Australian Government
Australian Institute of Health and Welfare

AIHW
Stronger evidence, better decisions, improved health and welfare

Family, Domestic and Sexual Violence

Responses and outcomes

Responses

Actions taken after family, domestic and sexual violence are referred to as ‘responses’ and include informal support (such as disclosure to a friend or family) and formal support (such as police and legal services, health professionals or housing assistance). These topic pages focus mainly on formal support due to data availability. The need for some of these supports could be viewed as an outcome of FDSV (e.g. hospitalisation) however are positioned as a response as the data relate to the events in which the service responds to the impact/outcome.

- Services responding to FDSV
- How do people respond to FDSV?
- Health services
- Helplines and related support services
- FDV reported to police
- Sexual assault reported to police
- Child protection
- Housing
- Legal systems
- Financial support and workplace responses
- Specialist perpetrator interventions
- FDSV workforce

Services responding to FDSV

A wide range of services work with victim-survivors, perpetrators and families when violence occurs. Timely and high quality information about these services helps us better understand the actions individuals and services take in the lead-up to violence, after violence has occurred and in the recovery process. Better data can also shed light on the outcomes achieved by those actions.

This page provides an overview of key concepts relating to services responding to FDSV, and discusses how they are used in the AIHW FSDV reporting. Some contributions from people with lived experience are also included on this page to deepen our understanding of how people interact with the service system.

Where do services fit?

Services responding to FDSV can be seen as part of a broader system of policies and initiatives that work to end violence, by engaging in activities from primary prevention through to recovery and healing (Figure 1).

Figure 1: Understanding the service system using a holistic approach

Note: Adapted from the *National Plan to End Violence against Women and Children 2022-2032*.

Source: DSS 2022.

The four focus areas in Figure 1 recognise that violence exists on a continuum, and ending violence requires a holistic and multi-sectoral approach:

- **Prevention** means stopping violence from occurring, by addressing its underlying drivers. This requires changing the social conditions that give rise to this violence, and reforming the institutions and systems that excuse, justify or even promote such violence.
- **Early intervention**, also known as 'secondary prevention', aims to identify and support individuals and families experiencing, or at risk of, violence to stop the violence from escalating, protect victim-survivors from harm and prevent violence from reoccurring.
- **Response** refers to efforts and programs used to address existing violence, for example services such as crisis risk assessment and safety planning, accommodation, counselling, financial, legal or medical assistance as well as police and justice responses, family law services and perpetrator interventions. Also known as 'tertiary prevention', these efforts aim to prevent the reoccurrence of violence by supporting victim-survivors and holding perpetrators of violence to account.
- **Recovery** refers to the ongoing process that aims to assist victim-survivors. Recovery services support victim-survivors to be safe, healthy and resilient, to have economic security, and to have post-traumatic growth. This support helps victim-survivors to recover from the financial, social, psychological and physical impacts of violence. Recovery helps to break the cycle of violence and reduce the risk of re-traumatisation. Recovery also relates to the broader rebuilding of a victim-survivor's life and ability to return to the workplace and community, obtain financial independence, and economic security.

What services are included in AIHW reporting?

For the AIHW FDSV reporting, the services in focus are those that engage directly with victim-survivors, perpetrators and families when FDSV has occurred. These services fall primarily under 'responses' in Figure 1, but may include activities that support victim-survivors in their recovery, or prevent violence from reoccurring (early intervention). Community-wide initiatives – that focus on prevention and early intervention – are not in scope for the AIHW FDSV reporting. Narrowing the scope of initiatives to those that engage individuals directly, enables us to adopt a person-centred approach to reporting on the FDSV service system. It also enables us to better understand the experiences of people engaging with services, so that we can build the evidence base around service use, which can improve service planning and delivery.

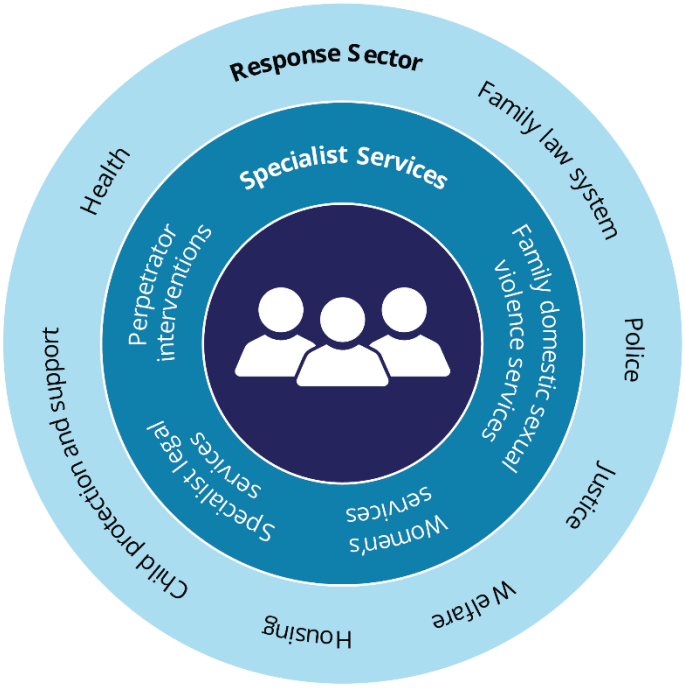
In Australia, primary prevention initiatives are currently being led by Our Watch, who work to embed gender equality and prevent violence where people in Australia live, learn, work and socialise. Our Watch also work to build the evidence base around primary prevention, by developing frameworks, academic papers and research and undertaking evaluations. This work complements the AIHW FDSV reporting, and more information can be found on the Our Watch website.

What are the different types of services responding to FDSV?

Services responding to FDSV are broad and span multiple sectors. In general, these services can be broken up into 'specialist' and 'mainstream' services (Figure 2):

- **Specialist FDSV services** are those that are specifically designed to assist people who experience or use FDSV. The services provided can vary, but in general, they assist and support victim-survivors, perpetrators, and others affected by FDSV, by providing short- and longer-term responses.
- **Mainstream services** refer to services available in the community that may be accessed by someone experiencing FDSV. These services may have a broader scope than FDSV, and can include health and welfare, and justice services.

Figure 2: Services responding to FDSV



Note: Adapted from the *National Plan to End Violence against Women and Children 2022-2032*.

Source: DSS 2022.

Every individual's pathway through the service system is unique. At different stages, a person may access both mainstream and/or specialist services depending on their needs.

Which services have you found most helpful?

'The referral service was incredibly helpful with information about creating a safety plan and giving me information on things I would need to do before I left, to ensure the safety of me and my son. They also recommended a good removalist who was sensitive to my needs and understood the danger we might be in. My GP was also essential in looking after my mental health during that really stressful period and beyond.'

Martina

WEAVERs Expert by Experience

'I undertook some creative art therapy with other victim-survivors, which was incredibly powerful and healing. With a friend of mine, who is also a victim-survivor, I developed a group for women who have experienced trauma, to create and write music. I have also been doing work for WEAVERS and have now been appointed to a government victim-survivor advisory council. I guess I have channelled my healing into practical ways to help others and hopefully raise awareness and increase prevention.'

Martina

WEAVERs Expert by Experience

Specialist FDSV services

Specialist FDSV services are specifically designed to assist people experiencing FDSV. In some cases, a single organisation may provide specialist FDSV services only, or specialist FDSV services along with other services (for example, alcohol and other drug treatment services).

Some examples are:

- specialist FDV crisis and/or longer-term support services (including perpetrator services and services dedicated to specific groups, such as Aboriginal and Torres Strait Islander people)
- specialist sexual violence crisis and/or longer-term support services
- specialist helplines/online services
- specialist family and domestic violence legal and/or court services.

Mainstream services

Mainstream services include a broad range of services available in the community to those who have experienced violence. Mainstream services can sometimes be separated into health and welfare services, and justice and legal services. This distinction can be useful for understanding the different pathways that an individual might take through the service system. It also recognises that justice and legal processes may be different from processes used in health and welfare services, as they operate within legislative frameworks.

Table 1: Mainstream services

Health and welfare services	Justice and legal services
• Housing services, specialist homelessness services • Child protection services • Child and family health services, family and relationship services • Government crisis payments • Hospitals (admitted patient care, emergency care, outpatient care) ambulance services, primary health care • Perinatal/antenatal health • Mental health services, alcohol and other drug treatment services • Disability services • Financial counselling services • Immigration/settlement services	• Courts, including court advocacy • Correctional services • Legal assistance services

What does it mean to feel supported by services?

'I think services should be more flexible in how we can engage, letting us set the pace of our work and letting us choose what we want to work on. We know our situations best and are the wisest in finding out own solutions to move forward.'

Anonymous

WEAVERs Expert by Experience

What data are available?

National data are available to report on the FDSV service system across these key areas:

- child protection
- specialist homelessness services
- health services
- police
- legal responses
- helplines.

While these data provide valuable insight into patterns in service use, it is important to acknowledge that a large proportion of people who experience FDSV may not disclose

violence to anyone, and may not come into contact with services. According to the 2021-22 Australian Bureau of Statistics (ABS) Personal Safety Survey, many people did not seek advice or support following an incident of partner violence. Of those who had experienced physical and/or sexual violence from a previous cohabiting partner, almost 2 in 5 women (37% or 574,000) and 2 in 5 men (39% or 166,000) did not seek advice or support from anyone. Further, support and advice was more likely to be sought from a family member or a friend than from any formal services – almost 1 in 2 women (45%, or 682,000) and 1 in 2 men (51% or 218,000*) who had experienced violence from a previous partner sought advice or support from a friend or other family member (ABS 2023).

The data available on FDSV services are only part of the picture, and should be brought together with other sources (such as prevalence surveys) to build a more comprehensive understanding of FDSV. For more information, see **How are national data used to answer questions about FDSV?**.

Data sources for measuring services responding to FDSV

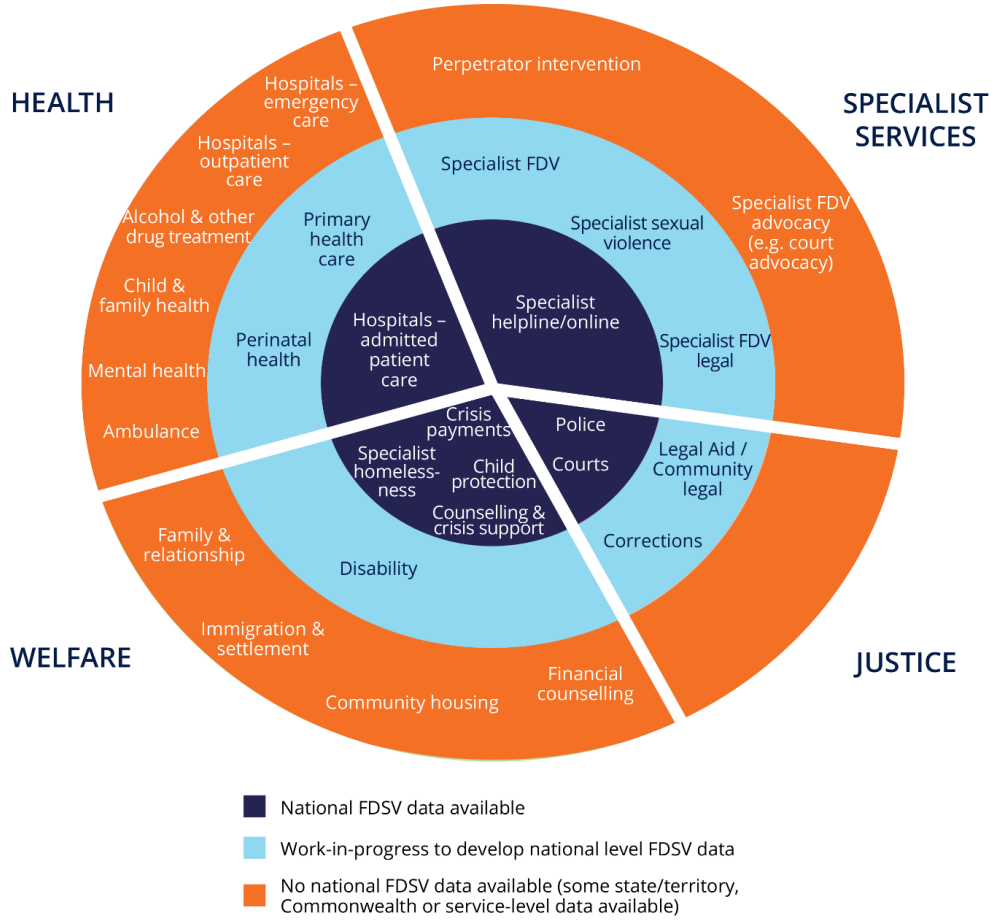
- ABS Criminal Courts
- ABS Recorded Crime, Victims
- ABS Recorded Crime, Offenders
- AIHW Child Protection
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services Collection
- Department of Social Services – 1800RESPECT
- Services Australia customer data – Crisis payments

For more information about these data sources, please see **Data sources and technical notes**.

Data gaps and development opportunities

There are many areas within the FDSV service system where data gaps remain. Figure 3 shows where national data are currently available, where the gaps are, and where some work is underway to develop national FDSV data.

Figure 3: FDSV data availability across services



Further, there is currently limited national data about:

- service quality and client experiences
- service outcomes
- service integration.

Improved service data can be used to improve response strategies. However, service data can only relate to those people using the services and cannot answer questions about the level of unmet demand or barriers to access. While data on specialist FDSV services are limited, however work is currently underway to develop a prototype specialist crisis FDV services data collection. For more information about this work, and about data gaps and development across FDSV more broadly, see **Key information gaps and development activities**.

Related material

- How are national data used to answer questions about FDSV?
- Policy context and international context

References

ABS (2023) *Partner violence*, ABS website, accessed 7 December 2023.

DSS (Department of Social Services) (2022) *National Plan to End Violence against Women and Children 2022–2032*, DSS, Australian Government, accessed 6 January 2023.

How do people respond to FDSV?

Key findings

- Based on 2021–22 PSS data, 2 in 5 women and 2 in 5 men did not seek advice or support for violence from a previous partner
- Friends or family are the most common source of support for those who have experienced partner violence or sexual assault
- Fewer than 1 in 5 (18%) people in 2022 who were sexually harassed at work lodged a formal report or complaint

Actions taken in response to family, domestic and sexual violence (FDSV) include informal support (such as disclosure to a friend or family) and formal support (such as police and legal services, health professionals or housing assistance).

This topic page provides a broad overview of help-seeking behaviour in response to FDSV. While the reporting focuses on national quantitative data, some contributions from people with lived experience are included on this page to deepen our understanding of how people respond.

Information about specific formal support provision is provided in related topics, see **Responses**.

What do we know?

There are many formal and informal supports that may be used by people who experience FDSV, including family and friends, health professionals and helplines. Support may be in the form of crisis or post-crisis responses and there are multiple entry points for victim-survivors to access support. Entry points may vary depending on victim-survivors' personal help-seeking needs or goals at different times, and awareness and availability of support services in their area.

However, FDSV frequently occurs behind closed doors and is often concealed by, and denied by, their perpetrators and sometimes by their victims (AIHW 2019). Intimate partner sexual violence, in particular, is under-reported and often not disclosed (Backhouse and Toivonen 2018). For victim-survivors of sexual or psychological forms of abuse, it may be more difficult for them to identify the behaviour as abuse and seek support (Hegarty et al. 2022).

The burden of responsibility to disclose violence often falls on the victim-survivor and this can be a key barrier to seeking support.

Disclosure

When deciding whether to disclose violence, victim-survivors make judgements about whether it is safe to do so. Spangaro et al. (2011) identified three dimensions of safety

that may be considered by women deciding whether to disclose intimate partner violence: safety from the perpetrator, safety from shame and safety from institutional control (for example, having no control regarding involvement with statutory child protection services).

The reasons victim-survivors don't disclose violence include:

- fear of making the violence worse or other consequences (including involvement of child protection and other social services)
- concerns they won't be believed or will be judged or criticised
- believing that they are to blame for the abuse or feeling shame and embarrassment
- concerns about confidentiality
- not recognising the behaviours as abusive
- dependency on the perpetrator, for example, for daily care
- perpetrator tactics of isolation and control (Backhouse and Toivonen 2018).

In a mixed-model study involving online surveys and qualitative interviews with over 1,100 victim-survivors of intimate partner and/or sexual violence, the three most common barriers to help-seeking that were identified were shame (63%), lack of awareness of services (62%) and concerns about confidentiality (50%) (Hegarty et al. 2022).

Disclosure of child abuse

Some of the challenges to disclosure for children are similar to those mentioned above (for example, feelings of fear, shame, embarrassment, concerns about not being believed, not recognising the behaviours as abusive). However, there are some specific challenges for children and young people when disclosing abuse. This includes not having the language skills to communicate the abuse, fear of upsetting their parents, lack of parental support and lack of confidence in adults and their ability to help (Alaggia et al. 2019, DCYJMA 2022, Esposito 2014).

See also **Children and young people** and **Child sexual abuse**.

With increasing awareness and understanding of FDSV in Australia, people may be more likely to identify and report violence and/or seek services (AIHW 2022).

Barriers to seeking formal support

In addition to the challenges of disclosing violence, barriers to seeking support include dependencies in the relationship for daily care or income, limited access to services, negative experiences with the police and legal systems and concerns about giving evidence against family members (Backhouse and Toivonen 2018; DSS 2022).

What are some of the challenges in getting help that people don't talk about?

'People don't talk enough about the enormous burden reaching out for help from services involves. It is so time consuming. Managing post separation abuse becomes a full-time job that you don't get paid for.'

Lily

WEAVERs Expert by Experience

In the mixed-model Hegarty et al. 2022 study described above, almost half (48%) of the participants said they could not get help when they needed it for relationship issues or sexual assault. Service-level barriers to receiving help included not being able to understand the terms used by the service workers, availability of appointments and the cost of services (Hegarty et al. 2022).

What was the main barrier for you in accessing support?

'The main barrier was finances and access to services. Violence doesn't occur only at convenient times, yet a lot of services were designed so that you could only access them at limited times in business hours. The services often assumed you weren't working, had access to unlimited childcare, and hours to come along and wait for assistance.'

Jasmine

WEAVERs Expert by Experience

The lack of services designed specifically for children and young people who experience family and sexual violence has been identified as a key issue in Australia (ANROWS 2016, FVRIM 2022, Royal Commission 2017). Disconnects between services that respond to family violence, including child protection and justice systems, has also been highlighted as a barrier to effective service provision (ANROWS 2016).

These barriers can be heightened for specific groups of people such as people living in regional and remote areas, women on temporary visas and women with disability. These are discussed further in **Is it the same for everyone?**.

To leave a violent relationship, victim-survivors also need safe and affordable housing, economic security and social support. The economic and financial impacts of violence can be substantial, and people may be faced with the choice between staying in a violent relationship and economic insecurity.

Strategies that can help to reduce some of the systemic barriers faced by victim-survivors include the provision of safe and affordable housing, social security supports such as crisis payments, social security payments and rent assistance, paid domestic and family violence leave and affordable childcare (DSS 2022). Some of these supports are discussed in further detail in **financial support and workplace responses**.

People who use violence

There is limited research on help-seeking behaviours of people who use intimate partner and/or sexual violence in Australia (Hegarty et al. 2022). The Hegarty et al. (2022) study included an online survey of around 560 people (mostly males) who used intimate partner and/or sexual violence against women. Of these participants, 74% had sought support about their behaviour, most often from a friend (45%).

Findings from the study indicate that people who use violence may also experience barriers to seeking support, including feelings of shame (41%) and issues with accessing services (35%). More than one-quarter (26%) of participants indicated the belief that violence is a normal part of a relationship and they didn't believe they needed to seek support (Hegarty et al. 2022).

What data are available to report on how people respond to FDSV?

Information on how people seek help can assist understanding and improvement of response strategies and provide information on the extent of under-reporting of family and domestic violence incidents in data collected as a by-product of service delivery.

Data from national surveys are available to show some of the actions taken when FDSV occurs, whether people sought support, the sources of support and the reasons for not seeking support.

Data sources for reporting on how people respond to FDSV

- ABS Personal Safety Survey
- AHRC national survey on sexual harassment in Australian workplaces
- National Student Safety Survey

For more information about these data sources, please see **Data sources and technical notes**.

What do the data tell us?

Data on advice or support (help) sought and received after incidents of FDSV are available from the ABS Personal Safety Survey (PSS). Data for experiences among men are only included where data are sufficiently statistically reliable.

People often do not seek advice or support for FDSV

The 2021–22 PSS showed that around:

- 1 in 2 (45%, or 78,100) women who had experienced physical and/or sexual violence from a **current partner** did not seek advice or support about the violence.
- 2 in 5 women (37% or 574,000) and 2 in 5 men (39% or 166,000) who had experienced physical and/or sexual violence from a **previous partner** did not seek advice or support about the violence (ABS 2023a).

The 2021–22 PSS collected detailed data from women about the most recent incident of sexual assault by a male that occurred in the last 10 years. Of the estimated 737,000 women who had experienced sexual assault by a male in the last 10 years, more than 2 in 5 (44%, or 324,000) did not seek advice or support after the most recent incident (ABS 2023b).

Friends or family are the most common source of support

Friends or family

are the most common source of support for those who have experienced partner violence

For women and men who did seek support following violence, the most common source of support was a friend or family member. The 2021–22 PSS showed that advice or support from a friend or family member was sought by around:

- 1 in 3 women (32%, or 56,100) who had experienced violence from a **current partner**
- 1 in 2 women (45%, or 682,000) and 1 in 2 men (51% or 218,000*) who had experienced violence from a **previous partner** (ABS 2023a).

Note that estimates marked with an asterisk (*) should be used with caution as they have a relative standard error between 25% and 50%.

In the 2021–22 PSS, 45% (331,000) of women who had experienced sexual assault by a male in the last 10 years had sought advice or support from a friend or family member after the most recent incident (ABS 2023b).

Police were not contacted for most incidents of partner violence or sexual violence

The 2021–22 PSS showed that people were unlikely to contact the police after physical and/or sexual violence from a partner.

The police were never contacted for violence that occurred among about:

- 8 in 10 women (79% or 136,000) who experienced violence from a current partner
- 7 in 10 men (73% or 312,000) who experienced violence from a previous partner
- 7 in 10 women (68% or 1.0 million) who experienced violence from a previous partner (ABS 2023a).

In the 2021–22 PSS, 92% (or 680,000) of women who had experienced sexual assault by a male in the last 10 years said the police were not contacted about the most recent incident (ABS 2023b).

Patterns in police reporting – including time between incident and report – are discussed in more detail in **Sexual assault reported to police** and **FDV reported to police**.

A study by the Australian Institute of Criminology assessed which characteristics of domestic violence affected whether the violence was reported to the police. It found that women were more likely to report violence than men, and a violent incident was more likely to be reported if it involved severe violence, physical assault (compared with other forms of intimate partner abuse) and/or physical injury. Frequent violence before the incident, and children witnessing the incident, also increased the likelihood of reporting. Presence of a weapon and the offender using alcohol were also linked to higher reporting (Voce and Boxall 2018).

Sexual harassment in the workplace often goes unreported

Data from the 2022 Survey on Sexual Harassment in Australian Workplaces show that over 1 in 3 (36%) people who experienced workplace sexual harassment sought support or advice in relation to the most recent incident. The majority of people did not seek support or advice. More than a quarter of people (27%) who did not seek support or advice did not do so because they thought it wasn't serious enough.

Fewer than 1 in 5 (18%) people who were sexually harassed lodged a formal report or complaint.

The most common reasons given for not reporting were that:

- 'it wasn't serious' (42%)
- 'it was easier to keep quiet' (38%)
- 'people would think they were over-reacting' (31%) (AHRC 2022).

Sexual assault and harassment at university often goes unreported

Data are available from the 2021 National Student Safety Survey (NSSS) to report on the experiences of sexual harassment at Australian universities. The NSSS was undertaken online from 6 September 2021 to 3 October 2021 with students from 38 Universities Australia member institutions. The in-scope population for the survey was students studying at Australian universities aged 18 years and over. Around 43,800 students participated in the survey for a completion rate of 11.6%. Due to the low response rate,

estimates from the survey may not be representative and should be interpreted with caution (Heywood et al. 2022).

According to the 2021 NSSS, sexual harassment is any unwelcome sexual advance, request for sexual favours or conduct of a sexual nature, in circumstances where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated.

Sexual assault is any unwanted sexual acts or sexual contact that happened in circumstances where a person was either forced, threatened, pressured, tricked, or no effort was made to check whether there was agreement to the act, including in circumstances where a person was asleep or affected by drugs or alcohol.

The data show that many students who had experienced sexual harassment or assault at university did not seek support or assistance:

- only 1 in 6 (17%) reported seeking support from within their university for sexual harassment and 1 in 4 (26%) for sexual assault
- less than two-thirds (62%) reported seeking support from outside the university for sexual harassment and 66% for sexual assault (Heywood et al. 2022).

A large proportion of sexual harassment and assault at university went unreported:

- 97% of respondents who were sexually harassed did not make a formal report or complaint to their university.
- 94% of respondents who were sexually assaulted did not make a report or complaint for the incident having most impact (Heywood et al. 2022).

When asked about reasons for non-report, the 3 most common reasons given by both those who were sexually assaulted and those who were sexually harassed were the same: they did not think they needed help, they did not think others would think it was serious enough, or they thought the incident would be too hard to prove. Many students also indicated systemic reasons for their non-report, such as thinking the issue would not be kept confidential, not knowing who to report or complain to, or being worried about the effect of reporting on their studies or career opportunities (Heywood et al. 2022).

People who seek support may not disclose the identity of perpetrators

Data from services can be used to report on people who seek formal support. Data are available from services operating across a range of sectors – such as health services, helplines, housing, police – to report on FDSV, either when the violence is disclosed or detected. However, even when people interact with services, they may be reluctant to disclose information about perpetrators.

Admitted patient care data can be used to show the number of people admitted to hospitals with injuries from assault. While these data show that a high proportion of

assault hospitalisations are FDV-related (see **Health services** for more information), a proportion of perpetrators are not specified.

Analysis of linked data, using the National Integrated Health Services Information Analysis Asset (NIHSI AA) can be used to show patterns in hospital stays among those who had an FDV-related hospital stay, and this information can indicate how identification of perpetrators has changed over time (Box 1).

Box 1: AIHW analysis of NIHSI data

An AIHW analysis used linked data to examine FDV hospital stays from 2010–11 to 2017–18. These data can be used to show patterns and outcomes for a 'FDV group'. The FDV group is anyone who had a FDV stay from 2010–11 to 2017–18 (but analysis includes stays that occurred in 2018–19) (AIHW 2021). FDV includes sexual assault where the perpetrator is spouse/domestic partner/parent or other family member. It does not include sexual assault committed by other perpetrators, such as strangers.

Over this period, there were around 34,400 hospital stays due to FDV. The number of people who had their 'first' FDV hospital stay steadily increased each year and was 32% higher in 2017–18 compared with 2010–11. However, some people may have had their first stay prior to this period. The increase in 'first' FDV hospital stays, and the increase in FDV hospital stays overall may be due to:

- increased disclosure of FDV in hospitals (as a result of increased awareness and/or changes in attitudes), and/or
- increased identification of FDV by health professionals (for example, through screening tools and/or increased training and awareness) and/or
- increased prevalence in FDV assault requiring hospitalisation (AIHW 2021).

This is supported by the data which showed a proportional decrease in 'other' assaults (i.e. assaults where no perpetrator was specified) over the analysis period. This suggests that 'other' assaults may have proportionally decreased due to increased identification of FDV assault (i.e. an increase in identification of an FDV defined perpetrator). It is also possible that some of the increase in FDV hospital stays overall is due to increased FDV events requiring hospitalisation.

See **Health services** for more information on how people use health services when violence occurs.

What services are most helpful?

While there are currently no national data to report on service experiences, findings from qualitative research conducted by Australia's National Research Organisation for Women's Safety (ANROWS) are available to look at the expectations of services for people who experience intimate partner and/or sexual violence (Box 2) and 'what works' for victim-survivors of sexual violence (Box 3).

Box 2: Expectations of services for people who experience intimate partner and/or sexual violence

Qualitative information sourced from the Hegarty et al. (2022) study indicated the practical and emotional support victim-survivors and perpetrators of intimate partner and/or sexual violence said they needed from services.

Responses from victim-survivors were grouped into five themes:

- To be taken seriously – to be heard and believed
- For services to have adequate resources to provide the support needed when it is needed
- For services to provide ongoing support and case management
- For services to recognise the person as an individual, with differing experiences of violence and support needs
- For services to address the perpetrator's behaviour (including legal and police action and therapeutic responses).

People who used intimate partner and/or sexual violence most valued services that helped them learn new ways to deal with relationship problems (92%) and made them feel listened to (92%).

The authors provided a range of recommendations for improvements across service responses including the need to: recognise the impact on children and offer accessible support for them; provide ongoing, flexible and tailored support; balance empathy with accountability and provide ongoing support for people who use intimate partner and/or sexual violence (Hegarty et al. 2022).

Box 3: What works for victim-survivors

In 2022, ANROWS published findings from a systematic review of crisis responses to sexual violence. The aim of the review was to provide an overview of the state of the evidence from high-income countries of existing systematic reviews in relation to the effectiveness of crisis and post-crisis interventions for victim-survivors of sexual violence (Coates et al 2022).

The most commonly evaluated interventions were:

- sexual assault response teams (SARTs) – multidisciplinary interventions that bring together professionals who respond to sexual assault across legal, medical, counselling and advocacy sectors to increase collaboration and improve responses for victim-survivors
- sexual assault nurse examiner (SANE) programs – nurses with specialist training who provide specialised healthcare and forensic examination to victim-survivors of sexual assault. SANEs also provide medical testimony and consultation to legal authorities in sexual assault cases (Coates et al 2022).

Reviews commonly assessed crisis responses for improvements in collaboration, criminal justice outcomes, increased referrals and victim-survivors' experiences of care. While there is emerging evidence that these interventions are effective across all of these outcomes, the evidence base is limited and the quality of the evidence overall poor (Coates et al 2022).

Key factors associated with effectiveness or acceptability of crisis responses were:

- the degree of participation and quality of relationships between medical and legal representatives within SARTs
- appropriate resourcing of SARTs
- the relationship between health workers, including counsellors, and victim-survivors.

Factors associated with effectiveness for post-crisis responses were:

- the individual and tailored delivery of interventions
- the informal support available to victim-survivors
- treatment duration and timing, the availability of specialist training in sexual violence for frontline providers
- the victim-survivors' relationship with the counsellor delivering the intervention.

The research highlighted that a key area for future research is the improved collection of data from victim-survivors to enhance evidence about service use (Coates et al 2022).

For more information, see What Works to reduce and respond to violence against women.

People with lived experience also report a wide range of services and therapies that have been most helpful for them.

Which types of services have been most helpful?

'Refuge was the most helpful for me. Being able to physically escape to a safe place really helped my journey. Even though I did go back a few times before finally completely leaving, the initial refuge planted seeds which formed the foundation and grew into confidence to leave. Through refuge, I saw what stability was like, discovered my independence and built on my relationship with my child – all things I couldn't do while living with a perpetrator of violence.'

Kelly

WEAVERs Expert by Experience

'The legal service I contacted through a telephone line was amazing and really helped me with practical information around the law and my rights in relation to intervention orders and finding a good lawyer.'

Martina

WEAVERs Expert by Experience

Other stories from people with lived experience are reported in **Services responding to FDSV**.

Activities that support healing and recovery

Healing and recovery can be lifelong, and can involve a range of activities outside formal support systems. Healing and recovery is also unique for each person, and people with lived experience report a range of different approaches.

What has been most helpful in your healing and recovery?

'The most helpful thing for me has been working as an expert with lived experience. Being able to share my story and experience in a professional setting while having the hope of making a difference to other people has been the most rewarding and healing thing I've done. It's built up a confidence I've never had before and helped shape my career and life for the better. We are empowered, guided, and encouraged as professionals, which I feel really works on that inner confidence that is often destroyed by perpetrators of family violence.'

Kelly

WEAVERs Expert by Experience

Is it the same for everyone?

Additional barriers to help-seeking for population groups

There are limited national data to understand how actions taken after FDSV vary across population groups. However, research shows that there can be additional barriers to help seeking, which can intersect in different ways for individuals. For example:

- Children are particularly at risk from adult perpetrators on whom they are dependent, have an emotional attachment to or view as an authority figure. Perpetrators of child sexual abuse can use grooming and other tactics to establish an emotional connection and build trust with the child or young person. Such attachments can make it more difficult for children to disclose violence (Royal Commission 2017).

  For children who are physically dependent on others for intimate personal care, it can be particularly challenging to determine the difference between intimate personal care and sexual abuse (Royal Commission 2017). As noted previously, children may experience specific challenges when disclosing violence or seeking support.
- People with disability may be more reliant on partners, family members or other carers for assistance and support. Fear that disclosure of abuse will put these relationships at risk and result in the loss of support and assistance can prevent people with disability seeking support (FVRIM 2022).

  Women with physical disabilities may not be able to physically access support services and women with communication difficulties may not be able to convey their story to workers (Breckenridge et al. 2015).

- People living in regional and remote areas may experience geographical and social isolation from support networks and limited access to services, particularly specialist services and crisis and long-term accommodation (Backhouse and Toivonen 2018). Victim-survivors in small communities may be reluctant to disclose family violence to a person known to them and/or the perpetrator (FVRIM 2022).
- Aboriginal and Torres Strait Islander (First Nations) women, children and communities may be less likely to disclose violence due to experiences of racism and a fear of losing children through the involvement of the child protection system (FVRIM 2022). For First Nations women in remote communities, concerns about confidentiality within tight family and community networks are heightened and they may need to travel long distances to seek support or rely on phone support (Backhouse and Toivonen 2018). Further discussion about specific barriers to First Nations women seeking support are reported in **Aboriginal and Torres Strait Islander people**.
- Women on a temporary visa may be dependent on a violent partner for residency and may not disclose violence due to the fear they may be deported. Conditions of temporary visas can result in social isolation due to, for example, restrictions to accessing employment, social security, housing and health care. These women, particularly those who speak languages other than English, may also experience challenges with communication and accessing information about their rights in complex matters relating to family violence, family law and immigration (Vaughan et al 2016).

Related material

- Health services
- Helplines and related support services
- FDV reported to police
- Sexual assault reported to police
- Housing
- Legal systems

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Health services

Key findings

In 2021–22:

- 9 in 10 hospitalisations for FDV-related injury by a partner were for females.
- Men were most likely to be hospitalised for a FDV-related injury by a family member other than their partner or parents
- With the exception of hospital admitted care, national data on other FDSV health service responses are very limited, although some data improvement work is underway.

Health services play an important role in responding to family, domestic and sexual violence (FDSV) (Garcia-Moreno et al. 2015). The 2021–22 ABS Personal Safety Survey (PSS) estimated that 1 in 5 women who experienced violence from a current partner sought advice or support from a general practitioner or other health professional (ABS 2023) (see **How do people respond to FDSV?**). It is also estimated that a full-time GP sees around five women per week who have experienced intimate partner violence in the last 12 months, representing an opportunity for early intervention and ongoing support (Roberts et al. 2006, as cited in RACGP 2022).

There are also financial costs, at both the health system and individual level. The health system cost associated with treating the effects of any violence against women was estimated to be at least $1.4 billion in 2015–16 (KPMG 2016). In addition, an analysis of the Australian Longitudinal Study on Women's Health found that:

- women with a history of intimate partner violence (IPV) have $48,413 higher lifetime health costs per person than women who do not experience IPV (William et al. 2022)
- the predicted average annual Medicare costs for women born in 1989–1995 who had experienced sexual violence were between $200 and $268 higher than for those who had not experienced sexual violence (Townsend et al. 2022)
- women born in 1989–1995 who had experienced sexual violence (22%) were more likely to have used at least one mental health consultation in 2018-19 when compared with women who had not experienced sexual violence (14%) (Townsend et al. 2022).

Examination of data on health service responses related to FDSV can provide insight on the use of different services, the extent and nature of violence experienced, and opportunities for intervention.

What do we know?

Australia's health services include a complex mix of service providers and health professionals that collectively work to meet the health care needs of people in Australia.

These services can assist victim-survivors and/or perpetrators of violence in a range of ways (Box 1).

Box 1: Health services responding to FDSV

Health services that respond to FDSV may include:

- primary care, including general practitioners (GPs) and community health services
- mental health services
- ambulance or emergency services
- alcohol and other drug treatment services
- hospitals (admitted patient care; emergency care; and outpatient care).

The type of interaction that victim-survivors and/or perpetrators have with these services will vary depending on the scope and aims of the service. Health services can assist in a range of ways including routine screening for domestic violence, risk assessment and safety planning, counselling, care and treatment for injuries due to FDSV, and first line responses, such as providing information and support.

To provide more holistic care for a person experiencing FDSV, some health services partner with other services to provide additional support in one physical location, for example health justice partnerships where health professionals and legal professionals work together at a hospital or health centre (AGD 2022).

Measuring health service use for FDSV

While each health service response has an important and different role to play, national service-level data on responses to FDSV are limited. Hospital records related to episodes of admitted care (hospitalisations) are the main nationally comparable data available, although some data related to FDSV responses in other health services are available in some states and territories. For this reason, national hospitalisation data from the AIHW National Hospital Morbidity Database are a focus of this topic page (for more information about this data source, please see **Data sources and technical notes**). However, information about other health services, such as primary care, including antenatal care, and ambulance services, are also discussed in the context of data development opportunities.

Even where service-level data related to FDSV are available, it is important to note that these data will not represent the complete picture as people may not always seek assistance, or when they do, they can be reluctant to disclose information related to violence involving a family member, or intimate partner. Additionally, personal accounts from service workers indicate a lack of resources and education may prevent adequate identification, treatment and documentation of victim-survivors engaging with health services (Cullen et al. 2022).

What do the data tell us?

Hospitals

Some people who experience family and domestic violence are admitted to hospital for treatment and care. The AIHW National Hospital Morbidity Database captures the number of cases admitted to hospital with an injury related to FDSV. Examining the number of hospitalisations for injuries related to FDV provides an indication of the demand for these services. However, these data do not include presentations to emergency departments and will relate to more severe (and mostly physical) experiences of family and domestic violence (FDV) (AIHW 2019; AIHW 2022a).

Box 2: How are FDV hospitalisations identified?

The 10th Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) is an international standard for coding of diseases and related health conditions developed by the World Health Organization (WHO). The Australian modification of the ICD-10 (ICD-10-AM) is used to classify episodes of hospital care including those where family, domestic and sexual violence is documented in the hospital record.

Coding captures a broad scope of injuries which could include physical, sexual and psychological abuse. FDV data are recorded using the following coding rules:

- a perpetrator coded as Spouse or domestic partner, Parent, or Other family member and,
- an injury principal diagnosis in the ICD-10-AM code range S00–T75, T79,
- a first recorded External causes of morbidity and mortality ICD-10-AM code in the range X85–Y09 (Assault).

Using this method there were 6,478 hospitalisations in 2021–22. If the method is expanded to include hospitalisations with FDV assault recorded as any external cause regardless of the principal diagnoses, then the number of hospitalisations increases by 25% (to 8,086). Of these 8,086 hospitalisations, 83% have a principal diagnosis related to injury and poisoning, and 5% have a principal diagnosis related to mental and behavioural disorders. Regardless of the method used, around 3 in 4 hospitalisations where FDV assault was documented were for females (AIHW 2023a).

Improvements in recording of perpetrator

Specific information about a perpetrator may not be available in assault hospitalisations for a number of reasons, including:

- information not being reported by, or on behalf of, victims, or
- information not being recorded in the patient's hospital record.

Additionally, the perpetrator of assault was less likely to be specified for:

- male victims when compared with female victims; young or middle-aged adults when compared with children and older victims (AIHW 2021).

However, the proportion of assault hospitalisations with a specified perpetrator recorded has improved by almost 25 percentage points from 42% in 2002–03 when perpetrator coding was introduced, to 67% in 2021–22 (AIHW 2023a).

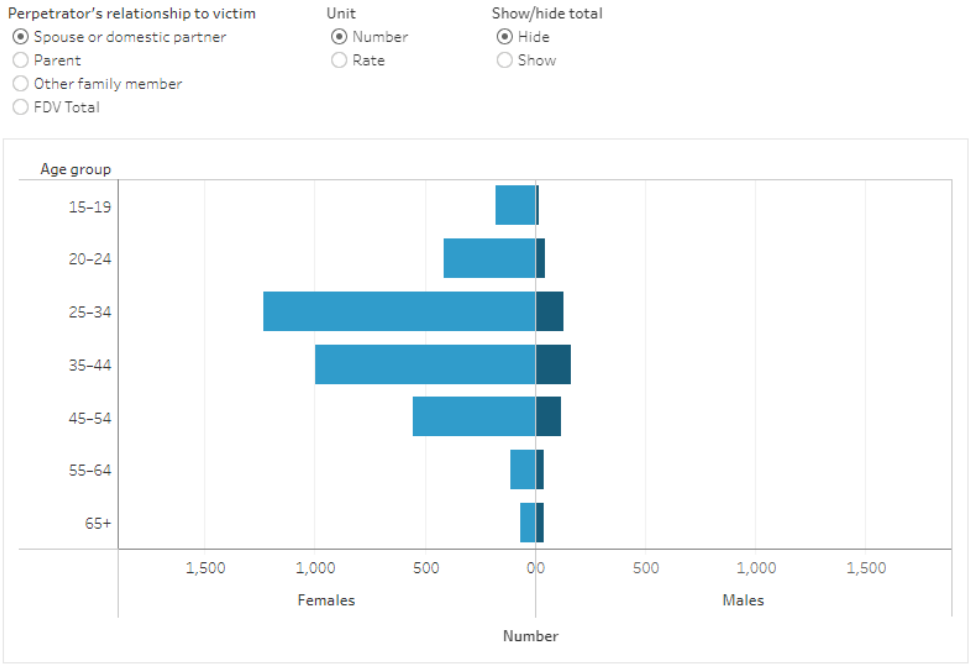
In 2021–22, **9 in 10 hospitalisations** for assault injury by a partner were for females

In 2021–22, 3 in 10 (32% or 6,500) assault hospitalisations were due to FDV. The overall rate of FDV hospitalisations was almost 3 times as high for females compared with males (Figure 1). Across all age groups, the number and rate of FDV hospitalisation were greater for females than males aged 15 and older.

Almost 9 in 10 (87%) hospitalisations due to injury from a spouse or domestic partner involved a female. Rates of hospitalisation where the perpetrator was a spouse or domestic partner were 6 times as high for females (33 per 100,000) than males (5.3 per 100,000) aged 15 and over.

These rates increased with age for younger females, peaking at age 25–34 (66 per 100,000), and then decreased with age to 2.8 per 100,000 for females aged 65 and over. Similarly, the rate of hospitalisations for assault by a spouse or partner increased with age for males, and was highest in 35–44 year olds (9.3 per 100,000), decreasing to 1.8 per 100,000 for males aged 65 or older (AIHW 2022a). See also **Young women**.

Figure 1: Family and domestic violence hospitalisations by relationship to perpetrator and age, 2019–20 to 2021–2022



n.p.: not published
Source: AIHW NHMD.

https://www.aihw.gov.au

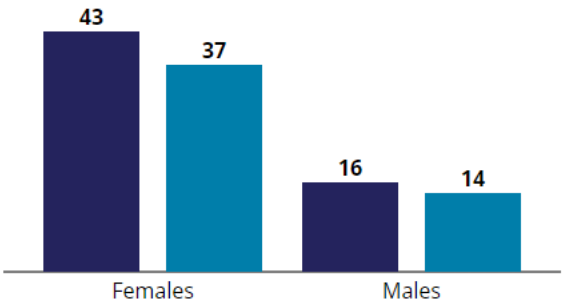
In 2021–22, men were more likely to be hospitalised for a family and domestic violence related assault injury by someone other than a partner or parent

In 2021–22, the majority (59%, or 930) of FDV hospitalisations for males aged 15 and over were for injuries from a family member other than their spouse or domestic partner or parent.

The rate of hospitalisations for males for assault by a family member (other than a partner or parent) was highest for 20–24 year olds (13 per 100,000), and decreased with age to 4.9 per 100,000 for males aged 65 years or older. The rate of females hospitalised for assault by other family members was highest for women aged 20–24 and 25–34 (each 12 per 100,000) and decreased with age to 4.1 per 100,000 for females aged 65 years or older (Figure 1).

Hospitalisations over time

Between 2020–21 and 2021–22, the rate of family and domestic violence hospitalisations for females fell by 15% and the rate for males remained relatively stable

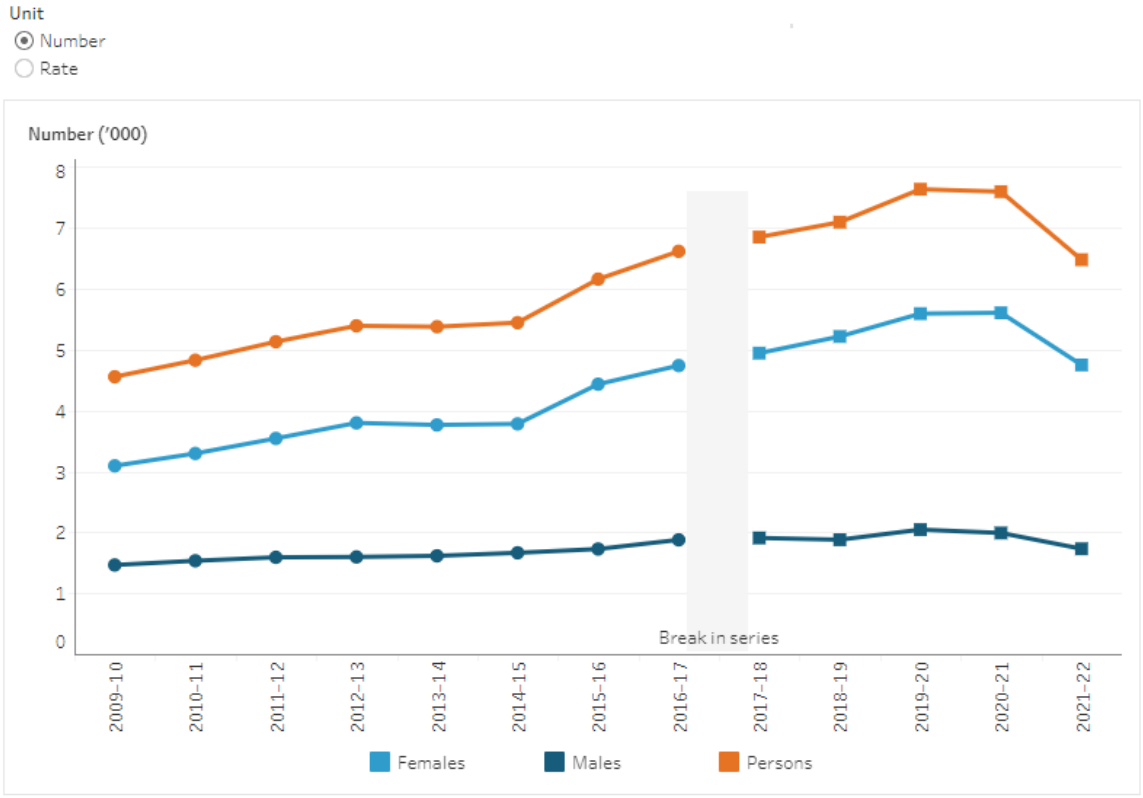


While examining hospitalisations over time can help to understand patterns of hospitalisations for FDV related cases, it does not represent the broader prevalence of FDSV across the population in Australia. Changes in hospitalisation rates may be due to changes in disclosure rates, changes in identification or recording of family and domestic violence by health professionals, and/or changes in family and domestic violence events requiring hospitalisation (AIHW 2022a).

Between 2020–21 and 2021–22 the rate of family and domestic violence hospitalisations for females decreased by 15% and the rate for males remained relatively stable. This is consistent with the data for all injury hospitalisations in 2021–22 – for information about the impact of COVID-19 restrictions on injury hospitalisations, see Injury in Australia. Characteristics of FDV-related injury hospitalisation in 2021–22 were relatively consistent when compared with 2020–21 (for example, the vast majority of hospitalisations were for females and most injuries were to the head) (AIHW 2023a).

For data relating to FDV-related injury hospitalisations during the COVID-19 pandemic, see **FDSV and COVID-19**.

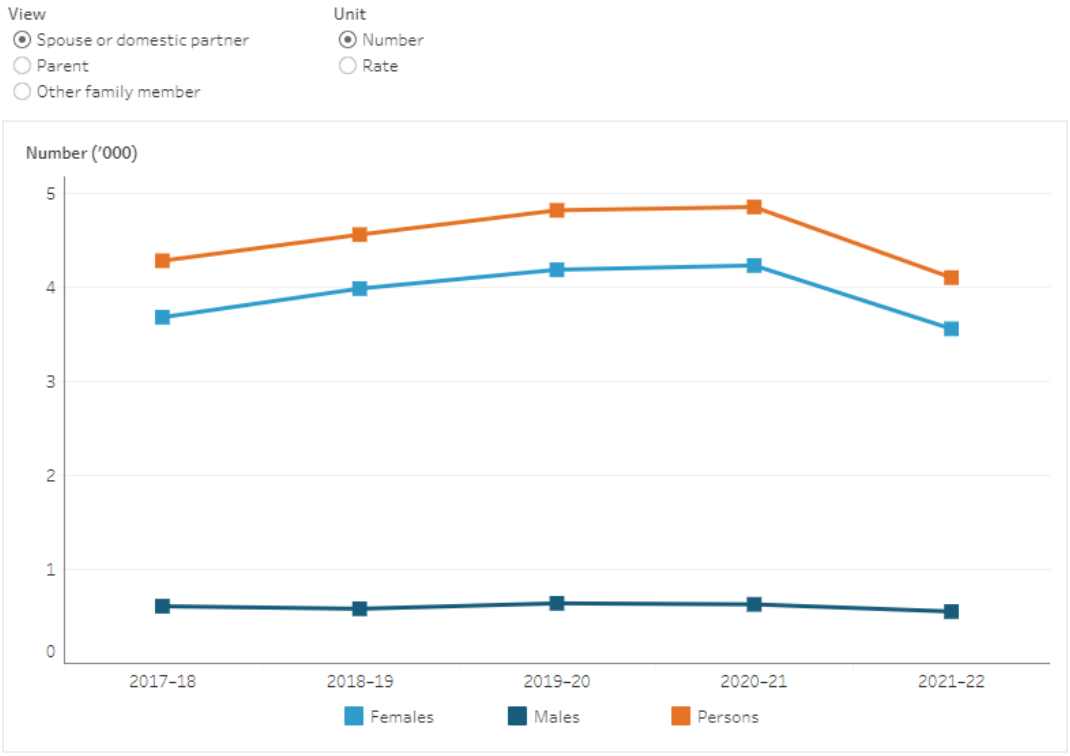
Figure 2: Family and domestic violence hospitalisations, by sex, 2009–10 to 2021–22



Source: AIHW NHMD. https://www.aihw.gov.au

The visualisation below allows users to explore the rate of family and domestic violence hospitalisations by relationship to perpetrator and sex, over time. Rates of hospitalisation where the perpetrator was a spouse or domestic partner were consistently around 6 times higher for females aged 15 years and over than for males (AIHW 2023a).

