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NSW Health Strategy for Preventing and Responding to Domestic and Family Violence

2021-2026

Contents

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September 2021

Message from the Secretary

Everyone deserves a life free from domestic and family violence and its adverse effects. I am pleased to introduce the NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026. It provides strategic direction and guides practical action for NSW Health over the next five years to strengthen the public health system's role in preventing and responding to domestic and family violence.

This strategy was developed through a partnership between local health districts (districts), specialty health networks (networks), the Ministry of Health, NSW Health Pillars, and partner agencies. It closely aligns to ***NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework*** and the NSW Government's Domestic and Family Violence Blueprint for Reform and reflects a range of work already underway across the system and new actions to address domestic and family violence.

Domestic and family violence is a significant public health issue that occurs across all ages and socioeconomic and demographic groups, but disproportionately impacts on the health of women, children, and their families. The profound health effects of domestic and family violence and NSW Health's role in the provision of universal health services mean that health professionals are well placed to respond to domestic and family violence across the public health continuum of primary, secondary, and tertiary intervention.

Releasing this strategy during the COVID-19 pandemic, which has elevated the risk to victims and increased the barriers to seeking help, adds to the impetus for reform and NSW Health's commitment to specific action in this area. As clinicians and managers in our public health system, we all need to ensure that domestic and family violence victims can access the critical support and services they need, through the pandemic and beyond.

I encourage you to use the strategy to review, plan, and deliver improved services for people who have experienced domestic and family violence, and contribute to NSW Health's prevention efforts in this area and role in the multi-agency response.

Elizabeth Koff
Secretary, NSW Health

Statement of commitment to Aboriginal families and communities

Aboriginal people are the first peoples of Australia and are part of the longest surviving culture in the world. With more Aboriginal people living in NSW than in any other Australian state or territory, improving the health and wellbeing of Aboriginal communities is a key focus for the NSW Government. It is the resilience of Aboriginal people that provides the very foundation upon which further efforts to improve Aboriginal health and wellbeing can be made.[1]

The consequences of colonisation as well as social determinants of health, such as education, employment, and housing, have had a devastating impact on the social, emotional, economic, and physical living conditions of Aboriginal people for more than 200 years. These factors continue to directly contribute to the health disparities experienced by many Aboriginal communities, and the significant over-representation of Aboriginal children and young people in the statutory child protection system.

Aboriginal family violence can only be understood in the context of the ongoing effects of violent colonisation, dispossession, and devastation of families through the removal of children. Flowing from the resulting intergenerational trauma and cumulative harm from this institutional violence, Aboriginal women are over-represented as victims of domestic and family violence and experience greater health impacts. An appreciation of these factors is critically important to closing the health gap between Aboriginal and non-Aboriginal people and achieving a significant and sustained reduction in violence and abuse against Aboriginal and Torres Strait Islander women and children towards zero.

NSW Health recognises that Aboriginal health encompasses not only the physical

wellbeing of an individual, but also the social, emotional and cultural wellbeing of the whole community within which each individual is able to achieve their full potential as a human being.[2] As such, there exists an appreciation that the health of each individual is inextricably linked to the health and wellbeing of the wider community.

Aboriginal children and young people, like non-Aboriginal children and young people, are vulnerable to the impact of trauma through direct exposure to accident, family violence and abuse.[3] In addition to this, it is important to acknowledge that the individual and collective experiences of trauma from historical events associated with the colonisation of Indigenous land and genocide can be profound.

The passing of trauma legacies through generations to children is commonly known as intergenerational trauma. Although the effects of childhood trauma can be severe and long lasting, recovery can be mediated by interventions that nurture the spirit, resilience and cultural identity of Aboriginal families and communities. Genuine appreciation and understanding of the impact of power dynamics, the importance of Aboriginal worldviews, and the limitations of Western approaches in the assessment and treatment of trauma is central to demonstrating respect for the lived experiences of Aboriginal people.

NSW Health is committed to improving the health and wellbeing of Aboriginal families and communities in NSW by supporting the ongoing efforts of Aboriginal people and their communities in reducing the impact of the social determinants of health, and the effects of individual and collective trauma legacies. NSW Health recognises the significance of family and community to identity and is committed to Aboriginal families being connected and determining their own futures.

Key terms

Term	Definition
Aboriginal Family Wellbeing and Violence Prevention workforce	Aboriginal-identified positions providing individual, family and community support activities, including initial crisis support, advocacy, and referral, specifically addressing family violence, sexual assault, and child abuse.
ACCHS	Aboriginal Community Controlled Health Services.
Adverse Childhood Experiences (ACEs)	Adverse childhood experiences are potentially traumatic events that occur in childhood. For example: experiencing violence, abuse, or neglect; witnessing violence in the home or community; or having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with: substance misuse; mental health problems; or instability due to parental separation or household members being in prison.
Bilingual Community Educators (BCE)	Work to improve health literacy and increase access to health services by people from culturally and linguistically diverse (CALD), migrant and refugee communities.
Burden of disease	Burden of disease studies measure the combined impact of living with illness and injury and dying prematurely on a population.
Case-finding or clinical enquiry	The identification of women experiencing violence who present to health-care settings through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient.
Clinical supervision	The purpose of clinical supervision is to support workers to provide high-quality care that is safe, confidential, and empowering for people and their families. It encourages workers to reflect on their professional practice and build their skills in working with complex issues of interpersonal violence, while also promoting awareness of the impact of vicarious trauma and strategies that strengthen worker and agency resilience.
Coercive control	Refers to both physical and non-physical actions that constrain the behaviour of others, undermining their liberty, self-determination, and the choices that they can make, and attacking their quality of life and physical and emotional safety.
Complex trauma	In contrast to 'single incident' trauma, complex trauma is cumulative, repetitive, and interpersonally generated, and includes ongoing abuse that occurs in the context of the family and intimate relationships.

Term	Definition
Cultural safety	Cultural safety is a concept that aims to recognise, respect and nurture the unique cultural identity of a person in order to create safety for them and meet their needs, expectations and rights.
Domestic and family violence (DFV)	This document adopts the NSW Government's shared policy definition: Domestic and family violence is defined to include any behaviour in an intimate or family relationship that is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour. An intimate relationship refers to people who are (or have been) in an intimate partnership, whether or not the relationship involves or has involved a sexual relationship — i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, or who are dating. A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, or sibling and extended family relationships. It includes the full range of kinship ties in Aboriginal and Torres Strait Islander communities, extended family relationships, and of family within communities of people with diverse sexualities, gender identities and those with intersex variations. People living in the same house, people living in the same residential care facility and people reliant on care may also be in a domestic relationship if their relationship exhibits dynamics that may foster coercive and abusive behaviours.
ECAV	***Education Centre Against Violence, NSW Health***
HETI	***Health Education Training Institute (NSW Health Pillar)***
Intergenerational trauma	The transmission of trauma and its negative consequences across generations. Intergenerational trauma can impact individuals, families, and communities.
Intimate partner violence	Terminology used in the public health literature to describe a pattern of sustained coercive and controlling behaviours in intimate partner relationships and after separation. Often used interchangeably with the term domestic violence.
LHD	***Local health district*** (district). NSW Health has 15 local health districts across NSW.
Life course approach	The life course approach focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime.
Medical Forensic Associate	Medical Forensic Associates are doctors or nurses who provide trauma-informed medical care to victims of violence, abuse and neglect through forensic evidence documentation and evidence

Term	Definition
	preservation as well as support for specialist medical forensic examinations.
Our Watch	***Our Watch*** provides national leadership to prevent all forms of violence against women and their children.
People with diverse sexualities, gender identities and those with intersex variations	This reference is used collectively to represent the communities who identify as lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual, questioning and others.
Person-centred care	Care that focuses on the views of individuals, carers, and families as participants in the health system. It considers the needs of people rather than individual diseases and respects social preferences and encourages choice in decision making.
Safer Pathway	The system-wide, service system infrastructure for domestic and family violence victims in NSW that aims to ensure that all victims receive a timely, effective and consistent response. Core components include: a common risk assessment tool; a single contact point for victims to access support; and sharing key information and working together to provide victims at serious threat with a targeted, priority response.
Safe Wayz	A NSW Health program, to be launched in 2021, responding to children under the age of criminal responsibility with problematic and harmful sexual behaviours. Safe Wayz is based on a public health model and includes prevention, early support and therapeutic treatment for problematic and harmful sexual behaviours.
Safety Action Meeting (SAM)	Fortnightly meetings, an element of Safer Pathway, attended by government agencies and local service providers to coordinate service responses for victims rated at serious threat.
Secondary trauma or re-traumatisation	The term 'secondary trauma' or 're-traumatisation' refers to experiences that occur after an initial trauma, because of that event or the subsequent actions or inactions of others.
Sexual assault service (SAS)	NSW has a network of ***Sexual Assault Services (SAS)*** delivered through every Local Health District in NSW (see full list here). SAS provide crisis and ongoing counselling, medical care, medical forensic examinations, advocacy, court support and community education. SAS primarily work to support the health and wellbeing needs of people who experience sexual assault and their families/ significant others, and also support the collection of evidence for possible criminal investigations. There is at least one SAS in each District offering the full range of services 24 hours a day, seven days a week. In addition to the network of SAS around the state, there are three Child Protection Units in NSW which provide crisis and ongoing counselling, medical and forensic services and support to victims of sexual and physical abuse and neglect under the age of 18 years and

Term	Definition
	their non-offending family members.
Social entrapment	A way of understanding the dynamics and effects of coercive control in intimate partner violence. It has three dimensions: the social isolation, fear and coercion that the abusive partner's violence creates in the victim's life; the indifference of powerful institutions to the victim's suffering; and the ways in which coercive control (and the indifference of powerful institutions) can be aggravated by the structural inequities of gender, class and racism.
SHN	***Specialty health network*** (network). NSW Health has three speciality health networks.
Trauma-specific services	Treatment approaches and services that provide clinical interventions designed to address trauma-related symptoms, offered within a trauma-informed service context.
Vicarious trauma	Vicarious trauma is the experience of symptoms similar to those who have experienced trauma directly, as a result of indirect exposure via close contact with survivors or exposure to traumatic materials.
Vicarious resilience	Vicarious resilience is the positive impact on, and personal growth of, workers resulting from exposure to their clients' resilience.
Victim	The term victim is used for brevity and refers to a 'person who has experienced domestic and family violence'. This gender-neutral term is used in recognition that NSW Health services are available to anyone who has experienced domestic and family violence regardless of their gender. The term victim/survivor is used in to recognise that harm has been done, but that victimisation does not tell the whole story of the person and their resistance to coercive control.
Violence, abuse and neglect (VAN) services	NSW Health services that provide dedicated responses to violence, abuse and neglect generally or a specific form (e.g. sexual assault).
WHO	***World Health Organization***

Overview

Playing our part

The ***NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026*** provides strategic direction and guides action for NSW Health over the next five years to strengthen the public health system's role in preventing and responding to domestic and family violence. It recognises that all staff in the health system are likely to encounter people experiencing domestic and family violence in the course of their work.

This strategy is closely aligned to NSW Health's ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework*** and is intended to help realise NSW Health's vision that:

All children, young people, adults and their families are supported by the public health system to live free of violence, abuse and neglect and their adverse impacts.

This strategy identifies actions to ensure NSW Health staff have the support they need from the public health system to prevent, respond to, and ameliorate the harmful effects of domestic and family violence (DFV). It also describes action needed to provide the statewide and local policies and procedures, resources and training that will support health services and staff in this important work.

The complex challenges and urgency of responding to domestic and family violence require partnerships across all levels of the government, non-government, and community sectors. The NSW Government's integrated, whole-of-government plan, ***Domestic and Family Violence Blueprint for Reform 2016-2021: Safer Lives for Women, Men and Children***, identifies six priority areas for action. NSW Health is committed to playing its part in the integrated multi-agency response to domestic and family violence. The strategic directions in this document are linked to each of these priority areas for action.

The NSW Health response

Domestic and family violence is an urgent public health issue that has multiple and serious health impacts. Effective health interventions that focus on safety and recovery are important for ameliorating its impacts and improving the outcomes for people affected.

At the heart of NSW Health's response are the violence, abuse and neglect (VAN) services, including the Aboriginal Family Wellbeing and Violence Prevention workforce, which provide specialist, trauma-specific services, and the broader psychosocial workforce, including social workers, for whom responding to domestic and family violence is a significant part of their role. These specialist services support broader health responses to domestic and family violence that are safety-focused and trauma-informed.

The health system also plays a vital role in primary and secondary prevention of domestic and family violence through the provision of universal health services at key life stages, such as the support provided to families to ensure that children have the best start in life in the ***First 2000 Days Framework***.

Health services: uniquely placed to make a difference

The effects of domestic and family violence on physical and mental health result in high use of health care by people experiencing the violence, making health services an important gateway to care.[4] Many clients of health services, such as mental health and alcohol and other drugs (AOD services) have current or past experiences of domestic and family violence but may not have made the link between their experiences and their health issues. Health professionals with an understanding of violence and its effects can offer trauma-informed responses that can broaden possibilities for recovery and reduce ongoing harm.

This strategy supports the health workforce to take up these opportunities to respond in ways that contribute to the safety and recovery of adults, children and young people who have been harmed by domestic and family violence. It also supports a system response that embeds perpetrator accountability in all health service delivery where a client is experiencing or perpetrating domestic and family violence.

Scope

This strategy adopts the NSW Government's definition of domestic and family violence, which includes violence and abuse across a broad range of intimate, family, and domestic relationships. This is important for building a shared understanding of domestic and family violence across all agencies and recognises that domestic and family violence can occur in every type of relationship and at any stage of life. At the same time, most service development and research primarily address intimate partner violence (IPV), the most common form of domestic and family violence.

The focus on IPV aligns with Australia's ***National Plan to Reduce Violence against Women and their Children 2010-2022***. Consistent with a public health approach, which focuses systematic interventions where the risk is highest, NSW Health adopts a gendered approach to intimate partner violence since women comprise the majority, though not all, of the victims of this form of domestic and family violence. Hence when specifically discussing IPV, this strategy uses gendered language. This strategy also recognises that gender intersects with other forms of social inequality, resulting in a higher risk of either experiencing IPV or severity of impacts for certain social groups that are designated priority populations for health intervention.

