



Submission to the House of Representatives Standing Committee  
on Social Policy and Legal Affairs

Inquiry into Family, Domestic and Sexual Violence

August 2020

Illawarra Women's Health Centre

and the

University of NSW

Committee Secretary  
House of Representatives Standing Committee on Social Policy and Legal Affairs  
PO Box 6021  
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Canberra ACT 2600



The House Standing Committee on Social Policy and Legal Affairs adopted an inquiry into family, domestic and sexual violence on 4 June 2020.

This submission responds to the call for submissions during June-July 2020.

This submission is public, it is not confidential, and names need not be withheld.

For further information on this submission please contact Sally Stevenson, General Manager, at

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This is a joint submission by **The Illawarra Women's Health Centre** and the **School of Population Health and the School of Social Sciences at the University of New South Wales**.

### **The Illawarra Women's Health Centre**

Nationally accredited, the Illawarra Women's Health Centre has a focus on mental health, women experiencing domestic and family violence and sexual assault, and sexual and reproductive health. The community-based Centre sees over 6,000 women a year and has an exceptional reputation, providing integrated care and social support to women with complex needs using a social model of health and a community development approach to service delivery.

The Centre is a women's only space, and its doctors, nurses, psychologists, counsellors and social workers are all female, experienced and trauma informed. The Centre offers specialised domestic and family violence programs for girls, boys and young women, and women with intellectual disabilities. It also developed the first in Australia, Mothers and Sons Program which focuses on raising young boys into respectful men.

The Centre also runs a wide range of health and wellbeing programs and group activities. These include community led group activities, as well as structured programs on healthy relationships and self-esteem. The groups are critical to reducing social isolation (a risk factor and symptom of domestic violence) and building community cohesion and capacity.

**Sally Stevenson AM** is General Manager of the Illawarra Women's Health Centre. She is the Principal Investigator on two joint University of Wollongong and Illawarra Women's Health Centre research projects on domestic and family violence, and Chief Investigator on a University of NSW project investigating persistent pain and trauma with Dr Cullen. Ms Stevenson is a board member of Women's Health NSW, the peak body for NSW women's health centres and has been on the board of Supported Accommodation & Homelessness Services Shoalhaven Illawarra (SASSHI) which is the region's specialist service for homelessness. She has worked for Médecins sans Frontières, the World Health Organisation and the World Bank, and has been a member of the Independent Review Committee of the Global Alliance for Vaccines and Immunisation, the International Advisory Committee for Sexual Health and Family Planning Australia and the Human Research Ethics Committee of the University of Wollongong.

**Dr Karen Williams** is a Special Advisor, Mental Health to the Illawarra Women's Health Centre. She is currently a general adult Psychiatrist at South Coast Private Hospital and has a special interest in trauma and trauma focused therapy. She has extensive experience working with patients who have complex Post Traumatic Stress Disorder. In 2016 she was awarded a fellowship from the NSW Institute of Psychiatry, is a Member of the RANZCP Family Violence Psychiatry Network Committee and the founder of is a member of 'Doctors Against Violence Towards Women', an Australian network of doctors calling for Australia's first domestic violence trauma recovery Centre and advocating for ongoing care for victims who suffer trauma.

### **The School of Population Health, UNSW**

The School of Population Health at UNSW brings together interdisciplinary expertise from psychology, epidemiology, health promotion, health systems, data science, social science, implementation science and health economics. It has a long and successful track record of collaborative research and a robust history of genuine partnerships with health services and communities, including Aboriginal and Torres Strait Islander communities and people with diverse lived experience.

