ACEs occur far less frequently, and where they do, the child and the family are offered support at the earliest opportunity”. The public health approach to violence, abuse and neglect which includes a focus on prevention will be addressed in more detail in the “How” section of this resource (see Sections 2.11, 2.12 and 2.13).
The **70/30 Campaign*** is a national campaign in the United Kingdom led by children’s charity, WAVE Trust, which is aiming for a 70% reduction in child abuse and neglect by the year 2030. This campaign has produced some excellent resources that clearly and succinctly explain the theory behind the ACE research and practical solutions for better responding and preventing childhood adversity. Some of these are reproduced below, however these and additional resources are available for download from their website at: [https://www.70-30.org.uk/infographics/](https://www.70-30.org.uk/infographics/).
Stress in Childhood
Stress is a natural & inevitable part of childhood, but the TYPE of stress can make a difference in the impact on a child’s brain & body.

Positive Stress
Mild stress in the context of good attachment.

Tolerable Stress
Serious, temporary stress, buffered by supportive relationships.

Toxic Stress
Prolonged activation of stress response system without protection.

Infographics: 70/30 Campaign (WAVE Trust, 2018).

70/30 Campaign: Empowering Communities to Protect Our Children

Childhood Trauma
An event that a child finds overwhelmingly distressing or emotionally painful, often resulting in lasting mental and physical effects.

2x more likely to develop DEPRESSION
3x more likely to develop ANXIETY DISORDERS

LONG-TERM IMPACTS:
- Affects perception of reality
- Takes away sense of safety
- Wires brain to expect danger
- Increases stress hormones flowing through the body
- Triggers fight, fright or freeze response
- Creates a sense of helplessness
- Results in serious behaviour problems

The initial trauma of a young child may go underground but it will return to haunt us
James Garbarino

Common causes:
- Child abuse (physical, emotional, sexual)
- Witness/Victim of violence
- Grief
- War/Terrorism
- Medical trauma
- Medical illness
- Substance misuse
- Bullying in school
- Separation from loved ones

Prefrontal Cortex (PFC)
"Thinking Centre"
Underactivated
Difficulties concentrating & learning.

Amygdala
"Fear Centre"
Overactivated
Difficulty feeling safe, calming down, sleeping.

Prefrontal Cortex (PFC)
"Thinking Centre"
Underactivated
Difficulties concentrating & learning.

Anterior Cingulate Cortex (ACC)
"Emotion Regulation Centre"
Underactivated
Difficulties with managing emotions.

Complex Trauma: a result of repetitive, prolonged trauma

Infographics: 70/30 Campaign (WAVE Trust, 2018).
ACE-informed Approach

An ounce of PREVENTION is worth a pound of cure. — Benjamin Franklin

Negative impacts of ACEs are significantly mitigated by having an Always Available (trusted) Adult (AAA)

People with 4+ ACEs and NO CONSTANT SUPPORT are

3x more likely to do any two of the following:

- heavy drinking
- poor diet
- daily smoking

than people with 4+ ACEs and CONSTANT AAA SUPPORT

3x

Infographics: 70/30 Campaign (WAVE Trust, 2018).

Note: in Fact Sheet Health outcomes of, and responses to, violence, abuse and neglect and Power Point resource for this Project, an additional principle on culture has been added to better reflect the Australian context.
2.8.3 Burden of disease of intimate partner violence

From a public health perspective, the health impacts of intimate partner violence can be extensive as illustrated by this diagram reproduced from *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence* (WHO, 2015).

**Burden of disease – intimate partner violence and child sexual abuse**

- **Intimate partner violence** contributes an estimated **5.1%** of the **burden of disease** (impact of illness, disability, and premature death) for women aged 18-44 years.
- **Child sexual abuse** contributes an estimated **1.2%** of the **burden of disease** for women aged 18-44 years.

This is more than any other risk factor, including alcohol, tobacco use and obesity. This is the 8th highest risk factor.
Further, burden of disease studies demonstrate that these health impacts of intimate partner violence are particularly pronounced for women. A burden of disease study by the Australian Institute of Health and Welfare (AIHW, 2016) estimated that partner violence alone (without considering non-partner sexual assault or other forms of violence):

- contributes more to the burden than any other risk factor in women aged 18-44 years, more than well known risk factors like tobacco use, high cholesterol or use of other drugs;
- makes a larger contribution than any other risk factor to the gap in the burden between Indigenous and non-Indigenous women aged 18-44 years; and
- has serious consequences for the development and wellbeing of children living with violence (Webster, 2016).

This 18-44 year old age group is particularly significant as these are women’s primary childbearing years and in addition to the interrelationship between domestic violence and child abuse already noted previously in this resource, “[s]tudies have also found a strong correlation between domestic violence during pregnancy and poor emotional regulation and academic outcomes in school (Durand, Schrailber, Franca-Junior & Barros, 2011); behavioural problems during infancy (Flach et al., 2011); poor maternal attachment (Quinlavin & Evans, 2005); an increase in internalising problems from as early as 24 months (McFarlane et al., 2014); and aggressive behaviours at school (Durand, Schrailber, Franca-Junior & Barros, 2011)” (Moore et al., 2007).

“Burden of disease studies measure the combined impact on a population of living with illness and injury and dying prematurely. These studies use an internationally recognised method to assess the health impact of diseases or risk factors across a population. Standard methods are used so that the effect of specific diseases and risk factors can be compared with another, or over time” (AIHW 2018a, pp.77-78).

In 2016, the AIHW was funded by ANROWS to produce a national report examining the burden of disease of intimate (current and former) partner violence against Australian women in terms of both illness/injury and death. This report is available at: Examination of the burden of disease of intimate partner violence against women in 2011: Final report (AIHW, 2016).

The infographics below were produced as part of this burden of disease research to provide a summary of key findings to accompany the main report, and are included in the resource: A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions (Webster, 2016).
Intimate partner violence is common.

1 in 4 Australian women have experienced physical or sexual violence by an intimate partner since age 15.1

1 in 3 Australian women have experienced physical or sexual violence and/or emotional abuse by an intimate partner since age 15.2

This includes violence or abuse by a partner they currently or have previously lived with, as well as violence perpetrated by a non-cohabiting partner.

1 in 4 Australian women have experienced physical or sexual violence since age 15.3

It has serious impacts on women’s health.1

This includes injuries and homicide, poor mental health, reproductive health problems and problems with alcohol and drug use.

It has serious impacts on women’s health.1

It contributes an estimated 5.1% of the burden in women aged 18-44 years.2

Partner physical and sexual violence and emotional abuse in cohabiting and non-cohabiting relationships

This is more than any other risk factor.

Infographics: Webster, 2016

It violates the human rights of women and their children.

Affects access to housing and employment and increases gender inequality.

Is costly to women and the economy.

Impairs children’s health and development now and in future generations.

Increases social and economic inequalities.

Intimate partner violence has other negative consequences.

Intimate partner violence is preventable.

Preventing it should be a high priority for preventing poor health among Australian women.

The best way to reduce the health burden is to stop violence occurring in the first place.

Primary prevention - stopping violence before it starts by tackling root causes

Early intervention with individuals and groups at high risk of perpetrating violence

Response - preventing recurring violence

Supporting recovery

Preventing health consequences

Minimising health consequences

Commonwealth, state and territory governments have developed policies, plans and conducted commissions and inquiries to identify the actions to achieve this. A coordinated national approach is also supported through:

The National Plan to Reduce Violence Against Women and Their Children 2010-2022. A plan of all Australian governments to support and coordinate prevention and early detection of violence as well as responses to it.


Intimate Partner Violence

An avoidable burden on the health of women and their children


4 As there are interactions between risk factors, it is not correct to add them together.

Intimate partner violence has other negative consequences.

It violates the human rights of women and their children.

Affects access to housing and employment and increases gender inequality.

Is costly to women and the economy.

Impairs children’s health and development now and in future generations.

Increases social and economic inequalities.

This is more than any other risk factor.

Top 8 risk factors contributing to disease burden in Australian women aged 18-44 years* (% estimate)

1 INTIMATE PARTNER VIOLENCE 5.1%

2 ALCOHOL USE 4.1%

3 TOBACCO USE 2.3%

4 WORKPLACE HAZARDS 2.2%

5 OVERWEIGHT/ OBESITY 1.8%

6 ILLICIT DRUG USE 1.8%

7 PHYSICAL INACTIVITY 1.8%

8 CHILDHOOD SEXUAL ABUSE 1.2%

*In the absence of interactions between risk factors, it is not correct to add them together.

Infographics: Webster, 2016

Intimate Partner Violence

An avoidable burden on the health of women and their children


Intimate partner violence is common.

1 in 4 Australian women have experienced physical or sexual violence by an intimate partner since age 15.1

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It contributes an estimated 5.1% of the burden in women aged 18-44 years.2

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Intimate Partner Violence

An avoidable burden on the health of women and their children


The estimated impact of 200 diseases among women across Australia are measured by:

- The numbers of years lost among women who die earlier than they would have if they had not suffered from those diseases.
- Years of ill-health that women live with as a result of suffering those diseases.
- Healthy life years that women live with as a result of suffering those diseases.

Together these are called the "total disease burden".

### Estimating the overall disease burden among Australian women

This takes into account the prevalence of violence, diseases caused and the years of ill-health and premature death.

### Estimating the disease burden of intimate partner violence

Depressive and anxiety disorders and suicide and self-harm are among the top 10 leading causes of the overall burden in women aged 18-44 age group.

A large part of this is contributed by intimate partner violence.

### Total disease burden

- Women aged 18-44 years

### Reducing intimate partner violence will help to reduce the burden of disease among Australian women.

Source: Data courtesy of the Australian Institute of Health and Welfare 2016.

Infographics: Webster, 2016
The contribution of intimate partner violence to the gap between Indigenous and non-Indigenous women

Intimate partner violence is common. An estimated 3 in 5 Indigenous women have experienced physical or sexual violence by an intimate partner since age 15. This includes violence or abuse by a partner they currently or have previously lived with, as well as violence perpetrated by a non-cohabiting partner.

It contributes an estimated 10.9% to disease burden in Indigenous women aged 18-44 years. This is more than any other risk factor.

Top 8 risk factors contributing to disease burden:

1. Intimate partner violence: 10.9%
2. Alcohol use: 7%
3. Overweight/obesity: 6.2%
4. Tobacco use: 5.9%
5. Childhood sexual abuse: 4.7%
6. Physical inactivity: 4.2%
7. Illicit drug use: 3.7%
8. High plasma glucose*: 3.4%

* A risk factor for diabetes and other chronic diseases.

There is a gap in the burden between Indigenous and non-Indigenous women. Among Indigenous women aged 18-44 years rates of burden for each disease due to intimate partner violence are higher among Indigenous women of the same age.

Estimated rates of burden for each disease due to intimate partner violence are higher among Indigenous women aged 18-44 years than non-Indigenous women of the same age.

Intimate partner violence contributes more than any other risk factor to the gap between Indigenous and non-Indigenous women aged 18-44 years.

Estimated contribution made by the top 8 risk factors to the gap in rate of total burden of disease between Indigenous and non-Indigenous women:

1. Intimate partner violence: 15.3%
2. Overweight/obesity: 10.5%
3. Tobacco use: 9.9%
4. Alcohol use: 9.4%
5. Childhood sexual abuse: 7.8%
6. Physical inactivity: 6.8%
7. High plasma glucose*: 5.7%
8. Illicit drug use: 5.6%

* A risk factor for diabetes and other chronic diseases.

Eliminating intimate partner violence will help to close the health gap between Indigenous and non-Indigenous Australians.

Source: Data courtesy of the Australian Institute of Health and Welfare 2016.

Infographics: Webster, 2016
The 2016 intimate partner violence burden of disease project estimated the amount of burden that could have been avoided if no adult women in Australia in 2011 were exposed to intimate partner violence. Research demonstrates there are a range of negative outcomes associated with intimate partner violence as listed in the table below (from Webster, 2016).

<table>
<thead>
<tr>
<th>Table 1 Negative health outcomes associated with intimate partner violence</th>
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<tbody>
<tr>
<td><strong>Fatal impacts</strong></td>
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<tr>
<td>Homicide</td>
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<tr>
<td>Suicide</td>
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<td><strong>Non-fatal impacts</strong></td>
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<td>Injuries</td>
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<td>Brain injury</td>
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<td>Loss of consciousness</td>
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<td>Genital trauma</td>
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<td>Fractures and sprains</td>
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<td>Lacerations, abrasions and bruising</td>
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<td>Self-harm</td>
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<td>Mental health</td>
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<td>Depression</td>
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<td>Anxiety</td>
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<td>Eating disorders</td>
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<td>Suicidal ideation</td>
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<td>Substance abuse</td>
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<td>Alcohol-use disorder</td>
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<td>Drug-use disorder</td>
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<td>Conditions occurring in the period immediately before and after birth</td>
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<td>Prematurity, low birth weight</td>
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<td>Maternal health</td>
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<td>Post-natal depression</td>
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<td>Reproductive health</td>
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<td>Early pregnancy loss (medical and spontaneous)</td>
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<td>Gynaecological problems</td>
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<tr>
<td>Involuntary symptoms causing pain or discomfort that cannot be explained by a medical cause (referred to as somatoform disorders)</td>
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<tr>
<td>Chronic fatigue</td>
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<td>Chronic pain</td>
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<td>Irritable bowel syndrome</td>
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<td>Chronic disease</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Cardiovascular: hypertension, coronary heart disease, stroke</td>
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<td>Musculoskeletal: arthritis, rheumatoid arthritis, gout, lupus, fibromyalgia</td>
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<tr>
<td>Infections</td>
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<td>HIV/AIDS</td>
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<tr>
<td>Other sexually transmissible infections</td>
</tr>
<tr>
<td>Behaviours and practices affecting health</td>
</tr>
<tr>
<td>Unsafe sex</td>
</tr>
<tr>
<td>High body mass index (BMI)</td>
</tr>
<tr>
<td>Harmful tobacco/drug/alcohol use</td>
</tr>
<tr>
<td>Barriers to accessing health/engaging in self-care</td>
</tr>
<tr>
<td>Lack of autonomy</td>
</tr>
<tr>
<td>Difficulties seeking care</td>
</tr>
<tr>
<td>Lack of access to contraception</td>
</tr>
</tbody>
</table>

Source: Adapted from WHO, 2013.

