

The Case for Change: **integrated prevention and response to violence, abuse and neglect in NSW Health**

Acknowledgements

NSW Health recognises Aboriginal 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 Elders past, present and emerging. We value Aboriginal history, culture and knowledge and the many ways it enriches the life of our nation and communities.

The strength and resilience of women, men, children, families and communities who have experienced violence, abuse and neglect underpins and drives this work. We acknowledge the lived experiences of all victims and survivors, and hope that this resource contributes to our collective vision for all communities and families to be healthy, safe and free from violence, abuse and neglect.

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Executive Summary

Project background

NSW Health is committed to strengthening its response to clients who have experienced violence, abuse and neglect, and has invested \$10 million per annum from 2017/18 to improve the capacity of services to meet the needs of victims and survivors of child abuse and neglect, sexual assault, and domestic and family violence.

As part of this funding enhancement, the Ministry of Health, in partnership with Local Health Districts (LHDs), Specialty Health Networks (SHNs) and NSW Health Pillars has undertaken a state-wide Violence, Abuse and Neglect (VAN) Service Redesign and Planning Project (the Project), to produce the NSW Health *Integrated Prevention and Response to Violence, Abuse and Neglect Framework* (the Framework).

The Framework and supporting resources provide guidance on the enhancement, development and implementation of system redesign and integrated service responses to violence, abuse and neglect by NSW Health and partner agencies that aim to promote:

- increased service accessibility and an integrated patient journey;
- holistic, collaborative care and enhanced service integration;
- equitable and comprehensive responses across NSW, particularly addressing context-specific needs for vulnerable clients and families;
- increased staff confidence and capacity in responding to victims of interpersonal violence; and
- increased capacity for LHDs and SHNs to meet NSW Health VAN service standards, policies and role delineation and the expectation of partner agencies.

Purpose of resource

The Case for Change: integrated prevention and response to violence abuse and neglect in NSW Health (the *Case for Change*) provides a summary of key findings from the research and clinical literature that underpins the Framework.

The *Case for Change* is a companion resource to the Framework, supporting its development and implementation by the Ministry of Health, the districts, Speciality Health Networks (SHNs) and NSW Health Pillars.

It presents a discussion of the evidence driving integrated prevention and response to violence, abuse and neglect in NSW, and aims to support NSW Health and partner organisations to “champion” integrated care initiatives through a shared understanding of the nature and impacts of clients’ experiences of violence, abuse and neglect.

The literature scan included in this resource considers Australian and international peer reviewed literature, “grey” literature including government reports and inquiries, meta-evaluations and promising practice frameworks for integrated care, clinical literature and practice-based research.

This resource is divided into the following sections:

- **Section 1:** outlines the Project background, objectives and policy context
- **Section 2:** provides an overview of research on violence, abuse and neglect
- **Section 3:** presents the ‘case for change’ – why integrated public health approaches are critical to preventing and reducing the impacts of violence, abuse and neglect
- **Section 4:** describes key benefits, principles and enablers of integrated responses to violence, abuse and neglect as identified in the literature.

What do we mean by violence, abuse and neglect?

“Violence, abuse and neglect” is used by NSW Health as an umbrella term to describe three primary types of interpersonal violence that are widespread in NSW and across Australia:

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

Increasingly, children and young people displaying or engaging in problematic or harmful sexual behaviours, often with their own experiences as victims of abuse and neglect, are presenting to NSW Health services, and the term violence, abuse and neglect also refers to the behaviours and experiences of these children and young people.

NSW Health provides a range of specialist VAN services that respond to these forms of interpersonal abuse, including the Sexual Assault Services, Child Protection Counselling Services, New Street Services, and Domestic Violence Routine Screening Program. Many other health services and partner agencies also provide care and support to clients who have experienced violence, abuse and neglect.

Key findings from the evidence-base

There are key concepts identified through the literature scan that underpin the Framework. Developing a shared understanding of these issues is an important component of designing, implementing, or building on integrated prevention and response to violence, abuse and neglect.

Violence, abuse and neglect in Australia

Violence, abuse and neglect is experienced by many people around the world. In Australia, one in five women and one in twenty men have experienced sexual violence since the age of 15, and most people are sexually assaulted by someone they know (ABS, 2017). Violence often occurs in the context of relationships or family. More than two million Australian women and 700,000 Australian men have experienced violence by an intimate partner since the age of 15 (ABS, 2017). 2.5 million Australian adults experienced abuse before they were 15, and for 94% of both male and female victims, the abuse was experienced by someone known to them (ABS, 2017).

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While violence, abuse and neglect is experienced across all NSW communities, particular groups of people may be more likely to experience violence and abuse, or to be more vulnerable to its impacts, requiring targeted health and other service responses. The majority of victims and survivors of sexual assault, child abuse and neglect, and domestic and family violence are women and children (ABS, 2017; AIHW, 2018b). In addition to gender and age, other factors may contribute to increased risk of violence and abuse. These include: developmental stage, ability, pregnancy and early motherhood, cultural identity or origin, sexual orientation, older age, migration and visa status, financial situation and geographical status, as well as discrimination associated with these factors.

Co-occurrence and links between forms of violence, abuse and neglect

Research on patterns of re-victimisation and co-occurrence of different forms of abuse shows that a single incident is often the exception rather than the norm, and that people often experience multiple forms of violence and abuse, either co-occurring, or over a lifetime (Laing, 2018). For example, sexual assault often occurs in contexts of domestic violence, and people who have been sexually abused as children, are often also victims of sexual violence as adults (ABS, 2017; Campbell et al., 2003; Cox, 2015; Walker et al., 2017).

There are significant detrimental effects on health for any type of abuse (sexual, physical, psychological and emotional). However, the health and wellbeing consequences of experiencing different types of abuse are cumulative and may be incrementally worse for victims who have experienced multiple episodes or forms of abuse (Golding, 1999; Laing, 2018; Taft, 2003; WHO, 2002).

Violence, abuse and neglect has serious health impacts

Sexual assault, child abuse and neglect and domestic and family violence have serious impacts on people's physical, psychological, emotional and sexual health, contributing to a range of negative health consequences in the immediate and longer-term. These include:

- physical injury
- poor mental health
- difficulties during pregnancy and birth
- problems with sexual and reproductive health
- alcohol and other drug misuse
- self-harm and other behaviours associated with risk.

Inconsistent and uncoordinated service responses can further compound poor health and wellbeing outcomes for individuals, families and communities, through secondary (systems-created) trauma and increasing the risk of clients' multiple and interrelated service needs not being met.

The public health approach

The World Health Organization promotes a public health approach to violence built on the socio-ecological model of health that recognises violence and abuse as the “result of the complex interplay of individual, relationship, social, cultural and environmental factors” (WHO, 2002, p.12).

Through its focus on addressing the social and environmental drivers of health, the public health model provides a framework for understanding violence as preventable and its impact reduced similarly to other public health issues (e.g. infectious diseases) (WHO, 2002 & 2004). Prevention of, and tertiary responses to, violence and abuse are highly connected in this model. Prevention refers to interventions aimed at stopping violence from occurring or re-occurring, as well as to preventing further harm from violence that has already occurred.

Multi-disciplinary and integrated service initiatives are a key feature of the public health model, which emphasises collective action, evidence-based interventions, and the crucial role of the health sector in preventing poor or worsening health outcomes for victims of violence and abuse through early intervention and coordinated care (WHO, 2012; Garcia-Moreno et al., 2015).

Trauma-informed and person-centred care

A trauma-informed approach and person-centred care are critical concepts that underpin integrated prevention and response to violence, abuse and neglect, at practice, service, and systems levels. Clients often have complex needs requiring multiple interventions by a range of services (Breckenridge et al., 2015). Internationally and in Australia, interagency and service partnership models are increasingly being implemented to support healing and recovery of the ‘whole person’ and to promote ongoing health and wellbeing (Desmond, 2011; Taylor & Green, 2014).

Based on the findings of the Project, including the literature reviewed in this resource:

Integrated service responses to violence, abuse and neglect are defined as the provision of service responses in accordance with a *person-centred approach* that provides *seamless care* across multiple services, adopts a *multidisciplinary and trauma-informed approach*, and is designed around the *holistic needs* of the individual *throughout the life course*. The degree to which service responses are integrated can be conceptualised as a *continuum*, ranging from service autonomy to full service integration. This continuum of service responses manifests at a *system, service and practice level*.

A trauma-informed approach and person-centred care are critical concepts that underpin integrated prevention and response to violence, abuse and neglect, at practice, service, and systems levels.

Integration requires collaboration and leadership at multiple levels

Service integration operates at multiple levels, including systems, organisational and practice levels. The degree to which responses to violence, abuse and neglect are integrated can be conceptualised along a continuum, ranging from individual service autonomy to highly coordinated multi-disciplinary provision of care, for example through co-location of services (Brown and Keast, 2003; Public Safety Canada, 2012).

The extent and capacity for integration is context-specific, and understanding integration as a continuum reflects that a 'one size fits all' approach to prevention and response to violence, abuse and neglect will not work. However, there are key features of successful health and broader social service integration initiatives identified through research and evaluation. These include:

- Active leadership and robust governance structures
- Shared goals and objectives between services
- Development of common frameworks and practice tools
- Formal information sharing and client consent protocols
- "Champions" of collaboration and integration in senior management
- Flexible and specific allocation of resources to respond to emerging priorities
- Maintaining up-to-date evidence-based policies and procedures that underpin service delivery, and identifying gaps in the knowledge-base that require further research.

Benefits of integrated prevention and response

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, 2017). 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.

Common benefits to 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
- Cost effectiveness and service efficiency through minimising duplication (Breckenridge, 2016; Humphreys & Healey, 2013; Polaschek, 2016; WHO, 2013).

1. Introduction

A note on terminology

'Violence, abuse and neglect' (VAN) is used by NSW Health as an umbrella term for three primary types of interpersonal violence that are widespread in Australia's communities:

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

Increasingly, children and young people who have engaged in harmful sexual behaviour towards others are presenting to NSW Health Services. This group often also have personal experiences as victims of abuse and neglect.

In this resource, 'VAN' is used to describe the specialist NSW Health services that respond to these forms of interpersonal violence, including the Sexual Assault Services (SAs), Child Protection Counselling Services (CPCSs), New Street Services, and Domestic Violence Routine Screening (DVRS).

'Violence, abuse and neglect' (VAN) is an umbrella term used to describe three primary types of interpersonal violence that are widespread in Australia's communities: all forms of child abuse and neglect, domestic and family violence, and sexual assault.

While each of these forms of violence and abuse has unique characteristics and impacts that require specific treatment and other service responses, there is also increasing recognition of the significant connection and overlap in the experiences of, and responses required to address these issues (Royal Commission into Family Violence, 2015; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

Victims and survivors of violence, abuse and neglect often have complex needs requiring multiple interventions provided by a range of services (World Health Organisation [WHO], 2002). Many clients of the public health system have experienced recent or historic sexual assault, domestic and family violence, and/or child abuse and neglect. Increasingly, children and young people engaged in harmful sexual behaviour are also presenting to health services, many of whom have complex needs and trauma backgrounds, have experienced abuse and neglect themselves, and are at increased risk of further abuse (El-Murr, 2017; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

The serious consequences and adverse impacts of violence, abuse and neglect on the health and wellbeing of victims and their families in both the immediate and longer term are well established. Further, the significant costs to individuals, communities and governments, particularly in relation to health, welfare and justice, of these forms of interpersonal violence are widely documented in the research and identified as a 'preventable burden' (Australian Institute of Family Studies [AIFS], 2016; KPMG, 2016; Webster, 2016, p. 2).

Research on cumulative abuse, co-occurrence and re-victimisation clearly demonstrates that victims of child abuse and neglect, domestic and family violence, and sexual assault rarely experience one type of violence or abuse in isolation of others; and a single abusive incident is often the exception rather than the norm (Cox, 2015; Laing, Hewerd-Belle, & Toivonen, 2018). Government and non-government service responses to these forms of interpersonal violence have, however, been historically siloed, fragmented and disconnected.

The negative consequences for clients' health and wellbeing of inconsistent and uncoordinated service delivery are well documented in the literature. Gaps in referral pathways, varied and unclear governance arrangements, restrictions on and reluctance to share clinical information, and differences in service models and agency philosophies have significantly affected the capacity of health systems to deliver consistently good outcomes for clients, and have increased the risk of further harm to those clients (Breckenridge et al., 2015; Laing et al., 2018).

This level of complexity in the delivery of services to this vulnerable but substantial cohort, and the numerous points in which clients enter the health system through specialist VAN services such as the Sexual Assault Services, Child Protection Counselling Services and New Street Services, as well as other primary and secondary health service responses (see Section 3.4), highlights the importance of developing an integrated, public health approach in the prevention of and response to these forms of interpersonal violence. 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 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)

Understanding these forms of interpersonal violence as a public health issue is critical to reducing the significant financial and health costs to governments and to individuals, and to preventing further harm and appropriately and proportionately responding to the health and wellbeing needs of all victims and survivors.

The Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health (the *Case for Change*) provides a summary of key findings from the research and clinical literature that underpins the NSW Health *Integrated Prevention and Response to Violence, Abuse and Neglect Framework* (the Framework).

The *Case for Change* is a companion resource to the Framework, supporting its development and implementation by the Ministry of Health, the districts, Speciality Health Networks (SHNs) and NSW Health Pillars.

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1.1. Project background

NSW Health is working to strengthen its response to victims of sexual assault, child abuse and neglect, and domestic and family violence, and has invested \$10 million per annum from 2017-18 to improve service capacity. As part of this funding enhancement, the Ministry of Health in partnership with the districts, SHNs and NSW Health Pillars is undertaking a state-wide Violence, Abuse and Neglect (VAN) Service Redesign and Planning Project (the Project) to review VAN service delivery and identify system reform and service improvement opportunities and priorities.