**Dr Patricia Cullen** is a NHMRC Early Career Fellow in the School of Population Health at UNSW where she co-leads the Child and Adolescent Health theme. She is also an Honorary Research Fellow at The George Institute for Global Health and at Ngarruwan Ngadju First Peoples Health and Wellbeing Research Centre at the University of Wollongong. Dr Cullen is collaborating across three NHMRC Centres of Research Excellence in Adolescent Health to improve health pathways for young people. She is also working with key community partners to co-design innovative care-coordination programs that work with and improve the lives of women, young people and families impacted by injury, violence and trauma. Much of this research is interdisciplinary and centres on de-pathologising how we view trauma, advancing our understanding of the social and structural determinants and integrating trauma-informed responses across sectors. As an advocate for preventing family and intimate partner homicide, she has led reviews of homicide cases in Australia to understand trajectories and strengthen responses. Demonstrating commitment to translational research, she has contributed to government and WHO commissioned reports, submissions to parliament, national and international conferences, and regularly engages with policy and community agencies

### **The School of Social Sciences, UNSW**

Hallmarked by our innovative multidisciplinary degree options, our world-class academics, the global impact of our research and our commitment to social justice, UNSW School of Social Science is leading the way for teaching and research in 21st-century social sciences. We're renowned globally for the strength of our research and leading academics, putting UNSW School of Social Sciences at the forefront of Social Science in Australia and beyond.

**Scientia Associate Professor Michael Salter** is a criminologist and research fellow at the University of New South Wales, where he studies the criminological aspects of complex trauma. His research focuses on the violence and exploitation that underlies trauma and dissociation, and the responses of professionals and services to the complex entanglements of abuse and trauma. He is the author of two books, *Organised Sexual Abuse* (Routledge, 2013) and *Crime, Justice and Social Media* (Routledge, 2017), and many papers on child abuse and gendered violence. He sits on the Board of Directors of the International Society for the Study of Trauma and Dissociation and advises child protection and violence prevention agencies in Australia and internationally, including White Ribbon Australia, the Australian Office of the eSafety Commissioner and the Canadian Centre for Child Protection. He is the associate editor of *Child Abuse Review* and he is a member of the editorial board of the *Journal of Trauma and Dissociation*.

## 1. Introduction

Our submission is particularly concerned with the health impacts of violence and abuse on women and the need to respond to the critical gap in services and support for women recovering from these impacts – many of them traumatic and long term.

The terms of reference do not call specifically for comment on the health impacts of family, domestic, and sexual violence (FDSV). However, the **health consequences of violence and abuse are critical, substantial, and ongoing**. Therefore, although this submission is most relevant to the following components, it takes an overarching approach to the terms of reference.

- d) The way that health, housing, access to services, including legal services, and women's economic independence impact on the ability of women to escape domestic violence.
- j) The views and experiences of frontline services, advocacy groups and others throughout this unprecedented time.
- l) Any other related matters

## 2. Summary

- 2.1 FDSV against women is a public health emergency and occurs in epidemic proportions in Australia.
- 2.2 The mental and physical health consequences of FDSV are significant, long lasting and evidence based - impacting women, children, future generations, our community, our economy and ultimately, our country.
- 2.3 The Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children 2010-2022 (The National Plan) acknowledges that progress toward ending violence against women and children is complex and will take sustained long-term action. At all levels of government there is increasing recognition of the need to go beyond the crisis intervention model and address the long-term impact of trauma, particularly in terms of the complex psychosocial needs of women and their families [NSW Domestic and Family violence Blueprint for Reform 2016-2021].
- 2.4 Our public health system does not offer adequate or appropriate support to women who experience FDSV, severely limiting their ability to recover from the trauma that results from this abuse [Salter et al., 2020].
- 2.5 The impact of the COVID-19 pandemic has critically exacerbated this emergency, and simultaneously thrown into stark relief the lack of services available to women seeking support because of FDSV. The FDSV and related health, financial, and social impact on women from the pandemic will last for decades and the consequences will flow through our entire community.
- 2.6 FDSV costs at least \$22billion a year to our country. In the context of the COVID pandemic, this is just the beginning [Morgan, Boxall, & Brown, 2020].
- 2.7 Evidence-based practical solutions are urgently needed.