Figure 3: Family and domestic violence hospitalisations, by relationship to perpetrator, 2017–18 to 2021–22



Source: AIHW NHMD. https://www.aihw.gov.au

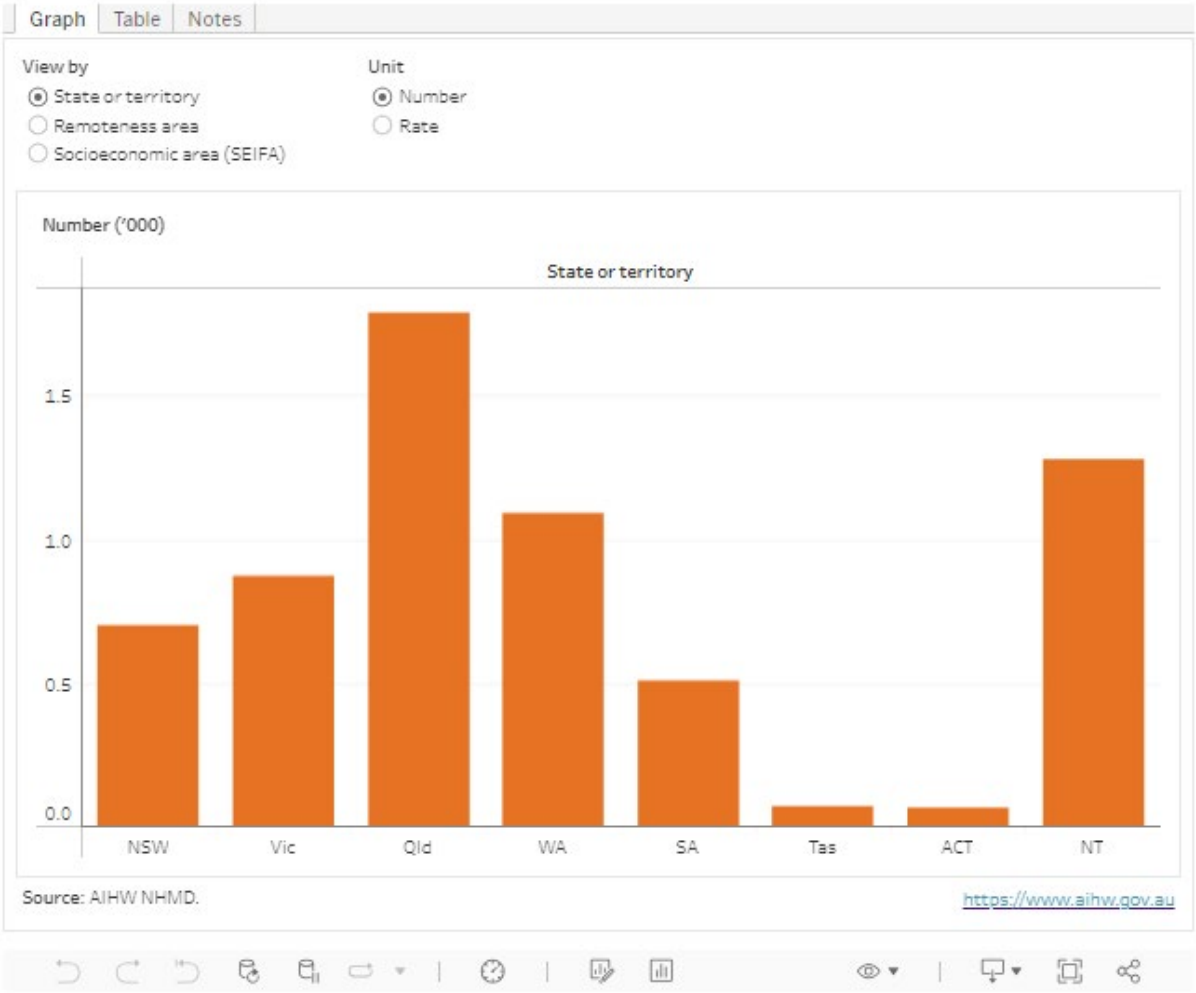
Is it the same for everyone?

Select population groups may be exposed to intersecting and unique challenges that impact rates of hospitalisation for FDV related injury. Investigating the prevalence of FDV in specific groups can be used to inform the development of more targeted and needs-based programs and services.

The visualisation below (Figure 4) allows users to explore the rate of family and domestic violence hospitalisations, by various population groups for which national data were available. In 2021–22, rates of family and domestic violence hospitalisations:

- were highest for those living in the Northern Territory
- increased with remoteness
- were highest for those in the most disadvantaged socioeconomic area compared with all other socioeconomic areas (AIHW 2023a).

Figure 4: Family and domestic violence hospitalisations, for select population groups, 2021–22



Rates of family and domestic violence hospitalisations were also higher for First Nations people than non-Indigenous people. See **Aboriginal and Torres Strait Islander people**.

For more information on specific groups see **Population groups**.

What else do we know about hospitalisations?

Hospitalisations for sexual assault

In 2021–22, there were 280 hospitalisations due to sexual assault (any perpetrator type). The vast majority of people hospitalised for sexual assault were female (93% or 260). Almost 3 in 10 (29%) people hospitalised for sexual assault were aged 25–34, followed by around 1 in 6 people aged 15–19 (17%), 20–24 (16%) and 35–44 (16%) (AIHW 2023a).

Of the 280 sexual assault hospitalisations, the most common perpetrator was an "Unspecified person" (27% or 76). Almost 1 in 4 (23%) females reported a "Spouse or

domestic partner" as the perpetrator while no males reported this category of perpetrator (AIHW 2023a).

The number of sexual assault hospitalisations was relatively stable between 2017–18 and 2021–22, with between 220 and 280 hospitalisations recorded each year. Each year from 2017–18 to 2021–22:

- females made up between 89–93% of sexual assault hospitalisations
- 25–34 year olds were the largest age group, ranging from 25–32% of sexual assault hospitalisation cases.

These data do not include any hospital activity in the emergency department or hospital outpatient units.

Analysis using linked data

The AIHW report, *Examination of hospital stays due to family and domestic violence 2010–11 to 2018–19* used linked data in the National Integrated Health Service Information Analysis Asset (NIHSI AA) to provide novel analysis of person-level, rather than episode-level data. In addition to providing hospital stay information at the person- level, through the use of linked records, the report also provided insight into emergency department presentations and subsequent deaths among the FDV cohort.

For the linkage report, an FDV hospital stay was defined as any hospital stay where FDV was identified anywhere within the record – that is, including information within *additional diagnoses*, and not limited to *principal diagnosis* information. A hospital stay within the report also refers to a continuous episode of care, which can include several hospitalisations.

The number of people who had an FDV hospital stay increased over time

The number of people who had their 'first' (first identified in the data) FDV hospital stay between 2010–11 and 2017–18 steadily increased each year, and was 32% higher in 2017–18 compared with 2010–11. However, some people may have had their first stay prior to this period. The total number of FDV hospital stays that occurred each year also increased over the same time period (up 50% by 2017–18) (AIHW 2021).

The increase in 'first' FDV hospital stays, and the increase in FDV hospital stays overall may be due to:

- increased disclosure of FDV in hospitals (as a result of increased awareness and/or changes in attitudes), and/or
- increased identification and recording of FDV by health professionals (for example, through screening tools and/or increased training and awareness), and/or
- increased FDV-related events requiring hospitalisation (AIHW 2021).

Hospital data shows a proportional decrease in 'other' assaults (i.e. assaults where no perpetrator was specified) over the analysis period. This suggests that 'other' assaults

may have proportionally decreased due to increased identification of FDV assault (i.e. an increase in identification of an FDV defined perpetrator) (AIHW 2019; AIHW 2021).

More than 1 in 10 people with an FDV hospital stay had been admitted 2 or more times

Of the people who had at least one FDV hospital stay from 2010–11 to 2017–18:

- 88% had one FDV hospital stay
- 9% had 2 FDV hospital stays
- 3% experienced 3 or more hospital stays for FDV in the time to 2018–19 (AIHW 2021).

These results remain consistent when looking at a 3-year follow-up period; 89% had one FDV hospital stay, 8% had 2, and 2% experienced 3 or more. The most common timeframe between FDV hospital stays for those that had multiple FDV hospital stays, was less than 1 year (62%), followed by 1–2 years (16%). People with 3 or more FDV stays were the most likely to have had 10 or more ED presentations (53%). From the national data, it cannot be determined whether these presentations were FDV-related (AIHW 2021).

For more information on long-term impacts of FDSV see **Health outcomes**.

Other health services and national development opportunities

National data from health services are essential for understanding the extent, nature and impact of family, domestic and sexual violence. The importance of building a nationally consistent and robust data framework was emphasised in the *National Plan to Reduce Violence against Women and their Children, 2022–2032* and the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into family, domestic and sexual violence (the Inquiry). The Australian Government supported in-principle, the Inquiry's recommendation that a 'data collection on service-system contacts with victim-survivors and perpetrators, including data from primary care, ambulance, emergency department, police, justice and legal services' be developed, in recognition of the important role of the health system response. A strong evidence base is essential to support and inform policy makers, service providers and government programs that address FDSV (AIHW 2022b, DSS 2023). The AIHW is developing a FDSV integrated data system, which can form the basis for further expansion and development. However, the true value of this system will only be realised when consistent data on FDSV specialist services are available nationally. For more see *Family, domestic and sexual violence: National data landscape 2022*.

Primary health care

Primary health care, that can include general practitioners, nurses, Aboriginal Health Workers and allied health professionals, may provide a formal point of contact and care

for people experiencing FDSV. As general practitioners are often a person's first point of contact for health care, they are particularly well-placed to identify, support and refer people experiencing intimate partner violence (RACGP 2022).

The primary health care sector is rich in clinical data and information to support the management of individuals' health care, however, the availability of data for national population research is limited. Specifically, there is no consistent collection of national data to understand how people use primary care, the conditions managed, health and wellbeing outcomes, and links between other services, such as hospitals or community services. Data are collected through a range of different mechanisms across jurisdictions, primary health networks (PHNs) and services, but not in a uniform and consistent way (AIHW 2022b).

Currently, if information is recorded on FDSV, it is usually recorded in free text fields, in a non-standardised way. Therefore, analysis of free text, using complex computing techniques, provides the most likely opportunity to identify FDSV in primary care. Similar strategies could possibly be applied to other service data, such as emergency departments, to help identify the prevalence of FDSV among service users.

Administrative by-product data collected by the Australian Government in relation to Medicare Benefits Schedule claims is used to report on some primary care activity related to specific areas, such as mental health. However, there are currently no specific claims items under the MBS which could be used to identify activity related to FDSV (House of Representatives Standing Committee on Social Policy and Legal Affairs 2021).

There are some national programs focused on primary health care providers under development. For example, the Australian Government has provided funding for an expansion and extension of the Recognise, Respond and Refer pilot program. This trial aims to improve system responses to FDSV, by recognising the key role primary health care plays within the broader system response to FDSV. The program is being trialled in select Primary Health Networks and provides opportunities to consider the scope and nature of data collected in primary care (TCA 2022).

Additionally, the AIHW is leading the establishment of a National Primary Health Care Data Collection. The work program to achieve this encompasses the development of processes for governance, standards, infrastructure, collection, analysis and reporting of primary health care data within Australia. In the longer term, this work may provide an opportunity to capture FDSV in a standardised way to inform national reporting and monitoring related to FDSV (AIHW 2020b).

Perinatal care

Pregnancy can represent a time of increased risk of exposure to violence for both mothers and babies. Many pregnant people have regular contact with health-care professionals during pregnancy, which presents an opportunity to identify and respond to violence (see **Pregnant people**).

Screening for FDV during pregnancy occurs in most states and territories, however, a variety of FDV screening approaches are used (AIHW 2015). In 2020, a voluntary family

violence screening question (which is defined as including "Violence between family members as well as between current or former intimate partners") was introduced into the National Perinatal Data Collection (NPDC) to identify whether screening for FDV was conducted. Due to the time lag between development, implementation and collection of data by the state and territory perinatal data collections and their inclusion in the NPDC, data are not yet available for reporting (AIHW 2023b).

The AIHW is working with the Commonwealth Department of Health and Aged Care and states and territories to develop the Perinatal Mental Health pilot data collection. This novel data collection will contain data from antenatal and postnatal perinatal mental health screening conducted in participating public maternity hospitals and maternal and child family health clinics; and some of the screening tools included in the pilot cover data on FDSV risk. Analysis of the pilot data will inform decisions about the appropriateness and feasibility of capturing this information on an ongoing basis (AIHW 2022b).

See also **Pregnant people**.

Emergency departments

Emergency departments (ED) are a critical point of contact for people who require urgent medical attention. In addition to providing immediate medical treatment, EDs also provide resources and additional services to people experiencing FDSV. Understanding how victim-survivors interact with EDs helps inform policy, resourcing and adequate training to staff effectively manage FDSV-related presentations.

The national emergency department (ED) data collection does not currently capture information on presentations related to family or domestic violence related injuries. Unlike for patients admitted to hospitals, the national ED data contains very little information about the context in which injuries occur (that is the ‘external cause’). While the nature of the injury (e.g. a fracture) is captured, information about the cause of the injury (e.g. assault), the place of occurrence (e.g. home) and the activity underway when the injury occurred is not (AIHW 2022b).

Currently, this gap inhibits understanding of the extent and impact of this issues on both the health system and the population. For example, it is difficult to answer questions about how FDV impacts EDs, or how many times the same person may be interacting with emergency departments because of violence (AIHW 2022b).

Some relevant information on emergency department presentations related to FDV is collected in some jurisdictions, for example Victoria (see Box 3).

In 2018–19, the AIHW, in conjunction with state and territory stakeholders, developed options for enhancing the capture of FDSV in national ED data, and national discussions continue about the options for capturing external cause data more broadly in national ED data (AIHW 2020b).

As more Urgent Care Clinics are established across Australia (Department of Health and Aged Care 2023), it is expected that some patients experiencing FDSV will present at these services instead of emergency departments. Development of the national Urgent

Care Clinic data collection may provide an opportunity to capture and report data related to FDSV in the future.

Box 3: Victorian emergency department FDV admissions

The Crime Statistics Agency (CSA) Victoria captures state data on emergency department responses to family, domestic and sexual violence. The CSA captures incidents where a clinician has indicated one of the following categories has contributed to injury:

- Sexual assault by current or former intimate partner
- Sexual assault by other family member (excluding intimate partner)
- Neglect, maltreatment, assault by current or former intimate partner or
- Neglect, maltreatment, assault by other family member (excluding intimate partner).

From 1 July 2017 to 30 June 2022, 6,900 people presented to a Victorian public hospital emergency department for family violence-related injury:

- Around 2 in 3 (64%) were female
- Around 1 in 4 (27%) were females aged 20–34
- The proportion of females (19%) who experienced injury to multiple body regions was twice as high as males (8.9%)
- Both males (39%) and females (34%) most commonly presented to ED for an injury to the head or face.

The ability to use these data to represent the extent of family violence-related presentations may be limited by the level of detail recorded, victim-survivor unwillingness or inability to seek assistance, or when they do, reluctance to disclose information related to violence involving a family member, or intimate partner.

Source: CSA 2022.

Ambulance services

Ambulance services can respond to health emergencies related to FDSV. Ambulance clinical records have the potential to capture characteristics of FDSV including the type of violence, relationships between victims and perpetrators, and other associated health factors (such as substance use or mental health concerns). Recording accurate data on attendance for FDSV may also help identify repeat incidents, or individuals who may require additional support or intervention (Scott et al. 2020a).

As noted previously, surveillance data on FDSV at a public health level are limited. Ambulance data has the potential to overcome some of the limitations with other data sources. However, ambulance services are run by states and territories – while many states and territories recognise the importance of identifying FDSV incidents, developments to capture national service-level data are required (AIHW 2022b). Box 4 outlines the data available for reporting from the National Ambulance Surveillance System.

Box 4: National Ambulance Surveillance System

The National Ambulance Surveillance System (NASS) is a world-first public health monitoring system providing timely and comprehensive data on ambulance attendances in Australia. The NASS is a partnership between Turning Point, Monash University and state or territory ambulance services across Australia. The NASS collates and codes monthly ambulance attendances data for participating states and territories for self-harm behaviours (suicidal ideation, suicide attempt, death by suicide and intentional self-injury), mental health and alcohol and other drug-related attendances. These coded data are routinely managed by AIHW; and there is potential to expand the system to capture data on FDSV-related attendances (AIHW 2022b).

Pilot use of the Turning Point data, captured FDV-related attendances in Victoria and Tasmania. These attendances are those in which paramedics recorded the third parties involved in the violent incident as an intimate partner (partner, de facto, married, estranged, previous relationship, other romantic relationships) or other family member (other family, extended family, step, foster and adopted family members). For more information about the NASS, please see **Data sources and technical notes**.

In 2016–17, there were almost 6,300 violence-related ambulance attendances, the majority (61%) of which were identified as community violence, occurring between individuals who are unrelated and may be unknown to each other. This may include violence against professionals such as paramedics or police. One-quarter (25%) were identified as other family violence (OFV) and 19% as intimate partner violence (IPV) (Scott et al. 2020b).

This pilot project demonstrated that routine coding and reporting of a violence module for these data could complement existing health, police, coronial and survey data (Scott et al. 2020a).

Intimate partner violence

- About 4 in 5 (84%) victims of IPV-related ambulance attendances were females.
- The highest proportion of victims were aged 18–29 and 30–39 (30% each).
- The highest proportion of perpetrators for IPV-related attendances were aged over 60 years (26%), followed by 18–29 year olds (24%).
- About 2 in 5 (42%) IPV-related ambulance attendances for victims were primarily for violence only, and 37% involved alcohol and other drugs.
- About 3 in 10 (28%) IPV-related ambulance attendances for perpetrators involved violence and mental health symptoms, with less than 1 in 5 (16%) involving violence only (Scott et al. 2020a).

Other family violence

- For ambulance attendances for victims of OFV, similar proportions were reported for females (51%) and males (49%).
- The highest proportion of perpetrators for OFV-related attendances were aged under 18 years (31%) (Scott et al. 2020a).

Box 5: A closer look at Victoria

Data from Ambulance Victoria captures indicative rates of events involving FDSV attended to by Ambulance Victoria between July 2017 and June 2022. These events have been flagged by attending paramedics as part of the administrative data collected. During this period, events of alleged FDSV were most likely to involve physical violence (84% of events for which the violence type was recorded, compared with less than 10% each for sexual violence, psychological or emotional violence or other violence). For around 3 in 5 (59%) events a partner/spouse was the alleged perpetrator (where the relationship to the perpetrator was recorded) (CSA 2022).

Other selected health services

Mental health

Given the complex interactions between FDSV and mental illness, services that are dedicated to mental health care can play an important role in responding to people who are at risk of or are experiencing violence. Examples of these services include community-mental health care services, residential mental health care services, specialised psychiatric hospital, or ward services; provided by psychologists, psychiatrists and other allied health professionals.

Nationally consistent data on FDSV is not currently available across any of these services. While some information on FDSV is available for people admitted to hospital, it is limited to hospitalisations where an FDV assault has been identified or disclosed (see Box 2).

Some relevant data are available in some jurisdictions. For example, in New South Wales screening for domestic violence is required for women aged 16 years and over who attend publicly-funded mental health services and data are available on screening uptake and the outcome (NSW Health 2023).

Alcohol and other drug treatment services

People who are at risk of or experiencing violence may use services dedicated to treatment for alcohol and/or other drug use. Examples of these services include alcohol and other drug (AOD) treatment services, and services provided in alcohol and other drug hospital treatment units.

The Alcohol and Other Drug Treatment Services National Minimum Data Set collects information on the majority of publicly-funded AOD treatment services. This data set does not collect specific information on FDSV, however some relevant data are collected in some states and territories. For example:

- In Queensland, three flags can be recorded in the AOD sector: experiencing family or domestic violence; experiencing family or domestic violence (Domestic Violence

Order); and experiencing domestic or family violence (police protection needed) (AIHW 2020a).

- As per mental health services, New South Wales domestic violence screening is required for women aged 16 years and over who attend publicly-funded alcohol and other drug services, and data are available on screening uptake and the outcome (NSW Health 2023).

Specialist sexual violence services

Health-related specialist sexual violence services are usually provided by specialist sexual assault service providers or designated wards/units within hospitals. These services respond to sexual assault by any perpetrator, including domestic and family members, and include medical and forensic sexual assault care, counselling and support, information and referrals. Services and/or interventions may target particular populations, for example, adults, children, victims and survivors of child sexual abuse.

Nationally consistent data on these services is not currently available, although some data are collected at the state/territory level. Under the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*, a baseline analysis of specialist and community support services for victims and survivors of child sexual abuse is underway. Several activities will be undertaken as part of this work including an assessment by the Australian Institute of Health and welfare (AIHW) on the feasibility of developing a nationally consistent minimum data collection for the relevant support services. This project has the potential to build the foundations for improved availability of national specialist sexual violence services data in the longer term (AIHW 2022b).

The Australian Government launched the National Redress Scheme in October 2020 for people who have experienced institutional child sexual abuse. As of 31 March 2021, the majority of applications (60%) from the scheme resulted in people accepting an offer of counselling and psychological care (DSS 2021). Some of this counselling and psychological care may have been provided by specialist sexual violence services.

For information on data development work being undertaken in relation to specialist FDSV services collections, please see **Key information gaps and development activities**.

Related material

- How do people respond to FDSV?
- Health outcomes
- Aboriginal and Torres Strait Islander people
- Children and young people
- Young women
- Pregnant people

More information

Injury in Australia

Family, domestic and sexual violence: National data landscape 2022

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Helplines and related support services

Help is available. If you or someone close to you is in immediate danger, please call 000. For information, support and counselling, see **Find support**.

Key findings

- There were almost 269,000 contacts (telephone and web chats) to 1800RESPECT in 2022–23.
- In 2021–22, the Blue Knot Helpline provided more than 25,000 occasions of service to callers, via phone, email and webchat.
- Men's Referral Service received over 7,600 helpline calls and almost 60,000 referrals from police in 2021–22.

The term 'helplines' is used broadly in this topic page to refer to services that include a telephone helpline as part of their range of supports.

For people experiencing family, domestic and sexual violence, helplines can provide an important source of advice, information and support.

The 2021–22 Personal Safety Survey estimated that 63% of women who experienced violence from a previous partner had sought advice or support (around 962,000). Of these women, around 10% had contacted a telephone helpline (around 100,000) (ABS 2023). See also **How do people respond to FDSV?**.

In the early years of the COVID-19 pandemic, helpline data, which can be more timely than other service data, was used to consider the impact of COVID-19 on violence and mental health; see also **FDSV and COVID-19** and Mental health services activity monitoring quarterly data.

This topic page provides an overview of available data on national helpline activity in Australia.

What are helplines?

Helpline providers offer a range of support services, across a range of contact methods

Helplines are an important entry point into the family, domestic and sexual violence service system for those in need of assistance. They provide a range of services and supports, including information, referral, counselling and advocacy.

Why are helplines important for those who have experienced violence?

'Helplines are vital for victims of violence. Helplines are often the first point of contact and sometimes the only contact, especially for those victims who are being kept isolated, or who live in remote locations.'

Lily

WEAVERs Expert by Experience

Some helplines are specifically designed to respond to family, domestic and sexual violence – for example, those connected to rape crisis centres, or specialist family violence services. Others may provide more general support in areas such as family relationships, mental health, or legal assistance, but will often respond to family, domestic and sexual violence as part of this work. Redress support for adult survivors of child sexual abuse is a growing area of service provision (Box 1).

Box 1: Redress support services

A growing area of service provision is supporting adult survivors of child sexual abuse as they explore or engage with a redress scheme, recognising that the client will need to revisit trauma through this process.

In acknowledgement of the harm caused by childhood abuse, redress schemes may provide a monetary payment, access to healing and counselling services, and a personal response or apology. There are number of redress schemes:

- The **National Redress Scheme,** established in 2018 by the Australian Government in response to one of the key recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. The scheme acknowledges that many children were sexually abused in Australian institutions, including orphanages, Children's Homes, schools, churches and other religious organisations, sports clubs, hospitals, foster care and other institutions.
- State and territory **redress schemes for Stolen Generation survivors** are currently available in New South Wales, Victoria, the Australian Capital Territory and the Northern Territory. These schemes recognise the harm and intergenerational trauma caused by the forcible removal of Aboriginal and Torres Strait Islander (First Nations) children from their families as a result of government policies. Many children from the Stolen Generations experienced physical, sexual and emotional abuse while living under state care or with non-Indigenous families.
- **Institutional redress schemes**, which may be available from some institutions where there has been physical, emotional or sexual abuse committed by their staff.

Sources: DSS 2022; knowmore 2022a; New South Wales Government 2022; NIAA 2022; Victoria Government 2022.

A variety of people may use helplines, including victim-survivors, friends, family, perpetrators of violence, and other service providers. People may contact helplines

about current or previous experiences of violence, as well as concerns about risk of violence.

Helplines are traditionally contacted via telephone, but technology-assisted methods of contact have become more widespread (Box 2).

Box 2: Technology-assisted services

The way people seek and engage with services has been changing in response to increasingly widespread use of communications technology (via smartphones, tablets, laptops and other personal computers). This has been accelerated by the COVID-19 pandemic which affected daily life through restrictions on people's movements, while also affecting how businesses and services could operate. For example, in Australia, COVID-19 prompted a rapid rise in 'telehealth' service delivery, which enables people to have healthcare consultations and mental health counselling by phone or video call – services that were traditionally delivered face-to-face.

Across a range of sectors, many services now provide multiple methods of contact and delivery, including telephone calls, online (webchat, text messages, email, videoconferencing) and face-to-face. An individual may engage with a service using multiple methods.

There are many reasons a person may opt to access support via technology-assisted methods. For some it is a convenience, for some it may be a necessity. In particular, for those experiencing family, domestic or sexual violence, technology-assisted services may provide greater access to options for seeking support – for example, for people living in remote geographic areas, those with mobility and/or transport limitations, and those whose autonomy may be restricted due to coercive control.

One example of a technology-assisted service is Ask Izzy, a website optimised for mobile use that connects people who are in crisis with the services they need, now and nearby. Users select the type of assistance they require, such as housing, food and health. In 2021–22, there were over 61,000 searches for family and domestic violence help on Ask Izzy, representing 3.8% of all searches. The most common related searches were for housing (54% of those also searching for FDV help), and mental health support (18%) (Infoxchange unpublished).

What do we know?

There are many helplines in Australia which respond to family, domestic and sexual violence. They vary in the type of supports provided, their target populations, the available methods of contact, and the degree to which they are available nationally and at the state/territory level. Table 1 provides some examples of national helpline services.

Table 1: Examples of national helpline services, including overview of target population and methods of contact

Service	Overview of target population	Telephone	Web chat	Email	Video conference	In person	Other online[(a)]
1800RESPECT	People affected by family, domestic or sexual violence	•	•				•
Blue Knot Foundation	People affected by complex trauma due to violence	•	•	•	•		
Kids Helpline	Children and young people aged 5–25	•	•	•			•
Bravehearts	People affected by child sexual abuse	•		•		•	
Men's Referral Service	Men who use or have used violence	•	•				
Full Stop Australia	People affected by family, domestic or sexual violence	•	•	•		•	
knowmore	Survivors of child sexual abuse	•					
1800 ELDERHelp	People affected by elder abuse	•					

(a) Includes mobile phone app, or social networking platform.

Note: See **Find support** for contact details.

There is currently no national data collection, so data need to be sourced from individual helplines. This topic page includes data for a modest number of national providers – while this offers some insights, it is acknowledged that the available data are fragmented and only provide a partial picture of the level of activity of helplines and related support services in Australia.

Data sources for reporting on helplines

- 1800RESPECT
- Kids Helpline

For more information about these data sources, please see **Data sources and technical notes**.

Data from published annual reports for various service providers have also been included.

What do the data tell us?

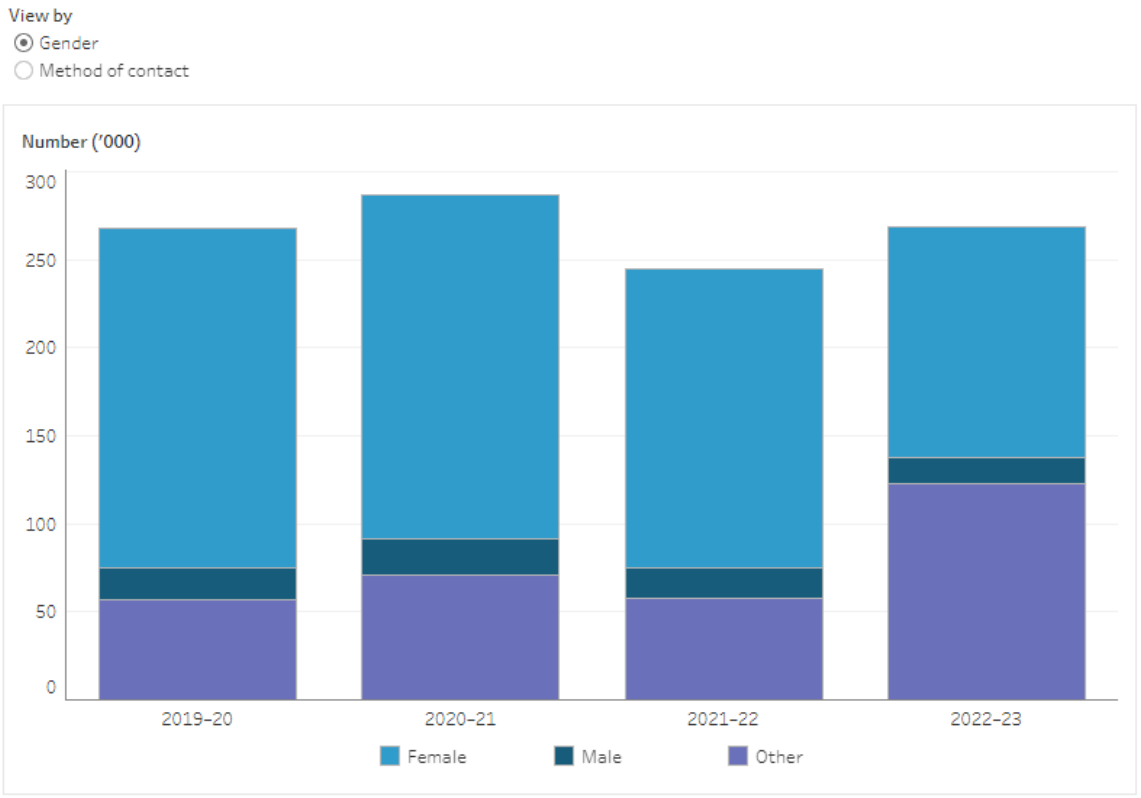
1800RESPECT

1800RESPECT is Australia's national telephone and online counselling and support service for people affected or at risk of family, domestic and sexual violence, their family and friends and frontline workers. In addition, the Daisy app can be used to connect people experiencing violence to services in their local area.

Of the almost 269,000 contacts answered by 1800RESPECT in 2022–23:

- The majority of contacts were by telephone (over 226,000), and the rest were web chats (almost 42,500).
- Most people identified as female (almost 131,000) (Figure 1).

Figure 1: 1800RESPECT answered contacts by gender and type of contact, 2019-20 and 2022-23



Source: Australian Government Department of Social Services (unpublished data) https://www.aihw.gov.au

Blue Knot Foundation

In 2021–22, the Blue Knot Helpline provided more than **25,000** occasions of service to callers, via phone, email and webchat

The Blue Knot Foundation provides support for people affected by complex trauma due to violence.

The Helpline and the Redress Support Service provide counselling, information, support and referrals for adult survivors of childhood trauma and abuse. In 2021–22, more than 25,000 occasions of service were provided to helpline callers, via phone, email and webchat. Over 5,500 occasions of service were provided to people enquiring about the National Redress Scheme, or being supported through the redress process (Blue Knot Foundation 2022).

The National Counselling and Referral Service provides counselling, information, support and referrals to services for people living with disability and experiences of violence, abuse, neglect and exploitation. In 2021–22, the service provided over 9,000 occasions of service to helpline callers, via the phone, email, webchat and videoconference. In

addition, 760 counselling sessions were provided over the phone to inmates in correctional centres (Blue Knot Foundation 2022).

Kids Helpline

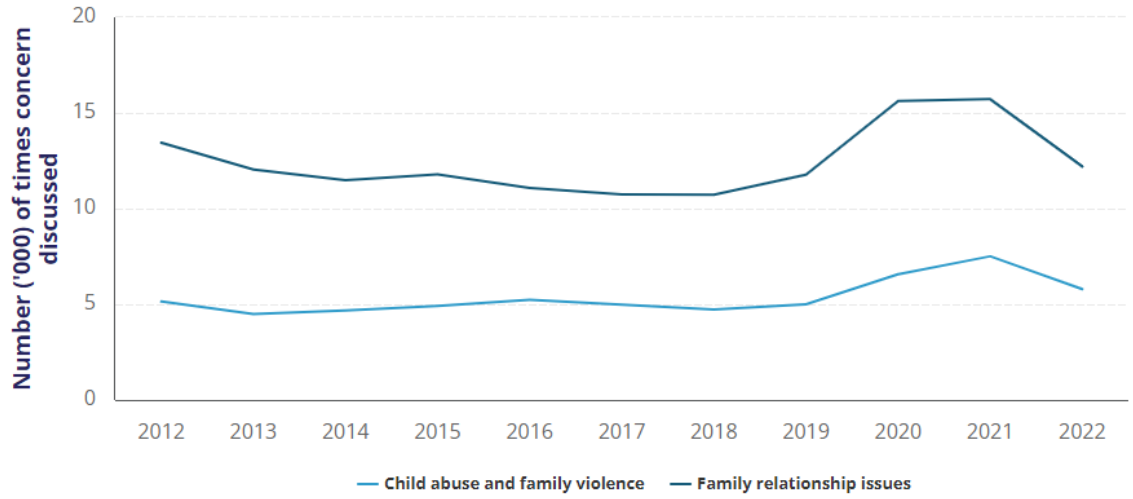
Kids Helpline is a free national helpline that provides support for children and young people aged 5 to 25. It offers counselling via phone, email, and web chat. In addition, counsellor moderated peer-to-peer support has been introduced via the social networking platform My Circle.

Children and young people contact Kids Helpline about diverse issues, including mental health, suicide, relationships (with family, peers and partners), child abuse and family violence, and bullying.

During counselling contacts in 2022, almost 5,800 child abuse and family violence concerns were discussed, and around 12,200 concerns about family relationship issues. The number of family violence and relationship concerns discussed during counselling contacts increased in the initial years of the COVID pandemic (2020 and 2021), then declined in 2022 (Figure 2). See also **FDSV and COVID-19**.

Emergency care actions are where Kids Helpline counsellors contact police, child safety or ambulances when a child or young person is deemed to be at imminent risk. In 2022, there were over 1,500 emergency care actions for child abuse (representing 31% of all emergency care actions).

Figure 2: Number of family violence and relationship concerns discussed during Kids Helpline counselling contacts, 2012 to 2022



Source: Kids Helpline (unpublished data) | **Data source overview**

Bravehearts

Bravehearts provides support for people affected by child sexual abuse.

The Information & Support Line ('the Line') provides advice and assistance, including what to do if someone has disclosed child sexual abuse. In 2021–22, over 4,500 enquiries were made to the Line, including via phone, email, website and other channels such as walk-ins. The Line lodged over 20 notifications to police and child safety authorities due to concerns a child was at risk of harm or that harm had already occurred (Bravehearts 2022).

Bravehearts' therapeutic services delivered over 2,800 counselling sessions in 2021–22 to children and families affected by child sexual assault and exploitation. The Turning Corners program, an early intervention initiative for young people aged 12–17 who are engaging in harmful sexual behaviours, delivered around 450 counselling sessions (Bravehearts 2022).

As a National Redress Scheme service provider, in 2021–22 Bravehearts helped over 700 clients, including redress assistance, support and advocacy (Bravehearts 2022).

Men's Referral Service

Men's Referral Service received over **7,600 helpline calls** in 2021–22

The Men's Referral Service provides support for men who have used or continue to use violence and who are seeking support to change their abusive behaviours.

In 2021–22, the Men's Referral Service responded to over 7,600 helpline calls nationally. Referrals are received from police in selected states and territories – almost 60,000 referrals were received from police in New South Wales, Victoria and Tasmania in 2021–22 (No To Violence 2022).

Further details are provided in **Specialist perpetrator interventions**.

Full Stop Australia

Full Stop Australia (formerly Rape & Domestic Violence Services Australia) supports people affected by sexual, domestic and family violence. From November 2021, 1800 FULL STOP is a national, free call number which directs callers to a suitable helpline operated by Full Stop Australia, including the National Violence and Abuse Trauma Counselling and Recovery Service, the National Sexual Abuse and Redress Support Service, the Rainbow Sexual, Domestic and Family Violence Helpline, and the NSW Sexual Violence Helpline.

In 2021–22, almost 22,500 calls were made to 1800 FULL STOP. More than 15,800 occasions of trauma counselling and recovery services were provided to almost 4,000 individual clients, via phone, online and face-to-face (Full Stop Australia 2022).

The Domestic Violence Cash Transfer Project supported nearly 500 victim-survivors with monetary assistance to escape violence. This included distribution of funding to family and domestic violence services to enable them to provide their clients with emergency

relief, and victim-survivors also had access to a lump sum cash payment (Full Stop Australia 2022).

knowmore

knowmore assists survivors of child sexual abuse by providing free legal advice and support regarding justice and redress options (including the National Redress Scheme).

Over the 4-year period 2018–19 to 2021–22, almost 68,900 calls were made to the telephone helpline, and around 11,900 people became clients. Among clients, 59% identified as male, 34% identified as First Nations people, and 19% had been allocated priority due to advanced age or immediate and serious health concerns (for example, diagnosis of terminal cancer) (knowmore 2022b).

1800 ELDERHelp

1800 ELDERHelp assists victim-survivors of elder abuse or other people who are concerned about an older person. It is a national, free call number which directs callers to a state and territory telephone helpline for elder abuse.

See **Older people** for available state/territory data.

Related material

- What is FDSV?
- How do people respond to FDSV?
- Services responding to FDSV

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Family and domestic violence reported to police

Key findings

- More than 1 in 2 (53% or 76,900) police-recorded assaults were related to FDV nationally (excluding Victoria and Queensland) in 2022.
- FDV-related sexual assault victimisation rates increased by 51% between 2014 and 2022.
- Police-recorded FDV data are an underestimate of FDV-related offences.

Police may be contacted following an incident of family and domestic violence (FDV). This can be done by a victim-survivor, witness or other person and, if considered a criminal offence, may be recorded as a crime by police. The ABS collects data on selected FDV crimes recorded by police in the Recorded crime – Victims and Recorded crime – Offenders collections (see Box 1). However, not all FDV crimes are reported to police and Recorded Crime data are an underestimate of FDV crimes and identified offenders. Further, not all FDV behaviours are considered criminal offences, and FDV offences will vary according to state and territory. This section discusses select FDV offences that are included in ABS Recorded Crime collections.

What do we know about reporting family and domestic violence to police?

The *National Plan to End Violence against Women and Children 2022–2032* (The Plan) highlights that, despite increasing awareness and readiness to talk about FDV, work is needed to remove barriers to reporting to police for victim-survivors (DSS 2022).

A 2022 review of research on police responses found that short-term police responses, such as attendance at a FDV incident, can increase reporting of future FDV and reduce FDV re-offending, and that protection orders and arrests improve victims' and survivors' perceptions of safety. It is unclear from the currently available research how arrests affect perpetrator re-offending and what factors influence the effectiveness of arrests in reducing re-offending (Bell and Coates 2022; Dowling et al. 2018).

Rates of reporting FDV to police have historically been negatively impacted by a range of factors including: fear of repercussions; misconceptions about what constitutes a crime; mistrust of police; concerns relating to the misidentification of the perpetrator; concerns relating to being believed and having to relive the experience; past negative experiences with police; institutional violence at the hands of police for some population groups; and barriers to accessing police, such as knowledge and understanding, geographical location and specific population group characteristics (ABS 2017; Douglas 2019; DSS 2022; Voce and Boxall 2018).

Reports into women and girls' experiences with the police and broader criminal justice system, such as the Queensland Hear her voice reports and the *National Plan Victim-Survivor Advocates Consultation Final Report*, acknowledge that work has been undertaken to improve police understanding of family, domestic and sexual violence (FDSV) and police responses to reports of gendered violence in recent years. However, they also highlight responses are still inadequate and lacking in consistency (Fitz-Gibbon et al 2022; Queensland Government 2022). Reports such as these also highlight the need to improve police response for those victim-survivors who experience intersecting forms of inequality and discrimination, for example, Aboriginal and Torres Strait Islander (First Nations) people, culturally and linguistically diverse people, people with disability, and LGBTIQA+ people, see **Population groups** (Fitz-Gibbon et al 2022; Queensland Government 2022). The Plan indicates that enhanced education and training of police in terms of responses to reporting of gendered crime and improved access to safe and/or alternative reporting options should be implemented to improve reporting experiences (DSS 2022).

To understand the current extent of police involvement in FDV crimes in Australia, data on level of reporting to police, available from the ABS Personal Safety Survey (PSS) should be examined alongside recorded crime data (ABS Recorded Crime – Victims and ABS Recorded Crime – Offenders). For more information about these data sources, please see **Data sources and technical notes**.

Police-recorded FDV data are an underestimate of FDV-related offences

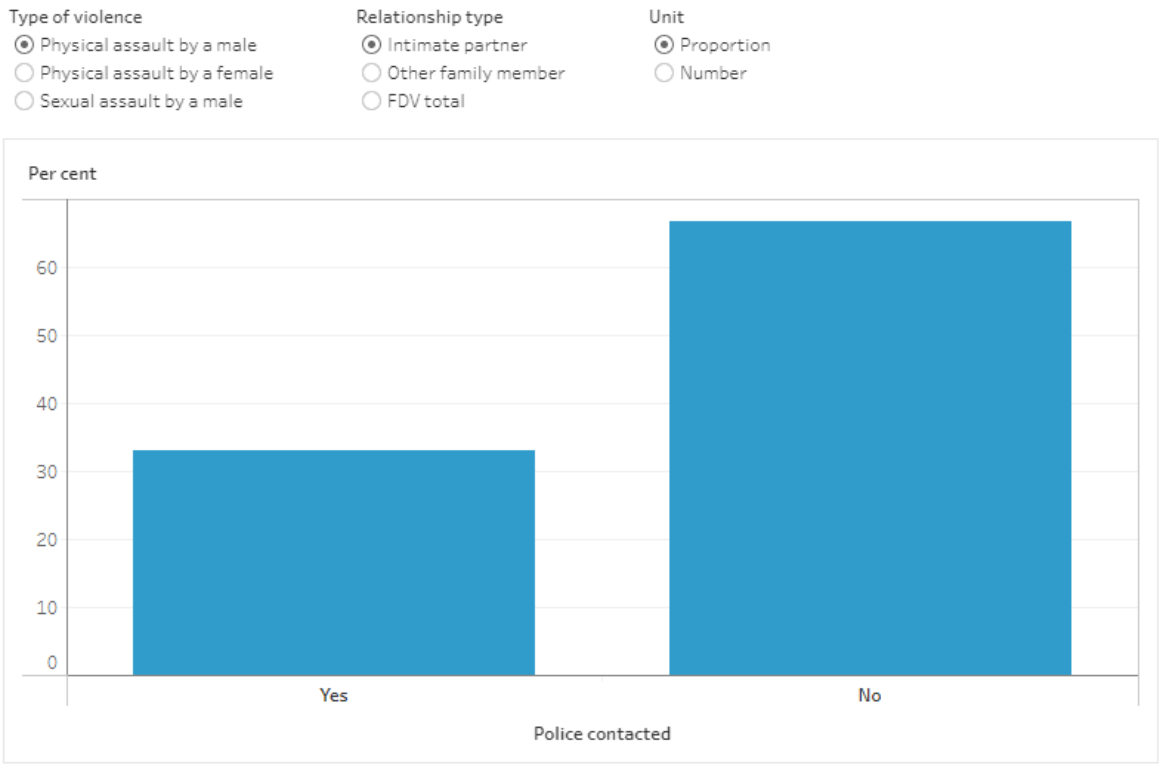
Examining whether or not police are contacted following family and domestic assault can provide an indication of reporting levels and utilisation of police services. Data on whether police were contacted (by the victim-survivor or another person) after an experience of family and domestic assault, as well as reasons for not contacting, are available from the ABS PSS. In the PSS, victim-survivors are referred to as people who have experienced violence, see **What is family, domestic and sexual violence** for more details.

The 2016 PSS includes data on most recent incidents of physical and/or sexual assault by a family member or intimate partner in the last 10 years. AIHW analysis of these data for female victim-survivor found that police were contacted in relation to around:

- 1 in 3 (32% or 278,000) FDV-related physical assaults by a male
- 1 in 6 (17% or 18,100) FDV-related physical assaults by a female
- 1 in 7 (14% or 50,100) FDV-related sexual assaults by a male (ABS 2017).

Figure 1 allows users to further explore police contact by relationship types. Data for females who experienced sexual assault by a female and males who experienced any type of FDV assault and are not available due to data quality issues, see **Data sources and technical notes**.

Figure 1: Police contacted after most recent incident of family and domestic assault, females, 2016



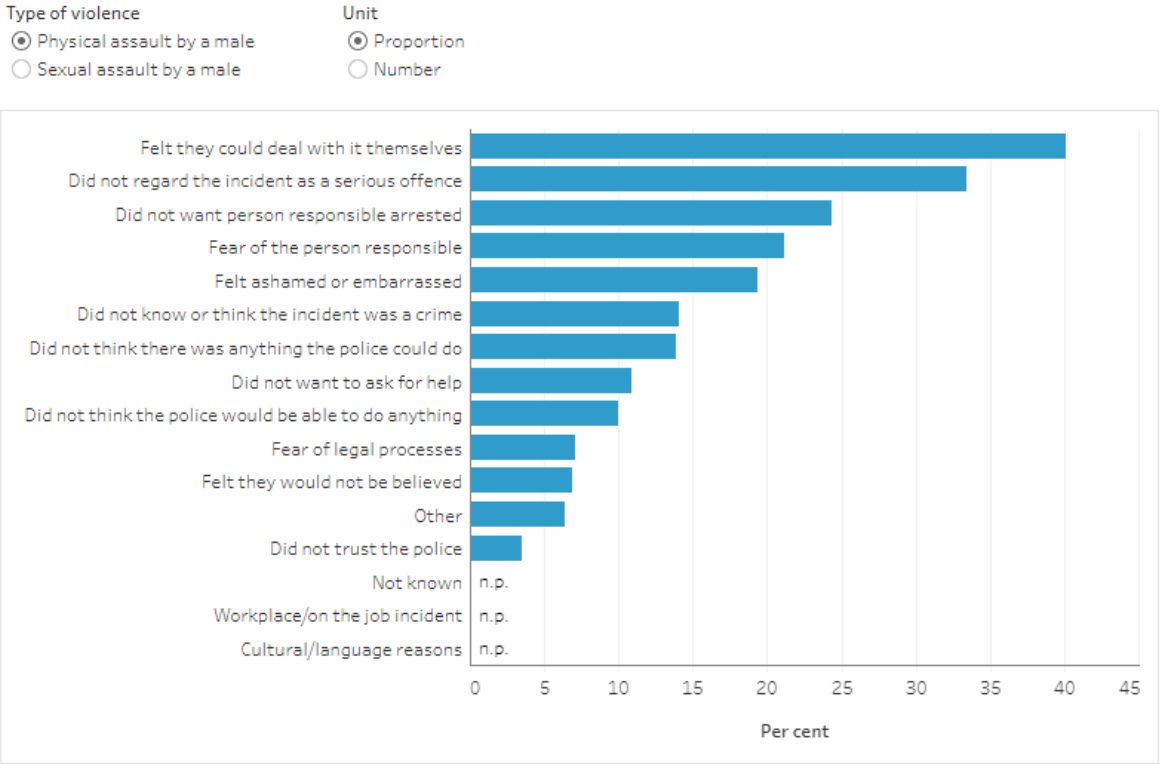
*: estimate has a relative standard error (RSE) between 25% and 50% and should be used with caution.
#: proportion has a margin of error >10 percentage points. n.p.: not published.
Source: ABS PSS 2016. https://www.aihw.gov.au

Examining reasons why people did not contact police after family and domestic assault can provide insight into how victim-survivors can be better supported and encouraged to seek help. There are a range of reasons why female victim-survivors may not contact police following their most recent incident of FDV assault by a male perpetrator in the last 10 years. AIHW analysis of the 2016 PSS found that the 2 most common reasons female victim-survivors did not contact police were:

- they felt like they could deal with it themselves (40% of those who experienced physical assault and 33% who experienced sexual assault)
- they did not regard the incident as a serious offence (33% of those who experienced physical assault and 35% who experienced sexual assault) (Figure 2) (ABS 2017).

Data for males and some violence types are not available due to data quality issues, see **Data sources and technical notes**.

Figure 2: Reasons police not contacted after most recent incident of family and domestic assault, females, 2016



*: estimate has a relative standard error (RSE) between 25% and 50% and should be used with caution.
n.p.: not published.
Source: ABS PSS 2016.

https://www.aihw.gov.au

What do recorded crime data tell us?

More than **1 in 2** (53% or 76,900) police-recorded assaults in 2022 were related to FDV nationally (excluding Victoria and Queensland)

The ABS collects data on a select range of offences recorded by police, including FDV incidents, and publishes these in the Recorded crime – Victims and Recorded crime – Offenders collections (see Box 1). These collections provide insight into police involvement in a subset of FDV incidents in the Australian community and the magnitude of FDV crimes relative to select crimes overall.

Box 1: FDV in ABS recorded crime collections

ABS Recorded Crime collections are based on crimes recorded by police in each state and territory and published according to the Australian and New Zealand Standard Offence Classification (ANZSOC) (ABS 2011). Only a select set of crimes are considered for inclusion in the ABS FDV data in the Recorded Crime collections, with individual incidents only included in FDV collections when:

- the relationship of offender to victim falls within a specified family or domestic relationship (spouse or domestic partner, parent, child, sibling, boyfriend/girlfriend or other family member to the offender) and/or
- a FDV flag has been recorded, following a police investigation and does not contradict any recorded detailed relationship of offender to victim information.
- FDV specific data are available in both the Victims and Offenders collections, however, data in the Offenders collection are experimental only and assessment is ongoing to ensure comparability and quality of the data. Victims data include each incident of FDV crime that police record (not all crimes are recorded) rather than reflecting a count of unique people. Victims data are not restricted by age and includes incidents of child sexual abuse (see **Children and young people**). Conversely, Offenders data reflect a count of unique alleged offenders aged 10 and over, irrespective of how many offences they may have committed within the same incident, or how many times police dealt with them during the reference period. Alleged offences recorded in offenders' statistics may be later withdrawn or not be substantiated. Offenders data include both court or non-court actions (for example warnings, conferencing, diversion). An individual offender may have more than one police proceeding recorded in the same reference period
- It is important to note that the number of police-recorded victims does not align with the number of recorded offenders nor the proceeding counts due to different counting rules, different reference periods, and variation in the time between when a crime is recorded and when police identify an offender. In some cases, police may never identify offenders.
- Due to differences in methodology, homicide numbers reported in ABS recorded crime collections may differ to those reported by the AIC National Homicide Monitoring Program. For more details, see **Domestic homicide**.
- The terms 'victim' and 'offender' are used here to align with the ABS recorded crime collections.