The Project aims to:

- identify opportunities for longer term health system reforms and improvements in VAN services across districts, Albury-Wodonga Health (AWH), and key SHNs, including Sydney Children's Hospital Network (SCHN), St Vincent's Health Network (SVHN), Justice Health, and the Forensic Mental Health Network, to achieve a comprehensive health system response to violence, abuse and neglect
- develop models of care for VAN services that improve client outcomes and promote service integration between specialist and mainstream health services and with government and non-government service partners
- improve governance and accountability, enhance service planning, and deliver more efficient and effective services.

The Project will provide a comprehensive picture of how VAN services are operating and tools to facilitate local implementation of integrated service approaches, including service profiles and analysis of LHDs and SHNs, a Self-Assessment Tool and the NSW Health *Integrated Prevention and Response to Violence, Abuse and Neglect Framework*.

The Framework and Self-Assessment Tool will support districts and SHNs to build on existing collaborative service delivery approaches and to develop innovative public health solutions to violence, abuse and neglect that promote and aim to provide:

- increased service accessibility and an integrated patient journey;
- holistic, collaborative care and enhanced service integration;
- equitable and comprehensive responses across NSW, particularly addressing context-specific needs for vulnerable clients and families;
- increased staff confidence and capacity in responding to victims of interpersonal violence; and
- increased capacity for the districts and SHNs to meet NSW Health VAN service standards, policies and role delineation and the expectation of partner agencies.

It is widely recognised that preventing and minimising the impacts of sexual assault, domestic and family violence, and child abuse and neglect requires whole of government and whole of community coordination and commitment. Interagency and collaborative partnership models for responding to the often complex and diverse needs of these vulnerable clients in integrated ways are increasingly being developed in Australia and internationally to better support healing and recovery of the 'whole person' and to promote ongoing health and wellbeing (Desmond, 2011; Taylor & Green, 2014).

This Project is part of a broader long-term vision of integrated service arrangements across the whole NSW Health system and with partner agencies, including, for example, with mental health, alcohol and other drugs, cultural healing services, and services for victims of violence and abuse with disabilities or other specialist needs.

1.2. Policy context

The Project is supported by an increasing interagency reform agenda being undertaken in NSW aimed at better supporting the needs of vulnerable children, young people and families. Recent and ongoing policy initiatives that are relevant to, and consistent with the principles underpinning the development and implementation of the VAN services redesign, include:

- NSW Premier's Priorities: 'Reducing domestic violence reoffending' and 'Protecting our kids'
- *NSW Domestic and Family Violence Blueprint for Reform 2016-2021: Safer Lives for Women, Men and Children*
- *NSW Domestic and Family Violence Prevention and Early Intervention Strategy 2017-2021*
- *NSW Sexual Assault Strategy 2018-2021*
- *Future Directions for Social Housing in NSW (2016)*
- *Royal Commission into Institutional Responses to Child Sexual Abuse (2013-2017)*
- NSW Ombudsman Inquiry into the Operation of the Joint Investigation Response Team Program
- *Their Futures Matter*. A new approach to child protection and family wellbeing
- *Aboriginal Family Wellbeing and Violence Prevention Strategy 2017-2022*
- Legislative Council's report *Unfinished business: Reparations for the Stolen Generations in New South Wales (2016)* and Stolen Generations Reparations Scheme.
- *NSW Domestic Violence Justice Strategy: Improving the NSW Criminal Justice System's Response to Domestic Violence*.

The VAN service redesign initiative is additionally part of a broader agenda across NSW Health to move away from volume-based care towards a value-based integrated approach to providing care that prioritises comprehensive wraparound support and that is responsive to local community contexts and individuals with complex needs, as outlined in the *NSW Health Strategic Framework for Integrating Care (2018)*.

2. Foundations: Overview of violence, abuse and neglect

A shared understanding of the nature, impact and extent of the primary forms of interpersonal violence, abuse and neglect is crucial to developing consistent and comprehensive integrated responses across the health system and with partner organisations, and to improving client outcomes (WHO, 2016a; Hegarty et al., 2017; McCulloch et al., 2016). To support this, definitions and an overview of the evidence for violence and abuse experienced by clients accessing health services in NSW are provided below.

2.1. Child abuse and neglect

The term 'child abuse and neglect' describes different types of maltreatment of a child, including physical abuse, neglect, sexual abuse, emotional abuse or psychological harm, including exposure to domestic violence, and assault, including sexual assault (NSW Health, 2013). Various forms of child abuse and neglect are identified as criminal offences under the *Crimes Act* (1900). Child abuse and neglect usually occurs within the context of adult-child relationships where the child trusts the adult and relies on them for basic needs; however, there is growing evidence that child sexual abuse may also be carried out by children and young people displaying or engaging in problematic or harmful sexual behaviour (El-Murr, 2017).

Understanding the prevalence of child abuse and neglect in Australia is foundational to applying a public health approach to addressing this issue. 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 can provide reliable prevalence data (Matthews, 2016).

However, several recent studies that have either measured one or two maltreatment types in detail, or have superficially measured all individual maltreatment types as part of a larger study, have been examined (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 Royal Commission into Institutional Responses to Child Sexual Abuse has recommended that the Australian Government should conduct and publish a nationally representative prevalence study on a regular basis to establish the extent of child maltreatment in institutional and non-institutional contexts in Australia (Recommendation 2.1).

The Australian Institute of Health and Welfare (AIHW) compiles annual national statistics relating to child protection in Australia. Some of these statistics are outlined below.

- In 2016/17:
 - 379,459 notifications of suspected child abuse and neglect involving 233,795 children were made to state and territory authorities (Australian Institute of Health and Welfare [AIHW], 2018a).
 - NSW recorded a total number of 18,919 substantiations¹ of notifications (confirmed cases of child abuse and neglect), and 66,689 children were engaged with child protection services (AIHW, 2018a).
 - 20,453 children were on care and protection orders, and 17,879 children were living in out of home care (AIHW, 2018a).
- Nationally, in the five years between 2012-13 and 2016-17, the numbers of notifications, investigations and substantiations all increased:
 - by 39% for notifications (from 272,980 to 379,459)
 - by 45% for investigations (from 122,496 to 177,056)
 - by 27% for substantiations (from 53,666 to 67,968) (AIHW 2018a).
- The 2016 Australian Bureau of Statistics' (ABS) Personal Safety Survey found that approximately one in six women (16% or 1.5 million) and one in nine men (11% or 992,000) have experienced physical and/or sexual abuse before the age of 15 (ABS, 2017).²

Child maltreatment is preventable and is one of the most potent predictors of poor mental health and wellbeing in children and adults (O'Connell, Boat et al., 2009). Children who grow up in unsafe home and community environments, and who experience trauma, violence and neglect, demonstrate difficulties in emotion regulation, behaviour, responses to stress, and interactions with others (Barth, Scarborough et al., 2008; Jordan and Sketchley, 2009; Bromfield & Miller, 2012).

Parental substance misuse, mental health problems and domestic violence are described as 'key risk factors' for child abuse and neglect that often co-occur as part of a complex set of social and family issues (Bromfield et al., 2010). Other risk factors include:

- **Economic factors:** poverty, unemployment, or overcrowded or unstable housing
- **Social factors:** racism, discrimination, social isolation and exclusion
- **Community factors:** dangerous, disadvantaged or socially excluded communities; communities who have lost many community members
- **Parental factors:** mental health, substance misuse, family/domestic violence, learning difficulties, parental anger, strong beliefs in corporal punishment, transgenerational trauma and its impact on parenting, lower levels of empathy
- **Child characteristics:** low birth weight, special needs, behavioural problems,
- **Family characteristics:** poor relationships, large number of children, single or early parenthood
- **Ecological/environmental factors:** violence, gambling, pervasiveness of unresolved grief, loss and trauma, previous experiences of abuse and neglect – for parents or children
- **Abuse or neglect:** Previous experiences of abuse and neglect (Bromfield et al., 2010).

1. "Substantiation" typically means that there is sufficient reason (after an investigation of a child protection notification) to believe that a child has been, is being, or is at risk of abuse and/or neglect (AIHW, 2018a). 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. Note that this is an under-representation of these issues, as the ABS Personal Safety Survey does not ask about experiences of child emotional abuse and neglect.

Exposure to risk factors is cumulative: the more risk factors in a child's life, the greater chance they will experience maltreatment. Risk factors when considered in isolation may not indicate that a child is 'at risk', but when examined in combination may indicate cumulative harm. Protective factors can also strengthen the resilience of families and their capacity to support the healthy development of their children. The ability to identify and respond to cumulative risks early is necessary to prevent children entering the statutory child protection system.

The National Framework for Protecting Australia's Children 2009-2020 provides a shared approach with national leadership, as reflected in its title, *Child Protection is Everybody's Business*. This is a move from the 'crisis-driven' system that has existed in the past to a public health model focused on universal support for all families, with more intensive, or targeted, responses for families that need additional support. Under this framework, crisis-driven or 'tertiary' responses should only be used as a last resort for the most vulnerable children and families. The Framework has a particular focus on the first 1000 days for a child. Action areas include:

- increasing awareness of the importance of child development and parenting, and normalising families asking for help
- improving access to evidence-based family support services for expectant, new and vulnerable parents when substance misuse, mental health, and domestic and family violence co-occur, and
- implementing joined-up responses for families with young children across agencies and sectors (Australian Government, 2009).

2.2. Children and young people displaying or engaging in problematic or harmful sexual behaviour

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, that is detrimental to development and normal functioning, that may harm the child themselves as well as other children subjected to this behaviour, or place either the child or children 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)

Children and young people's problematic or harmful sexual behaviour is a public health issue. There is a strong link between problematic and harmful sexual behaviour and the child's own experience of sexual abuse or other forms of 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).

There is a strong link between problematic and harmful sexual behaviour and the child's own experience of sexual abuse or other forms of interpersonal violence.

While this suggests 'no single causal factor can best explain or predict sexual behaviour problems in children', sexual abuse (including sexual contact and exposure to sexually explicit material) is recognised as a frequent precursor to these behaviours (Gil & Shaw, 2014, p. 8). In addition to sexual abuse, other factors associated with problematic sexual behaviour in children include: complex trauma histories including other forms of child maltreatment, domestic and family violence, problems in family functioning, poverty, loss, and family stress (Cashmore & Shackel, 2013; CEASE, 2012; Gil & Shaw, 2014; KMPG, 2014).

In efforts to understand this population, children under the age of 10 years are differentiated as a group from those aged over 10 years. This is related both to the age of criminal responsibility being 10 years old in Australian jurisdictions, and to developmental considerations. Terms such as 'reactive', 'problematic' or 'sexualised' behaviour are typically used to refer to children under 10, while the terms 'harmful sexual behaviours' and 'sexually abusive behaviours' are commonly used for children and young people aged over 10, reflecting recognition of different dynamics that require different approaches.

In NSW, the term 'problematic or harmful sexual behaviour' is used, and services for children under 10 years old and their families/caregivers are provided through multiple NSW Health services, including Sexual Assault Services, Child Protection Units, Child Protection Counselling Services, Child and Adolescent Mental Health Services, and Community Health Child and Family Services. For children and young people between 10 and 17 years old who have harmful sexual behaviours and who, for a range of reasons, have not been criminally prosecuted, services are provided by New Street Services, which provide specialist early intervention for this cohort.

Key messages from research regarding children and young people with harmful sexual behaviours, and providing evidence of its impacts, include:

- 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).
- Between 35 and 50 per cent of children under the age of 10 displaying or engaging in problematic or harmful sexual behaviour have experienced sexual abuse, and between 35 and 50 per cent 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 to prevent 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).
- A high proportion of clients of New Street (young people aged 10 to 17 who have demonstrated sexually harmful behaviours) have complex trauma histories. 10 per cent of New Street clients are girls who have significant prevalence of complex trauma, including sexual assault in their histories (KMPG, 2014).
- 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, 2017).
- 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 and 12 per cent of children and young people with harmful sexual behaviours are female (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

2.3. 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 between 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 (see section 2.5). Family violence is often connected to intimate partner violence, 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 violence is an ongoing pattern of behaviour aimed at coercing or 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 used 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 in Government 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 Department of Justice 2014)

The behaviours that may constitute domestic and family violence include (adapted from NSW Department of Justice 2014):

- physical violence including physical assault or abuse
- sexual assault and other sexually abusive behaviour, including reproductive coercion (e.g. contraceptive sabotage or unwanted or forced pregnancies or terminations)
- 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 or phone to abuse, monitor, humiliate or punish, or threats such as to distribute private photos or 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 *National Plan to Reduce Violence against Women and their Children 2010-2022* (COAG, 2011) identifies domestic and family violence and sexual assault as gendered crimes that have an unequal impact on women and are the most pervasive forms of violence experienced by women in Australia.

While national and international evidence and data acknowledge a small proportion of men are victims of domestic and family violence and sexual assault, most people who experience this kind of violence are women in their homes, and at the hands of men they know (ABS, 2017; AIHW, 2018b).

New South Wales 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 emphasised in the literature 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 et al., 2018).

The 2016 ABS Personal Safety Survey (ABS, 2017) found that in Australia:

- Since the age of 15, women were much more likely to experience all forms of violence from a partner or intimate partner than men:
 - Three-quarters (17.3% or 1,625,000) of victim-survivors of intimate partner violence in Australia are women, whereas one-quarter (6.1% or 547,600) of victim-survivors of this violence are men.
 - One in four women (23% or 2.2 million) and one in 13 men (7.8% or 703,000) experienced violence by an intimate partner.
 - One in five women (19% or 1.8 million) and one in 14 men (7.1% or 654,200) experienced physical violence by an intimate partner.
 - One in 11 women (9.2% or 864,000) and one in 83 men (1.2% or 104,800) experienced sexual violence by an intimate partner.
 - One in four women (23% or 2.2 million) and one in six men (16% or 1.4 million) reported experiencing emotional abuse by a current and/or previous partner since the age of 15.