NSW Health recognises that patients and clients of the public health system may have experienced trauma from multiple different forms of violence and abuse. This strategy is focused on domestic and family violence and the related forms of interpersonal violence that are covered by NSW Health's violence, abuse and neglect services (i.e. domestic and family violence, sexual assault and all forms of child abuse and neglect, children and young people displaying problematic sexual behaviour or engaging in harmful sexual behaviour). Other forms of violence and abuse — for example, abuse in residential care settings or paid carers within the home against older people or people with disability, or state-inflicted torture and oppression experienced by refugees and migrants before arrival in Australia — are responded to in other NSW Health strategies and actions.

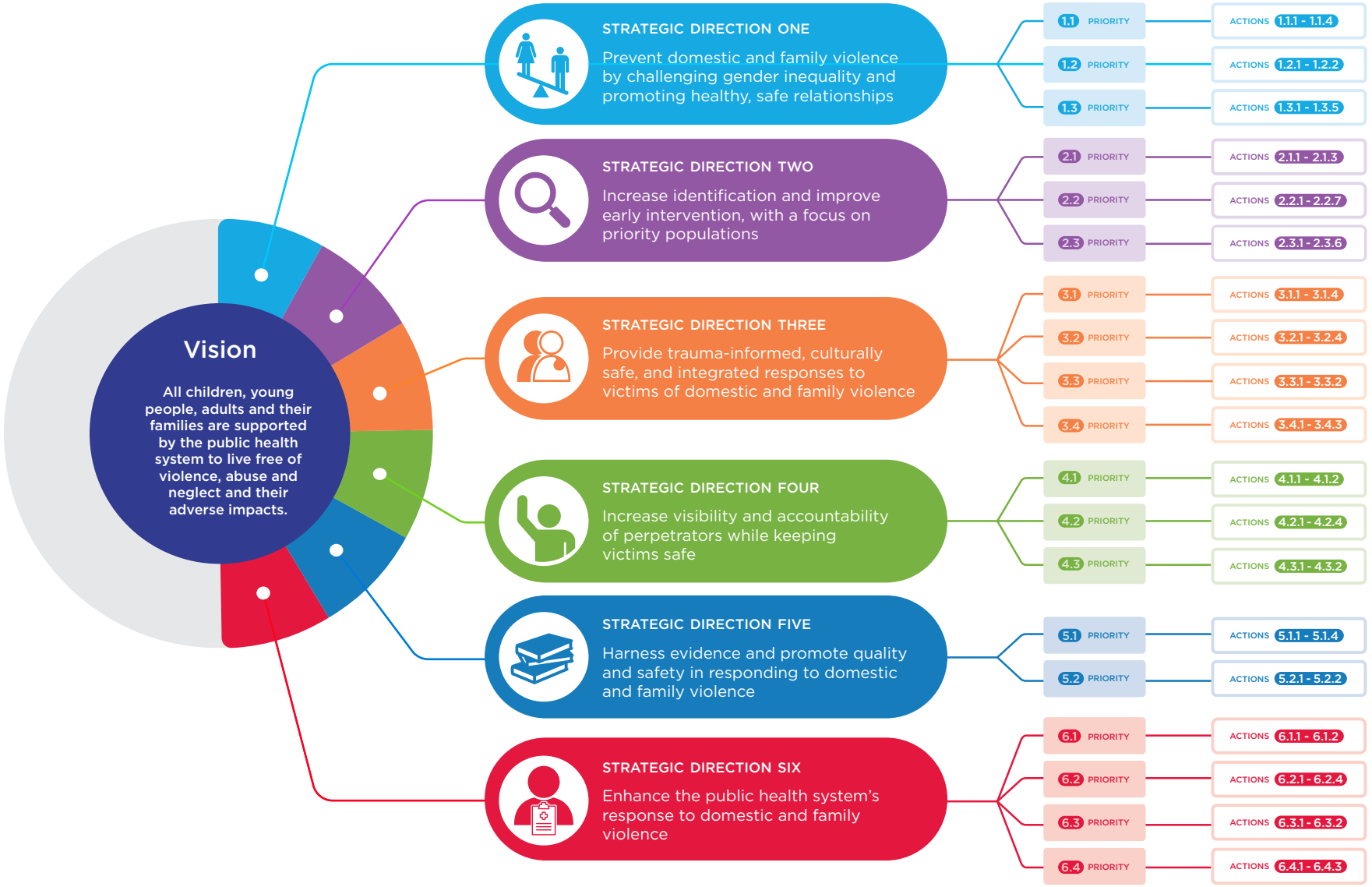
More broadly, all health professionals are required, in the course of delivering health services to patients and clients, to identify and respond to all forms of violence, abuse, neglect, exploitation, and oppression. This consists of ensuring relevant partner agencies and statutory bodies are notified, where appropriate, and providing patients and clients with supported referral through the appropriate pathway.

NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026 at a glance

The following pages provide a brief overview of the ***NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026***.

To provide clear guidance and to monitor progress, primary responsibility for actions across the NSW Health system is indicated through the key on page 11.

NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026 at a glance



KEY

	NSW Ministry of Health (MoH)
	Local Health Districts / Specialty Health Networks (LHDs/SHNs)
	Education Centre Against Violence (ECAV)
	Agency for Clinical Innovation (ACI)
	Bureau of Health Information (BHI)
	Clinical Excellence Commission (CEC)
	eHealth
	Health Education and Training Institute (HETI)

1.1	**PRIORITY - Adopt a life course approach to primary prevention**
1.1.1	ACTION - Identify opportunities for health services to contribute to primary prevention initiatives
1.1.2	ACTION - Equip health workforce to engage proactively with parents to promote equality and positive involvement of both genders in childcare, parenting and other duties
1.1.3	ACTION - Take opportunities to promote gender equality before, and as young people are establishing intimate relationships
1.1.4	ACTION - Provide support to increase the resilience of men at key life transitions
1.2	**PRIORITY - Build workforce capability across NSW Health to challenge gendered drivers of domestic and family violence and promote healthy and safe relationships**
1.2.1	ACTION - Develop and implement communication and workforce development strategies to promote shared understanding of domestic and family violence, including underpinning attitudes, beliefs and social norms across NSW Health
1.2.2	ACTION - Support NSW Health services to promote safe and respectful relationships through health service interventions
1.3	**PRIORITY - Partner with local communities on primary prevention activities**
1.3.1	ACTION - Partner with community organisations and other government agencies on prevention campaigns and advocacy
1.3.2	ACTION - Outreach to, engage with, and consult priority populations and representative bodies in developing and implementing prevention campaigns and local community engagement programs
1.3.3	ACTION - Raise awareness in the community and amongst NSW Health partner agencies about the adverse impacts of domestic and family violence on health and wellbeing of victims
1.3.4	ACTION - Adapt prevention activities to address the specificity of risk factors for domestic and family violence in rural and remote communities
1.3.5	ACTION - Continue to partner with Women NSW through their funding of Education Centre Against Violence to deliver the Tackling Violence Program in NSW

2.1	**PRIORITY - Improve early identification and initial response for victims**
2.1.1	ACTION - Undertake the Domestic Violence Routine Screening in Emergency Departments Pilot and prioritise NSW Health's response to the outcomes of the pilot
2.1.2	ACTION - Finalise and implement the revised Domestic Violence Routine Screening Protocol
2.1.3	ACTION - Establish consultation and referral pathways between Domestic Violence Routine Screening services and NSW Health violence abuse and neglect services and specialist domestic violence services outside of NSW Health
2.2	**PRIORITY - Identify and address the barriers to accessing support for priority populations**
2.2.1	ACTION - Provide guidance for staff in conducting screening and making sensitive enquiries around domestic and family violence when working with people from priority populations
2.2.2	ACTION - Facilitate ready access to trained interpreters (in community languages and Auslan)
2.2.3	ACTION - Consider opportunities to extend the Education Centre Against Violence Domestic and Family Violence Bilingual Community Education Program statewide
2.2.4	ACTION - Ensure people from priority populations can access targeted information
2.2.5	ACTION - Establish advisory groups with representation from priority populations within districts and networks to co-design and reduce barriers to access
2.2.6	ACTION - Develop and implement a Sexual Assault and New Street services access strategy for people with disability to build the capacity of the workforce to respond to sexual assault, problematic and harmful sexual behaviour in children and young people and its co-occurrence with other forms of violence, abuse and neglect, including domestic and family violence
2.2.7	ACTION - Clarify service expectations on meeting the needs of clients from priority populations as part of the review and update of NSW Health's violence, abuse and neglect service standards and associated audit tool
2.3	**PRIORITY - Promote Aboriginal family wellbeing and violence prevention**
2.3.1	ACTION - Develop and implement the NSW Health Aboriginal Family Wellbeing and Violence Prevention Strategy that provides strategic direction for the whole of the public health system to assist in achieving the Closing the Gap Target 13
2.3.2	ACTION - Develop updated operational guidelines supporting the Aboriginal Family Wellbeing and Violence Prevention workforce to work closely with local communities and develop innovative solutions based on local contextual factors
2.3.3	ACTION - Increase the Violence, Abuse and Neglect (VAN) Aboriginal workforce
2.3.4	ACTION - Build the cultural capability of Districts and Networks by: • Developing Sexual Assault Service Aboriginal Action Plans to strengthen community engagement and service accessibility • Delivering cultural competency training for violence, abuse and neglect services Senior Executives and practitioners
2.3.5	ACTION - Co-design the new holistic, public health based Safe Wayz program for children under the age of criminal responsibility with problematic and harmful sexual behaviours and their families to ensure it is a culturally safe model that responds to intersecting forms of violence, abuse and neglect
2.3.6	ACTION - Establish a statewide Prevention and Response to Violence, Abuse and Neglect Aboriginal Advisory Group to provide policy and system reform advice from an Aboriginal social and cultural perspective and to promote the development of cultural safety and reduction of institutional racism in NSW Health services

3.1	**PRIORITY - Expand specialist services for domestic and family violence statewide**
3.1.1	**ACTION** - Expand integrated statewide violence, abuse and neglect service provision for victims of domestic and family violence
3.1.2	**ACTION** - Develop and implement the NSW Health integrated domestic and family violence psychosocial, medical and forensic crisis response model
3.1.3	**ACTION** - Build medical and forensic workforce capacity to respond to domestic and family violence
3.1.4	**ACTION** - Review medical forensic payment determinations for rural and regional districts to consider their application to domestic and family violence medical and forensic responses
3.2	**PRIORITY - Promote comprehensive health service responses to domestic and family violence that incorporate risk assessment, safety planning, referral, and integrated support**
3.2.1	**ACTION** - Increase the capacity of NSW Health workers to assess domestic and family violence risk and undertake safety planning
3.2.2	**ACTION** - Develop and promote domestic and family violence referral pathways across government and non-government sectors
3.2.3	**ACTION** - Develop and implement policy and practice guidance to enhance the use of structured risk assessment to support referral, safety planning and response across key health settings
3.2.4	**ACTION** - Develop health protocols for identifying and referring clients at serious threat to the Safer Pathway program
3.3	**PRIORITY - Build workforce capacity to offer trauma-informed and culturally safe responses**
3.3.1	**ACTION** - Develop and promote workforce development opportunities that support trauma-informated and culturally safe practice
3.3.2	**ACTION** - Embed patient reported mesures into routine practice so that clinicians use this data to improve clinical practice, support patients and drive system-wide improvements in providing trauma-informed and culturally safe responses for victims
3.4	**PRIORITY - Support the workforce and build resilience**
3.4.1	**ACTION** - Ensure staff responding to clients experiencing domestic and family violence have regular access to experiencing vicarious trauma have regular access to clinical and/or specialist supervision, de-briefing and other workplace supports
3.4.2	**ACTION** - Promote provisions and supports available for NSW Health workers who may be experiencing domestic and family violence
3.4.3	**ACTION** - Promote access to Aboriginal cultural supervision for workers responding to Aboriginal clients experiencing domestic and family violence

4.1	**PRIORITY - Support the workforce to prioritise victim safety by keeping perpetrator tactics in view in all health interventions**
4.1.1	**ACTION** - Support identified workers to develop skills, knowledge, attitudes, and values that centralise adult and child victim safety and perpetrator accountability
4.1.2	**ACTION** - Undertake The Evidence to Support Safe and Together Implementation and Evaluation (ESTIE) Project
4.2	**PRIORITY - Provide learning and development opportunities that upskill workers to identify and respond effectively to perpetrators when domestic and family violence is identified**
4.2.1	**ACTION** - Develop and promote workforce development intitiatives to build the skills, confidence and competencies of staff, in line with their roles
4.2.2	**ACTION** - Support appropriate referrals to registered men's behaviour change programs
4.2.3	**ACTION** - Ensure that worker safety (physical and emotional) is explicitly addressed and regularly reviewed through clear policies and procedures and supervision
4.2.4	**ACTION** - Develop training for managers, human resources staff and other relevant staff and supervisors on how to support staff and create a safe working environment
4.3	**PRIORITY - Collaborate with interagency partners to prevent reoffending and keep victim-survivors and children safe**
4.3.1	**ACTION** - Participate in and support cross-agency initiatives that promote justice and behaviour change
4.3.2	**ACTION** - Progress strategies to promote information sharing about perpetrators with co-occurring mental health, alcohol and other drugs or disability issues between health services and other agencies to promote justice outcomes and victim safety

5.1	**PRIORITY - Implement evidence-informed policies and clinical interventions**
5.1.1	**ACTION** - Develop policy and practice guidance for NSW Health staff on best-practice approaches to documenting violence, abuse and neglect in clinical records, including recording perpetrator tactics and protective behaviours of victims
5.1.2	**ACTION** - Develop state-based designs of clinical systems to meet business requirements on information sharing and to support client safety, including guidance on implementation
5.1.3	**ACTION** - Develop and promote the evidence base around lesser known forms of domestic and family violence including non-fatal strangulation and reproductive coercion, and their health impacts, in collaboration with expert clinicians and partner agencies
5.1.4	**ACTION** - Develop clinical guidelines for non-fatal strangulation
5.2	**PRIORITY - Enhance quality, safety and incident management systems**
5.2.1	**ACTION** - Strengthen NSW Health's incident management systems to support improved identification, review and analysis of health responses to domestic and family violence and other forms of violence, abuse and neglect
5.2.2	**ACTION** - Enhance collaboration between Ministry of Health, Centre for Clinical Excellence, Domestic Violence Death Review Team and the Ombudsman in the system response to domestic violence-related homicides and serious incidents