For more details, see **Data sources and technical notes**.

Based on data from Recorded Crime – Victims, in Australia in 2022:

- more than 1 in 2 (53% or 76,900) recorded assaults were related to FDV violence (excluding Victoria and Queensland as data were unavailable), a 6.1% increase from 72,500 in 2021
- more than 1 in 3 (36% or 135) recorded homicides and related offences were related to FDV
- more than 1 in 3 (36% or 11,700) recorded sexual assaults were related to FDV
- around 3 in 10 (30% or 154) recorded kidnapping/abduction were related to FDV (ABS 2023).

Has it changed over time?

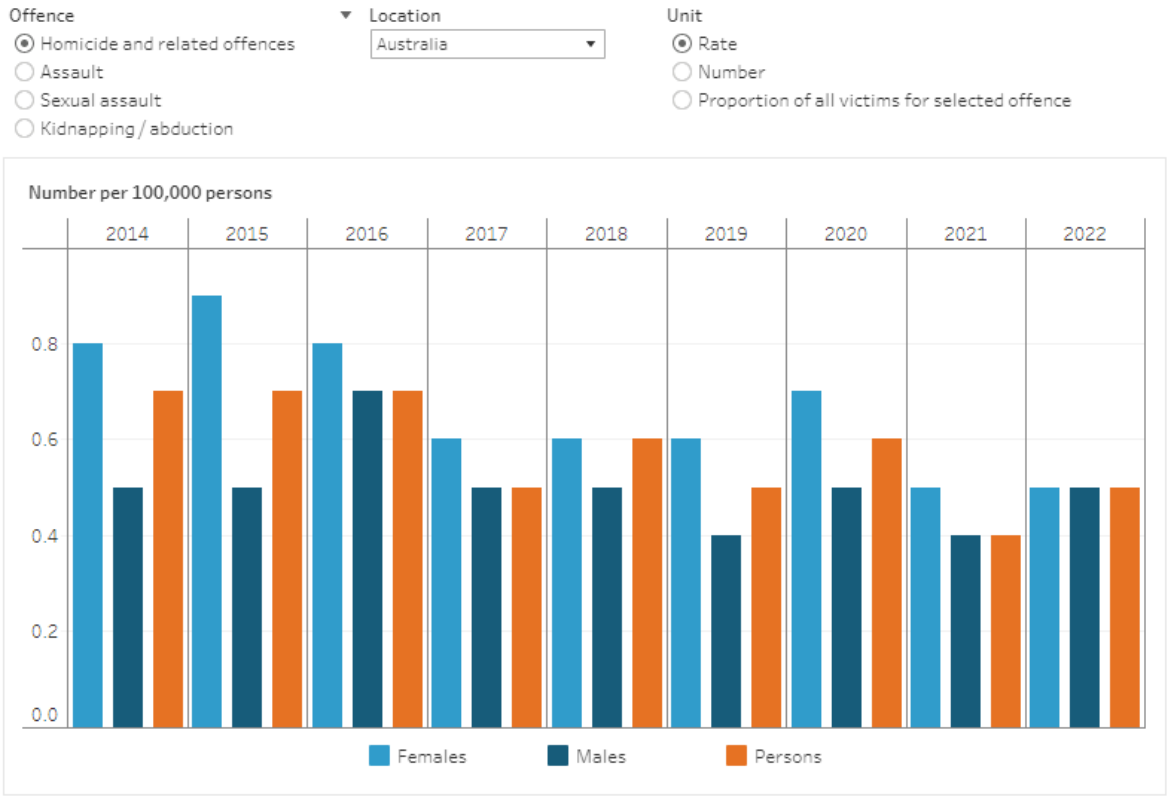
There was a 51% increase in the victimisation rate of police-recorded FDV-related sexual assault between 2014 and 2022

Recorded Crime – Victims data show that in Australia, between 2014 and 2022, patterns of FDV victimisation rates varied between offence types:

- Rates for FDV-related homicide and related offences fluctuated over time, with the number of offences ranging between 106 and 173 each year.
- The rate of FDV-related sexual assaults increased 51% (from 30 to 45 per 100,000 people), with rates consistently higher for females compared to males. It is unclear whether this increase is due to changes in reporting behaviour, increased awareness about forms of violence, changes to police practices, an increase in incidents and/or a combination of these factors.
- Rates for FDV-related kidnapping/abduction fluctuated over time, with the number of offences ranging between 113 and 159 each year.

Figure 3 allows users to further explore victimisation rates over time for selected FDV offences recorded by police per 100,000 people, by sex and location. These rates are based on all recorded incidents of a specific crime irrespective of age. To better understand the relationship between victimisation rates and sex, see Figure 4 and Figure 5. See **Data sources and technical notes** for more information on rates and definitions of specific offences.

Figure 3: Victims of family and domestic violence crimes, by sex, 2014 to 2022



n.a.: not available or calculation is not applicable due to denominator being equal to 0.
Source: ABS Recorded Crime – Victims.

https://www.aihw.gov.au

Is it the same for everyone?

Police recorded FDV offences can be explored in terms of a range of different victim and crime characteristics. Depending on the offence, these can include: sex of victim, state and territory in which the incident was reported, victim age at report, victim age at incident, time to report, setting where the crime occurred and relationship of offender to victim.

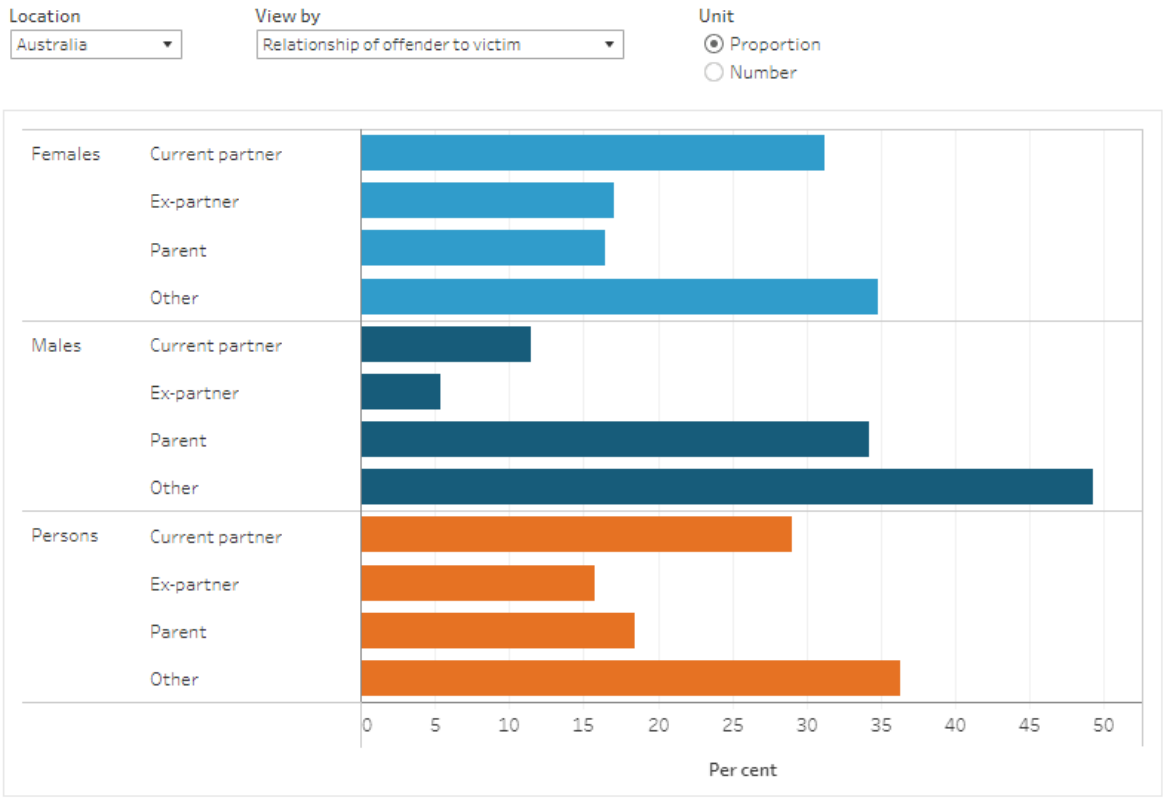
Of all police recorded FDV-related sexual assaults in Australia (excluding Western Australia for data relating to relationship to perpetrator) in 2022:

- 2 in 7 (29% or 3,100) were perpetrated by a current partner and around 1 in 6 (18% or 2,000) were perpetrated by a parent. Relationship data are not restricted to specific age groups and FDV-related sexual assaults involving a parent perpetrator can be broader than incidents of child sexual abuse, see Children and young people. Similarly, other relationship categories may include incidents of child sexual abuse.
- The proportion of female FDV-related sexual assaults perpetrated by a current partner (31%) is 2.7 times higher than for males (12%).
- Around 3 in 5 (62% or 7,200) involved victims aged less than 18 at the time of the incident, with 59% of female and 84% of male victims within this age group.

- Over half (57% or 6,700) were reported within the first year and around a quarter (24% or 2,800) were not reported for five or more years after the incident occurred (ABS 2023).

Figure 4 allows users to further explore the number and proportion of FDV-related sexual assaults recorded by police, by sex of victim, state and territory in which the incident was reported, age at incident, time to report and relationship of offender to victim for 2020 and 2022. For more information on these disaggregations, see **Data sources and technical notes**.

Figure 4: Characteristics of family and domestic violence-related sexual assaults, 2022



n.a.: not available.
Source: ABS Recorded Crime – Victims.

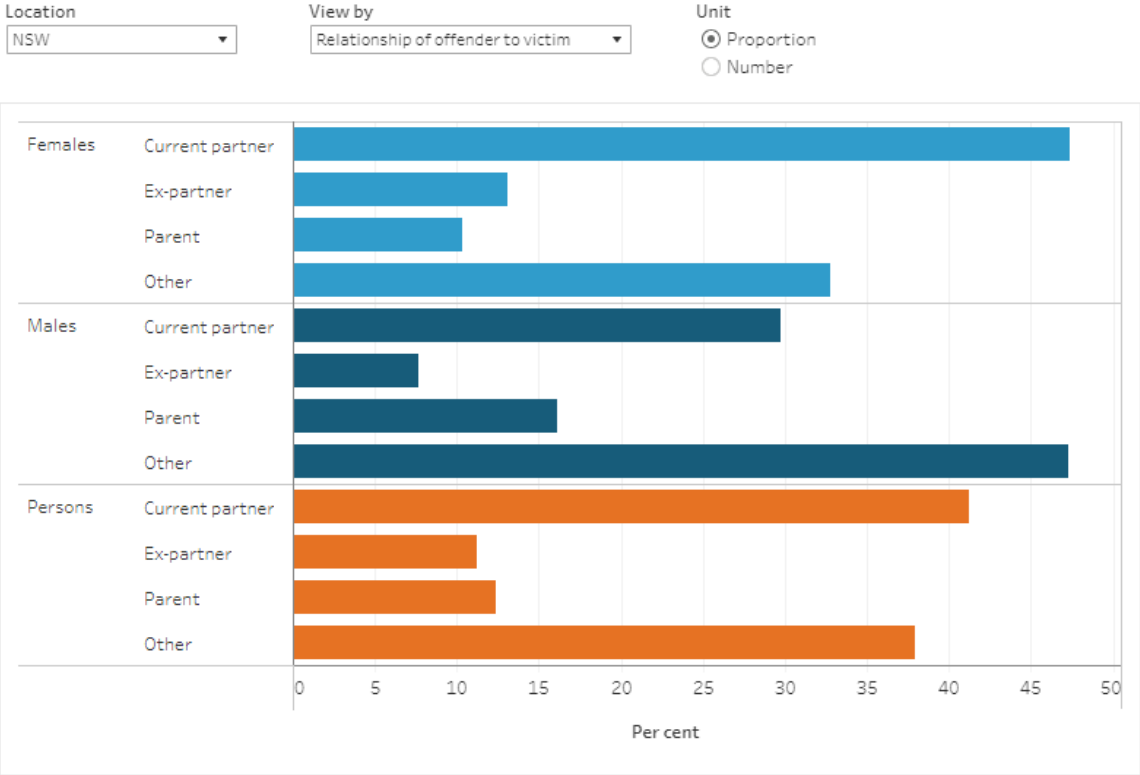
https://www.aihw.gov.au

In 2022, for states and territories where police-recorded FDV-related assault data were available:

- For females, current partners were the most common perpetrators for all states and territories. For males, current partners were only the most common perpetrator in Tasmania and the Northern Territory.
- Victims who were aged 25-34 at the time of report accounted for the highest proportion of all FDV-related assaults.
- The majority of FDV-related assaults occurred in a residential setting (ABS 2023).

Figure 5 allows users to further explore the number and proportion of police-recorded FDV-related assaults by several characteristics (sex of victim, state and territory in which the incident was reported, age at report, setting where crime occurred and relationship of offender to victim). For more information on these disaggregations, see **Data sources and technical notes**.

Figure 5: Characteristics of family and domestic assaults, 2022



n.a.: not available.
Source: ABS Recorded Crime – Victims.

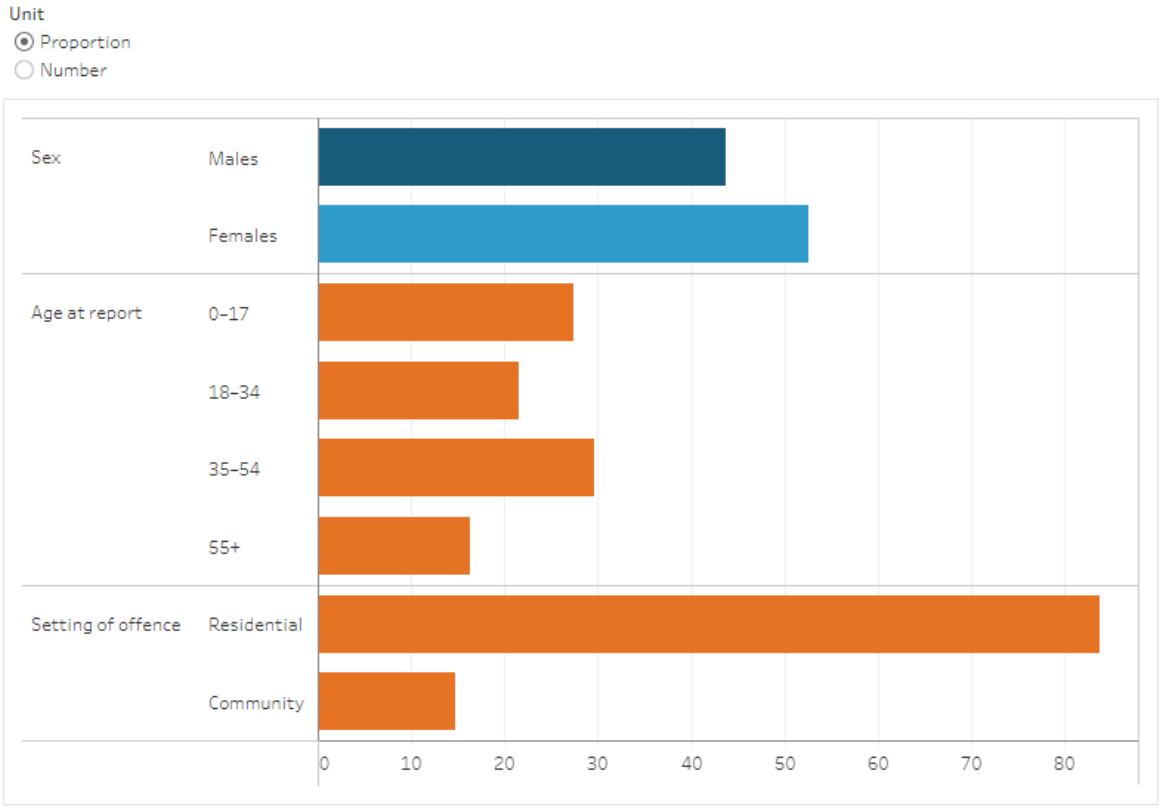
https://www.aihw.gov.au

Figure 6 allows users to explore the number and proportion of family and domestic homicides recorded by police, by several characteristics (sex of victim, state and territory in which the incident was reported, age at report, setting where crime occurred and relationship of offender to victim). It shows that of the 135 homicides recorded by police in 2022:

- over half (53% or 71) were female
- over a quarter (27% or 37) of victims were under 18 years of age
- 5 in 6 (84% or 113) occurred in a residential setting (ABS 2023).

For more information on disaggregations, see **Data sources and technical notes**.

Figure 6: Characteristics of family and domestic homicide, 2022



Source: ABS Recorded Crime – Victims.

https://www.aihw.gov.au

Offenders of FDV

The ABS Recorded crime – Offenders, 2022-23 collection includes experimental FDV data. These FDV experimental data show that in 2022–23:

- One in 4 (25% or 88,400) recorded offenders for any offence were proceeded against by police for at least one FDV related offence. The proportion was higher for male offenders (27%) than for female offenders (21%).
- The offender rate was 382 FDV offenders per 100,000 people, an increase of 5.5% from 2021 –22.
- The male offender rate (610 per 100,000) was higher than the female offender rate (158 per 100,000).

- Offender rates varied between age groups, with males aged 30 –34 having the highest rate (1,158 per 100,000).
- The most common principal offence amongst FDV offenders was assault (51% or 44,700 of all FDV offenders). Breach of domestic violence and non-violence orders was also common (28% or 24,800 of all FDV offenders) (ABS 2024).

Following police charges, individuals may become a defendant in 1 or more criminal court case. For more information on defendants in FDV cases, see **Legal systems**. FDV offenders may also take part in specialist perpetrator interventions, which work to hold perpetrators to account and change their violent, coercive and abusive behaviours. behaviours. More information can be found in **Specialist perpetrator interventions**.

Related material

- Sexual assault reported to police
- Who uses violence?
- Legal systems

More information

- National sexual violence responses
- Sexual assault in Australia

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Sexual assault reported to police

Key findings

- Female sexual assault victimisation rates increased by 43% between 2010 and 2022.
- 7.7% of women who experienced sexual assault by a male in the 10 years before 2021–22 contacted police about the most recent incident.
- 3 in 4 (76%) sexual assaults recorded by police in 2022 were perpetrated by someone known to the victim.

Victim-survivors of sexual violence may come in contact with police. This may be as a result of the victim-survivor, a witness or another person reporting the incident to the police. Incidents of sexual assault (a criminal offence) recorded by police are included in ABS Recorded Crime data (see Box 1). However, not all sexual assaults are reported to police, and as a result Recorded Crime data are an underestimate of sexual assaults in Australia.

What do we know about reporting sexual assault to police?

In recent years, there has been a growing awareness and willingness to address sexual violence, as seen through the #MeToo movement. Educational programs about consent have been introduced in schools and workplaces, alongside awareness campaigns, to further promote understanding and reduce barriers to addressing sexual violence (DSS 2022). Further, increased protections for some population groups in recent years, such as the expansion of laws on mandatory reporting of child sexual abuse, may have increased the propensity to report sexual assault by third parties. The *National Plan to End Violence against Women and Children 2022–2032* (the National plan) highlights that more work is needed to remove barriers to reporting of sexual assault to police by victim-survivors (DSS 2022).

Rates of reporting sexual violence, such as sexual assault, to police have historically been impacted by a range of factors including: misconceptions about what constitutes sexual assault; mistrust of police; concerns relating to being believed and having to relive the experience; past negative experiences with police; institutional violence at the hands of police for some population groups; and barriers to accessing police, such as knowledge and understanding, geographical location and specific population group characteristics (ABS 2023c; Douglas 2019; DSS 2022; Voce and Boxall 2018). Intersecting personal, situational, social, cultural, economic and political factors associated with inequality and discrimination may also impact victim-survivor ability to access police following an incident of sexual violence and/or likelihood of reporting sexual assault to police (Commission of Inquiry into Queensland Police Service responses to domestic and family violence 2022; DSS 2022). These factors may also influence the time a victim-

survivor takes to report incidents of sexual assault to police. Recent data from the ABS suggest that close to 1 in 3 (31%) sexual assault reported to police in 2022 had occurred more than a year earlier, and 8.4% of all sexual assaults reported in 2022 occurred 20 or more years ago (ABS 2023a).

Reports into women and girls' experiences with the police and broader criminal justice system, such as the Queensland Hear her voice reports and the *National Plan Victim-Survivor Advocates Consultation Final Report*, acknowledge that work has been undertaken to improve police understanding of family, domestic and sexual violence (FDSV) and police responses to reports of gendered violence in recent years. However they also highlight responses are still inadequate and lacking in consistency (Fitz-Gibbon et al 2022; Queensland Government 2022). Reports such as these also highlight the need to improve police response for those victim-survivors who experience intersecting forms of inequality and discrimination, for example Aboriginal and Torres Strait Islander (First Nations) people, culturally and linguistically diverse people, people with disability, and LGBTIQA+ people, see **Population groups** (Fitz-Gibbon et al 2022; Queensland Government 2022). The National plan indicates that enhanced education and training of police in terms of responses to reporting of gendered crime and improved access to safe and/or alternative reporting options should be implemented to improve reporting experiences for all people in Australia (DSS 2022).

To understand the current extent of police involvement in sexual assaults in Australia, data on level of reporting to police, available from the ABS Personal Safety Survey (PSS), should be examined alongside recorded crime data (ABS Recorded Crime – Victims and ABS Recorded Crime – Offenders). For more information about these data sources, please see **Data sources and technical notes**.

Police-recorded sexual assault data are an underestimate of sexual assaults

7.7% of women who experienced sexual assault by a male in the 10 years before 2021–22 contacted police about the most recent incident.

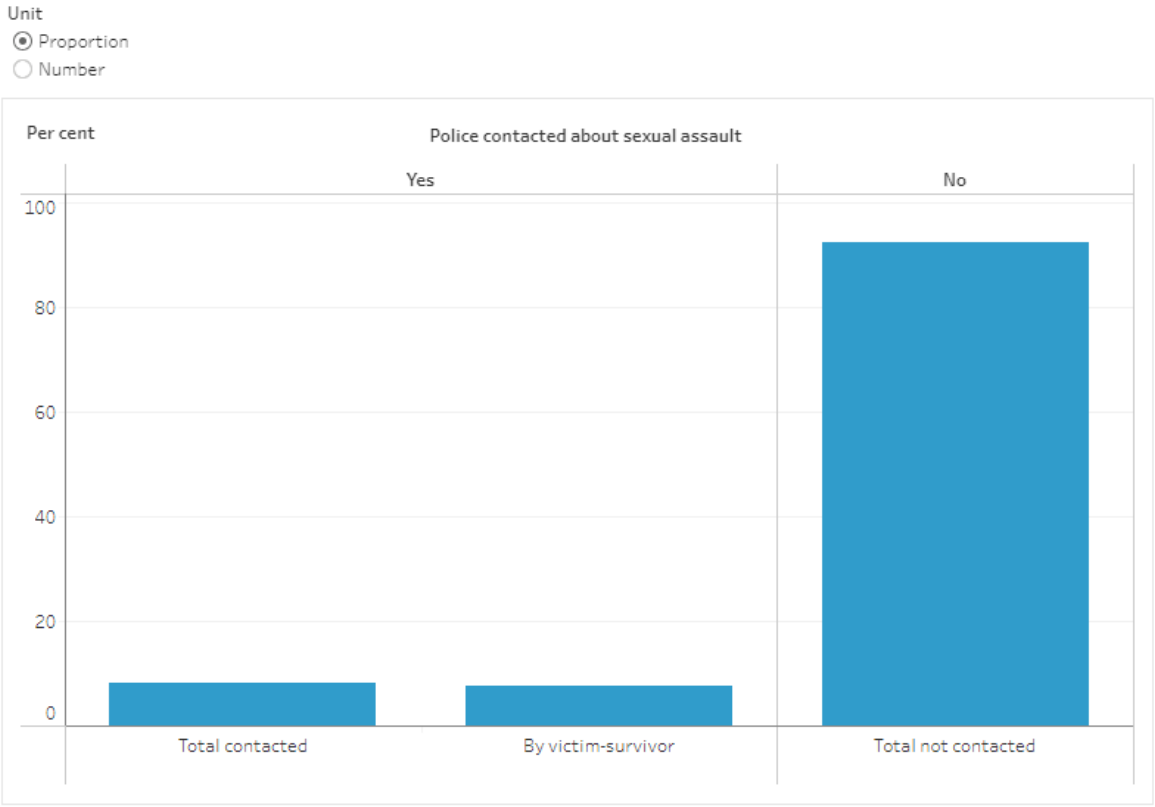
Examining whether police are contacted following sexual assault can provide an indication of reporting levels and utilisation of police services. Data on whether police were contacted (by the victim-survivor and/or another person) after sexual assault, as well as reasons for not contacting, are available from the ABS PSS. In the PSS, victim-survivors are referred to as people who have experienced violence, see **What is FDSV?** for more details.

The 2021–22 PSS includes data on female victim-survivors' most recent incident of sexual assault by a male in the last 10 years. According to these data:

- the police were contacted in relation to 8.3% of sexual assaults
- 7.7% of victim-survivors contacted police themselves (Figure 1) (ABS 2023c).

Data for males who experienced sexual assault are not available here due to data quality issues, see **Data sources and technical notes**.

Figure 1: Police contacted after most recent incident of sexual assault, females, 2021–22



Source: ABS PSS 2021–22. https://www.aihw.gov.au

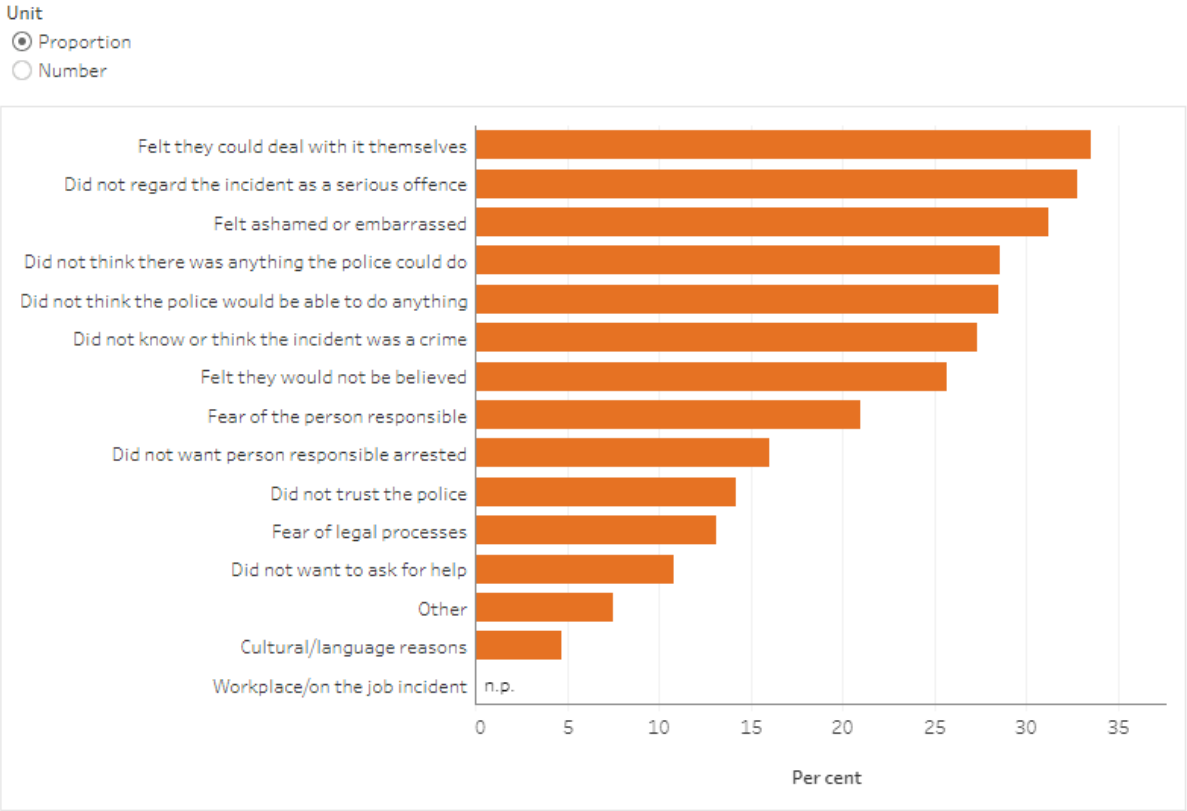
Family, domestic and sexual violence data in Australia includes data on the proportion of sexual assaults in the 12 months prior to the PSS that were reported to police between 2005 and 2016. Comparable data are not available for the 2021–22 PSS.

Examining reasons why people did not contact police after a sexual assault can provide insight into how victim-survivors can be better supported and encouraged to seek help. Figure 2 shows that there were a range of reasons why female victim-survivors did not contact police following their most recent incident of sexual assault by a male perpetrator in the last 10 years. According to the 2021–22 PSS, the 2 most common reasons were female victim-survivors did not contact police were they:

- felt like they could deal with it themselves
- did not regard the incident as a serious offence (ABS 2023c).

Data for males who experienced sexual assault are not available here due to data quality issues, see **Data sources and technical notes**.

Figure 2: Reasons police not contacted after most recent incident of sexual assault by a male perpetrator, females, 2021–22



n.p.: not published.
Source: ABS PSS 2021–22.

https://www.aihw.gov.au

What do Recorded Crime data tell us?

The ABS collects data on sexual assaults recorded by police in the Recorded Crime – Victims and Recorded Crime – Offenders collections (see Box 1). These collections provide insights into police involvement in responses to sexual assaults in the Australian community over time and across different population groups (see Figure 4 and 5), as well as the different characteristics (see Figure 6) of those sexual assaults recorded by police.

Box 1: Sexual assault in ABS Recorded Crime collections

- ABS Recorded Crime collections are based on crimes recorded by police in each state and territory and published according to the Australian and New Zealand Standard Offence Classification (ANZSOC) (ABS 2011). While there may be some jurisdictional differences in police reporting due to legislative differences, as a general rule, for recorded crime data, sexual assault refers to any physical contact, or intent of contact, of a sexual nature directed toward another person where that person does not give consent, gives consent as a result of intimidation or deception, or consent is unable to be given because of youth, temporary/permanent (mental) incapacity or familial relationship. Differences in consent laws between states and territories may also impact

sexual assaults captured in recorded crime data, see **Consent** for more information. Sexual assault includes aggravated sexual assault and non-aggravated sexual assault (see **Data sources and technical notes** for details).

- Information on sexual assaults recorded by police are available on victims (Recorded Crime – Victims) and offenders (Recorded Crime – Offenders). Victims data include each incident of sexual assault that police record (not all sexual assaults are recorded) rather than reflecting a count of unique people. Victims data are not restricted by age and includes incidents of child sexual abuse (see **Children and young people**). Conversely, Offenders data include a count of unique alleged offenders aged 10 and over, irrespective of how many offences they may have committed within the same incident, or how many times police dealt with them during the reference period. Alleged offences recorded in offenders' statistics may be later withdrawn or not be substantiated. Offenders data also include a count of police proceedings which are categorised as court or non-court actions (for example, warnings, conferencing, diversion). An individual offender may have more than one police proceeding recorded in the same reference period.
- It is important to note that the number of police-recorded victims does not align with the number of recorded offenders nor the proceeding counts due to different counting rules, different reference periods, and variation in the time between when a crime is recorded and when police identify an offender. In some cases, police may never identify offenders.
- The terms 'victim' and 'offender' are used here to align with the ABS recorded crime collections.

For more details, see **Data sources and technical notes**.

According to ABS Recorded Crime – Victims data, in Australia in 2022:

- 32,100 sexual assaults were recorded, with 5 in 6 (84% or 27,000) perpetrated against females
- the rate of sexual assault was higher for females (206 per 100,000), than males (39 per 100,000)
- there was significant variation in sexual assault rates between states and territories. ACT had the lowest rate of sexual assaults (71 per 100,000 persons) while NSW had the highest rate (152 per 100,000) (ABS 2023a).

Has it changed over time?

There was a 43% increase in the rates of police-recorded sexual assault for women between 2010 and 2022

Recorded Crime – Victims data show that in Australia, between 2010 and 2022, sexual

assault victimisation rates were consistently higher for females compared to males. During this time:

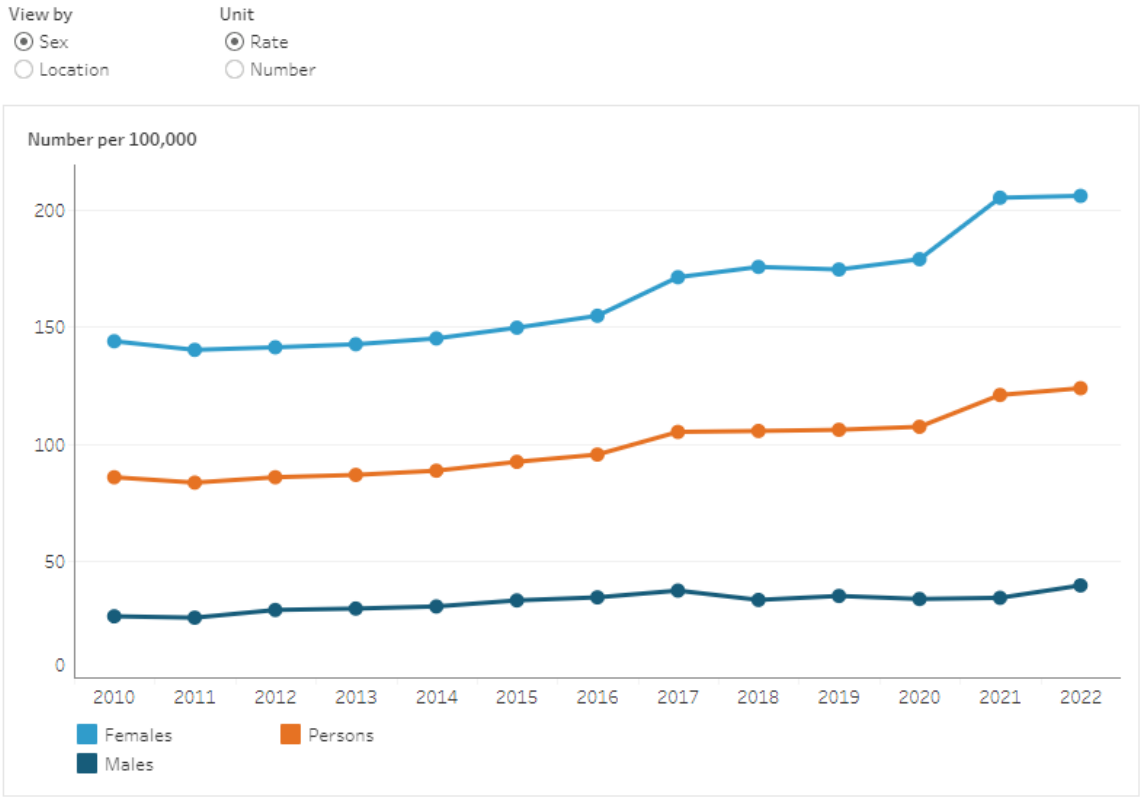
- the victimisation rate for females increased by 43% (from 144 to 206 per 100,000 females), with a 15% increase evident between 2020 and 2021
- the victimisation rate for males increased by 51% (from 26 to 39 per 100,000 males), with a 16% increase evident between 2021 and 2022
- the increase was generally consistent across jurisdictions, although the rate and pattern of increase varied (ABS 2023a).

Victimisation rates are based on all recorded sexual assaults irrespective of age and include incidents of child sexual abuse. See **Data sources and technical notes** for more information on rates and definitions related to sexual assault.

Changes in crime rates may be due to changes in reporting behaviour, increased awareness about forms of violence, changes to police practices, and/or an increase in sexual assault incidents. Between 2014 and 2022 there was a smaller increase in the number of sexual assaults that were reported to police less than a year after the incident (39%) than for those reported 12 or more months after (108%) (ABS 2023a).

Figure 3 allows users to further explore the number and rate of sexual assaults recorded by police per 100,000 people since 2010, by sex of victim and the state and territory the sexual assault was recorded, over time.

Figure 3: Victims of sexual assault, by sex and location, 2010 to 2022



Source: ABS Recorded Crime – Victims. https://www.aihw.gov.au

Is it the same for everyone?

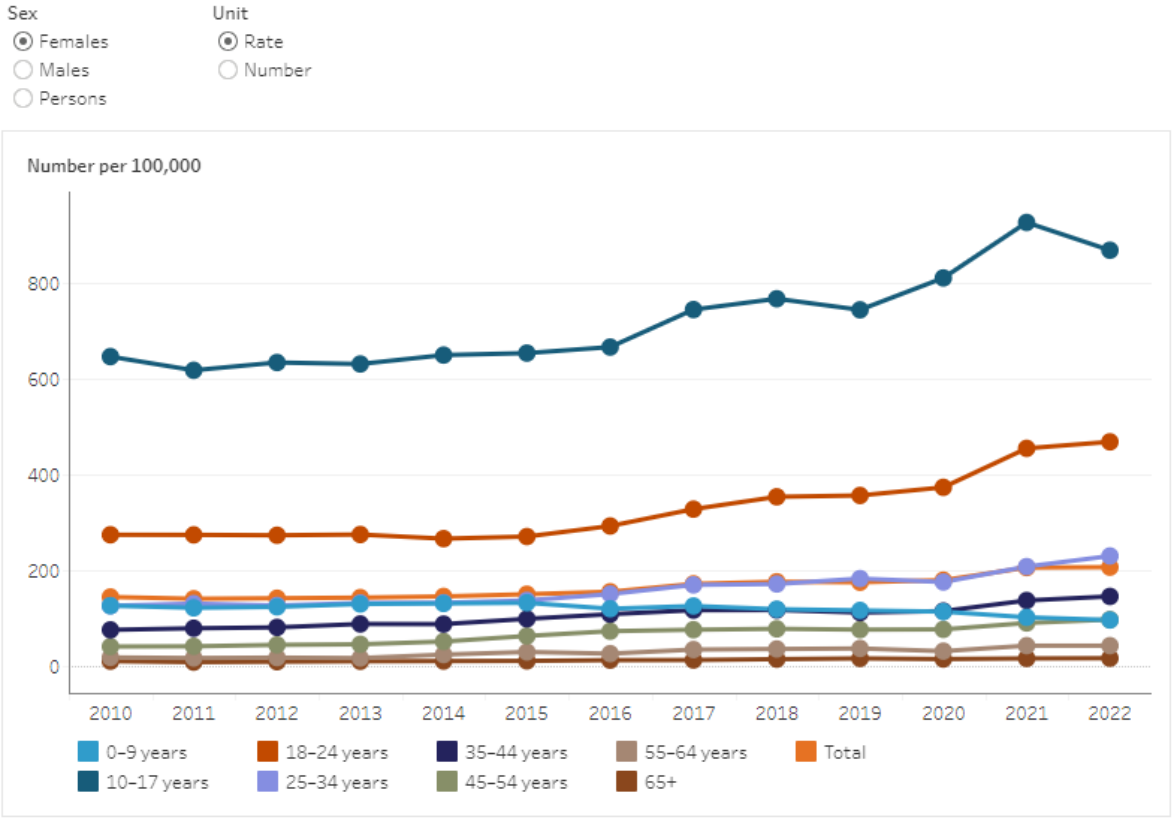
Police-recorded sexual assaults can be explored in terms of a range of victim and crime characteristics, including: sex of victim, age at report, time to report, setting where the crime occurred, whether a weapon was used and relationship of offender to victim. Examining data by victim characteristics provides insight into which groups are most affected by sexual assault.

Sexual assault perpetrated against children is considered a form of child sexual abuse (see **Children and young people**). Incidents of child sexual abuse recorded by police are captured in ABS sexual assault victims data and can be examined when data are reported by age at report. According to Recorded Crime – Victims data, in 2022:

- The sexual assault victimisation rate was highest amongst people aged 10-17 years (489 per 100,000) and lowest for those aged 65 and over (11 per 100,000) at the time of reporting to police. This is true for both females and males.
- Between 2010–2022, the sexual assault victimisation rate increased across all age groups, except 0–9 years (ABS 2023a).

Figure 4 allows users to further explore the number and rate of sexual assaults recorded by police per 100,000 people since 2010, by sex of victim and age group, over time.

Figure 4: Victims of sexual assault, by age at report, 2010 to 2022



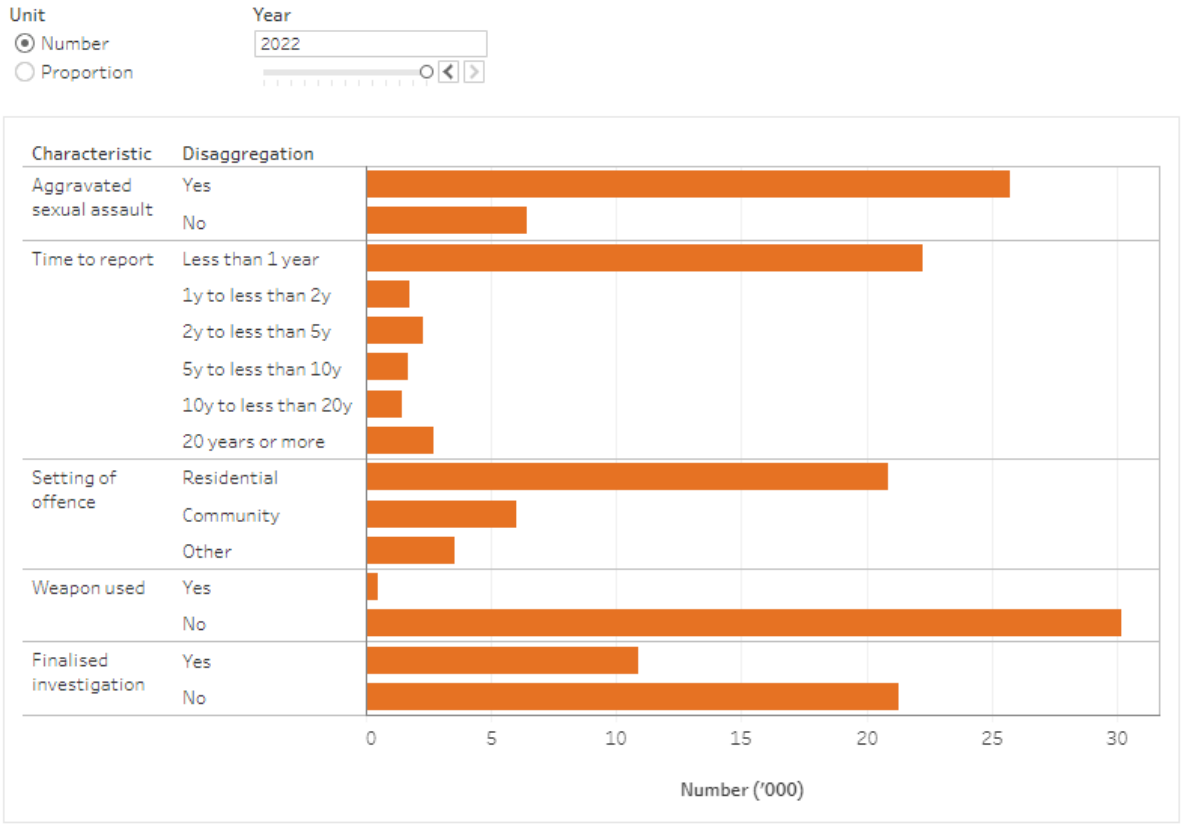
Source: ABS Recorded Crime – Victims. https://www.aihw.gov.au

Consistently over time, most sexual assaults were classified as aggravated, and most did not involve the use of weapon. Sexual assaults in a residential setting were consistently more common than in the community. In 2022, 80% of all sexual assaults were classified as aggravated and 65% occurred in a residential setting (ABS 2023a, ABS 2023b). See **Data sources and technical notes** for information on terminology used here.

Of all sexual assaults recorded in 2022, over 2 in 3 (69% or 22,200) were reported to police within the first year following the incident. A lower proportion was reported when only looking at sexual assaults categorised as family and domestic violence (FDV) (57%). Police investigations were still ongoing 30 days after an offence was recorded in around 2 in 3 (66% or 21,300) sexual assaults recorded in 2022.

Figure 5 allows users to further explore the number and proportion of sexual assault victims, by type of assault, time to report, setting where crime occurred, use of weapon, and outcome of investigation.

Figure 5: Characteristics of sexual assault, 2010 to 2022



Source: ABS Recorded Crime – Victims (published and unpublished). https://www.aihw.gov.au

Perpetrators of sexual assault are often known to the victim

3 in 4 (76%) sexual assaults recorded by police in 2022 were perpetrated by someone known to the victim.

Recorded Crime – Victims data, for the 7 states and territories (excludes Western Australia) where relationship data were available, show that of all sexual assaults in 2022:

- 76% were perpetrated by someone who knew the victim
- 19% were perpetrated by strangers, with similar proportions for females (19%) and males (18%)
- 5.7% of cases a perpetrator wasn't able to be identified or a relationship was not specified (ABS 2023b).

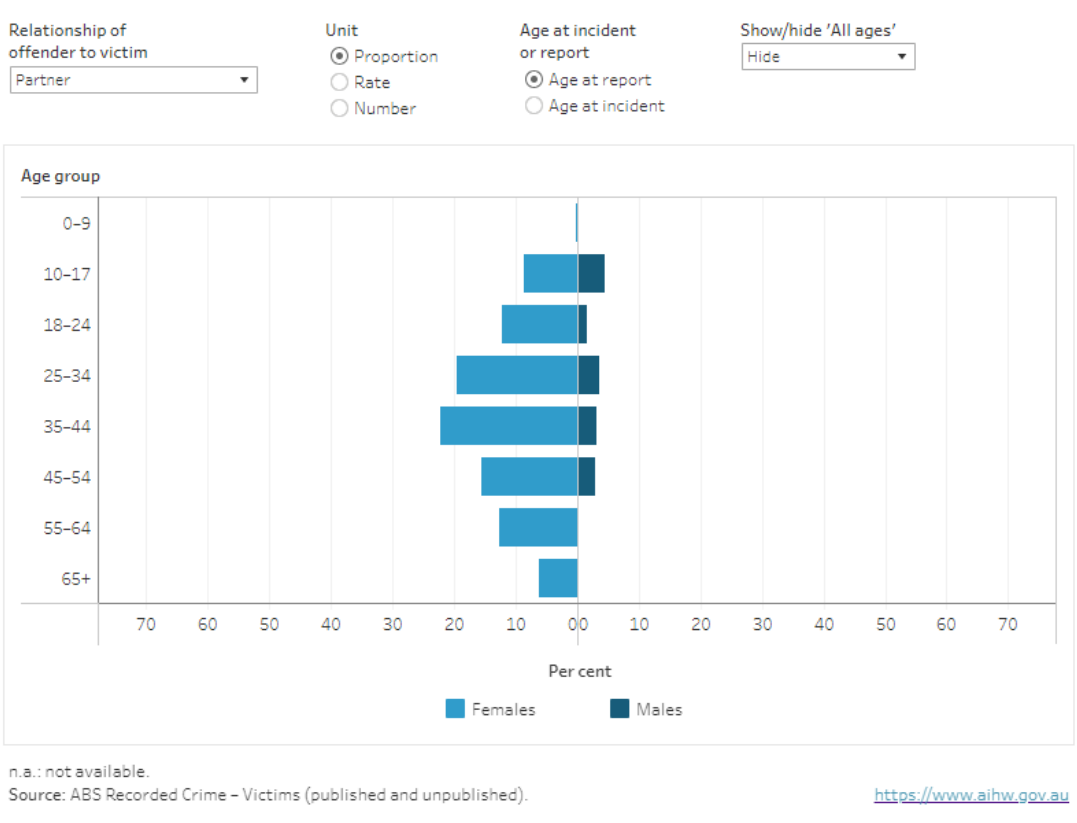
When looking at victims by age at incident in 2022:

- For females and males aged 0–9, the sexual assault offender were most commonly a family member (61% and 46% respectively). Around 1 in 10 were perpetrated by siblings (12% for females and 8.6% for males) (ABS 2023b).

- For each male age group from 10 years onwards, offenders were most commonly a known person who was not a family member (ABS 2023b).
- For females in the middle age groups (25–34 to 45–54) the offender was most commonly a family member, while a known person who was not a family member was most commonly the perpetrator for the remaining age groups (10–24 and 55 and over).
- For females, more than 1 in 10 (12%) sexual assaults were pepetrated by a current partner, with females aged 35-44 having the highest proportion of any age group (1 in 4 or 26% perpetrated by current partner).

Figure 6 allows for further examination of sexual assaults, by sex of victim, relationship to offender and across age at incident and age at report. Presented proportions are based on all sexual assaults for a specific age group.

Figure 6: Sexual assaults by relationship of offender to victim, 2022



n.a.: not available.
Source: ABS Recorded Crime – Victims (published and unpublished). https://www.aihw.gov.au

How many people are recorded as sexual assault offenders?

According to ABS Recorded Crime - Offenders data, around 6,400 people had a principal offence of sexual assault recorded during 2022–23. This represents a rate of 28 offenders per 100,000 people (ABS 2024). These data do not reflect the total number of sexual assaults that recorded offenders were involved in or proceeded against by police

during the period and do not include offenders of sexual assault whom police were unable to identify. There are currently no data available to establish the number offenders police were unable to identify. Future development work may provide some insight (Box 2).

Following police charges, individuals may become a defendant in 1 or more criminal court case. For more information on defendants in sexual assault cases, see **Legal systems**. Sexual assault offenders may also take part in specialist perpetrator interventions, which work to hold perpetrators to account and change their violent, coercive and abusive behaviours. More information can be found in **Specialist perpetrator interventions**.

Box 2: Improving data on recorded sexual assault offenders

There are several national data projects underway which will help improve understanding of sexual offender interactions with police and the broader criminal justice system in the future. The Australian Institute of Criminology piloted the Australian Sexual Offences Statistical (ASOS) collection in 2022–23. The ASOS is a comprehensive statistical collection of sexual offences proceeded against by the police in Australia each year. It includes information on the offence, the offender's characteristics and the victim's characteristics. A report based on the pilot data will be published in 2023–24. More broadly, the National Crime and Justice Data Linkage Project aims to link administrative datasets from across the criminal justice sector, including police, criminal courts and corrective services, forming the ABS Criminal Justice Data Asset. Once fully established, this data asset could provide insight on how perpetrators of FDSV, including sexual assault, move through the criminal justice sector.