- In the most recent physical assault by a male in the last 10 years, women were most likely to be physically assaulted by a male they knew (92% or 370,500) and the location of the incident was most likely to be in their home (65% or 689,800). Men were most likely to be physically assaulted by a male stranger (66% or 873,100) and the location of the incident was most likely to be either a place of entertainment or recreation venue (28% or 370,700) or outside location (28% or 370,500).
- One in nine (11% or 2 million) Australians witnessed violence (physical assault) towards their mother by a partner before the age of 15; and one in 22 (4.5% or 819,000) witnessed violence (physical assault) towards their father by a partner before the age of 15.
- Fifty per cent (60,300) of Australian women who were caring for children while experiencing violence from a current partner reported that their children either heard or saw the violence. For women who reported experiencing violence from a previous partner, the rates were higher, with an estimated 68 per cent (418,200) of women who had children in their care at the time of experiencing violence reporting that the children saw or heard the violence.
- 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. Humphreys (2007) highlights this violence as 'double-intentioned', where perpetrators may aim physical violence at their partner's abdomen, genitals or breasts, so that abuse is both of the mother and child.

Further research highlights that in Australia:

- For eight in 20 hospitalisations for female assault victims (45% or 2,800), and for one in 20 hospitalisations for male assault victims, a spouse or domestic partner was the perpetrator (where the perpetrator was identified) (National Hospital Morbidity Database, as cited in AIHW, 2018b).
- Four in five (79% or 99) victims of intimate partner homicide were female and one in five (21% or 27) victims of intimate partner homicide were male in the two years from mid-2012 to mid-2014 (National Homicide Monitoring Program, Bryant and Bricknell, 2017; Cussen & Byrant, 2015).
- Intimate partner violence contributes more to the burden of disease (the impact of illness, disability and premature death) of adult women in their reproductive age (18-44 years) than any other risk factor. It contributes an estimated 5.1 per cent of the burden for women aged 18 to 44 years (Ayre et al. 2016; Webster, 2016).

While male-to-female partner violence is by far the largest category of domestic and family violence, other patterns of violence can occur. While data is limited, emerging evidence indicates that people who identify as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI) experience violence from partners in similar rates to those in heterosexual relationships (O'Halloran, 2015). Domestic and family violence also occurs against other family members, such as elders or extended family. These types of violence may be harder to identify, and victims may find it more difficult to disclose violence and to access services (COAG, 2011; AIHW, 2018b).

There is also evidence that female-to-male violence does occur. However, the nature and consequences of women's violence is commonly different to men's violence towards women. When comparing male and female perpetrated violence, the violence women experience is more severe, more frequent and women are more likely to be seriously injured and to die at the hands of a male partner (Humphreys & Stanley, 2006; World Health Organization, 2012; Flood, 2006; James, 1999).

In addition, men are more likely to use violence *instrumentally* to dominate, control, injure, terrorise 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 separation. In this way, men's violence against their female partners reflects common definitions of domestic violence as patterns of coercive and controlling behaviours. 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 (DeKeseredy & Schwartz, 1998; James, 1999; Muftic & Bouffard, 2007; Swan & Snow, 2002).

Empirical research clearly demonstrates that there are underlying individual, community and social determinants of domestic and family violence, and thus that this violence is preventable. The single most common driver of domestic and family violence is inequality of power between men and women. Expressions of gender inequality that are the drivers of violence against women, and critical to address in preventing gender-based violence, include:

- 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 emphasise aggression and disrespect towards women (Our Watch et al., 2015).

2.4. Sexual assault

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, NSW Health defines sexual abuse with regard to children and young people as:

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. (NSW Health, 2013, p. 38)

The ABS defines 'sexual violence' as including two key components: sexual assault (acts of a sexual nature carried out against a person's will, and which would be considered an offence under state and territory criminal law), and sexual threat (the threat of acts of a sexual nature that are made face-to-face where the person believes it was able to and likely to be carried out) (2017).

The 2016 ABS Personal Safety Survey (ABS, 2017) found that in Australia, since the age of 15:

- Approximately one in five women (18% or 1.7 million) and one in 20 men (4.7% or 428,800) experienced sexual violence.³
- Approximately one in six women (16.9% or 1.6 million) and one in 23 men (4.3% or 384,800) have experienced sexual assault.

- Sexual assault is much more likely to be perpetrated by someone known to the victim:
 - One in five Australian women (19% or 1.8 million) and one in 27 Australian men (3.7% or 330,300) experienced sexual violence by a known person.
 - One in 22 Australian women (4.6% or 433,300) and one in 71 men (1.4% or 128,300) Australian men experienced sexual violence by a stranger.
- Women (one in 20) were eight times more likely to experience sexual violence by a partner than men (one in 167).
- Before the age of 15, almost one in 14 Australians (7.7% or 1.4 million) experienced sexual abuse; which includes almost one in 10 women (10.7% or 1.0 million) and almost one in 22 men (4.6% or 411,800).

Further research shows that:

- The vast majority (approximately 95%) of perpetrators of sexual assault against both male and female victims are male (ABS, 2017; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; Strathopoulos, 2014).
- A woman who is being physically abused by a partner and who is also experiencing forced sexual activity is more than seven times more likely than other abused women to be killed (Campbell et al., 2003).
- Between 4.0 and 26.8% of Australian females and 1.4 and 16.0% of Australian males have experienced child sexual abuse (variance depends on methodology, including age and definition of abuse) (Child Family Community Australia, 2017).
- The sexual abuse of boys is more common than generally believed, and, in comparison to girls, boys are more likely to be assaulted by siblings or other boys and in institutional settings (Cashmore & Shackel, 2013; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).
- Sibling sexual abuse is more prevalent than other types of intra-familial sexual abuse (Tapara, 2012; Caffaro & Con-Caffaro, 2005).

3. The term 'sexual violence' as defined by the ABS (2017) includes two key components: sexual assault (acts of a sexual nature carried out against a person's will, and which would be considered an offence under state and territory criminal law), and sexual threat (the threat of acts of a sexual nature that are made face to face where the person believes they were able to be and likely to be carried out).

2.5. Violence, abuse and neglect in Aboriginal communities

NSW Health recognises the impact of racism, colonisation and oppression on Aboriginal women, children, young people and their families, caregivers and communities, and the injustices Aboriginal people and workers face in using or working in government and non-government mainstream services. Aboriginal people are impacted by issues such as the overrepresentation of Aboriginal children on child protection orders and in out-of-home care, threatened closure of remote communities, over-representation in the criminal justice and prison systems, poverty and income management policies, and intergenerational trauma. These impacts are recognised in the *NSW Aboriginal Health Plan 2013-2023*, which states that the barriers faced by Aboriginal people in using mainstream services are a result of systemic racism.

Aboriginal people and communities remain resilient and deeply connected to their culture, kinship, family and history

Despite these abuses, Aboriginal people and communities remain resilient and deeply connected to their culture, kinship, family and history (NSW Health, 2012; Secretariat of National Aboriginal and Islander Child Care [SNAICC] et al., 2017; Zubrick et al., 2010). It is also evident that building connection to culture and community can help buffer women, children, young people and families in the face of adversity, including violence, abuse and neglect (Bamblett, Frederico, Harrison, Jackson, & Lewis, 2012; SNAICC et al., 2017).

Responses to Aboriginal and Torres Strait Islander victims and survivors of violence, abuse and neglect must challenge deficit-based thinking by recognising Aboriginal and Torres Strait Islander cultural strength as a key protective factor against family and other interpersonal violence. All responses should be community-led, trauma-informed, and built on notions of cultural healing in partnership with Aboriginal people and communities (Fogarty et al., 2018; SNAICC et al., 2017).

The development of culturally safe and culturally competent health services is a key strategic direction of the *NSW Aboriginal Health Plan 2013-2023*. Cultural safety involves Aboriginal children, women and families feeling and believing that their Aboriginal identity is valued and respected, as well as their being provided the freedom to express their identity (Victorian Aboriginal Child Care Agency [VACCA], 2008). These principles enable women, children, young people, adults and communities to experience a culturally safe atmosphere in a health service where they are not judged, misunderstood or assaulted based on their cultural identity and connection.

Herring, Spangaro, Lauw and McNamara (2013) emphasise that cultural competence is critical in appropriately meeting the health and wellbeing needs of Aboriginal people and that it can only be effective in increasing the accessibility and safety of mainstream health services if this competency actively addresses the trauma and ongoing racism that Aboriginal people experience. Cultural competence can be defined as:

A system of care that acknowledges and incorporates the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cross-cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (Cross, Bazron, Dennis, & Isaacs, 1989 in Herring et al., 2013, p. 3)

Localised, tailored referral processes that are designed and implemented in consultation with Aboriginal health and family violence legal services and other community and specialist organisations are highlighted as essential to supporting the safety and wellbeing of Aboriginal people experiencing violence, abuse and neglect (Cripps & Adams, 2014; McCulloch et al., 2016; SNAICC et al., 2017).

The terminology used to describe domestic, family and sexual violence are contested by Aboriginal individuals, researchers and communities, with debate focused on whether emphasis should be placed on violence perpetrated by intimate (domestic) partners or on more broadly occurring violence within families (Laing & Greer, 2001). Violence perpetrated within institutions is typically considered separately, reflecting the evidence that violence against Aboriginal people within institutions is more often perpetrated by non-Indigenous⁴ offenders. Cripps & Davis use the term 'family violence' in an Indigenous context to describe:

The range of violence that takes place in Indigenous communities, including the 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. (2012, p. 2)

Aboriginal women, children and families disproportionately experience and are impacted by violence, abuse and neglect. Key findings from the research include:

- In 2016-17, Aboriginal and Torres Strait Islander children were seven times more likely than non-Indigenous children to have received child protection services (AIHW 2018b).
- 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 1000 (AIHW 2018b).
- In 2007, one out of five reviewable deaths in NSW were Aboriginal children (NSW Ombudsman, 2009).
- Of all NSW sexual abuse victims aged 15 years and younger, 9.8 per cent were Aboriginal while Aboriginal children make up only 4 per cent of children in NSW (NSW Ombudsman, 2012).
- Sexual assault of Aboriginal children is widespread and under-reported (Aboriginal Child Sexual Assault Taskforce, 2006; NSW Ombudsman, 2012).
- In 2014-15, Aboriginal women were 32 times more likely than non-Indigenous women to be hospitalised due to family violence (Australia Productivity Commission, 2016).
- There is a gap in the burden of disease between Indigenous and non-Indigenous women. Among Indigenous women aged 18 to 44 years, the rates of burden due to intimate partner violence are 6.3 times higher than for non-Indigenous women in the same age group (Webster, 2016).
- Existing data indicates that the prevalence and severity of violence affecting Aboriginal and Torres Strait Islander people increases as geographic remoteness increases (AIHW, 2018b).

4. 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, '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.

- Seventy to 90 per cent of Aboriginal and Torres Strait Islander women imprisoned in Australia are survivors of sexual and family violence (Human Rights Law Centre, 2017).
- The recorded rate of victimisation for sexual assault and child sexual assault is three times higher for Aboriginal people than the total population (Aboriginal Child Sexual Assault Taskforce [ACSAT], 2006).
- The recorded rate of victimisation for domestic violence-related assault is six times higher for Aboriginal people than the total population (ACSAT, 2006).
- Three times as many Indigenous women will experience an incident of sexual violence compared to non-Indigenous women (12% compared to 4%) (Mouzos & Makkai, 2004).
- Approximately 14.3 per cent of survivors who told their story in a private session during the Royal Commission into Institutional Responses to Child Sexual Abuse were Aboriginal and/or Torres Strait Islander (Commonwealth of Australia, 2017).

2.6. Gender, diversity and vulnerability: priority populations⁵

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

Priority population groups

- Aboriginal people
- Children
- Young women and girls
- Women in pregnancy and early motherhood
- People with disability or mental illness
- Lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) people
- Culturally and linguistically diverse people, migrants and refugees
- People living in rural and remote areas
- Older women

The research strongly reflects that domestic and family violence, and sexual assault, are gendered crimes disproportionately experienced by and impacting on the health and wellbeing of women and girls, and overwhelmingly perpetrated by men (ABS, 2017; AIHW, 2018b). In addition to gender identity, other factors, including age and developmental stage, ability, sexual orientation, Indigeneity, ethnicity, migration and visa status, religion, and economic and geographical status, and discrimination related to these factors, can contribute to increased vulnerability to violence and its impacts requiring proportionate, targeted and appropriate health service responses.

5. 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 the NSW and national policy landscape (Council of Australian Governments, 2011; Centre for Epidemiology and Evidence, 2018).

Each victim and survivor's experience of violence is unique and, in practice, must be carefully assessed on an individual basis no matter which community they belong to. While robust quantitative data is limited, there is growing evidence supported by practice-based research that highlights often unique characteristics, additional or compounding impacts, and specific barriers to help-seeking for people from priority population groups. A brief snapshot of key findings from the literature for priority population groups is outlined below.