Table source: Webster, 2016

In estimating the burden of disease in the 2016 study (AIHW, 2016), however, only seven diseases were causally linked to exposure to intimate partner violence: depressive disorders; anxiety disorders; alcohol use disorders; suicide and self-inflicted injuries; homicide and violence (injuries due to violence); early pregnancy loss; and complications from being born too early (Webster, 2016). Six of these are provided in the table below (from AIHW 2018a, pp.78) which identifies the contribution of intimate partner violence to the total disease burden. (Note, complications from being born too early were excluded as the study focused on adult women.) As the studies for most of the conditions in...
the table above did not meet the required standard of evidence for inclusion in the burden of disease study, it is likely that the findings of this study are an underestimation of the true impact of intimate partner violence on the burden of disease.

The 2016 AIHW study (AIHW, 2016 and Webster 2016) including the infographics reproduced above reported on key findings on the burden of disease due to physical and sexual violence, as well as emotional abuse, by intimate partners which include that:

- **Intimate partner violence** contributes an estimated **2.2%** to the **burden of disease** for all **women aged 18+ years**, making it the 7th largest risk factor contributing to the burden of disease.

- **Intimate partner violence** contributes an estimated **6.4%** to the **burden of disease** for all **Indigenous women aged 18+ years**, making it the 3rd largest risk factor contributing to the burden of disease.

- **Intimate partner violence** contributes an estimated **5.1%** to the **burden of disease** for **women aged 18-44 years**, which is more than any other risk factor. This is greater than other well-known health risk factors such as alcohol use, tobacco use and obesity. It is particularly important to note that this impact is not isolated to women as these are women’s key reproductive and child-bearing years and the numerous Adverse Childhood Experiences studies (see for example Anda et al., 2008; Brown et al., 2010; Burke Harris, 2018; Dong, Dube, Felitti, Giles, & Anda, 2003; and Dube et al., 2009) demonstrate the substantial negative impact of toxic stress (as caused by partner violence) in pregnancy and adverse childhood experiences on both physical and mental health across the lifecourse.

- **Intimate partner violence** contributes an estimated **10.9%** to the **burden of disease** for
Indigenous women aged 18-44 years, which is more than any other risk factor.
- Childhood sexual abuse contributes 1.2% to the burden of disease for women aged 18-44 years, making it the 8th highest risk factor.

These findings are demonstrated in the tables and content below reproduced from *A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women: Key findings and future directions* (Webster, 2016, pp.18-20).

**Figure 4** Estimated contribution of physical and sexual intimate partner violence and emotional abuse to the total disease burden in Australian women (2011)

Note: Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016

**Figure 5** Comparing the burden of intimate partner violence(a) with the burden of other risk factors in women 18+ years: top eight risk factors (2011)

Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016.
The largest proportion of the intimate partner violence burden in women was due to mental health conditions, with depressive disorders and anxiety disorders estimated to account for around 70% of the burden as illustrated below.

Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships.
(b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016.

The largest proportion of the intimate partner violence burden in women was due to mental health conditions, with depressive disorders and anxiety disorders estimated to account for around 70% of the burden as illustrated below.
Figure 12 Estimated contribution of physical and sexual intimate partner violence to the total disease burden in Indigenous women (2011)

Note: Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016.

Figure 13 Top eight risk factors contributing to the burden in Indigenous women 18+ (2011)

Notes: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016.

Figure 14 Top eight risk factors contributing to the burden in Indigenous women 18-44 years (2011)

Notes: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016.
2.8.4 Acquired brain injury and family violence

Domestic and family violence is a significant, and often overlooked or misidentified, cause of acquired brain injury (Royal Commission into Family Violence, 2016). Brain injury, including traumatic brain injury (TBI) due to an external force applied to the head, can result in physical, cognitive and behavioural disability, with long-term consequences.

Physical disabilities caused by TBIs include paralysis, chronic pain, seizures; vision, hearing and speech impairment; and cognitive disabilities such as fatigue, problems with memory and concentration, difficulty making decisions, thinking through consequences and responding to environmental change. Long-term impacts can include early onset dementia, movement disorders, psychiatric disorders, and motor neuron disease (Brain Injury Australia, 2018).

Following recommendations made by the Victorian Royal Commission into Family Violence, Brain Injury Australia, as part of a consortium with Monash University, Domestic Violence Victoria, No to Violence, the Men’s Referral Service and the Centre for Excellence in Child and Family Welfare, were funded by the Victorian Government to undertake the first evidence-based study of acquired brain injury and family violence in Australia.

Brain Injury Australia’s (2018) research identified significant gaps in service responses, ranging from lack of screening for brain injury through to inadequate opportunities for effective rehabilitation, recovery and support, and emphasises the role of the health sector in improving identification, referral and response to victims and perpetrators with acquired brain injury. Injury exacerbates the impacts and avoidable costs of family violence for families and for the wider community, and death, permanent disability or temporary disability result in lost opportunities for economic and social participation, independence and quality of life.

For adult and child victims, and perpetrators, brain injury hampers their capacity for change, recovery and future wellbeing. For the community, the costs of policing, hospitalisation and rehabilitation, the increased need for supports, such as income, housing, education and parenting, and lost productivity and increased disability are all higher when brain injury is associated with family violence.

The infographics below were produced as part of the research project led by Brain Injury Australia (2018). As well as further data analysis, the complete report includes evidence from a systematic literature review and interviews undertaken with practitioners working with victims and perpetrators of family violence, and can be downloaded from https://www.braininjuryaustralia.org.au/download-bias-report-on-australias-first-research-into-family-violence-and-brain-injury/

While likely a significant under-estimation of the prevalence of acquired brain injury among victim-survivors and perpetrators of domestic and family violence in Australia, due to the sample being limited to cases that presented to Victorian hospitals, Brain Injury Australia’s (2018) study indicates an important and often overlooked area of potential intervention in health and other agencies efforts to prevent violence and reduce its impacts:
Of 16,296 people presenting at Victorian hospitals between July 2006 and June 2016 for family violence reasons, brain injuries were sustained by:

- **57%** of major trauma cases
- **54%** of hospital admissions
- **32%** of emergency department presentations

14% of major trauma cases with a serious brain injury died during their hospital stay, compared to 2.9% of cases without serious brain injury. New cases of permanent disability related to brain injury will be added each year as a result of family violence-related admissions to Victorian hospitals. Among family violence-related emergency department presentations who identified as Aboriginal or Torres Strait Islander, 42% sustained a brain injury.

Infographics: Brain Injury Australia, 2018
2.9 Economic impacts of violence, abuse and neglect

The economic costs of all forms of violence, abuse and neglect on the Australian community and Australian economy are substantial. Similar to burden of disease studies, however, there is no Australian research that analyses the economic costs of all forms of this violence. Nevertheless, there are useful separate studies of the costs of violence against women (physical and sexual violence, emotional abuse and stalking) and child abuse and neglect which demonstrate the substantial costs of these forms of violence alone.

2.9.1 The economic costs of violence against women and their children
In 2016 KPMG produced a report on behalf of the Australian Government under the National Plan to Reduce Violence against Women and their Children 2010-2022 titled The cost of violence against women and their children in Australia (KPMG, 2016).

Based on data from the 2012 Personal Safety Survey (PSS), KPMG estimated that the total cost of violence against women and their children is $22 billion in 2015-16. However, Aboriginal and Torres Strait Islander women, pregnant women, women with disability, and women experiencing homelessness are underrepresented in the PSS. Taking these groups fully into account KPMG estimated may add $4 billion to these costs in 2015-16. Key findings and data tables from the report are reproduced below.

This year alone over 1 million women have or will experience violence, emotional abuse and stalking.

The cost of violence against women and their children in Australia is $22 billion in 2015-16.

Victims and survivors bear $11.3 billion, or 52 per cent, of the total costs.

The Australian Government, state and territory governments bear $4.1 billion or 19 per cent of the total costs.

The community, children of women experiencing violence, the perpetrators, employers, and friends and family bear $6.5 billion, or 29 per cent, of the total costs.

Underrepresentation of Aboriginal and Torres Strait Islander women, pregnant women, women with disability, and women who are homeless within national prevalence estimates may add a further $4 billion to the cost of violence against women and their children in Australia in 2015-16.
The cost of physical and sexual violence is estimated at $12 billion

The cost of emotional abuse and stalking is estimated at $10 billion

Infographic: KPMG, 2016, p.9

Table 1 below shows the prevalence of violence against women in Australia, based on the results of the PSS and KPMG calculations provided in the Detailed Report.

Table 1: Prevalence estimates, based on the PSS 2012

<table>
<thead>
<tr>
<th>Primary categories of violence</th>
<th>Prevalence estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Assault</td>
<td>263,500</td>
</tr>
<tr>
<td>Physical Threat</td>
<td>189,900</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>87,800</td>
</tr>
<tr>
<td>Sexual Threat</td>
<td>17,600</td>
</tr>
<tr>
<td>Total (physical &amp; sexual)</td>
<td>467,300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional categories of violence</th>
<th>Prevalence estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Abuse</td>
<td>272,650</td>
</tr>
<tr>
<td>Stalking</td>
<td>237,130</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total (including all violence categories)</th>
<th>Prevalence estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,033,910</td>
</tr>
</tbody>
</table>


Infographic: KPMG, 2016, p.7

Table 6.2: Estimated costs to the Australian economy of violence against women and children, 2015–16

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain, suffering and premature mortality of victims</td>
<td>10.4 billion</td>
</tr>
<tr>
<td>The pain and suffering experienced by the victim, which can lead to long-term effects on psychological and physical health, and premature mortality for victims</td>
<td></td>
</tr>
<tr>
<td>Consumption</td>
<td>4.4 billion</td>
</tr>
<tr>
<td>Replacing damaged property, defaulting on bad debts, and the costs of moving</td>
<td></td>
</tr>
<tr>
<td>Production</td>
<td>1.9 billion</td>
</tr>
<tr>
<td>Being absent from work, and employer administrative costs (for example, employee replacement)</td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>1.7 billion</td>
</tr>
<tr>
<td>Police, incarceration, court system costs, counselling, and violence prevention programs</td>
<td></td>
</tr>
<tr>
<td>Transfer payments</td>
<td>1.6 billion</td>
</tr>
<tr>
<td>Loss of income tax of victims/survivors, perpetrators and employers; additional social welfare payments; victim compensation payments and other government services</td>
<td></td>
</tr>
<tr>
<td>Health system</td>
<td>1.4 billion</td>
</tr>
<tr>
<td>Public and private health system costs associated with treating the effects of violence against women</td>
<td></td>
</tr>
<tr>
<td>Second generation</td>
<td>333 million</td>
</tr>
<tr>
<td>The costs of children witnessing and living with violence, including child protection services and increased juvenile and adult crime</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>21.7 billion</td>
</tr>
</tbody>
</table>

Source: KPMG, 2016 AIHW 2018a, p.79
Nearly half of the costs (10.4 billion) were linked to the ongoing effects of violence on women’s physical and mental health. Depression and anxiety accounted for 60% of these health costs; substance abuse related to alcohol, tobacco and drug use accounted for 25%; and suicide 12% (KPMG 2016) (Figure 6.7). The proportion of health costs attributed to depression and anxiety are consistent with research identifying mental health conditions as the largest contributor to the burden due to physical/sexual violence by an intimate partner (Figure 6.6) (Ayre et al. 2016).
Of the further $4 billion of estimated costs of violence against women under-represented in the Personal Safety Survey this includes:

- The risk of violence is higher for pregnant women during pregnancy and in the period after childbirth. We estimate the additional cost of violence against pregnant women is approximately **$821 million**

  The 2012 PSS found that 21.7 per cent of women reported experiencing violence during pregnancy, and that for 13.3 per cent of women, the violence occurred for the first time during pregnancy. While this figure is relatively high, it represents a decrease from the 2015 rate of 16.8 per cent. These results are significant, given that the experience of domestic violence during pregnancy and childbirth heightens the vulnerability of pregnant women. In these cases, violence against women may also have critical implications on the health and safety of the pregnant mother, the unborn child, and the long-term physical and psychological health of the mother and child.

Source: [KPMG, 2016 p.14](#)
2.9.2 The economic costs of child abuse

The Cost of Child Abuse in Australia Report (Access Economics Pty Limited, Australian Childhood Foundation and Child Abuse Prevention Research Australia at Monash University, 2008) assesses the cost to the economy and society of the abuse of children and young people aged 0 to 17 years. Five main types of abuse are considered in this report; physical, emotional and psychological, sexual abuse, neglect and witness of (or knowledge of) family violence (Access Economics et al., 2008, p.ix).

The key finding of this report is that:

“The Cost of Child Abuse and Neglect Incurred by the Australian Community in 2007 In 2007, it is estimated that 177,000 children under the age of 18 were abused or neglected in Australia. This figure could be as high as 666,000 children and young people. Based on these numbers, the best estimate of the actual cost of child abuse incurred by the Australian community in 2007 was $10.7 billion, and as high as $30.1 billion”. (Access Economics et al., 2008, p.viii.)

Cost Summary

The annual cost of child abuse and neglect that occurred in 2007 was nearly $4.0 billion (with a lower bound of close to $3.5 billion and an upper bound of over $5.5 billion). In addition, the value of the burden of disease represents a further $6.7 billion (lower and upper bounds of $1.6 billion and $24.5 billion, respectively).