Related material

- FDV reported to police
- Sexual violence
- Who uses violence?
- Legal systems

More information

- National sexual violence responses
- Sexual assault in Australia

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Child protection

Key findings

- 1 in 32 (or almost 178,000) children in Australia came into contact with the child protection system in 2021–22
- 57% of children who were the subject of a substantiation of maltreatment in 2021–22 had emotional abuse recorded as the primary type of abuse
- Over 1 in 2 (53%, or 5,000) young people under youth justice supervision in 2020–21 had contact with the child protection system between 1 July 2016 and 30 June 2021

Child maltreatment is a broad term covering any abuse and neglect of children aged under 18 years by parents, caregivers, or other adults considered to be in a position of responsibility, trust or power. It includes intentional and non-intentional behaviours that result in a child being harmed, or placed at risk of harm, physically or emotionally (AIFS 2018; WHO 2022).

When a child is exposed to violence within their family this is considered family violence. A child can experience violence directly (where behaviours are directed against or towards the child) and/or indirectly, by living in a family where there is violence directed at, or between, parents, caregivers or other family members and the child sees, hears or is otherwise affected by the violence (AIFS 2018; Richards 2011).

The Australian Government, in partnership with all state and territory governments, have developed national strategies for preventing and responding to child abuse and neglect, including child sexual abuse (DPMC 2021; DSS 2021). See **Policy and international context** for more information about *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* and the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.

Child protection services aim to protect children from maltreatment in family settings. In Australia, states and territories are responsible for statutory child protection – the provision of services to anyone aged under 18 who has been, or is at risk of being, abused, neglected or otherwise harmed, or whose parents are unable to provide adequate care and protection. In some jurisdictions, support for young people in out-of-home care is extended up to the age of 21 years (AIHW 2023a).

Child protection system in Australia

Australia's child protection system includes: the provision of support services to help families create a safe home environment for their children, avoid the need for out-of-home care, and to help reunite families after a child has been removed; investigation and case management for reports of maltreatment; legal interventions such as care and protection orders; and, when children are unable to live safely at home, they may be placed in out-of-home care. The services provided depend on the individual

circumstances and level of intervention required to ensure the safety of the child (AIHW 2023a, 2022b).

Box 1: National child protection reporting

The Child Protection National Minimum Data Set (CP NMDS) contains information on children and young people who came into contact with the child protection system. Children may receive a mix of child protection services – when reporting a unique count of children who came into contact with the child protection system, each child is counted once if they were the subject of an investigation, of a notification, on a care and protection order and/or were in out-of-home care (see the Child protection Glossary).

Substantiations of child maltreatment are also recorded in the CP NMDS (that is, where an investigation concludes that there was reasonable cause to believe that a child had been, was being, or was likely to be, abused, neglected or otherwise harmed) (AIHW 2023a). Four main types of substantiated child maltreatment are reported:

- Physical abuse – any non-accidental physical act inflicted upon a child by a person having the care of a child.
- Sexual abuse – any act by a person, having the care of a child that exposes the child to, or involves the child in, sexual processes beyond his or her understanding or contrary to accepted community standards.
- Emotional abuse – any act by a person having the care of a child that results in the child suffering any significant emotional deprivation or trauma. Children affected by violence directed at, or between, parents, caregivers or other family members are also included in this category.
- Neglect – any serious acts or omissions by a person having the care of a child that, within the bounds of cultural tradition, constitute a failure to provide conditions that are essential for the healthy physical and emotional development of a child (AIHW 2023c).

If a child was the subject of more than one type of maltreatment as part of the same report, the type of abuse or neglect reported is the one considered by the child protection workers to cause the most harm to the child (AIHW 2023a).

Source: AIHW 2023a, 2023c.

Neglect of children has been included in the data reported for child protection services because children are often neglected when family, domestic or sexual violence occurs in the home. For example, perpetrators may prevent their partner from caring for or seeking medical treatment for children (QCDFVR 2020).

What do we know about child maltreatment?

Many cases of child maltreatment are not disclosed to authorities (AIFS 2020). The CP NMDS only includes cases reported to state and territory departments responsible for child protection and reflects the incidence of substantiations of harm, or risk of harm. It does not provide the prevalence of child maltreatment in Australia (AIHW 2023a, 2022b).

The experience and impacts of child maltreatment and exposure to family violence were explored in 2021 as part of the first national child maltreatment study in Australia (Haslam et al. 2023). Findings from the Australian Child Maltreatment Study are presented in the **Children and young people** and **Child sexual abuse** topics.

Family and domestic violence, parental alcohol and other drug use, and parental mental health issues have been identified as key behavioural risk factors in reports of child maltreatment and placement in out-of-home care (Luu et al. 2024). Family and domestic violence, including child maltreatment, can have a wide range of significant adverse impacts on a child's development and later outcomes. This includes, but is not limited to, adverse effects on the person's mental and physical health, housing situation and general wellbeing. Research also indicates there is a link between adverse childhood experiences, including child maltreatment, and the future use of violence by victim-survivors (Ogilvie et al. 2022).

See also **Factors associated with FDSV** and **Children and young people**.

Several Australian linkage projects have brought together data from different data collections to better understand some of the outcomes for children in contact with the child protection system. These projects found that children who had contact with the child protection system were more likely:

- than other children to be under youth justice supervision and to seek assistance from specialist homelessness services (AIHW 2016, 2022c)
- to have lower levels of literacy and numeracy than all students (AIHW 2015, see also Box 2)
- to receive income support payments at ages 16–30 when compared with the Australian population of the same age (AIHW 2022a, see also **Economic and financial impacts**).

Box 2: New South Wales and South Australian data linkage projects – educational outcomes for children who had contact with child protection services

- The New South Wales Child Development Study included linked data for 56,860 Australian children and their parents across a range of data collections including those related to child protection services and educational outcomes. The data showed that children who had contact with child protection services had lower 3rd- and 5th-grade literacy and numeracy levels when compared with children who did not have contact with child protection services. Children with substantiated risk of significant harm reports who were not placed in out-of-home care had the lowest levels for literacy and numeracy when compared with all other children, including children who were placed in out-of-home care. This suggests that placement in out-of-home care may have a potential beneficial effect (Laurens et al. 2020).
- The South Australian Early Childhood Data Project includes data from a range of sources for around 450,000 South Australian children born from 1991 onwards, and their parents

and carers. Australian Early Development Census (AEDC) data were used to examine childhood development at age 5 (the year children enter formal schooling) according to contact with child protection services. The analysis found that children who had contact with child protection services were more likely to be classified as vulnerable on 1 or more domains compared with children who did not have contact. Vulnerability increased for children who had a greater level of contact with the child protection system – children who had experienced out-of-home care were almost 1.5 times as likely to have developmental vulnerabilities at age 5 compared with those who had a notification to a child protection department only (Pilkington et al. 2019).

What do the data tell us about the child protection system?

Child protection data are recorded in the Child Protection National Minimum Data Set (see Box 1 and **Data sources and technical notes**).

1 in 32 children

in Australia came into contact with the **child protection** system in 2021–22

During 2021–22, 1 in 32 (or almost 178,000) children in Australia came into contact with the child protection system:

- 119,000 (21 per 1,000) were the subject of an investigation
- 72,300 (13 per 1,000) were on a care and protection order
- 55,800 (9.8 per 1,000) were in out-of-home care.

About two-thirds (70%) of the children were repeat clients, that is, they had been in contact with the system before (AIHW 2023a).

Emotional abuse is the main type of substantiated maltreatment

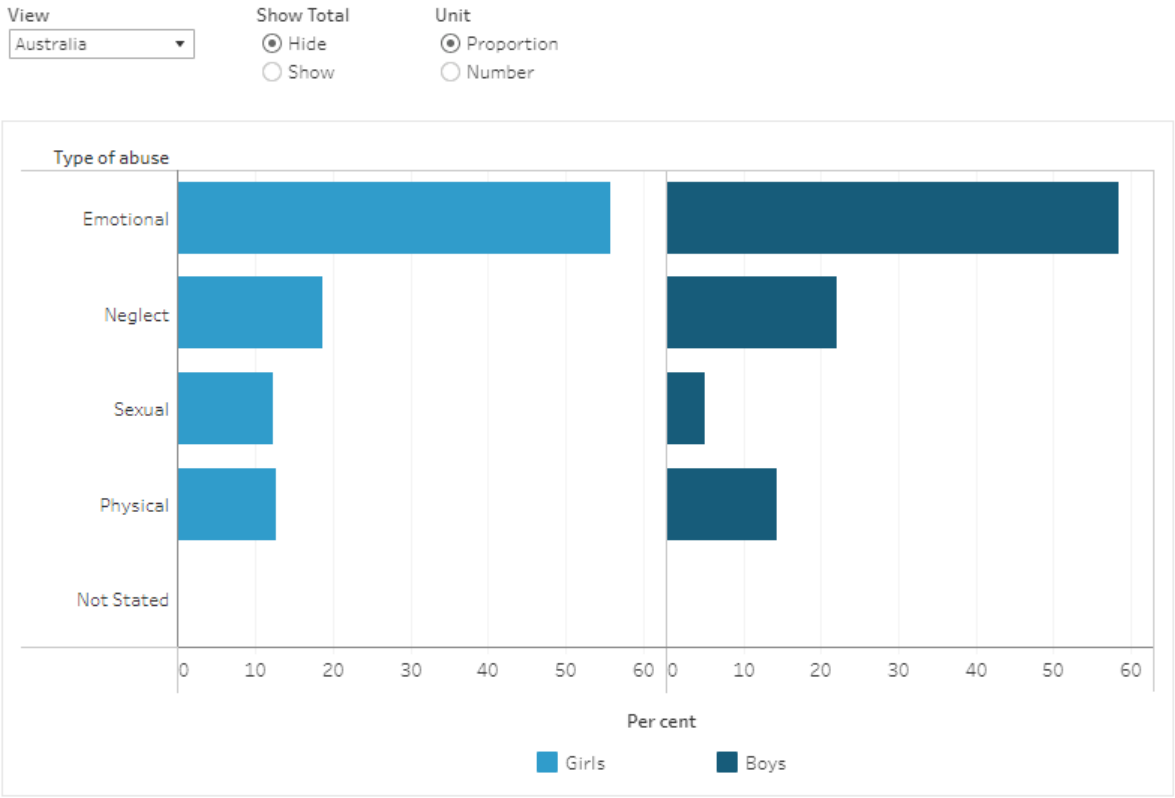
57% of children who were the subject of a substantiation of maltreatment in 2021–22 had emotional abuse recorded as the primary type of abuse

In 2021–22, nearly 45,500 children (8 per 1,000 children) were the subjects of substantiated maltreatment following an investigation (that is, an investigation concluded that there was reasonable cause to believe that a child had been, was being, or was likely to be, abused, neglected or otherwise harmed). For more than half (57%, or 25,900) of these children, emotional abuse was the primary type of substantiated maltreatment. This category includes children who experienced violence directly and those affected by exposure to family and domestic violence. However, it is not possible to separately report the number of children affected by exposure to family and

domestic violence from those who experienced other forms of emotional abuse (AIHW 2023a).

Neglect was the next most common substantiated type of maltreatment (21%), followed by physical abuse (13%) and sexual abuse (9%) (AIHW 2023a). The pattern of substantiated abuse types was similar for girls and boys, however, girls (12%) were more likely to be the subjects of substantiations for sexual abuse than boys (5%) (Figure 1, AIHW 2023a).

Figure 1: Children who were the subjects of substantiations, by primary type of maltreatment and sex, 2021–22



n.p.: not published.
Source: AIHW CP NMDS.

https://www.aihw.gov.au

Intensive family support services

Almost **36,200** children commenced intensive family support services in 2021–22

National data for reporting on family support services in the child protection context is currently limited to intensive family support services. These are services that explicitly work to prevent imminent separation of children from their primary caregivers because of child protection concerns, and to reunify families where separation has already occurred (AIHW 2023a).

In 2021–22, almost 36,200 children commenced intensive family support services and of these 23% (or about 8,200) were aged under 5 (AIHW 2023a).

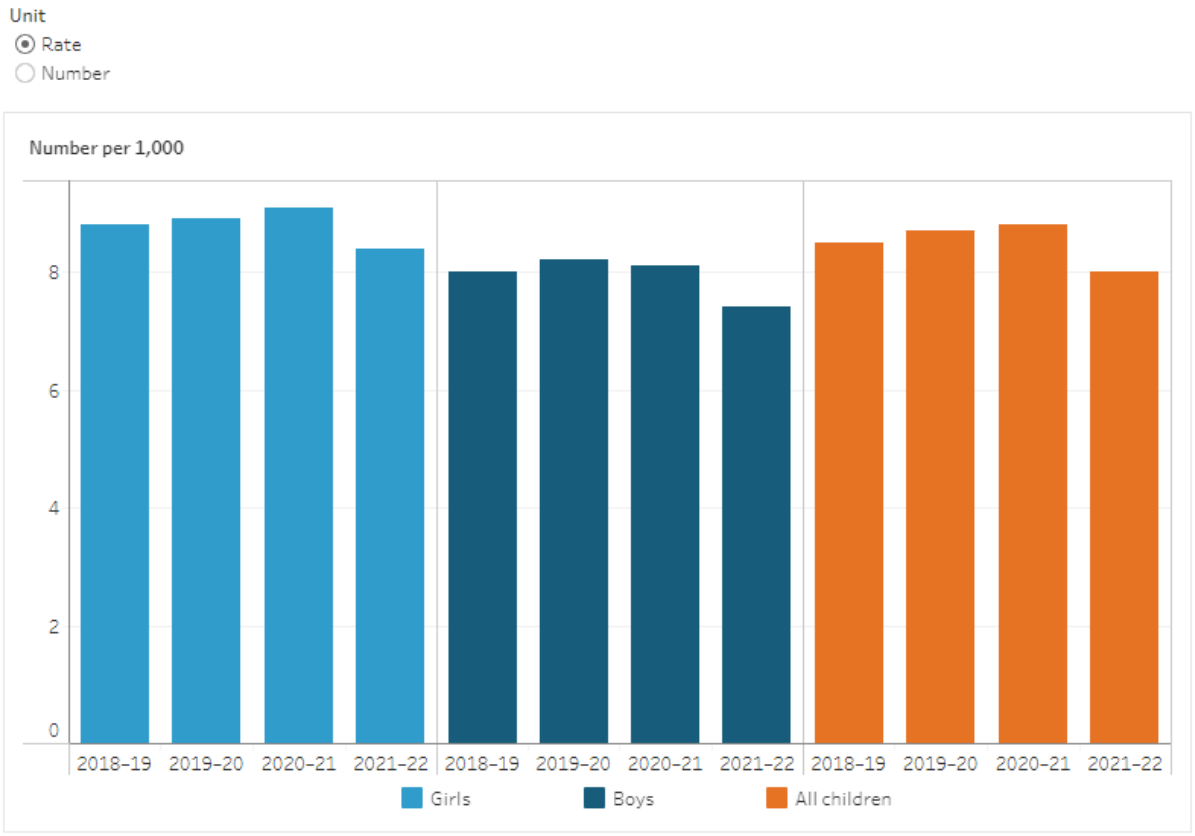
Has the rate of children who had contact with the child protection system changed over time?

The rate of children who had contact with the child protection system was relatively stable between 2018–19 and 2021–22, at around 31 per 1,000 children (AIHW 2023a).

Figure 2 shows that the rate of children who were the subjects of substantiations was relatively stable between 2018–19 and 2020–21 (at around 9 per 1,000 children), with a slight decrease to 8 per 1,000 children in 2021–22. This pattern was similar for boys and girls, however, the rate of substantiations was slightly higher for girls over the period (ranging from 8.4 to 9.1 per 1,000 for girls, compared with a range of 7.4 to 8.2 per 1,000 for boys).

Data for 2017–18 have not been included in this analysis as data on substantiations were unavailable for New South Wales for that period.

Figure 2: Children who were the subjects of substantiations, by sex, 2018–19 to 2021–22



Source: AIHW CP NMDS. https://www.aihw.gov.au

Emotional abuse was the most common substantiated primary type of maltreatment between 2018-19 and 2021-22. It was recorded as the primary type of maltreatment for more than half of the children who were the subjects of substantiated maltreatment, ranging from 54% in 2018–19 and 2019–20 to 57% in 2021–22 (AIHW 2023a).

Are the rates of substantiations of child maltreatment the same for all children?

Figure 3 shows the number and rate (number per 1,000 children) of children who were the subjects of substantiations in 2021–22 for select population groups. The rates of substantiations of child maltreatment are higher for:

- infants (children aged under one) – 15 per 1,000 children compared with 5 per 1,000 for children aged 15–17
- First Nations (Aboriginal and Torres Strait Islander) children, a rate of 40 per 1,000
- children from *Very remote areas* (25 per 1,000 children), compared with *Major cities* (6.6 per 1,000)
- children from the lowest socioeconomic areas (33% of substantiations were for children in the lowest socioeconomic areas, compared with 7.2% in the highest) (Figure 3; AIHW 2023a).

Figure 3: Children who were the subjects of substantiations, for select population groups, 2021–22

n.a.: not available.
Source: AIHW CP NMDS.

https://www.aihw.gov.au

What else do we know?

There is substantial overlap between the child protection system and youth justice supervision

Over 1 in 2 (53%) young people under youth justice supervision in 2020–21 had contact with the child protection system between 1 July 2016 and 30 June 2021

Of the nearly 9,300 young people aged 10 and over under youth justice supervision (community-based supervision and/or detention) in 2020–21:

- over 1 in 2 (53%, or nearly 5,000) had contact with the child protection system between 1 July 2016 and 30 June 2021
- over 1 in 4 (28%, or nearly 2,600) had contact with the child protection system in 2020–21 (AIHW 2022c).

The proportion of children and young people who had contact with the child protection system between 1 July 2016 and 30 June 2021 was higher for those in youth detention in 2020–21 (60%) than those under community-based supervision (54%) (AIHW 2022c).

Some children in out-of-home care may be the subject of further abuse

Box 2: Reporting on the safety of children in care

The national collection on safety in care provides information about substantiations of abuse for children in care by their carer or another person in the household or care facility. Children in care are those children who were placed in out-of-home care, on third-party parental responsibility orders, or on other orders that transfer full or partial parental responsibility for the child to an authority of the state or territory.

Notifications of suspected abuse in care are investigated, and will be substantiated where it was concluded there was reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed. This includes cases of physical abuse, sexual abuse (including sexual exploitation), emotional abuse (including exposure to family and domestic violence), and neglect (including inadequate supervision and failing to provide appropriate food, clothing, shelter and medical care).

Source: AIHW 2021

In 2021–22, about 1,200 children were the subject of a substantiation of abuse in care. The most common primary type of abuse in care was physical abuse (32%). This was followed by emotional abuse (29%), neglect (18%) and sexual abuse (15%) (AIHW 2023b).

Physical abuse (36%) was the most common type of abuse in care for boys, followed by emotional abuse (28%). For girls, emotional abuse (31%) was the most common,

followed by physical abuse (27%). Girls (19%) were more likely to be the subjects of substantiations for sexual abuse in care than boys (12%) (AIHW 2023b).

Related material

- Factors associated with FDSV
- Children and young people
- Economic and financial impacts
- Family and domestic violence
- Policy and international context

More information

- Child protection Australia 2021-22
- National framework for protecting Australia's children indicators
- Income support receipt for young people transitioning from out–of–home care 2022
- Young people under youth justice supervision and their interaction with the child protection system 2020-21

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Housing

Key findings

- Of those assisted by specialist homelessness services in 2022–23 around 104,000 people, or 38% of all clients, have experienced FDV.
- The rate of specialist homelessness services clients who have experienced FDV increased by 13% between 2011–12 and 2022–23.
- Among specialist homelessness services clients who have experienced FDV, 9 in 10 were women (aged 15 or older) and children (0-14 years old).

Family and domestic violence (FDV) is the main reason women and children leave their homes in Australia (AHURI 2021). Many women and children leaving their homes may experience housing insecurity, and in some cases, homelessness (Fitz-Gibbon et al. 2022). For this reason, women and children affected by FDV are a national homelessness priority group in the *National Housing and Homelessness Agreement* (NHHA), which came into effect on 1 July 2018 (CFFR 2019). Additionally, the *National Plan to End Violence against Women and Children 2022-2032* identified housing as a priority response area (DSS 2022). Safety at home can also be a concern for people who have experienced sexual violence outside of the family, for example if the perpetrator lives nearby, or knows where they live.

Housing assistance provided by governments and community organisations is available to eligible people in Australia who may have difficulty securing stable and affordable housing. There are also specialist homelessness services (SHS) that can provide a specialised response service for people experiencing homelessness or at risk of homelessness, including those who may need to leave their home due to family, domestic and/or sexual violence (FDSV) (DSS 2022).

This page focuses primarily on SHS data, as this is the only national housing-related collection which currently includes information on clients who have experienced family, domestic and sexual violence.

Understanding housing and FDSV

When violence occurs within the home, it can create an unsafe and unstable environment, leading some individuals and families to leave for their safety (AIHW 2023b). For many, leaving the home (either temporarily or permanently) can result in housing insecurity and/or homelessness due to a lack of housing options or barriers in accessing resources and support.

The 2021–22 Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) estimated that almost 2 in 3 (64%, or about 867,000) women who experienced partner violence while living with a previous partner, moved away from home when the relationship finally ended (ABS 2023). Equivalent estimates for men from the 2021–22 PSS were not

sufficiently reliable for reporting. However, estimates from the 2016 PSS indicate that around 3 in 5 (61%, or about 223,000) men who experienced partner violence while living with a previous partner, moved away from home when the relationship finally ended (ABS 2017).

Following final separation from a violent partner, many people experienced homelessness at some point (e.g. slept rough, stayed temporarily with a friend or relative, or in accommodation without a permanent address). For example, 2 in 3 women (67% or 577,000) relied on friends or relatives for accommodation (ABS 2023).

For some victim-survivors, lack of suitable housing options may lead them to stay in or return to a violent relationship (Flanagan et al. 2019). There is research suggesting that returning to a previously violent partner can increase the level of violence experienced by victim-survivors who return (Anderson 2003). Providing suitable options for secure long-term housing accommodation is essential to support victim-survivors leaving a violent relationship (ANROWS 2019; Flanagan et al. 2019).

The *Safe Places Emergency Accommodation (Safe Places) Program* was established under the Fourth Action Plan of the *National Plan to Reduce Violence against Women and their Children 2010-2022*. Safe Places is a capital works program for emergency accommodation for women and children leaving FDV. Additional funding to continue the Safe Places Program was announced as part of the Australian Government investment in women's safety and the *National Plan to End Violence against Women and Children 2022-2032* (DSS 2023).

Housing assistance provided by the Australian and state and territory governments includes the provision of social housing (public housing, state owned and managed Indigenous housing, community housing and Indigenous community housing) and financial assistance:

- Social housing is generally allocated according to priority needs – people identified as having the greatest need (such as those at risk of homelessness, including people whose life or safety was threatened within their existing accommodation), and those with special needs for housing assistance (such as people with disability).
- Financial assistance includes Commonwealth Rent Assistance (CRA) and Private Rent Assistance (PRA) to help with private rental market costs and Home Purchase Assistance (HPA) (AIHW 2023a).

For information about the financial supports available to those who have experienced violence, see **Financial support and workplace responses**.

For those experiencing FDSV, SHS can provide an immediate response and crisis support. However, the pathway into stable, secure and long-term housing can be challenging (Flanagan et al. 2019). Systemic barriers, such as limited supply of affordable housing, make it difficult for women and children affected by FDV to move from crisis or transitional accommodation into permanent, independent housing (Flanagan et al. 2019; ANROWS 2019).

Why is housing important for those leaving violent situations?

'A key aspect to being stable and free from violence was having housing. I was luckily placed into government housing which offers people stability and affordability while learning life skills. Things you wouldn't have time for if you were in the private rental market.'

Kelly

WEAVERs Expert by Experience

People and families who are homeless or at risk of homelessness may be at risk of additional forms of violence and exploitation, including sexual violence, as well as other challenges such as poverty and poor health (Fitz-Gibbon et al. 2022). The co-occurrence of homelessness and FDV can also have a significant impact on the mental health and well-being of individuals and families. Experiencing violence and homelessness can lead to trauma, significant stress and other mental health issues, further compounding the difficulties faced when leaving situations involving FDV (Fitz-Gibbon et al. 2022; AIHW 2021). For more information see **Health outcomes**.

How do specialist homelessness services respond to FDSV?

Specialist homelessness services (SHS) deliver accommodation-related and personal services to people who seek support who are homeless or at risk of homelessness.

SHS agencies vary in size and in the types of assistance they provide. Across Australia, agencies provide services aimed at prevention and early intervention, as well as crisis and post crisis assistance to support people experiencing, or at risk of, homelessness. For example, some agencies focus specifically on assisting people experiencing homelessness, while others deliver a broader range of services, including youth services, FDV services, and housing support services to those at risk of becoming homeless. The service types an agency provides range from basic, short-term interventions such as advice and information, meals and shower or laundry facilities through to more specialised, time-intensive services such as financial advice and counselling and professional legal services. Some people receive support from SHS agencies on multiple occasions and the reason for seeking support may differ (AIHW 2023b).

National data sources for measuring specialist homelessness services

SHS agencies that receive government funding are required to provide data to the Specialist Homelessness Services Collection (SHSC). The SHSC includes data on clients, the services that were provided to them and the outcomes achieved for those clients. For more information about the SHSC, please see **Data sources and technical notes**.

Box 1 provides information about the National Housing and Homeless Agreement (NHHA) Performance Indicators.

Box 1: National Housing and Homelessness Agreement (NHHA) Performance Indicators

Under the National Housing and Homelessness Agreement (NHHA), there are 2 key indicators to measure national homelessness performance:

- the number of people who experience repeat homelessness; and
- the proportion of people who are at risk of homelessness that receive assistance to avoid homelessness (AIHW 2023b).

Data on women and children affected by FDV are collected against these indicators. However, these data are primarily used to report progress against the objectives and outcomes of the NHHA and may not reflect progress for addressing FDV specifically.

In 2022–23, for SHS clients affected by FDV:

- there were 15,500 women and children experiencing persistent homelessness (homeless for more than 7 months over a 24-month period); an increase of 2,400 since 2018–19.
- there were 7,900 women and children affected by family violence that returned to homelessness (that is, used homelessness services with periods of permanent housing in between, only to return to SHS since July 2011) (430 client decrease since 2018-19).
- 78% of women and children at risk of homelessness avoided homelessness (no change from 2018-19).

For more information see National Housing and Homelessness Agreement Performance Indicators.

What do the data tell us about homelessness in the context of FDV?

SHS clients who experience FDV

Examination of the number of SHS clients experiencing FDV provides an indication of the level of service response for this group. Data on people seeking support from SHS agencies are drawn from the AIHW Specialist Homelessness Services Collection (SHSC) (see Box 2). The AIHW Specialist homelessness services annual report includes additional details on Clients who have experienced family and domestic violence.

Box 2: Reporting clients experiencing FDV in the SHSC

In the SHSC, a client is reported as experiencing FDV if they identified FDV as a reason for seeking assistance and/or one of the services they needed was FDV assistance. In this context, family and domestic violence is defined as physical or emotional abuse inflicted on the client by a family member.

The SHSC reports on clients experiencing FDV of any age, including both victim and perpetrator services provided.

Clients of SHS agencies are considered to be either experiencing homelessness or at risk of homelessness:

- Clients are considered to be experiencing homelessness if they are 'sleeping rough' in non-conventional accommodation, such as on the street or in a park, staying in short-term or emergency accommodation or staying in a dwelling without tenure (couch surfing).
- Clients are considered to be at risk of homelessness if they are living in public or community housing, private or other housing or in institutional settings.

Agencies funded to provided SHS vary widely in terms of the services they provide and the service delivery frameworks they use. Each state and territory manage their own system for the assessment, intake, referral and ongoing case management of SHS clients. Changes implemented by states and territories in the delivery of services and their associated responses have the potential to impact SHSC annual data.

In the SHSC, there is also data available on clients who identified sexual abuse by a family member or non-related individual as a reason for seeking assistance, and clients who needed and/or were provided with assistance for incest/sexual assault. In 2022–23, there were around 4,800 clients who reported sexual abuse as a reason for seeking assistance. Due to the relatively small number of clients, further analysis on this client group was not undertaken for this page.

Source: AIHW 2023b.

In 2022–23, around 104,000 clients assisted by SHS agencies had experienced FDV, representing 38% of all SHS clients, and a population rate of 40 per 10,000. Of these, around 3 in 5 (62%) had previously been assisted by a SHS agency at least once since the collection started in July 2011.

SHS clients may be provided with multiple forms of assistance. Among the 104,000 clients who had experienced FDV in 2022-23:

- 67% (70,000) needed specific assistance for FDV, with 61,900 receiving this service
- 46% (48,100) needed short-term or emergency accommodation, with 33,500 receiving this service
- 44% (45,400) needed money for accommodation (for example, bond or rent) and transport, and/or other non-monetary assistance, such as clothing, food vouchers and tickets for public transport. Of those, 40,100 received this service (AIHW 2023b).

SHS clients may seek victim and/or perpetrator support. Among SHS clients aged 10 and over who had experienced FDV in 2022–23:

- 65% (52,000) needed victim support, with 45,600 receiving this service
- 4.6% (3,700) needed perpetrator support, with 2,300 receiving this service
- 3.0% (2,400) needed victim and perpetrator support, with 1,400 receiving this service (AIHW 2023b).

Note, these groups are not mutually exclusive and clients can be counted in more than one group.

For information on health-related services for SHS clients, see also **Health services**.

Fewer were experiencing homelessness at the end of support

Information on where clients were residing before and after they were supported by a SHS agency provides some insights on housing outcomes for those who have experienced FDV. Among clients who have experienced FDV whose support ended in 2022–23:

- More than 2 in 5 (42% or 9,400 clients) who were experiencing homelessness at the start of support were housed at the end of support.
- Almost 9 in 10 (88% or 30,000 clients) who were at risk of homelessness at the start of support were housed at the end of support (primarily in private rental accommodation (20,600 clients or 60%)).

It is important to note that some clients may seek assistance from SHS agencies again in the future.

Has SHS clients experiencing FDV changed over time?

The rate of specialist homelessness services clients across Australia who have experienced FDV **increased by 13%** between 2011–12 and 2022–23.

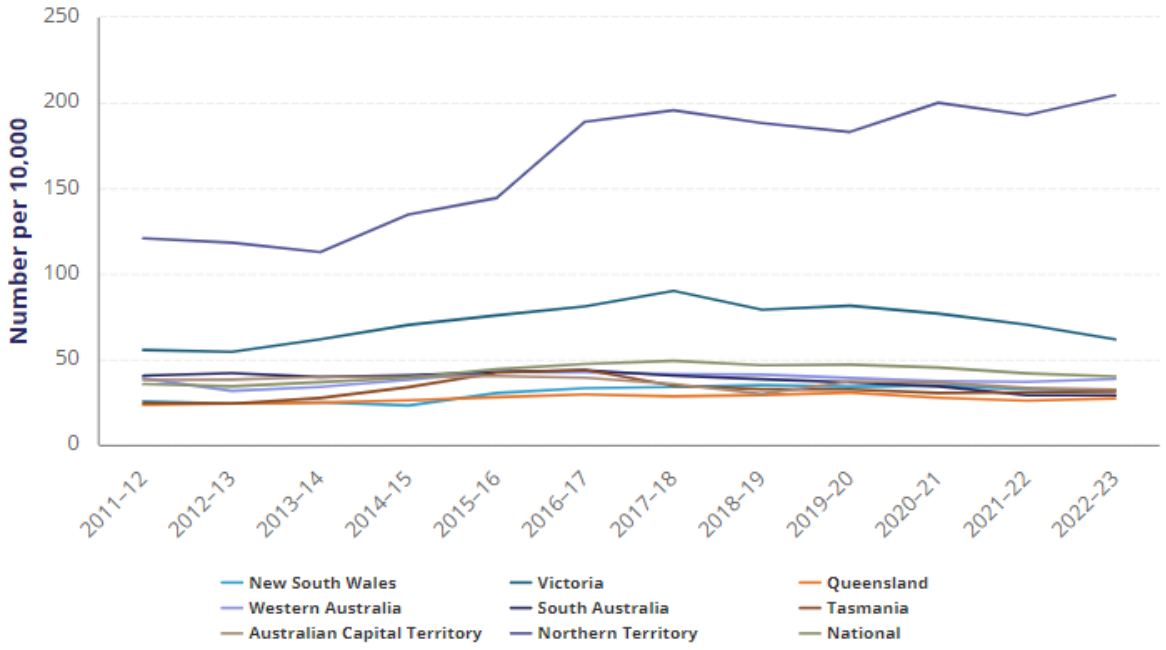
Among SHS clients who experienced FDV, the rate of clients between 2011–12 to 2022–23:

- increased by 13% from 36 per 10,000 population to 40 per 10,000
- increased on average by a rate of 1.1% per year
- increased for all jurisdictions except Western Australia, South Australia and the Australian Capital Territory (Figure 1, AIHW 2023b).

Changes over time for Victoria should be interpreted with caution due to changes in practice which may result in a decrease in FDV client numbers since 2017–18 (AIHW 2023b).

See also **FDSV and COVID-19**.

Figure 1: Specialist homelessness services clients who have experienced FDV, by state/territory, 2011-12 to 2022-23



Source: AIHW SHSC | **Data source overview**

Is it the same for everyone?

Among specialist homelessness services clients who have experienced FDV, **9 in 10** were women and children.

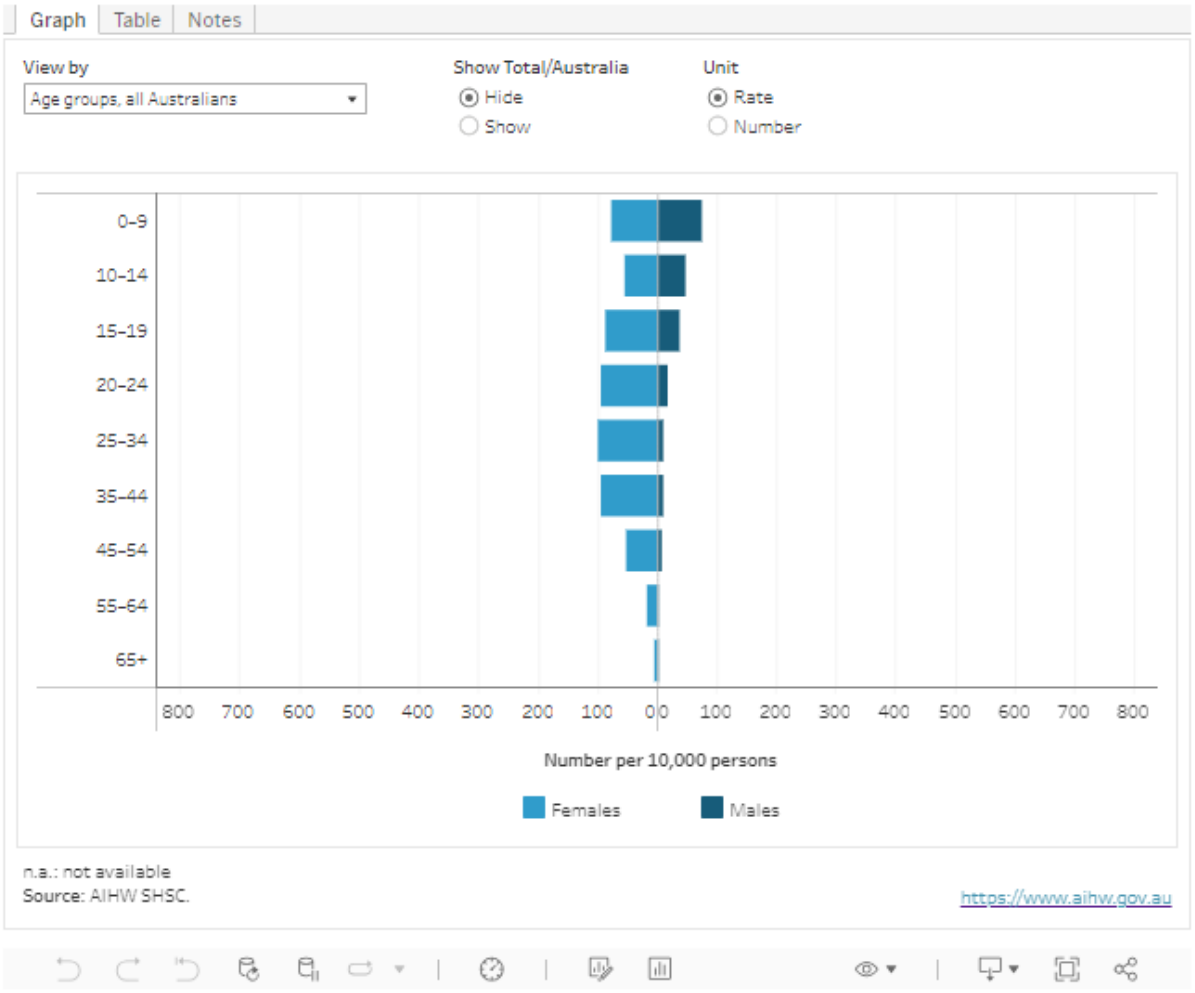
Some population groups may be at higher risk of homelessness due to FDV. Understanding which groups are at higher risk, can be used to inform the development of more targeted programs and services for these clients.

Figure 2 shows that of the 104,000 clients in 2022–23 who have experienced FDV:

- 9 in 10 clients were women and children. Around 6 in 10 (60% or around 62,300 clients) were females aged 15 and older, and a further 3 in 10 (31% or 32,100 clients) were children aged 0-14 years. See also **Mothers and their children**, **Young women**, and **Children and young people**.
- Just over 1 in 4 (29% or around 29,400 clients) were First Nations (Aboriginal and Torres Strait Islander) people. See also **Aboriginal and Torres Strait Islander people**.

- 1 in 6 (18%, or around 18,600 clients) spoke a main language other than English at home.
- Around 3 in 5 (61%, or around 63,100 clients) were in *Major cities*
- Almost 1 in 10 (7.7% or 8,100 clients) were living with disability. See also **People with disability**.

Figure 2: Specialist homelessness services clients who have experienced FDV, for select population groups, 2022-23



SHS clients who experience FDV may also experience other vulnerabilities, such as mental health issues and problematic drug or alcohol use. Of the 80,400 clients aged over 10 who have experienced FDV, many had additional vulnerabilities – 12% reported experiencing problematic drug or alcohol use, and 42% had a current mental health issue. See also **Factors associated with FDSV**.

The co-occurrence of FDSV and homelessness is especially heightened for children and young people, who face increased risks of violence, interruptions to education, and repeat homelessness. Experiencing homelessness can limit access to medicine, treatment and basic hygiene and expose young people to sexual exploitation, violence and social isolation. Young people can also experience high levels of mental health

problems, including anxiety, depression, behavioural problems and alcohol and drug misuse. Due to a combination of these factors, homeless young people face a high mortality rate when compared with the general population and represent a priority group under the Commonwealth Government National Housing and Homelessness Agreement (NHHA) to address the national housing crisis (see Box 1) (Aldridge et al. 2017; Heerde & Patton 2020; AIHW 2021).

What else do we know?

Many female SHS clients who have experienced FDV were long term clients

Analysis of the SHS longitudinal data set, provided insight into the patterns of support for female clients experiencing FDV over time. The study focussed on a cohort of nearly 55,500 females aged 18 and over, who during 2015–16 were SHS clients that have experienced FDV. Of these, nearly half (47%) had used specialist homelessness services in the past 4 years (2011–12 to 2014–15) and 45% continued to use services in the 4 years after 2015-16. Almost 1 in 3 (29%) were long-term clients, who needed SHS support over a 10-year period (AIHW 2022).

This cohort were also 8 times more likely to need assistance for incest or sexual assault, and almost 6 times more likely to require court support, compared to women clients without a FDV experience in 2015–16 (AIHW 2022). For further details, see Specialist homelessness services: Female clients with family and domestic violence experience in 2015–16.

Victim-survivors of violence often bear the costs for leaving the family home

More than 1 in 2 (55%) women who permanently left a violent partner moved out of their home, while their partner remained in the home.

According to the 2021 –22 ABS PSS, an estimated 755,000 women (55%) who permanently left a violent previous partner reported that only they, not their partner, had moved out of their home (ABS 2023). While equivalent 2021–22 data for men are not sufficiently reliable for reporting, 2016 data showed that an estimated 180,000 men (49%) who permanently left a violent previous partner reported that only they, not their partner, had moved out of their home (ABS 2017).

In March 2021, the Parliamentary *Inquiry into family, domestic and sexual violence* found that victim-survivors of violence often bear the costs for leaving the relationship, the family home and their community. Relocation expenses can include deposits or rental bonds for new dwellings, travel costs, furnishing costs and safety upgrades. These costs, in addition to other costs such as legal and medical costs and the costs of providing for

any dependents, may result in economic instability and the accumulation of debt (HRSCSPLA 2021).

The inquiry recommended federal and state and territory governments consider funding for emergency accommodation for people who use violence (perpetrators) in order to prevent victim-survivors being forced to flee their homes or continue residing in a violent home (see Box 3). This would reduce the burden on victim-survivors and hold perpetrators accountable for their behaviour (HRSCSPLA 2021).

Box 3: Housing options for perpetrators

The National Plan Victim-Survivor Advocates Consultation Final Report provided by Monash University's Gender and Family Violence Prevention Centre noted some victim-survivors advocated for further investment in perpetrator housing pathways. Increasing housing for perpetrators would support primary victim-survivors to remain in the home.

Some state and Federal level initiatives have been developed, for example, the Victorian Government committed additional funding in August 2020 to increase short- and long-term accommodation options for perpetrators of family violence and people at risk of using family violence. The strategy was positioned as part of an increased government commitment to ensuring perpetrator visibility at all points of the system response to family violence. At the federal level, the Commonwealth Government funds the Keeping Women Safe in their Homes program, in which they have invested $34.6 million since 2015−16. See more at **Who uses violence?**

Source: Fitz-Gibbon et al. 2022.

Related material

- Factors associated with FDSV
- Mothers and their children
- Young women
- Children and young people
- Aboriginal and Torres Strait Islander people
- FDSV and COVID-19

More information

- Specialist homelessness services annual report – Clients who have experienced family and domestic violence
- Specialist homelessness services client pathways – Female clients with family and domestic violence experience in 2015–16
- National Housing and Homelessness Agreement performance indicators (see 'women and children affected by FDV' cohort)
- Specialist Homelessness Services: monthly data

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Legal systems

Key findings

- The principal offence for the majority of defendants finalised for family and domestic violence criminal court cases in 2021–22 were either *Acts intended to cause injury* (48% or 40,400) or *Breach of violence order* (40% or 33,600).
- About 4 in 5 (81% or 67,600) defendants finalised for family and domestic violence offences in 2021–22 were found guilty.
- About half (51% or 135,000) of civil cases in the Magistrates' Courts in 2021–22 involved a domestic violence order.
- The number of defendants finalised with a principal offence of *Sexual assault and related offences* has generally increased each year between 2010–11 to 2021–22.

Family, domestic and sexual violence (FDSV) causes immediate and long-lasting harm. The legal systems in Australia provide formal responses for people who experience FDSV (victim-survivors) that can prevent or reduce violence and punish those who have used violence. In this section, we highlight the available data on legal responses to FDSV.

How do victim-survivors interact with legal systems?

This page outlines aspects of legal systems that are specific to FDSV, such as the definitions of family and domestic violence (FDV) and sexual violence used in legislation across Australia, the legal responses available to prevent or respond to FDSV, and the legal assistance services available to help people engage with legal systems, see Table 1. Police are a key entry point to formal FDSV responses for many victim-survivors and people who use violence including those offered by legal systems. However, many victim-survivors of FDSV do not contact police, and not all cases reported to police are pursued further in legal systems (ABS 2009). For more information on FDSV and the police, see **Family and domestic violence reported to police** and **Sexual assault reported to police**.

Legal definitions of FDV and sexual violence

There is currently no uniform legal definition for FDV or sexual violence across federal and state and territory legislation, which includes family law, criminal law and other types of legislation (Table 1). Due to this, the legal responses to FDSV and to specific offences vary across states and territories. In cases where legal definitions of FDV are related to eligibility to receive a specialist FDV (or FV) service, differences in the definition of FDV can restrict access to support for victim-survivors in some jurisdictions (ALRC and NSW LRC 2010; SCSPLA 2021).

Table 1: Legal systems and FDSV

Legislation related to FDSV	Legal responses to FDSV	Legal assistance services
FDSV is defined in these federal, state and territory legislation. **Federal** • Family legislation • Criminal legislation • Human rights legislation • Migration legislation **State/Territory** • Child protection legislation • Family violence legislation • Family legislation (Western Australia only) • Criminal legislation • Human rights legislation • Victims' compensation and support legislation	Legal responses to FDSV describe the use of legal systems to enforce laws that can punish or prevent violence. **Police** enforce criminal law, can intervene in certain situations and can charge a person with a crime. This may result in a person going to court. **Courts** assess evidence and make judgements about how laws apply to situations, whether laws have been broken and what happens in response. They can include mainstream or specialist family and domestic violence courts. **Specific responses related to FDSV:** • Domestic Violence Orders (DVOs) • Proceedings for criminal FDV offences and sexual assault and related offences • Parenting orders and financial orders	Legal assistance services help people who have experienced FDSV to engage with legal systems. **Legal assistance services include:** • Legal aid commissions • Family Advocacy and Support Service • Specialist family and domestic violence services • Health justice partnerships • Aboriginal and Torres Strait Islander Legal Services • Family Violence Prevention Legal Services • Community Legal Centres • Family Relationship Centres For more information, visit the Attorney-General's Department website.

Note: The terms used to identify DVOs vary between states and territories, see Box 1.

Sources: AGD n.d.a; ALRC and NSW LRC 2010; SCSPLA 2017, 2021.

The types of abusive behaviours covered in each jurisdiction's legislation not only differ but also can change over time to incorporate other forms of FDV such as economic abuse, technology-facilitated abuse, and coercive and controlling behaviours (refer to **Coercive control**, **Intimate partner violence** and **Stalking and surveillance**). Similarly, legal definitions of consent and sexual violence continue to evolve to better

protect people from different forms of sexual violence (refer to **Sexual violence** and **Consent**).

The laws around child protection also vary across states and territories. The jurisdictions have responsibility for investigating and responding to child protection issues, including exposure to or experiences of domestic and family violence (National Legal Aid 2019b). For a discussion of data related to child protection, see **Child protection**.

Legal responses to FDSV

Legal responses to FDSV can involve civil and criminal proceedings of state and territory courts. On this page, proceeding refers to all the processes required to formally complete a case by a court:

- Civil proceedings can result in domestic violence orders (DVOs) that aim to protect victim-survivors of FDV from future violence.
- Criminal proceedings can punish people for criminal conduct related to FDV and sexual violence.

The terms used to refer to DVOs vary across jurisdictions (see Box 1). This report uses the term DVO to collectively refer to all terms used for DVOs nationally. In some states and territories temporary DVOs can be issued by police. If a DVO is breached, the matter can become a criminal offence. FDV that forms the basis for a DVO may also be the grounds for criminal proceedings (for example, physical and/or sexual assault). FDV that is not considered criminal under FDV legislation may still be used as the basis for DVOs (ALRC and NSW LRC 2010).

Box 1: Domestic violence orders

A Domestic Violence Order (DVO) is a civil order issued by a court that sets out specific conditions that must be obeyed and can include preventing a person from threatening, contacting, tracking or attempting to locate the protected person, and preventing a person from being within a certain distance of the protected person. The terms used to identify DVOs differ across jurisdictions:

- New South Wales – apprehended domestic violence order
- Victoria – family violence intervention order
- Queensland – domestic violence order
- Western Australia – family violence restraining order
- South Australia – intervention order
- Tasmania – family violence order
- Australian Capital Territory – family violence order
- Northern Territory – domestic violence order (Douglas and Ehler 2022).

Due to the National Domestic Violence Order Scheme all DVOs issued in states or territories from 25 November 2017 are automatically recognised and enforceable across Australia

(AGD n.d.b). DVOs issued before 25 November 2017 can become nationally recognised by being 'declared' as a DVO recognised under the scheme at any local court (AGD n.d.b).

Most criminal and civil proceedings related to FDV are formally completed in the Magistrates' Courts of each state and territory jurisdiction (see Box 2 for an explanation of court level groups). Criminal proceedings related to sexual violence are also often formally completed in Higher Courts (ABS 2023b; Productivity Commission 2024).

Box 2: State and territory court levels

There is a hierarchy of courts within each state and territory with some variation in the levels of courts and names used in each jurisdiction (Productivity Commission 2024). Cases related to family, domestic and sexual violence (FDSV) can be heard in all levels of court. The Australian Bureau of Statistics (ABS) Criminal Courts, Australia data collection groups the court levels used in each state and territory into three categories:

- Higher Courts – including Supreme Courts, District Courts and County Courts, which hear the most serious matters (including murder and the most serious sexual offences)
- The Magistrates' Courts – including Magistrates Courts, Local Courts, Court of Summary Jurisdiction, and Court of Petty Sessions, which hear less serious offences, or conduct preliminary hearings
- Children's Courts – Each state and territory has a Children's Court, which hears offences alleged to have been committed by a child or juvenile (ABS 2023b).

Throughout this topic page these court level groups are used to simplify discussions of both state and territory civil and criminal courts.

The Federal Circuit and Family Court of Australia, the Family Court of Western Australia and any specialist FDV courts are not included in the above court level groups and are discussed separately (ABS 2023b).

Restorative justice is an alternative response to FDSV whereby parties involved with a specific offence collectively resolve how to deal with an offence and its implications for the future (see Box 3).

Box 3: Restorative justice in Australia

There is still some debate around which practices can be considered restorative justice. Generally, restorative justice includes practices that involve the parties with a stake in a particular offence meeting to discuss and resolve the offence. In some cases, key participants do not meet face-to-face and instead exchange information by other means. The three most common practices are:

- victim–offender mediation, which can involve victims and offenders being given the opportunity to discuss their views with each other either face-to-face or indirectly, with active management and supervision by a mediation officer

- conferencing, which can involve people related to an offence including victims, offenders, victim or offender supporters, police officers and conference conveners coming together to discuss an offence and its impact
- circle and forum sentencing, which involves judges, lawyers, police officers, offenders, victims and community members coming together to determine an appropriate sentence for the offender (ALRC and NSW LRC 2010; Larsen 2014).

Restorative justice practices can be used at any stage in the criminal justice process, including at the time a person is charged, sentenced, and after they have served their sentence. Restorative justice practices are used throughout Australia with conferencing for young offenders used in all states and territories and some states and territories using restorative practices for adults (ALRC and NSW LRC 2010; Larsen 2014).

The evidence on the impact restorative justice has on reoffending suggests it is as good as traditional court sanctions. There is increasing evidence for other key benefits it may have, such as victim satisfaction, offender responsibility for actions and increased compliance with orders (Larsen 2014).