Domestic and family violence

When considering domestic and family violence, those cohorts with increased vulnerabilities include:

- **Women:** Since the age of 15, one in four women (23% or 2.2 million) experienced violence by an intimate partner, compared to one in 13 men (7.8% or 703,000) (ABS, 2017).
- **Aboriginal and Torres Strait Islander people:** In 2014-15, Indigenous women were 32 times more likely than non-Indigenous women to be hospitalised due to family violence (Australia. Productivity Commission, 2016). See Section 2.5 for further information.
- **Migrants, refugees and people who are culturally and linguistically diverse:** 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. Women on temporary visas are at particularly significant risk (Segrave, 2017).
- **People with disabilities:** Women with disabilities are 40 per cent more likely to experience domestic and family violence than other women, and more than 70 per cent of women with disabilities have been victim-survivors of sexual violence. Almost all (90%) of women with an intellectual disability have experienced sexual abuse (Australian Law Reform Commission 2010, in Frohmader, Dowse, & Didi, 2015).
- **LGBTQI people:** Rates of family violence for people who identify as LGBTQI have been found to be at the same or higher rates than for violence experienced by heterosexual women, and lesbian, gay and bisexual people are at greater risk of experiencing sexual coercion than heterosexual females (O'Halloran, 2015).
- **Women with a mental illness:** In 2011, domestic and family violence contributed to more burden of disease than any other risk factor for women aged 25 to 44. Mental health conditions were the largest contributor to the health burden of physical/sexual intimate partner violence, with anxiety disorders most prevalent (35%), followed by depressive disorders (32%) (Ayre et al. 2016).
- **Older women:** Available evidence indicates that older women are significantly more likely than older men to be victims of abuse, and, for some older women, experiences of family violence and sexual assault can represent 'the continuation of a lifelong pattern of spousal abuse' (Australian Human Rights Commission, 2017).
- **Women in pregnancy and early motherhood:** Violence perpetrated against pregnant women by a partner is particularly dangerous and a significant indicator of future harm to the woman and child, and can cause premature birth, serious injury or death to the baby, while also causing detriment to the mother's mental and physical health (Keeling, 2012; Manzolli et al., 2009; O'Reilly, 2007; Oweis, Gharaibeh, & Alhourani, 2009 in Cooper, 2013).
- **Women in regional, rural and remote areas:** 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 & Flood 2015).
- **Young women:** Global prevalence of partner violence is 29 per cent among young women aged 15 to 19, suggesting that violence can occur in women's earliest relationships (AIHW, 2018b).

Child abuse and neglect

In examining current national child protection data, it is evident that those children who were younger, lived in isolated geographic or lower socio-economic communities, or who were Aboriginal or Torres Strait Islander were more likely to have child protection reports made about them substantiated (AIHW 2018a). Across Australia in 2016-17:

- **Younger children:** Infants (children aged less than one year) were most likely to be the subject of a child protection substantiation (37.2 per 1000 infants), followed by children aged one to four years (29.7 per 1,000 children aged one to four) (AIHW 2018a).
- **Aboriginal and Torres Strait Islander children:** Aboriginal and Torres Strait Islander children were almost seven times more likely to be the subject of substantiated reports than non-Indigenous children (with a rate of 46.0 per 1000 children compared with 6.8 per 1000 respectively) (AIHW, 2018a).
- **Children living in remote areas:** Children from remote and very remote areas were most likely to be the subject of substantiations (18.0 per 1000 and 25.4 per 1000 respectively) compared with children in major cities (6.2 per 1000) (AIHW 2018a).
- **Children living in lower socio-economic areas:** 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 per cent of substantiations occurring in the highest socio-economic areas compared with 35.0 per cent in the lowest socio-economic areas (AIHW, 2018a).

Sexual assault

Population groups at higher risk of experiencing and/or having experienced sexual assault, include:

- **Women:** Since the age of 15, approximately one in five women (18% or 1.7 million) and one in 20 men (4.7% or 428,800) experienced sexual violence (ABS, 2017). Women were also eight times more likely to experience sexual violence by a partner than men; approximately one in 20 (5.1% or 480,200) Australian women compared to one in 167 (0.6% or 53,000) Australian men experienced sexual violence by a partner since the age of 15 (ABS, 2017).
- **Young women and girls:** Women aged between 18 and 34 years were three times more likely to experience sexual violence than men aged 18 to 34 years or women aged 35 years and over (ABS 2017). Before the age of 15 as well, almost one in ten women (10.7% or 1.0 million) experienced sexual abuse compared to almost one in 22 men (4.6% or 411,800) (ABS, 2017).
- **Aboriginal and Torres Strait Islander women:** Three times as many Indigenous women will experience an incident of sexual violence compared to non-Indigenous women (12% compared to 4%) (Mouzos & Makkai, 2004).
- **Aboriginal children and young people:** Of all NSW sexual abuse victims aged 15 years and younger, 9.8 per cent were Aboriginal while Aboriginal children make up 4 per cent of children in NSW (NSW Ombudsman, 2012).
- **Previous experiences of sexual assault, especially child sexual assault:** Several studies relate that people who have been sexually abused as children are two to three times more likely to be sexually re-victimised in adolescence and/or adulthood (Stathopoulos, 2014).
- **People (adults, children and young people) with intellectual disabilities, psychiatric disabilities or complex communication disabilities:** In the 12 months preceding the Personal Safety Survey, for example, 1.5 per cent of all women with disabilities had experienced sexual assault (42,800), compared with 0.8 per cent of women without a disability (45,000) (ABS, 2013, cited in Mitra-Kahn, Newbiggin & Hardefeldt, 2016).

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- **People in correctional facilities:** People in correctional and juvenile justice settings frequently have histories of sexual victimisation (Clark & Fileborn, 2011; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; Crome, 2006).
 - **Older women:** Across Australia, 344 reports of 'alleged or suspected unlawful sexual contact' were made in residential aged care during 2011-2012 (Mann, Horsley, Barrett, & Tinney, 2014).
 - **Children and young people displaying or engaging in problematic or harmful sexual behaviour:** Being abused by others (e.g. as a result of poor boundaries and indiscriminate friendliness) (Chaffin et al., 2008). 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).

2.7. Vulnerability, risk and responsibility

In the contexts of adult sexual assault and domestic and family violence, 'vulnerability' and 'responsibility' are often used interchangeably and confused. These forms of violence are crimes for which the perpetrator or offender is entirely responsible.

There are factors that can make people vulnerable, such as gender, age, disability, being affected by drugs or alcohol, mental health issues or previous history of violence. It is important to remember, however, that violence and abuse happens when the perpetrator *exploits* these vulnerabilities or emphasises the victim's vulnerabilities or their actions (e.g. what they were wearing, previous sexual activity) to minimise the nature, extent or impact of their violence and invalidate the experiences and credibility of their victims (Yarrow Place, 2009; Costello, 2009). Such strategies seek to shift responsibility from the offender to the victim ('victim-blaming') by blurring the boundaries between vulnerability and responsibility.

Vaughan et al. (2016) similarly emphasise that 'risk' and 'vulnerability' are often used interchangeably in discussions about domestic and family violence and sexual assault victimisation for priority population groups such as immigrant and refugee women. Distinguishing between the two terms is vital to recognising that risk of domestic violence and sexual assault is *caused* by the deliberate behaviours of perpetrators, and that adult victims of this violence are *made* vulnerable by people who exploit their circumstances, traumas and experiences of disadvantage and discrimination.

Developing a shared understanding of 'risk', 'responsibility' and 'vulnerability' across NSW Health and other services engaging with clients who have or are experiencing violence, abuse and neglect, is critical to supporting the implementation by service providers of key practice concepts (see Section 3.5) and to the redesign of current Health VAN service responses that aim to meet the health and wellbeing needs of all clients, including priority population groups within local areas that may experience additional barriers to seeking care and support, or who may be more vulnerable to increased severity or heightened impacts of violence, abuse and neglect due to additional experiences of discrimination and disadvantage.

2.8. Keeping perpetrators⁶ ‘in view’

Understanding specific characteristics of interpersonal violence and patterns of victimisation is critical for health professionals to appropriately and proportionately respond to clients’ safety and therapeutic needs. Increasingly though, research and clinical literature is highlighting the importance of maintaining a focus on the behaviours of perpetrators, rather than solely focusing on the protective strategies available to victims and survivors in health and other service responses. For example, the most consistently identified risk factor for risk of re-assault on a victim of domestic and family violence is a history of previous violence by the perpetrator. An 11-city study in the United States undertaken by Campbell, Webster & Glass (2009) found that 72 per cent of intimate partner homicides were preceded by physical violence by the male perpetrator and that when there was an escalation in frequency or severity of the violence over time, abused women were five times more likely to be killed than other women.

Multi-agency service collaborations are increasingly being implemented across Australia’s jurisdictions, particularly in response to cases of violence that are assessed as ‘high-risk’ (e.g. Victoria’s Risk Assessment and Management Panels [RAMPs], or NSW’s Safety Action Meetings [SAMs]). These coordinated case management approaches are identified in the literature as a promising practice model for health and other service interventions with victims and survivors of domestic and family violence and sexual assault, prioritising safety, health and wellbeing needs while keeping the focus of risk assessment and management processes in therapeutic interventions ‘squarely on perpetrators’ through coordinated case-management and active information sharing, and involving justice and corrections to monitor court-order conditions and escalate interventions as needed (Centre for Innovative Justice, 2015; Polascek, 2016).

Multi-agency service collaborations are increasingly being implemented across Australia’s jurisdictions, particularly in response to cases of violence that are assessed as ‘high-risk’

6. The term ‘perpetrator’ is used consistently in the literature and in NSW policy, legislative and practice contexts related to sexual assault and domestic and family violence. The term is used to reinforce the serious nature of these forms of interpersonal violence. In some therapeutic and behaviour-change contexts, ‘man/person who uses violence’ is preferred, as it is seen to label the behaviour and its causes more so than the person. Terminology used to describe abusers of children is more varied and dependent on the service context. In criminal justice settings, ‘offender’ is more common (Australia. Department of Social Services, 2015; Chen, 2017; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

3. Case for change

Violence, abuse and neglect are recognised by the World Health Organization (WHO, 2014) as serious public health issues with long-term personal, social, health and economic costs to individuals, families, communities and governments, and as a *preventable burden*. The consequences of violence, abuse and neglect are wide-ranging, varied and include impacts on all aspects of an individual's life, as well as on the lives of their families and communities.

Violence, abuse and neglect are recognised by the World Health Organization (WHO, 2014) as serious public health issues with long-term personal, social, health and economic costs to individuals, families, communities and governments

As outlined in Section 2, an understanding of the unique characteristics of and evidence to support specialised service responses to sexual assault, domestic and family violence, and child abuse and neglect is essential to meeting the health and broader service needs of victims and survivors. However, it is clear from the empirical research and from clinical and practice expertise that these forms of interpersonal violence rarely occur in isolation, and there is a high-degree of connection and overlap in the experiences of these issues, and with the experiences of children and young people displaying or engaging in problematic or harmful sexual behaviour.

This section outlines key findings from the evidence-base supporting the development and implementation of a redesign of VAN services across NSW Health, and the longer-term vision of whole-of-Health and multi-agency integrated-service responses that effectively manage the safety and support the health and wellbeing needs of all clients.

3.1. Co-occurrence and links between forms of violence, abuse and neglect, and children and young people displaying or engaging in problematic or harmful sexual behaviour

Although practitioners and policy makers often talk about domestic and family violence, child abuse and neglect, and sexual assault as separate and quite distinct types of violence, the evidence strongly suggests that these forms of interpersonal violence are intrinsically linked and connected. It is difficult to separate out and respond to one single issue, and one type of abuse rarely occurs in isolation to others (Laing, 2018).

Further, many people experience different types of abuse across their lifespan (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 that domestic and family violence, sexual assault and child abuse often co-occur, and that there is a relationship between experiences of these forms of abuse and children and young people displaying or engaging in problematic or harmful sexual behaviour.

There are several terms used to describe these connections and the cumulative effect of experiencing a number of types of violence at different points in time. These include: accumulated trauma/exposures to violence, re-traumatisation, re-victimisation, co-occurrence, cumulative exposure/effects, or poly-victimisation. What is important is that a single abusive experience is often the exception rather than the norm.

There is substantial evidence demonstrating the prevalence and impact of commonly co-occurring forms of violence, abuse and neglect and for heightened vulnerability to re-victimisation for survivors of abuse.

While there are significant detrimental effects on health for any type of abuse (sexual, physical, psychological and emotional), the health and social consequences of experiencing different types of abuse are cumulative and may be incrementally worse for victims who have experienced multiple episodes of abuse throughout and across their lives (Golding, 1999; Laing, 2018; Taft, 2003; WHO, 2002). There is substantial evidence demonstrating the prevalence and impact of commonly co-occurring forms of violence, abuse and neglect and for heightened vulnerability to re-victimisation for survivors of abuse. For example:

- The 2016 ABS Personal Safety Survey found that since the age of 15, 5.1 per cent (480,000) of Australian women have experienced sexual violence by a partner (ABS, 2017). Physically abused women who are also experiencing forced sexual activity (commonly referred to as ‘intimate partner sexual violence’), are seven times more likely than other abused women to be killed (Campbell et al., 2003).
- About one in three 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 to 55 per cent of children who experienced sexual abuse were also exposed to domestic violence (Kellogg and 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 of Child Protection, 2013).
- A meta-analysis of 80 studies (12,252 survivors) found the mean prevalence of sexual re-victimisation across studies was 47.9%. That is to say, almost half of child sexual abuse survivors are also sexually victimised 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 and 70 per cent (Holt et al., 2008).
- More than half (56.8%) of children and young people surveyed aged 10 to 17 years 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 to 70 per cent have been found, with higher rates found in clinical samples (Bidarra, Lessard, & Dumont, 2016)

-
- Between 35 and 50 per cent of children under the age of 10 displaying or engaging in problematic or harmful sexual behaviour have experienced sexual abuse, and between 35 and 50 per cent 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 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, & Kavanagh, 2013).

3.2. Health consequences of violence, abuse and neglect

It is clear that violence, abuse and neglect have serious impacts on people's health, contributing to a range of negative outcomes, including poor mental health, difficulties during pregnancy and birth, alcohol and other drug misuse, suicide, injuries and, in the worst instances, death (Hamby et al., 2010; Webster, 2016; WHO, 2002, 2013, 2014).