<table>
<thead>
<tr>
<th>Type</th>
<th>Best Estimate</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>383</td>
<td>91</td>
<td>1,400</td>
</tr>
<tr>
<td>Additional educational assistance</td>
<td>93</td>
<td>24</td>
<td>332</td>
</tr>
<tr>
<td>Productivity losses of child abuse survivors</td>
<td>20</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Children on an order and in out-of-home care only</td>
<td>5</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>All children abused or neglected</td>
<td>24</td>
<td>5</td>
<td>91</td>
</tr>
<tr>
<td>Productivity losses due to premature death</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Crime</td>
<td>756</td>
<td>750</td>
<td>774</td>
</tr>
<tr>
<td>Government expenditure on care and protection(a)</td>
<td>1,897</td>
<td>1,897</td>
<td>1,897</td>
</tr>
<tr>
<td>Deadweight losses</td>
<td>807</td>
<td>728</td>
<td>1,080</td>
</tr>
<tr>
<td>Burden of Disease DALYs</td>
<td>26,232</td>
<td>6,341</td>
<td>95,473</td>
</tr>
<tr>
<td>Net Burden of Disease ($ million)</td>
<td>6,744</td>
<td>1,632</td>
<td>24,538</td>
</tr>
<tr>
<td>Total A (excluding burden of disease)</td>
<td>3,947</td>
<td>3,497</td>
<td>5,509</td>
</tr>
<tr>
<td>Total B (excluding burden of disease)</td>
<td>3,966</td>
<td>3,501</td>
<td>5,580</td>
</tr>
</tbody>
</table>

Figures in tables rounded. (a) Care and protection programs only apply to children known to care and protection services.

Data source (reproduced from): Access Economics et al., 2008, p.xii.
Health System Expenditures

Health system cost estimates are based on data from the Australian Institute of Health and Welfare (AIHW), and consist of both expenditure data and attributable fractions for conditions shown in the literature to be associated with child abuse. The prevalence cost is $383.0 million in 2007, with lower and upper bounds of $91.0 million and $1,399.7 million, respectively.

- Of the total, hospital costs comprised over a third – $137.6 million (inpatients 26.2% and outpatients 9.7% of the total).
- Costs of pharmaceuticals were the second largest – $73.4 million (19.2%), closely followed by aged care homes – $60.8 million (15.9%).
- Depression and anxiety comprised over two thirds of the total health system costs, with a combined total of $259.3 million (67.7%) – treating depression represented half the health costs of child abuse.
- Assaults and physical injuries made up $14.7 million (3.8%) and $85.8 million (22.4%) respectively.

The lifetime (incidence) health costs range from $90.2 million (lower bound) to $437.4 million (best estimate) to $1,644 million (upper bound) for children abused for the first time in 2007. The health system costs associated with child abuse estimated in this study triangulate well with the only other Australian study and equate to $18.20 for every Australian man, woman and child in 2007.


Cost of Protection and Care Programs

The cost of care and intervention programs is estimated from data on Australian, State and Territory Government expenditure on relevant intervention programs. The focus is on expenditure on ‘remedial’ services because it is conceptually important to separate the expenditure on preventing a harm from occurring (an investment) with the cost impacts of that harm occurring (ie. the failure to prevent/protect).

State and Territory government programs include child protection and out-of-home care ($1.7 billion), intensive family support ($148 million), child protection treatment and support (unable to be costed), children’s advocacy (SA data only) and, jointly with the Australian Government, the Supported Accommodation and Assistance Program (SAAP). The component of the latter attributable to child abuse is $48 million in 2006-07. Other program spending for which the child abuse component was unable to be costed include the Crisis Accommodation Program and various Royal Commissions and Inquiries. In total approximately $1.897 billion was spent in 2007 by governments on care and intervention services — $90 per Australian in 2007 — to ameliorate the harmful impacts of child abuse and neglect. The lifetime cost for children newly involved with child protection services in 2007 is around $3.0 billion.


Burden of Disease

To those experiencing or who have suffered from child abuse and neglect, fear, mental anguish, physical pain and disability are often as (or more) important than tangible impacts on employment. Fear, mental anguish and pain are known as the burden of disease, and can be measured in disability adjusted life years (DALYs). A DALY of 0 represents a year of perfect health, while a DALY of 1 represents death.

Using attributable fractions from the AIHW for 2007, the burden of disease associated with child abuse and neglect amounted to a total of 26,232 DALYs (lower and upper bounds of 6,341 to 95,473), which is approximately 0.9% (0.2% to 3.4%) of total DALYs for the year. The majority of the burden of disease resulted from depression and anxiety, which are most prevalent through the middle years of life, although suicide was responsible for the greatest number of life years lost. These DALYs are valued at $266,843 with a lower bound of $164,553, based on meta-analysis of the value of a statistical life year (Access Economics, 2008). Netting out costs borne by the individual elsewhere to avoid double-counting, the value of the burden of disease is estimated as $6.7 billion (lower bound of $1.6 billion and an upper bound of $24.5 billion).

Over their lifetime, the burden of disease experienced by children newly abused in 2007 would be a best estimate of 29,182 DALYs, a low of 6,019 DALYs and a high of 109,708 DALYs. These equate to a lifetime (net) estimate of the value of lost health and wellbeing of approximately $7,657 million (under the best estimate), with lower and upper bounds of $1,477 million and $29,154 million, respectively.

More recent data on the economic costs of child abuse is available in the Child Family Community Australia (CFCA) Fact Sheet, *The economic costs of child abuse and neglect* (AIFS, 2018).

This paper argues that although the Productivity Commission’s Report on Government Services (Steering Committee for the Review of Government Service Provision [SCRGSP], 2018) details spending on child protection, out-of-home care (OOHC) and family support services, estimating the financial costs associated with child abuse and neglect is more difficult. They argue these costs need to consider both the costs of interventions (e.g. child abuse prevention programs; services provided by health, education and many other systems; and inquiries and reviews into child protection services across Australia) as well as longer-term costs that include reduced quality of life and the increased need for specialist services for adults who were abused as children. This includes support, treatment and interventions for issues such as: housing and homelessness problems; drug and alcohol problems; mental illness; poor physical health; and criminality.

Taking this into account the CFCA Fact Sheet (AIFS, 2018) notes that:

- “nationally, approximately $5.2 billion in 2016/17 was spent on child protection, OOHC services, intensive family support services and family support services. This includes $1.85 billion in NSW”.
- “In 2016, McCarthy and colleagues (2016) estimated the lifetime economic costs for children who were abused and neglected in 2012/13 for the first time to be $9.3 billion. Their estimate considered costs associated with child protection, health, education, criminal justice, housing and homelessness services, as well as lost productivity.”
- “Kezelman, Hossack, Stavropoulos and Burley (2015) reported that a conservative estimate of the cost to Australian taxpayers of unresolved childhood trauma is at least $6.8 billion per year for child sexual, emotional and physical abuse alone. When broader definitions of childhood trauma are taken into account, this figure increases to at least $9.1 billion (Kezelman et al., 2015)*.”
2.10 Community Attitudes

The National Community Attitudes towards Violence against Women Survey (NCAS) tells us how people understand violence against women, their attitudes towards it, what influences their attitudes, and if there has been a change over time. It also gauges attitudes to gender equality and people’s preparedness to intervene when witnessing violence or its precursors.

The key NCAS summary publication from which the information below and infographics is from is: *Are we there yet? Australians’ attitudes to violence against women and gender equality* (ANROWS, 2018a).

The key NCAS report is: *Australians’ attitudes to violence against women and gender equality. Findings from the 2017 National Community Attitudes towards Violence against Women Survey (NCAS)* (Webster, K., et al., 2018).

Methodology publications are also available on the NCAS website.

The NCAS survey collects information through telephone interviews with over 17,500 Australians 16 years of age and over. Results are analysed for:

- the Australian community as a whole;
- each state and territory;
- young people;
- Aboriginal people and Torres Strait Islanders;
- people from non-English speaking backgrounds;
- people with disabilities; and
- other relevant demographic and contextual indicators.

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7 The information in this section is reproduced from the NCAS website and the summary publication referenced above.
The Australian Government’s Department of Social Services (DSS) funds the NCAS as part of the National Plan to Reduce Violence against Women and their Children 2010-2022 (the National Plan). The 2017 NCAS is closely aligned with Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia (Change the Story) (OurWatch, VicHealth & ANROWS, 2015), which was developed to support achievement of the National Plan goals. The NCAS also complements the Australian Bureau of Statistics’ Personal Safety Survey (PSS) (ABS, 2017), which asks people about their experiences of violence.

The NCAS is the world’s longest-running survey of community attitudes towards violence against women. It was initially developed on behalf of the Australian Government in 1995, drawing on an earlier 1987 survey. The last two national surveys took place in 2009 and 2013 (led by VicHealth). Australia’s National Research Organisation for Women’s Safety (ANROWS) led the 2017 NCAS in collaboration with research partners.

The NCAS tells us:

- about people’s understanding of, and attitudes towards, violence against women;
- about their attitudes towards gender equality;
- what influences their attitudes;
- if there has been a change over time; and
- whether people are prepared to intervene when witnessing abuse or disrespect towards women.

### Overall findings

#### Encouraging results

- Most Australians have accurate knowledge of violence against women and do not endorse this violence.
- Most Australians support gender equality and are more likely to support gender equality in 2017 than they were in 2013 and 2009.
- Australians are more likely to understand that violence against women involves more than just physical violence in 2017 than they were in 2013 and 2009.
- Australians are less likely to hold attitudes supportive of violence against women in 2017 than they were in 2013 and 2009.
- There has been improvement in knowledge and attitudes related to 27 of the 36 questions asked in 2013 and again in 2017.
- There has been improvement in knowledge and attitudes related to all but two of the 11 questions asked in the 1995 NCAS and again in 2017.
- If confronted by a male friend verbally abusing his female partner, most respondents say they would be bothered (98%), would act (70%) and would feel they would have the support of all or most of their friends if they did act (69%).

#### Concerning results

- There continues to be a decline in the number of Australians who understand that men are more likely than women to perpetrate domestic violence.
- A concerning proportion of Australians believe that gender inequality is exaggerated or no longer a problem.
- Among attitudes condoning violence against women, the highest level of agreement was with the idea that women use claims of violence to gain tactical advantage in their relationships with men.
- 1 in 5 Australians would not be bothered if a male friend told a sexist joke about women.

#### Predictors

The strongest predictors of attitudes supportive of violence against women are people having a low level of support for gender equality and a low level of understanding of the behaviours constituting violence against women (relative to other respondents).^a^
Change in knowledge and attitudes over time

Responses to individual questions show that the majority of Australians have a good understanding of violence against women, support gender equality, reject attitudes supportive of violence against women, and say they would act, or would like to act, when witnessing abuse or disrespect towards women. There was an improvement between 2013 and 2017 on 27 of the 36 questions asked in both survey waves.

To measure change over time at an overall level, statistical modelling was used to account for the fact that not every question was asked in every survey wave. Using the composite measures, each respondent was given a score based on their answers to questions in the composite measures. An average for the Australian population was then calculated. Scores range from 1 to 100.

Between 2013 and 2017 there was positive change on all three composite measures:
- The average score for Australians on the measure of understanding violence against women increased from 64 to 70 (ranging from 1 to 100, with 100 indicating the highest level of understanding).
- The score for attitudinal support for gender equality increased from 64 to 66 (with 100 indicating the highest level of support for gender equality).
- On the measure of attitudinal support for violence against women, the average score fell from 36 to 33 (this is a positive result with 1 representing the lowest level of endorsement of violence-supportive attitudes).

Both men and women have improved on all three measures since 2013, however there are gender differences on the three measures. Men have a lower level of understanding of violence against women, a lower level of support for gender equality, and a higher level of attitudinal support for violence against women.

Changing attitudes and improving knowledge takes time. The current results show that Australians’ knowledge of, and attitudes towards, violence against women and gender equality are gradually improving. In spite of this progress, there remain areas of concern.

Infographic: ANROWS, 2018a
Data source: NCAS 2017 (Webster et al., 2018).
2.11.1 Knowledge

**Encouraging results: Knowledge**
- The majority of Australians have a good understanding of the problem of violence against women.
- More Australians in 2017 than in 2013 recognise most of the behaviours constituting violence against women.
- There was an 11 percentage point increase between 2013 and 2017 in the number of people who understand that denying a partner access to their money is a form of domestic violence.
- Most Australians (81%) are aware that having non-consensual sex in marriage is illegal.
- Most Australians (72%) are aware that violence against women is common and this is higher than in 2013 (68%).

**Concerning results: Knowledge**
- Although more Australians are now aware of the many different forms violence against women can take, there is still more work to do to emphasise that it can be more than physical violence.
- There has been an ongoing decline in awareness that men are more likely to commit domestic violence and that women are more likely to suffer physical harm from domestic violence (see page 7).
- 1 in 3 Australians are unaware that a woman is more likely to be sexually assaulted by someone she knows, than by a stranger16-20 (with 18% disagreeing with the question, and 16% responding that they do not know). Awareness of this fact has not improved since 2013, and is lower than in 2009 and 1995. This lack of awareness can lead to undue emphasis on preventing sexual assaults by strangers, rather than the more common problem of assault by someone known to the victim.
- Although most Australians are aware that non-consensual sex in marriage is illegal, 12% mistakenly believe that it is not illegal, and a further 7% did not know.
- 2 in 5 Australians would not know where to get outside help for a domestic violence issue.

---

**Does knowledge reflect the evidence? Who is more likely to commit domestic violence?**

**THE EVIDENCE**
- **Men** are more likely than women to perpetrate intimate partner violence, and are more likely to use frequent, prolonged and extreme violence.2,10,22
- **Men** are more likely than women to sexually assault their partner.23
- **Men** are more likely than women to subject their partner to controlling and coercive behaviours.24,25
- **Women** are more likely than men to use violence against their partner in self-defence or in response to a loss of control or dignity from ongoing violence or control by their partner.21,26-30

**WHAT AUSTRALIANS BELIEVE**
While most Australians (64%) recognise that mainly men, or men more often, commit acts of domestic violence, the percentage who recognise this has dropped 7 percentage points since the 2013 NCAS. This decline has been occurring since 1995, when 86% recognised this fact. In 2009, recognition was down to 74% and it dropped a further 3 percentage points to 71% in 2013.