6.1	**PRIORITY - Strengthen leadership, governance, and accountability**
6.1.1	**ACTION** - Develop and implement updated NSW Health policy and procedures for identifying and responding to domestic and family violence
6.1.2	**ACTION** - Review and update the NSW Health guide to role delineation of clinical services to incorporate service responses to domestic and family violence
6.2	**PRIORITY - Integrate health responses for victims of domestic and family violence**
6.2.1	Progress responses to the recommendation of the Domestic Violence Death Review Team on the intersection of mental health, alcohol and other drugs and domestic and family violence in collaboration with our interagency partners
6.2.2	**ACTION** - Develop communities of practice involving the violence, abuse and neglect sector and broader mental health workforce and interagency and non-government organisation partners responding to domestic and family violence
6.2.3	**ACTION** - Establish links between different NSW Health networks and governance structures that directly and indirectly respond to domestic and family violence to enhance collaboration
6.2.4	**ACTION** - Develop and implement a specialist treatment service for adult survivors of child sexual assault, including strategies to address the intersection of sexual assault and domestic and family violence
6.3	**PRIORITY - Align NSW Health systems to national and state reforms**
6.3.1	**ACTION** - Contribute to interagency planning, implementation, monitoring and evaluation mechanisms of domestic and family violence responses in NSW
6.3.2	**ACTION** - Work with primary health networks to strengthen the capacity and capability of general practice doctors and nurses to identify and respond to domestic and family violence
6.4	**PRIORITY - Expand policies, guidance and workforce development to address all forms of domestic and family violence**
6.4.1	**ACTION** - Develop and implement a NSW Health Competency and Training Framework for Preventing and Responding to Violence, Abuse and Neglect
6.4.2	**ACTION** - Collaborate with agency partners to broaden responses to all forms of domestic and family violence
6.4.3	**ACTION** - Ensure that violence, abuse and neglect policies link with intersecting policy areas, e.g. youth, disability, older people

Key statistics

Many people across Australia experience **domestic and family violence.**

Violence by an intimate partner

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

23%
1 in 4 WOMEN
(2.2 million)

7.8%
1 in 13 MEN
(703,000)

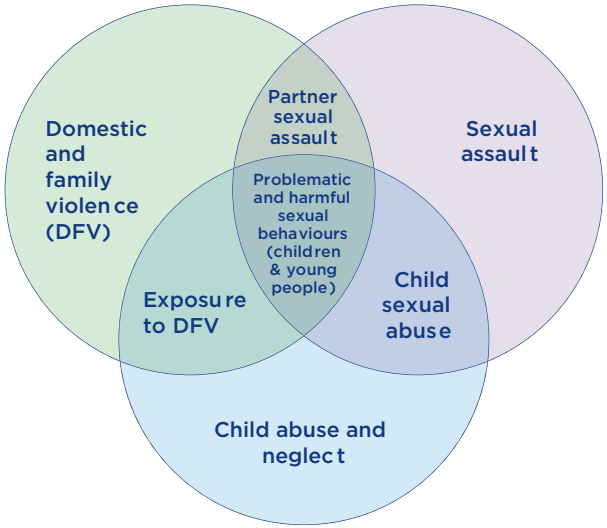
Witness violence to a parent

1 in 9
AUSTRALIANS
(2M)
witnessed **violence**[3] toward their **mother by a partner**

11%

1 in 22
AUSTRALIANS
(819,000)
witnessed **violence**[3] toward their **father by a partner**

4.5%



Violence, abuse and neglect are rarely experienced as a single incident. Many people experience multiple forms of violence, abuse and neglect, either co-occurring or at different stages across their life.

POWER & CONTROL

The central element of domestic and family violence is an ongoing pattern of behaviour aimed at controlling a partner or other family members through fear and coercion.

The impacts of domestic and family violence are **serious and long-lasting.**

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

Some people experience **multiple**, **overlapping challenges** that may heighten the **likelihood**, **impact or severity of domestic and family violence**.T his requires both general and targeted health responses and prevention efforts

1. Physical and/or sexual violence since the age of 15. 2. Current and/or previous partner, girlfriend, boyfriend or date. 3. Physical assault only witnessed before the age of 15.
Infographics: Costello & Backhouse, 2019a. Data sources: ABS, 2017 (Personal Safety Survey) & Costello & Backhouse, 2019b (pp.109-111).

The **health and financial costs** of domestic and family violence to individuals, communities and governments are **significant and preventable.**

In 4 in 10 hospitalisations for female (45% or 2,800) and **1 in 20 for male** (4.4% or 560) **assault victims, a spouse or domestic partner** was the **perpetrator**[4].

Indigenous women are **32x more likely** than non-Indigenous women to be **hospitalised due to family violence injuries**[5].

Every week in Australia, at least **3 women** are **hospitalised** with a **brain injury** as a direct result of **family violence**[6].

Intimate partner violence

contributed an estimated

5.1%

of the **burden of disease** (impact of illness, disability, premature death) for women aged 18-44 years.

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

The **disease burden** of domestic and family violence for **Indigenous women** aged 18-44 years is **6.3 times higher** than for non-Indigenous women in the same age group.

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

$22 billion

This includes **$1.4 billion** to the **HEALTH SYSTEM**[11].

Domestic and family violence is the **leading reason for seeking assistance from specialist homelessness services** (40% of clients; of which 92% were women and children)[8].

Between 2010-2014, there were **152** (121 women, 31 men) **intimate partner homicides** in Australia that followed an identifiable history of **domestic violence**[9].

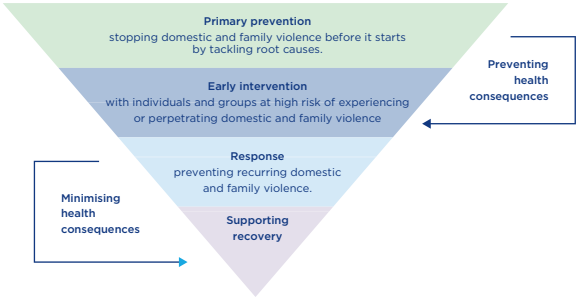
19%

1 in 5

VICTIMS (103)

of **domestic violence homicide**

were **children killed** by a **relative or kin**, in NSW between 2000-2019[10].



The **health sector** plays a vital role in addressing domestic and family violence through an **integrated public health approach**[12].

4. AIHW, 2018 (National Hospital Morbidity Database 2014-15); 5. Productivity Commission, 2016; 6. Brain Injury Australia, 2015; 7. Webster, 2016; 8. AIHW, 2017 (Specialist Homelessness Services Collection 2016–17); 9. Australian Domestic & Family Violence Death Review Network, 2018 (National Minimum Dataset); 10. NSW Domestic and Family Violence Death Review Team, 2020 11. KPMG, 2016; 12. Costello & Backhouse, 2019a (adapted from Webster, 2016). Infographics: Costello & Backhouse, 2019a.

An urgent public health issue

Prevalence

Domestic and family violence is a prevalent global public health issue that has extensive and devastating health consequences. According to the Personal Safety Survey (PSS), one in four women (23% or 2.2 million) and one in 13 men (7.8% or 703,000) in Australia have experienced physical or sexual violence by an intimate partner since the age of 15.[5]

Although there is no comparable prevalence data based on a nationally representative sample for other forms of domestic and family violence, data on domestic violence-related assaults reported to NSW Police indicates that 37 per cent involved people in non-intimate relationships (family violence) and five per cent of intimate partner assaults involved same-sex couples.[6] Information from calls to the NSW Elder Abuse Helpline and Resource Unit suggests that around 70 per cent of victims are women, and around 70 per cent of perpetrators are family members, particularly adult children, with around 10 per cent being spouses.[7]

Health impacts

There is an extensive body of evidence about the effects of domestic and family violence on health. Much of the research has focused on intimate partner violence (IPV), because the effects of this violation of human rights on women's health are profound. As Table 1 indicates, these health impacts are not only injury-related; they affect multiple domains of physical and mental health and can continue beyond the relationship in which the violence occurred. They are associated with higher rates of health care use by women who experience either physical or nonphysical IPV, compared to non-abused women, in both the immediate and longer term.[8]

For women aged 25-44, IPV contributes more to their burden of disease (the impact of illness and premature death) than any other risk factor. Mental health conditions (anxiety disorders, depression) are the largest contributor to this burden of disease, followed by suicide and self-inflicted injuries.[9] As these are women's core parenting years, effective health interventions that focus on safety and recovery can reduce the exposure of children to IPV and consequently reduce the risk of long-term harm to health, development, and wellbeing.

> ***"If the idea of having a home encompasses living in a place that affords physical and psychological safety and security, then a woman experiencing violence in her own home is, in a very real sense, homeless."***
>
> Source: Astbury & Cabral (2000, pp. 65-66) [10]

In addition to the considerable evidence of the impact of IPV on women's health, the accompanying social impacts, such as social isolation and housing and income insecurity, affect the quality of women's lives. Separation does not necessarily end the violence, and women are often subjected to new tactics of coercive control orchestrated by the perpetrator in the context of post-separation parenting arrangements.

Table 1: Health outcomes associated with intimate partner violence

Health Outcome	Examples
Fatal	Femicide Suicide Other
Non-fatal	
Injury	Brain injury Loss of consciousness Genital trauma Fractures and sprains Lacerations, abrasions and bruising Self-harm
Mental health	Depression Anxiety Eating disorders Suicidal ideation
Substance abuse	Alcohol-use disorder Drug-use disorder
Chronic disease	Cancer Cardiovascular: hypertension, coronary heart disease, stroke Musculoskeletal: arthritis, rheumatoid arthritis, gout, lupus, fibromyalgia
Somatoform	Chronic fatigue, chronic pain, irritable bowel syndrome
Perinatal	Prematurity, low birth weight
Maternal	Antenatal complications (haemorrhage, pre-eclampsia) Postnatal depression
Reproductive	Abortion (medical and spontaneous) Gynaecological problems
Infections	HIV/AIDS Other sexually transmitted infections
Behavioural and biomedical risk factors affecting health	Unsafe sex High body mass index Harmful tobacco/drug/alcohol use
Health care-seeking	Lack of contraception Lack of autonomy Difficulties seeking care or other services

Source: Ayre et al. (2016) [11]

Social inequalities exacerbate health impacts

Some groups of women who experience multiple, intersecting social inequalities experience higher rates of domestic and family violence and consequently, more severe effects on their health and wellbeing. These include, for example, Aboriginal women and women with disability.

Aboriginal family violence can only be understood in the context of the ongoing effects of violent colonisation, dispossession, and devastation of families through the removal of children. Flowing from the resulting intergenerational trauma and cumulative harm from this institutional violence, Aboriginal women are over-represented as victims of domestic and family violence and experience greater health impacts. The disease burden of domestic and family violence in Indigenous women aged 18-44 years is 6.3 times higher than for non-Indigenous women in the same age group.[12]

Compared to their peers, women with disability experience significantly higher levels of all forms of violence more intensely and frequently and are subjected to violence by a greater number of perpetrators. Their experiences of violence last over a longer period, and more severe injuries result from the violence.[13]

Co-occurring abuse, cumulative harm, and complex trauma

Although this strategy focuses on domestic and family violence, it is important to note that it is rare for one type of interpersonal violence to occur in isolation from others; a single abusive experience is often the exception rather than the norm.[14] For example, sexual assault often occurs in contexts of domestic violence[15] and all forms of child abuse and neglect co-occur with domestic violence and are more severe in this context.[16]

Cumulative abusive experiences are also common, such as abuse in childhood and violence as an adult from one or multiple perpetrators. For example, women who experienced childhood sexual assault are 2.44 times more likely to experience psychological abuse and 2.75 times more likely to experience physical abuse by a partner in adulthood.[15] While it is difficult to tease out the impacts and interactive effects of multiple victimisations, there is consensus that health consequences are incrementally worse for victims experiencing multiple types of abuse, either co-occurring or compounding over a lifetime.[14]

Many clients of health services are experiencing complex trauma, which is cumulative, repetitive, and interpersonally generated, and includes ongoing abuse that occurs in the context of family and intimate relationships.[17]

Figure 1: Co-occurrence of violence, abuse and neglect

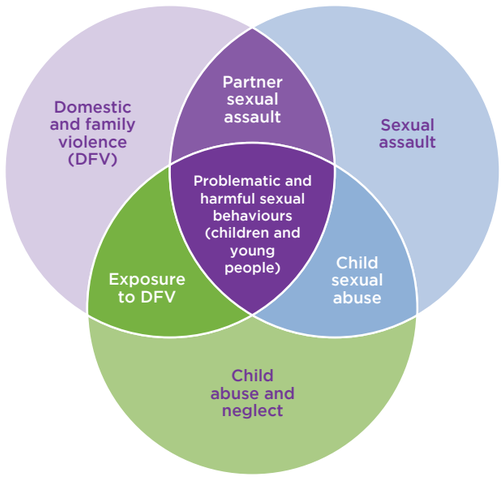


Figure reproduced from: Costello & Backhouse (2019b)[18]

Protecting children and young people and promoting their healthy development through violence prevention and response

Using a narrow definition of witnessing physical assault, the ***Personal Safety Survey*** found that, before age 15, one in nine Australians (two million) has witnessed violence towards their mother by a partner and one in 22 Australians (819,000) has witnessed violence towards their father by a partner.[5] This underestimates the multiple ways in which children and young people are exposed to domestic and family violence as, in addition to excluding various other forms of domestic and family violence like sexual assault and emotional abuse, research also indicates that children are aware of both overt expressions of physical violence and patterns of coercive control, and report living with a sense of constant fear.[19] Preventing domestic and family violence and reducing its effects through effective intervention are not only child protection interventions; they also play a vital role in laying the foundations for children's healthy development into adulthood.

NSW Health's ***First 2000 Days Framework*** outlines how exposure to stressors before birth and exposure to adverse experiences in early childhood increase the probability that an individual will have poor health and wellbeing later in life. The strong, graded relationship between the number of adverse childhood experiences (ACEs) and chronic disease is true for both physical disease and mental health. The common co-occurrence of domestic and family violence and all forms of child abuse and neglect, together with the effects of domestic and family violence on mental health and substance use, can increase the number of ACEs faced by children.