These health impacts are particularly pronounced for women and children:

- Intimate partner violence contributes more to the burden of disease than any other risk factor (5.1%) for women aged 18 to 44 years, more than well known risk factors like tobacco use, high cholesterol or use of illicit drugs.
- Intimate partner violence contributes five times more to the burden of disease among Indigenous than non-Indigenous women.
- In 2010-12, approximately 41 per cent of hospitalised assaults on women were perpetrated by an intimate partner.
- Intimate partner violence makes a larger contribution than any other risk factor to the gap in the burden between Indigenous and non-Indigenous women aged 18 to 44 years.
- Intimate partner violence has serious consequences for the development and wellbeing of children living with violence. (Ayre et al., 2016; Webster, 2016)

A summary of the health consequences of violence for women, men and children is provided in the table below. As previously highlighted, the co-occurrence between the different forms of violence, abuse and neglect, and the similarities and compounding impacts across abuse types, means that it is appropriate to identify these impacts all together.

Table 1: Health impacts of violence, abuse and neglect

Health impact	Key facts and consequences
Physical injury	<ul style="list-style-type: none"> • 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 et al, 2000). • Analysis of national databases reveals that Indigenous women are 32 times more likely to be hospitalised for injuries related to family violence assaults than other women (Australia. Productivity Commission, 2016). • Children who experience physical violence are at risk of physical injury and death (Doherty, 2002). • 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 abusive head trauma (or ‘shaken baby syndrome’). Health problems resulting from abusive head trauma may include brain damage, spinal cord injuries, hearing loss, speech difficulties and even death (Child Welfare Information Gateway, 2008).
Death	<ul style="list-style-type: none"> • 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). • Research suggests that abuse and neglect significantly increase the risk of suicidal ideation and attempted suicide for young people (Hunter, 2014). 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 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 due to insufficient investigations and a failure to run post-mortem examinations (Gilbert et al., 2009; WHO, 2010 in Hunter, 2014). • Previous contact with child protection services, often with an intergenerational family history, feature as a common factor in child deaths across Australia (Goldsworthy, 2017).



Health impact	Key facts and consequences
Mental health	<ul style="list-style-type: none">• Violence against women has been identified as a determinant of mental health and wellbeing (State of Victoria, Department of Health and Human Services, 2008).• Violence and abuse increase the risk of depression, post-traumatic stress disorder, sleep difficulties and insomnia, eating disorders, self-harm, suicidal thoughts, anxiety, suicide and emotional distress. (Black et al., 2012; Campbell, 2002; Cryan & Dinan, 2013; Gunnar & Quevedo, 2007; Moore et al., 2015; 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 (Campo, 2015; Laing, 2000; Whitfield et al, 2003).
Physical health	<ul style="list-style-type: none">• A longitudinal study compared children who had documented experiences of physical abuse, sexual abuse and/or neglect with non-maltreated children and followed these cohorts over 30 years. The study found a number of medical problems in adulthood that 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 et al., 2012).• The Adverse Childhood Experiences (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 include increased likelihood of autoimmune diseases (Dube et al., 2009), heart disease (Anda et al., 2008; Dong et al., 2004), liver disease (Dong et al., 2003), and cancer (Brown et al., 2010), stroke, diabetes, skeletal fractures, and poor self-rated health as an adult (Dube et al., 2009; Anda et al., 2008; Brown et al., 2010; Dong et al., 2003).• While further longitudinal research is needed, there is evidence that early stress in childhood, including trauma, may be associated with changes in the development of key brain structures (McLean, 2016).



Health impact	Key facts and consequences
Physical health (continued)	<ul style="list-style-type: none">• Chronic health conditions can be seen in victims of abuse indirectly through long term psychological stress, include stomach ulcers, spastic colon, frequent indigestion, diarrhoea, 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).
Sexual and reproductive health	<ul style="list-style-type: none">• Sexual assault, domestic and family violence, and child sexual abuse are associated with sexually transmitted infections (including HIV/AIDS); unintended/unwanted pregnancies; gynaecological problems; induced abortions; and adverse pregnancy outcomes, including miscarriage, low birth weight and foetal death (WHO, 2002; National Council to Reduce Violence against Women and their Children, 2009).





Health impact	Key facts and consequences
Behaviours associated with risk	<ul style="list-style-type: none">• 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 (Coker et al., 2000, Campbell, 2002; National Health Service Taskforce, 2010).• 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) with evidence suggesting that all types of child maltreatment are significantly related to higher levels of substance use (tobacco, alcohol and illicit drugs) (Moran, Vuchinich, & Hall, 2004).• Some studies show that rates of child sexual assault among women in drug and alcohol programs are between 47 and 74 Per cent. (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 (Ethier et al., 2004; Mills, 2004; Shaffer, Huston, & Egeland, 2008; Campo, 2015), attachment and interpersonal relationship issues, and using violence themselves (Gilbert et al., 2009; Maas et al., 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 and young people displaying or engaging in problematic or harmful sexual behaviour behaviour can be at increased risk of this behaviour escalating and continuing into adolescence (Silovsky & Niec, 2002).

3.3. Public health model for responding to violence, abuse and neglect

The health sector plays a crucial role in efforts to respond to and minimise the impacts of sexual assault, domestic and family violence and child abuse and neglect. The provision of high-quality care and support services to victims of violence can contribute to ‘reducing trauma, helping victims heal and preventing repeat victimisation and perpetration’ (WHO, 2014, p. 8). Further, high quality care and interventions with children and young people displaying problematic or harmful sexual behaviour are important child protection initiatives that aim to maximise safety and reduce the risk of harm to that child and other children as well as to minimise the onset of longer-term health and social impacts.

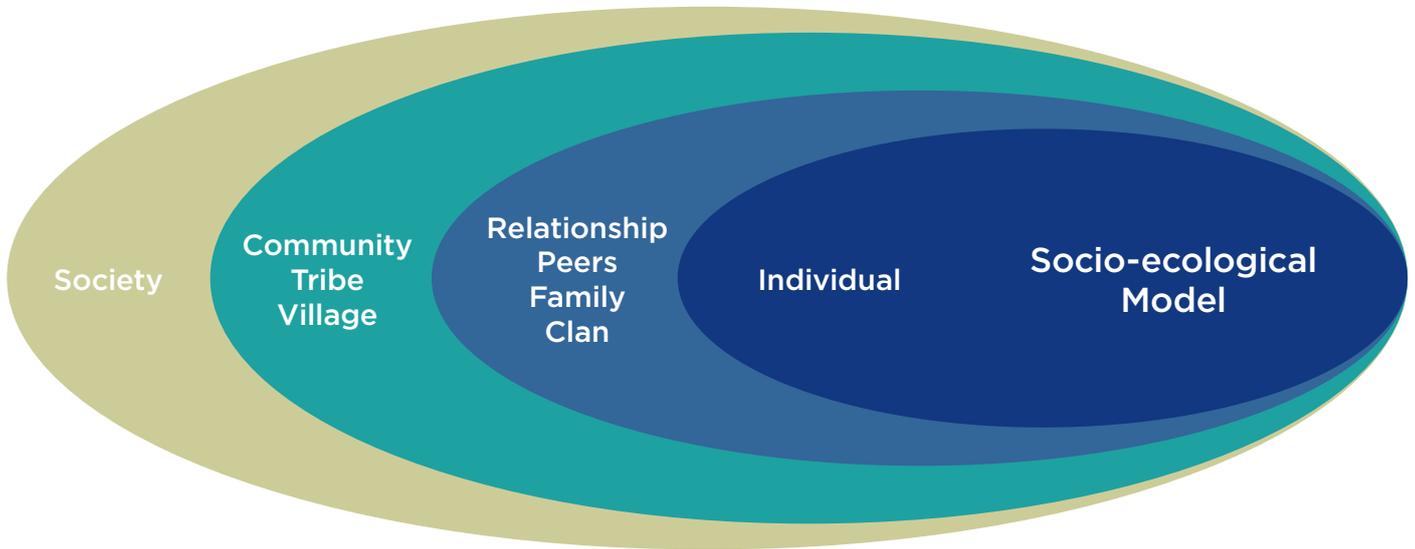
‘The public health sector is directly concerned with violence not only because of its huge effect on health and health services, but also because of the significant contributions that can and should be made by public health workers in reducing its consequences. Public health can benefit from efforts 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 health system also has an important part to play in primary prevention (i.e. prevention of violence before it starts), for example, through: documenting violence against women, including publicising data about its prevalence, health burden, and costs; advocating coordinated action with other sectors; and contributing to efforts to counter community acceptability of such violence (Garcia-Moreno et al, 2015).

As outlined in Section 3.2, the immediate and long-term negative health consequences of violence are serious, continue long after the abuse has ended, and, for many victims, are lifelong. People who have experienced or been exposed to violence 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 (WHO, 2002).

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).

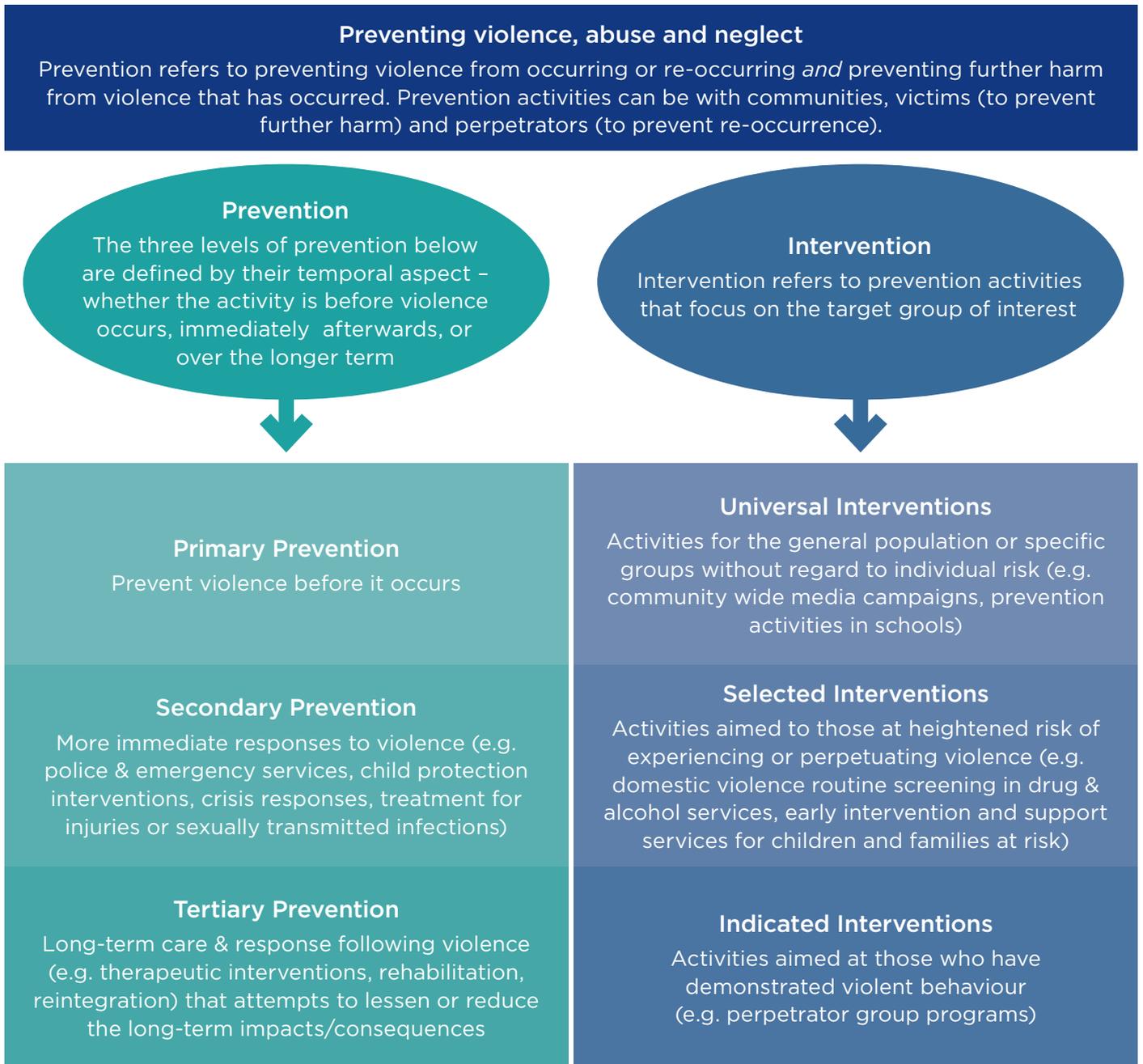
Figure 1: Socio-ecological model for understanding violence, abuse and neglect



This public health approach provides the framework for understanding violence as a problem that is preventable and can have 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 2: Public health approach to prevention



Women, men, children and young people 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 specialist services, such as Sexual Assault 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.

3.4. NSW Health responses to violence, abuse and neglect: promoting an integrated approach

Responding to violence, abuse and neglect, 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. However, some NSW Health services have particularly important roles and responsibilities in the prevention, identification and response to violence, abuse and neglect. An outline of these NSW Health services is provided below, divided into three conceptual categories based loosely on the public health approach:

- 1. VAN services:** NSW Health services with primary responsibility for responding to either specific types of violence, abuse and neglect (i.e. child abuse and neglect, domestic and family violence, sexual assault, and children and young people displaying or engaging in problematic or harmful sexual behaviour) or that provide an integrated VAN service. These services work across the continuum of prevention from primary, secondary and tertiary prevention and universal, selected and indicated interventions.
- 2. Secondary responses to violence, abuse and neglect:** activities and programs within services whose primary responsibility is not violence, abuse and neglect. However, they provide services to people at heightened risk of experiencing or perpetrating violence. Responses from these services may include activities across the spectrum of primary, secondary and tertiary prevention. Responses may specifically identify and/or respond to violence, abuse and neglect (e.g. Routine Screening for Domestic Violence or treatment of violence-related injury in an Emergency Department) or may indirectly reduce risks, vulnerabilities, and short or long-term impacts associated with experiences of violence, abuse and neglect (e.g. mental health or drug and alcohol interventions).