---

**Does knowledge reflect the evidence? Who is more likely to suffer physical harm from domestic violence?**

**THE EVIDENCE**
- **Women** are more likely than men to suffer physical harm, including injuries requiring medical treatment, time off from work and days in bed.20,31
- **Women** are more likely than men to be the victims of domestic homicide.22-33

**WHAT AUSTRALIANS BELIEVE**
While most Australians (81%) recognise that women are more likely to suffer physical harm from domestic violence, the percentage who recognise this has dropped 5 percentage points since the 2013 NCAS. This decline has been occurring since 2009, when 89% recognised this fact. In 2013, recognition was down to 86%.

Infographic: [ANROWS, 2018a](https://www.anrows.org.au). Data source: NCAS 2017 ([Webster et al., 2018](https://www.anrows.org.au)).
2.11.2 Gender equality

**Encouraging results: Gender equality**

- Most Australians agree that both men and women can play a range of roles regardless of their gender.
- There has been a 13 percentage point decrease in the proportion of people believing men make better political leaders than women (from 27% in 2013 to 14% in 2017).
- Nearly all Australians (97%) reject the idea that it is okay for men to joke with their male friends about being violent towards women.

**Concerning results: Gender equality**

- 1 in 7 Australians do not agree that women are as capable as men in politics and in the workplace.
- Nearly one quarter of Australians see no harm in telling sexist jokes.
- 2 in 5 Australians believe many women exaggerate how unequally women are treated in Australia.
- 1 in 3 think it is natural for a man to want to appear in control of his partner in front of his male friends.

**Relative levels of support for gender equality by themes^ (means)^**

<table>
<thead>
<tr>
<th>Theme</th>
<th>All</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejecting male peer relations involving aggression &amp; disrespect towards women</td>
<td>82$^+$</td>
<td>80$^+$</td>
<td>79$^+$</td>
</tr>
<tr>
<td>Rejecting rigid gender roles, stereotypes &amp; expressions</td>
<td>76$^+$</td>
<td>76$^+$</td>
<td>75$^+$</td>
</tr>
<tr>
<td>Promoting women's independence &amp; decision-making in private life</td>
<td>79</td>
<td>79</td>
<td>74</td>
</tr>
<tr>
<td>Promoting women's independence &amp; decision-making in public life</td>
<td>69</td>
<td>69</td>
<td>64</td>
</tr>
<tr>
<td>Recognising gender inequality is a problem</td>
<td>63$^+$</td>
<td>61$^+$</td>
<td>58$^+$</td>
</tr>
</tbody>
</table>

2.11.3 Attitudes

**Encouraging results: Attitudes to violence against women**

- The majority of Australians reject attitudes supportive of violence against women.
- A small and declining proportion believe that violence can be excused because alcohol is involved.
- A small and declining proportion of Australians agree that intimate partner violence is a private, family matter.
- There is clear public support for intervention policies enabling violent partners to be removed from the home.
- Few Australians believe that women are lying about sexual violence just because they don’t report straight away.
- Few people think that women should have to deal with violence on their own.

**Concerning results: Attitudes to violence against women**

- Too many Australians are willing to excuse violence as part of a ‘normal’ gender dynamic in a relationship.
- 1 in 5 Australians believe domestic violence is a normal reaction to stress, and that sometimes a woman can make a man so angry he hits her without meaning to.
- 1 in 8 believe that if a woman is raped while she is drunk or affected by drugs she is at least partly responsible.
- 1 in 3 Australians believe that if a woman does not leave her abusive partner then she is responsible for the violence continuing.
- Nearly 1 in 5 Australians do not believe financial control is a serious problem.
- 2 in 5 Australians believe that women make up false reports of sexual assault in order to punish men.
- Many Australians hold attitudes suggesting that sexual aggression can be attributed in part to men’s ‘natural sex drive’ (i.e. 33% of Australians believe that ‘rape results from men being unable to control their need for sex’ and 28% believe that, when sexually aroused, ‘men may be unaware a woman does not want to have sex’).

**Top 6 predictors of attitudinal support for violence**

1. Understanding of violence against women (UVAWS)
2. Prejudiced attitudes (PAC)
3. Attitudes to violence in general (GVC)
4. Age
5. Education
6. Attitudes to gender equality (GEAS)

**Influence of gender equality themes in predicting attitudinal support for violence**

- Denying gender inequality is a problem: 40%
- Promoting rigid gender roles, stereotypes and expressions: 21%
- Undermining women’s independence and decision-making in public life: 14%
- Undermining women’s independence and decision-making in private life: 13%
- Condoning male peer relations involving aggression and disrespect towards women: 11%

Relative endorsement of attitudes supportive of violence against women by themes* (means)†

- **Mistrusting women’s reports of violence**
  - Women: 38
  - Men: 35
  - All: 33

- **Disregarding the need to gain consent**
  - Women: 26
  - Men: 26
  - All: 26

- **Minimising violence against women**
  - Women: 28
  - Men: 28
  - All: 28

- **Excusing the perpetrator & holding women responsible**
  - Women: 22
  - Men: 25
  - All: 25

### Key findings

- Among the four themes, Australians are most likely to support the idea that women’s claims of violence cannot be trusted.
- Attitudes disregarding the need to gain consent in sexual relationships are the second most widely held among Australians.
- Men tend to have a higher level of support for attitudes that endorse violence against women across the four themes.

*The data used in this figure are means, not percentages. They rank the themes relative to one another, rather than showing an absolute level of attitudinal support for each theme in the population.

†All differences between men and women are statistically significant, p≤.01.

**Infographic:** ANROWS, 2018. Data source: NCAS 2017 (Webster et al., 2018).
2.11.4 NCAS social media materials

The *Australians’ attitudes to violence against women and gender equality: The 2017 National Community Attitudes towards Violence against Women Survey (NCAS) Stakeholder kit* [ANROWS, 2018b] offers an extremely useful resource of key messages from NCAS as well as the infographics, videos and images reproduced below from pages 12 -15 that are of particular value for social media.

High resolution versions of these infographics can be downloaded from the NCAS website.

**Social Media Content #NCAS**

These social media tiles can be used to promote the NCAS through your organisation’s or personal social media channels. High-resolution versions of the images and links to videos can be retrieved from ncas.anrows.org.au

<table>
<thead>
<tr>
<th>Social media resource</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two minute video of findings:</td>
<td>ncas.anrows.org.au/findings/</td>
</tr>
<tr>
<td>30 second video of findings:</td>
<td>ncas.anrows.org.au/findings/</td>
</tr>
</tbody>
</table>
Mistrusting women’s reports of violence

Recognising gender inequality is a problem

Disregarding the need to gain consent

Minimising violence against women

Condoning male peer relations involving aggression and disrespect towards women

Excusing the perpetrator and holding women responsible

Understanding of sexual violence

**THE HOW**

### 2.12 Understanding the causes of violence, abuse and neglect

The World Health Organization (WHO) promotes a public health approach to violence, abuse and neglect built on the socio-ecological model where violence is understood as “the result of the complex interplay of individual, relationship, social, cultural and environmental factors” (WHO, 2002, p.12) as illustrated in the figure below (adapted from WHO, 2002 & 2004 by the NSW Health Education Centre Against Violence (ECAV).

![Socio-ecological model for understanding violence](image)

**Data source:** Model adapted from World Health Organisation (WHO), 2002 and 2004 by ECAV

#### 2.12.1 Gender and violence, abuse and neglect

As demonstrated in the statistics detailed in the “What” section of this resource above, violence, abuse and neglect is gendered in that the majority of victims are female, the vast majority of perpetrators are male, and gendered differences in victimisation experience exist (e.g. women are more likely than men to be assaulted by a partner, girls are more likely to be assaulted in family and community contexts, and boys are more likely to be assaulted in institutions).

The gendered nature of violence, abuse and neglect does, however, extend beyond these statistics of victimisation and perpetration in two main interrelated ways. First, violence, abuse and neglect are usually not one-off incidents but occur in a broader context of gendered and other power relations at individual, community, system and societal levels. This is illustrated in the graphic below reproduced from *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia* (OurWatch, VicHealth and ANROWS, 2015, p.21) which uses an adaptation of the WHO’s socio-ecological model to explain the causes of violence against women with a particular focus on the issue of gender.
Significantly, these gendered power relations affect the relationship between both men and women and men and other men since men are also subjected to stereotypes and dominating social expectations around traditional models of masculinity (NASASV, 2015).

*Change the story* provides an explanatory model of violence which is based on this socio-ecological model and a strong evidence base identifying gender inequality as the fundamental social context underpinning violence against women. *Change the story* is based on extensive research evidence (Webster and Flood, 2015; Our Watch, ANROWS & VicHealth, 2015) which indicates there are underlying individual, community and social determinants of violence against women with the single most common determinant being inequality of power between men and women that occurs at every level of the system from individual relationships to global levels. Importantly, gender inequality does not operate in isolation and intersects with other forms of social, political and economic discrimination and disadvantage to make some women (e.g. Aboriginal women or women with a disability) and some men (e.g. men who don’t conform to rigid constructions of masculinity) particularly vulnerable to sexual assault (Our Watch, VicHealth and ANROWS, 2015; Costello, 2009). This is illustrated by the graphic below reproduced from Our Watch, VicHealth and ANROWS (2015, p.22).
Violence, abuse and neglect is also gendered in that it is not only underpinned by gender inequality but also acts to express and reinforce gendered power relations. It does this by being a “masculinising” act for the perpetrator and a “feminising” act for the victim regardless of the actual gender of the perpetrator or victim. This is particularly evident in the experience of male rape victims for whom one of the most “traumatising” effects of the rape is often feminisation or being “made to feel like a woman” (Atmore, 1999; Gillespie, 1996).

Built on this conceptual and evidence base, the explanatory model in Change the story as illustrated in the graphic below (reproduced from Our Watch, VicHealth & ANROWS, 2015, p.8), identifies gendered drivers of violence against women alongside the reinforcing factors (Our Watch, VicHealth & ANROWS, 2015) which increase the probability of violence occurring.

**Gendered drivers**

Particular expressions of gender inequality consistently predict higher rates of violence against women:

1. Condoning of violence against women
2. Men's control of decision-making and limits to women's independence in public and private life
3. Rigid gender roles and stereotyped constructions of masculinity and femininity
4. Male peer relations that emphasise aggression and disrespect towards women.

Reinforcing factors – *within the context of the gendered drivers – can increase frequency or severity of violence:*

5. Condoning of violence in general
6. Experience of, and exposure to, violence
7. Weakening of pro-social behaviour, especially harmful use of alcohol
8. Socio-economic inequality and discrimination
9. Backlash factors (increases in violence when male dominance, power or status is challenged).

Infographic: Our Watch, VicHealth & ANROWS, 2015, p.8
2.12.2 Applying the socio-ecological model to child abuse and neglect

**Societal-cultural context factors include:**
- Social attitudes to violence
- Social attitudes to women
- Social attitudes to children
- Social attitudes to corporal punishment
- Intergenerational trauma history within Aboriginal communities
- Current attitudes on motherhood and fatherhood
- Prevalence of violence
- Prevalence of domestic violence
- Society’s attitude to alcohol and other drugs

**Parental factors include:**
- History of childhood maltreatment
- Childhood history of insecure or disorganised attachment
- Ability to reflect coherently on childhood history
- Mental health issues e.g. depression, anxiety
- Parental stress
- Substance abuse
- Lack of emotionally supportive relationships
- Lack of positive cultural identity
- Attributional style of focus on control
- Reactivity to aversive stimuli
- Young age of parent
- Affect regulation
- Low self-efficacy
- Low self-esteem

**Parenting factors include:**
- Beliefs about discipline and parenting
- Parenting style
- Unplanned pregnancy
- Step parent role

**Child factors include:**
- Age
- Prematurity
- Low birth weight
- Perinatal problems
- Temperament
- Disability
- Poor physical health
- Behaviour

**Community, Tribe, Village factors include:**
- Limited social support networks
- Limited practical assistance from others
- Social fabric of neighbourhood
- Presence and accessibility of illicit drugs
- Social disorganisation
- Poverty

**Relationship, Peers Family, Clan factors include:**
- Dynamics, roles and family systems
- Patterns of communication
- Intergenerational patterns of trauma
- Size of family
- Changing structures
- Limited support from extended family
- Impoverished communities
- Transcience

Infographic: Costello & Backhouse, 2019a, adapted from NSW Health 2019a.
2.13 Prevention and Response

The public health approach promoted by the World Health Organisation (WHO) argues violence is a problem that is preventable, and its impact reduced similarly to other public health concerns (e.g. infectious diseases). The public health approach includes: being evidence-based; emphasising collective action, collaboration and integration across many sectors and disciplines; and focusing on prevention, both of violence occurring or re-occurring and preventing further harm from violence that has occurred (WHO, 2002 & 2004). The public health model conceptualises prevention as illustrated in the figure below (developed from WHO, 2002, p.15).

Figure: Public health approach to prevention

Another representation of these same concepts of the public health approach to violence is provided in *Change the Story*.

Based on this model and the understandings of violence identified above, *Change the Story* proposes the following approaches to prevent violence against women and their children in the figures below. A detailed discussion of these approaches is provided in the *Change the Story* publications and the accompanying resources on the OurWatch website.

**Essential actions to address the gendered drivers of violence against women**

1. Challenge condoning of violence against women
2. Promote women’s independence and decision-making in public life and relationships
3. Foster positive personal identities and challenge gender stereotypes and roles
4. Strengthen positive, equal and respectful relations between and among women and men, girls and boys
5. Promote and normalise gender equality in public and private life.

**Supporting actions to address the reinforcing factors**

6. Challenge the normalisation of violence as an expression of masculinity or male dominance
7. Prevent exposure to violence and support those affected to reduce its consequences
8. Address the intersections between social norms relating to alcohol and gender
9. Reduce backlash by engaging men and boys in gender equality, building relationship skills and social connections
10. Promote broader social equality and address structural discrimination and disadvantage.

**Lower probability of violence against women**

Infographic: *Our Watch, VicHealth & ANROWS, 2015*, p.15

Infographic: *Our Watch, VicHealth & ANROWS, 2015*, p.9
Violence against women is preventable if we all work together.

Gendered drivers of violence against women:
- Condoning of violence against women
- Men’s control of decision-making and limits on women’s independence
- Stereotyped constructions of masculinity and femininity
- Disrespect towards women and male peers

Gender inequality sets the necessary social context.