2.8 Our **recommendation** to the Committee is that as part of the next National Plan to Reduce Violence against Women and their Children, the Commonwealth Government invest in the establishment of an Australian-first community-led **Women's Trauma Recovery Centre**.

- Strongly aligned with priorities in both the National Plan and the National Women's Health Strategy 2020 -2030, this initiative will comprehensively address the impacts of FDSV to improve long-term health and psychosocial outcomes for women and families, including breaking the cycles of ongoing exposure to violence and intergenerational trauma.
- It will be an integrated service providing wrap-around support with medical and health care (including non-clinical support such as group therapy and peer support), with legal, financial counselling and ongoing individual casework and advocacy.
- The trauma informed and patient centred concept of the Centre builds on recently published ground-breaking Australia's National Research Organisation for Women's Safety (ANROWS) and UNSW research on what is required to support women's recovery and well-being in the face of trauma related violence and abuse [Salter et al., 2020].
- The Centre is a world leading, cost effective and comprehensive response to the FDSV crisis. It has wide-spread community and professional support.

### 3. The mental and physical health impacts of FDSV

3.1 In Australia, one in four women has experienced violence by an intimate partner since the age of 15 and one in five experience sexual violence across their lifetime [Australian Bureau of Statistics, Personal Safety, 2017].

3.2 Beyond physical injury, **women who have experienced FDSV have increased rates of health service access, poorer physical health, increased rates of mental health disorders including anxiety, depression, post-traumatic stress and substance use, and are over-represented in prison** [Weissbecker et al., 2007, Lagdon , et al., 2014, Ellsberg et al., 2008, Hegarty et al., 2012, Loxton et al., 2017].

3.3 At the population level, partner violence has been shown to be a major contributor to disease burden (the impact of illness, disability and premature death) among women aged 25–44 years [AIHW, 2019].

3.4 Data from the Australian Women's Longitudinal Health Study (ALSWH) is unequivocal. Findings are extensive, and include:

- Women who experienced domestic violence had consistently poorer mental health than women who had never experienced domestic violence. There is a *lifetime deficit in mental health associated with domestic violence*. This health deficit remained even after the abuse had ceased.
- Compared to women with no abuse history, women who experienced both childhood sexual abuse and violence in adulthood were *two to three times* more likely to have poor general health, depression, and anxiety

- Women who had experienced domestic violence were less likely to have adequate cervical cancer screening and more likely to have experienced cervical cancer than those who had not experienced domestic violence.
- Long term, domestic violence was associated with allergies or breathing problems, pain or fatigue, bowel problems, vaginal discharge, eyesight and hearing problems, low iron, asthma, bronchitis or emphysema, and cervical cancer [ALSWH, Policy Brief 2019].

3.5 Research in Victoria [Brain Injury Australia et.al, 2019] shows that of the 16,000 Victorians who attended hospital over a decade due to family violence, 2 in every 5 sustained a **brain injury** (40%).

- 31% of victims of family violence attending Victorian hospitals over a ten-year period were children under the age of 15, and 25% of these children sustained a brain injury.

3.6 Other studies also show that violence against women may be associated with **mental health** consequences that often persist well into the life course, including long after the violence has stopped [Ayre et al., 2016; Moulding et al., 2020].

- In addition, recent research centred upon fear showed that divorced/separated women reported a higher likelihood of fear of their partner than married women—from fourfold to eightfold higher—highlighting longer term mental health impacts of IPV (Signorelli et al., 2020).

3.7 Another study of 658 Australian women who had a self-reported history of intimate partner violence found that just over half of the women (52%) reported receiving a diagnosis of mental illness. Of the women, 43 percent were diagnosed during a period when IPV was being perpetrated, and 44 percent were diagnosed after leaving the relationship. Only 13 percent of the women reported having a diagnosis of mental illness prior to the IPV occurring [Moulding et al., 2020].