Adolescence presents another opportunity for health services to protect young people from domestic and family violence and promote their healthy development. Many studies on the impact of ACEs on adolescents show that as the number of ACEs increases, the risk for adolescent health and behaviour problems such as suicidal ideation, tobacco use and self-directed violence increase in a strong and graded fashion. The second decade provides opportunities to undo harm done in earlier years through early intervention.[20]

The role of health professionals in preventing domestic and family violence before it starts and reducing its effects is a critical part of preventing ACEs and contributes to the promotion of children and young people's safety and future health and wellbeing.

Opportunities to make a difference

While violence, abuse and neglect (VAN) services are an important part of NSW Health's service response, most people experiencing domestic and family violence do not enter the health system via specialist VAN services. Women, children, young people, and men present at various points within the broad health system with both physical and mental health issues that are a direct or indirect consequence of violence. Each presentation is an opportunity to identify and respond to the underlying domestic and family violence.

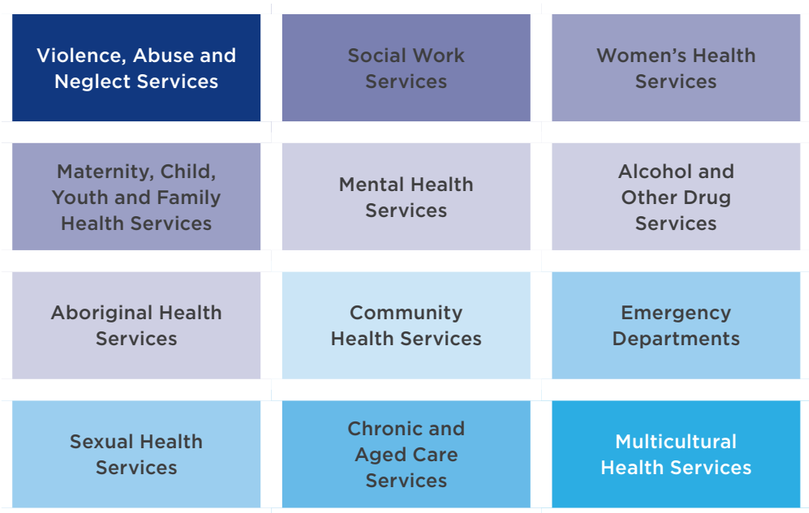
For example, victims of domestic and family violence often present to emergency departments with mental health issues such as generalised depression and anxiety and chronic medical conditions such as upper and lower abdominal issues, fatigue, pain, and inflammatory conditions. Other opportunities for identification of domestic and family violence arise when children present to health services with emotional or behavioural problems, which may indicate that they are living with domestic and family violence.

Despite high health care use, identification of domestic and family violence rarely occurs without active health intervention such as routine screening or sensitive clinical inquiry. There are many reasons that experiences of violence can remain hidden without proactive efforts by health professionals, including:

- the person has not recognised or named their experience as violence
- fear of the consequences from the person using violence, of being blamed or disbelieved, or of intervention (e.g. removal of children)
- the perpetrator interfering with the victim's full access to healthcare.

Health professionals therefore have an important role to play in identifying domestic and family violence in health settings as diverse as paediatrics, perinatal and infant mental health, substance-use in pregnancy and parenting services (SUPPS), aged care, sexual health, multicultural health, sexual assault, and women's health. However, disclosure is only helpful if health care providers respond in a person and family-centred, supportive manner consistent with the principles in NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework.

Figure 2: Priority settings within NSW Health for DFV



Other opportunities for health professionals to make a difference arise through the provision of universal health services. Through their regular and ongoing contact with infants, young children and families, staff working in maternity and child and family health play an important role in primary prevention through the promotion of respectful relationships, the early identification of domestic and family violence, and opening referral pathways to supports.

The priority settings within NSW Health for preventing, identifying, and responding to domestic and family violence are set out in Figure 2 above.

Tackling risk and complexity

Targeting risk factors

A vital step in the public health approach to domestic and family violence is the identification of risk factors. This enables preventive efforts to be targeted to achieve the greatest impact. International and Australian research consistently identifies gender as the biggest risk factor for intimate partner violence: women are predominantly the victims and men the perpetrators.[21]

Based on this evidence, NSW Health takes a gendered approach in developing systematic interventions such as Domestic Violence Routine Screening (DVRS), which is implemented for women in health services where rates or risks of violence are known to be higher — during pregnancy and early childhood or in mental health and alcohol and other drugs (AOD) settings. Beyond targeted programs, however, all victims of domestic and family violence, inclusive of diverse gender identities and sexualities, are provided with services and supports from NSW Health to address their safety, the safety of their children, and to support recovery from the impacts of the violence they have experienced.

Gender inequality

Gender inequality is the social context that underpins gender as the most common risk factor. While multiple factors interact across individual, institutional and social contexts to contribute to domestic and family violence, comparative, cross-national research finds consistently that gender inequality is the root cause of IPV.[22]

The following factors associated with gender inequality are the most consistent predictors of violence against women: condoning of violence against women; men's control of decision-making and limits to women's independence; rigid gender roles and identities; and male peer relations that emphasise aggression and disrespect towards women.[21] Australia's primary prevention efforts, led by ***Our Watch***, are targeted towards these drivers of violence and the additional factors that reinforce them[23] and provide guidance for NSW Health to develop evidence-based primary prevention efforts.

Gender inequality

Gender inequality is a social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity between them. It often results from, or has historical roots in, laws or policies formally constraining the rights and opportunities of women and is reinforced and maintained through more informal mechanisms. These include, for example, social norms such as the belief that women are best suited to care for children, practices such as differences in childrearing practices for boys and girls, and structures such as pay differences between men and women.

Source: Our Watch (2015, p. 22) [23]

Intersecting social inequalities

Although domestic and family violence is prevalent across the Australian community, some social groups experience disproportionately higher rates of violence. This is because other forms of social inequality and disadvantage intersect with gender inequality to increase the likelihood of being victimised. Structural discrimination based on factors such as class, race, ability, age, citizenship status, gender identity and sexual orientation interacts with gender inequality to increase not only the risk of victimisation but also barriers to receiving effective help. Understanding this social context is vital to reducing harmful victim-blame. A public health approach to targeting those at highest risk guides NSW Health in identifying priority population groups for identification and response.

Figure 3: Priority populations for DFV

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

Women

1 in 4 women (23% or 2.2 million) compared to 1 in 13 men (7.8% or 703,000) have experienced physical and/or sexual violence by an intimate partner since the age of 15 (ABS, 2017).

3 in 4 (75% or 488) victims of intimate partner homicide in Australia in the 10 years from mid-2002 to mid-2012, were female (AIC National Homicide Monitoring Program, in Bryant and Bricknell 2017).

Women are 8-times more likely than men to experience sexual violence by a partner since the age of 15 (ABS, 2017).

Aboriginal women

Of 121 female victims of intimate partner homicide in Australia in the 4 years between July 2010-June 2014, 1 in 5 women (22.3% or 27) killed by a male partner, identified as Aboriginal (The Network, 2018).

Indigenous women experience intimate partner homicide at 2-times the rate of Indigenous men (AIHW, 2018a).

Aboriginal women were 2-times as likely as men to have experienced domestic and family violence in the 12 months preceding the 2014-15 NATSISS (ABS, 2019).

Women with mental illness

In 2011, domestic and family violence contributed to more burden of disease (the impact of illness, disability and premature death) than any other risk factor for women aged 25–44.

Mental health conditions are the largest contributor to the burden of physical/sexual intimate partner violence, with anxiety disorders making up the greatest proportion (35%), followed by depressive disorders (32%) (Ayre et al. 2016).

Women in pregnancy and early motherhood

During pregnancy, domestic violence can become particularly dangerous, causing premature birth, serious injury or death to the baby, while also impacting the mother's mental and physical health (Keeling, 2012; Manzolli et al., 2009; O'Reilly, 2007; Oweis, Gharaibeh & Alhourani, 2009 - all cited in Cooper, 2013).

Women with disabilities

Studies show women with disabilities are 40% more likely to experience domestic and family violence than other women (Australian Law Reform Commission 2010, in Frohmader, Dowse, & Didi, 2015).

Every week in Australia, 3 women are hospitalised with a brain injury as a direct result of family violence (Brain Injury Australia, 2015 in Frohmader et al., 2015).

Lesbian, gay, bisexual, transgender, queer and intersex people

1 in 3 LGBTQI Australians have reported experiencing abuse in a relationship, including 65% of transgender males and 43% of intersex females (in O'Halloran, 2015).

Migrants, refugees and people who are culturally and linguistically diverse

Immigrant and refugee women tend to seek help only after enduring years of abuse and are prompted by escalating frequency and severity and fears for the impact on their children (Segrave, 2017).

Experience of child abuse

1 in 3 women (36% or 535,800) and 1 in 6 men (15% or 152,600) who have experienced abuse before the age of 15, have also experienced violence by a partner as an adult (ABS, 2017).

Older women

International evidence suggests women aged over 50 who are victims of domestic violence are suffering in silence because the problem is ignored by professionals and policy makers (Lazenbatt & Devaney, 2014).

Women in regional, rural and remote areas

Women living in regional and remote areas are more likely to have experienced violence since the age of 15 years than those living in major cities (Webster & Flood 2015).

Women experiencing sexual violence

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

Young women and adolescents

Global prevalence of partner violence is 29% among young women aged 15–19, indicating that violence can occur in women's earliest relationships (AIHW, 2018a).

Infographics reproduced from: Costello & Backhouse, 2019b, pp. 97-98 [18]

A multi-level NSW Health response

NSW Health's response to domestic and family violence is informed by the World Health Organization's call for a public health response. A public health model aims to prevent problems from occurring in the first place by targeting key risk and social factors at a whole population level through a cross-disciplinary and multi-agency approach.[24]

Prevention strategies are differentiated according to their timing:

- Primary prevention: Strategies aimed at preventing violence before it occurs.
- Secondary prevention (early intervention): Programs that involve early detection of risk or early manifestations of the problem. In health services, this encompasses efforts to identify domestic and family violence, which is often not disclosed or recognised beneath presenting issues, as well as systematic interventions with population groups at highest risk of experiencing domestic and family violence, such as Domestic Violence Routine Screening (DVRS).
- Tertiary prevention (response or intervention): Responses after the violence has occurred with the aim of reducing the consequences and impacts of violence and preventing recurrence.

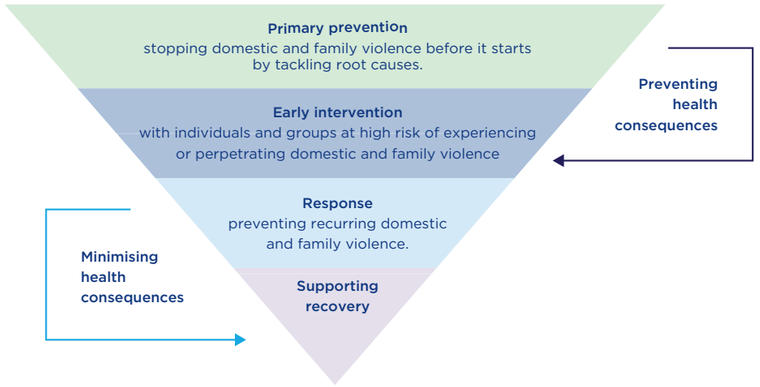
The complexity of domestic and family violence means that these levels of prevention can overlap, and one intervention can address several levels of prevention simultaneously. For example, the provision of trauma-specific counselling for children who have lived with domestic and family violence is both an example of tertiary prevention, as the violence has occurred, and of secondary prevention as the risk of intergenerational violence is reduced.

Similarly, identification of domestic and family violence through screening during pregnancy may identify warning signs about the possible emergence of

domestic and family violence and lead to early intervention (secondary prevention) while identification of domestic and family violence through screening in alcohol and other drug (AOD) services may identify cumulative harm due to the effects of multiple experiences of abuse and violence from childhood through to the person's current and previous intimate relationships, identifying the need for a specialist (tertiary) response.

The health system has a vital role to play at all these levels of prevention as part of a comprehensive contribution to addressing domestic and family violence. This work is done in partnership with a wide range of interagency partners, including the education, justice, child protection, housing and community welfare sectors. This approach supports the Government's efforts under the ***NSW Domestic and Family Violence Prevention and Early Intervention Strategy 2017-2021***, as well as violence prevention efforts both nationally and internationally.

Figure 4: The public health response to DFV



Infographics reproduced and adapted from: Costello & Backhouse (2019a) [25]

The **health sector** plays a vital role in addressing domestic and family violence through an **integrated public health approach**[12].

Strategic directions

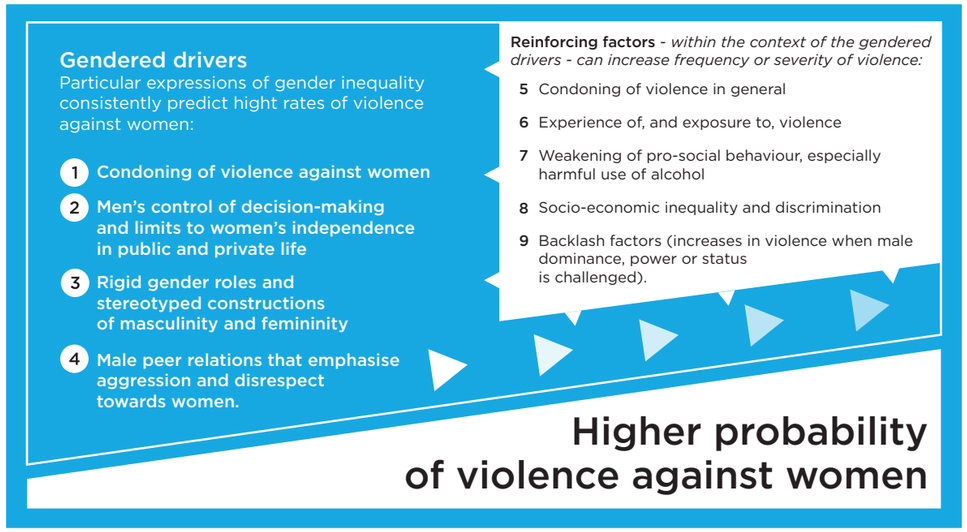
Strategic Direction One:

Prevent domestic and family violence by challenging gender inequality and promoting healthy, safe relationships

NSW Health is ideally placed as a universal provider of health care to engage in primary prevention initiatives that promote gender equality and respectful relationships.