657 domestic violence matters are dealt with by the Australian police.

Every week one woman is murdered by her current or former partner.

Actions that will prevent violence against women:

- Challenge condoning of violence against women
- Promote women’s independence and decision-making
- Challenge gender stereotypes and roles
- Strengthen positive, equal and respectful relationships

Mutually reinforcing actions are needed through legislation, institutional, policy and program responses:
- By governments, organisations and individuals
- In settings where people live, work, learn and socialise
- Tailored to the context and needs of different groups.

This approach in *The First One Thousand Days* (Moore et al., 2017) is consistent with the public health informed approach taken in the 70/30 Campaign, outlined in Section 2.8.2 on Adverse Childhood Experiences as illustrated through this infographic from the campaign.

Infographic: Centre for Community and Child Health, The Children’s Hospital, Melbourne.

Similar to Change the Story, *The First One Thousand Days* (Moore et al., 2017) promotes a public health approach in the separate, but related, field of child health and wellbeing and herein recognises the social determinants of health with particular attention to exposure to child abuse and neglect and domestic and family violence including in utero. The authors propose the following model for prevention and response.

This is too late.
In seeking to prevent violence, abuse and neglect it is important to recognise that this is a multi-generational complex social change endeavour that requires sustained effort and monitoring of progress as detailed in the accompanying publication to Counting on change: A guide to prevention monitoring (OurWatch & ANROWS, 2017) and as illustrated in the diagrams below.

**Infographics:** Our Watch & ANROWS, 2017

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**MEDIUM TERM**
6–50 years

**LONG TERM**
10+ years
Indicators and data sources

*Counting on change* sets out a total of 5 long-term indicators, 33 medium-term indicators, and 43 suggested measures for prevention infrastructure and programs. Select examples of indicators and suggested measures identified in the Guide are outlined below. For a full list of the proposed indicators and suggested measures, please visit the Our Watch website www.ourwatch.org.au for a copy of *Counting on change*.

**PREVALENCE OF VIOLENCE AGAINST WOMEN (5 INDICATORS IN TOTAL)**

**INDICATOR:** Proportion of women subjected to physical, sexual or psychological violence, by a current or former intimate partner in the last 12 months.  
**SOURCE:** Personal Safety Survey.

**INDICATOR:** Proportion of women subjected to sexual violence, by persons partner other than an intimate partner in their lifetime.  
**SOURCE:** Personal Safety Survey.

**DRivers of violence against women (23 indicators in total)**

**INDICATOR:** Community attitudes towards violence against women.  
**SOURCE:** National Community Attitudes Survey (NCAS).

**INDICATOR:** Proportion of time women spend in unpaid care work compared to men.  
**SOURCE:** Household Income and Labour Dynamics Australia.

**REINFORCING FACTORS OF VIOLENCE AGAINST WOMEN (10 INDICATORS IN TOTAL)**

**INDICATOR:** Percentage of women who experienced violence reporting that children heard or saw the violence.  
**SOURCE:** Personal Safety Survey.

**INDICATOR:** Percentage of population who express denial of continued gender inequality and hostility towards women.  
**SOURCE:** National Community Attitudes Survey (NCAS).

**Prevention infrastructure and programs (43 suggested measures)**

**POSSIBLE MEASURE:** An increasing number of university/TAFE courses include preservice qualification standards and competencies on prevention.

**POSSIBLE MEASURE:** Governments (federal, state/territory, and local) have a dedicated policy for primary prevention, aligned with *Change the story*.

Infographics: *Our Watch & ANROWS, 2017*
2.14 NSW Health responses to violence, abuse and neglect

The complexity of the prevalence, health impacts, causes, and responses to violence, abuse and neglect, and by association children and young people with problematic or harmful sexual behaviour, necessitates a whole of health system response. Women, men, children and young people may enter the NSW Health system with health issues that are either a direct or indirect consequence of violence, abuse and neglect. A history of violence, abuse and neglect is, however, usually not disclosed when presenting to a generalist health service. While presentations directly to Violence, Abuse and Neglect (VAN) services (e.g. Child Protection Counselling Services) make the obvious link between experiences of violence, abuse and neglect and an individual’s health, there are significantly more health service presentations for these issues that are less straightforward. In many circumstances, the person would not have made the connection between their experiences of violence, abuse and neglect and the health complication they are seeking treatment for.

A public health approach to preventing and responding to interpersonal violence is consistent with the World Health Organisation (WHO)’s identification of the vital role that health services must play as part of a multi-sectoral response. The health sector plays a crucial role in efforts to prevent, respond to, and minimise the impacts of violence, abuse and neglect (WHO, 2013; Garcia-Moreno et al., 2015). The provision of high-quality care and support services to victims of violence contribute to “reducing trauma, helping victims heal and preventing repeat victimisation and perpetration” (WHO, 2014, p.8). Further, high quality interventions with children and young people displaying problematic or engaging in harmful sexual behaviour maximise safety and reduce the risk of harm to that child/young person and others and minimise longer-term health and social impacts.

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).
The response of the health sector must also reflect the public health model’s understanding of both the causes and the health impacts of the violence by responding at all levels from early intervention to supporting recovery as illustrated in the diagram below:

Responding to violence, abuse and neglect across the lifespan (from conception through to death), as well as to children and young people displaying or engaging in problematic or harmful sexual behaviour, is the responsibility of the whole Health system. Nevertheless, the NSW Health services listed in the table below (from NSW Health, 2019b) have particularly important roles and responsibilities in the prevention, identification and response to these issues. These current Health service responses are divided into the following categories based loosely on the public health approach:

**NSW Health responses to violence, abuse and neglect**

- **Violence, Abuse and Neglect (VAN) services**: have principal responsibility for responding to violence, abuse and neglect as well as children and young people displaying or engaging in problematic or harmful sexual behaviours AND undertaking a range of prevention, community education, professional development, systems advocacy and capacity building concerning violence, abuse and neglect.

- **Other health services**:
  - **Secondary / targeted responses** - provide treatment and services to people and families who have experienced, or are at heightened risk of experiencing or perpetrating, violence, abuse and neglect even though this is not identified as their principal or core responsibility.

- **Primary / universal responses** - provide universal services, interventions and initiatives aimed at the general population or specific groups in the population which help to reduce vulnerability or risk.
1. **VAN services**: which have a principal responsibility for responding to violence, abuse and neglect and children and young people displaying problematic or engaging in harmful sexual behaviours (i.e. this is their key focus or activity).

2. **Other health services** consisting of:
   - secondary responses - which provide treatment and services to people and families who have experienced, or are at heightened risk of experiencing or perpetrating, violence, abuse and neglect even though this is not identified as their key responsibility or core business; and
   - primary responses - which provide universal services, interventions and initiatives aimed at the general population or specific groups in the population which help to reduce vulnerability or risk.

<table>
<thead>
<tr>
<th>VAN services</th>
<th>Secondary responses</th>
<th>Primary responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aboriginal Family Wellbeing and Violence Prevention Program (AFWVP)</td>
<td>• Aboriginal Health Services</td>
<td>• Aboriginal Maternal and Infant Health Service (AMIHS)</td>
</tr>
<tr>
<td>• Child Protection Counselling Services (CPCS)</td>
<td>• Adult Mental Health Services</td>
<td>• Bilingual Community Education Program</td>
</tr>
<tr>
<td>• Child Protection Units / Teams (CPUs)</td>
<td>• Alcohol and Other Drug Services</td>
<td>• Building Strong Foundations for Aboriginal Children, Families and Communities (BSF)</td>
</tr>
<tr>
<td>• Child Wellbeing Units (CWUs)</td>
<td>• Aged care services</td>
<td>• Child and Family Health Services</td>
</tr>
<tr>
<td>• Domestic Violence Services</td>
<td>• Child and Adolescent Mental Health Service (CAMHSS)</td>
<td>• Community Health Centres</td>
</tr>
<tr>
<td>• Education Centre Against Violence (ECAV)</td>
<td>• Domestic Violence Routine Screening (DVRS)</td>
<td>• Early Childhood Health Service</td>
</tr>
<tr>
<td>• Joint Child Protection Response Program (previously the Joint Investigative Response Teams, ‘JIRTs’)</td>
<td>• Emergency Departments</td>
<td>• Maternity Services</td>
</tr>
<tr>
<td>• Responses to children under 10 displaying problematic or harmful sexual behaviours (e.g. Kaleidoscope ‘Sparks Clinic’)</td>
<td>• Family Care Centres and Residential Family Care Services</td>
<td>• “Mums and Kids Matter” (MaKM) Program</td>
</tr>
<tr>
<td>• New Street Services (for children and young people 10 to 17 years engaging in harmful sexual behaviours)</td>
<td>• Family Referral Services (FRSs)</td>
<td>• Perinatal and Infant Mental Health Service (PIMHS)</td>
</tr>
<tr>
<td>• Sexual Assault Services (SASs)</td>
<td>• Forensic Mental Health Services</td>
<td>• Pregnancy Advice Line</td>
</tr>
<tr>
<td>• Specialist Services for Children and Young People in Out-Of-Home Care (OOHC)</td>
<td>• Local Coordinated Multi-agency Offender Management (LCM)</td>
<td>• Refugee Health Service</td>
</tr>
<tr>
<td>• Whole Family Teams (WFTs)</td>
<td>• Paediatric Services</td>
<td>• Sustained Health Home Visiting</td>
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<td></td>
<td>• SAFE START (specialist perinatal support for families with complex needs)</td>
<td>• Universal Health Home Visiting (UHHV)</td>
</tr>
<tr>
<td></td>
<td>• Safety Action Meetings (SAMs)</td>
<td>• Women’s Health Centres</td>
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<tr>
<td></td>
<td>• Service for the Treatment and Rehabilitation of Torture and Trauma Services</td>
<td>• Youth Health Services</td>
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<tr>
<td></td>
<td>• Social Workers: Community and Hospital</td>
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<tr>
<td></td>
<td>• Sustaining NSW Families</td>
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<tr>
<td></td>
<td>• Youth Alcohol and Other Drug Services</td>
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<tr>
<td></td>
<td>• Youth Mental Health Services</td>
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</tbody>
</table>

A public health model emphasises collaboration and integration as core elements of effective interventions. No single service or service system has the capacity or expertise to respond to the needs of every client. Many clients engage with a range of services across their lifetime and navigating the service system itself can be traumatic (Royal Commission into Institutional Response to Child Sexual Abuse, 2017b). Services and therapeutic responses that enhance healthy development, prevent
violence, and respond to the causes and impacts of abuse and neglect, are likely to be multi-systemic in nature.

NSW Health’s *Case for Change* (NSW Health, 2019b) details the key elements of effective integrated practice in the context of violence, abuse and neglect and some of the key concepts and levels identified there are illustrated in the figure below.

**Figure: key concepts and levels for effective integrated practice**

**Infographic: Costello & Backhouse, 2019a.**

**Data source: NSW Health, 2019b.**
Common benefits of integrated and collaborative prevention and response to violence, abuse and neglect identified through the literature include:

- improved health outcomes for victims and survivors;
- reduction in secondary (systems-created) trauma, in part through coordinated and transparent information sharing arrangements;
- better meeting immediate and long-term needs through a continuum of post-crisis care;
- improved access to services through robust referral pathways and service agreements; increased accountability for perpetrators and offenders; and
- cost effectiveness and service efficiency through minimising duplication (Breckenridge et al., 2015; WHO, 2013).
The 3 ‘M’s – common myths, mistakes and misinformation
3 The 3 ‘M’s – common myths, mistakes and misinformation

This section addresses common myths, mistakes and misinformation (the 3 ‘M’s) about violence, abuse and neglect. For each of the 3 ‘M’s, tools to support effective communication of key messages from the statistics and research are provided, including: infographics, a brief discussion from the research about where the 3 ‘M’s have come from, and tips and strategies to dispel them. The infographics provide an evidence-based counter narrative to the common myth, mistake or misinformation. They are designed as tools to support health system education and advocacy, and to inform policy, service design and delivery, research and evaluation.

Inaccurate and misleading representations of research and statistics from both widely validated and more contested data sources are sometimes used, often unintentionally, by health promotion advocates, researchers, political representatives and the media. Accurate and contextualised use of statistics is critical to the effective implementation of public health approaches to the prevention of and response to violence, abuse and neglect, and to supporting health workers and other services responding to this violence to provide evidence-based assessment and management of clients’ needs.

Sometimes, however, misuse of statistics and decontextualising of evidence are intentional, and a form of active resistance to social change (Malbon et al., 2018). One of the most common examples of this, is when the claim that “one in three victims of domestic violence are men” is made, citing ABS PSS statistics on incidents of violence by a partner in the last 12 months. This claim is not correct, not only because it uses the wrong type of data, as prevalence data (since the age of 15) should be used when making general claims like this about experiences in a population, but also because it confuses definitions of “violence by a partner” with “domestic violence”.

Terminology on ‘violence by a partner’ and ‘domestic violence’ is often used interchangeably by mistake. However, the effect is to undermine and misrepresent evidence of the gendered nature of domestic and family violence, including minimising the statistics and research that show that women’s experiences of violence by a partner are different to men’s, and are much more like common understandings of domestic violence than for men, involving ongoing patterns of behaviour aimed at exercising power and control through fear (COAG, 2011; ABS, 2017)

RESISTING BACKLASH
“Men are afraid that women will laugh at them. Women are afraid that men will kill them”
Margaret Atwood (n.d.).

Resistance or “backlash” is an often predictable and perhaps inevitable accompaniment to social change (Faludi, 1991; Flood et al., 2018; Salter, 2016; VicHealth, 2018). The terms ‘backlash’ and ‘resistance’ are sometimes used interchangeably, however for people working to promote gender equality or to prevent and provide support for the impacts of gendered forms of violence, backlash is often used to describe more extreme or aggressive resistance (VicHealth, 2018).

Resistance is most likely to come from people that are advantaged by the status quo and can range from passive blocking techniques that seek to maintain the status quo, to strategies that aim to minimise or co-opt change efforts, to active, aggressive undermining and opposition (VicHealth, 2018). This means that men are more likely than women to resist gender equality initiatives. However, resistance can also come from women and other unexpected sources.