- 3. Primary responses to violence, abuse and neglect:** universal services, interventions and initiatives aimed at the general population or specific groups in the population without regard to their individual risk of violence, abuse and neglect. Responses from these services focus indirectly on primary prevention of violence, abuse and neglect by delivering services that reduce vulnerability and risk such as by supporting vulnerable families. Similarly to secondary responses, some of these services may work with populations at heightened risk of either experiencing violence or where the impact of the violence is likely to be more severe due to the vulnerabilities of the people involved (e.g. in pregnancy and early childhood). In this context, however, direct responses tend to focus on early intervention by identifying people who have experienced, or are at risk of experiencing, violence, abuse and neglect and referring them to the appropriate service.

As is often the case with conceptual models, these categories are ideal types and an individual service response or intervention may appropriately be categorised in more than one of these categories. The most relevant NSW Health services and interventions responding to violence, abuse and neglect are therefore outlined in the tables below in the category that is most appropriate, while acknowledging potential overlaps in practice.

Table 2: NSW Health responses to violence, abuse and neglect

VAN services	Secondary responses	Primary responses
<ul style="list-style-type: none"> • Aboriginal Family Wellbeing and Violence Prevention Program (AFWVP) • Child Protection Counselling Services (CPCS) • Child Protection Units/ Teams (CPUs) • Child Wellbeing Units (CWUs) • Domestic Violence Services • Education Centre Against Violence (ECAV) • Joint Child Protection Response Program (previously the Joint Investigative Response Teams, 'JIRTs') • Responses to children under 10 displaying problematic or harmful sexual behaviours (e.g. Kaleidoscope 'Sparks Clinic') • New Street Services (for children and young people 10 to 17 years engaging in harmful sexual behaviours) • Sexual Assault Services (SASs) • Specialist Services for Children and Young People in Out-Of-Home Care (OOHC) • Whole Family Teams (WFTs) 	<ul style="list-style-type: none"> • Aboriginal Health Services • Adult Mental Health Services • Aged Care Services • Alcohol and Other Drug Services • Child and Adolescent Mental Health Service (CAMHS) • Domestic Violence Routine Screening (DVRS) • Emergency Departments • Family Care Centres and Residential Family Care Services • Family Referral Services (FRSs) • Forensic Mental Health Services • Local Coordinated Multi-agency Offender Management (LCM) • Paediatric Services • SAFE START (specialist perinatal support for families with complex needs) • Safety Action Meetings (SAMs) • Service for the Treatment and Rehabilitation of Torture and Trauma Services • Social Workers: Community and Hospital • Substance Use in Pregnancy and Parenting Services • Sustaining NSW Families • Youth Alcohol and Other Drug Services • Youth Mental Health Services 	<ul style="list-style-type: none"> • Aboriginal Maternal and Infant Health Service (AMIHS) • Building Strong Foundations for Aboriginal Children, Families and Communities (BSF) • Bilingual Community Education Program • Child and Family Health Services • Community Health Centres • Early Childhood Health Service • Maternity Services • "Mums and Kids Matter" (MaKM) Program • Perinatal and Infant Mental Health Service (PIMHS) • Pregnancy Advice Line • Refugee Health Service • Sustained Health Home Visiting • Universal Health Home Visiting (UHHV) • Women's Health Centres • Youth Health Services

As highlighted in Section 3.1, there is increasing recognition of the connections between, and co-occurrence of, different forms of violence, abuse and neglect. As part of the redesign process, NSW Health is undertaking substantial work to integrate and reorient services, policies and clinical practice to ensure consistent and comprehensive responses across the NSW Health system, as part of a broader cultural shift across health services towards person-centred and trauma-informed care and practice. Of particular note here are:

1. efforts to communicate the responsibilities all Health workers have regarding these issues and build capacity in the broader Health system to respond to violence, abuse and neglect with support from the specialist services;
2. to realign our specialist violence, abuse and neglect services to ensure they have expertise and provide appropriate integrated responses to all forms of violence, abuse and neglect and not solely those issues for which they have primary responsibility; and
3. the importance of health service prevention and intervention activities at all levels of the socio-ecological model (individual, relationship, community and society).

3.5. Key concepts for effective practice

This section aims to provide a shared understanding of the key concepts identified in the evidence base as critical for effective or 'best'-practice Health service delivery to victims and survivors of violence, abuse and neglect. These concepts are different to the principles outlined in Section 4, which aim to support service-system redesign, but are related to and underpin those principles by highlighting the specific considerations for all Health services responding to domestic and family violence, sexual assault and child abuse and neglect, unique to other health presentations and requiring specific investment and responses.

3.5.1. Trauma-informed care

Over the past 30 years, there has been a significant shift in understanding about the impacts of trauma on individuals, families and communities. Research on trauma and resilience, as well as lessons from victims, survivors, advocates, clinicians and therapeutic workers, has demonstrated the importance of holistic, wraparound service responses to victims of trauma in minimising the risks of systems-created, or secondary, trauma.

Trauma-informed care (TIC), trauma sensitive practice and trauma-informed approaches are based on an understanding and acknowledgement of trauma theory. The key element of a trauma-informed approach is that the care model aims to provide a safe, supportive environment to clients and staff that reflects available research about the prevalence and effects of trauma exposure and the best methods for supporting clients exposed to trauma (Wall, Higgins, & Hunter 2016).

To be considered trauma informed, an agency would have moved through the following transformative steps: being trauma aware (seek information out about trauma); becoming trauma sensitive (operationalise concepts of trauma within the organisation's work practice), be trauma responsive (respond differently, making changes in behaviour); and ultimately move to becoming trauma informed (shift its entire culture to reflect a trauma approach in all work practices and settings) (Wall et al., 2016).

In addition to being trauma informed, much of the work of VAN services is trauma specific. A trauma-specific service is one that is aware of the possibility of ongoing or re-traumatisation of clients and of the direct and indirect impacts on its staff and takes steps to reduce this wherever possible. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients.

Some features of a trauma-specific service include:

- staff training in the impact of trauma
- use of standardised and evidence-based assessments of trauma history and symptoms
- use of trauma-focused therapeutic interventions
- supporting and developing emotional regulation with families
- actively seeking the participation of the child, family and community in planning and delivering interventions and in providing feedback about what has been achieved
- providing services that are strength based and promote positive development by building on the strengths, knowledge and lived experience of the individual, family and community
- using written policies that explicitly include and support trauma-informed principles (Johnson, 2017).

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

3.5.2. Secondary and vicarious trauma

Secondary trauma refers to experiences that occur after an initial trauma, as a result of that event or the subsequent actions or inactions of others (Herman, 1997). For clients of a VAN service it can include some unavoidable corollaries of the initial experience, such as painful medical treatment, adversarial legal action, or a child being removed from their family. Other secondary traumas are induced by people's lack of understanding, disbelief, denial, blame (for example, family responses to what has happened), or even poor professional practice (Jackson et al., 2013). Secondary trauma can have the same impact on a person as the direct initial exposure to trauma and can lead to a number of consequences such as increasing the risk of harm, or complicating a client's efforts in recovery (Pynoos, Steinberg, & Goenjian 1996).

When thinking about trauma impacts on Health staff, it is well recognised that practitioners may experience secondary trauma as a result of engaging empathically with clients and bearing witness to the traumatic events in their lives. This kind of secondary trauma is often referred to as vicarious trauma (VT) (Russ, Lonne, & Darlington, 2009). In addition to the high prevalence of violence abuse and neglect in the general population, there are many professionals, and in particular health workers, with their own histories of violence, abuse and neglect (McLindon et al., 2018). These personal traumatic experiences may also intersect with the professional practice of health staff and their experiences of the impacts of the work.

3.5.3. Staff support, revision and reflective practice

A culture of supervision and staff support is an essential component of workforce health and safety. In particular, it is vital for staff retention, staff support and wellbeing to prevent burnout and to mitigate the effects of vicarious trauma (Royal Commission Vol. 9, p.145). Failure to ensure access to quality supervision and reflective processes can have detrimental effects for clients, practitioners and the health service, as has been demonstrated by numerous inquiries in Australia and overseas (Munro, 2008; HETI, 2012; Frederico, Jackson, & Dwyer, 2014). Consequences of inadequate supervision can include: problems in risk assessment and case planning; lack of clarity in roles, goals and outcomes; interagency conflicts; difficulties managing priorities, waiting lists, and case closure; and worker stress, vicarious trauma and staff turnover.

Factors that protect practitioners from the effects of burnout and vicarious trauma include:

- ensuring appropriate and diverse caseloads
- providing effective and regular supervision
- encouraging a culture of debriefing and providing appropriate forums for this debriefing
- staff and peer support and ongoing professional development
- encouraging critically reflective practice and critical reflection
- building a workplace culture that negates the risks and experiences of vicarious trauma, embracing approaches to trauma-informed systems of care.

Supervision

Supervision is a relationship-based activity which can enable clinicians to reflect upon their work. It provides 'a supportive, administrative and development context within which responsiveness to clients and accountable decision making can be sustained' (Davies, 2000, cited in HETI, 2012, p. 6). It also provides an opportunity for critical reflection. Supervision is important to underpin effective practice, to meet the needs of clients, and for building and retaining a strong workforce.

A key strategy for maintaining ethical practice and monitoring the quality, safety and wellbeing of staff is to provide external professional supervision, ensuring opportunities for counselling, debriefing, assistance, mentoring and clinical development (Royal Commission Vol. 9, p. 145).

Supervision has three main functions:

- **Educational:** meeting the developmental needs of the worker by providing knowledge and skills, developing capacity for self-reflection and self-awareness, and integration of theory and practice. This can include identifying learning needs and supporting access to training within the scope of their practice.
- **Support:** ensuring the worker is supported in managing the stresses of the work, developing a professional identity and sustaining morale.
- **Administrative:** providing accountability, role clarity, management of workloads, and addressing organisational issues. (HETI, 2012).

The *NSW Health Clinical Supervision Framework* lists five core principles for clinical supervision:

- **Principle 1:** Clinical supervision is available to all health professionals to optimise client care and outcomes.
- **Principle 2:** Clinical supervision supports best practice and consistent delivery of client care.
- **Principle 3:** Clinical supervision is high quality and effective in addressing the needs of health professionals.
- **Principle 4:** Clinical supervision contributes to continuous professional learning and practice improvement.
- **Principle 5:** Clinical supervision supports high-quality care through data collection and monitoring for continuous improvement.

Reflective practice

The process of reflection can support practitioners with the complex task of making in-the-moment decisions as well as more structured thinking and planning. Reflective practice combines critical reflection with improved knowledge and transformative practice. The process uses multiple sources of information and systematically checks intuitive forms of reasoning against objective evidence. It is a reiterative process that supports the practitioner's decision-making on a number of levels, and informs their professional development. There are three important characteristics of reflective practice:

1. It involves a process of critical reflection that occurs before, during and after practice: planning for practice, reflection on practice, reflection in practice.
2. It uses intuitive as well as analytic forms of knowledge: understanding is derived from integration.
3. It derives learning and new knowledge from experience (Thompson & Pascal, 2012).

Reflective practice and critical reflection are crucial in negating the effects of vicarious trauma for Health staff.

3.5.4. Strengths-based practice

Critical to effective work with families, children and young people is a focus on strengths, and not just vulnerabilities, which requires a thoughtful analysis of both deficits and strengths. Supporting family members to 'discover resources' in themselves 'however small' shifts the focus from problem finding to 'solution building' and allows the family to participate in finding and creating 'building blocks for change' (Turnell & Edwards, 1999, p. viii).

A strengths-based approach does not mean ignoring risks or minimising harm. Rather it contributes to a partnership that is built on transparency and engages vulnerable families in a process of finding hope. Managing and securing a balance between working with clients' strengths while acknowledging vulnerability requires a constant process of assessing, establishing, monitoring and sustaining safety.

It is particularly important to challenge deficit-based thinking and recognise resilience when responding to violence and abuse in Aboriginal communities. In practice, this means working meaningfully with Aboriginal people, specialist health workers, and community and health organisations in coordinated ways when responding to interpersonal violence (see Section 2.5).

4. Integrated service responses to violence, abuse and neglect

Government and professional recognition of victims' and survivors' often complex needs requiring multiple interventions from a range of government and non-government community-based services, has led to an increased focus on addressing systemic gaps and 'siloed' service responses to violence, abuse and neglect. The benefits to both clients and services of more collaborative approaches are outlined in this section and include, particularly: reduction in secondary (systems-created) trauma and increased safety from future harm, and improved cost effectiveness through minimising duplication of service provision (Breckenridge, 2015). There is also some evidence to suggest that collaborative interventions have led to an increase in arrests and convictions of domestic and family violence and sexual assault offenders (Messing et al., 2014; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

Government and professional recognition of victims' and survivors' often complex needs requiring multiple interventions from a range of government and non-government community-based services

This section provides an overview of the evidence base regarding integrated health system and service responses to violence, abuse and neglect, focusing on findings from the research that provide guidance on designing and implementing coordinated service responses. Several recent frameworks guiding the health and social service sectors are analysed to identify common principles and enablers to support NSW Health and partner organisations to implement the Service Redesign Framework.