Change the Story provides a national framework for a consistent and integrated approach to primary prevention in Australia, which identifies that violence against women is underpinned by the range of gendered drivers and reinforcing factors outlined in Figure 5 below.

Figure 5: Gendered drivers and reinforcing factors for violence against women



Infographic reproduced from Our Watch (2015, p. 8) [23]

Priority 1.1: Adopt a life course approach to primary prevention

Adopting a life course perspective helps to both identify early risk factors and the best times to intervene using a primary prevention approach. For example, infancy (0-4 years), childhood and early adolescence (5-14 years) and adolescence and young adulthood (15-25 years) are crucial points for health's primary prevention activities.[26]

Under ***The First 2000 Days Framework***, NSW Health offers universal, evidence-based, seamless care and services for all children and their families from pregnancy to school entry. A key role of these services is to provide families and communities with the information and support they need to raise children in safe and nurturing environments where children can develop healthy, equitable and safe relationships. Partnerships with other human services agencies, such as education, are vital to these efforts.

Adolescence and young adulthood are important life stages for preventive efforts that support young men and women to establish positive gender expressions and relationship practices. The findings of the most recent national survey of young people's attitudes to violence against women identify some areas towards which prevention could be targeted, given the centrality of coercive control in the dynamics of IPV. For example, almost one in three young people (31%) believe that women prefer a man to be in charge of a relationship. Young men are more likely to endorse men's control over decision-making in private life than young women, with young men (22%) almost twice as likely as young women (12%) to agree that men should take control in relationships. [27]

A life course approach to primary prevention of domestic and family violence is consistent with the ***NSW Men's Health Framework***, which promotes men's health and wellbeing through interventions that support and increase the resilience of men during stressful points of transition in their lives, such as relationship breakdown, and that prepare them to take an active and positive role in parenting.

Priority 1.1 - Actions:

1.1.1	Identify opportunities for health services to contribute to primary prevention initiatives (LHDs/SHNs)
1.1.2	Equip health workforce to engage proactively with parents to promote equality and positive involvement of both genders in childcare, parenting and other duties (LHDs/SHNs)
1.1.3	Take opportunities to promote gender equality before, and as young people are establishing intimate relationships (LHDs/SHNs)
1.1.4	Provide support to increase the resilience of men at key life transitions (LHDs/SHNs)

Priority 1.2: Build workforce capability across NSW Health to challenge gendered drivers of domestic and family violence and promote healthy and safe relationships

Building the health workforce's understanding of the gendered drivers of domestic and family violence will enable health professionals to challenge the attitudes, beliefs, and social norms underpinning gender inequality and to promote gender equality. This should prioritise staff offering universal health services at key life course transitions such as maternity and child and family and youth health services.

Other relevant sectors are women's health, men's health and sexual health services, and health services whose role is to increase access to health services for priority groups, such as the multicultural health and the Aboriginal Family Wellbeing and Violence Prevention workforces.

Western NSW Local Health District

In the Western NSW Local Health District, the Prevention and Response to Violence, Abuse and Neglect (PARVAN) team works closely with the media unit to do effective social media messaging for the community regarding domestic and family violence, its impacts, and to let people know where to get help and to promote national community education campaigns. Staff also make videos that provide messages of hope and offers of support to victims.

Priority 1.2 - Actions:

1.2.1	Develop and implement communication and workforce development strategies to promote shared understanding of domestic and family violence, including underpinning attitudes, beliefs and social norms across NSW Health (MoH, ECAV, HETI, LHDs/SHNs)
1.2.2	Support NSW Health services to promote safe and respectful relationships through health service interventions (LHDs/SHNs)

Priority 1.3: Partner with local communities on primary prevention activities

Prevention efforts need to be tailored to local contexts. For example, there is some research evidence on the experience of domestic and family violence in rural and remote communities that traditional gender norms and a narrower view of masculinity in those communities can act to normalise male control and abuse.

These attitudes combine with specific risk factors such as geographical isolation and increased access to firearms to exacerbate domestic and family violence risk in those communities.[28] Specific, localised primary prevention activities are needed to counteract such attitudes and the violence they engender in rural and remote communities.

Partnering with other organisations across NSW in important campaigns, such as the United Nations International Day for the Elimination of Violence against Women and 16 Days of Activism, sends a message of the importance of preventing violence to building healthy communities.

Tackling Violence

Tackling Violence is a community education, early intervention and prevention program funded by Women NSW and delivered by NSW Health's Education Centre Against Violence (ECAV). It uses involvement in sport by men, women and young people as the context for attitude and behaviour change towards domestic and family violence. Sponsorship packages are offered to more than 40 rugby league clubs in NSW. Most participating clubs are in regional and remote locations with high rates of domestic and family violence and high Aboriginal populations. The program's successful reach and reputation across rural and remote NSW communities was noted in a recent program evaluation. [29]

Priority 1.3 - Actions:

1.3.1	Partner with community organisations and other government agencies on prevention campaigns and advocacy (LHDs/SHNs)
1.3.2	Outreach to, engage with, and consult priority populations and representative bodies in developing and implementing prevention campaigns and local community engagement programs (LHDs/SHNs)
1.3.3	Raise awareness in the community and among NSW Health partner agencies about the adverse impacts of domestic and family violence on the health and wellbeing of victims (LHDs/SHNs, MoH)
1.3.4	Adapt prevention activities to address the specificity of risk factors for domestic and family violence in rural and remote communities (LHDs/SHNs)
1.3.5	Continue to partner with Women NSW through their funding of the Education Centre against Violence to deliver the Tackling Violence Program in NSW (ECAV)

Family Harmony and Healthy Relationships (FHHR) Bilingual Community Education Program

The Family Harmony and Healthy Relationships (FHHR) Bilingual Community Education Program, developed by the Education Centre Against Violence (ECAV) and run through two local health districts, is a primary prevention program that is delivered by trained bilingual community educators (BCEs) from various culturally and linguistically diverse (CALD) communities.

Programs are delivered in participants' first language and draw on the evidence that tailored and sensitive community education strategies that reflect CALD women's context and concerns are effective in DFV prevention practice. The program is supported by the provision of DFV Z-cards, discrete resources providing information on domestic violence and support services in 18 languages. Following an evaluation in 2017, the program is being extended to be delivered to CALD men by male BCEs.[30]

Strategic Direction Two:

Increase identification and improve early intervention, with a focus on priority populations

When supported with knowledge and skills that equip them to ask about domestic and family violence and, crucially, to respond effectively, health professionals are well placed to identify and provide "first line support".[31]

This includes being non-judgemental and validating what the victim is saying, providing practical care and support, helping them access information about resources, assisting them to increase safety for self and children, and providing or mobilising social support.

NSW Health has a well-established, evidence-based program of identification through routine screening for domestic violence, which is conducted in targeted health settings where IPV is known to be prevalent. ***The Domestic Violence Routine Screening (DVRS) program*** was introduced in 2004 for all women using maternity, child and family, mental health and alcohol and other drug services. This policy is supported by a strong suite of evidence-based training and resources.

The evidence underpinning the DVRS program indicates that screening by a skilled health worker who directly asks questions increases the identification of women experiencing abuse; it has little or no adverse effect on women; and can bring about benefits to women, particularly when associated with referral to counselling. A study with women who had experienced abuse and screening found that the women reported useful outcomes, regardless of whether they had disclosed. The most helpful impact reported was that screening prompted a re-evaluation of their situation and reduced isolation.[41]

In addition to the structured DVRS program, NSW Health has long-standing policy on the important role of all health workers to identify and respond to domestic and family violence by asking direct questions when they have concerns. Resources underpinning the DVRS are available to support health staff outside routine screening areas to contribute to identification in this way.

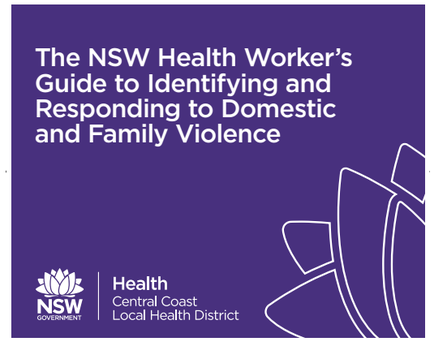
Another way that domestic and family violence is frequently identified by NSW Health staff is in the context of child protection and wellbeing concerns. At least 30 per cent of the 16,000 annual contacts to the health Child Wellbeing Unit (CWU) from health workers involved domestic and family violence. NSW Health's CWUs assess risk and plan early interventions with health workers to prevent the need for a report to, or intervention by, the statutory child protection system whenever possible.

Priority 2.1: Improve early identification and initial response for victims

NSW Health will ensure that staff delivering the DVRS program are well supported and that the program is monitored to ensure that its implementation meets the WHO guidelines for safe enquiry about violence. [31] ECAV, Health Education and Training Institute (HETI) and PARVAN workforce learning and development trainers offer a range of evidence-based training and resources to support health workers in this area. An annual DVRS forum, hosted by ECAV, provides the opportunity for ongoing skill development and sharing of practice knowledge.

The NSW Health Domestic and Family Violence Flipchart is an important resource for clinicians who receive disclosures of domestic and family violence. It is tailored to each district (see example below) and provides brief guidance on responding to disclosures, supportive responses, and appropriate referral to statewide and local services. Staff who conduct screening are also supported in responding to disclosures by access to consultation with specialist VAN services and psychosocial services, depending on local staffing.

An additional flipchart has been developed

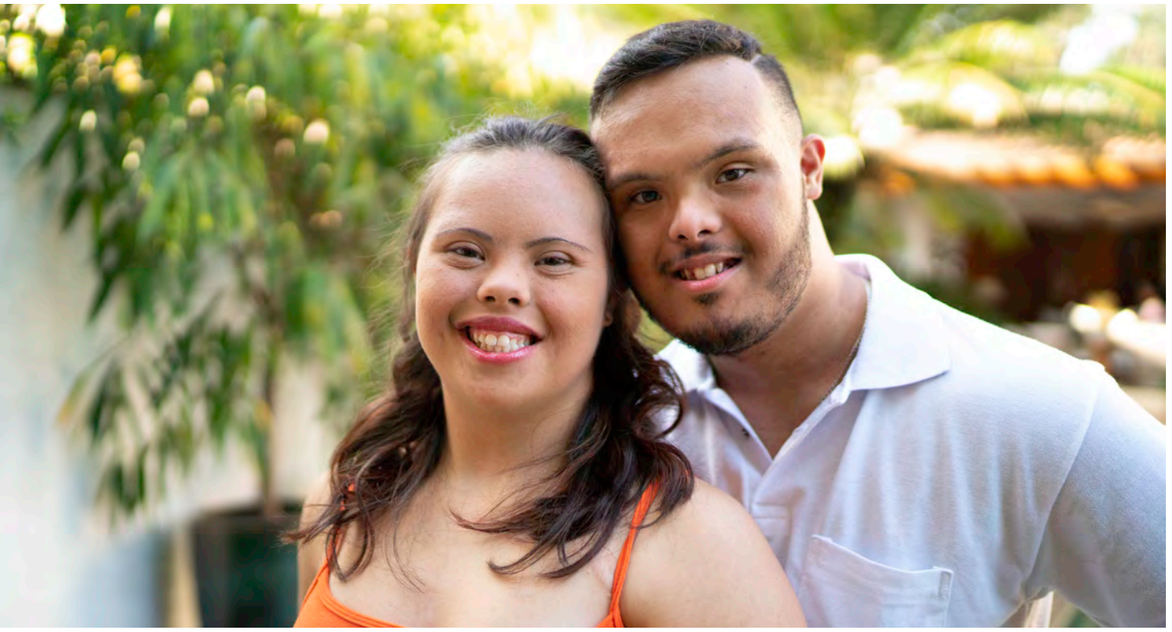


by ECAV to provide a resource for all health staff responding to domestic and family violence with CALD clients. ECAV's flipchart includes information to support health workers when engaging interpreters in DVRS.

Further systemic support for routine screening is provided through the implementation of a revised DVRS protocol, which outlines the clinical requirements for conducting DVRS using the common screening tool. It provides detailed clinical guidelines on screening, supporting disclosures, risk assessment and referrals. This supports local health districts and specialty health networks that have expanded the program to relevant, non-mandated health settings such as sexual health, women's health and paediatrics. NSW Health is also exploring expanding the DVRS program to emergency departments. A three-site study has demonstrated that routine screening in emergency departments is feasible but further trials are required to establish and embed practices.

Priority 2.1 - Actions:

2.1.1	Undertake the DVRS in Emergency Departments Pilot and prioritise NSW Health's response to the outcomes of the pilot (MoH, LHDs/SHNs, eHealth, ECAV)
2.1.2	Finalise and implement the revised DVRS Protocol (MoH, LHDs/SHNs)
2.1.3	Establish consultation and referral pathways between DVRS services and NSW Health violence, abuse and neglect services and specialist domestic violence services outside of NSW Health (LHDs/SHNs)



Priority 2.2: Identify and address the barriers to accessing support for priority populations

As discussed in this strategy, certain groups are more at risk of experiencing domestic and family violence. They also face additional barriers to seeking and receiving help, because the perpetrator can use their victim's social location to tailor strong strategies of entrapment.

For example: a perpetrator may threaten a migrant woman with revocation of her spousal visa if she tells anyone about the violence; a perpetrator may depend on the shame and isolation of a refugee woman to silence her; the perpetrator in a same-sex relationship may threaten to 'out' their partner to family or work colleagues; a partner of a woman with limited mobility may place the phone or mobility aids out of reach; an adult child may manipulate their parent's loyalty to silence them about the abuse they are inflicting; and, in geographically isolated areas, a perpetrator may control access to transport.

Compounding these tactics of abuse is increased social entrapment arising from discrimination experienced through racism, ableism, ageism, homophobia and transphobia, including in the context of service delivery. For victims dealing with substance-use issues, fear of stigmatisation and blame can create a further barrier to accessing help. For victims with disability, carer stress can be used to excuse or minimise coercive and violent behaviours.