Research demonstrating that resistance stems from a “defence of privilege”, the idea that people who are advantaged will “lose out” if they give equal rights and opportunities to other people who have fewer advantages, is useful for understanding why some women resist progressive policies, programs and perspectives that support gender and sexual equality (Flood et al., 2018; VicHealth, 2018, p.6). That is to say, that gender is not the only dimension of privilege, and some women may perceive benefits to resisting the social progression of other women if greater equality is seen as a threat to their social position and other advantages.

While it is common for health promotion programs, gender equality initiatives and efforts to address other social injustices to be met with resistance, the forms resistance takes is context-specific (Flood et al., 2018). For example, since the 1970s, organisations and other groups in Australia and internationally concerned with a perceived threat to “men’s rights”, have often claimed that the gains made towards gender equality, and the role of women and feminists in advancing social change, have caused harm to men and undermined their rights (Salter, 2016; Malbon et al., 2018). In this discourse, a moral argument is made using the language of human rights promotion to suggest that men need “protecting” from the impacts of reforms that have, over the past 40 years, contributed to more equitable outcomes for women in policy and legislation regarding for example, parenting arrangements, child support payments and domestic violence protections (Salter, 2016).

More recently, there has been a shift in language used by proponents of “men’s rights”, away from discourses of rights and a focus on legal recourse, towards vocabulary of health and health promotion that tends to exaggerate or emphasise that men have unmet needs that require increased community attention and government investment (Salter, 2016). Salter (2016) argues that the language of public health approaches to improving outcomes for clients and the broader population, which seek to address the social determinants of health such as the gendered drivers of violence against women (see Section 2.11), is increasingly being mobilised to frame gender and sexual equality as a negative ‘social determinant’ responsible for men’s poor health outcomes.

Identifying backlash approaches in statistics and evidence

Recognising that resistance and backlash to efforts to address violence and inequality are to be expected, and learning how to identify it, is a useful first step to being prepared for and responding to resistance (VicHealth, 2018). Common tactics that are used to manipulate findings from data and research regarding the extent, characteristics and impacts of violence, abuse and neglect, include:
• Appropriation of infographic and communications styles (e.g. co-option of public health promotion strategies for representing general population statistics through misleading headlines with unrelated or inaccurate statistics below).

• Misleading and false comparisons of proportional data on violence and health. For example, the claim that ‘1 in 3 victims of violence by a partner are men’ (which has its population all victims) is often presented alongside the statistic ‘1 in 3 women are victims of violence by a partner’ (which has as its population all women) to invoke similarity in prevalence rates of relationship violence for men and women. It is very important to be clear on the different populations that are being considered when any comparative claim about men’s and women’s experiences is made.

• Decontextualising the evidence (e.g. making claims about ‘domestic violence’ based on data that only tell us about experiences of ‘violence by a partner’).

• Minimising gender inequality and its impacts, by focussing on individual incident data rather than prevalence data that tell us that the experiences and drivers of violence, abuse and neglect for men and women are different.

• Use of percentages only, without including the actual number of people in the population being considered. This is a particularly important omission when making claims about the differences in men’s and women’s experiences. For example, ‘1 in 3 victims are men’ and ‘1 in 3 women are victims’ might sound comparable, even in the more limited 12-month data, the total number of men (75,500) in the Australian population who are victims of violence by a partner is still significantly lower than the total number of women (155,900) who are victims.

• Diverting attention away from the evidence on violence, by introducing data and statistics on issues such as men’s mental health or suicide to suggest causal relationships and interactions for which there is no reliable evidence.

Encountering resistance: strategies to effectively respond to backlash

VicHealth’s (2018) resource [(En)coutering resistance: strategies to respond to resistance to gender equality initiatives](#), suggests the use of four kinds of strategies to manage resistance:

1. **Framing strategies** that pay attention to the ways in which gender equality initiatives are articulated and explained.

2. **Organisational strategies** that offer guidance on how to involve leaders to address policies, practices and structures.

3. **Teaching and learning strategies** that cultivate a supportive climate for change and lessen the likelihood of resistance.

4. **Individual strategies** that encourage individuals working towards gender equality to practice self-care and address the abuse and domination techniques they may experience in their work.
VicHealth’s (2018) ‘Forms of resistance’

The images below describe eight forms of resistance identified by VicHealth (2018): denial, disavowal, inaction, appeasement, appropriation, co-option, repression and backlash. Resistance ranges from passive denial to more active and aggressive backlash:

**DENIAL**

“There’s no problem here.”

Denial of the problem or the credibility of the case for change. Blame the victims.

**DISAVOWAL**

“It’s not my job to do something about it.”

Refusal to recognise responsibility.

**INACTION**

“It’s not a priority right now.”

Refusal to implement a change initiative.

**APPEASEMENT**

“Yes. Yes. We must do something (one day).”

Efforts to placate or pacify those advocating for change in order to limit its impact.

**APPROPRIATION**

“Of course we’d appoint more women, if only they were more experienced.”

Simulating change while covertly undermining it.

**CO-OPTION**

“What about men’s rights? Men are victims too, you know.”

Using the language of progressive frameworks and goals for reactionary ends.

**REPRESSION**

“We tried that once and women didn’t want to take up the promotion/training/opportunity.”

Reversing or dismantling a change initiative.

**BACKLASH**

“These feminists deserve all the abuse they get.”

Aggressive, attacking response.

Infographics: VicHealth, 2018
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3.1. Myth: Domestic and family violence isn’t a big issue

**Myth: Domestic and family violence isn’t a big issue**

Many people across Australia experience domestic and family violence. The *impacts* of this violence are *serious and long-lasting*. The *health and financial costs* to individuals, communities and governments are *significant and preventable*.

1 in 6 people (16% or 2.9 million) have experienced violence by an intimate partner since the age of 15**

On average, *one woman is killed every week* by an intimate partner²

**This is more than any other risk factor, including alcohol, tobacco use and obesity³**

This includes:

1 in 4 WOMEN (23% or 2.2 million) & 1 in 13 MEN (7.8% or 703,000)¹

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

$22 billion

This includes $1.4 billion to the HEALTH SYSTEM⁴


**TIPS**

- Despite its limitations, the ABS Personal Safety Survey is the most comprehensive quantitative study and source of data on interpersonal violence in Australia. In 2016-17, over 21,000 people completed the survey in face-to-face interviews in their homes.

- To dispel this myth in a defensible way, provide statistics for all victims (both for men and women together, and separately), and use this to note that domestic violence is a particularly big issue for women.

- **Definition reminder** – Partner (current or previous) is defined as a person the respondent lives with, or lived with at some point, in a married or defacto relationship. **Intimate partner** is a broader category, defined as a current or previous partner with whom the respondent has lived, or current or previous boyfriend, girlfriend or date with whom the respondent did not live with (ABS, 2017).

- **Definition reminder** – Violence is defined as an incident of physical or sexual violence (assault or threat) (ABS, 2017). Domestic violence, is instead usually defined as patterns of behaviours intended to control and create fear. The ABS PSS provides some limited information on characteristics of violence by a partner that are included in common definitions of domestic violence, such as on experiences of anxiety and fear.
Domestic and family violence is a serious issue, affecting many people internationally. The social, economic and health costs of intimate partner violence to governments, communities and individuals is significant, and this violence is preventable. These impacts of abuse can be reduced by identifying and responding to violence after it has occurred. There is also increasing evidence that violence against women can be prevented before it starts (Webster et al., 2018).

Intimate partner violence is the most pervasive form of violence experienced by women in Australia and women are most at risk of violence in their homes by a man they know. Men also experience violence by their partners, however they are far more likely to experience violence by a man in a place of entertainment, such as a pub (ABS, 2017).

Despite the gendered nature of domestic and family violence, which is overwhelmingly perpetrated by men against women, when people say that ‘domestic and family violence is not a big issue’, it is usually underpinned by ideological assumptions and attitudes about gender roles and gender equality (Webster et al., 2018). For example, Change the story (Our Watch et al., 2015) provides evidence that particular expressions of gender inequality consistently predict higher rates of violence against women:

- Condoning of violence against women.
- Men’s control of decision-making and limits to women’s independence in public and private life.
- Rigid gender roles and stereotyped constructions of masculinity and femininity.
- Male peer relations that emphasis aggression and disrespect towards women.

Therefore, in dispelling this myth, it is important to emphasise that domestic and family violence can be prevented by addressing the socio-ecological drivers of this violence and identifying opportunities for early intervention to prevent future harm and reduce the impacts of violence that has occurred (Our Watch et al., 2015; WHO, 2002).

Providing evidence of the gendered drivers and reinforcing factors that create the social conditions for domestic and family violence to occur can also be useful as a response to denial that is caused by a sense of overwhelm at the extent of the problem. This can be helpful because the gendered drivers make clear that preventing and responding to domestic and family violence requires whole-of-community and whole-of-government collaboration and commitment, and that while individuals play a role, it is through collective action that domestic and family violence can be reduced.

A useful strategy to effectively frame a response to the myth that domestic and family violence is not a big issue and one that is used throughout this resource generally, is to narrate a story of violence that starts with the ‘big picture’, and progressively becomes more specific. For example:

1. Domestic and family violence is prevalent across Australia.
2. Domestic and family violence has serious impacts in the immediate and long-term.
3. The violence women experience by their partners is more frequent and more severe.
4. Domestic and family violence can be prevented, and its impacts reduced by identifying factors that lead to this violence in the first place (e.g. gender inequality) and opportunities for early intervention.

The statistics provided in the infographic above are included to support this approach.
3.2. Myth: Children aren’t affected by domestic and family violence

Myth: Children aren’t affected by domestic and family violence

Children often experience abuse in contexts of domestic violence, as direct victims and through exposure to adult violence by a partner. Abuse of children is also a tactic used by men to exert power and control in their violence against women.

Before the age of 15 years:

1 in 9 AUSTRALIANS witnessed physical assault towards their mother by a partner  

1 in 22 AUSTRALIANS witnessed physical assault towards their father by a partner

In NSW between 2012-13 and 2016-17:

1 in 4 CHILDREN reported to child protection services as at risk of significant harm (ROSH), were experiencing or exposed to domestic and family violence

17% 1 in 4 VICTIMS of domestic violence homicide

1 in 4 CHILDREN were children killed by a relative or kin, in NSW between 2000-2014


TIPS

• Statistics from the ABS Personal Safety Survey are likely an under-representation of the extent of child abuse, particularly as the survey: relies on adult recall of abuse experienced before the age of 15; only collects information on perpetrators aged 18 years and over (so does not capture abuse perpetrated by other children or young people); and does not collect data on emotional abuse or neglect.

• The evidence of severe short and long-term impacts of exposure to domestic and family violence on children demonstrate that children are victims and survivors in their own right, not just ‘bystanders’ to adult violence.

• It is important to be cautious of victim and mother-blaming language and use of statistics that wrongly suggest that children are exposed to domestic and family violence because of a “maternal failure to protect”.

Other research and discussion

Historically, responses to children experiencing domestic and family violence have been fragmented, disconnected, and underpinned by the different philosophical approaches of child protection, health, specialist family violence and family law professionals. There is increasing recognition that children directly experience domestic and family violence in their own right, not just as ‘bystanders’ witnessing adult violence, and that targeted, multi-disciplinary and integrated approaches are required to respond to the “linked but separate” health, safety and wellbeing needs of women and children (Fitzgibbon et al., 2018).

Exposure to domestic and family violence, including witnessing, has serious consequences for children’s physical, emotional and psychological safety in the immediate and longer-term. Behavioural and learning difficulties, depression, anxiety and other mental illness is common in children living with domestic and family violence (Campo, 2015) and an Australian study found that of 5,007 children under 15 years who attended Victorian hospitals between 2006-2016 in family violence related cases, 25% (1,252) of these children sustained a brain injury (Brain Injury Australia, 2018).

Studies examining the impact of childhood adversity on longer-term outcomes, show that experiences of adverse and traumatic events in childhood, including family violence, physical and sexual abuse, and neglect, can significantly increase risk of a range of serious health conditions and chronic illnesses in adulthood, including autoimmune diseases, cancer, diabetes, heart disease, mental illness and psychiatric disorders (Burke Harris, 2018; Dube et al., 2009; Green et al., 2010).

There are also strong links between experiences of abuse as a child and domestic violence victimisation as an adult. The 2016 PSS found that 1 in 3 women (553,800) and 1 in 6 men (152,000) who experienced abuse before the age of 15, also experienced violence by a partner as an adult (ABS, 2017).

Many women also experience violence while pregnant. Nearly half (48% or 325,900) of women who had experienced violence by an ex-partner and who were pregnant during that relationship, experienced physical and/or sexual violence while pregnant (ABS, 2017). Violence perpetrated by men against intimate partners during this time can be a significant indicator of escalating or severe harm to both the woman and child. Humphreys (2007) describes this violence as “double intentioned”, where perpetrators may aim physical violence at the partner’s abdomen, genitals or breasts.

Importantly, fear of child removal continues to influence the decisions women make about disclosing and seeking help for domestic and family violence. This is particularly acute for Aboriginal women (SNAICC et al. 2017). There is also evidence that immigrant and refugee women, including women on temporary visas, tend to seek help only after years of enduring abuse, and are prompted by escalating frequency and severity and fears for the impact on their children (Segrave, 2017; Vaughan et al., 2016).

It is important when communicating statistics and research on the risks and safety of children and families, to challenge discourses of “maternal failure to protect”, in which women are blamed for children’s exposure to domestic violence, often leading to an over-emphasis on separation from the violent partner as the goal of interventions, particularly in child protection cases (Laing et al. 2018, p. 6; Robinson et al. 2016). This is significant given the evidence that women are most at risk of being killed in the 3 months after a relationship has ended, and routine recognition by specialist service providers that relationship separation and parenting and family law proceedings, indicate high risk of severe violence against women by their male partners, as well as increased risk of harm to children (NSW DVDRT, 2017).
3.3. Mistake: One in three women are victims of domestic violence

**Mistake: 1 in 3 women are victims of domestic violence**

This statistic* refers to the proportion of Australian women who have experienced at least one incident of physical violence by any type of perpetrator (not just partners), since the age of 15.