There are some limitations and challenges to the application of restorative justice in cases of FDSV as these offences often relate to power and control. For example, such cases can involve: perpetrators being unwilling to take personal responsibility and using the informal nature of restorative justice sessions to gain information about victims or assert ongoing forms of subtle control; victims with histories of trauma, ongoing fear and attachment to the perpetrator, which may result in greater difficulty advocating for themselves or increased pressure to reconcile with perpetrators; community members who are participating in the restorative justice process condoning violence due to societal tolerance of offences and negative gender norms (Jeffries et al. 2021).

FDSV can affect decisions related to family law. This includes cases where there are issues around the division of finances and/or property after separation, and/or issues with parenting orders (a set of orders about the parenting arrangements for a child). Some matters related to family law can be considered in the Magistrates' courts. The most complex family law disputes, including those involving FDV, are considered in the Federal Circuit and Family Court of Australia, and the Family Court of Western Australia. The Federal Circuit and Family Court of Australia was formed by combining the previous Family Court of Australia with the Federal Circuit Court of Australia as of 1 September 2021 (FCFCOA 2022e; SCSPLA 2017).

There are specialist FDV courts in locations around Australia (ALRC and NSW LRC 2010). These courts specialise in the handling of civil and/or criminal FDV matters. While the model for each court varies between jurisdictions, they generally use specialised case coordination mechanisms, integration with support and referral services, and special arrangements for victim-survivor safety (McGowan 2016). Evaluations of these specialist courts generally show advantages compared with mainstream courts, such as simpler navigation through legal systems, faster processing of cases and improved access to services for victim-survivors (McGowan 2016; ARTD consultants 2021).

Legal assistance services related to FDSV

General and tailored legal assistance services are available to advise and help people who have experienced or perpetrated family, domestic and sexual violence engage with legal systems (AGD n.d.a):

- Each state and territory has a Legal Aid Commission that provides services, including legal advice and representation in courts and tribunals for victim-survivors and perpetrators of FDSV (AGD n.d.a). Services are free of charge to people who meet means and merits tests set by each commission.
- Each Legal Aid commission has a Family Advocacy and Support Service that combines free legal advice and support at court for people affected by FDV (National Legal Aid 2019a).
- Specialist domestic violence units help women affected by FDV, who may otherwise be unable to access the support they need, with tailored legal assistance and other holistic support (AGD n.d.c).
- Through health justice partnerships, lawyers provide women affected by FDV with legal assistance in healthcare settings (AGD 2022).
- Aboriginal and Torres Strait Islander Legal Services (ATSILS) provide culturally appropriate and safe legal assistance services to First Nations (Aboriginal and Torres Strait Islander) victim-survivors and perpetrators of FDSV. The National ATSILS website provides links to State and Territory specific services (NATSILS 2022).
- The National Family Violence Prevention Legal Services program include First Nations community-controlled organisations throughout Australia who provide culturally safe legal services for First Nations people who experience FDV (NFVPLS 2022).
- Community legal centres are independent, community-managed, non-profit organisations offering free and accessible legal help to everyday people (CLCA 2019).
- Family Relationship Centres provide information about healthy family relationships, family dispute resolution mediation, advice around separation and referral to other specialist services (Family Relationships Online 2022).

Related formal responses and services

Apart from legal systems, there are a wide range of other services that work with victim–survivors, perpetrators and families in preventing and responding to FDSV. For more information, see **Services responding to FDSV**.

For example, perpetrator intervention programs aim to help people who use violence to stop using it. Court judgements can mandate individuals to attend perpetrator interventions as a part of legal proceedings (ANROWS 2021; Mackay et al. 2015).

For information related to specific services, see **Specialist perpetrator interventions**, **Health services**, **Housing** and **Helplines and related support services**.

What do we know?

DVOs are the most broadly used legal response to FDV (Taylor et al. 2015). Research suggests that DVOs can help as a deterrent through risk of punishment, through setting boundaries and reducing access to the victim-survivor, and by clearly defining the violence and its criminality (Dowling et al. 2018). There are, however, relatively few studies that assess the effectiveness of DVOs. Reviews of the available research found that DVOs:

- result in a small but significant reduction of re-victimisation
- are more effective for victim-survivors who are employed and/or in a higher socioeconomic group
- are less effective where perpetrators have histories of FDV and criminal offending, mental health issues, and they share children with the victim-survivor
- can improve victim's and survivors' perceptions of safety (Bell and Coates 2022; Dowling et al. 2018).

Research into how Australian legal systems respond to FDSV have identified some key issues, including:

- **Misidentification of the victim–survivor as the perpetrator** – this can occur when legal systems do not consider the wider context of violence and misinterprets the victim–survivor's behaviour. For example, a victim–survivor may use violence in response to violence perpetrated against them and may appear agitated or 'uncooperative'. These are normal responses to trauma and can be misinterpreted (Nancarrow et al. 2020).
- **Adversarial environments** – legal proceedings can expose victim–survivors to victim-blaming, unfair treatment and re-traumatisation. Historically, unsafe practices have also been used, such as shared waiting rooms and inappropriate lines of questioning (Deck et al. 2022; DSS 2022).
- **Barriers to accessing legal services** – access to legal systems can be limited due to many factors including: negative experiences with police and the judiciary; costs; the complexity of legal processes; concerns about giving evidence against family members due to shame, stigma, a fear of retaliation, or other reasons; and limitations in available legal services, culturally and linguistically appropriate services and coordination between legal and other services (DSS 2022).
- **Legal system abuse** – Legal systems can be misused by perpetrators of FDSV to further victimise people (see Box 3).

Box 3: Legal systems abuse

Research has shown that it is possible for legal systems to be manipulated by perpetrators of FDSV to threaten, harass and assert power and control over people (systems abuse). A perpetrator of FDSV may abuse legal systems through:

- misusing applications for DVOs to intimidate a person into withdrawing their DVO application (cross applications), or by misleading a victim-survivor into breaching a DVO
- using proceedings as an opportunity to continue harassment of someone and deny or minimise abuse
- interrupting, delaying or prolonging formal processes to increase a victim–survivor's costs and disrupt their life
- engaging multiple lawyers in the same area to prevent someone from accessing legal representation on the basis of conflict of interest. This is a particular concern in regional, rural and remote communities (Douglas 2018; Douglas and Ehler 2022).

Systems abuse can adversely affect a victim–survivor's health, wellbeing, finances and social connections. It can result in a victim-survivor being unprotected or falsely charged as a perpetrator and undermines legal systems. For more general information about systems abuse and how it relates to coercive control, see **Coercive control**.

Issues within legal systems have contributed to mistrust of the systems and are worsened by historical and ongoing discrimination and stereotyping experienced by parts of Australian society including First Nations people, culturally and linguistically diverse communities, LGBTIQA+ people, older people and people with disability (DSS 2022).

There are ongoing efforts to respond to these issues and combat systems abuse, such as the development of specialist courts that deal with FDV offences and sexual offences, tailored legal assistance services and legal system reforms. Future efforts towards improving legal systems are highlighted in the *National plan to end violence against women and children 2022–2032* and *The Meeting of Attorneys-General work plan to strengthen criminal justice responses to sexual assault 2022–2027* (DSS 2022; AGD 2022).

The 2 main national data sources used in this topic page are ABS Criminal Courts and the Report on Government Services – Courts. For more information about these data sources, please see **Data sources and technical notes**.

What do the data tell us about legal systems?

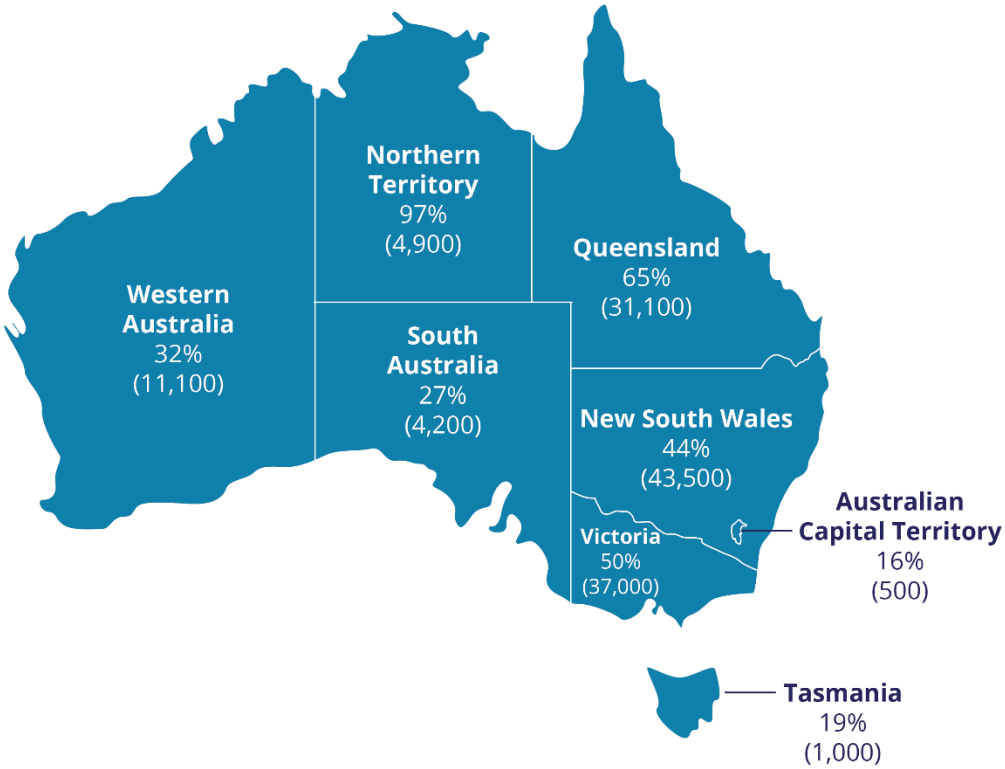
Civil courts – Domestic violence orders

Box 4: National data on domestic violence orders

National data are available on applications for domestic violence orders (DVOs) through the Magistrates' Courts. The data relate to finalised originating applications, which are new applications and exclude interim orders, applications for extension, revocations or variations. Civil non-appeal lodgements that have had no court action in the past 12 months are counted as finalised. While DVOs are generally dealt with at the Magistrates' Court level, they can also be made at other court levels. National data are not currently available on the number of DVOs in effect (Productivity Commission 2024).

Almost half (47% or 133,000) of civil cases finalised in the Magistrates' Courts in 2022–23 involved finalised originating applications for DVOs. The Northern Territory (97%) had the highest proportion of civil cases involving applications for DVOs and the Australian Capital Territory had the lowest (16%) (Productivity Commission 2024; Figure 1). Offences such as breaches of DVOs are dealt with by state and territory criminal courts (see **Criminal courts**).

Figure 1: Proportion of civil cases finalised in the Magistrates' Courts that involved finalised originating applications for DVOs, by state or territory, 2022–23



Notes
1. Finalised originating applications for DVOs include new applications and exclude interim orders, applications for extension, revocations or variations. Civil non-appeal lodgements that have had no court action in the past 12 months are counted as finalised.
2. In Tasmania, police can issue Police Family Violence Orders (PFVOs) which are more numerous than court-issued orders. PFVOs are excluded from this table.
Source: Productivity Commission 2024.

Box 5: ABS Criminal Courts, Australia data collection

Data from the ABS Criminal Courts data collection (ABS criminal courts data) includes information on the characteristics of defendants dealt with by state and territory criminal courts, including case outcomes and sentences associated with those defendants. A defendant refers to a person against whom one or more criminal charges have been laid which are heard together as one unit of work by the court. ABS criminal courts data only relate to defendants and cases taken to court and do not include defendants from specialist FDV courts. There is a delay between when someone is charged and when their case reaches court (ABS 2023b).

On this topic page, we discuss defendants whose cases have been '**finalised**', which means all charges relating to the one case have been formally completed (within the reference period). Unless otherwise stated, a 'finalised' defendant refers to a person whose charges have been finalised by methods other than 'transfer to other court levels'. This is to reduce double-counting of defendants that are transferred then finalised again at a different court level. A defendant that is **acquitted** indicates that charges were not proven (see **Data sources and technical notes**) (ABS 2023a, 2023b).

ABS criminal courts data on family and domestic violence (FDV) defendants are considered experimental with further assessment required to ensure comparability and quality. Data on FDV defendants are limited to certain offence categories defined by the Australian and New Zealand Standard Offence Classification (ANZSOC) including:

- *Acts intended to cause injury (02)* – Acts, excluding attempted murder and those resulting in death, which are intended to cause non-fatal injury or harm to another person and where there is no sexual or acquisitive element.
- *Breach of violence order (1531)* – An act or omission breaching the conditions of a violence order (referred to as a DVO in this topic page)
- *Sexual assault and related offences (03)* – Acts, or intent of acts, of a sexual nature against another person, which are non-consensual or where consent is proscribed (as in, the person is legally deemed incapable of giving consent because of youth, temporary/permanent (mental) incapacity or there is a familial relationship) (see **Data sources and technical notes** for a full list of offences) (ABS 2011; 2023a).

To address state and territory variation in the legislation and coding of harassment and stalking offences, the ABS combined these data for output in 2021–22 in the category *Stalking, harassment and threatening behaviour*. This combined category includes some ANZSOC offence codes that are also included in the categories *Acts intended to cause injury* and *Abduction/harassment* (ABS 2023b).

Predominantly this topic page discusses data related to the principal (most serious) offence category (see **Data sources and technical notes**). Data are also presented on all defendants with an FDV-related *breach of violence order*, regardless of whether it was the principal offence.

Some defendants finalised for *Sexual assault and related offences* may also be counted in the number of FDV defendants (ABS 2023a).

Family and domestic violence offences

About 83,800 defendants were 'finalised' for FDV offences in Australia in 2021–22 (FDV defendants). Of these:

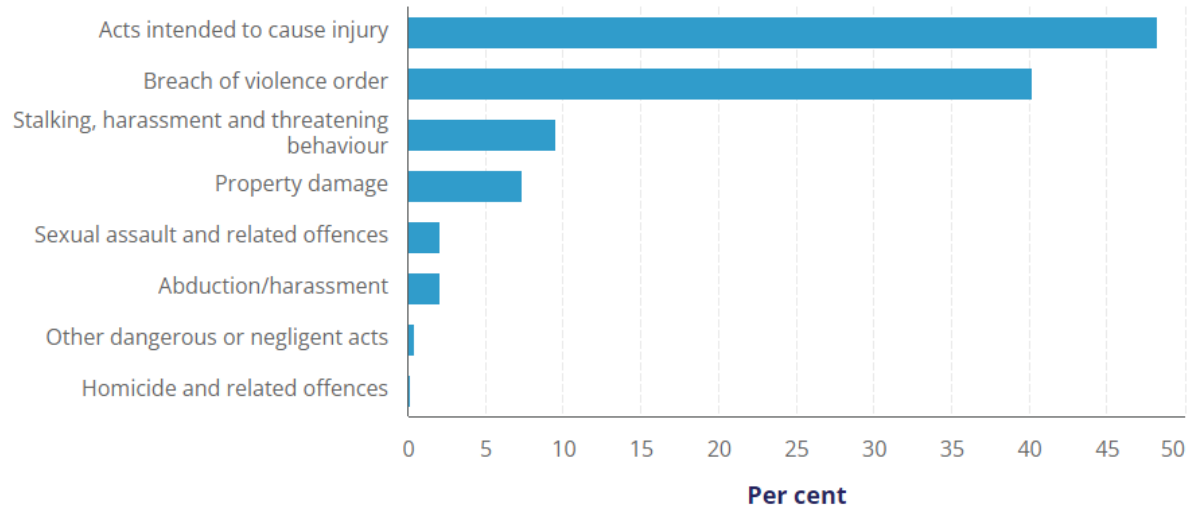
- about 4 in 5 (81%, or about 67,600) were found guilty
- about 1 in 20 were acquitted (4.9%, or about 4,100)
- about 1 in 7 (14%, or about 11,900) were withdrawn by the prosecution (ABS 2023a).

The proportion of defendants finalised for FDV offences that were found guilty varied by state and territory, with the proportion about 70% or greater for all except South Australia (40%). The majority of defendants were finalised in the Magistrates' Courts (91%, or about 78,300) (ABS 2023a).

The most serious offence for the majority of family and domestic violence court cases in 2021–22 was either *Acts intended to cause injury* (48% or 40,400) or *Breach of violence order* (40% or 33,600)

The most common principal offences among defendants finalised for FDV in 2021–22 were *Acts intended to cause injury* (48%, or about 40,400), including around 33,900 with a principal offence of *Assault*, and *Breach of violence order* (40%, or around 33,600) (Figure 2).

Figure 2: The most common principal offence categories among FDV defendants, 2021–22 (%)



Source: ABS Criminal Courts | **Data source overview**

The offence *Breach of violence order* is often heard in cases involving 'more serious' FDV-related offences (for example assault), which usually become the principal FDV offence for the defendant (ABS 2023b). The total number of FDV defendants finalised for *Breach of violence order*, regardless of whether this was their principal FDV offence, was about 47,600 in 2021–22 (ABS 2023a).

The proportion of finalised FDV defendants found guilty in 2021–22 varied by principal FDV offence category with the highest proportion for *Breach of violence order* (92%) compared with *Property damage* (88%), *Stalking, harassment and threatening behaviour* (79%), *Acts intended to cause injury* (72%) and *Sexual assault and related offences* (57%) (ABS 2023a).

The majority of orders given to defendants that were found guilty for FDV offences in 2021–22 were non-custodial orders (73%, or 49,300 of 67,600). This pattern was similar for most principal FDV offences but not for *Homicide and related offences* (98% custodial orders) and *Sexual assault and related offences* (66% custodial orders) (ABS 2023a).

The most common non-custodial order varied by principal FDV offence, with the most common for:

- *Acts intended to cause injury* – other non-custodial orders (including good behaviour bond/recognisance orders, nominal penalty) (32%, or 9,200 of 28,900)
- *Breach of violence order* – monetary orders (39%, or 12,000 of 30,800) (ABS 2023a).

About 4 in 5 (81%) finalised family and domestic violence defendants in 2021–22 were male.

About 4 in 5 (81%, or 68,000) finalised FDV defendants in 2021–22 were male and less than 1 in 5 (19%, or 15,800) were female (ABS 2023a).

The pattern for the most common principal FDV offence among all finalised FDV defendants (including transfers to other court levels) was similar for males and females:

- *Acts intended to cause injury* was the most common offence for both (47% or 32,200 and 51% or 8,100, respectively)
- followed by *Breach of violence order* (41%, or 27,800 and 37%, or 5,800, respectively), and all other FDV offences (ABS 2023a).

Most finalised FDV defendants were aged 25–29 (15% or 12,700), 30–34 (16% or 13,300) or 35–39 (15% or 12,900) with decreasing numbers for younger (5.9% for people aged 10–19) and older age groups (6.5% for people aged 55 years and over) (ABS 2023a).

Sexual assault and related offences

About 3 in 5 (58%) defendants finalised for *Sexual assault and related offences* in 2021–22 were found guilty.

About 7,300 defendants were 'finalised' for *Sexual assault and related offences* in 2021–22. Of these:

- About 3 in 5 finalised defendants were found guilty (58%, or about 4,300).
- About 1 in 8 finalised defendants were acquitted (13%, or about 990).
- About 1 in 4 were withdrawn by the prosecution (27%, or about 2,000) (ABS 2023a).

As noted previously, on this topic page 'finalised' indicates that charges have been finalised by methods other than 'transfer to other court levels' (see **Data sources and technical notes**). The number of defendants finalised for *Sexual assault and related offences* by transfer to other court levels in 2021–22 was about 3,500 compared with about 7,300 finalised by other methods (ABS 2023a).

Almost all (96%) finalised defendants for *Sexual assault and related offences* in 2021–22 were male.

Almost all finalised defendants with a principal offence of *Sexual assault and related offences* in 2021–22 were male (96%, or about 7,100) with only 3.8% (280) female (ABS 2023a). The proportion of defendants across 5-year age groups were similar for those aged 20–24, 25–29, 30–34, 35–39 and 40–44 years with each contributing to between about 10% and 12% of all defendants (ABS 2023a).

Family courts

Experiences of family violence were alleged in 4 in 5 (80%) applications for parenting or parenting and property orders in 2021–22.

Box 6: Notice of Child Abuse, Family Violence or Risk of Family Violence

A Notice of Child Abuse, Family Violence or Risk of Family Violence (Notice) is a form that is used during proceedings related to parenting orders to notify the court whether a child or person involved in proceedings is at risk of or has experienced abuse and/or family violence. This includes exposure to family violence, as well as other circumstances related to the experiences and/or risks of harm to the child (risk factors) (FCFCOA 2022c).

Other risk factors include allegations that:

- drug, alcohol or substance misuse by a party or mental health issues of a party had caused harm to a child or posed a risk of harm to a child
- a child was at risk of being abducted
- there had been recent threats made to harm a child or other person relevant to the proceedings (FCFCOA 2022a).

From 31 October 2020 it became compulsory in the Federal Circuit and Family Court of Australia to file a Notice with applications for parenting orders including when filing an Initiating Application, Response to initiating Application, or Application for Consent Orders or when making new allegations of child abuse or family violence after filing or when the case is transferred to the Federal Circuit and Family Court of Australia (FCFCOA 2022c).

Data from the Notices of Child Abuse, Family Violence or Risk filed with applications for final orders seeking parenting or parenting and property orders with the Federal Circuit and Family Court of Australia in 2021–22 indicated that:

- in 7 in 10 (70%) matters, one or more parties alleged that a child had been abused or was at risk of child abuse
- in 4 in 5 (80%) matters, one or more parties alleged they have experienced family violence
- in 2 in 3 (66%) matters, there were four or more risk factors alleged by either party (FCFCOA 2022a).

The Federal Circuit and Family Court of Australia have recently launched a new case management model that aims to better prioritise and address cases in which there is increased risk of harm from FDV (see Box 7).

Box 7: The Lighthouse model and the Evatt list

The Lighthouse model is part of the Federal Circuit and Family Court of Australia response to ensure that family safety risks are identified at the earliest point in proceedings and that case management decisions are risk-informed. After a successful pilot in Adelaide, Brisbane and Parramatta Federal Circuit Court registries (launched in December 2020), the model was adopted by all 15 family law registries on 28 November 2022 (FCFCOA 2022d).

The Lighthouse model involves:

- early risk screening through a secure online platform
- early identification and management of family safety risks
- assessment and triage of cases by a specialised team who will provide support and refer the party to appropriate services
- safe, and suitable case management, including referring high risk cases to a dedicated court list, known as the Evatt List (FCFCOA 2022d).

As a part of the pilot, about 4,200 eligible matters had been filed by 30 June 2022. A risk screen was completed by at least one party for most of these matters (69%). Three in 5 (60%) risk screens completed by individuals were classified as high risk (with 17% medium risk and 23% low risk) (FCFCOA 2022a).

High risk cases are reviewed by a Family Counsellor and can involve a telephone conference with litigants for further risk assessment (a Triage Interview). This can provide more tailored service referrals and support. The most common risk factors identified in these reviews and interviews as at 30 June 2022 include:

- family violence (76%)
- concerns for children's emotional and psychological wellbeing (64%)
- mental health concerns (63%)
- child abuse and neglect (59%) (FCFCOA 2022a).

After a review by a Family Counsellor some high-risk matters may be referred to the Evatt list. Matters on the Evatt list receive intensive case management and resources during family law proceedings and are allocated dedicated Judges, Senior Judicial Registrars, Evatt List Judicial Registrars, Court Child Experts and court staff (FCFCOA 2022b).

There were 890 matters included in the Evatt List by 30 June 2022, with about 550 added to the list in 2021–22. Among these matters:

- Over half (55%) had a current DVO in place
- The majority (88%) had an Independent Children's Lawyer appointed to assess the best interests of the child (FCFCOA 2022a).

In 2021–22, about 105 Family Court cases were started that involve serious allegations of child physical abuse and/or sexual abuse.

In 2021–22, about 105 cases involving serious allegations of physical abuse and/or sexual abuse of a child were started in the Federal Circuit and Family Court of Australia, and about 130 cases were finalised (FCFCOA 2022a). These cases are referred to as Magellan cases, and undergo special case management by a team consisting of a judge, a registrar and a family consultant. Typically, a Magellan case is addressed by the Federal Circuit and Family Court of Australia where one (or both) parties have raised serious allegations of sexual abuse or physical abuse of children in a parenting dispute (FCFCOA 2022a).

Has it changed over time?

Since the COVID-19 pandemic began there has been an increase in deferrals and delays across all court proceedings. This has been due, in part, to complications related to conducting proceedings electronically and the effect of public health measures such as stay-at-home orders. Hence, changes over time and differences between states and territories may reflect these effects rather than, for example, crime rates or sentencing changes (ABS 2023a; FCOA 2021).

Civil courts– Domestic violence orders

The proportion of finalised applications in the Magistrates' court involving DVOs decreased from 51% in 2021–22 to 47% in 2022–23 (Productivity Commission 2024; Table 2).

Table 2: Finalised originating applications involving DVOs in Magistrates' courts, 2018–19 to 2022–23

Year	Finalised applications involving DVOs ('000)	Proportion of all civil cases
2018–19	120.9	35%
2019–20	110.6	33%
2020–21	125.2	41%
2021–22	135.4	51%
2022–23	133.3	47%

Notes:
1. In Tasmania, police can issue Police Family Violence Orders (PFVOs) which are more numerous than court-issued orders. PFVOs are excluded from this table.
2. Finalised applications involving DVOs only includes originating applications and non-appeal cases.
3. Finalised applications includes transfers to other court levels.

Source: Productivity Commission 2024.

Criminal courts

Family and domestic violence offences over time

From 2019–20 to 2021–22, there was a 30% increase in the total number of finalised defendants for FDV offences in Australia (from about 64,500 to 83,800) (ABS 2023a). The number increased for all states and territories over this period (Table 3). Changes over time may reflect an improved methodology for identifying FDV-related offences that was introduced in South Australia and Western Australia in 2021–22 (ABS 2023b).

Table 3: Defendants finalised for FDV offences, by state and territory, 2019–20 to 2021–22 and the percentage change between 2019–20 and 2021–22

State or Territory	2019–20	2020–21	2021–22	% change 2019–20 to 2021–22
NSW	25,083	32,995	30,396	21% increase
Vic	14,126	12,293	17,944	27% increase
Qld	12,754	18,436	19,486	53% increase
WA	5,352	5,282	6,935	n.p.
SA	2,403	2,731	3,679	n.p.
Tas	1,493	1,821	1,715	15% increase
ACT	529	616	587	11% increase
NT	2,790	3,371	3,107	11% increase
Australia	64,530	77,545	83,849	30% increase

n.p.: Data not published.

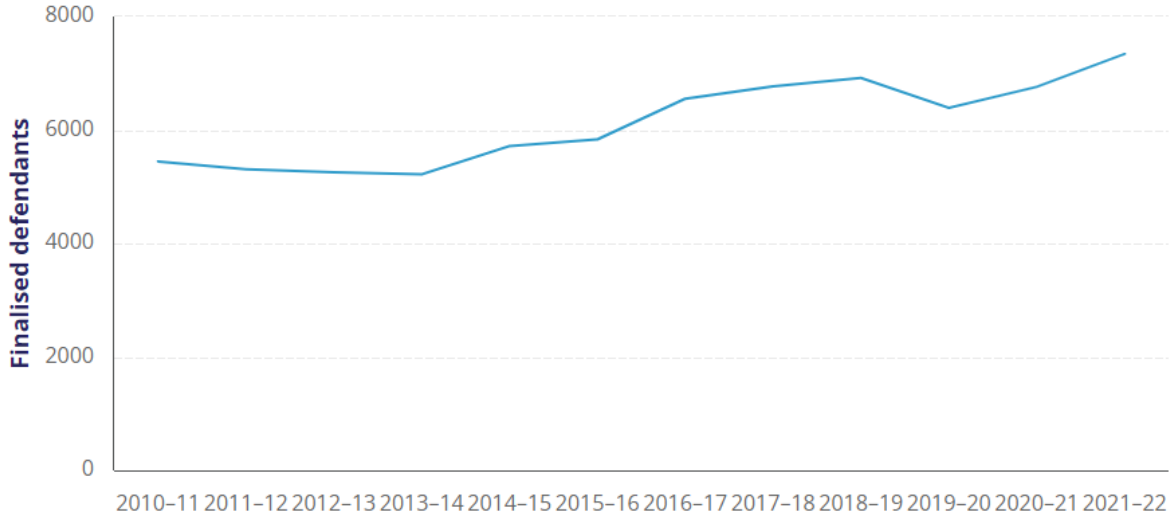
Notes:
1. Defendants finalised excludes those finalised through transfer to other court levels, see **Data sources and technical notes**.
2. Court operations in all three financial years were impacted by the COVID-19 pandemic and changes may reflect these impacts rather than, for example, crime rates or sentencing changes.
3. Changes over time may reflect an improved methodology for identifying FDV-related offences that was introduced in South Australia and Western Australia in 2021–22.
4. Due to perturbation, component cells may not add to total.
Source: ABS 2023a.

Sexual assault and related offences over time

The number of defendants finalised for *Sexual assault and related offences* has generally increased from 2010–11 to 2021–22

From 2010–11 to 2021–22, the number of defendants finalised (including transfers to other court levels) for *Sexual assault and related offences* has generally increased, with the lowest number in 2013–14, about 5,200, and highest in 2021–22, about 7,300 (Figure 3).

Figure 3: Defendants finalised for *Sexual assault and related offences*, 2010–11 to 2021–22



Source: ABS Criminal Courts | **Data source overview**

Family Courts

Notices of Child Abuse, Family Violence or Risk of Family Violence were increasing over time before they became compulsory.

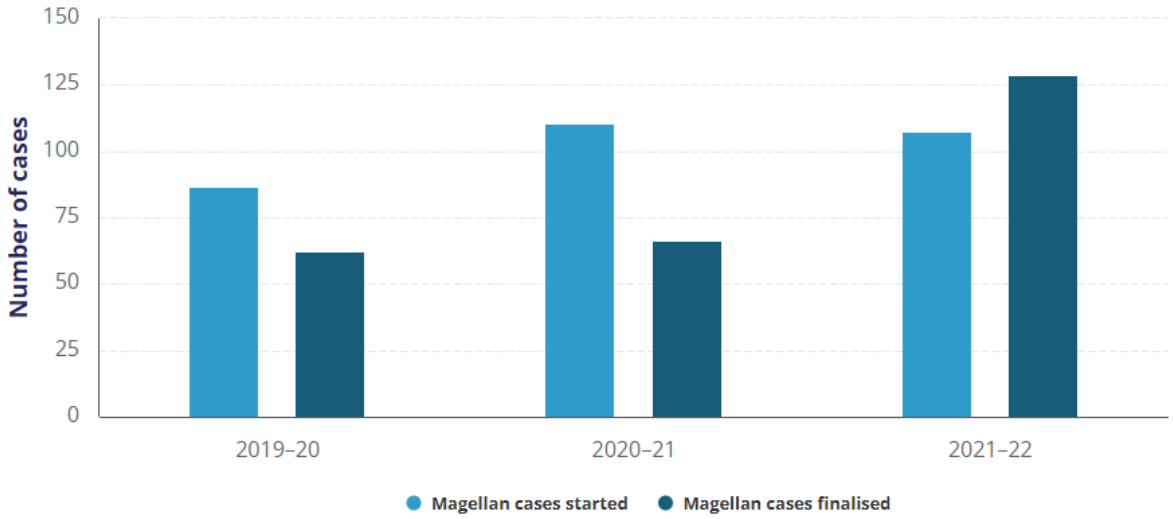
From 2014–15 to 2019–20, the number of cases in which a Notice was filed increased (from about 470 cases in 2014–15 to about 740 in 2019–20) (FCOA 2019, 2020).

This may have reflected an increase in the extent to which violence plays a role in Family Court cases and/or growing awareness of family violence in the community. Note that these cases do not include those dealt with in the Family Court of Western Australia (FCOA 2020).

As it became compulsory to file a Notice with every initiating application seeking parenting orders from 31 October 2020, changes in notices over time no longer relate to changes in allegations of abuse.

The number of Magellan cases (cases involving serious allegations of physical abuse and/or sexual abuse of a child) that were started and finalised each year has varied between 2019–20 and 2021–22 (Figure 4).

Figure 4: Magellan cases, 2019–20 to 2021–22



Source: Federal Circuit and Family Court of Australia | **Data source overview**

Related material

- How do people respond to FDSV?
- FDV reported to police
- Sexual assault reported to police
- Child protection
- Specialist perpetrator interventions

More information

National sexual violence responses

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Financial support and workplace responses

Key findings

- Since 1 July 2018, 17,100 people have applied to the National Redress Scheme and 8,700 have accepted an offer of redress
- Between 2015–16 and 2022–23, the number of claims granted for family and domestic violence Crisis Payments increased by about 60% (17,400 to 27,700).

Support may be provided to both victim-survivors and perpetrators of family, domestic and sexual violence (FDSV), through financial support and/or through supports for employees in the workplace. Financial support can include financial assistance (such as one-off payments to help a person leave a violent relationship) and financial advice and planning (to help a person establish independence). In general, these responses are intended to provide assistance in the short- or long-term, to reduce the economic and financial impacts of violence.

Workplaces can also respond to FDSV by providing support to employees. These supports may be accessed in the form of leave entitlements or through employee assistance programs. Some workplaces may also have organisation-specific policies or mechanisms to respond to violence that occurs in the workplace.

This topic page looks at the financial supports available for those who have experienced violence and a range of workplace responses.

What do we know?

Family and domestic violence (FDV) is the main reason women and children leave their homes in Australia. Victim-survivors of FDV who are leaving violent situations, are often faced with the substantial cost of leaving the home. These costs can include deposits, rental bonds and items for a new home; legal and medical costs; travel or moving costs; and for mothers, providing for their children (AHURI 2021; HRSCSPLA 2021). These costs may prevent women from leaving an abusive relationship and may be a reason women return to a previous violent partner (HRSCSPLA 2022). Financial implications have been reported by single mothers as a reason for returning to a previous violent partner following a temporary separation. This is a choice many women face when they experience violence – the choice between staying in a violent situation or poverty (see **Economic and financial impacts** for more detail).

A range of services are designed to provide immediate support to people who have to leave their home due to violence, including crisis payments and accommodation (see also **Services responding to FDSV**). Some services are designed to provide longer-term

financial support, in the form of training courses, financial planning and advice, so that victim-survivors can become more independent and economically secure.

Some victim-survivors of violence may also receive financial support in the form of payments or loans from services not specific to FDSV, such as emergency relief services, however these broader services are not in scope for this topic.

Workplaces can also respond to FDSV by providing access to supports, and by working directly with victim-survivors and/or perpetrators, to provide counselling or advice, or by implementing initiatives that improve workplace safety and/or support employees experiencing violence.

What data are available to report on financial and workplace support?

Data are available from Services Australia about Crisis payments designed to support those who have experienced violence. Data are also available from a number of sources about workplace specific initiatives that respond to violence (such as the Workplace Agreements Database and Workplace Gender Equality Agency data). For more information about these data sources, please see **Data sources and technical notes**.

What do the data tell us?

Financial support

Crisis Payment for extreme circumstances family and domestic violence

Between 2015–16 and 2022–23, the number of claims granted for family and domestic violence **Crisis Payments** increased by about 60%

People who are in severe financial hardship and have experienced changes in their living arrangements due to family and/or domestic violence, and are receiving, or are eligible to receive, an income support payment or ABSTUDY Living Allowance (see Box 1), may receive a one-off Crisis Payment. This payment is paid in addition to a person's income support payment (Services Australia 2023).

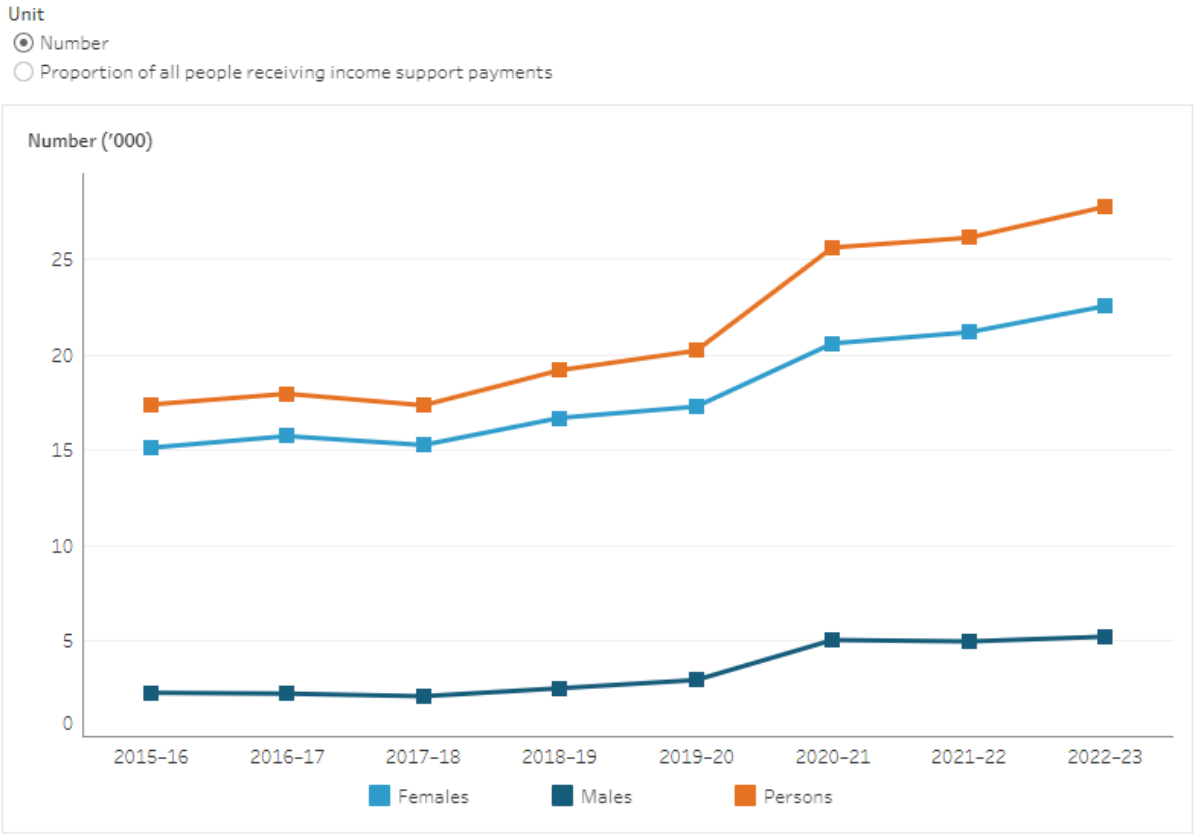
Box 1: Financial support definitions

Income support payment: A sub-category of benefits paid by the Australian Government which are regular payments that assist with the day-to-day costs of living.

ABSTUDY Living Allowance: A fortnightly payment by the Australian Government to help Aboriginal and Torres Strait Islander Australians with living costs while studying or training.

Between 2015–16 and 2022–23, the number of claims granted increased by about 60% (17,400 to 27,700). The proportion of income support recipients who received at least one family and domestic violence Crisis Payment each year increased slightly from 0.34% to 0.56% (Figure 1).

Figure 1: Claims granted for family and domestic violence Crisis Payments by gender, 2015–16 to 2022–23

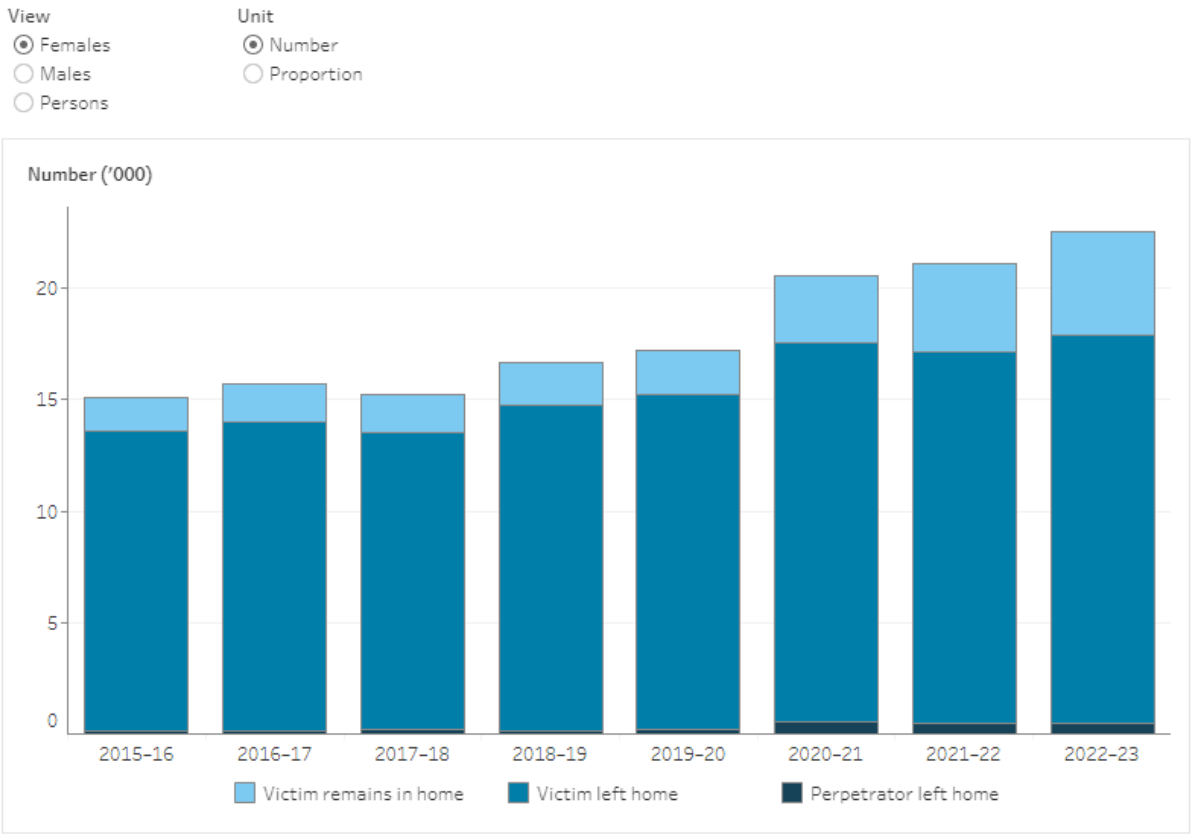


Source: Services Australia (unpublished)

https://www.aihw.gov.au

Data are also available for the number of family and domestic violence Crisis Payment claims granted per year by gender and sub-category of Crisis Payment. Between 2015–16 and 2022–23, the most common sub-category of family and domestic violence Crisis Payment each year was *Victim left home*, regardless of gender (Figure 2).

Figure 2: Claims granted for family and domestic violence Crisis Payments by gender and sub-category, 2015–16 to 2022–23



Source: Services Australia customer data (unpublished). https://www.aihw.gov.au

Redress payments

For people who have experienced institutional child abuse, payments are also available through the National Redress Scheme. The National Redress Scheme is designed to acknowledge that many children were sexually abused in Australian institutions; recognise the suffering they endured because of this abuse; hold institutions accountable for this abuse; and help people who have experienced institutional child sexual abuse gain access to counselling, a direct personal response, and a redress payment (Box 2).

Box 2: National Redress Scheme

The National Redress Scheme was created in response to the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. A person can apply under the scheme if they experienced institutional child sexual abuse before 1 July 2018, are aged over 18 or will turn 18 before 30 June 2028 and are an Australian citizen or permanent resident.

Under the scheme, an offer of redress consists of 3 components:

- counselling and psychological care

- a redress payment
- a direct personal response from participating institution/s responsible for the abuse.

People can apply for redress at any time until 1 July 2027.

For more information about the scheme, see National Redress Scheme.

In 2021–22:

- 6,000 people applied to the Scheme for redress
- 3,100 determinations were made and of these, 3,000 people were determined as eligible for redress, 90 applications were deemed ineligible.
- 2,700 people accepted an offer of redress
- 36 people declined an offer of redress (DSS 2022a).

More than 1,300 institutions were found to have been responsible for abuse, and almost 2,700 redress payments were made ranging from less than $10,000 to $150,000, with an average payment of around $90,800. The total value of redress monetary payments was $242.9 million, and just over 2,200 people accepted the offer of counselling and psychological care services as part of their redress outcome (DSS 2022a).

Since 1 July 2018, 17,100 people have applied to the scheme and 8,700 have accepted an offer of redress (Figure 3) (DSS 2019; DSS 2020; DSS 2021; DSS 2022).

Figure 3: Number of people who accepted an offer of redress, 2018–19 to 2021–22

Source: Australian Government Department of Social Services National Redress Scheme data | **Data source overview**

A person who accepts an offer of redress in a given time period, may have applied to the redress scheme in previous years of operation. There are a number of reasons why

applications for redress are not finalised, for example, where relevant institutions have not joined the scheme, or where more information is being sought from an applicant. Since 2018–19, the number of institutions participating in the scheme has increased.

Financial and banking services

People who experience FDV may also receive support from banks and financial institutions. Banks can play a role in identifying FDV, particularly when financial or economic abuse has occurred in the context of intimate partner violence or coercive control. Data from banks are currently limited. For more information on economic abuse, see **intimate partner violence**.

Workplace responses for employees

Workplaces can respond to violence FDV in many ways, for example, by making resources and supports available for people to access if it occurs. Workplaces can also respond to specific instances of sexual violence, and take formal actions to provide support to victim-survivors or hold perpetrators to account.

Leave entitlements

People who experience FDV may need to take time off work to make arrangements for their safety, access police and specialist services, or attend appointments with medical, financial, legal or health professionals.

One way workplaces can support individuals is by granting time off work. Under the National Employment Standards (NES), all employees in Australia are entitled to unpaid FDV leave. In October 2022, these entitlements were replaced with an entitlement to paid FDV leave (Box 3).

Box 3: Who can access unpaid family and domestic violence leave?

In Australia, all employees (including part-time and casual employees) are entitled to 5 days unpaid leave in a 12-month period if they have experienced FDV. FDV means violent, threatening or other abusive behaviour by an employee's close relative that seeks to coerce or control the employee, and/or causes them harm or fear.

A close relative is:

- an employee's spouse or former spouse, de facto partner or former de facto partner, child, parent, grandparent, grandchild, sibling
- an employee's current or former spouse or de facto partner's child, parent, grandparent, grandchild or sibling, or
- a person related to the employee according to Aboriginal or Torres Strait Islander kinship rules.

More information about FDV leave is available on the Fair Work Ombudsman website, at Family & domestic violence leave.

Entitlement to paid FDV leave

In October 2022, the Fair Work Amendment (Paid Family and Domestic Violence Leave) Bill was passed. The Bill amended the Fair Work Act 2009 and replaced the current entitlement in the NES (to 5 days of unpaid FDV leave in a 12-month period) with an entitlement to 10 days of paid FDV leave for full-time, part-time and casual employees. The Bill also: extends the definition of FDV to include conduct of a current or former intimate partner of an employee, or a member of an employee's household.

The leave will be available from:

- 1 February 2023, for employees of non-small business employers (employers with 15 or more employees on 1 February 2023)
- 1 August 2023, for employees of small business employers (employers with less than 15 employees on 1 February 2023).

More information about the new paid FDV leave entitlements can be found on the Fair Work Ombudsman website at New paid family and domestic violence leave.

While the NES sets out the minimum entitlements for all employees covered by the national workplace relations system, some people are covered by registered agreements, enterprise awards or state reference public sector awards, and have access to further entitlements.

Data from the Workplace Agreements Database are available to report on the number of agreements approved that contain an entitlement to paid FDV leave, and the number of people covered by these agreements. Note that these data are only available from 2016 and cannot be used to show the uptake of leave entitlements.

In 2021, there were 1,900 agreements approved which included paid FDV leave entitlements. These agreements covered 354,000 employees, and made up 44% of new approved agreements that year. The proportion of approved agreements with paid FDV leave entitlements has generally risen over time – from 21% in 2016 to 44% in 2021. (Attorney-General's Department unpublished).

Employees will continue to be entitled to 5 days of unpaid family and domestic violence leave until they can access the new paid entitlement.

How can workplaces best support people who are experiencing FDV?

'Workplaces could provide confidential supervision, or better promotion of employee assistance programs, more information on vicarious trauma in the workplace, and a discrete way to apply for FV leave. While I know it's available, many co-workers don't apply for fear of judgement and repercussions.'

Kelly

WEAVERs Expert by Experience

Keeping workplaces safe

Another way that workplaces respond to FDSV, is through implementing initiatives or adopting strategies to make the workplace a safe space for employees, or having policies in place to provide support when FDV or SV occurs.

Data from the Workplace Gender Equality Agency (WGEA) show that in 2021–22, 98% of the almost 4,800 organisations surveyed had policies and strategies in place targeting sexual harassment. Many of the organisations (73% or almost 3,500) surveyed also had formal policies or strategies in place to support employees experiencing family and domestic violence. This has doubled over the last 8 years (WGEA 2022).

These data highlight that responding to sexual violence in the workplace remains a key priority (Box 4).

Box 4: Respect@Work: Sexual Harassment National Inquiry

The National Inquiry into Sexual Harassment in Australian Workplaces was announced in June 2018. It was conducted by the Australian Human Rights Commission (AHRC) and builds on the data collected in the National Survey on Sexual Harassment in Australian workplaces. The purpose of the Respect@Work inquiry was to improve how Australian workplaces prevent and respond to sexual harassment. The AHRC received 460 submissions from government agencies, business groups, community bodies and victims. From September 2018 to February 2019, it conducted 60 consultations. These consultations informed the inquiry report, which outlines:

- the current context in which workplace sexual harassment occurs
- what is understood about workplace sexual harassment
- how primary prevention initiatives outside the workplace can be used to address workplace sexual harassment
- the current legal and regulatory systems for responding to workplace sexual harassment and how these can be improved
- a proposed new framework for workplaces to address sexual harassment
- the support, advice and advocacy services that are available, and how access to these services, can be improved (AHRC 2020).

The inquiry made 55 recommendations across a range of areas. The Australian Government's response to these is outlined in the Roadmap to Respect report. Five reform priorities were identified:

1. establishing the Respect@Work Council
2. conducting data collection and research on workplace sexual harassment
3. initiating targeted education and training initiatives and the development of resources
4. adopting a joined-up approach across agencies, support services, legal assistance providers and other bodies to ensure better advice and support on workplace sexual harassment issues

5. supporting disclosure of historical workplace sexual harassment (AHRC 2020).

For more information, see Respect@Work: Sexual Harassment National Inquiry Report.

Data on workplace sexual harassment, are reported in **sexual violence**.