These complexities require interventions that address the specific barriers for priority groups. Mainstream service responses require augmentation or specific program development, such as outreach initiatives, to identify and support victims who experience discrimination and stigmatisation. The following examples indicate some of the processes in train to increase access to DFV health services for priority populations and identify gaps that will be addressed over the life of this strategy.

Several programs are in place to reduce barriers to identification and support of victims from CALD backgrounds. These include training provided to health workers by ECAV on culturally informed practice with migrant and refugee communities and training for health staff conducting routine screening on working with interpreters. In addition, ECAV provides training for interpreters when working with victims of domestic and family violence and builds capacity for Bilingual Community Educators to increase awareness of domestic and family violence within their communities.

NSW Health is committed to inclusive and equitable health care for people with disability. In response to the recommendations by the Royal Commission into Institutionalised Responses to Child Sexual Abuse, ECAV has been commissioned to develop and implement a Sexual Assault and New Street services access strategy for people with disability. The co-design approach to the development of the strategy seeks to elevate the voices of people with disability into the design and implementation of the strategy and develop co-design capacity and skills within NSW Health.

The strategy will enhance the skills of violence, abuse and neglect services to respond to people with disabilities experiencing sexual assault, problematic and harmful sexual behaviour in children and young people and its co-occurrence with other forms of violence, abuse and neglect, including domestic and family violence. ECAV has established a disability portfolio team to support the development and implementation of the access strategy and related workforce development initiatives.

NSW Health is currently creating the first health strategy for people with diverse sexualities, gender identities and those with intersex variations. This strategy will provide direction to the NSW Health system to improve health outcomes for this priority population, as well as guide important partnership work with primary care and other community-based health services. A needs assessment conducted to inform development of this health strategy

revealed relatively high levels of difficulty in accessing a range of social services, including DFV services. It highlighted the need for the development of more targeted supports for this priority population when experiencing domestic and family violence and will inform ongoing service development.

Priority 2.2 - Actions:

2.2.1	Provide guidance for staff in conducting screening and making sensitive enquiry around domestic and family violence when working with people from priority populations (MoH, ECAV)
2.2.2	Facilitate ready access to trained interpreters (in community languages and Auslan) (ECAV, LHDs/SHNs)
2.2.3	Consider opportunities to extend the Education Centre Against Violence Domestic and Family Violence Bilingual Community Education Program statewide (ECAV, LHDs/SHNs)
2.2.4	Ensure people from priority populations can access targeted information (ECAV, LHDs/SHNs)
2.2.5	Establish advisory groups with representation from priority populations within districts and networks to co-design and reduce barriers to access (LHDs/SHNs)
2.2.6	Develop and implement a Sexual Assault and New Street services access strategy for people with disability to build the capacity of the workforce to respond to sexual assault, problematic and harmful sexual behaviour in children and young people and its cooccurrence with other forms of violence, abuse and neglect, including domestic and family violence (MoH, ECAV, LHDs/SHNs)
2.2.7	Clarify service expectations on meeting the needs of clients from priority populations as part of the review and update of NSW Health's violence, abuse and neglect service standards and associated audit tool (MoH)

Priority 2.3: Promote Aboriginal family wellbeing and violence prevention

NSW Health contributed to the development of targets under the National Agreement on Closing the Gap. This includes Target 13, which is aimed at reducing family violence and abuse against Aboriginal and Torres Strait islander women and children. During 2020-21, NSW Health is prioritising the development of a new Aboriginal Family Wellbeing and Violence Prevention Strategy which will provide strategic directions for the whole of the public health system to assist in achieving this target.

The new Aboriginal Family Wellbeing and Violence Prevention Strategy will provide whole-of-system guidance to the health sector on prevention, early intervention, and response to all forms of violence, abuse and neglect in Aboriginal communities. The strategy will also provide direction on improved governance and accountability for Aboriginal programs. The strategy will provide guidance on: how to nurture the spirit, resilience and cultural identity of Aboriginal families; the promotion of healing through cultural resilience; building partnerships; cultural respect; and co-design of services with Aboriginal communities. NSW Health services will be supported through the strategy to increase integration of Aboriginal models of practice.

The new strategy will strengthen the public health system's support for the critical role of NSW Health's Aboriginal Family Wellbeing and Violence Prevention workforce, which works closely with Aboriginal families and communities in different locations across the state. The Ministry of Health and ECAV continue to support this workforce through ongoing training and support for its statewide network. The Ministry is also prioritising work with the network to update the operational guidelines for this workforce.

Another strong foundation for the new strategy is the ECAV Aboriginal Qualification Pathway, which is building the capacity of the Aboriginal health workforce both within NSW Health and in Aboriginal Community Controlled Health Services and other non-government organisations, to deliver trauma-informed, culturally safe services to Aboriginal communities. The other plank of this foundation is ECAV's training for the wider health system on developing culturally safe, trauma-informed practice with Aboriginal families and communities.

The Aboriginal education team at the ECAV adopts a community development approach to informing Aboriginal communities about Aboriginal family violence. Guided by the Aboriginal Communities Matter Advisory Group, the team conducts a series of family violence workshops in communities, building trust over time. The program incorporates key elements that Aboriginal communities have identified as essential in prevention initiatives: a holistic approach and involvement of both men and women. Aboriginal leadership at all levels of the programs is a key element in creating cultural safety for participants. It is critical that NSW Health services prioritise community engagement strategies with Aboriginal communities through supporting strong links with these programs.

In addition to the Aboriginal Family Wellbeing and Violence Prevention Strategy, NSW Health is implementing initiatives through its response to the Royal Commission into Institutional Responses to Child Sexual Abuse that will build and support the Aboriginal workforce and improve access to Sexual Assault and VAN services for Aboriginal communities. This will see an expansion of the VAN Aboriginal workforce, strategies to support recruitment and retention, strategic and local planning, actions to improve accessibility of SAS and VAN services for Aboriginal people, and co-designing initiatives with Aboriginal people to ensure cultural safety and appropriateness in recognition of the intersection between different forms of violence.

Priority 2.3 - Actions:

2.3.1	Develop and implement the NSW Health Aboriginal Family Wellbeing and Violence Prevention Strategy that provides strategic direction for the whole of the public health system to assist in achieving the Closing the Gap Target 13 (MoH)
2.3.2	Develop updated operational guidelines supporting the Aboriginal Family Wellbeing and Violence Prevention workforce to work closely with local communities and develop innovative solutions based on local contextual factors (MoH)
2.3.3	Increase the Violence, Abuse and Neglect (VAN) Aboriginal workforce (MoH, LHDs/SHNs)
2.3.4	Build the cultural capability of Districts and Networks by: • Developing Sexual Assault Service Aboriginal Action Plans to strengthen community engagement and service accessibility (LHDs/SHNs) • Delivering cultural competency training for VAN Senior Executives and practitioners (MoH, ECAV)
2.3.5	Co-design the new holistic, public health based Safe Wayz program for children under the age of criminal responsibility with problematic and harmful sexual behaviours and their families to ensure it is a culturally safe model that responds to intersecting forms of violence, abuse and neglect (MoH, ECAV, LHDs/SHNs)
2.3.6	Establish a statewide Prevention and Response to Violence, Abuse and Neglect Aboriginal Advisory Group to provide policy and system reform advice from an Aboriginal social and cultural perspective and to promote the development of cultural safety and reduction of institutional racism in NSW Health services (MoH)

Education Centre Against Violence courses

For NSW Health staff

- Developing Culturally Safe Trauma Informed Practice in Aboriginal Communities

Aboriginal community workshops

- Weaving the Net
- Strong Aboriginal Men
- Strong Aboriginal Women

These address child protection, domestic and family violence, and sexual assault

Aboriginal Qualification Pathway three tiers:

1. Certificate IV in Aboriginal Family Wellbeing and Violence Prevention Work
2. Advanced Diploma of Aboriginal Specialist Trauma Counselling
3. Graduate Certificate in Human and Community Services (Interpersonal Trauma Stream) in a partnership with the University of Sydney.

Strategic Direction Three:

Provide trauma-informed, culturally safe, and integrated responses to victims of domestic and family violence

Strengthening NSW Health's specialist responses to victims of domestic and family violence is a core element of the first phase of NSW Health's ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework***.

Phase 2 of the implementation of the framework focuses on the broader health system's response to violence, abuse and neglect, including domestic and family violence. This will involve a cultural shift across all NSW Health services towards trauma-informed care and practice.

Trauma-informed care and practice is a strengths-based framework that recognises that many clients of welfare and health services, particularly those accessing mental health and alcohol and other drug services, have a history of trauma, and often of complex trauma.

Clients and health services may not recognise this trauma nor connect it to the presenting health issues that have brought the client to the health service. Trauma-informed approaches were developed in recognition that trauma-specific interventions on their own are insufficient; to maximise recovery and healing, attention needs to be directed to the context in which services are provided. The aim is to provide a safe, supportive environment to clients and staff that reflects an understanding of the impact of trauma. A collaborative approach between health care provider and victim, which restores a sense of dignity and control to the victim, is crucial.

NSW Health is developing an integrated trauma-informed care (ITIC) framework that will support the provision of trauma-informed, integrated health services to vulnerable children, young people and their families and carers. The framework has a focus on improving outcomes for those involved in the statutory child protection system, including out-of-home care. However, it also reflects a systems-level approach for NSW Health's response to all forms of violence, abuse and neglect, including domestic and family violence.

Six key principles of a trauma-informed approach

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical and gender issues

Source: SAMHSA, 2014 [32]

A key element of trauma-informed care is cultural safety. The concept of cultural safety was developed in New Zealand in response to the poor health status of Maori and has become an essential principle in efforts to reshape the ways in which health services are offered to Indigenous peoples, who bear similar legacies of colonisation and ongoing racism and disadvantage.

Fundamentally concerned with the operation of power in health care, the provision of cultural safety requires health care providers to examine their professional culture and their power and privilege, and to question taken-for-granted assumptions about difference. It does not entail learning about the cultures of 'others', but rather focuses on the health care provider. Crucially, assessment of cultural safety is in the hands of the recipient.[33]

Priority 3.1: Expand specialist services for domestic and family violence statewide

NSW Health is working to extend violence, abuse and neglect (VAN) services to include 24-hour trauma-specific and integrated psychosocial, medical and forensic responses to victims of domestic and family violence as part of the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework***. Victims of domestic and family violence will also receive additional follow-up psychosocial support and referral to facilitate their safety and recovery from trauma.

To support consistent statewide implementation, NSW Health is developing an evidence-informed, integrated domestic and family violence psychosocial, medical and forensic crisis response model for victims of domestic and family violence. The response model is being developed in partnership with NSW Police, Forensic and Analytical Science Service, and other stakeholders. The model will draw on NSW Health's well-established Sexual Assault Service model and existing psychosocial responses to domestic and family violence. It will standardise medical and forensic responses as part of an integrated counselling, medical and forensic response.

ECAV is broadening training provided to NSW Health's workforce of adult sexual assault medical examiners to develop their capability to respond to all forms of violence, abuse and neglect, including domestic and family violence. This includes offering a new Graduate Diploma in the Medical and Forensic Management of Violence, Abuse and Neglect. ECAV will also offer training to targeted NSW Health clinicians from outside violence, abuse and neglect services to take on the role of 'medical forensic associates' who provide trauma-informed medical care to victims of violence, abuse and neglect through forensic evidence documentation and evidence preservation, as well as support for specialist medical forensic examinations.

NSW Health recognises the ongoing workforce challenges in providing medical and forensic services in rural and regional NSW. The existing 'payment determination' to encourage and attract examiners to provide medical forensic sexual assault services in rural and regional local health districts will be reviewed by the Ministry of Health in consultation with districts, to consider how the determination could support the provision of 24/7 violence, abuse and neglect crisis responses.

Priority 3.1 - Actions:

3.1.1	Expand integrated statewide violence, abuse and neglect service provision for victims of domestic and family violence (LHDs/SHNs)
3.1.2	Develop and implement the NSW Health integrated domestic and family violence psychosocial, medical and forensic crisis response model (MoH, LHDs/SHNs)
3.1.3	Build medical and forensic workforce capacity to respond to domestic and family violence (ECAV, LHDs/SHNs)
3.1.4	Review medical forensic payment determinations for rural and regional districts to consider their application to domestic and family violence medical and forensic responses (MoH, LHDs/SHNs)

Priority 3.2: Promote comprehensive health service responses to domestic and family violence that incorporate risk assessment, safety planning, referral, and integrated support

Domestic and family violence might be identified by any part of the health system and health workers need to be aware of what is required to ensure victims receive appropriate support. This includes building the broader health workforce's capacity to provide an initial response and its awareness and use of consultation and referral pathways with specialist health violence, abuse and neglect services and the broader service system.

NSW Health is working to adopt an integrated system of identification, risk assessment and safety planning that:

- ensures that immediate safety concerns or serious threats are ascertained and addressed and, where appropriate, facilitates referral to NSW Health's crisis response and to Safer Pathway (see also priority action 1)
- links victims to specialist domestic violence services (within and outside NSW Health) for ongoing support
- promotes health practitioners' ongoing work with victims to identify and respond to their safety and health needs.

Risk assessment is an important part of NSW Health's initial and ongoing response to disclosures. It means making a professional judgment about the risk factors that are present, combined with the client's own assessment of risk to determine the likelihood of future violence and the potential for harm, including serious injury or death. Partnering with the victim is essential in risk assessment and safety planning, which must be informed by the actions she is already taking (often not visible to others) towards increased safety for herself and any children, and her experience of the perpetrator's responses.

While only trained psychosocial staff or specialist violence, abuse and neglect clinicians should undertake formal risk assessment, all health workers need to understand general issues around risk so that they can take appropriate action when violence or abuse is disclosed. That action might be referral to a specialist violence, abuse and neglect service or another agency that can respond with detailed risk assessment, safety planning and support.

The use of a common risk assessment tool is a core element of the Safer Pathway program, the system-wide, service system infrastructure for DFV victims in NSW, which aims to provide all victims with a timely, effective, and consistent response. As part of this multi-agency response, health staff participate in safety action meetings (SAMs), attended fortnightly by government and community-based services to provide targeted, interagency responses aimed at reducing serious threat to victims. Beyond NSW Health's engagement through SAM meetings, NSW Health will work with interagency partners to strengthen referral pathways from NSW Health to Safer Pathway.