In contrast:

- **1 in 6 WOMEN** (17% or 1.6 million) experienced violence by a partner since the age of 15
- **1 in 16 MEN** (6.1% or 547,600) experienced violence by a partner since the age of 15

When boyfriends, girlfriends and dates are included, these numbers increase:

- **1 in 4 WOMEN** (23% or 2.2 million) experienced violence by an intimate partner since the age of 15
- **1 in 13 MEN** (7.8% or 703,000) experienced violence by an intimate partner since the age of 15


**TIPS**

- **Definition reminder** – Partner (current or previous) is defined as a person the respondent lives with, or lived with at some point, in a married or de facto relationship. Intimate partner is a broader category, defined as a current or previous partner with whom the respondent has lived, or current or previous boyfriend, girlfriend or date with whom the respondent did not live with.

- The PSS is not a measure of ‘domestic violence’ and does not adequately record certain characteristics of domestic violence including:
  - multiple experiences of different types of violence;
  - coercion and intimidation used to maintain power and control without resorting to violence; and
  - some forms of domestic violence such as spiritual abuse, and some types of emotional abuse.
Other research and discussion

The claim that ‘one in three women are victims of domestic violence’ is commonly stated using statistics from the ABS Personal Safety Survey. This is not accurate. It is, however, accurate to say that since the age of 15, one in three Australian women have experienced:

- at least one incident of physical violence by any type of perpetrator, male or female (33.3% or 2.9 million) (i.e. not necessarily a partner) (ABS, 2017);
- violence [physical and/or sexual violence] by a known perpetrator, male or female (37% or 3.4 million) [ABS, 2017]; or
- violence [physical and/or sexual] by a known male perpetrator (31.1% or 2.9 million) (ABS, 2017).

The claim that ‘one in three women are victims of domestic violence’, citing PSS data, is incorrect because the PSS does not collect information on domestic violence, which is commonly understood by the community and by professionals, and supported through research, as characterised by patterns of coercive and controlling behaviours and fear. Instead, the PSS collects data on incidents of violence by a partner. In this context, the PSS finds that, since the age of 15:

- 1 in 6 (17% or 1.6 million) Australian women have experienced violence by a partner they have lived with in a marriage or de facto relationship.

When a broader range of intimate partner relationships are considered and boyfriends, girlfriends and dates the respondent has not lived with are included, the numbers increase:

- 1 in 4 (23% or 2.2 million) Australian women have experienced violence by an intimate partner.

There is one instance in which the statement ‘1 in 3 women are victims of intimate partner violence’ (i.e., still not ‘domestic violence’), could be said to be accurate. When experiences of emotional abuse in cohabiting relationships were included in the estimation of prevalence rates for intimate partner violence (which includes cohabiting and non-cohabiting current and former partners, and typically only refers to physical and/or sexual violence), it can be said based on the 2012 PSS data, that:

- 1 in 3 (32.7%) Australian women have experienced physical and/or sexual violence by an intimate partner (cohabiting partner and/or boyfriend, girlfriend, date), and/or emotional abuse by a cohabiting partner (the PSS does not collect data on experiences of emotional abuse for non-cohabiting intimate partners) (Webster, 2016).

Despite its limitations, the PSS is the most robust data source in Australia that provides population-level data on the extent of violence in relationships. Although the claim ‘one in three women are victims of domestic violence’ is not accurate when using PSS data, it is clear that the extent of violence against women by their intimate partners is significant. Even the more limited measure of partner violence, which is the closest approximation of the prevalence of domestic violence in Australia, indicates that 1.6 million women have experienced violence by a partner they lived with since the age of 15 (ABS, 2017). Further, the PSS does collect some information on the characteristics of partner violence, such as experiences of fear and anxiety and patterns of non-disclosure that suggests that women’s experiences of partner violence are generally more like domestic violence than men’s.
3.4. Misinformation: One in three victims of domestic violence are men

Misinformation: 1 in 3 victims of domestic violence are men

This claim confuses the definition of domestic violence with violence by a partner and uses data from the last 12 months.

General claims about victimisation should use lifetime prevalence data, which shows that 1 in 4 victims of violence by a partner, are men.¹

In comparison:

- **1 in 6 WOMEN** (17% or 1.6 million) experienced violence by a partner since the age of 15
- **1 in 16 MEN** (6.1% or 547,600) experienced violence by a partner since the age of 15

**12 month data** can be useful for service planning and monitoring. Noting that these statistics represent the proportion of total victims and not total Australians, it is true that:

- **2 in 3 AUSTRALIAN VICTIMS** (1.7% or 155,900) of violence by a partner in the past 12 months are women
- **1 in 3 AUSTRALIAN VICTIMS** (0.8% or 75,500) of violence by a partner in the past 12 months are men

¹ That is, men make up about 500k (or 1%) of the just over 2M people who experienced violence by a partner.

**TIPS**

- When making general claims about the extent of violence by an intimate partner and violence by a partner, it is best to use lifetime prevalence data (i.e., since the age of 15).
- Identify the ‘1 in 3’ statistic (in the infographic) for men’s experiences that is correct, and explain why this provides an inadequate picture of the extent of violence in the general population.
- A similar claim people make and to be cautious of, sometimes citing crime victimisation data including from the PSS, is that ‘domestic violence happens just as much to men as women’.
- **Definition reminder** – Partner (current or previous) is defined as a person the respondent lives with, or lived with at some point, in a married or defacto relationship. Intimate partner is a broader category, defined as a current or previous partner with whom the respondent has lived, or current or previous boyfriend, girlfriend or date with whom the respondent did not live with (ABS, 2017).
- **Definition reminder** – Violence is defined as an incident of physical or sexual violence (assault or threat) (ABS, 2017). Domestic violence, is instead defined as patterns of behaviours intended to control and create fear. The ABS PSS provides some limited information on characteristics of violence by a partner that are included in common definitions of domestic violence, such as on experiences of anxiety and fear.
Other research and discussion

It is common to hear the claim, citing Personal Safety Survey data, that “1 in 3 victims of domestic violence are men”. This statistic tends to be used to misrepresent the proportion or of victims of partner violence in the Australian community that are men.

When using PSS data, this claim relies on a misleading measure of domestic violence as a single incident of physical or sexual violence in a 12-month period (ABS, 2017).

This statistic is the namesake of ‘One in Three’, an Australian group that has been widely criticised for its approach to advocating for male victims, which tends to focus on 12-month data to make misleading claims about the prevalence and nature of violence experienced by the general population (Costello, 2015). Data from 12 months prior to the survey is valuable for service planning as it gives a closer indication of the likely presentation to services in any given period. However, it provides a limited picture of the scope of violence and its impacts in Australia.

Prevalence data (since the age of 15) is the best data to use to understand the extent of violence as it provides lifetime prevalence (i.e. the overall number of people in a population who have experienced violence in their lives). Lifetime prevalence data is of particular use to inform policy, research, service planning and public health programs to respond to and reduce the impacts of violence (Costello, 2015).

As with other claims about domestic violence that rely on data from the PSS, it is important to remember that the PSS does not measure domestic violence. Instead, the PSS classifies a person as experiencing partner violence if, since the age of 15, they have experienced at least one incident of physical or sexual violence by a partner, which is not consistent with definitions of domestic violence that include sustained patterns of behaviours (ABS, 2017). So, although the ‘partner violence’ cohort will include people who have experienced coercive control, it will also include people whose experience of violence is more sporadic and incidental (Cox, 2016).

It is important to be clear on the population that is being considered. In the case of the statement ‘1 in 3 victims are men’, the population is all victims in Australia. This is important as this myth is often used carelessly to infer ‘1 in 3 Australian men are victims’ (i.e. the population is all men). The first statement is correct (from 12-month data), while the second is not. It refers to the 547,600 men who experienced partner violence since the age of 15, where the statement would be “1 in 16 Australian men have experienced at least one incident of violence by a cohabiting partner”.

Correct statistics from the PSS relating to men’s experiences of violence and the proportion of victims of violence by a partner in the Australian community who are men include:

- **1 in 3 Australians who had experienced at least one incident of physical or sexual violence by a partner in the one year preceding the survey, were men.** This is 0.8% or 75,500 Australian men (ABS, 2017). In comparison, 155,900 or 1.7% of Australian women experienced physical or sexual violence by a partner in the 12 months preceding the survey. This means that while some men are victims, two-times as many women as men experienced partner violence in the last 12 months (ABS, 2017).

- **1 in 4 Australians who have experienced at least one incident of physical or sexual violence by a partner since the age of 15, are men.** This is 25% or 547,600 of victims of violence by partner. In comparison, 75% (3 in 4 or 1.6 million) victims of partner violence, are women (ABS, 2017).
3.5. Misinformation: Women and men are equally violent in intimate relationships (‘gender symmetry’)

**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:*

- 75% of VICTIMS (75% or 2.1 million) were women who experienced violence from a male perpetrator.
- 3 in 4 VICTIMS (75% or 488) of intimate partner homicides in Australia between 2002-2012 were women killed by men.

*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:**

- Coercion and control
- Anxiety and fear
- Sexual violence by an Intimate partner
- Homelessness
- Hospitalisation
- Interruptions to employment
- Restraining order against perpetrator
- Police charging perpetrator

Infographic: Costello & Backhouse, 2019a.


**TIPS**

- Check the methodological validity, framing assumptions and limitations of the data source.
- The Conflict Tactics Scale (CTS) is most commonly used to make this claim, and its validity is widely critiqued.
- Consider what contextual information on the nature, severity and impacts of violence is not provided.
- Statistics and research do not ‘speak for themselves’ and it is important to understand why and for what purpose false claims of ‘gender symmetry’ are used, and to use accurate statistics and evidence in context.
- What definitions of violence are used?

**Other research and discussion**

The claim that women and men are equally violent in relationships is made by proponents of “gender symmetry”, who argue that focussing on gender inequality as a driver of domestic violence is
misplaced, and that policy and practice responses should focus on individualised interventions rather than on those that aim to address broader social determinants of health (Malbon et al., 2018).

People who make this claim almost exclusively rely on studies using the Conflict Tactics Scale (CTS). The CTS is an instrument developed by sociologist Murray Straus in the 1970s, and later revised as the CTS-2, which measures the extent to which intimate partners engage in physical and psychological attacks on one another to deal with conflict (Straus et al. 1996; DeKeseredy and Schwartz 1998; Bender 2016). Typically, an 18-question survey is administered to men and women in intact heterosexual relationships and asks about incidents of certain violent behaviours that occurred in response to conflict or in an argument (DeKeseredy and Schwartz 1998; Malbon et al., 2018).

Identifying the framing assumptions that underpin data and research is important as “theories of what causes intimate partner violence affect the policies implemented to address them, and thus affect social outcomes” (Malbon et al., 2018, p. 6). The CTS is based on conflict theory, which sees conflict as an inevitable part of relationships and violence as a tactic used to deal with conflict (Straus et al., 1996). However, commonly accepted theories of domestic violence demonstrate that relationship violence is rarely experienced as a single incident, is not caused by conflict, and involves patterns of coercive behaviours intended to exert power and control over victims (Kimmel, 2002 in Costello, 2015).

Despite this, the CTS has been used in many studies examining partner violence and this research repeatedly finds that violence in relationships is ‘sexually symmetrical’, that is, that men and women perpetrate and experience partner violence at roughly similar rates (Bender 2016). These results are surprising given that service, administrative and prevalence data consistently tell us that intimate partner violence is a gendered phenomenon, overwhelmingly perpetrated by men against women.

Because data from the CTS is most commonly used to resist efforts to recognise and address gender-based violence, an effective strategy to respond to and dispel ‘gender symmetry’ is to outline the critiques of the conceptual assumptions and methods of the identified in the literature (Flood et al., 2018). Limitations of the CTS include:

- The framing assumption of the CTS is that physical violence is a one-off result of an argument, difference or ‘conflict’ rather than a pattern of a range of behaviours intended to assert power or control, which is likely to lead to under-reporting of violence that is more like domestic violence (Kimmel, 2002).
- Limitation of interviewing current partners only, which is a significant omission given the evidence that many women experience violence by their ex-partners, which is often more severe. Most women are killed in NSW within 3 months of separating from their partner (NSW DFVDRT, 2017).
- The exclusion of certain types of commonly recognised abusive behaviours such as economic abuse, sexual assault, stalking, and isolation of victims (Malbon et al., 2018). The CTS-2 and other adaptations of the survey have sought to address these omissions in part, including new scales to measure severity, sexual coercion and physical injury (Straus et. al., 1996). However, the underlying ideological assumption of violence in relationships being only in response to conflict remains (DeKeseredy & Schwartz, 1998).
- Studies using the CTS most often asks about incidents of violence experienced in the previous 12 months only, which when used inappropriately to describe the nature of domestic violence, both excludes evidence of the systematic patterns of abuse many women over periods of time, or reduces enduring abuse to a single, decontextualised, incident (Kimmel, 2002; Bender, 2016).
3.6. Myth: Women who have used violence cannot be victims of violence

Myth: Women who have used violence cannot be victims of violence

The motivations for men’s and women’s violence are often different. Promoting victims’ safety when responding to an incident requires considering intent and identifying the predominant aggressor – the person who poses the most serious, ongoing threat.

Women tend to use violence expressively, such as in anger or frustration to a situation or in self-defense

Men’s violence against their intimate partners tends to be used instrumentally, through patterns of coercive and controlling behaviours intended to create fear and compliance.

Most intimate partner homicides in Australia involve patterns of abuse perpetrated by men against a female partner before the homicide, no matter which partner is killed.

For example:

1 in 4 female domestic violence homicide offenders* (25% OR 7)

were protected under a Domestic Violence Order against the male homicide victim.

TIPS

• The key assumption underpinning this myth is that women who experience violence receive it passively. There is substantial evidence that women use violence expressively against their partners, in retaliation to violence or in self-defence, while men are more likely to use violence instrumentally, with coercive and controlling intent. These qualitative differences are important contextual information to help accurately frame statistics on men’s and women’s use of, and motivation to use, violence in relationships (Kimmel, 2002).