In recent years, several initiatives have included introducing law reforms or developing resources as a response to sexual violence that occurs in workplaces and in institutions:

- The Australian Human Rights Commission (AHRC) developed the *National Principles for Child Safe Organisations* which were endorsed by the Council of Australian Governments on 19 Feb 2019. A suite of 11 Child Safe Organisation e-learning modules were also designed to help organisations increase their knowledge and understanding of the National Principles and identify the steps they need to take as they work towards implementing them.
- Safe Work Australia has published a *Model Code of Practice: Sexual and gender-based harassment* and the guide *Preventing workplace violence and aggression*. These documents provide practical guidance to minimise the risk of sexual and gender-based harassment and gendered violence in the workplace.
- In 2021, *The Sex Discrimination and Fair Work (Respect at Work) Amendment Act 2021* (Respect at Work Amendment Act) took effect. This Act aims to make sure more workers are protected and empowered to address unlawful sexual harassment in the workplace by amending the *Fair Work Act 2009* and *Sex Discrimination Act 1984*.

Responses from specific organisations

Some workplace responses to FDSV are specific to the forms of violence, employers or industries. Experiences of sexual violence in universities, and some of the actions taken, are discussed in **sexual violence**. In some instances, workplace responses address violence that has occurred within the workplace, or in a work-related environment.

Sexual assault in the Australian Defence Force

Data are available from the Australian Defence Force on the reported number of sexual assault incidents per year. These assaults include matters of a historical nature, such as those that occurred more than one year before reporting. Reporting sexual misconduct triggers a further inquiry or investigation by the Joint Military Police Unit (JMPU) or state/territory police.

In 2021–22, there were 148 incidents of sexual assault reported. Of these:

- 88 were aggravated sexual assaults (penetrative acts committed without consent, threat of penetrative acts committed with aggravating circumstances, or instances where consent is unable to be given)
- 60 were non-aggravated sexual assaults (for example, touching of a sexual nature without consent where penetration does not occur) (Department of Defence 2022).

About 48% of allegations of sexual assault made to the JMPU were made by members who did not wish to make a statement of complaint, did not want the matter

investigated by the JMPU or state/territory police or withdrew their complaint. The number of reported sexual assault incidents was lower in 2021–22 than in previous years – 187 in 2020–21, 160 in 2019–20, 166 in 2018–19 and 170 in 2017–18. Due to differences in reporting frameworks, these numbers cannot be compared with those before 2017–18 (Department of Defence 2022).

Support for Defence personnel regarding matters of sexual violence is also provided through the Department of Defence's Sexual Misconduct Prevention and Response Office (SeMPRO) (Box 5).

Box 5: SeMPRO

The overarching intent of SeMPRO is to help people who impacted by sexual misconduct and prevent sexual misconduct in Defence workplaces. SeMPRO works to do this by:

- providing education and training about sexual misconduct to Defence personnel
- providing client support to people affected by sexual misconduct
- shaping Defence policy to provide accessible resources that aid those impacted by sexual misconduct, their supporters, and managers.

SeMPRO also offers support to those around people directly affected by sexual misconduct – such as commanders, managers, colleagues, friends, and family members – to help them provide support to a friend or colleague, or manage an incident.

For more information, see Sexual Misconduct Prevention and Response Office.

In 2021–22, SeMPRO assisted 440 clients. Of these clients, 213 were directly affected by sexual misconduct (sexual offences, sexual harassment, sex-based discrimination, or adjacent incidents such as stalking and intimate image abuse. SeMPRO clients were majority women (88%).

For the third consecutive year, the 1800 SeMPRO Service saw an increase in client demand from those directly impacted by sexual misconduct. (Department of Defence 2022).

The Office of the Commonwealth Ombudsman, within its Defence Force Ombudsman jurisdiction, receives reports of contemporary and historic serious abuse within the Australian Defence Force.

Box 6: The Defence Force Ombudsman

The Defence Force Ombudsman provides a confidential mechanism to report serious abuse for those who feel unable, for whatever reason, to access Defence's internal mechanisms.

Serious abuse means sexual abuse, serious physical abuse or serious bullying or harassment that occurred between 2 (or more) people who were members of Defence at the time. Reports received by the Ombudsman are assessed against several thresholds to determine if they can be accepted as a report of serious abuse in Defence.

Between December 2016 to December 2022:

- almost 4,100 reports of abuse were received, of which nearly 210 reports were withdrawn, leaving almost 3,900 reports
- almost 2,700 assessment decisions were made with nearly 2,400 reports considered wholly or partially within the jurisdiction of the Defence Ombudsman. Of the reports that contained incident data, more than 1,200 involved sexual abuse (Office of the Commonwealth Ombudsman 2022).

Related material

- Economic and financial impacts
- Services responding to FDSV
- Legal systems

More information

- Family, domestic and sexual violence data in Australia

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Specialist perpetrator interventions

Key findings

- In 2021–22 the Men's Referral Service responded to 7,600 inbound calls from people seeking support related to men's family violence
- Police referrals to the Men's Referral Service increased by 2.8% between 2020–21 and 2021–22

A broad range of services and service providers may respond to FDSV when it occurs. A subset of these services work directly with perpetrators with the goal to hold perpetrators to account for their violence, and stop violence from recurring in the future. These services are often referred to as 'perpetrator interventions'.

The majority of perpetrator interventions fall into 2 categories: police and legal responses, and behaviour change interventions. Understanding how many people access the services, and the different pathways that people take through these services can help inform the development and evaluation of policies, programs and services to prevent and better respond to FDSV.

This topic page builds on **FDV reported to police**, **Sexual assault reported to police** and **Legal systems** to look specifically at behaviour change interventions, and discuss where they fit into the broader perpetrator interventions system.

What are perpetrator interventions?

Perpetrator interventions are part of the system of services responding to FDSV – an overlapping system of services and service providers that respond to violence. While many service providers may come into contact with people who use violence, a subset of these service providers have a specialised role in stopping violence once it has occurred and holding perpetrators to account for their behaviour. These service providers work with perpetrators and people who use violence (Box 1).

Box 1: Who are perpetrators?

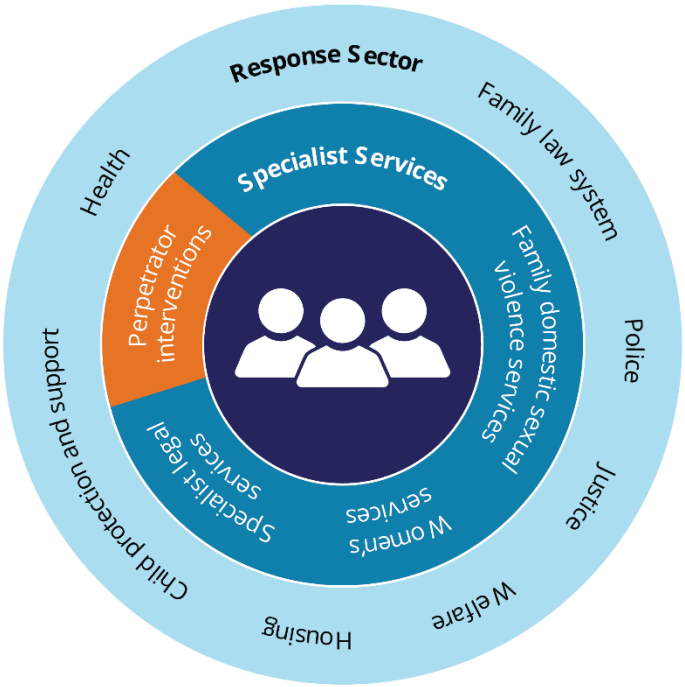
The term perpetrator is used to describe adults (aged 18 years and over) who use violence, while 'people who use violence' is a broader, more inclusive term that extends to children and young people who use violence.

On this page, the term 'perpetrator interventions' is used, as the focus is on interventions for adult perpetrators, who have used violence against other adults. Other specialist interventions – such as those for young people who use violence, or those that intervene to stop offenders of child sexual abuse – require more consideration and are not discussed in detail here. A more detailed discussion about the language used to describe people who use violence can be found in **Who uses violence?**

‘Perpetrator interventions’ captures a broad range of services and service providers that work with people who use violence. The term ‘perpetrator interventions’ is used for simplicity, as it is the most commonly used term to describe this category of services.

Perpetrator interventions are diverse, and span multiple sectors. Perpetrator interventions work alongside other services responding to FDSV, to end violence and keep people and communities safe (Figure 1).

Figure 1: Perpetrator interventions



In general, there are 2 types of interventions for perpetrators: behaviour change interventions (often referred to as men’s behaviour change programs), and police and legal responses. The term ‘responses’ is used to refer to the services and service providers that play a role in assisting people when violence has occurred.

On this topic page, behaviour change interventions are referred to as ‘specialist perpetrator interventions’ to distinguish them from police and legal responses. These interventions work within the broader service system – as well as with the community – to hold perpetrators to account.

What does perpetrator accountability mean to you?

'Perpetrator accountability describes the process of perpetrators, as individuals and as a collective, being visible and taking responsibility for their use of family, domestic and sexual violence (FDSV). Perpetrator accountability includes service systems holding perpetrators accountable and ensuring that the impact of their responses is not complicit in, nor perpetuates, FDSV.'

Leanne

WEAVERs Expert by Experience

'Perpetrator accountability means framing the issues of family, domestic, and sexual violence as fundamentally a problem of perpetration. It is the perpetrator's behaviour that should be scrutinised and questioned – not just by systems and institutions, but by friends, family, peers, employers, and community members. It is the perpetrator's behaviour and use of abuse that needs to change.'

Lula

WEAVERs Expert by Experience

Perpetrators may also interact with health services, alcohol and other drug treatment services, specialist homelessness services (see **Housing**) and other human services that deal with issues that may be related to the use of FDSV. These services comprise the broader service system, but are not included on this topic page as they may not necessarily be purpose-built to intervene with violence. A discussion about how services work together to respond to FDSV can be found in **Services responding to FDSV**.

Not all responses to FDSV occur within the service system. Some responses are informal, and involve seeking support from families and friends. Those are discussed in more detail in **How do people respond to FDSV?**

Men's Behaviour Change Programs

Men's Behaviour Change Programs (MBCPs) are the most common interventions for people who use violence (AIHW 2021). MBCPs vary substantially in how they operate, how they are accessed, and the legislative frameworks that they operate under. Some MBCPs are available to those who self-refer or are concerned about their own behaviours. Perpetrators can also be required to attend programs, either informally by their partners or communities, or formally through courts or corrective services (AIHW 2021).

Across MBCPs in Australia, there is a large variation in the approach adopted and the mode used to administer the program. Bell and Coates' (2022) systematic review found that behaviour change programs can be informed by:

- the Duluth model, which uses a psychoeducational and feminist approach
- psychological models such as cognitive behaviour therapy or motivational approaches

- anger management or substance use treatment.

Further, the mode of delivery can also vary. Some programs last as long as a year, while others are much shorter. Some programs also offer individual case management, while others are limited to group work only (Bell and Coates 2022).

Legal and police responses

In addition to behaviour change interventions, legal and police services intervene directly with perpetrators who use violence. Some common legal and police responses to FDSV include: protection orders; arrests and criminal charges; and prosecution and sentencing in criminal courts. These responses are discussed in **Legal systems**, **FDV reported to police** and **Sexual assault reported to police**.

What do the data show?

No single data source is available to report on specialist perpetrator interventions in Australia. However, some data are available from specific organisations to look at service use. For example, the No to Violence Annual Report (see **Data sources and technical notes**).

Men's Referral Service

The Men's Referral Service provides support for men who have used or continue to use violence and who are seeking support to change their abusive behaviours.

In 2021–22 the Men's Referral Services responded to 7,600 inbound calls from people seeking support related to men's family violence. There was an increase of 61% in people seeking men's family violence support via the webchat.

Men's Referral Services also receive referrals from police in selected states and territories. Almost 60,000 referrals were received from police in New South Wales, Victoria and Tasmania. Police referrals increased by 2.8% from 2020–21, with the biggest increase coming from New South Wales (up from 34,500 in 2020–21 to 38,000 in 2021–22) (No To Violence 2022).

Men's Referral Service counsellors also facilitate the Brief Intervention Service (BIS), a flexible, multi-session service designed to provide counselling support and referral options to men as they begin the behaviour change journey. BIS focuses on short term multi-session counselling and support for men who have not yet accessed a behaviour change program.

Just over 500 men engaged with the Brief Intervention Service during 2021–22, for an average of 6 sessions (No To Violence 2022).

To see information about other helplines responding to FDSV, see **Helplines and related support services**.

What else do we know?

There has been valuable work to build the evidence base on perpetrator interventions through research into what currently works to stop violence.

'What Works' to reduce and respond to violence against women

Australia's National Research Organisation for Women's Safety's (ANROWS) 'What Works' project provided a framework to support the assessment of the overall value and effectiveness of FDSV interventions, programs and strategies. The aim was to develop:

- an evidence portal/What Works framework that allows comparison of practices and that provides a summary of the evidence base of what works to reduce or respond to violence against women
- accessible and practical information about the applicability of interventions, as well as information about the implementation
- directions for future research, including suggestions in terms of research design and recommendations around the measurement of outcomes.

As part of the 'What Works' framework, ANROWS developed 3 overviews:

- *Reducing relationship and sexual violence,* which provides an overview of the evidence from systematic reviews of respectful relationships programs and bystander programs in education settings.
- *The effectiveness of interventions for perpetrators of domestic and family violence,* which provides an overview of the evidence in relation to 2 key types of interventions for perpetrators: behaviour change interventions, and legal and policing interventions.
- *The effectiveness of crisis and post-crisis responses for victims and survivors of sexual violence,* which assesses the evidence from existing systemic reviews into the effectiveness of crisis and post-crisis interventions for victim-survivors of sexual violence.

This work demonstrates the value of consolidating information on perpetrator interventions and services to understand the extent to which evidence-based practices are implemented (Box 2).

Box 2: The effectiveness of interventions for perpetrators of domestic and family violence

Bell and Coates (2022) conducted a systematic review of 2 key intervention types for perpetrators of FDV and IPV: behaviour change interventions, and legal and policing interventions. Reviews across the international literature were included if they concerned high-income countries. Reviews limited to only low- or middle-income countries were excluded.

The aim of the review study was to provide an overview of the evidence on effectiveness as reported by reviews of interventions for perpetrators of FDV. The study found:

- Of 29 reviews that assessed the effectiveness of behaviour change interventions for a reduction in FDV/IPV, only one concluded that the intervention works.
- A total of 24 reviews reported on the impact of behaviour change interventions on perpetrator-specific outcomes. While some reviews reported promising results such as improvements in gender-based attitudes, reduced acceptance of violence, improved mental health outcomes or a reduction in substance misuse, most reported mixed findings and concluded that there is currently insufficient evidence.
- Effectiveness was found to be associated with a range of factors, most commonly treatment modality for behaviour change interventions and perpetrator characteristics such as previous history of offending for legal and policing interventions. Albeit based on a smaller evidence base, interventions that included substance use treatment and motivational enhancement or readiness for change approaches were associated with more promising results than Duluth or cognitive behaviour change-based interventions.

More information about this stream of work can be found on the ANROWS website, at 'What Works' to reduce and respond to violence against women.

Monitoring perpetrator interventions

One way to understand whether perpetrator interventions are effective, is to monitor progress over time. Under the *National Plan to Reduce Violence against Women and Children 2010–2022* (completed), the *National Outcome Standards for Perpetrator Interventions* (NOSPI) were developed to guide and measure the actions taken to intervene with perpetrators (Box 3).

Box 3: National Outcome Standards for Perpetrator Interventions

The *National Outcome Standards for Perpetrator Interventions* (NOSPI) were developed as a set of headline standards, or principles, to guide and measure the actions that governments and community partners take to intervene with perpetrators of FDSV, and the outcomes achieved by these actions. The following six headline standards were agreed by the former Council of Australian Governments (COAG) in 2015:

1. Women and their children's safety is the core priority of all perpetrator interventions
2. Perpetrators get the right interventions at the right time
3. Perpetrators face justice and legal consequences when they commit violence
4. Perpetrators participate in programmes and services that change their violent behaviours and attitudes
5. Perpetrator interventions are driven by credible evidence to continuously improve
6. People working in perpetrator intervention systems are skilled in responding to the dynamics and impacts of domestic, family and sexual violence.

In collaboration with states and territories, a reporting framework was developed with 27 key indicators to measure the 6 headline standards. Where data were not available, indicators were developed as aspirational, to guide data development activities (AIHW 2021).

Limitations

The AIHW undertook work to collect and report data against the 27 indicators. This work highlighted some barriers to data collection and reporting:

- perpetrator interventions are fragmented and multi-sectoral
- data are not comparable between states and territories
- data on specific population groups are limited.

While data were not available to report comprehensively against the NOSPI, the NOSPI reporting work highlighted the initiatives underway in states and territories to respond to perpetrators. Further data improvement is required before nationally comparable indicators are possible. For more information, see Monitoring Perpetrator Interventions in Australia.

Data gaps and development activities

While specialist perpetrator interventions remain a data gap, there are areas in which data improvements can help shed light on how people who use violence may interact with the service system when violence occurs.

Specialist FDV services data

At a national level there are very limited data from specialist family and domestic violence services, which include things like crisis services. The AIHW is leading the delivery of a prototype specialist FDV services data collection, which will inform recommendations for an ongoing national specialist services data collection which could be expanded and built on in the future. Improved data on specialist services could potentially be a valuable source of information about related perpetrator services, including pathways and referrals into perpetrator intervention services.

Improving data on behaviour change programs

In 2019, ANROWS undertook a study into developing a minimum data set for Men's Behaviour Change Programs (MBCPs) in Australia. A minimum data set would fill a critical gap in the perpetrator interventions landscape (Box 4).

Box 4: Developing a national minimum data set for MBCPs

Currently, there is no uniform data collection and management tool in Australia to collect data from MBCPs. In 2020, Australia's National Research Organisation for Women's Safety (ANROWS) published findings from their work, which looked into building a minimum data set that aimed to address this data gap. The study focused on key variables related to participants' demographic characteristics, recidivism, and attrition and retention in MBCPs.

The study involved the development of a survey for service providers, which asked questions about key variables to understand:

- if the item was collected or collated
- the frequency of data collection
- and the perceived importance of individual variables being included in a data collection.

The study concluded that the implementation of a national minimum data set across all MBCPs in Australia would be highly valuable in confirming variables predicting program attrition, and consequently could help determine MBCP suitability for certain types of perpetrators. Study results suggest that a 'one-size-fits-all' structure of mainstream national MBCPs is not the best approach, and further development of a data set could allow for MBCPs to be adapted and diversified to improve their effectiveness (Chung et al 2020).

More information about this work can be seen in the ANROWS' report Improved accountability – the role of perpetrator intervention systems.

Linked data

The National Crime and Justice Data Linkage Project aims to link administrative datasets from across the criminal justice sector, including police, criminal courts and corrective services, forming the Australian Bureau of Statistics (ABS) Criminal Justice Data Asset. Once fully established, this data asset could provide insight on how perpetrators of family and domestic violence move through the criminal justice sector, including corrective service outcomes for FDSV offenders. In the future, other health and welfare datasets could also be included to provide a more holistic view of perpetrators, and potentially, victim-survivors.

A more general discussion about data gaps and development activities can be found in **Key information gaps and development activities**.

Related material

- Who uses violence?
- Services responding to FDSV
- Helplines and related support services
- FDV reported to police
- Sexual assault reported to police

More information

- Monitoring perpetrator interventions in Australia
- NOSPI Baseline Report 2015–16

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Family, domestic and sexual violence workforce

Key findings

- Family, domestic and sexual violence workforce workers are generally confident in identifying family, domestic and sexual violence
- Many workers report experiencing suboptimal working conditions, such as harassment from clients and working unpaid hours
- Digital delivery of services since COVID-19 has brought challenges and benefits

What is the family, domestic and sexual violence workforce?

Workers from many different services and sectors interact with people affected by family, domestic and sexual violence (FDSV). The specialist FDSV workforce includes those who work directly and mostly with victim-survivors or perpetrators, as well as professionals who may work directly with these workers, such as trainers or specialist consultants in policy. The non-specialist FDSV workforce includes primary prevention and the broader workforce that may intersect with FDSV as part of their wider role in the community, for example, health professionals, police officers and teachers. There are benefits to non-specialist workforces understanding FDSV, and where appropriate, being trained to identify and respond appropriately (see Box 1). This topic page focuses on Australia's specialist FDSV workforce (FDSV workforce).

The FDSV workforce is essential for FDSV prevention, intervention, response and recovery. The *National Plan to End Violence against Women and Children 2022-2032* (National Plan) has highlighted building 'a resourced service system with an appropriately skilled and qualified workforce' as a focus area to prevent violence occurring again (DSS 2022). However, the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into family, domestic and sexual violence identified 'significant workforce shortages and a lack of coordination and resourcing to support retention, skill development and leadership' across the sector (SCSPLA 2021). Workers are often under substantial pressure and required to learn specialist skills on the job, contributing to work safety risks and vicarious trauma (DSS 2022).

The Australian and New Zealand Standard Classification of Occupations used in the Census of Population and Housing does not contain FDSV-specific occupation codes. The lack of in-depth knowledge and systematic, regular data collection on the FDSV workforce can make efficient workforce planning challenging (ABS 2022; Family Safety Victoria 2021a).

Box 1: The role of the non-specialist workforce

The importance of the non-specialist workforce in supporting FDSV victim-survivors has been increasingly recognised in policy in recent years. The National Plan highlights building capacity across all sectors that may interact with victim-survivors to ensure there is no wrong path for seeking support. It is known that victim-survivors seek help from various services, such as educational institutions, hospitals and hairdressers (DSS 2019). Hence, primary care and the broader workforce that may intersect with FDSV can play an equally significant role in identifying, referring and supporting victim-survivors. A full-time general practitioner is likely to see around five women who have experienced intimate partner abuse and violence every week (RACGP 2022). Almost 1 in 5 female victims that were physically or sexually assaulted by a male sought advice or support from other health professionals (AIHW 2022). The National Plan includes capacity-building initiatives such as enabling workforces to provide trauma-informed support and improving collaboration across sectors to coordinate responses to women affected by FDSV (DSS 2022).

Victoria undertakes the Census of Workforces that Intersect with Family Violence every 2 years to understand the breadth and nature of workforces that intersect with family violence (FV) and identify capacity-building opportunities. The 2019-20 census found that 49% of the primary prevention workforce were extremely or very confident in their capacity to perform their roles, while only 28% of the broader workforce that intersects with FV were extremely or very confident that they have had enough training and experience to effectively respond to FV (Family Safety Victoria 2021b).

What do the data tell us?

There are limited national data on the workforce for specialist family, domestic and sexual violence services. The University of New South Wales Social Policy Research Centre (SPRC) National Survey of Workers in the Domestic, Family and Sexual Violence Sectors (the National Survey of Workers) provides some information about those working in services used by people affected by violence, including workforce characteristics, workforce strengths, gaps, skill levels and skill-development needs (see Box 2 and **Data sources and technical notes**). The survey was designed to produce findings that can be used to build the capacity of the workforce and improve responses to those affected by violence (Cortis et al. 2018).

This topic page focuses mainly on the National Survey of Workers, however more recent findings on the specialist FV workforce from the Victorian 2019-20 Census of Workforces that Intersect with Family Violence are also included.

Data in this section were collected prior to the first national lockdown in response to COVID-19. Please refer to the **impacts of COVID-19** section for data collected during the COVID-19 pandemic.

Box 2: National Survey of Workers in the Domestic, Family and Sexual Violence Sectors

The National Survey of Workers in the Domestic, Family and Sexual Violence Sectors was led by the University of New South Wales Social Policy Research Centre for the Department of Social Services in 2018. The study involved a survey of workers, and a separate survey of service leaders. The surveys were developed through consultations with those involved in the sector, including peak bodies, employers, unions and training specialists.

The survey of workers captured the experiences of those working in services used by people affected by violence, including information about confidence in areas of practice, and job satisfaction. The survey of service leaders captured service-level information about staff numbers, perceptions of capacity, and workforce development priorities and strategies.

As there is no comprehensive list of relevant services across Australia, a sampling frame was developed to help identify relevant service providers, based on funding provided by the Department of Social Services and the Attorney-General's Department. In addition, lists of services funded by the states and territories were provided by the Department of Social Services. Services included (but were not limited to):

- services funded under the Australian Government Families and Children Activity
- Australian Government-funded Legal Assistance services
- Australian Government-funded services under the Settlement Grants program
- Australian Government-funded services under the Financial Wellbeing and Capability Activity
- services funded under the specialist homelessness services program
- services funded under specialist perpetrator programs.

The service survey was distributed to 1,000 services and completed for 320 services. The worker survey was completed by 1,200 workers. As there is no national data set providing a profile of relevant services which could be used to determine population weights, no weights were applied. The survey is not intended to be representative of the entire workforce. Instead it sheds some light on the shared experiences of workers in the family, domestic and sexual violence space.

The term LGBTIQ used in the survey refers to people who identified as lesbian, gay, bisexual, trans, intersex or queer.

Source: Cortis et al. (2018).

Most workers in the family, domestic and sexual violence sectors are female

Four in 5 (83%) workers surveyed were female. One in 5 (20%, or 228) workers had personal caring responsibilities, 1 in 12 (8.0%, or 92) identified as LGBTIQ, and 1 in 13

(7.5%, or 86) spoke a language other than English at home. One in 20 (4.9%, or 56) were from Aboriginal and Torres Strait Islander (First Nations) backgrounds, and 1 in 25 (3.7%, or 43) identified as having disability. Most employees (61%) were working full time (Cortis et al. 2018).

In the 2019-20 Census of Workforces that Intersect with Family Violence, almost 7 in 10 (67%) respondents working in specialist FV response roles had less than 5 years of experience in their current role, and 4 in 10 (40%) used their cultural or faith-based knowledge and experience when undertaking their work (Family Safety Victoria 2021a).

Workers are generally confident in identifying family, domestic and sexual violence

In general, surveyed workers were confident they could identify signs of abuse. However, fewer were confident they could identify financial or sexual abuse, compared with physical or emotional abuse. Almost 9 in 10 (89%) felt able to work creatively to meet clients' needs, and 2 in 3 (66%) felt able to spend enough time with each client (Cortis et al. 2018).

Many workers felt they needed additional training to support specific client groups such as First Nations people; LGBTIQ people; asylum seekers; people experiencing homelessness; and the perpetrators of violence. Overall, the most common areas where workers felt training was needed were in risk assessment, therapeutic approaches, legal training, general counselling, screening, and supervision training. Those working frequently with perpetrators listed priority areas for skill development as working with clients resistant to intervention, promoting behaviour change, and evaluating participants' progress.

Many workers experience suboptimal working conditions

Many workers reported experiencing suboptimal working conditions. Among surveyed respondents:

- around half (49%) reported experiencing bullying, harassment, violence or threats from a client in the last 12 months, with this proportion increasing to 66% for workers who had daily contact with perpetrators
- almost half (48%) reported feeling emotionally drained from work
- almost half (45%) reported they felt pressure to work harder
- almost 2 in 5 (38%) disagreed they are paid fairly for the work they do

- more than 30% of practitioners and other frontline support staff regularly worked unpaid hours, with this proportion increasing to more than 70% for workers in leadership positions (that is CEO and senior managers) (Cortis et al. 2018).

Many workers also expressed concern over sector resourcing and accessibility of services. Only 2 in 5 respondents (38%) felt their service had enough staff to get work done, and about 1 in 5 (19%) disagreed with the statement 'people who need our services can get them' (Cortis et al. 2018).

Nevertheless, sense of purpose and satisfaction with supervision are high among the workforce. Over 9 in 10 (93%) workers reported that their work makes a difference in people's lives, and over 70% were very or moderately satisfied with the frequency of supervision, the amount of time supervisors spent with them and the quality of support (Cortis et al. 2018).

What are the impacts of COVID-19?

The COVID-19 pandemic has pushed the specialist family, domestic and sexual violence workforce to adapt and innovate ways to serve clients while staying COVID-19 safe. The University of New South Wales conducted a nation-wide study that explored service adaptations and the challenges faced by frontline domestic and family violence (DFV) practitioners in Australia between July and October 2020 (Cullen et al. 2020).

Increased workload and insecurities about the future

Frontline DFV practitioners reported a substantial increase in workload and unpaid work hours during the early months of COVID-19. They also expressed concerns over insecure funding and short-term contracts, and fears of burning out with the new pace and methods of working (Cullen et al. 2020).

Digital delivery of services brought challenges and benefits

The widespread adoption of digital service delivery during COVID-19 has brought challenges and benefits to the workforce. Frontline staff have reported difficulty separating home and work life, fatigue from transitioning to remote working, feelings of isolation from colleagues and constrained access to protective measures put in place by organisations. Many organisations have introduced mitigative measures that workers view as beneficial and would like to see continued. These include flexible working arrangements, digital and telehealth options for clients, connecting with colleagues online, enhanced supervision and wellbeing initiatives (Cullen et al. 2020).

Related material

- Services responding to FDSV
- How do people respond to FDSV?

More information

Family, domestic and sexual violence service responses in the time of COVID-19

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Outcomes

Violence impacts the physical and mental health and well-being of victim-survivors in the short and long term. These topic pages explore a range of outcomes that may be experienced by victim-survivors. However, it is important to note that the experience of FDSV is unique and impacts on a person may be mediated by protective factors (for example, strong family or social support) or exacerbated by other factors (for example, more severe and enduring violence).

- Health outcomes
- Behavioural outcomes
- Domestic homicide
- Economic and financial impacts
- FDSV and COVID–19

Health outcomes

Key findings

- In 2021–22, 2 in 3 (67% or 496,000) women who had experienced sexual assault by a male perpetrator in the past 10 years reported they had felt anxiety or fear for their safety in the 12 months after their most recent incident of violence.
- In 2018, if no woman had experienced intimate partner violence, the disease burden among women due to homicide and violence would have been reduced by 46%.

Family, domestic and sexual violence can involve single and/or repeated traumatic experiences which impact victim-survivors' health and wellbeing. The health outcomes can be serious and long-lasting, affecting an individual's physical and mental health, which in turn can affect a person's employment and education, relationships, and financial and housing stability.

This topic page focuses on the short-term, long-term, and permanent health outcomes among victim-survivors of FDSV, particularly intimate partner violence. While the reporting focuses on national quantitative data, some contributions from people with lived experience are included on this page to deepen our understanding. For other pages relating to the impacts and outcomes of FDSV, see also **Behavioural outcomes**, **Economic and financial impacts** and **Domestic homicide**.

What do we know?

Health outcomes associated with FDSV will vary in nature and extent depending on the type and severity of violence experienced. Some health outcomes are immediate, for example an injury, and some, such as mental illness, may develop over time and persist for many years after the violence has ceased (Loxton et al. 2017). For some people, ongoing or severe experiences of FDSV can lead to permanent disability, or death (On et al. 2016). However, with appropriate intervention, support and resources, these outcomes are preventable (WHO and PAHO 2012).

Evidence of the health outcomes associated with FDSV can inform the development of policy and service interventions that aim to improve outcomes for individuals experiencing violence.

This page includes information on mental health, injury and death, and sexual and reproductive health. For information on how FDSV may affect health behaviours, see **Behavioural outcomes**.

Some population groups may be at greater risk of experiencing FDSV and poorer health outcomes (see **Population groups**).

For information on behaviours and/or factors that may increase the likelihood of FDSV victimisation, see **Factors associated with FDSV**.

National data sources to measure health outcomes

Evidence of the health outcomes due to, or associated with, FDSV can be obtained using longitudinal surveys, cross sectional studies, burden of disease analysis and administrative data sets (such as hospital data).

Different types of data and research impact the questions that can be answered about health outcomes. For example, longitudinal studies follow the same individuals (that is, a cohort) over time to provide insight on the link between exposure (for example to FDSV) and subsequent outcome (for example, a mental health disorder). Cross sectional studies sample people at a point in time and can assist with measuring associations between 2 areas of interest (for example FDSV and health), however, they do not provide insight into the timing of events (for example, whether depression was experienced before or after experiences of FDSV). For more information, see **How are national data used to answer questions about FDSV?**.

Data sources for reporting on health outcomes

- ABS Personal Safety Survey
- Australian Longitudinal Study on Women's Health
- AIHW Australian Burden of Disease Study
- AIHW National Hospital Morbidity Database

For more information about these data sources, please see **Data sources and technical notes**.

What do the data tell us?

Burden of disease

Burden of disease refers to the quantified impact of living with and dying prematurely from a disease or injury. According to the 2018 Australian Burden of Disease Study (ABDS, see Box 1), child abuse and neglect contributed to 2.2% of the total disease burden and contributed to around 810 deaths (for more information on FDV during childhood see **Children and young people**). Among females, intimate partner violence (IPV) contributed to 1.4% of the total disease burden and contributed to around 230 deaths (AIHW 2021a).

Box 1: Australian Burden of Disease Study

The Australian Burden of Disease Study (ABDS) 2018 estimated the impact of various diseases, injuries and risk factors on total burden of disease for the Australian population. It combines health loss from living with illness and injury (non-fatal burden) and dying prematurely (fatal burden) to estimate total health loss (total burden).

The ABDS includes estimates of the contribution made by selected risk factors on the disease burden in Australia, including intimate partner violence (IPV) and child abuse and neglect. The disease burden due to IPV is currently only available for females, as there is not

sufficient published research indicating a causal link between disease burden and the risk of IPV for males. The burden of disease analysis could be expanded in future studies to explore additional risk factors on violence.

National work on the health impact of violence

In 2020, the AIHW undertook a review of data sources for violence prevalence and a literature review on health outcomes of non-partner family violence and community violence.

The 2016 Personal Safety Survey was found to be the most suitable data source to estimate national prevalence of the various forms of violence. The literature review found:

- probable evidence that sexual violence may result in depressive disorders and anxiety disorders (specifically post-traumatic stress disorder or PTSD)
- possible evidence that sexual violence may result in drug use disorders, alcohol use disorders and generalised anxiety disorder
- less convincing evidence for other types of violence (physical and emotional) and other health outcomes such as pre-term birth, attention deficit hyperactivity disorder (ADHD) and diabetes.

There was inconclusive evidence on the association between perpetrator relationship and health outcomes.

Reporting of the risk factor sexual violence by any perpetrator with the health outcomes of anxiety disorders and depressive disorders may be considered for future ABDSs. Consideration may also be given to future exploratory work to include an experimental 'total' violence burden estimate which would combine the burden due to existing ABDS risk factors (IPV in women and child abuse and neglect).

Source: AIHW 2021a

For more information on how burden of disease is determined, see Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2018, Summary.

Diseases that were causally linked to IPV

The ABDS 2018 estimated the amount of burden that could have been avoided if no females aged 15 and over in Australia experienced IPV. In estimating this burden, 6 diseases were causally linked to exposure to intimate partner violence in females:

- depressive disorders (contributing to 15% of depressive disorders total burden in females)
- anxiety disorders (11%)
- early pregnancy loss (17%)
- homicide and violence (injuries due to violence) (46%)
- suicide and self-inflicted injuries (19%)
- alcohol use disorders (4%) (AIHW 2021b).

For example, if no women had experienced IPV in 2018 the disease burden among women due to homicide and violence would have been reduced by 46% (AIHW 2021b).

Diseases that were causally linked to child abuse and neglect

Child abuse and neglect was causally linked to:

- anxiety disorders (contributing to 27% of anxiety disorders burden)
- depressive disorders (20%)
- suicide and self-inflicted injuries (26%) (AIHW 2021b).

For more information on variation in burden attributable to intimate partner violence, and child abuse and neglect, by age and over time, see Australian Burden of Disease Study 2018: Interactive data on risk factor burden.

For more information about health outcomes associated with child maltreatment, please see **Children and young people**.

Mental health

FDSV includes traumatic experiences which can affect an individual's psychology and nervous system (trauma). This trauma can have short and/or long-term impacts on mental health, and cause behavioural changes (see **Behavioural outcomes**). Complex trauma, as a result of repeated and cumulative traumatic experiences, will usually have a greater impact on the individual; and childhood experiences of trauma are particularly damaging (RANZCP 2020).

Trauma may cause a range of health-related problems, including mental conditions, suicidality and self-harming behaviours; and the consequences of trauma can be intergenerational (RANZCP 2020). However, the relationship between FDSV and mental illness is complex, for example people with mental illness may have increased vulnerabilities that increase their risk of FDSV victimisation, and mental illness may develop or increase in severity as a result of FDSV victimisation (see **Factors associated with FDSV**). Recovery can take a lifetime and is unique to each person.

What does recovery mean to you?

'Recovery relates to one's own sense of self, redefining boundaries, trusting your own judgement and capability, choosing to love and heal yourself. It is about making healthy choices and feeling empowered to do so. It includes mental, emotional and physical wellbeing and finding the right supports to manage ongoing impacts of trauma and other injuries that have resulted from the abuse.'

Lula

WEAVERs Expert by Experience

'You are never the same person after experiencing violence. Recovery is learning about the new version of yourself and navigating life while managing the ongoing impacts of the trauma. Recovery is learning to trust yourself and others again. This is often intertwined with recovering from poverty; recovering from being jobless and homeless.'

Lily

WEAVERs Expert by Experience

This section draws on national data from the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) and the Australian Longitudinal Survey of Women's Health (Box 2).

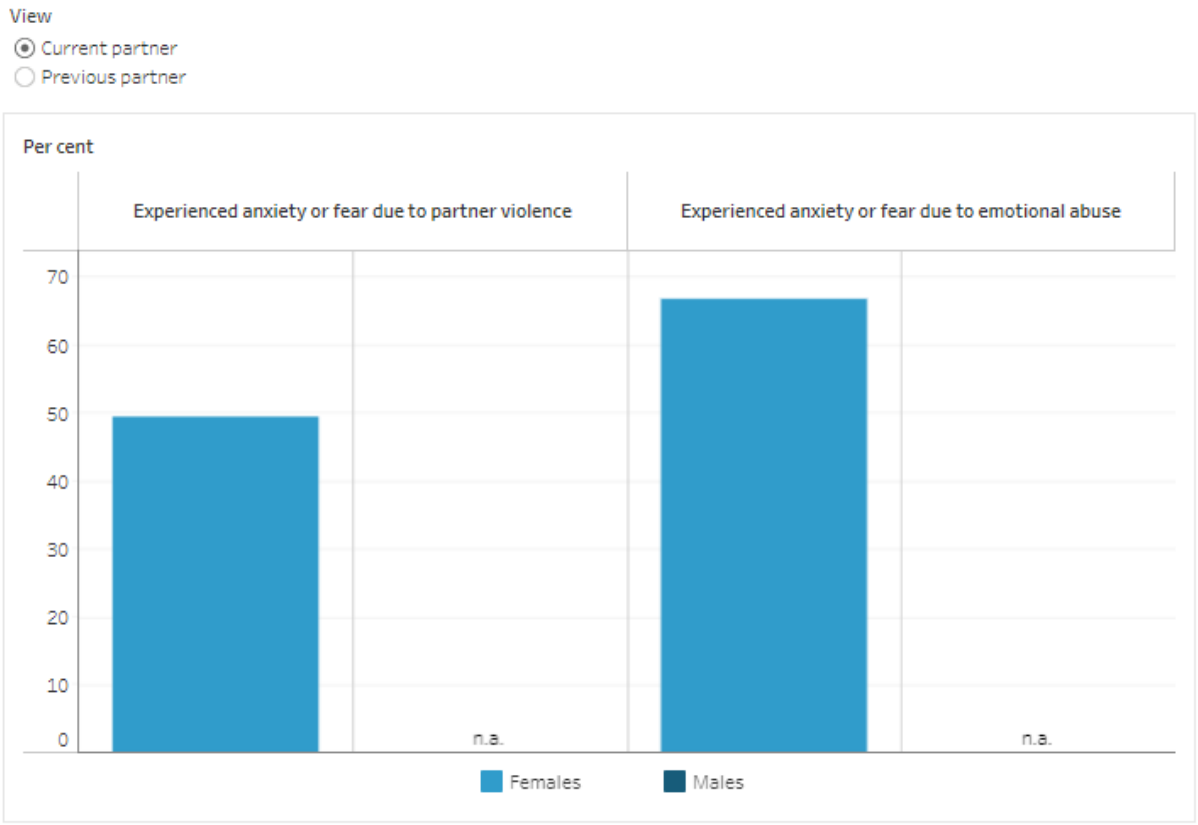
Anxiety or fear for personal safety due to violence

Partner violence

The ABS PSS collects data on the impacts of physical and/or sexual violence from a partner and/or emotional abuse from a partner. In 2021–22:

- the proportion of women who reported they had experienced anxiety or fear due to emotional abuse by a current partner was higher than for anxiety or fear due to partner violence
- when compared with men, a higher proportion of women reported they had experienced anxiety or fear due to violence by a previous partner and due to emotional abuse by a previous partner (ABS 2023a; Figure 1).

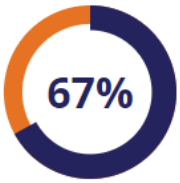
Figure 1. Proportion of people who experienced anxiety or fear due to experience of violence by a partner in their lifetime, by violence type, and current and previous partner, 2021–22



n.a.: not available
Source: ABS PSS 2021–22.

https://www.aihw.gov.au

Sexual violence



of women in 2021–22 who had experienced sexual assault by a male perpetrator in the past 10 years had felt anxiety or fear for their safety in the 12 months after their most recent incident

Findings from the 2021–22 PSS estimated that more than 2 in 3 (67% or 496,000) women who had experienced sexual assault by a male perpetrator in the past 10 years reported they had felt anxiety or fear for their safety in the 12 months after their most recent incident of violence (ABS 2023b). Data for males are not available due to data limitations.

Box 2: FDSV and mental health among women using longitudinal data

The Australian Longitudinal Survey of Women's Health (ALSWH) is an ongoing longitudinal study of women's health. The study began in 1996 and follows groups of women born in 1921–26, 1946–51, 1973–78 and 1989–95. The ALSWH collects information relevant to the health of women, including experiences of violence.

Some key findings from the data include:

- Women who had experienced sexual violence were more likely (than those who hadn't) to report: a recent diagnosis of and/or treatment for depression; a recent diagnosis of and/or treatment for anxiety; high levels of stress; and high levels of psychological distress (Townsend et al. 2022).
- Depression was associated with childhood sexual abuse (Mishra et al. 2019)
- Women who had experienced domestic violence reported poorer mental health (that is, they were more likely to have felt that life was not worth living at some point in their lives) than those who had not experienced domestic violence (Mishra et al. 2019).

Injury

The 2018 ABDS identified IPV experienced by females as a significant risk factor for injury, associated with 7.2% of the total burden of injury (AIHW 2021a). National hospital data, drawn from the AIHW National Hospital Morbidity Database, provide an indication of more severe and mostly physical injury cases due to FDV that have resulted in a person being admitted to hospital. They do not include presentations to emergency departments and only include assault hospitalisations where the perpetrator is coded as being a family member (including spouse or domestic partner). Hospital records can provide insight on the nature of the injury and how it occurred (for example, the type of force or weapon). For more information on FDV hospitalisations see **Health services**.

3 in 4 hospitalisations for family and domestic violence injury were for females

In 2021–22:

- around 3 in 4 (73%) hospitalisations for injury perpetrated by a spouse, domestic partner, parent or family member were for females
- around 9 in 10 (87%) hospitalisations for injury by a spouse or domestic partner were for females (AIHW 2023a).

Most partner assault of women involved bodily force

In 2021–22, 3 in 5 (61%, or 2,200) hospitalisations of women aged 15 years and older for assault by a spouse or domestic partner involved assault with bodily force and 1 in 5 (20%) involved assault with either a blunt (13%) or sharp (7.1%) object. For males, hospitalisations for assault by a spouse or domestic partner were most likely to involve

injury from assault with a sharp object (37%, or 205 hospitalisations), followed by assault by bodily force (28%, or 150 hospitalisations) or with a blunt object (24%, or 130 hospitalisations) (AIHW 2023a).

Head and/or neck injuries are the most common injuries due to assault by a spouse or domestic partner

In 2021–22, almost 3 in 4 (72%, or 2,600) hospitalisations of women aged 15 years and older due to spouse or domestic partner assault involved injuries to the head and/or neck, including 375 (11%) hospitalisations for brain injury. Trunk injuries were more common among pregnant women (48%) than among women who were not pregnant (29%) (AIHW 2023a). For more information, see **Pregnant people**.

Of hospitalisations for males aged 15 years and older for assault by a spouse or domestic partner, 51% (or about 280) had a head and/or neck injury recorded, including 41 (7.5%) brain injuries. More than half (52%, or about 280) involved injury to limbs (shoulder, arm and/or hand) and 28% (or 150) had an injury to the trunk recorded (AIHW 2023a). (Note: a hospitalisation may have multiple injuries recorded and therefore proportions sum to more than 100%).

For more information about FDV hospitalisations, please see **Health services**, **Children and young people** and **Pregnant people**.

Separate analysis of linked hospital data over time showed that some individuals were hospitalised more than once for treatment and/or care after a FDV assault. Around 1 in 8 people with a FDV hospital stay during 2010–11 to 2017–18, had more than one FDV stay over a 9 year period (AIHW 2021c).

Sexual and reproductive health

Sexual and reproductive health outcomes associated with FDSV includes injury to reproductive organs, sexual dysfunction, gynaecological problems, sexually transmitted infections, abortion (medical and spontaneous) and birth complications. Additionally, violence can take the form of reproductive coercion (see **Pregnant people**). While both men and women can experience outcomes that affect their sexual and/or reproductive health, most available data are related to women. Additionally, national data on many of these health outcomes among people who have experienced FDSV are limited.

Data from the ALSWH showed that, when compared with women who had not experienced domestic violence, women who had experienced domestic violence were:

- more likely to be diagnosed with a sexually transmitted infection, including human papillomavirus (HPV) (23% of women aged 22–27 in 2017, compared with 11%) (Loxton et al. unpublished in AIHW 2019)
- less likely to be screened for cervical cancer (75% of women aged 45–50 in 1996 and 53–58 in 2004 compared with 81%) (Loxton et al. 2009, in AIHW 2019).

Among more than 14,000 women aged 45–50 in 1996, women who had been diagnosed with cervical cancer were twice as likely to have experienced domestic violence,

compared with women who had not been diagnosed with cervical cancer (29% versus 15%, respectively) (Loxton et al. 2009).

Women of childbearing age can experience increased risk of reproductive health and/or pregnancy outcomes. For more see **Pregnant people** and **Mothers and their children**.

Sexual health and dysfunction

Sexual violence may impact a victim-survivor's sexual health and relationships. This violence can occur in the context of family violence, commonly intimate partner violence, or sexual violence by any perpetrator. Sexual violence may result in short-term injury directly related to an event, or longer-term impacts to sexual and reproductive function, whether that be physical, or psychological. However, it is important to note, not all people who experience sexual violence sustain physical trauma at the time of an event (Rees et al. 2011).

Health outcomes due to sexual violence can include, but are not limited to:

- damage to urethra, vagina and anus, and chronic pelvic pain
- gastrointestinal problems (including irritable bowel syndrome) and eating disorders
- sexually transmissible infections
- gynaecologic symptoms: for example, dysmenorrhea (severe pain or cramps in the lower abdomen during menstruation), menorrhagia (abnormally heavy or prolonged bleeding during menstruation) and problems associated with sexual intercourse (Rees et al. 2011).

Sexual dysfunction can occur in victim-survivors of sexual violence, particularly childhood sexual abuse. This may impact sexual function, satisfaction, and increase risk taking behaviours (Gewirtz-Meydan and Ofir-Lavee 2021). Currently, there is no national data available to indicate the prevalence of sexual dysfunction following sexual violence.

Deaths

Using data from the National Homicide Monitoring Program, the ABDS 2018 (see Box 1) estimated that intimate partner violence contributed to around 230 female deaths (or 0.3%) in 2018 (AIHW 2021a). Most of these deaths were due to homicide and violence, followed by suicide and self-inflicted injuries. For more information, on direct FDSV death outcomes, see **Domestic homicide**.

While homicides provide direct evidence of the permanent consequences of family and domestic violence, they underestimate the impact of family and domestic violence on mortality more broadly (or indirectly). IPV is a risk factor for a range of health outcomes which may increase a person's risk of death, including by suicide or due to other means (On et al. 2016). Many studies have found strong associations between IPV and both suicidal thoughts and suicide attempts (Devries et al. 2013; Potter et al. 2021).

Family and domestic violence-related deaths by suicide

There is no nationally consistent collection of data for FDV-related deaths by suicide, although the Australian Domestic and Family Violence Death Review Network has

indicated an intent to broaden their reporting to include FDV-related suicide deaths in the future (ADFVDRN) (Box 3). FDV-related deaths by suicide can occur among victim-survivors and perpetrators.

National data on suicide (intentional self-harm) is derived from information collected as part of the death registration process. Deaths must be certified by either a doctor, using the Medical Certificate of Cause of Death, or by a Coroner. Deaths from suicide are referred to a coroner and can take time to be fully investigated. The Australian Bureau of Statistics (ABS) collects information on all registered deaths from states and territories, and national data on suicide are reported annually (ABS 2021; AIHW 2023b). From these data, it is not possible to determine the extent or involvement of FDV in a death by suicide, however, information recorded on psychosocial risk factors can provide some insight on related factors. For example, in 2021, 'problems in spousal relationship circumstances' was the third most common risk factor for intentional self-harm, present in 24% of deaths by suicide (ABS 2021). 'Problems related to alleged sexual abuse of child by person within primary support group' occurred in 5.0% of suicides of females aged 5–24 years (ABS 2021). For more information see **Data sources and technical notes**.

Box 3: Work towards a national FDV-related suicide data set

The Australian Domestic and Family Violence Death Review Network (ADFVDRN) (the Network) was established in 2011 to analyse and share knowledge about deaths that occur in the context of family and domestic violence so as to improve service responses. The first stage of this work involved the development of a national minimum dataset for intimate partner homicides preceded by a reported or anecdotal history of violence between offender and victim (IPV homicides), with an intent to expand this to include homicides within a family relationship, 'bystander' homicides, and FDV-related suicides.

The dataset focuses on IPV homicides currently, and data on FDV-related suicide remains limited to suicide by offenders after homicide. In Australia, between 1 July 2010 and 30 June 2018, there were 45 cases where the offender of an IPV homicide died by suicide following the homicide.

For further discussion of the dataset and IPV homicides, see **Domestic homicide**.

Source: ADFVDRN and ANROWS 2022.

State and territory data

Some data on FDV-related suicides are available from some states and territories, however methods and definitions for defining a FDV-related suicide vary between the jurisdictions, and are not suitable for comparison. In some analysis, it is also not clear whether the person who has died by suicide was a victim or perpetrator of FDV.

- In New South Wales, there were 330 completed suicides between 1 July and 31 December 2013. Of these, 49% of the female suicides and 52% of the male suicides had a recorded or apparent history of domestic and family violence, relationship conflict or relationship breakdown (NSW DVDRT 2017).

- In Victoria, between 2009 and 2012 almost 35% of women who died by suicide had a reported history of family violence victimisation; around 50 deaths a year (CCV 2015).
- In Queensland, between July 2015 and 30 June 2021, 280 FDV-related suicide deaths were identified (DFVDRAB 2021).
- In Western Australia, there were 410 people who died by suicide between 1 January and 31 December 2017 – 68 of these people were women and children who were victims of family and domestic violence, including 20 children and young women (aged under 26 years) (Ombudsman Western Australia 2022).
- In Tasmania, a review identified characteristics of the 505 closed cases of death by suicide that occurred between January 2012 and December 2018. The review identified that 42% of people experienced conflict with their partner, and 19% experienced violence involving a partner that was considered a contributing stressor prior to their death. Additionally, 48% of people who died by suicide had ever experienced abuse or violence, however, available data do not specify whether the abuse was FDSV-related (Garrett and Stojcevski 2021).