Priority 3.2 - Actions:

3.2.1	Increase the capacity of NSW Health workers to assess domestic and family violence risk and undertake safety planning (MoH, ECAV, LHDs/SHNs)
3.2.2	Develop and promote domestic and family violence referral pathways across government and non-government sectors (LHDs/SHNs)
3.2.3	Develop and implement policy and practice guidance to enhance the use of structured risk assessment to support safety planning and response across key health settings (MoH, LHDs/SHNs)
3.2.4	Develop health protocols for identifying and referring clients at serious threat to the Safer Pathway program (MoH, LHDs/SHNs)

Characteristics of helpful, safety-promoting responses to Domestic and Family Violence

- Respond to disclosures of violence with belief and empathy and avoid blame and judgement.
- Recognise that IPV is a pattern of harmful behaviour that belongs to the abusive person (not the relationship) and is bigger than the incidents of physical violence that occur on any occasion (which may include the victim physically fighting back).
- In assessing risk, focus in detail on the behaviours that the person using violence is employing to exercise coercive control and their effects on the victim and their children, rather than on what the victim is *not* doing.
- Recognise that victims resist coercive control, but that safety requires multi-agency strategies for containing, challenging and changing the behaviours of those using violence.

Source: Adapted from NZ Family Violence Death Review Committee (2015) [34]

Priority 3.3: Build workforce capacity to offer trauma-informed and culturally safe responses

Many clients of health services, such as mental health, alcohol and other drug, and child protection, have extensive trauma histories, and consequently, have complex service needs that cannot be responded to by one health service or one agency alone. A trauma-informed lens provides a common framework for understanding the various manifestations of trauma responses, no matter where in the health system a victim discloses or is identified. This can promote collaborative health and cross-agency interventions to address complex client needs without fragmentation of service delivery. For Aboriginal clients with complex intergenerational trauma histories, the barriers to receiving help are compounded by current and past experiences of racism. Effective assistance needs not only to be trauma-informed but also culturally safe.

Patient reported measures (PRMs) are a critical component of achieving the NSW Health vision for truly integrated, better-value care across the state by better understanding patient experience. PRMs are typically divided into two groups:

- patient reported outcome measures

(PROMs), which capture the patient's perspectives about how illness or care impacts on their health and wellbeing

- patient reported experience measures (PREMs), which capture a person's perception of their experience with healthcare systems or services.

Routine collection, measurement and timely reporting of PRMs provide significant opportunities to improve clinical practice, support patients and drive system-wide improvements in providing trauma-informed and culturally safe responses for victims.

Priorty 3.3 - Actions:

3.3.1	Develop and promote workforce development opportunities that support trauma-informed and culturally safe practice (MoH, HETI, ECAV, LHDs/SHNs)
3.3.2	Embed patient reported measures into routine practice so that clinicians use this data to improve clinical practice, support patients and drive system-wide improvements in trauma-informed and culturally safe responses for victims (ACI, LHDs/SHNs)

Priority 3.4: Support the workforce and build resilience

Staff responding to domestic and family violence should be supported by good line management and clinical supervision. In addition to continuous improvement of clinical practice, the provision of supervision also addresses current client and worker safety issues and the challenges of engaging in work with domestic and family violence, including the impacts of vicarious trauma and support to increase vicarious resilience.[35]

The prevalence of domestic and family violence and other forms of interpersonal violence in the community makes it inevitable that the health workforce will include staff with their own present or past experiences of violence. Line managers and clinical supervisors will respond as required by consulting with violence, abuse and neglect specialists, assessing risk to the staff member and other health staff, developing safety plans, providing support in accessing domestic violence leave and other work adjustments, and referring as appropriate, including to legal services and employee assistance programs.

Priority 3.4 - Actions:

3.4.1	Ensure staff responding to clients experiencing domestic and family violence or experiencing vicarious trauma have regular access to clinical and/or specialist supervision, de-briefing and other workplace supports (LHDs/SHNs, HETI)
3.4.2	Promote provisions and supports available for NSW Health workers who may be experiencing domestic and family violence (LHDs/SHNs)
3.4.3	Promote access to Aboriginal cultural supervision for workers responding to Aboriginal clients experiencing domestic and family violence (LHDs/SHNs, MoH, ECAV)

Strategic Direction Four:

Increase visability and accountability of perpetrators while keeping victims safe

Intervention with perpetrators of domestic and family violence is a complex area that requires specialist skills and knowledge and is primarily offered by registered, specialist men's behaviour change programs in the community sector. However, men who perpetrate domestic and family violence access a broad range of health services and are entitled to have their health needs addressed. This means that health professionals need to understand the dynamics of domestic and family violence to avoid increasing risk to the safety of victims.

Effective health responses to domestic and family violence should always prioritise victim safety and promote perpetrator accountability.

The actions of perpetrators of domestic and family violence should be 'kept in view' during NSW Health service delivery. This means that all NSW Health services should have procedures and processes in place to ensure that any identification or disclosure of violence is addressed, and services do not inadvertently collude with the perpetrator; for example, by blaming a woman for not leaving, or by holding her equally accountable for the violence and the impacts on her children. This also includes ensuring relevant information is shared with other services in accordance with laws and NSW Health policy to promote victim safety. Responses to clients who are identified as perpetrators should be informed by a thorough understanding of risk, safety and wellbeing of adult and child victims and the community.

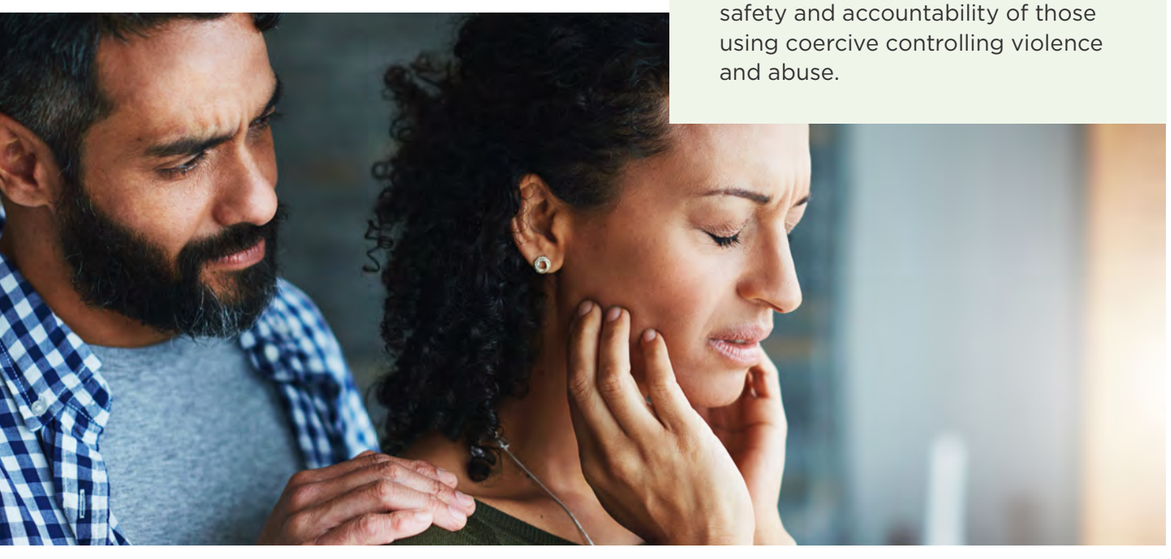
It is important to recognise that children and young people who engage in domestic and family violence require a different response to adults. The frequent co-occurrence of child abuse and domestic and family violence means that the violent behaviours of young people need to be assessed within a child protection context and that interventions need to be developmentally appropriate and recognise that adolescence is a developmental period in which there is opportunity for early intervention (see also Strategic Direction Six).

Key principles when responding to a man who may be using coercive controlling behaviours, including violence and abuse

1. Keeping victim safety (including that of children) at the centre of all decisions and actions taken.
2. Keeping the man in view of the service system so that his risk of violence and harm to others can be effectively managed.
3. Contributing to and supporting a multi-agency risk management response, appropriate to your service's engagement and practitioner role with the man.

This is achieved with:

1. consistent, shared understandings of domestic and family violence and risk indicators
2. knowledge of the accountability systems in place to respond to the risk of violence and workplace protocols to safely engage with those accountability systems
3. consistent information-sharing, effective referrals, and collaboration between services that promote victim safety and accountability of those using coercive controlling violence and abuse.



Priority 4.1: Support the workforce to prioritise victim safety by keeping perpetrator tactics in view in all health interventions

NSW Health will support staff to prioritise the safety of adult and child victims and reduce victim blame through workforce development that addresses:

- assessing and responding to risk
- identifying perpetrator tactics and patterns of coercive control
- partnering with the victim and other services supporting the victim
- keeping the perpetrator's tactics in view
- supporting the victim's resistance and efforts to establish their own and their children's safety
- legal responses to perpetration and legal protections for victims
- the importance of interagency collaboration for safety and accountability.

NSW Health participated in the Safe and Together: Addressing Complexity (STACY) research project to develop practice with families experiencing co-occurring domestic violence, mental health and substance use issues. The Safe and Together model is a collaborative approach that aims to keep children safe and together with the non-offending parent and reduce the risk of harm to the child by holding the perpetrator to account for the use of violence and coercive control. The STACY project undertook action research and involved the participation of NSW Health (primarily Whole Family Teams), non-government, and statutory child protection staff in communities of practice, coached by the consultants from the Safe and Together Institute.

A key outcome of the STACY project was the development of the forthcoming resource: ***Practice Guide: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues***.[36] This process drew on the expertise of participants and provides a cohort of health staff who are an important resource for the health system in the continuing development of this innovative approach.

As a next step in the process, NSW Health has engaged the University of Melbourne to undertake the Evidence to Support Safe and Together Implementation and Evaluation (ESTIE) project. This project will focus on workforce capacity building, practice-led policy design, and evaluation of practice development using the Safe and Together model. NSW Health has engaged the Safe and Together Institute for two years from June 2020 to support the ESTIE project and run parallel training for the violence, abuse and neglect workforce to increase worker knowledge and capacity in working with children and families living with domestic and family violence where there are intersecting mental health and AOD issues.

Priority 4.1 - Actions:

4.1.1	Support identified workers to develop skills, knowledge, attitudes, and values that centralise adult and child victim safety and perpetrator accountability (LHDs/SHNs, ECAV, HETI, MoH)
4.1.2	Undertake The Evidence to Support Safe and Together Implementation and Evaluation (ESTIE) Project (MoH, LHDs/SHNs)

Priority 4.2: Provide learning and development opportunities that upskill workers to identify and respond effectively to perpetrators when domestic and family violence is identified

The type and level of engagement with perpetrators regarding their use of violence will vary depending on the role and responsibilities of health practitioners. Health workers who have frequent contact with perpetrators, particularly in child and family health, child protection, alcohol and other drug, and mental health services, should have sound knowledge of the dynamics of domestic and family violence, and the opportunity to develop skills including:

- where it is identified as safe to do so, naming the behaviour and holding the perpetrator accountable
- where a perpetrator discloses their use of violence, responding to promote victim safety and avoid minimising or excusing the behaviour
- providing referral pathways to specialist services for perpetrators, including the Men's Referral Service and registered men's behaviour change programs
- recognising that staff working with men who are using violence have an ethical responsibility to the adult and child victims who may not be the primary client.[37]

In addition, training tailored to understanding the ways in which perpetrator strategies may manifest in specific health contexts will inform health professionals about the ways in which perpetrators can use the victim's vulnerabilities and use of health care to shape their tactics of coercive control.

ECAV provides training for both specialist men's behaviour change professionals, and for wider system workers seeking safer practices for engaging men towards safety and change where no specialist men's behaviour change program is available.

Training is embedded in a gender-focused, intersectional and collaborative framework that prioritises the safety and wellbeing of partners, children and other family members impacted by domestic and family violence.

Staff will also be supported in how to respond to perpetration by policy guidance (including legal requirements such as exchange of information and mandatory notification), referral resources and specialist consultation from violence, abuse and neglect services and Child Wellbeing Units. The impacts on staff safety and wellbeing will also be addressed with clearly outlined debriefing and supervision frameworks.

Priority 4.2 - Actions:

4.2.1	Develop and promote workforce development initiatives to build the skills, confidence and competencies of staff, in line with their roles (LHDs/SHNs, ECAV, HETI)
4.2.2	Support appropriate referrals to registered men's behaviour change programs (LHDs/SHNs)
4.2.3	Ensure that worker safety (physical and emotional) is explicitly addressed and regularly reviewed through clear policies and procedures and supervision (LHDs/SHNs, HETI)
4.2.4	Develop training for managers, human resources staff and other relevant staff and supervisors on how to support staff and create a safe working environment (HETI, LHDs/SHNs)

Examples of coercive and controlling behaviours

- Depriving a person of their basic needs
- monitoring their time
- monitoring them via online communication tools or using spyware
- taking control over everyday aspects of their life, such as where they can go, who they can see, what to wear and when they can sleep
- depriving them of access to support services, such as medical services
- repeatedly putting them down, such as telling them they are worthless
- enforcing rules that humiliate, degrade, or dehumanise them
- forcing them to take part in criminal activity such as shoplifting or neglect or abuse of children to encourage self-blame or prevent disclosure to authorities
- threatening to reveal or publish private information
- preventing them from having access to transport or work
- reproductive coercion, such as forcing or stopping contraceptive usage

Source: Adapted from Home Office (2015) [38]

Priority 4.3: Collaborate with interagency partners to prevent re-offending and keep victim-survivors and children safe

Victim safety and perpetrator accountability require sound and safe integrated practice models across government and community agencies. Where appropriate, health staff participate in cross agency initiatives such as Safer Pathway (discussed earlier) and the Local Coordinated Multi-agency offender management program (LCM). The LCM brings together the following government agencies: Department of Communities and Justice (including Corrective Services and Family and Community Services), NSW Police and NSW Health to share information and expertise with the aim of reducing re-offending, including in the area of domestic and family violence.