Other research and discussion

The claim that ‘women have used violence cannot be victims of violence’ is often made to misrepresent the reasons why women use violence against their partners in relationships and to minimise women’s resistance to violence and use of protective strategies. This claim is often underpinned by an assumption that all domestic or relationship violence is ‘uni-directional’ violence, in which coercive and controlling behaviours are used to unilaterally dominate a person and induce fear and compliance in them without the person victimised responding or resisting in any way.
Theories of domestic violence as unilateral reinforce the myth that women who experience violence must be passive and not engage in violent acts to qualify as victims and minimises the ‘violent resistance’ that many women and other victims use to protect themselves and others from injury (Costello, 2015; Family Court of Australia, 2016). These theories also usually ignore the agency of victims more generally by discounting the many active strategies of resistance, protection of themselves and others (including children), and other responses to violence from the vast majority of victims.

Further research shows that there are substantial qualitative differences between men’s and women’s violence. Men are more likely to use violence instrumentally to dominate, control, injure and instil fear in their partner and this violence often escalates if their partner uses violence in self-defence or they experience some other loss of control of their partner such as through separation (this is a key reason why prevalence data that includes violence perpetrated by both previous and current partners provides the most accurate estimation of domestic violence). In this way, men’s violence against their female partners reflects common definitions of domestic violence (Costello, 2015; Malbon et al., 2018).

In contrast, women are more likely to use violence expressively as a reflection of their dependence on their male partner and in response to frustration, stress or in self-defence (Kimmel, 2002). Johnson (1995; 2006 in Swan et al., 2008) contend that coercive control is the key factor that differentiates relationship types in which violence occurs. In relationships that are characterised by patterns of coercive and severe violence, sometimes referred to as ‘intimate terrorism’, most victims are women and the perpetrators are almost always men (Johnson, 2006 in Swan et al., 2008).

In contrast, ‘situational couple violence’ – typically an incident of conflict – seems equally likely to be initiated by men and women (Johnson, 1995 in Swan et al., 2008). Recognising the differential motivations of violence for men and women as identified in the evidence, is critical to designing and delivering services that are appropriate for, and meet the safety and wellbeing needs, of all victims. In particular, there is evidence that the failure of police to identify the ‘predominant aggressor’ when attending domestic and family violence incidents, has led to victims being wrongly charged with violence related offences and inappropriately having protection orders taken out against them (NSW Ombudsman, 2009 in ALRC, 2010).

Predominant aggressor policies, require services to consider that violence has different meanings in different contexts, and to look beyond the single incident of violence that may present. A similar framework can be applied to communicate the evidence that women are not passive recipients of partner violence and that women’s violence often occurs in the context of men’s violence against them (Swan et al., 2008; the Network, 2018). Factors to consider include:

- whether there is a history of violence perpetrated by one party against the other;
- the nature of the injuries sustained by both parties;
- the likelihood of violence in the future, and
- whether one person was acting in self-defence (Wangmann, 2009 in ALRC, 2010).

As health workers with women who have experienced domestic and family violence, we must also actively explore the various ways women may have resisted this violence including being open to this resistance potentially including violence by the victim towards the perpetrator (including pre-emptive violence used to manage a partner’s violence and help keep themselves or their children safe).
3.7. Myth: Men are not victims of sexual assault

**TIPS**

- Provide statistics for both men and women separately, to demonstrate that while men are victims, most victims of sexual assault are women and girls.
- Emphasise the gendered differences in characteristics of sexual assault for men and women, and that this means that just like women, male victims may require specific support services.
- The statistic from the 2016 PSS that ‘women are 8-times more likely than men to experience sexual violence by a partner’, is useful to demonstrate the differences in severity of sexual violence experienced by men and women.

**Other research and discussion**

Sometimes this claim is made based on common misconceptions about sexual assault, including gender stereotypes relating to masculinity, violence and sexuality that suggest that men are not sexually assaulted because they are men. Men do experience sexual assault. One in 23 (4.3% or 384,000) men have been sexually assaulted since the age of 15, although this is lower than the rates of women (1 in 6 or 1.6 million) (ABS, 2017).
All violence is wrong, and all victims deserve an appropriate and proportionate response. However, men’s and women’s experiences of sexual assault are different and therefore their therapeutic and safety needs will be different too. Providing contextual information on the different characteristics of sexual assault perpetrated against men and women by providing statistics for both men and women separately, can be an effective strategy to dispel this myth. Doing so acknowledges that some men are victims too, but that the violence men and women experience have distinct dynamics and drivers, requiring targeted and specific responses and prevention strategies (Costello, 2015; Flood, 2012 in Flood et al., 2018). Section 2.3 provides detailed statistics and analysis on the gendered nature of sexual assault and sexual abuse. The following statistics are provided as examples.

The overwhelming majority of perpetrators of sexual assault are men. Women were much more likely to experience sexual assault by a male perpetrator than a female perpetrator, whereas men were almost as likely to experience sexual assault by a male perpetrator as a female perpetrator. Since the age of 15:

- **1 in 6 women** (16.5% or 1.5 million) and **1 in 52 men** (1.9% or 173,300) experienced sexual assault by a **male perpetrator**.
- **1 in 140 women** (0.7% or 67,000) and **1 in 39 men** (2.5% or 228,900) experienced sexual assault by a **female perpetrator** (ABS, 2017).

Men were also more likely to have experienced sexual violence by a male stranger (1% or 89,000) than a female stranger (less than 1% or 40,800) (ABS, 2017). Both men and women are more likely to be sexually assaulted by someone known to them than a stranger. However, women are eight times more likely to experience sexual violence by a partner than men and half (51%) of victims of sexual assault are assaulted by an intimate partner, including current and ex-partners, boyfriends and dates (ABS, 2017). Further research shows that sexual assault that occurs in contexts of domestic violence:

- Is a uniquely dangerous form of exerting power and control. Campbell et al., (2003) found that physically abuse women who also experienced forced sexual activity or rape, were 7-times more likely than other abused women to be killed.
- More so that other forms of violence, sexual assault that is perpetrated by partners is under-reported by victims. Shame and stigma caused by commonly held assumptions that discussing sex or sexual assault in relationships is ‘taboo’ are a significant barrier to seeking help (Wall, 2012 in Backhouse & Toivonen, 2018).

Because the number of men who experience sexual assault is much less than women, there is limited, and less reliable, information on the characteristics of perpetrators who sexually assault men (ABS, 2017). However, we know that women’s experiences of sexual assault and domestic violence are not separate, and that men who are sexually assaulted are less likely to be assaulted by an intimate partner than women.

Further, we also know that sexual assault is gendered in terms of the way it is underpinned by gender inequality and acts to express and reinforce gendered power relations. It does this by being a masculinising act for the perpetrator and a feminising act for the victim regardless of the actual gender of the perpetrator or victim. This is particularly evident in the experience of male rape victims for whom one of the most traumatising effects of the rape is often feminisation or being “made to feel like a woman” (Atmore, 1999; Gillespie, 1996).

Accurate representation of the gendered nature and impacts of sexual assault is useful to inform appropriate policy and practice that responds to the health and wellbeing needs of all victims and survivors, no matter what their gender or sexuality.
3.8. Misinformation: Men are excluded from domestic and family violence and sexual assault services

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

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**TIPS**

- Recognise the need to address and enhance access and equity for a whole range of population groups that may not be accessing health services in the numbers we would expect.

- Dispelling this myth by providing a picture of the different prevalence, nature, impacts and, therefore, health and welfare service needs of women and men in response to violence can be an effective strategy.

- Acknowledge that all violence is wrong and that, in general, men experience the most violence in Australia (physical assault by any type of perpetrator), but also highlight that women experience by far the most partner and sexual violence and the impact, severity and consequences of these types of violence on women demonstrate the need for some specialist services.

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Other research and discussion

It is sometimes claimed that while men account for a substantial proportion of victims of domestic, family and sexual violence, they are excluded from domestic and family violence and sexual assault services. While robust data on services that victims and perpetrators receive is limited, the available evidence indicates that a high volume of responses to domestic and family violence and sexual assault are provided by mainstream whole-of-population services including hospitals and other health services and by welfare, child protection, police and justice agencies (AIHW, 2018a).

There is consensus across the research that mainstream services are, and should be, gender-neutral, however there is also strong evidence indicating significant demand for specialist services that prioritise women.

For example, the majority of domestic and family violence and sexual assault is perpetrated by men against women (ABS, 2017; AIHW, 2018a). The nature and impact of violence and abuse are also different for men and women. Women are eight times more likely than men to experience sexual violence by a partner (ABS, 2017). The domestic, family and sexual violence that women experience is more severe, more frequent, and more often results in death, serious injury, and a range of other negative health and wellbeing consequences (WHO, 2012). Thus, women are likely to require specific, integrated health and support services that address the impacts of more frequent and severe domestic, family and sexual violence.

The myth that men are excluded from specialist violence services is often used to support the argument that men’s health and welfare service needs are not being met because of government and community attention on domestic violence against women (Salter, 2016). There is no evidence for this claim. Even Straus, who developed the Conflict Tactics Scale that is reputable for its lack of gender analysis, concluded:

... although women may assault their partners at approximately the same rate as men, because of the greater physical, financial, and emotional injury suffered by women, they are the predominant victims. Consequently, the first priority in services for victims and in prevention and control must continue to be directed toward assaults by husbands (Straus, 1997 cited in Kimmel, 2002, p.1348).

The differential rates and impact of domestic and family violence and sexual assault demonstrate the need for some specialist resources to be allocated and targeted towards women, even though the bulk of the health, justice and human services response to this violence are, and should be, gender-neutral.
3.9. Misinformation: Men are less likely to disclose experiences of violence than women

Misinformation: Men are less likely to disclose experiences of violence than women

All victims deserve to feel safe and receive a supportive and compassionate response.

Overall, more men than women in Australia did disclose that they had experienced violence:

37% of WOMEN (3.4 million) and 42% of MEN (3.8 million) reported experiencing violence* since the age of 15.

This includes men who disclosed their experiences of partner and sexual violence

However, the total number of women who did not seek advice or support about violence by a partner is substantially higher than men.

Women often over-estimate their use of violence and under-estimate their victimisation, while men often under-estimate their use of violence and over-estimate their victimisation

* By any type of perpetrator (not just partners).

TIPS

• Many more women experience violence by a partner in terms of numbers, and they are the much higher proportion of overall victims. Therefore, while the % of male victims that do not report is higher than for women, the number of women in the Australian community that did not seek support is much higher than the number of men.

• Both women and men were highly unlikely to contact the police concerning violence by a partner.

• Men’s lower rates of disclosure could because the violence they experience is less severe.

• Women are more likely to under-report their experiences of, and over-estimate their own, violence, and for men it is the opposite.

• The Conflict Tactics Scale (CTS) is a widely critiqued measure of domestic violence, primarily because it is used to argue ‘gender symmetry’. However, in the context of this myth about men’s willingness to disclose violence by a partner, the CTS does show that men and women are equally likely to disclose violence in their relationships, depending on how the violence is framed.

• Research indicates high rates of non-disclosure by women.
Other research and discussion

It is sometimes claimed that men are less likely to report their experiences of violence by a partner than women due to shame or stigma, and that crime victimisation surveys such as the Personal Safety Survey therefore do not provide an accurate representation of men’s experiences. It is true that a larger percentage of male victims than female victims of partner violence reported that they did not seek advice or support about the violence (ABS, 2017). Because the total number of women experiencing violence is much larger than for men, the percentage for men not seeking advice or support, or reporting partner violence, appears to indicate that less men seek help. However, overall, a much larger number of women in Australia did not seek help for violence by a partner. For example, since the age of 15, 506,800 (37%) of women and 235,300 (59%) of men who had experienced violence by a previous partner did not seek advice or support about that violence. Including the total numbers as well as the percentages assists this data to be accurately understood.

There may be other reasons than shame or stigma that some men don’t disclose their experiences of violence or seek help. For example, it may be that men’s reporting is lower because the violence they experience in their relationships is less severe or less likely to result in serious injury or other harms, or less likely to be part of an ongoing pattern of violence and abuse that characterises domestic violence. We cannot conclude from PSS data the reasons for men’s non-disclosure (Costello, 2015).

Kimmel (2002) argues that claims that men are less likely to report their experiences of violence than women are speculative and empirically groundless rather than evidence-based. Research reviewed by Kimmel (2002) suggests instead that:

- women tend to over-estimate their own use of violence and under-estimate their victimisation; whereas
- men tend to under-estimate their own use of violence and over-estimate their victimisation.

Kimmel (2002) also cites research showing men who are assaulted by intimate partners are more likely than women to call the police, to press charges and to not drop those charges. Research with male perpetrators of domestic violence has also shown that, in the initial stages of disclosure of the abuse, the man is likely to exaggerate the extent of the female partner’s violent acts against himself in an attempt to establish a self-defence argument as a means of avoiding both prosecution and shame (Miller, 2001; Scott and Straus, 2007). Such research again highlights the importance of establishing the ‘predominant aggressor’ in domestic violence police and court responses (ALRC, 2010).
4 References

The 5 key resources for this project which are available to download at:
http://www.ecav.health.nsw.gov.au/van-statistics-and-research/ include:


Costello, M. & Backhouse, C. (2019b). Avoiding the 3 ‘M’s: accurate use of violence, abuse and neglect statistics and research to avoid myths, mistakes and misinformation – A resource for NSW Health Workers. The NSW Health Education Centre Against Violence (ECAV) and Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit, Ministry of Health.

Three Fact Sheets:

1. Violence, abuse and neglect in Australia.
2. Health outcomes of, and responses to, violence, abuse and neglect.
3. Avoiding the 3 ‘M’s: Myths, mistakes and misinformation about violence, abuse and neglect.


Avoiding the 3 ‘m’s

Herman, J. L. (1997). Trauma and recovery: the aftermath of violence - from domestic abuse to political terror (Rev. ed.). New York: Basic Books.