Box 4: People who had a FDV-related hospital stay had a higher rate of death, and different causes of death, when compared with those who had never been to hospital for FDV

An AIHW study investigated whether there were differences in the number of, and causes of death between people who had at least one family or domestic violence-related (FDV-related) hospital stay and people without a history of FDV-related hospital stays.

This study used longitudinal, national linked hospital and death data from the National Integrated Health Services Information Analysis Asset (NIHSI AA) from 2010–11 to 2018–19. People who had a FDV-related hospital stay (the FDV hospital cohort) were compared with a comparison group that had a hospital stay (but not a FDV hospital stay) in the same 9-year period, and matched on age, sex, Indigenous status, year of contact and remoteness area to assist with interpretation of the results.

The FDV hospital cohort had a higher rate of death and different causes of death compared with the comparison group. Between 2010 and 2019:

- 5.7% of the FDV hospital cohort died compared with 4.4% of the comparison group
- The FDV group were 10 times as likely to die due to assault, 3 times as likely to die due to accidental poisoning or liver disease, and 2 times as likely to die due to suicide, as the comparison group
- Almost 2 in 5 (39%) deaths among the FDV hospital cohort occurred before age 50, compared with fewer than 1 in 3 (31%) among the comparison group.

For more information on hospitalisations see **Health services**.

Source: AIHW 2021c.

Related material

- Health services
- Behavioural outcomes
- Domestic homicide
- Children and young people
- Pregnant people
- Mothers and their children

More information

- Burden of disease
- Injury in Australia
- Examination of hospital stays due to family and domestic violence 2010–11 to 2018–19

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Behavioural outcomes

Key findings

Following the most recent incident of sexual assault (in the past 10 years and since the age of 15):

- 38% of women reported changes to their usual social or leisure activities
- 38% of women reported changes to their sleep routine
- 22% reported changes to their eating habits
- 28% reported changes in building and maintaining relationships.

In the context of family, domestic and sexual violence (FDSV), a behavioural outcome may be considered as a change in a victim-survivors' behaviour that can be attributed to experiences of FDSV. A change in behaviour may be directly, or indirectly attributed to FDSV. For example, trauma due to FDSV can cause behavioural changes (direct), and physical and mental health outcomes associated with FDSV can also influence a victim-survivors' behaviour (indirect) (see **Health outcomes**). Therefore, the relationship between FDSV and behavioural outcomes is complex due to the multi-directional relationship between behaviour and physical and mental health.

This topic page focuses on a selection of behavioural outcomes associated with FDSV:

- engaging in risky consumption of alcohol and other drugs (health risk behaviours),
- changes to physical activity, sleep and diet (personal habits and heath promoting behaviours)
- difficulties maintaining personal relationships (social interactions and personal relationships
- changes to engagement with employment (employment)
- reduced educational attainment (education).

What do we know?

Experiencing FDSV is a cause of traumatic stress. Trauma is associated with behavioural changes, and these can have an impact on a victim-survivor's daily routine and lifestyle, relationships, education and employment. Trauma may also cause a range of health-related problems (see **Health outcomes**). For example, experiences of sexual violence are associated with behavioural changes that can lead to adverse health outcomes, including smoking, high risk alcohol and other drug use and lower levels of physical activity (Bacchus et al. 2018; González-Chica et al. 2019; Miller-Graff et al. 2021; Townsend et al. 2022).

In some cases, experiencing trauma may lead to post-traumatic stress disorder (PTSD). PTSD is associated with a range of behavioural symptoms such as avoidance of triggers

(including people, places or events) and arousal and reactivity (sudden anger, difficulty engaging emotionally, feeling numb, trouble sleeping and startling easily) (NIH 2023).

FDSV can also have a negative impact on social connections. Perpetrators may use coercive and controlling behaviours intentionally to isolate victim-survivors from friends, family or support networks (both online or in person) (HRSCSPLA 2021) (See **Coercive control**). Social withdrawal and isolation may also be an indirect outcome of violence, as people may find themselves withdrawing from social networks following traumatic and/or violent events. In relation to sexual assault trauma, women may avoid situations that remind them of the incident including locations or people who remind them of the perpetrator, as well as restrict social activities due to the belief that the world is inherently unsafe (Boyd 2011).

Social isolation can result in negative physical and mental health outcomes. For example, social isolation has been linked to mental illness, emotional distress, suicide, the development of dementia, premature death, poor health behaviours, smoking, physical inactivity, poor sleep, and biological effects, including high blood pressure and poorer immune function (AIHW 2023). For more information, see Australia's welfare – Social isolation, loneliness and wellbeing.

For some victim-survivors of intimate partner violence (IPV), gambling venues can be safe spaces in which they can escape from or cope with the violence and/or the resulting social isolation. This may increase their risk of developing a gambling problem and contribute to their ongoing victimisation (Hing et al. 2020).

National data sources to measure behavioural outcomes

Evidence on the behavioural outcomes due to or associated with FDSV are available from 2 main national data sources – the ABS Personal Safety Survey and the Australian Longitudinal Study on Women's Health. For more information about these data sources, please see **Data sources and technical notes**.

As behaviours are commonly measured via self-report, these sources are surveys. For more information on how different types of data and research answer questions, see **How are national data used to answer questions about FDSV?**.

What do the data tell us?

Health risk behaviours

Childhood maltreatment

is associated with current cannabis dependence, recent suicide attempt and recent self-harm

The 2021 Australian Child Maltreatment Study (ACMS) found associations between adults with self-reported experiences of child maltreatment and six health risk

behaviours: cannabis dependence, suicide attempts, non-suicidal self-injury, smoking, binge drinking and obesity. The strongest associations were for current cannabis dependence, recent suicide attempt and recent self-harm (Haslam et al. 2023). See **Children and young people** and **Data sources and technical notes** for more information.

Women who have experienced sexual violence may be more likely to engage in smoking, high-risk alcohol consumption and illicit drugs, than women who have not experienced sexual violence

Women who have experienced sexual violence may be more likely to engage in smoking, high-risk alcohol consumption and illicit drug use, than women who have not experienced sexual violence (Townsend et al. 2022). According to the Australian Longitudinal Study of Women's Health (ALSWH), compared with women who had never experienced sexual violence, women who were born from 1989-95 and had experienced sexual violence were:

- 60% more likely to be current smokers
- 30% more likely to have used illicit drugs in the past 12 months.

Similarly, compared with those who had never experienced sexual violence, those who had and were born from 1973-78 were:

- 26% more likely to be current smokers
- 30% more likely to have used illicit drugs in the past 12 months.

There was little association between smoking and sexual violence for those born from 1946-51 and no data reported on illicit drug use in the past 12 months (Townsend et al. 2022).

Women who were born in 1946-51, 1973-78 and 1989-95 and had experienced sexual violence were 16–73% more likely to engage in high-risk alcohol consumption compared with women who had not experienced sexual violence (Townsend et al. 2022).

Personal habits and health promoting behaviours

Some people experience changes to their social/leisure activities, sleeping and eating habits following injury from sexual assault.

Findings from the 2021–22 Personal Safety Survey (PSS) estimated that there were 166,000 women aged 18 years and over who were physically injured in their most recent incident of sexual assault perpetrated by a male in the last 10 years.

Of these:

- 38% reported changes to their sleep routine
- 22% reported changes to their eating habits (ABS 2023b).

According to the ALSWH, women who had experienced sexual violence, and were born from 1989-95 and 1973-78 were 3% less likely to report high levels of physical activity compared with those who had not experienced sexual violence (Townsend et al. 2022). There was little association between sexual assault and high levels of physical activity for those born 1946-51.

Social interactions and personal relationships

The 2021–22 PSS shows that among those who had experienced emotional abuse from a previous partner since the age of 15, the proportion who had experienced controlling social behaviours (see **Coercive control**) was:

- 63% for women
- 56% for men (ABS 2023a).

According to the 2021–22 PSS, after the most recent incident of sexual assault perpetrated by a male in the last 10 years which caused an injury:

- 38% of women aged 18 years and over reported changes to their usual social or leisure activities routine
- 28% reported changes in building and maintaining relationships (ABS 2023b).

Employment

Work life can be disrupted following experiences of FDSV due to avoidance of social situations and feelings of low self-worth and self-doubt (Boyd 2011).

The 2021–22 PSS asked women and men who experienced violence from a current or previous partner since the age of 15 whether the partner violence resulted in them taking time off work and found that:

- women were more likely to have taken time off work due to violence from a previous partner (23%) than a current partner (12%*)
- about 1 in 4 women (23%) and men (23%*) had taken time off work due to violence from a previous partner (ABS 2023a).

Note that estimates marked with an asterisk (*) should be used with caution as they have a relative standard error between 25% and 50% and that data related to current partner violence for men is not sufficiently statistically reliable for reporting.

The 2021–22 PSS found that 1 in 10 (11%) women who had experienced sexual assault perpetrated by a male in the last 10 years, indicated they took time off work in the 12 months after the most recent incident (ABS 2023b).

Disruption to work and employment can negatively impact support networks, financial stability, and self-worth. Under the National Employment Standards, all employees in Australia are entitled to 10 days of paid FDV leave for full-time, part-time and casual employees. For more information see **Economic and financial impacts** and **Financial support and workplace responses**.

According to the ALSWH, women born 1989-95 who had ever experienced sexual violence were 7% less likely to have full-time employment than those who had not experienced sexual violence (Townsend et al. 2022). However, women born 1946-51 who had experienced sexual violence were 8% more likely to be employed full-time than those who had not.

Education

According to the ALSWH, women born in 1989-95 and 1973-78 who had ever experienced sexual violence were 46-63% less likely to have completed year 12 than those who had not experienced sexual violence (Townsend et al. 2022). Women born from 1989-95 were also 34% less likely to have obtained qualifications beyond year 12. However, women born 1946-51 who had experienced sexual violence were 33% more likely to have attained a qualification beyond year 12 than those who had not experienced sexual violence.

Related material

- Coercive control
- Economic and financial impacts
- Health outcomes
- How are national data used to answer questions about FDSV?

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Domestic homicide

Key findings

- One woman was killed every 15 days and one man was killed every 28 days by an intimate partner on average in 2020–21.
- Intended or actual separation are risk factors for intimate partner homicide.
- The intimate partner homicide victimisation rate decreased (from 0.7 to 0.2 per 100,000) from 1989–90 to 2020–21.

Some family and domestic violence incidents are fatal. Intimate partner homicide is the most common form of domestic and family homicide with the majority involving a female victim. Domestic and family homicides rarely occur without warning and in many instances there have been identifiable risk factors and repeated episodes of abuse prior to the homicide (ADFVDRN and ANROWS 2022).

Understanding the prevalence of family and domestic homicide, its nature and risk factors can allow us to better identify people at higher risk and design and assess the policies and programs that aim to prevent domestic homicide.

What is domestic homicide?

Domestic homicide refers to the unlawful killing of a person in an incident involving the death of a family member or other person in a domestic relationship, including people who have a current or former intimate relationship.

Domestic homicide is defined differently by the criminal law of each Australian state and territory, with some differences in how each defines or determines offender intent and responsibility and the severity of the crime (ABS 2018). Generally, homicide can include:

- Murder – an unlawful killing where there is intent to kill, intent to cause grievous bodily harm with the knowledge that it was probable that death or grievous bodily harm would occur, and/or no intent to kill but it occurs while committing a crime.
- Manslaughter – an unlawful killing while deprived of the power of self-control by provocation, or under circumstances amounting to diminished responsibility or without intent to kill, as a result of a careless, reckless, negligent, unlawful or dangerous act (other than the act of driving) (ABS 2023c).

Data sources for measuring domestic homicide

This report includes homicide data from 3 main sources – Australian Institute of Criminology (AIC) National Homicide Monitoring Program (NHMP), ABS Recorded Crime – Victims and the Australian Domestic and Family Violence Death Review Network (ADFVDRN). For more information about these data sources, please see **Data sources and technical notes**.

There are differences in the scope, collection methods and criteria for identifying a family or domestic violence homicide between these data sources, see Box 1.

Box 1: Differences in deaths data

The scope, collection methods and criteria for identifying a family or domestic violence homicide differ between data sources. These collections are not directly comparable but complement each other as statistical sources.

AIC National Homicide Monitoring Program

Data for the NHMP are derived from both police records and coronial records (Bricknell 2023). The NHMP also undergoes a quality control process that involves cross referencing and supplementing data with additional material from court documents and media reports. The NHMP collects information on homicides. This topic page uses the NHMP for domestic homicide prevalence data from 1989–90 to 2020–21. The homicide classification used here is based on the closest relationship between the victim and primary offender. Domestic homicides include homicides where the relationship of the victim to the offender was:

- an intimate partner – victim and offender are current or former partners (married, de facto, boyfriend/girlfriend and so on)
- a child
- a parent
- a sibling
- another family member – any other family relationship including nephew/niece, uncle/aunt, cousins, grandparents and kinship group.

Family relationships include biological, adoptive, foster and kinship care, and step relatives. In this topic page these relationships have been further grouped into intimate partner homicides and family member homicides (all domestic homicides excluding intimate partner homicides).

ABS Recorded Crime – Victims

Data for the ABS Recorded Crime – Victims collection (the ABS collection) are derived from police records and compiled according to the National Crime Recording Standard to maximise consistency between states and territories (ABS 2023c). As these data are processed differently to the NHMP, these 2 data sources are not directly comparable. The ABS collection includes information on homicides and related offences (including murder, attempted murder and manslaughter). This report uses the ABS collection data for 2022 to present further information on homicides and attempted murder to complement NHMP prevalence data. In the ABS collection, family and domestic violence (FDV) related data are derived from 2 variables: an FDV flag recorded by police officers and through known relationship information. FDV related offences include the following relationships:

- partner (spouse, husband, wife, boyfriend, and girlfriend)
- ex-partner (ex-spouse, ex-husband, ex-wife, ex-boyfriend, and ex-girlfriend)
- parent (including step-parents)

- other family member (including, but not limited to, child, sibling, grandparent, aunt, uncle, cousin, niece, nephew)
- other non-family member (carer, guardian, kinship relationships) (ABS 2023c).

Australian Domestic and Family Violence Death Review Network

Data used by the ADFVDRN in their reporting are derived from case reviews, coronial records, and police and media reports (ADFVDRN and ANROWS 2022). Unlike the NHMP and ABS Recorded Crime – Victims collection, the ADFVDRN only includes data on intimate partner homicides preceded by a reported or anecdotal history of domestic violence between offender and victim (IPV homicides). The ADFVDRN defines domestic violence to include behaviours such as physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation and economic deprivation. The ADFVDRN developed a first-stage National Minimum Dataset (NMDS) to examine national trends and patterns related to intimate partner homicides.

The ADFVDRN worked together with ANROWS to report data from the NMDS on about 310 cases of IPV homicides between July 2010 and June 2018 including data about the primary abuser, as identified from reported and anecdotal accounts of abuse in the relationship between IPV homicide offenders and victims (see **Data sources and technical notes**). A focused dataset (containing about 290 cases) allowed further analysis of characteristics such as domestic violence orders and separations (see **Data sources and technical notes**) (ADFVDRN and ANROWS 2022).

What do we know?

Since 1989–90, the rate of domestic homicide has halved (Bricknell 2023). Intimate partner homicide is the most prevalent type of domestic homicide in Australia and is most commonly perpetrated by a male against a female partner (Bricknell 2023).

Existing data suggests that females are disproportionately the victims of intimate partner and domestic homicide around the world. A United Nations Office on Drugs and Crime report estimated that globally, while 81% of all homicide victims are males, 82% of intimate partner homicide victims are female and 64% of intimate partner/family-related homicide victims are female (UNODC 2019). It was also estimated that around 1 in 3 (34%) women intentionally killed worldwide are killed by an intimate partner, however, there are large differences across regions. Oceania (which includes Australia) had the highest estimated proportion of women killed exclusively by intimate partners (42%) and Europe had the lowest (29%) (UNODC 2019).

Risk factors for domestic homicide

Much of the national and international research on domestic homicide offenders has focused on identifying common characteristics of homicide offenders, their relationships and other factors that could relate to an increased likelihood of committing homicide (risk factors), particularly for intimate partner homicide. Some of the individual- and relationship- level risk factors for intimate partner homicide are:

- history of sexual violence by the homicide offender (Spencer and Stith 2020)

- history of non-fatal strangulation of the victim by the offender (Glass et al. 2008)
- offender mental and physical health problems, particularly depression and suicidal ideation (Lysell et al. 2016; Boxall et al. 2022; Lawler et al. 2023)
- offender has experienced traumatic life events including war, homelessness, incarceration, abuse and neglect as a child, and the death of significant family members (Kivisto 2015; Boxall et al. 2022)
- separation between victim and offender (Dobash and Dobash 2011; Spencer and Stith 2020; Boxall et al. 2022)
- offender's jealousy and perception of violations to gendered norms (such as a victim dedicating herself to a career or refusing to submit to the offender) (Dobash and Dobash 2011; Kivisto, 2015; Boxall et al. 2022).

While there may be an association between these risk factors and cases of intimate partner homicide, this does not mean any one factor or combination cause the homicide. For example, while people with depression are over-represented among perpetrators of intimate partner homicide, a recent study found depression alone holds limited explanatory value for understanding intimate partner homicide and should be considered in the context of co-occurring risk factors (Lawler et al. 2023).

Pathways into and intervention strategies for intimate partner homicide

A recent report by the AIC identified three main pathways into which the majority of male-perpetrated homicides of a female intimate partner in Australia could be classified (see Box 2). This study identified a number of intervention points and strategies that may reduce male-perpetrated female intimate partner homicide including:

- through the use of evidence-based intimate partner violence intervention programs in and out of criminal justice settings
- integrating intimate partner violence intervention programs with alcohol and other drug programs and mental health services
- investment in frontline staff education and identification of coercive control with an emphasis on treating identified cases seriously
- improved identification of high-risk victims and targeted and timely responses to protect them (including through safety planning around domestic violence orders)
- investment in new techniques to detect and monitor potential homicide offenders (intelligence-led approaches such as the use of GPS data, online activity data, mental health data, family law process information, and so on) (Boxall et al. 2022).

Box 2: Pathways to male-perpetrated female intimate partner homicide

The AIC report, *The "Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia*, identified three main pathways of male-perpetrated homicide of a female intimate partner by analysing 199 incidents between

1 July 2007 and 30 June 2018 for patterns in the sequence of events, interactions and relationship dynamics preceding and coinciding with the homicide:

- The **fixated threat pathway** (33% of cases) typically involves successful middle-class men who have power over their partner (for example, difference in age, income, and so on) and use abusive and controlling behaviours but have little justice system contact. Upon a loss of control (e.g. through separation), violence escalates and the homicide often involves planning. In these cases the offender typically pleads not guilty.
- The **persistent and disorderly pathway** (40% of cases) involves offenders with complex histories of trauma, co-occurring mental and physical health problems, significant histories of violence towards partners and others, and justice system contact (including protection orders). The homicides are often similar to previous instances of violence in the relationship but involve additional risk factors such as heavy alcohol use or isolation. Separation is relatively rare in these cases.
- The **deterioration/acute stressors pathway** (11% of cases) involves offenders who are in long-term, non-abusive relationships with low levels of, or an absence of, violence or justice system contact. Substantial life stressors result in the onset or exacerbation of mental and physical health problems for the offender and trigger increased conflict in the relationship. The homicides are often during an argument, and the result of a nearly instantaneous decision to harm the victim. Offenders are likely to demonstrate remorse and plead guilty (Boxall et al 2022).

The remaining cases involved: overlapping features of the three pathways (15%) or were considered outliers due to unique circumstances (1.5%) (Boxall et al 2022).

What do the data tell us?

Domestic homicide victims made up over one-third (35% or 78) of all homicide victims (220 victims) in 2020–21 in the National Homicide Monitoring Program (NHMP) (AIC 2023).

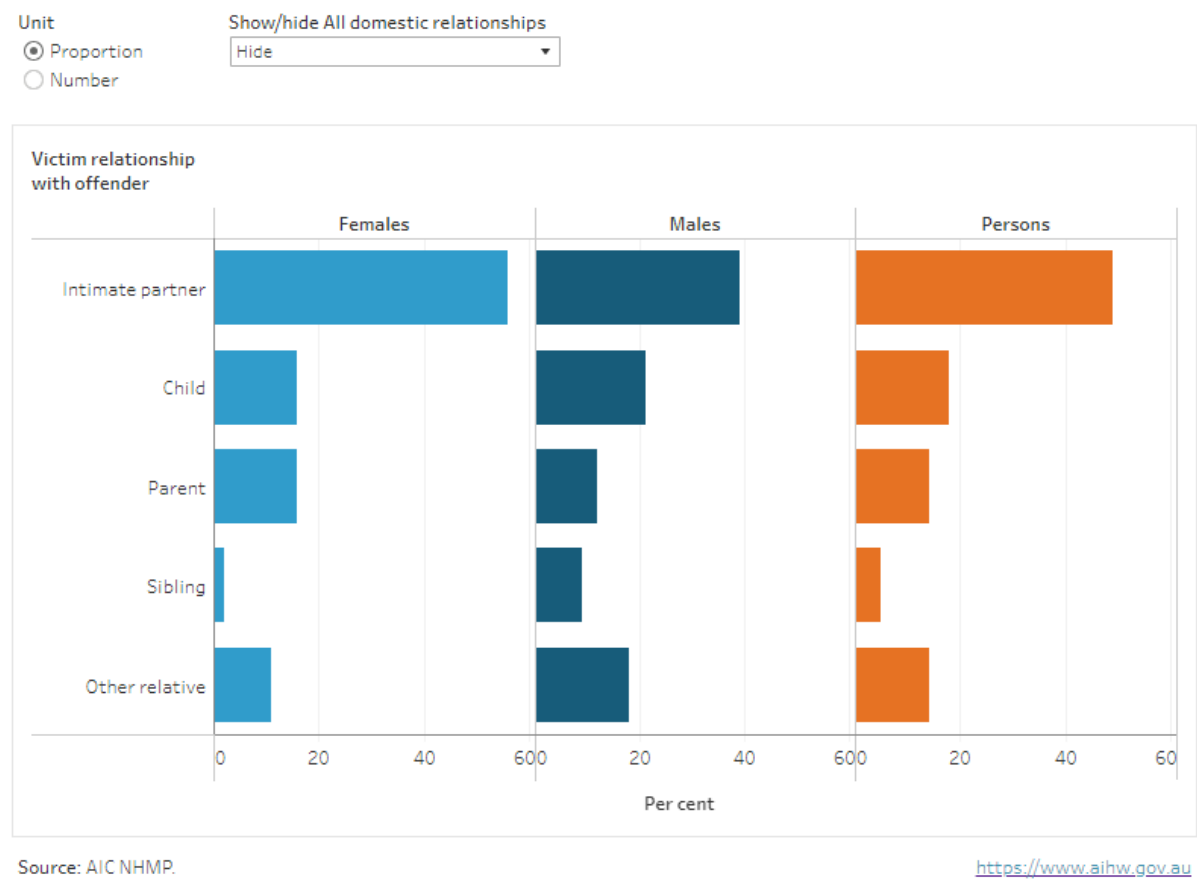
The majority of domestic homicide victims are killed by an intimate partner.

Of the 78 domestic homicide victims in 2020–21:

- 38 were killed by an intimate partner
- 40 were killed by a family member with:
  - 14 killed by a parent

- 11 killed by a child
- 4 killed by a sibling
- 11 killed by a family member other than child, parent or sibling (AIC 2023; Figure 1).

Figure 1: Domestic homicide victims, by relationship with offender and sex, 2020–21



More females than males are victims of domestic homicide.

There were 45 female domestic homicide victims and 33 male victims in 2020–21. Among these:

- most were killed by an intimate partner – 5 in 9 female victims (56%) and about 2 in 5 male victims (39%)
- more male than female victims were killed by a family member (61% compared with 44%) (Figure 1).

Of the 135 victims of family and domestic violence homicides and related offences in 2022 in the ABS Recorded Crime – Victims data collection:

- 71 were victims of murder, with 35 female victims and 34 male victims

- 42 were victims of attempted murder, with twice as many females as males (29 compared with 13)
- 14 were victims of manslaughter, with similar numbers of female and male victims (ABS 2023a).

There were 41 recorded intimate partner homicides and related offences in Australia (excluding data from Western Australia) in 2022, with about 3 times as many females (28) as males (11) (see **Data sources and technical notes**) (ABS 2023b).

Note that values from the ABS Recorded Crime – Victims data collection have been randomly adjusted to avoid the release of confidential data. Component items may not sum to totals.

Characteristics of intimate partner homicides that had a history of domestic and family violence

Among about 310 IPV homicides between July 2010 and June 2018 that were included in the ADFVDRN IPV homicide dataset, the majority involved a male killing a current or former partner:

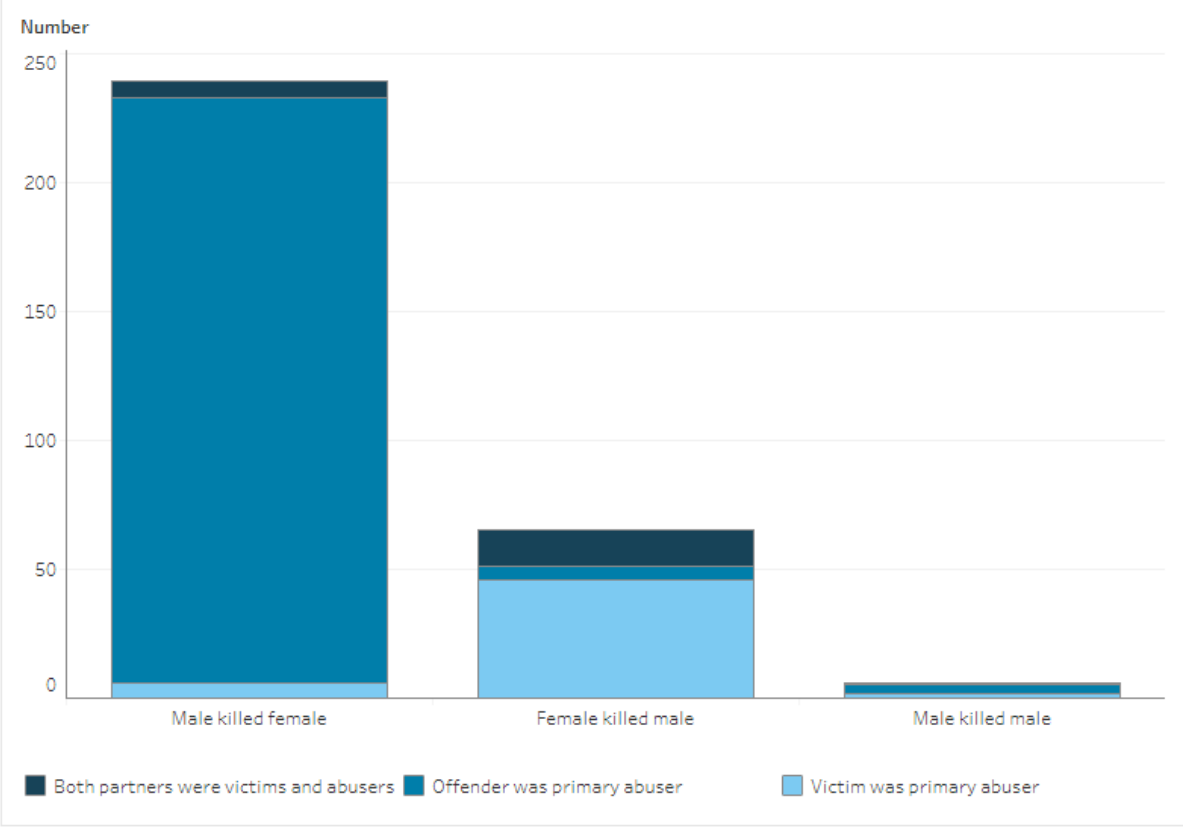
- about 4 in 5 (77%) involved a male killing a current or former female partner
- about 1 in 5 (21%) involved a female killing a male partner
- about 1 in 20 (1.9%) involved a male killing a male partner
- no cases involved a female killing a female partner (ADFVDRN and ANROWS 2022).

In most IPV homicides a male is the primary domestic violence abuser.

A male was most commonly the primary domestic violence abuser in the relationship, including when a female killed a male partner (see **Data sources and technical notes**). The male was the primary abuser:

- in the vast majority (95%) of cases where a male killed a female partner
- in about 7 in 10 (71%) cases where a female killed a male partner (Figure 2).

Figure 2: Domestic violence perpetration/victimisation status in IPV homicides, July 2010–June 2018



Source: ADFVDRN Intimate partner violence homicides data. https://www.aihw.gov.au

Emotional and psychological abuse, and physical abuse were the most common forms of abuse leading up to IPV homicides where a male primary abuser killed a female partner.

In the IPV homicide dataset, among cases where a male primary abuser killed a female partner (about 210), the most common forms of abuse used in the relationship were emotional and psychological abuse (82%), and physical abuse (80%). Other common forms of abuse included:

- social abuse (63%)
- financial abuse (27%)
- sexual abuse (16%) (ADFVDRN and ANROWS 2022).

As multiple forms of abuse could be recorded for each case, proportions will not sum to 100%.

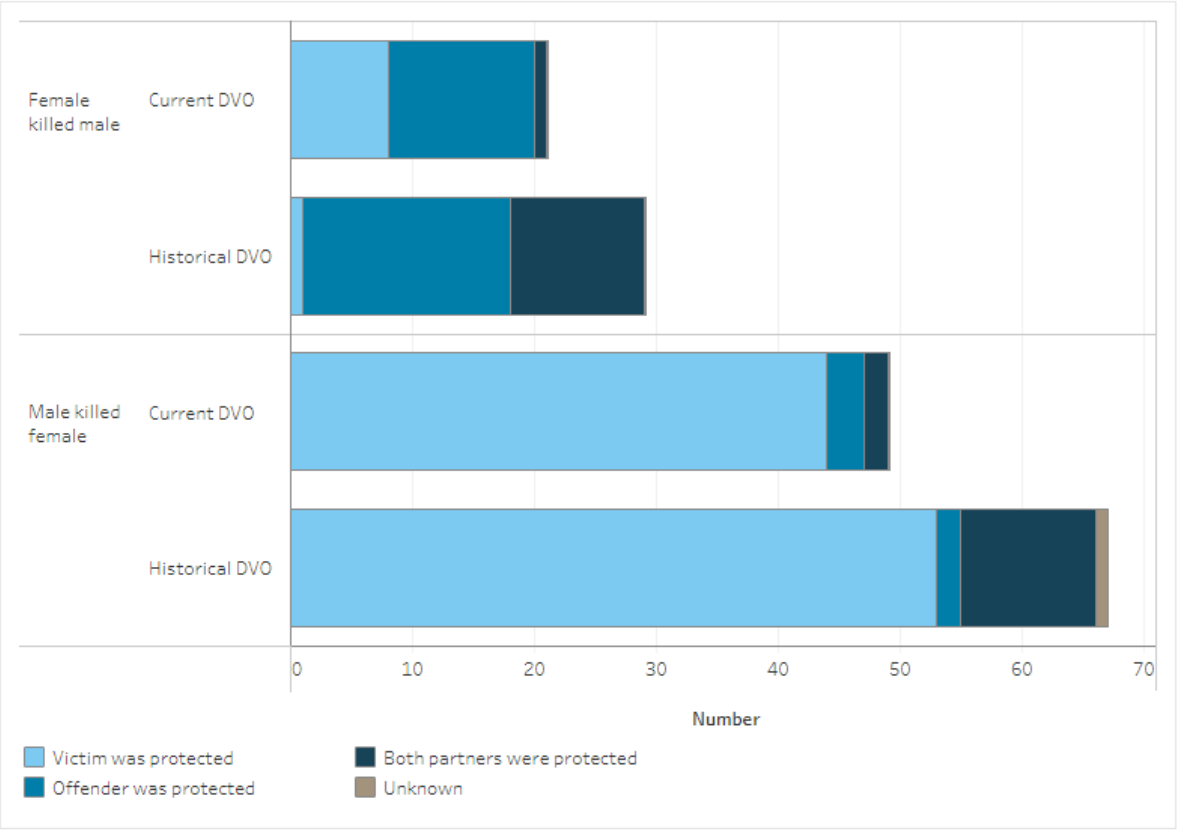
Among cases where a male primary abuser killed a female partner, the male abuser stalked the female victim in about 2 in 5 (42%) cases. This could occur both during the relationship (33%) and/or after the relationship (21%). See **Stalking and surveillance** for more information on the prevalence and effects of stalking.

A current domestic violence order was in place in about 1 in 5 (22%) IPV homicides where a male killed a female.

Domestic violence orders (current or historical) were held in over 2 in 5 (43%) cases where a male killed a female intimate partner in the ADFVDRN focused dataset (about 225 cases) (see Box 1 for definition):

- In about 1 in 5 (22%) cases there was a current domestic violence order, with the majority of these (90%) naming the female victim as the protected person.
- In 3 in 10 (30%) cases there was a historical domestic violence order, with most of these (79%) naming the female victim as the protected person (Figure 3).

Figure 3: IPV homicide victims where historical or current domestic violence orders (DVO) were in place, July 2010 – June 2018



Source: ADFVDRN Intimate partner violence homicides data. https://www.aihw.gov.au

Domestic violence orders (current or historical) were held in two-thirds (66%) of the cases where a female killed a male intimate partner (about 60):

- In about 1 in 3 (34%) cases there was a current domestic violence order, with over half of these (57%) naming the female homicide offender as the protected person.

- In about 1 in 2 (47%) of cases there was a historical domestic violence order, with over half of these (59%) naming the female homicide offender as the protected person (Figure 3).

It is possible that while a person is identified as the protected person in a domestic violence order, they may still be the primary abuser. Determining the person most in need of protection in domestic violence orders can be complex and instances where the legal system has been manipulated by an abuser to exert power over a victim (systems abuse) have occurred (AIJA and AGD 2022). As systems abuse is not explored or captured in the ADFVDRN dataset, it is important to keep this complexity in mind when interpreting data related to who is protected by a domestic violence order. For more information on the number of domestic violence orders, see **Legal systems**.

In more than 2 in 5 (43%) IPV homicide cases the children of homicide offenders and victims were exposed to violence between their parents.

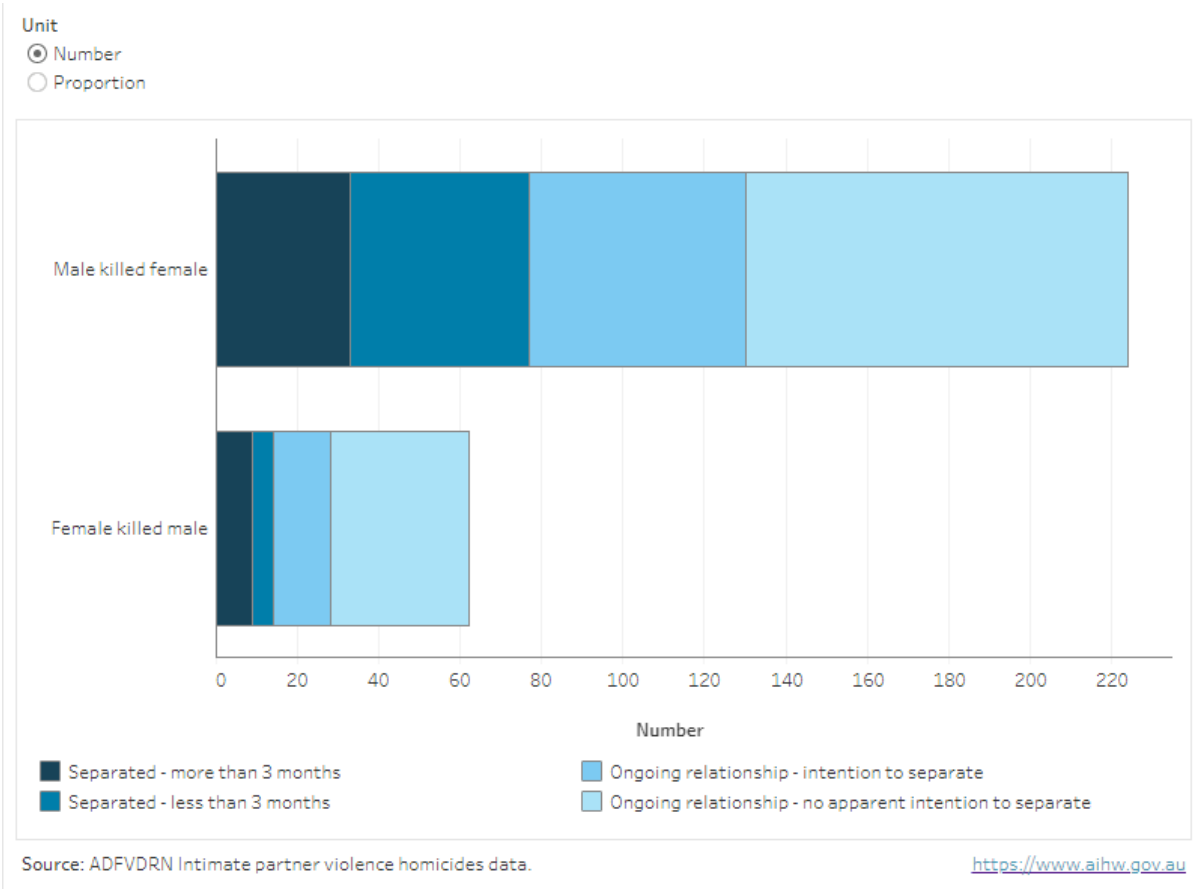
In more than 2 in 5 (43%) IPV homicide cases children were exposed to the violence between their parents/caregivers. The IPV homicide offenders and victims were joint parents of about 170 children aged under 18 at the time of the homicide. Eight children were killed during the homicide (ADFVDRN and ANROWS 2022). For more information on children exposed to family, domestic and sexual violence, see **Children and young people**.

Female IPV homicide victims are more likely to be killed during a period of intended or actual separation.

In about 3 in 5 (58%) of the cases where a male killed a female partner in the ADFVDRN focused dataset (about 225), one or both partners intended to separate or they had separated at the time of the homicide (see Box 1 for definition):

- In about 1 in 3 (34%) cases the couple was separated, with almost 3 in 5 of these cases involving a separation within the past 3 months (57% of separated couples).
- In about 1 in 4 (24%) cases the couple were in an ongoing relationship where at least 1 person had expressed their intention to separate, with the majority (94%) of these cases involving the female victims intention (Figure 4).

Figure 4: Relationship status at the time of IPV homicide, July 2010 – June 2018



Source: ADFVDRN Intimate partner violence homicides data. https://www.aihw.gov.au

Among the 62 IPV homicide cases where a female killed a male partner in the ADFVDRN focused dataset, intended or actual separation was present in less than half (45%):

- In about 1 in 4 (23%) cases men were separated, with about 1 in 3 (36%) of these cases involving a separation in the past 3 months.
- In about 1 in 4 (23%) cases one or both parties intended to separate, with the female offender being the one intending to separate in about 3 in 5 (57%) of these cases (Figure 4).

Note that values may not add to totals due to rounding.

Only just over one-third (36%) of IPV homicide victims and offenders were in formal, paid employment.

Workplaces can be an important site of intervention and prevention for FDV for both victims and perpetrators. However, only just over one-third (36%) of all IPV homicide offenders and victims were engaged in formal, paid employment at the time of the homicide in the ADFVDRN IPV homicide dataset (ADFVDRN and ANROWS 2022).

3 in 5 (60%) IPV homicide offenders had problematic drug and/or alcohol use before or at the time of the homicide.

Three in 5 (60%) IPV homicide offenders engaged in problematic drug and/or alcohol use in the lead up to and/or at the time of the homicide in the ADFVDRN IPV homicide dataset. This was similar for both male offenders (61%) and female offenders (58%) (ADFVDRN and ANROWS 2022).

This represents a pattern of behaviour and possible site of intervention but does not identify problematic substance use as a causative factor for IPV homicide (ADFVDRN and ANROWS 2022).

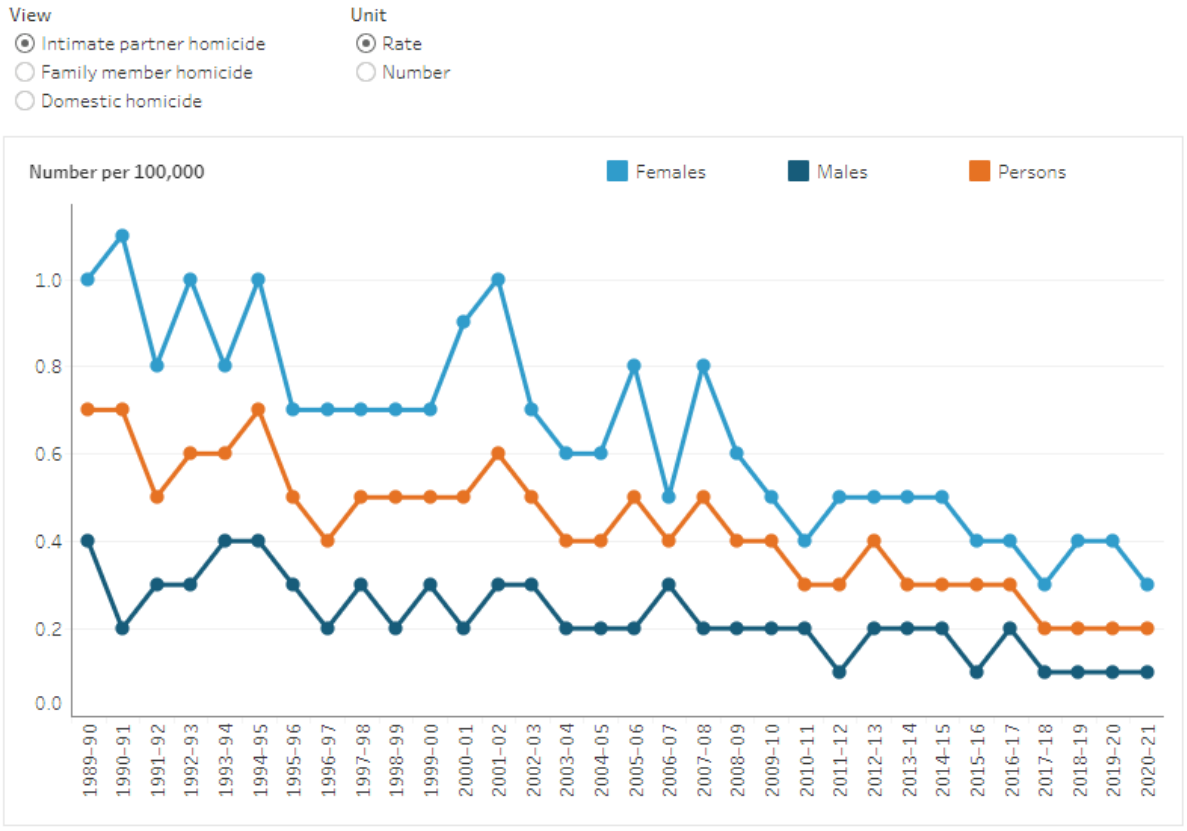
Has it changed over time?

The intimate partner homicide victimisation rate decreased from 0.7 to 0.2 per 100,000 between 1989–90 to 2020–21

The **domestic homicide victimisation rate** decreased from 0.8 to 0.3 per 100,000 people from 1989–90 to 2020–21 in the NHMP:

- The female victimisation rate decreased from 0.9 to 0.3 per 100,000 females
- The male victimisation rate decreased from 0.6 to 0.3 per 100,000 males (Figure 5).

Figure 5: Domestic homicide victims, by sex, 1989–90 to 2020–21



Source: AIC NHMP (unpublished). https://www.aihw.gov.au

The **intimate partner homicide victimisation rate** decreased (from 0.7 to 0.2 per 100,000 people aged 18 years and over) from 1989–90 to 2020–21:

- The female victimisation rate has consistently been more than twice as high as the male victimisation rate.
- The victimisation rate has decreased for both females (from 1.0 to 0.3 per 100,000) and males (from 0.4 to 0.1 per 100,000), see **Data sources and technical notes** (Figure 5).

A 25% reduction per year in female victims of intimate partner homicide is an identified target in the **Outcomes Framework 2023-2032**. For related data, see the **Data dashboard**.

The **family member homicide victimisation rate** decreased (from 0.3 to 0.2 per 100,000 people) from 1989–90 to 2020–21. The male victimisation rate has generally been higher than the female victimisation rate, with similar rates in 2020–21 (both 0.2 per 100,000) (Figure 5).

According to data from the ABS Recorded Crime – Victims data collection, from 2014 to 2022, the recorded victimisation rate for:

- family and domestic violence homicide and related offences decreased from 0.7 to 0.5 per 100,000 people
- intimate partner homicide and related offences decreased from 0.3 to 0.2 per 100,000 people (excluding data from Western Australia) (see **Data sources and technical notes**) (ABS 2023a, 2023b).

Is it the same for everyone?

People of all ages and backgrounds can be victims of domestic homicide. However, some people are at a greater risk than others.

Based on the latest available report on the demographic features of Australian domestic homicide victims using NHMP data (see Box 1), between 1 July 2002 and 30 June 2012, the most common age groups when homicide occurred varied by homicide type:

- for intimate partner homicides, about 2 in 5 (39%) victims were aged 35–49
- for filicide (a parent killing a child), around 1 in 2 (51%) victims were aged 1–9
- for parricide (a child killing a parent), around 2 in 5 (38%) victims were aged 65 and over
- for siblicide (a sibling killing a sibling), over 1 in 3 (35%) victims were aged 35–49
- for homicides involving other family members, about 1 in 5 (23%) victims were aged 35–49 (Cussen and Bryant 2015).

Demographic features of IPV homicide offenders and victims

Among intimate partner homicides preceded by a reported or anecdotal history of violence between offender and victim (IPV homicides) in the ADFVDRN IPV homicide dataset (about 310), differences are apparent for:

- Aboriginal and/or Torres Strait Islander people, who were disproportionately represented in IPV homicide offenders (27%) and victims (27%) compared with their representation in the general population (3.2%) (ABS 2022a; ADFVDRN and ANROWS 2022).
- People with disability, who were under-represented in IPV homicide offenders (9.6%) and victims (7.1%) compared with their representation in the general population (18%) (ABS 2019; ADFVDRN and ANROWS 2022).

People known to be born overseas had a similar representation among IPV homicide offenders (28%) and victims (26%) compared to their representation in the general population (29%) (ABS 2022b; ADFVDRN and ANROWS 2022).

Values presented give an indication of differences rather than the true number of homicide offenders and victims from specific population groups, see **Data sources and technical notes**.

For further information on family, domestic and sexual violence related to population groups, see **Aboriginal and Torres Strait Islander people**, **People with disability** and **People from culturally and linguistically diverse backgrounds**.

Related material

- Family and domestic violence
- Intimate partner violence
- Stalking and surveillance
- Coercive control
- Legal systems

More information

- Family, domestic and sexual violence data in Australia
- Family, domestic and sexual violence: National data landscape 2022
- Family, domestic and sexual violence
- Injury in Australia: Assault and homicide

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Economic and financial impacts

Key findings

- Women aged 24–30 in 2019 who had experienced sexual violence were 63% more likely to not have completed Year 12 compared with those who had not experienced sexual violence.
- Sexual violence was consistently associated with high financial stress over time – women across different age cohorts were 30–45% more likely to experience high financial stress if they had experienced sexual violence, compared with those who had not experienced sexual violence.

The impacts of family, domestic and sexual violence (FDSV) can be wide-ranging, affecting a person's education, employment, financial security and emotional and social wellbeing. The economic and financial impacts of FDSV can be substantial, with both direct and indirect costs to individuals, families and broader society.

This page looks at both the immediate costs of FDSV, the longer term financial costs and the economy-wide costs. While the AIHW's FDSV reporting focuses on national quantitative data, some contributions from people with lived experience are included on this page to deepen our understanding of the economic and financial impacts.

What do we know?

The flow-on effects of FDSV can be substantial, influencing a person's living circumstances and economic security. Some people leave their homes and seek assistance from specialist homelessness services (see **Housing**) when violence occurs. Some people receive crisis payments from the government or financial assistance from specialist services. Some people make use of leave entitlements in the workplace, in order to seek assistance (see **Financial support and workplace responses**).

Some of the costs of FDSV can be direct. For example, people who experience intimate partner violence may incur the costs associated with separation such as moving and legal costs or healthcare costs for treatment and/or recovery from harm. However, there can also be indirect costs, which continue long after the violence has occurred. For children and adolescents experiencing FDSV, the impacts can be serious and long-lasting, affecting their health, wellbeing, education, relationships and housing outcomes, which in turn affect their employment outcomes and economic security (ANROWS 2018).

What are some of the hidden costs of leaving a violent situation?

'Fleeing violence felt like leaving a life-threatening situation to enter poverty. It cost me career choices. I had to leave my law degree because the University changed its model of teaching, and I couldn't afford the childcare to attend and make a shifting university timetable, flexible work, and childcare work.'

Jasmine

WEAVERs Expert by Experience

'I had to find work that was flexible enough to allow me to drop my child off to childcare and pick them up before the service closed – that was far harder than it sounds! My career choices became solely based on what could bring enough money in to put food on the table and what could allow me to pick up and drop off my daughter.'

Jasmine

WEAVERs Expert by Experience

The impacts of FDSV can also be broader than those seen by the individuals and families who experience violence. The economic and financial impacts can be borne by communities, systems responding to violence and the broader economy.

What data are available to report on economic and financial costs of FDSV?

Data from surveys are available to look at some impacts of FDSV on families and individuals while cost estimates can be used to understand the magnitude of the cost of violence to the economy. For more information about the ABS Personal Safety Survey and the Australian Longitudinal Study on Women's Health, please see **Data sources and technical notes**.

What do the data tell us?

Separation

Data from the ABS Personal Safety Survey (PSS) are available to report on separations among women who experienced violence from their cohabiting partners. Although separation does not end exposure to intimate partner violence, understanding how many couples separate following intimate partner violence can shed light on how a person's economic circumstances may change.

Many women move away from home when their relationship with a violent partner ends, leaving behind property or assets

The 2021–22 PSS estimated that about 2 in 3 (64% or 867,000) women moved away from home when their relationship with a violent previous partner that they lived with ended. Of those that moved away, 7 in 10 (69% or 597,000) left property or assets behind (ABS

2023a). For further characteristics of partner violence and separations, see **Intimate partner violence.**

For many women, separation can also mean heightened economic insecurity. Additional analysis of 2016 PSS data can help shed light on the choice many women face – between staying in a violent situation or poverty (Box 1).

Box 1: The choice between violence or poverty

Financial implications have been reported by single mothers as a reason for returning to a previous violent partner following a temporary separation. The Summers (2022) analysis of the 2016 PSS showed that of the 'single mothers' who had experienced previous partner violence, more than half (55%, or an estimated 92,600) had ever temporarily separated from the violent partner. Almost one-quarter (24%) of these women said they had returned to the violent partner because they had no money or financial support and 14% said they had nowhere else to go (Summers 2022).