4.1. Overview of the evidence base

There is a growing body of evidence supporting the development and implementation of integrated service responses to violence, abuse and neglect in Australia and internationally. This literature includes: studies on specific intersections of experiences of violence, abuse and neglect, such as the co-occurrence and patterns of re-victimisation across experiences of sexual assault and domestic and family violence, or between child and adult sexual assault; systematic literature reviews and meta-evaluations; government inquiries, death review and Coroner's Courts reports; and practice and clinical grey literature representing the lived experiences of victims and survivors and demonstrating barriers and enablers for effective integrated responses that best support clients' needs.

There is also substantial literature demonstrating the negative impacts of fragmented service responses for victims and survivors of violence, abuse and neglect. Empirical evidence of effective integrated health system responses to violence, abuse and neglect is varied, and further trials, research, monitoring and evaluation are needed (Carrington & Phillips, 2006; Breckenridge et al., 2015; Hayes et al., 2011; Price-Robertson, 2012). However, the available evidence does indicate that integrated service responses can improve outcomes for, and reduce the impacts of, experiences of violence, abuse and neglect.

For example, Breckenridge et al.'s (2016) meta-evaluation of collaborative interagency interventions and integrated service responses to violence against women highlights that of 48 evaluations reviewed relating to 33 integrated service programs or initiatives across Australia, most reported qualitative positive impacts to clients, practitioners and services. Non-systematic literature reviews and findings from significant government inquiries and policy reviews similarly report that integrated service responses deliver better quality responses and can improve outcomes for clients that have experienced domestic and family violence, sexual assault, and child abuse and neglect (McDonald & Rosier, 2011; Mulroney, 2003; Price-Robertson, 2012; Taylor et al., 2014).

In addition to reviewing the relevant literature, this resource is also informed by analysis of a range of Australian policy frameworks supporting service integration, particularly in relation to health and welfare, to identify common components of an integrated service response. These frameworks include:

1. National Strategic Framework for Chronic Conditions (COAG, 2017)
2. NSW Health Strategic Framework for Integrating Care (NSW Ministry of Health, 2018)
3. Strategic Framework for Integrated care of the older person with complex health needs (ACI, 2014)
4. Western Australia End-of-Life and Palliative Care Strategy 2018-2028 (Government of Western Australia. Department of Health, 2018)
5. Framework on Integrated, People-Centred Health Services (WHO, 2016b)
6. Roadmap for National Mental Health Reform 2012-2022 (COAG, 2012)
7. Healthy, Safe and Thriving: National Strategic Framework for Children and Youth Health (COAG Health Council, 2015)
8. Healthcare that counts: A Framework for Improving care for vulnerable children in Victorian Health services (Victoria Department of Health and Human Services, 2017)
9. Northern Territory's Domestic, Family and Sexual Violence Reduction Framework 2018-2028 (NT Government, 2018)
10. Queensland Domestic and Family Violence Prevention Strategy 2016-2026 (Queensland Government, 2016)
11. Strategic Direction for Sexual Assault and Abuse Services: Lifelong care for victims and survivors 2018-2023 (National Health Service, 2018)

4.2 Defining integrated service responses

Conceptual definitions of 'service integration' vary across service delivery contexts and between professional disciplines (Dowling, Powell, & Glendinning, 2004; Wilcox, 2010; WHO, 2016a). In the domestic violence, sexual assault, and child abuse and neglect research and clinical literature, definitions of integration most commonly focus on coordination between distinct service providers or agencies. For example, Breckenridge et al. (2016) define integrated service responses as those that involve two or more agencies or services supported by a formalised partnership or joint service agreement, common principles or goals, and shared case coordination and management. Similarly, Cocozza et al. (2005) in the *Women with Co-occurring Disorders and Violence Study (WCDVS)* defined integrated responses in terms of organisational integration, defined as 'linkages across agencies for the purpose of ensuring that services were comprehensive, integrated and trauma-informed', and clinical integration, defined as 'the simultaneous and coordinated provision of substance abuse, mental health and trauma services'.

Consistent with the broader health literature, common to most descriptions of collaborative approaches to integration is a consensus that victims, survivors and clients should be centrally involved in decisions made and information shared about the care and support they receive from services (ACI, 2014; NSW Ministry of Health, 2018). In most cases, these decisions are focused on meeting the holistic needs of the individual across and beyond the health sector (WHO, 2016a; ACI, 2014).

While definitions of service integration vary, reflecting diverse professional disciplines and practice contexts, there are key features identified through research and in Australian practice frameworks. Based on these findings, the following definition is used to describe service integration in the context of responding to interpersonal violence:

Based on these findings, the following definition is used to describe service integration in the context of responding to interpersonal violence:

Integrated service responses to violence, abuse and neglect are defined as the provision of service responses in accordance with a *person-centred approach* that provides *seamless care* across multiple services, adopts a *multidisciplinary and trauma-informed approach*, and is designed around the *holistic needs* of the individual *throughout the life course*. The degree to which service responses are integrated can be conceptualised as a *continuum*, ranging from service autonomy to full service integration. This continuum of service responses manifests at a *system, service and practice level*.

This definition incorporates concepts of:

- person-centred approaches (ACI, 2014; NSW Ministry of Health, 2018)
- seamless care (ACI, 2014; NSW Ministry of Health, 2018)
- multidisciplinary approaches (WHO, 2016a)
- trauma-informed approaches (Cocozza et al., 2005)
- addressing the holistic needs of the individual (ACI, 2014)
- taking a life-course approach (WHO, 2016a)
- a continuum of service response integration (Wilcox, 2010)
- conceptualising service integration at multiple levels, including a system, service and practice level (WHO, 2016a; Quadara & Hunter, 2015).

Figure 3 outlines a continuum of service integration to accompany the definition above. This definition uses terms describing the degree of integration (i.e. 'limited', 'partial' and 'full'). Other sources in the literature, particularly on domestic and family violence and child abuse and neglect, focus on terms such as 'cooperation', 'collaboration', 'coordination', 'interagency' and 'partnership' (Breckenridge et al., 2015; Healey, Humphreys, & Wilcox, 2013).

Figure 3: Continuum of service integration

No integration	Limited integration	Partial integration	Full integration
<ul style="list-style-type: none"> A highly fragmented system with service delivery organisations working in isolation 	<ul style="list-style-type: none"> Loose, informal cooperation (e.g. information sharing) between practitioners Sharing of office location, facilities and overheads, but no integration of services 	<ul style="list-style-type: none"> Some formal sharing of resources (e.g. staff, tools, data) and joint planning Information on multiple services available through single employee or website portal 	<ul style="list-style-type: none"> Integrated staffing, funding, technology applications, service delivery tools and case management Simultaneous and coordinated provision of multidisciplinary services

Adapted from Brown and Keast (2003) and Public Safety Canada (2012).

4.3 Benefits of integrated service responses

The key concepts for effective practice in responding to violence, abuse and neglect, as outlined in Section 3.5, demonstrate a range of benefits for high-quality integrated health service responses to clients, services and staff. Additional common benefits of integrated service responses identified in the literature include:

- **Improved health outcomes for victims and survivors:** In particular, coordinated *trauma-informed approaches* have been found to decrease risk of psychiatric symptoms and substance use, improve clients' daily functioning and improve housing stability (Mental Health Coordinating Council [MHCC], 2013).
- **Reduction of secondary trauma:** Formal information sharing and referral arrangements, robust monitoring mechanisms, multi-agency case management approaches, alongside collaborative person-centred care, can minimise secondary (systems-created) trauma caused by fragmented and disempowering responses (Quadara and Hunter, 2016).
- **Better meeting of clients' immediate and long-term needs:** Victims and survivors often have interdependent and multiple needs and may receive support from several services and government agencies, or from different units within those agencies. Clear entry points into, and pathways between, different parts of the service system increase long-term outcomes (Commonwealth of Australia, 2017; Healy & Humphreys, 2013).
- **Improved services and quality of care:** Collaborative practice contributes to greater staff satisfaction and engagement, and improved timeliness and quality of care (Meyer, 2014; Bosch & Mansell, 2015; Morley & Cashell, 2017). It also reduces clients' experiences of fragmentation, duplication, gaps and delays in their care (Ham & Walsh, 2013; Morley & Cashell, 2017).
- **Improved access to services:** Coordinated service provision is more likely to ensure that VAN services are physically and geographically accessible and meet the needs of survivors and their families (Commonwealth of Australia, 2017; Healy & Humphreys, 2013).
- **Increased perpetrator and offender accountability:** Effective monitoring and supervision of perpetrators requires multi-agency and collaborative service responses that maintain focus on victims' safety by holding offenders accountable for their behaviours (Meyer, 2014; Day et al. 2010; Hovell, Seid & Liles 2006).
- **Improved service efficiency:** The WHO (2013) suggests that vertical stand-alone services may be costly to sustain and risk drawing staff or resources from other already under-staffed specialist services. Further, integrated services may be able to provide more efficient services than broader integrated service settings, particularly through minimising elements of duplication or inefficiency as a result of delivering multiple services by multiple agencies (Healy & Humphreys, 2013; WHO, 2013).
- **Cost effectiveness and service efficiency:** This is achieved through minimising duplication of services. Holistic services that provide coordinated support internally across a range of clients needs may reduce the costs and limited resources sustained by vertical stand-alone specialist services (WHO, 2013).

4.4 Organising principles and enablers for integrated service responses

This section outlines core organising principles and key enablers for integrated service responses as identified in the literature and through promising

practice frameworks. The table below outlines common enablers identified across multiple service integration frameworks. The list of example frameworks is included in Section 4.1.

Table 3: Enablers identified in Australian service integration frameworks

Enabler	Level	Description	Example Frameworks
Person-centred care	Core organising principle	Collaborative approaches to planning and delivering care centre the client in decision-making, and actively involve families and carers in therapeutic responses.	1, 2, 4, 6,
Trauma- informed approach	Core organising principle	Holistic, wrap-around service responses that are sensitive to trauma and resilience or trauma-specific in approach minimise risks of system-created (secondary) trauma.	2, 3, 6, 8, 10, 11
Leadership and governance	System	‘Champions’ of integration and clear authorising leadership from senior management, as well as formal governance arrangements, improve system performance and outcomes for clients.	1, 3, 5, 8
Information sharing	System	Coordinated information sharing, particularly in cases assessed as ‘high risk’, enhances safety and wellbeing.	2, 3, 5
Technology	System	Technological systems and equipment provide enabling tools for coordinated provision of care and for targeted health initiatives.	1, 3
Workforce	System	Training, proportionate resources, clinical support and skills-distribution with clear roles and responsibilities outlined for staff and between agencies are essential.	1, 4, 5, 11
Collaboration and coordination	System	To respond to clients’ diverse and sometimes competing needs, collaborative and consistent approaches, supported by shared frameworks among services, are required.	1, 4, 5, 8, 10, 11

Table 3: Enablers identified in Australian service integration frameworks (continued)

Enabler	Level	Description	Example Frameworks
Resources	System	While cost-effectiveness for quality of care increases, adequate resource investment is required, and the efficiency and efficacy of its use monitored.	1, 4, 5
Evidence-based policy and practice	System	Tools, frameworks, service plans, policies and procedures, clinical responses and program decisions are evidence-based, using relevant research and data.	1, 5
Safety and wellbeing	Practice principle	Child safety and the safety of young people and vulnerable adults is promoted and adequate systems are in place to prevent harm.	8, 9, 10, 11
Equity of access	Practice principle	High-quality care is available to everyone, everywhere, regardless of background or personal circumstance.	1, 2, 4, 6, 7, 8, 9
Joint accountability	Practice principle	Care is multidisciplinary and interdisciplinary and all service providers share responsibility for the person's health and wellbeing.	2, 9, 10
Early intervention	Not included	Universal and targeted prevention services and early intervention for those identified as in need is best practice and essential for achieving optimal health outcomes.	6, 7,

4.4.1 Core organising principles

The key concepts for effective practice in responses to violence, abuse and neglect as outlined in Section 3.5 are critical to and underpin effective implementation of integrated service responses. Importantly, collaboration between services and within individual agencies is not a goal in itself, but a means to enhancing the health, safety and long-term wellbeing of victims and survivors, and thus the evidence-based practice concepts are intrinsically linked to, and cannot be separated from service system design and governance structures. Person-centred and trauma-informed care is identified across the literature and in best-practice frameworks as minimum practice for coordinated responses to sexual assault, child abuse and neglect, and domestic and family violence.

Integrated service responses to violence, abuse and neglect are driven by a recognition that clients are the experts of their own lived experiences.

Person-centred care

Integrated service responses to violence, abuse and neglect are driven by a recognition that clients are the experts of their own lived experiences. Therefore, all assessments of, and responses to, clients' health and wellbeing are fundamentally based on the principle that collaboration with victims and survivors in decision-making and information-sharing processes is essential, as is actively involving families and carers in therapeutic responses and community outreach programs.

Key features of person-centred approaches in integrated care include:

- Services are adaptable to the needs of individuals across the life course (ACI, 2014).
- Clients and their families are actively involved as equal partners in planning, developing and monitoring care (ACSQHC, 2010).
- Choice, control and consent in care responses are critical. All clients, no matter their ability, age, gender, sexuality, language or culture are empowered to make informed decisions about their healthcare and other service and healing needs (NSW Ministry of Health, 2018).
- Strengths-based approaches that challenge deficit-based thinking and that empowers clients by collaborating with them to emphasise resilience and autonomy (Quadara, 2015).
- Staff and service-system competencies support cultural safety for Aboriginal and Torres Strait Islander people in particular, through actively addressing intergenerational and complex traumas and minimising secondary victimisation through collaborative approaches (Herring et al., 2013; NSW Health, 2018)
- There is equitable access to services for all clients, including proportionate and appropriate support for all individuals (COAG, 2017).