The complexity of the intersections of mental health, substance use and domestic and family violence requires the development of new practice approaches and enhanced collaboration, including information sharing, to address these intersecting issues while maintaining the focus on adult and child victim safety and perpetrator accountability. These intersections and opportunities for improved systems responses have been highlighted in NSW Domestic Violence Death Review Team reports and feature in a number of the team's recommendations. [39, 40] NSW Health is also progressing this work through participation in the ESTIE Project and the progression of NSW Health responses to Domestic Violence Death Review Team recommendations that seek to address these complex intersections (see Strategic Directions actions 4.1.2 and 6.2.1).

Priority 4.3 - Actions:

4.3.1	Participate in and support cross-agency initiatives that promote justice and behaviour change (MoH, LHDs/SHNs)
4.3.2	Progress strategies to promote information sharing about perpetrators with co-occurring mental health, alcohol and other drugs or disability issues between health services and other agencies to promote justice outcomes and victim safety (MoH, LHDs/SHNs)

Strategic Direction Five:
Harness evidence and promote quality and safety in responding to domestic and family violence

High-quality care and support services contribute to reduced trauma for victims and prevent repeat victimisation and perpetration.

The NSW Health system is committed to the continued development and delivery of high-quality, evidence-informed services and responses to support the prevention of, and response to, domestic and family violence.

The priorities for action within this strategic direction recognise the importance of using diverse evidence and data sources and expertise from both within and beyond NSW Health to support continuous improvement to NSW Health's responses. These will ensure that service delivery is based on the best available evidence and that, no matter where in NSW people and their families present to the NSW Health system, they receive a similar, high-quality and comprehensive service response that addresses their health, safety and wellbeing needs appropriately.

Priority 5.1: Implement evidence-informed policies and clinical interventions

The Ministry of Health provides leadership through the development and continuous review of policies, clinical guidelines, protocols and work and service processes to ensure that the workforce has the best available and most comprehensive evidence to guide their work. For example, the ***NSW Health Violence, Abuse and Neglect Service Standards*** provide districts and networks with a tool to: improve consistency across service provision; define the minimal, acceptable level of service delivery provided by violence, abuse and neglect services; facilitate service users receiving a consistent and high-quality service; and support continuous review and improvement of services.

The Ministry has engaged the Agency for Clinical Innovation to establish the Violence, Abuse and Neglect (VAN) Clinical Network in NSW Health. The network brings together clinicians, managers, clients and carers to develop innovative models of care, give guidance to the system, and improve service delivery, system capability and client and staff experience relating to violence, abuse and neglect service delivery and mainstream responsiveness, including in the area of domestic and family violence.

Clinical documentation is critical not only for the purposes of ongoing healthcare. Victims of domestic and family violence are commonly involved in multiple legal systems — criminal, civil, statutory child protection and family law — where clinical records can facilitate access to justice. The provision of expert evidence can also support victims' access to justice and is an important element of NSW Health's contribution to the integrated, interagency response to domestic and family violence.

Creating greater clarity and consistency in how information is recorded and managed in the various clinical information systems is important to delivering a more comprehensive and integrated response that ensures the right people have access to the right information at the right time. Appropriate safeguards need to be implemented to ensure that information-sharing is balanced with protection of the confidentiality of sensitive client information and that safety is always centred.

NSW Health has a leading role in promoting and translating emerging evidence around the health impacts of lesser known forms of domestic and family violence to both internal and external stakeholders. This includes profiling evidence around family violence being a significant cause of acquired brain injury, which can result in physical, cognitive and behavioural disability, with long-term consequences.[13]

Evidence informs the training that is provided to continue to build a health workforce with the knowledge and skills to prevent and respond to domestic and family violence. ECAV leads the health sector in this area through its training and workforce programs that emphasise the translation of evidence into practice, ensuring high quality clinical responses, cross-agency partnerships and advocacy. For example, ECAV has conducted forums to disseminate emerging evidence about assessing high-risk factors such as non-fatal strangulation.

Priority 5.1 - Actions:

5.1.1	Develop policy and practice guidance for NSW Health staff on best practice approaches to documenting violence, abuse and neglect in clinical records, including recording perpetrator tactics and protective behaviours of victims (MoH, LHDs/SHNs, eHealth, CEC)
5.1.2	Develop state-based designs of clinical systems to meet business requirements on information-sharing and to support client safety, including guidance on implementation (eHealth)
5.1.3	Develop and promote the evidence base around lesser known forms of domestic and family violence, including non-fatal strangulation and reproductive coercion, and their health impacts, in collaboration with expert clinicians and partner agencies (MoH, ECAV, ACI)
5.1.4	Develop clinical guidelines for non-fatal strangulation (ACI)

Priority 5.2: Enhance quality, safety and incident management systems

In addition to the specific initiatives addressing the quality of violence, abuse and neglect responses, quality and safety are supported by broader health structures and policies. For example, the Clinical Excellence Commission (CEC), a NSW Health pillar, provides specialist services and support to frontline health teams in hospitals and care settings. Its role is to lead, support and promote improved safety and quality in clinical care across the NSW health system through consultation and collaboration with clinicians, health consumers, other pillars and the NSW Ministry of Health. It is responsible for setting standards for safety and monitoring clinical safety and quality processes and improving performance of individuals, teams and systems in prioritising safety. Supported by the Ministry of Health, the CEC continues to expand its knowledge, capacity and capability to provide leadership on NSW Health's response to violence, abuse and neglect, including domestic and family violence.

During 2020, new legislation to strengthen NSW Health's incident management system was developed along with a new incident management policy, education and resources. The revised system provides increased flexibility around the methodology used to review serious adverse events and incidents, allowing for alternate methodologies to root cause analysis. In developing the new NSW incident management policy, NSW Health considered how to incorporate processes to review and learn from deaths, major harm and 'near misses' resulting from domestic and family violence and child abuse and neglect where NSW Health did not take appropriate action or intervention to respond to the abuse.

Priority 5.2 - Actions:

5.2.1	Strengthen NSW Health's incident management systems to support improved identification, review and analysis of health responses to domestic and family violence and other forms of violence abuse and neglect (CEC, MoH, BHI)
5.2.2	Enhance collaboration between the Ministry of Health, Clinical Excellence Commission, NSW Domestic Violence Death Review Team and the NSW Ombudsman in the system response to domestic violence-related homicides and serious incidents (MoH, CEC)

Strategic Direction Six:

Enhance the public health system's response to domestic and family violence

The NSW Government has set a broad reform agenda for its response to domestic and family violence, including the Premier's Priority on reducing domestic violence reoffending and the ***NSW Domestic Violence Blueprint for Reform***.

NSW Health is an active participant in the whole-of-government reforms as well as working to strengthen its system internally through the ***Violence, Abuse and Neglect Redesign Program***, of which the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework*** is a key deliverable.

Priority 6.1: Strengthen leadership, governance, and accountability

Strengthening leadership, governance and accountability is a key objective in the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework***. During phase one of the redesign process, NSW Health has consolidated governance of its VAN services through the VAN statewide governance and meetings structure, which includes strong system-wide leadership by the PARVAN Senior Executive Steering Committee alongside a number of specialist working groups reporting to this committee.

As part of strengthening governance, phase one of the redesign program focuses on consolidating NSW Health strategies, policies and procedures across VAN service streams, including for domestic and family violence. This will include, for example, updated guidance around risk assessment and safety planning, the Safer Pathway program and NSW Health's service response and referrals for perpetrators of domestic and family violence.

Data collection and reporting is being reviewed through PARVAN's Data Systems and Analytics Implementation Roadmap. The roadmap includes a NSW Health Violence, Abuse and Neglect Minimum Data Set, Domestic Violence Routine Screening Minimum Data Set, development of solutions to store these data collections in the Ministry's Enterprise Data Warehouse (EDWARD), and reporting tools as required. This approach is aligned with the NSW Health Analytics Framework, and, in time, will allow violence, abuse and neglect data to be monitored to inform service planning and evaluation.

Priority 6.1 - Actions:

6.1.1	Develop and implement updated NSW Health policy and procedures for identifying and responding to domestic and family violence (MoH, LHDs/SHNs)
6.1.2	Review and update the NSW Health guide to role delineation of clinical services to incorporate service responses to domestic and family violence (MoH)

Priority 6.2: Integrate health responses for victims of domestic and family violence

The second phase of implementation of the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework*** focuses on developing integrated responses to violence, abuse and neglect, including domestic and family violence, between VAN services and other NSW Health services and with partner agencies. An integrated response entails the provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course. This approach is consistent with current health policies underpinning transformative system change, such as NSW Health's ***Strategic Framework for Integrating Care*** and the ***Leading Better Value Care Program***. These provide strong systemic support for the ongoing development and strengthening of prevention and responses to domestic and family violence.

Mental health and alcohol and other drug services are priority areas for integrating health responses for victims of domestic and family violence during the second phase of implementation of the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework***. This work will give effect to a number of recommendations by the NSW Domestic Violence Death Review Team in its 2017-19 report[39] and in previous reports and will be further supported by the implementation of the ESTIE project (see Strategic Direction Four, priority 1).

An integrated, specialist treatment service for adult survivors of child sexual abuse with complex needs pilot project is being progressed as part of NSW Health's response to the Royal Commission into Institutional Responses to Child Sexual Abuse. This project includes development of an integrated therapeutic treatment and case management model between sexual assault, mental health, and alcohol and other drug services and subsequent statewide rollout of a new specialist service. Addressing the significant intersections between domestic and family violence and sexual assault (including childhood sexual abuse), is part of this initiative.

Priority 6.2 - Actions:

6.2.1	Progress responses to the recommendations of the Domestic Violence Death Review Team on the intersection of mental health, alcohol and other drugs and domestic and family violence in collaboration with our interagency partners (MoH, LHDs/SHNs)
6.2.2	Develop communities of practice involving the violence, abuse and neglect sector and broader health workforce and interagency and non-government organisation partners responding to domestic and family violence (ACI, ECAV)
6.2.3	Establish links between different NSW Health networks and governance structures that directly and indirectly respond to domestic and family violence to enhance collaboration (MoH, ACI)
6.2.4	Develop and implement a specialist treatment service for adult survivors of child sexual assault, including strategies to address the intersection of sexual assault and domestic and family violence (MoH, LHDs/SHNs)

Priority 6.3: Align NSW Health systems to national and state reforms

No single service or service system has the capacity or expertise to respond to all facets of complex health and social issues such as domestic and family violence.

Over the past four years, NSW Health has been collaborating with its partner agencies in the NSW DFV system to implement the ***NSW Domestic Violence Blueprint for Reform***. NSW Health is represented on the Domestic and Family Violence Reforms Delivery Board, which provides leadership and governance to the system. NSW Health's reform directions in the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework*** and this strategy, including increasing service integration and strengthening responses to priority populations such as Aboriginal communities, are consistent with findings and recommendations of the recent ***Blueprint Evaluation Report***.

As well as collaborating with NSW state government partner agencies, NSW Health aligns its initiatives and responses to the ***Fourth Action Plan under the National Plan to Reduce Violence against Women and their Children 2010-2022***, which was endorsed by the Council of Australian Governments in August 2019. One of the Commonwealth Government's initiatives under the plan is investment in training and resources to improve the capacity of general practice doctors and nurses to identify and respond to domestic and family violence.

NSW Health also has its own contract with the Royal Australian College of General Practitioners to support capacity building in the primary care sector in violence, abuse and neglect. NSW Health continues to explore opportunities to support general practitioners' identification and response to domestic and family violence, including supporting referrals into the public health system through the Health Pathways project under development.

Priority 6.3 - Actions:

6.3.1	Contribute to interagency planning, implementation, monitoring and evaluation mechanisms of domestic and family violence responses in NSW (MoH, LHDs/SHNs)
6.3.2	Work with public health networks to strengthen the capacity and capability of general practice doctors and nurses to identify and respond to domestic and family violence (MoH, LHDs/SHNs)

Priority 6.4: Expand policies, guidance and workforce development to address all forms of domestic and family violence

Building and maintaining an appropriately skilled workforce is critical to achieving the priorities for action set out in this strategy. As outlined in the ***Integrated Prevention and Response to Violence, Abuse and Neglect Framework***, ECAV and the Ministry of Health, in collaboration with districts, networks and the Health Education and Training Institute (HETI), will develop and implement a NSW Health Competency and Training Framework for Preventing and Responding to Violence, Abuse and Neglect. This will identify different competency levels required across the NSW Health system. A learning and development continuum will facilitate health professionals in acquiring, maintaining, and building skills for better responding to domestic and family violence throughout their career. HETI and ECAV will work in close partnership to ensure a range of customised learning pathways are accessible to health workers across NSW throughout the course of their employment. Staff should be actively encouraged and supported to participate in ongoing training and professional development; with training on DVRS for workers in priority settings particularly promoted.

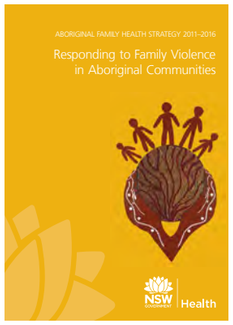
IPV has traditionally been the focus of research, policy and practice development in Australia and internationally. The data on family violence indicates that there is a need to develop NSW Health's identification and response to other forms of family violence in collaboration with agency partners. For example:

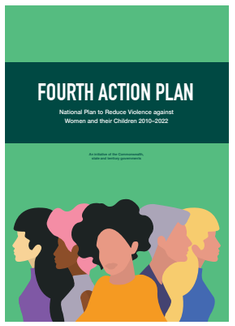
- Around seven per cent of all DFV assaults are committed by young people, yet there is a dearth of services responding to this form of domestic and family violence and a large proportion of these young people become involved in the criminal justice system and are subject to an apprehended violence order. Both can have severe effects on the young person's future life chances. These responses do not address the fact that most of these young people have also been victims of domestic and family violence.
- Abuse of older people can involve the continuation of IPV or abuse of an older person by other family members exploiting their vulnerability, such as financial abuse by adult children. Ageism can render these experiences invisible.

Priority 6.4 - Actions:

6.4.1	Develop and implement a NSW Health Competency and Training Framework for Preventing and Responding to Violence, Abuse and Neglect (ECAV, MoH, HETI, and LHDs/SHNs)
6.4.2	Collaborate with agency partners to broaden responses to all forms of domestic and family violence (MoH, ECAV, LHDs/SHNs)
6.4.3	Ensure that violence, abuse and neglect policies link with intersecting policy areas — e.g. youth, disability, older people (MoH)

Appendix 1 - Related strategies





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