The analysis also highlighted the financial issues experienced by single mothers following separation from a violent partner:

- 75% of single mothers who had moved out of the home when they separated from their most recently violent previous partner left behind property or assets.
- 50% of single mothers had government benefits as their main source of income.
- 60% of single mothers had one or more cash flow problems in the previous 12 months (for example, could not pay electricity, gas or telephone bills on time, sought financial assistance from friends or family) (Summers 2022).

The proportion of single mothers who relied on government benefits and had experienced cash flow problems was higher than for all other household groups, although high proportions were also reported for lone person households (Summers 2022).

Chapman and Taylor (2022) analysed the Household, Income and Labour Dynamics in Australia (HILDA) survey HILDA data from 2006 to 2019 to determine the equivalised household income (total annual income of all household members adjusted for the number and age of people the income supports) for women, including mothers, following separation from a partner. Findings indicated that after separation, all mothers experienced significant decreases in equivalised household income – around 20% on average. There was a much higher drop for mothers who were categorised as 'likely to have experienced partner violence' (36%) compared with mothers who were categorised as 'unlikely to have experienced partner violence' (20%). However, this finding should be interpreted with caution due to the small sample size for mothers 'likely to have experienced partner violence' (35 women) and the method used to categorise the experience of partner violence – respondents were asked whether they had experienced physical violence, not specifically whether it involved a domestic partner (Chapman and Taylor 2022).

The economic and financial impacts of violence – particularly those that result from separation – can also be experienced through changes to a person's housing situation or housing security.

What are some of the hidden costs of leaving a violent situation?

'Due to violence, we moved a number of times usually spending any bit of money we had in the process. Years later and we're about to face legal fees and potentially lose our home in the process. I feel for survivors who feel they have little choice but to return home to the perpetrator to feed their children. That is a reality for a lot of people. How much better would it be if we could offer some stability for survivors and some service options to help them heal. We might just break the cycle for the next generation.'

Jasmine

WEAVERs Expert by Experience

People fleeing violence in the home may seek assistance from specialist homelessness services (see **Housing** for more detail).

Long-term economic impacts for people who have experienced violence

For some people, the economic impacts of FDSV are lifelong. Children who experience violence may have impaired social, emotional, and educational functioning, which can be seen later in life by looking at main sources of income, their experiences of financial stress and reduced economic security (ANROWS 2018).

Income support

Data from the 2016 PSS are available to look at the types of income received by those who experienced abuse as children. These data show associations – rather than causal relationships – between child abuse and whether a person was receiving a government pension, benefit or allowance in 2016.

Child abuse in the PSS is measured as any physical and/or sexual abuse that occurred before the age of 15. These findings relate to all forms of child abuse, and are not limited to those experienced in an FDV context. Data are not yet available from the 2021–22 PSS to report on these characteristics.

People who experienced childhood abuse

were more likely to receive government income support

People who were abused as children were more likely to receive a government pension, benefit or allowance:

- 43% of women who were abused as children were receiving a government pension, benefit or allowance, compared with 34% of women who weren't abused as children
- 3 in 10 (31%) men who were abused as children were receiving a government pension, benefit or allowance, compared with 22% of men (ABS 2017).

Women who experienced childhood abuse had lower income compared with those who did not experience childhood abuse. The median gross personal weekly income was $767 for women who experienced childhood abuse and $863 for women who did not experience childhood abuse.

When children are unable to live safely at home, they may be placed in out-of-home care. Young people who are, or have been, in out-of-home care (OOHC), such as foster, relative/kinship or residential care, also face greater disadvantage and a higher risk of experiencing poor outcomes in key areas important to wellbeing (AIHW 2022, see Box 2).

Box 2: Income support receipt for young people transitioning from out-of-home care

An AIHW analysis of linked Australian Government (Centrelink) and state and territory out-of-home care (OOHC, excluding Queensland) administrative data, examined income support and other payment receipt characteristics for around 45,000 young people, born between 1990 and 2001, who had at least one OOHC placement lasting 7 or more days (the 'OOHC study population') (AIHW 2022). The linked data asset used for the study was created as a collaborative effort between the AIHW, and all states and territories (excluding Queensland).

Findings from the analysis show that young people in the OOHC study population were 3 times as likely to receive income support payments at ages 16–30 as the Australian population of the same age – about 3 in 5 (56%) compared with about 1 in 5 (18%), respectively. The OOHC study population were also up to 13 times as likely to receive Crisis Payment than the Australian population of the same age (AIHW 2022).

The findings highlighted that the OOHC study population are in need of income support for longer or are repeatedly moving in and out of income support into their late 20's, suggesting they are at increased risk of not being able to maintain ongoing employment. Further, despite income support payments generally declining to age 30, a considerable proportion of the OOHC study population were still receiving income support at age 30 – over 1 in 5 (22%) were receiving unemployment payments, 1 in 7 (14%) were receiving parenting payments and 1 in 7 (14%) were receiving disability support pension (AIHW 2022).

For more information, see Income support receipt for young people transitioning from out–of–home care 2022.

Financial stress

Financial stress indicators can be used to illustrate how a person experiences economic hardship. Financial stress is often associated with low income and can have severe short- and long-term consequences for individuals, families and the community. Financial stress can be a long-term, indirect, impact of violence.

In the 2016 PSS, financial stress is indicated through several measures, for example, by asking respondents if they had cash flow problems or whether they could raise a certain amount of money within a week. Data are not yet available from the 2021–22 PSS to report on these characteristics.

People who experienced childhood abuse were also more likely to experience financial stress as adults

Of women who experienced childhood abuse:

- 22% were unable to raise $2,000 within a week, compared with 13% of women who did not experience childhood abuse
- 31% had experienced one or more cash flow problem, compared with 15% of women who had not experienced childhood abuse (ABS 2017).

Of men who experienced childhood abuse:

- 14% were unable to raise $2,000 within a week, compared with 10% of men who did not experience childhood abuse
- 24% had experienced one or more cash flow problem, compared with 13% of men who had not experienced childhood abuse (ABS 2017).

Long-term economic and financial costs of sexual violence

The long-term costs associated with FDSV may vary across different types of violence. For sexual violence, data are available from the Australian Longitudinal Study on Women's Health (ALSWH) to estimate the economic and financial impacts of sexual violence over the life course (Box 3).

Box 3: A life course approach – using the Australian Longitudinal Study on Women's Health (ALSWH)

The Australian Longitudinal Study on Women's Health (ALSWH) is a longitudinal survey of more than 57,000 women that began in 1996. The ALSWH explores factors that influence health throughout the lifespan among women who are broadly representative of the entire Australian population. The study began with 3 cohorts of women born in 1973–78, 1946–51 or 1921–26; in 2012, a fourth cohort was added of women born in 1989–95.

In the ALSWH, participants were randomly selected from the Medicare database, except that women from rural and remote areas were sampled at twice the rate of women in urban areas, to ensure numbers were large enough for statistical comparison. Women in the study are sent surveys by mail every 3 years.

A life course approach to determining the prevalence and impact of family and domestic violence in Australia

A study conducted in 2022 analysed data from the ALSWH in relation to sexual violence. The analysis included measures of family and domestic violence, socio-demographic factors, financial outcomes, health behaviours, mental health, physical health and social support. Data on healthcare costs and mental health consultations were sourced from MBS and PBS datasets linked to ALSWH participant data, to investigate the associations between health service use and sexual violence.

Two key aims of the study were to: identify the impact of sexual violence on socio-economic factors over time, such as education, paid employment and financial stress; measure health

service use in relation to sexual violence, including costs of selected health services and satisfaction with general practitioner services.

For more information, see A life course approach to determining the prevalence and impact of sexual violence in Australia: Findings from the Australian Longitudinal Study on Women's Health.

Sexual violence and economic factors

Women across different age cohorts were 30–45% more likely to experience high financial stress if they had experienced sexual violence, compared with those had not experienced sexual violence

Data from the ALSWH are available to look at experiences of sexual violence and factors related to education and employment. Compared with women of the same age who did not experience sexual violence in their lifetime:

- women aged 24–30 in 2019 who had experienced sexual violence were 63% more likely to not have completed Year 12 and 7% less likely to be in full-time employment
- women aged 40–45 in 2018 who had experienced sexual violence were 46% more likely to not have completed Year 12 (Townsend et al. 2022).

Despite differences across cohorts, sexual violence was consistently associated with high financial stress over time for all three cohorts (women were 30–45% more likely to experience high financial stress if they had experienced sexual violence). Women were considered to have experienced high financial stress if they said that they had been 'very stressed' or 'extremely stressed' about money the 12 months prior to the survey (Townsend et al. 2022).

Sexual violence and health services

Data from the ALSWH show that across all cohorts, women who had experienced sexual violence had higher average annual costs for non-referred health services than women who had not experienced sexual violence. Non-referred services include those such as consultation with a general practitioner or registered doctor. This difference in annual cost also increased over time. There was higher uptake of at least one mental health consultation for women who had experienced sexual violence compared with those who had not experienced sexual violence. However, for women who had at least one mental health consultation, the total number of consultations and government-subsidised costs for mental health services were similar between women who had and had not experienced sexual violence (Townsend et al 2022).

Child abuse is associated with higher long-term costs

Previous studies using data from the ALSWH showed that women who had experienced childhood sexual abuse were more likely to have poor general health, and to experience

depression and bodily pain than those who had not experienced sexual abuse during childhood (Coles et al. 2018). Women who had experienced childhood abuse (including psychological, sexual and physical abuse) or household dysfunction during childhood (such as witnessing intimate partner violence) had higher long-term primary, allied, and specialist health-care costs, compared with women who had not had these experiences during childhood (Loxton et al. 2018).

Economy-wide impacts of FDSV

The cost of violence is borne by victim-survivors, perpetrators and the community. The direct cost of the health system, counselling and other related services, the justice system, and child and welfare support, as well as indirect costs, such as lost wages, productivity and potential earnings, are just a part of what societies pay for violence against women (Puri 2016). Globally, the cost of violence against women could amount to about 2% of gross domestic product – about the size of Canada's economy (Puri 2016).

Violence against women and children cost $22 billion in 2015–16

The Department of Social Services commissioned KPMG to calculate the economic impact of violence against women in Australia. KPMG used a broad definition of violence against women that included physical assault, sexual assault, emotional abuse and stalking by any type of perpetrator. KPMG estimated that, in 2015–16, violence against women and children cost Australia an estimated $22 billion. It based its estimates on the ABS 2012 PSS (KPMG 2016).

KPMG noted that four groups of women were underestimated in the PSS estimates: Aboriginal and Torres Strait Islander women, women with disability, pregnant women and women who are homeless. Accounting for these women may add another $4 billion (KPMG 2016).

The 2015–16 Australian cost estimates were divided into seven categories (Table 1).

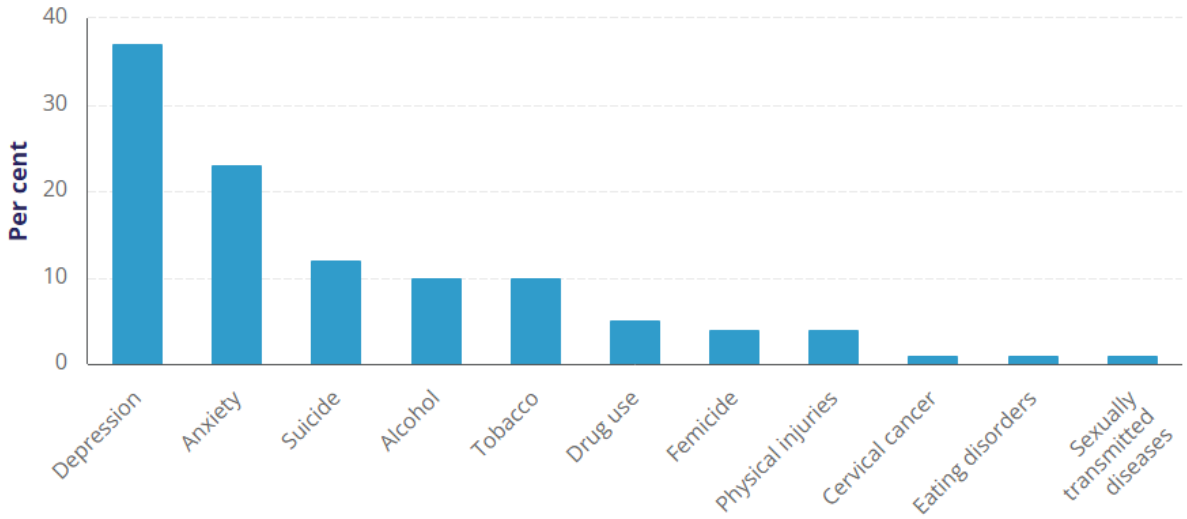
Table 1: Estimated costs to the Australian economy of violence against women and children, 2015–16

Categories	Cost ($)
Pain, suffering and premature mortality of victims The pain and suffering experienced by the victim, which can lead to long-term effects on psychological and physical health, and premature mortality for victims	10.4 billion
Consumption Replacing damaged property, defaulting on bad debts, and the costs of moving	4.4 billion
Production Being absent from work, and employer administrative costs (for example, employee replacement)	1.9 billion
Administrative	1.7 billion

Police, incarceration, court system costs, counselling, and violence prevention programs	
Transfer payments Loss of income tax of victims/survivors, perpetrators and employers; additional social welfare payments; victim compensation payments and other government services	1.6 billion
Health system Public and private health system costs associated with treating the effects of violence against women	1.4 billion
Second generation The costs of children witnessing and living with violence, including child protection services and increased juvenile and adult crime	333 million
Total	**21.7 billion**

Nearly half of the costs ($10.4 million) were linked to the ongoing effects of violence on women's physical and mental health. Depression and anxiety accounted for 60% of these health costs; substance abuse related to alcohol, tobacco and drug use accounted for 25%; and suicide 12% (Figure 1; KPMG 2016). The proportion of health costs attributed to depression and anxiety are consistent with research identifying mental health conditions as the largest contributor to the burden due to physical/sexual violence by an intimate partner (Ayre et al. 2016).

Figure 1: Cost impact of violence on women's physical and mental health, by health condition, 2015–16



Source: KPMG analysis of various data sources | **Data source overview**

Related material

- Health outcomes

- Financial support and workplace responses

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Family, domestic and sexual violence and COVID-19

This topic page examines the effects the COVID-19 pandemic had on FDSV in Australia using information available prior to 15 November 2023. Other topic pages in this website are regularly updated with data from a range of sources and may provide more recently available data. For more information, see the Release schedule.

Key findings

- Between 2016 and 2021–22 the proportion of women who experienced physical and/or sexual violence by a cohabiting partner decreased from 1.7% to 0.9%.
- The proportion of women and men who experienced emotional abuse by a cohabiting partner decreased between 2016 (women: 4.8%, men: 4.2%) and 2021–22 (women: 3.9%, men: 2.5%).
- Available data on FDSV service use during the pandemic show that the picture is mixed. Service use can change for several reasons, including due to public awareness campaigns or changes to availability or accessibility of services.

With ready access to vaccines and treatments, as well as high population immunity, Australia is no longer in the emergency phase of the COVID-19 pandemic response (DoHAC 2023). While the country has moved towards managing COVID-19 in a manner that is more consistent with other infectious diseases, we are still learning about the impact of the pandemic and related public heath responses on family, domestic and sexual violence (FDSV).

The effects of a pandemic can be wide-ranging with people experiencing different impacts depending on their situation. Situational stressors experienced during the pandemic may have influenced the severity or frequency of violence. For example, victims and perpetrators spending more or less time together, and increased financial or economic hardship (Payne et al. 2020). It is also possible that increased protective factors, such as access to income support, time away from a perpetrator, or increased social cohesion, could suppress violence (Diemer 2023). Pandemics may also impact how individuals respond to incidents of violence through the actions they take.

We continue to learn about the impact of the COVID-19 pandemic on FDSV. By improving our understanding of the short- and long-term impacts of the pandemic, we can better prepare for future pandemics and disaster events.

COVID-19 in Australia

In terms of morbidity and mortality, COVID-19 has had less of an impact on Australia than many other countries (OECD 2021). However, Australia has not been spared, with multiple waves of the disease having varying impacts across the states and territories (Box 1).

COVID-19 was first declared a human biosecurity emergency in March 2020, with the determination expiring in April 2022 (DoHAC 2022). During this time, the number of COVID-19 cases varied across age groups, with older people at greater risk of having poorer outcomes from COVID-19. Mortality rates were highest in people aged 80 years and over, with 30% of all COVID-19 deaths in Australia occurring in residents of aged care facilities (AIHW 2022).

While new variants, sub-variants and lineages are likely to continue to emerge, under the current approach to managing COVID-19 it is less likely that we will experience the public health restrictions associated with previous waves.

This page focuses primarily on FDSV during the emergency phase of the COVID-19 pandemic, including the prevalence of FDSV, service responses to FDSV and differences in experiences of FDSV across select population groups. More general information about the impact of COVID-19 on the Australian population can be found on the AIHW's COVID-19 page.

Box 1: Waves of COVID-19 in Australia

In Australia, the prevalence of COVID-19 has varied across the states and territories over time. The waves of COVID-19 are summarised below, including the main locations affected.

- The first wave occurred from March to April 2020 at the start of the pandemic, with cases in all states and territories.
- The second wave began in the winter of 2020, with most cases in Victoria.
- The third wave started in the winter of 2021 and daily case numbers started to decline from the end of October 2021. While most cases in the third wave were in New South Wales and Victoria, there was also a major outbreak in the Australian Capital Territory.
- The fourth wave started in December 2021 after the introduction of Omicron BA.1. It affected all jurisdictions. International and domestic border restrictions – and a suite of public health restrictions that continued into 2022 – resulted in a delayed but rapid progression of COVID-19 cases during March 2022 in Western Australia. The Omicron wave for Australia flattened from the end of January 2022 but increased again at the end of March 2022 when BA.2 became the dominant sub-variant.

Each wave was associated with a range of public health restrictions, which also differed across states and territories.

What do we know?

From the beginning of the pandemic in March 2020, a range of public health measures were implemented to limit the spread of COVID-19. These measures included stay-at-home orders, border closures, and restrictions on the way businesses, schools, residential aged care and public services operated. These had an effect on the community and economy, and resulted in significant changes to people's mobility, social interactions and home environments.

Within many households, individuals, couples and families had to deal with the additional pressures of job losses, increased financial stress, home-learning and added caring responsibilities (ABS 2021a; Hand et al. 2020). For some, the pandemic also had implications for alcohol use and mental health:

- 1 in 5 (20%) adults who usually drank alcohol said their alcohol consumption increased during COVID-19 restrictions, however between 13% and 27% said it had decreased (AIHW 2021a).
- The prevalence of 'severe' psychological distress in adults rose from 8.4% in February 2017 to 10.6% in April 2020, reaching a peak of 12.5% in October 2021– the highest level recorded since the onset of the pandemic (AIHW 2021b).

These factors, combined with increased social isolation and reduced access to sources of support, are not causes of FDSV themselves, but can be seen as situational stressors that can exacerbate the underlying drivers of violence and increase the likelihood, complexity and severity of violence (Boxall and Morgan 2021a; Peterman et al. 2020).

However, people experienced the pandemic in different ways. For some, the pandemic brought about a range of situations that may have decreased the likelihood of violence (Diemer 2023). For example, imposed social restrictions may have limited contact between victims and perpetrators if they were "locked down" in separate houses. The restrictions may have also resulted in fewer opportunities for victims to be approached by their perpetrators in the community, as attendance at venues and activities (for example, workplaces, children's sports events) was limited (Hegarty et al. 2022).

Similarly, while many households and businesses were strongly financially affected by the health restrictions (The Treasury 2021), some people reported that pandemic-related income support payments helped to reduce levels of financial stress (Botha, Butterworth and Wilkins 2022).

In a 2022 report, Australia's National Research Organisation for Women's Safety (ANROWS) presented results from a survey of over 1,000 women victim-survivors about their experiences of intimate partner violence. Qualitative questions explored how intimate relationships were affected during periods of COVID-19-related isolation (Hegarty et al. 2022). The responses below offer insight into some women's experiences during the pandemic:

"It was easier for my ex-partner to manipulate me when I was cut off from the outside world."

"[It's] definitely worse during lockdowns – he can still access alcohol/cigarettes and all the things that fuel his behaviour – I was not able to access any support to assist with being away from the abuse such as gyms, yoga class etc."

"I felt safer as I didn't need to go into my work premises where he (or his family/friends) could be … [and] I feel safer at home as I know I'm unlikely to be being watched." (Hegarty et al. 2022: 54-55).

A range of data sources can be used to understand the nature and extent of FDSV during the pandemic, and the demand for FDSV services. It is important to note that results from different sources, using different methods, are not comparable and need to be interpreted within the specific context they were collected.

Data sources for measuring FDSV during the COVID-19 pandemic

- ABS Personal Safety Survey
- ABS Recorded Crime – Offenders
- ABS Recorded Crime – Victims
- AIHW Child Protection National Minimum Data Set
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services Collection
- Kids Helpline
- Services Australia customer data – Crisis payments

For more information about these data sources, please see **Data sources and technical notes**.

What do the data tell us?

The following sections present a range of data collected during the pandemic. Data are primarily drawn from standard data collections, however the results of COVID-specific surveys are also included. Depending on data availability, analysis of FDSV data may focus on:

- national population prevalence data collected during the pandemic (March 2021 to May 2022), compared with previous survey year
- changes that occurred at the onset of the pandemic (March–May 2020) compared with previous years for the same month, to account for seasonal effects
- changes that occurred over the duration of the pandemic to date, to identify variations that may be associated with the waves of COVID-19 in Australia (Box 1)
- yearly data to provide context for overall changes in patterns of FDSV or service use over time.

Due to the differences in how states and territories have experienced the pandemic, data are presented by state and territory where appropriate. This information updates

and expands on the AIHW's Family, domestic and sexual violence service responses in the time of COVID-19 report.

How common was FDSV during the COVID-19 pandemic?

The proportion of women who experienced physical and/or sexual violence by a cohabiting partner decreased from **1.7%** to **0.9%** between 2016 and 2021–22

It is difficult to capture the full extent of FDSV, as incidents often occur behind closed doors, and can be concealed or denied by perpetrators and sometimes by the victims. In Australia, the Australian Bureau of Statistics' (ABS) Personal Safety Survey (PSS) is the source of national FDSV prevalence data for adults aged 18 years and over.

The most recent PSS was conducted between March 2021 and May 2022, during the COVID-19 pandemic (ABS 2023a). Key FDSV-related survey findings are presented in Table 1, showing the prevalence of select types of FDSV in the 12 months before the survey, compared with 2016 results.

Between 2016 and 2021–22 there was:

- a decrease in the proportion of women who experienced physical and/or sexual violence by a cohabiting partner
- a decrease in the proportion of women and men who experienced emotional abuse by a cohabiting partner
- no change in the proportion of women who experienced sexual violence
- a decrease in the proportion of men and women who experienced sexual harassment (ABS 2023a).

Note that due to data quality issues, data for men are not available in some instances.

Table 1: Select types of violence experienced by people in the 12 months before the Personal Safety Survey, by sex, 2016, 2021–22

	Prevalence rate[a]			
	Females		Males	
Type of violence	2016	2021–22	2016	2021–22
Sexual violence	1.8%	1.9%	*0.7%	n.p.
Intimate partner violence[b]	2.3%	1.5%^	1.3%	n.p.
Cohabiting partner violence[c] (Total)	1.7%	0.9%^	0.8%	n.p.
Cohabiting partner violence[c] – Physical violence	1.3%	0.7%^	0.8%	n.p.
Cohabiting partner violence[c] – Sexual violence	0.5%	0.4%	n.p.	–
Cohabiting partner emotional abuse	4.8%	3.9%^	4.2%	2.5%^
Sexual harassment	17.3%	12.6%^	9.3%	4.5%^
Stalking	3.1%	3.4%	1.7%	n.p.

*: Estimate should be used with caution because Relative Standard Error (RSE) is between 25% and 50%.

^: The difference in prevalence rate between 2021–22 and 2016 is statistically significant.

–: Nil or rounded to zero. Does not necessarily indicate a complete absence of the characteristic in the population.

n.p.: not published due to reliability and/or confidentiality reasons.

a. The proportion (rate) of people in each population that have experienced the selected type of violence in the last 12 months.

b. Physical or sexual violence by a cohabiting partner, boyfriend/girlfriend or date, and ex-boyfriend/ex-girlfriend.

c. Violence experienced by a partner the person lives with, or has lived with at some point, in a married or de facto relationship.

Source: ABS (2023a).

Using a different methodology to the PSS, findings from an online survey conducted by the Australian Institute of Criminology (AIC) indicated that the pandemic coincided with first-time and escalating intimate partner violence in Australia for some women (Table 2). The survey was completed by more than 10,100 women between 16 February 2021 and 6 April 2021 and asked about experiences of intimate partner violence in the 12 months before the survey.

Table 2: Intimate partner violence [(a)] experienced by women in Australia during the first 12 months of the COVID-19 pandemic

	Physical violence	Sexual violence	Emotionally abusive, harassing and controlling behaviours
Overall prevalence of intimate partner violence [(b)]	9.6%	7.6%	32%
Experienced intimate partner violence for the first time [(b)]	3.4%	3.2%	18%
Reported that intimate partner violence had increased in frequency or severity [(b, c)]	42%	43%	40%

(a) Violence from a person the respondent had a relationship with during the previous 12 months. This includes current and former partners, cohabiting, or non-cohabiting.

(b) Of women aged 18 years and older who had been in a relationship longer than 12 months.

(c) Of women who had a history of violence from their current or most recent partner.

Source: Boxall and Morgan 2021a.

What were the service responses to FDSV during the COVID-19 pandemic?

Between 2020 and 2022, there were numerous reports of increased demand for services related to FDSV (for example, Pfitzner et al. 2020; Carrington et al 2021). These reports drew from data sources that include police, domestic violence helplines, specialist crisis services and workforce surveys. FDSV services span a number of sectors and the introduction of COVID-19 restrictions had differing impacts on the availability and accessibility of these services (Box 2).

Box 2: How has COVID-19 affected FDSV services?

The COVID-19 pandemic has affected the way FDSV services are delivered. For example, the move towards remote working in some services may have led to face-to-face contact being replaced by telephone, videoconferencing or other online contact. Changes in how FDSV services were provided increased the complexity of delivering some forms of service or support, particularly for select population groups (Carrington et al. 2021). However, for some people it improved the accessibility of services.

When considering changes in FDSV-related service use, it is important to be aware that changes in service use may be due to a combination of factors. For example, an increase in service use may be a result of increased availability of services, increased awareness of services and FDSV in general, and/or increased need for services (AIHW 2019).

Note that data on service use capture only part of the picture. A large proportion of FDSV goes undisclosed and may never enter into view of services. COVID-19 restrictions can make it more difficult for victims and survivors to seek assistance or leave abusive relationships and this may not be reflected in the data.

Helplines

Helplines are an important point of contact for those experiencing family and domestic violence. For more information, see **Helplines and related support services**.

During the COVID-19 pandemic, helplines were especially important as they provide options to seek help without leaving the home.

Kids Helpline counselling contacts increased at the onset of the pandemic

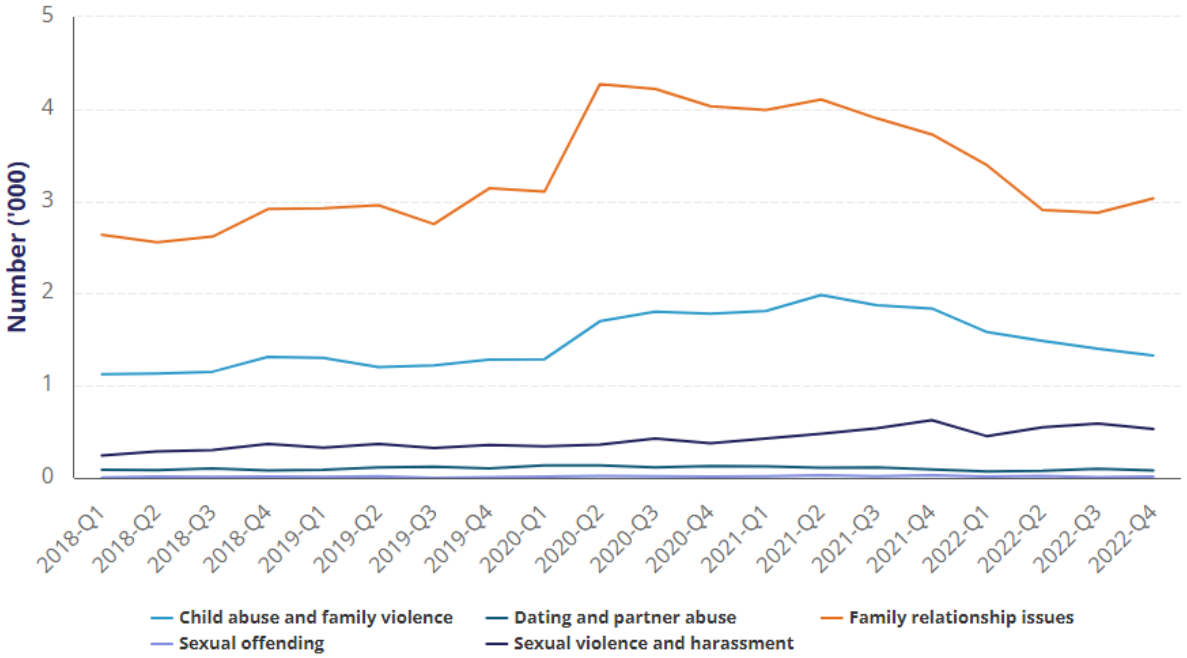
Kids Helpline provides support and counselling for children and young people aged 5 to 25. Children and young people contact Kids Helpline about diverse issues, including child abuse, family and relationship issues, and forms of sexual harassment and abuse.

As shown in Figure 1, data on counselling contacts indicates that after the onset of COVID-19, there was:

- an increase in the number of family relationship concerns being discussed (44% change from Q2 2019 to Q2 2020), and another peak around the beginning of wave 2. From 2022, the number of family relationship concerns being discussed during counselling contacts appeared to be trending back towards pre-pandemic numbers.
- an increase in the number of child abuse and family violence concerns being discussed (41% change from Q2 2019 to Q2 2020). The number of concerns discussed during counselling contacts peaked at 1,985 contacts in the second quarter of 2021 (around the beginning of wave 2) with numbers getting closer to pre-pandemic levels in 2022.
- the number of sexual violence and harassment (including child sexual abuse) concerns being discussed increased slightly in 2020 compared to 2019. The number of concerns being discussed during counselling contacts peaked in the fourth quarter of 2021 at 626 calls.

- the number of concerns related to dating and partner abuse being discussed during counselling contacts remained relatively steady throughout the pandemic.

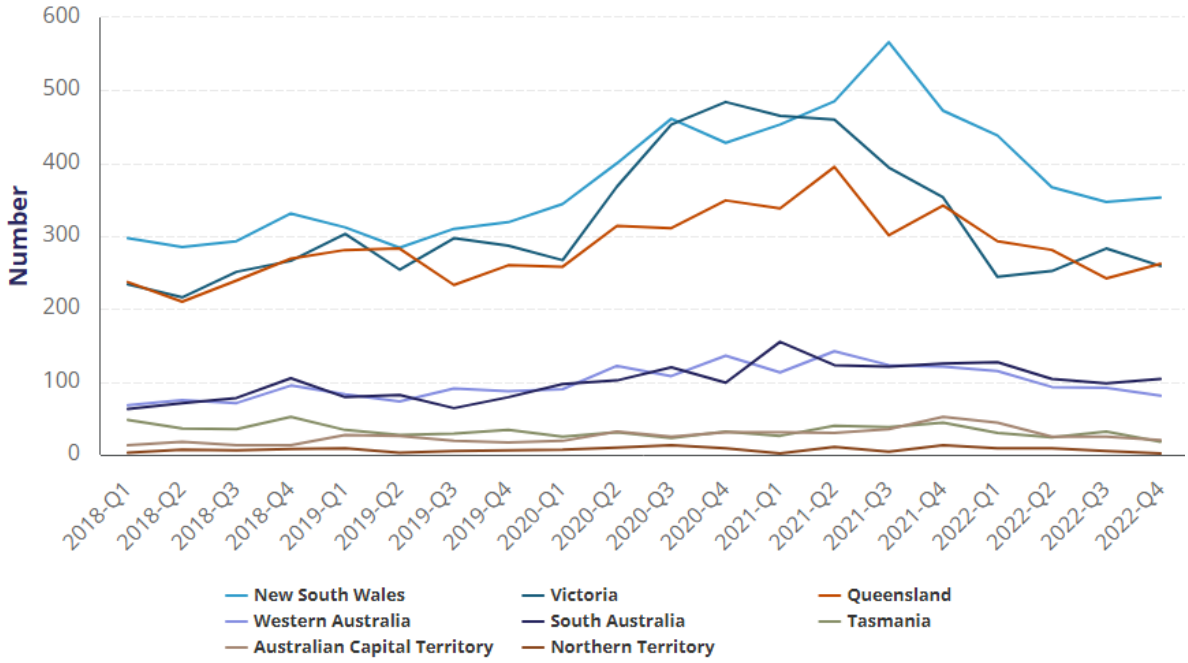
Figure 1: Number of FDSV-related concerns discussed during Kids Helpline counselling contacts, January 2018 to December 2022



Source: Kids Helpline (unpublished data) | **Data source overview**

Figure 2 shows the number of Kids Helpline counselling contacts where child abuse and family violence were discussed, by states and territories. Contacts related to child sexual abuse are included in these counts. The time series shows that patterns in the number of contacts varied across states and territories.

Figure 2: Number of child abuse and family violence concerns discussed during Kids Helpline counselling contacts, states and territories, 2018 to 2022



Source: Kids Helpline (unpublished data) | **Data source overview**

Kids Helpline also provides emergency responses for children and young people. Emergency responses involve contacting emergency services or another agency to protect a young person who is experiencing, or is at imminent risk of, significant harm. In 2021, average daily emergency responses increased in states and territories experiencing lockdowns. For example, in NSW there were 2 additional emergency responses, on average, each day during lockdown (YourTown 2021).

Child protection

The child protection system aims to protect children from maltreatment in family settings. For more information, see **Child protection**.

The COVID-19 pandemic may have affected child protection processes, and changes to people's mobility and interactions may also have affected the way child maltreatment was detected or reported (AIHW 2021c).

At the same time, the pandemic affected the way families live and work. Several risk factors for child maltreatment increased during COVID-19, including financial hardship, housing stress, and poor mental health. Access to support networks may also have been limited during this time.

Data from the child protection system are available between March and August 2020 to show changes at the onset of the pandemic, including the first and part of the second wave of COVID-19 in Australia. Key findings include:

- Child protection notifications fluctuated considerably between March and August 2020, and patterns varied across jurisdictions. A common pattern observed in most jurisdictions was a drop in notifications in April 2020 (during the initial COVID-19 restrictions) followed by an increase in May or June (once restrictions had eased).
- The number of substantiations recorded each month remained relatively stable from March to August 2020 for all jurisdictions (data were not available for Tasmania). However, the total number of substantiations for the 6-month period varied across jurisdictions (AIHW 2021c).

The AIHW's Child protection in the time of COVID-19 report provides more detail on the impact of the early stages of COVID-19 observed in child protection data. While the long-term impact of COVID-19 on child protection processes is still unknown, there have been no specific impacts on the annual data.

Specialist homelessness services

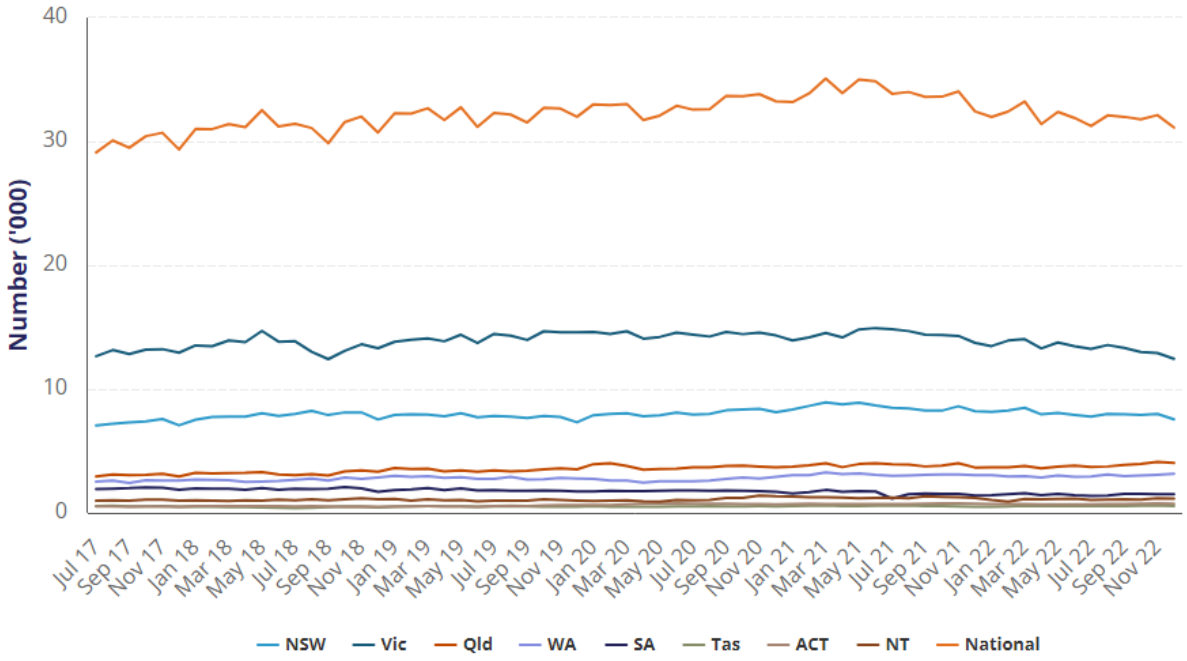
Family and domestic violence is the most common main reason clients seek assistance from specialist homelessness services (SHS). For more information, see **Housing**.

A nationwide survey of service providers highlighted that public health responses during the COVID-19 pandemic often made it harder for victim-survivors to leave a violent relationship, due to travel restrictions, lack of transport options, and difficulty accessing formal and informal support. Financial stress also meant that victim-survivors may no longer be able to afford rent, leading to increased housing instability (Morley et al. 2021). In recognition of the increased pressure on homelessness services during the pandemic, some governments invested additional funding to increase the operational capacity of these services (for example, Williams 2020).

The number of SHS clients who have experienced FDV peaked around the third wave of COVID-19

The number of SHS clients who have experienced family and domestic violence was similar in April 2020 compared with previous years (Figure 3) (AIHW 2021d). Over the 5 years to December 2022, the monthly number of FDV clients receiving assistance from SHS peaked around the winter of 2021, around the time of the third wave of COVID-19. However, the number of SHS clients who received support changes from one month to the next for many reasons and are not necessarily due to changes in demand.

Figure 3: Number of FDV clients receiving assistance from SHS, July 2017 to December 2022



Source: AIHW SHSC | **Data source overview**

Government payments

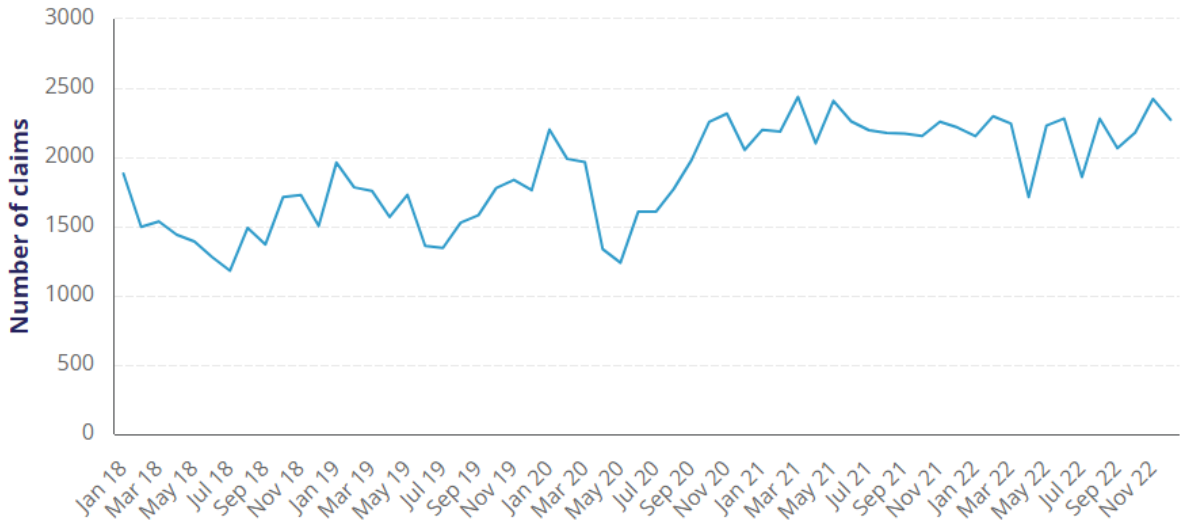
People who are in severe financial hardship and have experienced changes in their living arrangements due to family and/or domestic violence, and are receiving, or are eligible to receive, an income support payment or ABSTUDY Living Allowance, may receive a one-off Crisis Payment. For more information, see **Financial support and workplace responses**.

Number of FDV Crisis Payments granted fell at the onset of the pandemic

Overall, the number of claims for FDV Crisis Payments granted annually rose between 2018 and 2021, with a small decrease in 2022. The highest number of claims granted per month was in March 2021 at just over 2,400 claims.

The number of FDV Crisis Payment claims granted was lower in April and May 2020 compared with the same period in previous years (see Figure 4). There were 1,337 claims granted in April 2020, compared with 1,569 in April 2019 and 1,441 in 2018. Similarly, the number of claims granted in May 2020 (1,239) was lower compared with 2019 (1,730) and 2018 (1,392).

Figure 4: Number of claims granted for FDV Crisis Payments, monthly, January 2018 to December 2022



Source: Services Australia customer data (unpublished) | **Data source overview**

Hospitalisations

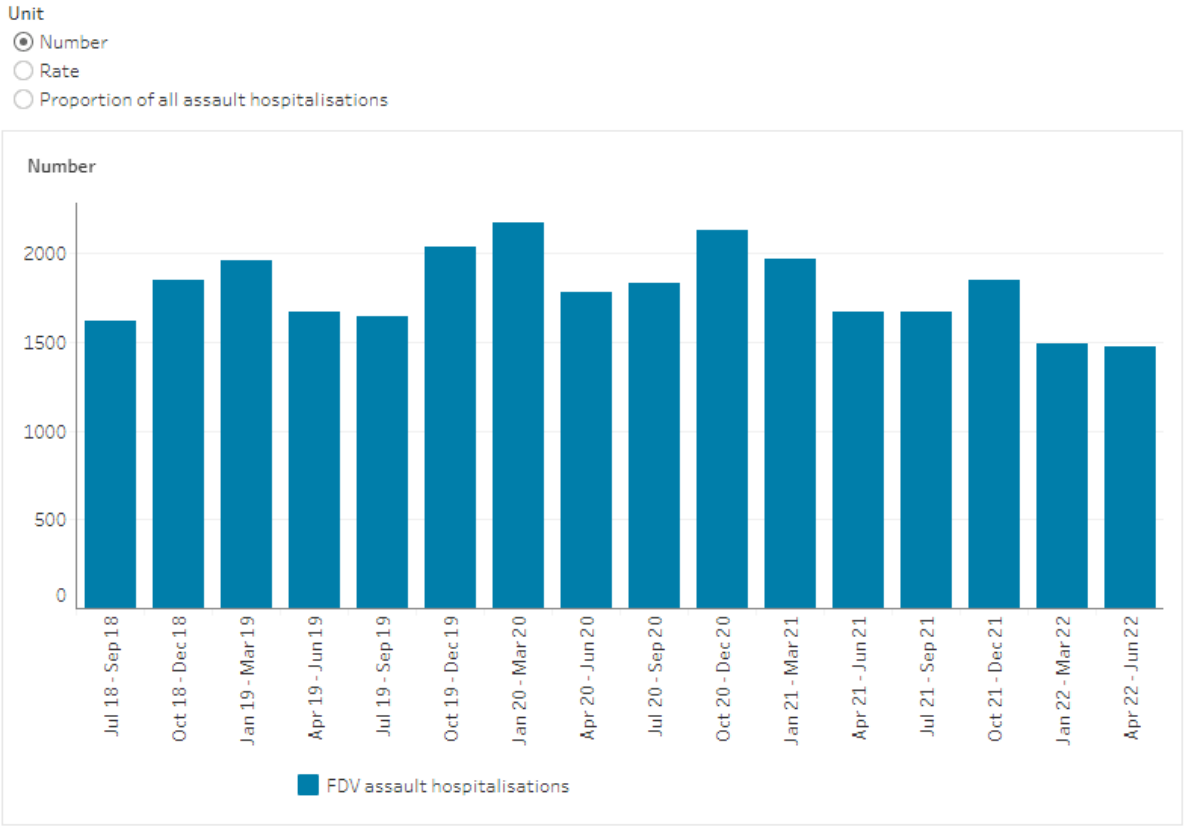
People who experience FDV-related assault (assault where the perpetrator was identified as a spouse or domestic partner, or other family member) may be admitted to hospital to receive care (hospitalisations). Data are available from the AIHW National Hospital Morbidity Database to report on FDV-related assault hospitalisations, by financial year. However, these data do not include presentations to emergency departments and will relate to more severe (and mostly physical) experiences of FDV (AIHW 2019). For more information, see **Health services**.

Rates of FDV-related injury hospitalisations fluctuated over time, with some seasonal fluctuations – highest in the October-December and January-March quarters – of each financial year (see Figure 5).

Between July 2018 and June 2022:

- the highest number of FDV-related injury hospitalisations per quarter was 2,174 in the first quarter of 2020 (January – March)
- FDV-related assault injuries made up a greater proportion (38%) of total assault injuries in the second quarter of 2020 (April – June) than in any other quarter (AIHW 2023).

Figure 5: FDV-related assault hospitalisations, 2018–19 to 2021–22



Source: AIHW NHMD. https://www.aihw.gov.au

Police

Police responses to family, domestic and sexual violence are recorded in the ABS Recorded Crime–Victims, 2022 and ABS Recorded Crime–Offenders, 2021–22 collections. These data are not available by month, but the data over a 12-month period can be used to show general patterns in police responses over time. Changes in crime rates may be due to a range of factors, such as changes in reporting behaviour, increased awareness about forms of violence, changes to police practices, and/or an increase in incidents. In the context of the pandemic, research indicates that the likelihood of reporting intimate partner violence to police also varies according to the individual, the relationship, and abuse characteristics (Morgan et al. 2022). For more information, see **FDSV reported to police**.

Overall, the number of victims recorded by police for sexual assault and FDV-related assault (for the states and territories where data are available) have increased over time. In 2022, the number of victims of sexual assault was the highest number recorded across the 30-year time series. Table 3 shows the number of FDSV-related assaults in 2019, 2020, 2021 and 2022. For FDV-assaults overall, the Northern Territory had the greatest percentage increase between 2019 and 2022 (69%), while the ACT showed the only decrease (-0.1%) (ABS 2023b).

Table 3: Number of FDSV-related assaults, by type of assault, 2019–2022

Type of violence	2019	2020	2021	2022
Sexual assault	26,860	27,538	31,074	32,146
FDV-related sexual assault	8,985	10,175	11,362	11,676
FDV-related assault*	64,969	70,028	72,461	76,862

* Data on FDV-related assault are not available for Victoria or Queensland.

Source: ABS (2023b).

Over the same period, the number of FDV offenders proceeded against by police varied across states and territories (see Table 4).

- Between 2018-19 and 2021-22, the number of offenders proceeded against for an FDV-related offence increased across most states and territories, with the greatest overall increases in Queensland (33%) and New South Wales (18%).
- A reduced number of offenders proceeded against by police was recorded in South Australia (-11%) between 2019–20 and 2021–22 and in Western Australia (-9.2%) between 2018–19 and 2021–22 (ABS 2023c).

Table 4: Number of FDV offenders proceeded against by police, by states and territories, 2018–19 to 2021–22.

	2018–19	2019–20	2020–21	2021–22
NSW	26,209	27,525	29,903	31,008
Vic	16,210	16,925	17,448	17,169
QLD	13,136	13,899	15,730	17,412
SA	np	4,963	4,970	4,401
WA	7,636	7,588	7,417	6,930
Tas	1,321	1,337	1,437	1,471
NT	2,672	2,605	3,080	2,919
ACT	554	584	510	565

Source: ABS (2023c).

For context, the number of offenders proceeded against Australia-wide for any offence decreased each year since 2018–19. Further, it is important to note that FDV statistics from the ABS Recorded Crime–Offenders collection are experimental, with further assessment required to ensure comparability and quality of data.

Is it the same for everyone?

Looking at the experiences of FDSV across different population groups during the pandemic can help us understand who is most affected. While the impact of the pandemic is not yet fully understood, research in the early stages of the pandemic identified a number of population groups that may be at higher risk of experiencing FDSV during the pandemic.

In May 2020, the AIC published the results of an online survey of 9,300 women aged 18 and over who had been in a relationship in the 12 months prior to the survey (Boxall and Morgan 2021b). The study found several population groups had an increased likelihood of experiencing domestic violence in the 3 months prior to the survey. Select findings are summarised below:

	First Nations respondents were more likely than non-Indigenous respondents to experience physical/sexual violence (4 times as likely) and coercive control (5 times as likely)
	Women with a restrictive long-term health condition were more likely than women who did not have a health condition to experience physical/sexual violence (3 times as likely) and coercive control (3 times as likely)
	Women aged 18-24 years were more likely than women aged 55 years and over to experience physical/sexual violence (8 times as likely) and coercive control (6 times as likely)
	Pregnant women were more likely than other women to experience physical/sexual violence (3 times as likely) and coercive control (2.5 times as likely).

For more information on coercive control, see **Coercive control**.

Women with higher levels of financial stress were more likely to experience intimate partner violence

In February 2021, the AIC published the results of an online survey of more than 10,000 women aged 18 and over who had been in a relationship in the 12 months prior to the survey. The survey explored the relationship between economic insecurity and intimate partner violence (IPV) (Morgan and Boxall 2022).

The study identified that compared to women who reported low levels of financial stress, those women who reported high levels of financial stress were:

- 3 times as likely to experience physical violence
- 3 times as likely to experience sexual violence

- 2.6 times as likely to experience emotional abuse.

The study also found that compared to women who said their partner was the main income earner or they had comparable income, those women who were the main income earner were:

- 1.7 times as likely to experience physical violence
- 1.6 times as likely to experience sexual violence
- 1.5 times as likely to experience emotional abuse.

Related material

- Services responding to FDSV
- Helplines and related support services
- FDSV reported to police
- Health services
- Housing
- Child protection

More information

COVID-19

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