Trauma-informed care

Essential to person-centred care in the context of VAN services delivery is adopting a trauma-informed response, including specialist responses in universal services where appropriate. VAN clients have varying experiences with trauma, ranging from trauma stemming from a single episode of abuse, to complex trauma stemming from multi-type maltreatment or individually perpetrated abuse in childhood (Price-Robertson et al., 2013). Research outlining best practice in trauma-informed and trauma-specialist responses to violence, abuse and neglect is outlined in Section 3.5.1.

Further to this, the ability of services across multiple disciplines to provide integrated care hinges on each service delivering a trauma-informed response that is nuanced and tailored to the type of trauma that a victim has suffered, as well as addressing victims' holistic needs through coordinating with other services. Without a consistent trauma-informed response across multiple services, victims risk having their complex and interdependent needs being addressed in a single-faceted way by multiple service systems, and thus the risk to clients of being re-traumatised increases (Mental Health Coordinating Council, 2013).

The US government's Substance Abuse and Mental Health Services Administration (SAMHSA) describes being trauma-informed as:

A program, organisation or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist re-traumatisation. (SAMHSA, 2015, as cited in Quadara, 2015, p. 12)

Research published by the Royal Commission (2017) provides evidence that trauma-informed approaches can increase collaboration between clinicians and consumers, while service users feel they have a more significant voice in the care they received. Additionally, valuations of the five-year *Women with Co-occurring Disorders and Violence*

Study (WCDVS) have found that clients receiving trauma-informed services reported better outcomes in relation to mental health symptomology, severity of post-traumatic stress disorder symptoms, and drug addiction severity (see Quadara, 2015 for a review). More generally, trauma-informed approaches to service delivery result in more integrated, therapeutic care for those experiencing violence, abuse and neglect (Commonwealth of Australia, 2017; Machtinger et al., 2015; Quadara, 2015).

Trauma-informed practice requires a systems-level approach that involves modifying all aspects of the system that shape the delivery of care, including funding structures, workforce development, and policies and guidelines. Quadara (2015, p. 24), found that to achieve a trauma-informed system, policies and initiatives at the system level are needed to:

- address governmental policy and responsibility for systems change
- foster recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma
- support funding models for the development of a trauma-informed service system and implementation of evidence-based and promising trauma treatment models and services
- support service models that integrate trauma awareness into their core business and that support integrated, co-ordinated cross system care
- incorporate trauma awareness in workforce development, standards, competencies and operational practice
- encourage undergraduate education in universities and accredited colleges to offer curriculums preparing students to work with trauma survivors, and
- encourage and support consumer and survivor involvement in trauma-informed practice implementation (Quadara, 2015, p.24).

4.4.2 System enablers

This section outlines key enablers of an integrated service response at a system level. As with the core organising principles identified above, these enablers do not only apply to system-level integration but are also intrinsically linked to service and practice principles supporting integration in more localised contexts.

Table 4: System enablers for service integration

Leadership and governance	
Key activities	<p>Leadership</p> <ul style="list-style-type: none"> • Active leadership by senior management to drive system and service integration across management, clinical and specialist services (Gear, Koziol-McLain, Wilson, & Clark, 2016; Colombini et al. 2017, Spangaro & Ruane, 2014). • ‘Champions’ of integration are in all levels of governance and practice, particularly by senior management (Gear et al., 2016; Spangaro & Ruane, 2014). • A lead agency is identified for integrated programs to provide overall leadership and secretariat responsibilities, ensuring that policies and documentation are available to/agreed by all organisations involved in the integrated response (Mulroney, 2003; Meyer, 2014). <p>Governance</p> <ul style="list-style-type: none"> • Clearly defined governance framework that supports integration across levels within a service/organisation, as well as across the service system (Colombini et al., 2012; Connolly, Healy and Humphreys, 2017; Garcia-Moreno et al., 2015; Healey, Humphreys et al., 2013; KPMG, 2009; Mulroney, 2003; Potito et al., 2009; WHO, 2013). • Clear and consistent system-level referral pathways across multiple service systems (Wilcox, 2010). • Strong authorising environment that supports system and service integration, particularly in relation to information sharing (Connolly et al., 2017). • Establishing clear roles and responsibilities between and among services and clear and transparent communication of intentions and expectations (Sun & Buys, 2013). • Maintaining local interagency networks through regular and planned contact, for example, through communities of practice (Spangaro & Ruane, 2014). • Embedding ongoing clinical and organisational monitoring and evaluation processes, including adequate reporting mechanisms, to assess the extent to which activities supporting integration are effective (Sun & Buys, 2013).

Table 4: System enablers for service integration (continued)

Policy and principles	
Key activities	<ul style="list-style-type: none"> • Positioning violence, abuse and neglect as a priority public health issue to inform both therapeutic service responses and population-health and community-based prevention initiatives (WHO, 2014). • Adopting a common vision and shared goals and principles across the system that are clearly articulated and transparent (Mulrone, 2003; Potito et al., 2009; WHO, 2016a). • Policy and legislation that enables services to provide an integrated response that prioritises clients' safety and wellbeing, for example through greater information-sharing arrangements (Connolly et al., 2017; Spangaro & Ruane, 2014). • Embedding and maintaining evidence-based approaches to developing policies and frameworks, and which necessarily entails the development of a stronger evidence base on integrated service responses for VAN (Breckenridge et al., 2015).
Funding and resources	
Key activities	<ul style="list-style-type: none"> • Using funding mechanisms to require and enable collaboration between service providers across the VAN system (Commonwealth of Australia, 2017). • Allocating specific resources and/or funds to support service integration (Breckenridge et al. 2016; Gear et al., 2016).

Table 4: System enablers for service integration (continued)

Tools, data and technology	
Key activities	<p>Data management</p> <ul style="list-style-type: none"> • Developing data communication and linkages between systems in the VAN service system for client data (Connolly et al., 2017; Spangaro & Ruane, 2014). • Developing common protocols and tools to better document VAN as it occurs and share information (Spangaro & Ruane, 2014). • Consistently sharing de-identified data in accordance with privacy legislation to better understand how efforts to improve service integration are impacting outcomes for VAN clients. <p>Technology</p> <ul style="list-style-type: none"> • Better using electronic medical records such as My Health Record to support more integrated service delivery (ACI 2013; COAG, 2017; Nicholson, Jackson & Marley, 2013). • Better using technology to improve the accessibility of VAN services in accordance with the ‘no wrong door’ principle (COAG, 2017). • Using linked datasets to improve the quality of integrated services (COAG, 2017). <p>Risk assessments</p> <ul style="list-style-type: none"> • Using joint or integrated risk assessment and risk management tools (Connolly et al., 2017). • Aligning risk assessment tools across multiple service systems (Connolly et al., 2017).
Workforce	
Key activities	<ul style="list-style-type: none"> • Training multidisciplinary practitioners in common approaches, languages and service approaches (Connolly et al., 2017; Spangaro & Ruane, 2014; Quadara and Hunter, 2016). • Systematically providing mentoring (Spangaro & Ruane, 2014). • Training the whole VAN workforce, including practitioners, frontline staff, receptionists and executives, in person-centred, trauma-informed care (Quadara & Hunter, 2016). • Ensuring that the workforce is adequately resourced and supported to work in an integrated way (COAG, 2017). • Supporting people with lived experience to participate in the VAN workforce as appropriate (e.g. as mental health peer-support workers) (MHCC, 2013).

4.4.3 Service responses

As above, each of the system-level enablers of an integrated service delivery response (leadership and governance; policy and principles; funding and resources; tools, data and technology; and workforce) are applicable to an individual service level, with appropriately adapted key activities.

This draws on the concept of *multi-level integration*, a term used to describe multiple vertical integration activities, spanning from system-level integration to integrated service delivery, and clinical practice to partnerships and collaborations at the local level (e.g., Colombini et al., 2017; Colombini, Mayhew, & Watts, 2008; García-Moreno et al., 2015; KPMG, 2009; Spangaro & Ruane, 2014; Taskforce on the Health Aspects of Violence Against Women and Children, 2010; WHO, 2013).

In addition to these components, individual VAN and mainstream services will need to consider how their operating model supports and enables *horizontal* integration, or activities between units and agencies operating at the same level or stage in the process of service delivery (e.g. Wilcox, 2010; WHO, 2016a). Lewis et al. (2010) consider service-level integration across four service domains: organisational, functional, service and clinical.

Table 5: Lewis et al.’s (2010) four domains of service-level of integration (Lewis et al., 2010)

Domain	Description
Organisational	Multiple service organisations are pursuing further integration through a range of activities, from coordinated provider networks to mergers.
Functional	Integration of back-office functions and non-clinical supports across departments/units, or potentially across organisations, is improved.
Service	Integration of services is provided at a single organisational level, either across the organisation or between the organisation and other services.
Clinical	There are shared guidelines and protocols within and across professions.

4.4.4. Practice responses

In addition to the enablers of an integrated service delivery response at a system and service level, the literature identifies practice-level activities critical to furthering integration on the front line.

Importantly, the activities outlined in the table below require support from, and consistency with, system and service-level actions.

Table 6: Practice-based activities supporting service integration

Skills and capabilities	
Key activities	<ul style="list-style-type: none">• Being able to provide first-line psychological support• Having skills in stress management techniques, injury management and other emergency care• Delivery of a trauma-informed response and a holistic assessment of the client’s physical and mental health, wellbeing, safety, and family context, regardless of where the client has come from (Kezelman & Stavropoulos, 2012)
Roles and responsibilities	
Key activities	<ul style="list-style-type: none">• Clarity and transparency of the roles and responsibilities of each agency and practitioner supporting victims• Knowledge and awareness of other practitioners’ roles, responsibilities, skill sets and ability to ‘speak the language’ of other service providers (NSW Department of Human Services, 2010)• Having a shared vision, a common understanding of families’ issues and agreement on approaches to case management practice (NSW Department of Human Services, 2010)• Holding a high level of trust in each other’s knowledge and expertise (NSW Department of Human Services, 2010)
Principles and attitudes	
Key activities	<ul style="list-style-type: none">• Practice guided by principles relating to respect, confidentiality, privacy and safety• Views on empathy, non-judgemental approaches, gender equality and acceptability of violence against women

Table 6: Practice-based activities supporting service integration (continued)

Information sharing	
Key activities	<ul style="list-style-type: none"> • A willingness to pro-actively share information, and compliance with legislative requirements and protocols to share information (Commonwealth of Australia, 2017; State of Victoria, 2016) • Use of information sharing as a tool to record and monitor treatment outcomes, and empower both clients and service providers with data to recognise improvements or support changes in therapeutic approach
Knowledge	
Key activities	<ul style="list-style-type: none"> • Knowledge of referral networks/pathways • Knowledge of available services (e.g. procedures for sexual assault clinical care) • Knowledge of the service sector (e.g. an understanding of key aspects of the evidence-base on violence, abuse and neglect) • Participation in training and development
Contributing to a supporting environment	
Key activities	<ul style="list-style-type: none"> • Contributing to the sector by encouraging attendance at family violence response group meetings, sending newsletters, establishing information pathways, visiting general practices with specialists and building strong community relationships (Gear et al., 2016)

4.4.5. Challenges and considerations for implementation

While the value of collaboration between services is evident, the different histories, knowledge bases, and organisational cultures of each sector (such as child protection, domestic and family violence, mental health and drug and alcohol) present formidable challenges to the development of effective working relationships and the sharing of respective expertise (Laing, Irwin, & Toivonen 2012). A recent meta-evaluation involving evaluations of 33 Australian integrated service responses to domestic and family violence initiatives found that there can also be significant implementation challenges that should be taken into account in the design of coordinated and integrated service models and frameworks, such as referral pathways and providing appropriate support to priority population groups (Breckenridge et al., 2015). These are:

- different philosophical approaches and power imbalances between agencies
- loss of specialisation and tailored responses, including adequate responses for victim-survivors with complex service needs
- individual (client) perceptions of cross-agency control, communication and information-sharing concerns and frustrations
- a lack of properly directed resources.

5. Next steps

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 during their lifetime and, for many people, navigating the service system can itself be traumatic. Services and therapeutic responses that enhance development, prevent abuse, and respond to the causes and impacts of violence, abuse and neglect are likely to be multi-systemic in nature.

It is clear from the evidence that a collaborative, interagency approach is critical in responding to clients of the public health system.

It is clear from the evidence that a collaborative, interagency approach is critical in responding to clients of the public health system. Evidence of the negative consequences of fragmentation, disconnection and 'siloes' service delivery and the benefits of collaboration mean that coordinated approaches and integration are widely regarded as best practice in responding to clients who have experienced violence, abuse and neglect, particularly for individuals and families who may be experiencing multiple and complex needs.

Along with input and ongoing engagement from Project partners and key stakeholders, the *Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health* has been developed as a companion resource to inform the development and implementation of the *Integrated Prevention and Response to Violence, Abuse and Neglect Framework*.

This resource outlines key findings from the evidence-base that provide guidance on effective practices in the prevention and response to child abuse and neglect, sexual assault, domestic and family violence, and to children and young people displaying or engaged in problematic or harmful sexual behaviour.

The Framework recognises and is informed by efforts undertaken to date by those within and outside of NSW Health which have helped deliver better care for people and families who have experienced violence, abuse and neglect. Building on this ongoing work, the Framework outlines the guiding principles and key priorities for strengthening NSW Health VAN services in the more immediate term, and provides the foundation for implementing integrated services, systems and initiatives that provide holistic, wrap-around care in partnership with broader government and non-government health, welfare and specialist services.

All children, young people, adults and their families deserve to live free of violence, abuse and neglect. The Framework provides a good practice platform for agencies across NSW Health to provide consistent, high quality, comprehensive and integrated services to the people and families of NSW to help achieve this vision.

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