3.8 Violence is also associated with **pregnancy**, with women in the ALSWH study who had a pregnancy *more than three times as likely as women who had not had a pregnancy to report domestic violence* only (27% and 8%, respectively). Also,

- pregnant women were also almost twice as likely to report physical, sexual, or domestic violence, than those who were not pregnant (38% versus 21%).
- domestic violence and recently experienced physical or sexual violence were strongly associated with miscarriage and termination. *Women reporting experiences of domestic violence were more than twice as likely to have terminated a pregnancy*, and those who reported domestic violence and recent physical or sexual violence were more than three times as likely as women who had not experienced violence to have terminated a pregnancy.

3.9 The **association between mental and physical health** and other forms of violence has also been investigated using ALSWH data.

- Women from the 1946-51 cohort who had experienced some form of physical, mental, emotional or sexual violence in their lifetime were more likely to report new onset of *coronary heart disease* than those who did not report violence.
- Similarly, women in the 1973-78 cohort who had experienced physical or sexual violence were more likely to be depressed than those women who had not experienced violence. Women who reported sexual violence were also more likely to report self-harm, depression, and anxiety. Women in the 1973-78 cohort who reported experiences of sexual violence were more likely to have recurrent sleep difficulties and to use prescription sleep medication than women who had not experienced sexual violence.

3.10 In Australia, one quarter of women subject to gendered violence report at least three different forms of interpersonal victimisation in their lifetime, such as child sexual abuse, domestic violence, sexual assault and stalking (Rees et al., 2011). Being exposed to multiple, *repeated forms of interpersonal victimisation may result in complex trauma*, which involves a range of traumatic health problems and psychosocial challenges [Salter et al., 2020].

#### 4. Impact of FDSV legal issues and health

4.1 The groundbreaking 2019 Law and Justice Foundation report *Quantifying the legal and broader life impacts of domestic and family violence* highlights the health consequences of the legal system on those who experience FDSV. This includes:

- Domestic and family violence respondents were 10 times more likely than others to experience legal problems other than domestic violence, including a wide range of family, civil and crime problems;
- The legal problems of domestic and family violence respondents were more likely to be *severe*;
- Domestic and family violence respondents' legal problems led to greater adverse impacts on broad life circumstances compared to other respondents' legal problems, **including stress-related illness (53% vs 19% of problems) and physical ill health (43% vs 18%);** and
- Experiencing domestic and family violence has a compounding effect on legal and related problems, *often requiring a holistic, joined up approach to legal and human services*.

4.2 **The co-location of services is crucial** in reducing barriers to help and promoting safety and recovery from the impacts of FDSV. Multiple appointments with services in multiple locations can pose an insurmountable obstacle for women in crisis periods, particularly where they also have parenting responsibilities [Salter et al., 2020].



## 5. Treatment of health impacts is prevention

5.1 If a child **witnesses or experiences** domestic and family violence it can have serious lifelong consequence on the child's development and wellbeing. 65% of women who had children in their care when they experienced violence by a current or former partner, reported that the children had seen or heard the violence (ABS, 2017).

5.2 Women who as children witnessed partner violence against their parent were **more than twice as likely to be subjected to partner violence themselves** (ABS, 2017).

5.3 While it is difficult to accurately estimate the number of children in Australia who have experienced child abuse, approximately 2.5 million Australian adults (13%) report having experienced abuse during their childhood (ABS, 2019).

5.4 Analysis of the 2016 Personal Safety Survey childhood abuse data confirms the impact on children who live in abusive environments:

- Persons who experienced childhood abuse were *twice as likely to experience violence* as an adult compared to those who did not experience abuse (71% compared to 33%).
- Persons who experienced childhood abuse were *three times more likely to experience partner violence as an adult* than those who did not experience abuse (28% compared to 8.9%).

5.5 Multiple studies have found that treatment for and recovery from the health impacts of FDSV can **reduce or prevent ongoing and intergenerational violence**.

- A failure to identify the psychosocial impact of abuse may result in the internalisation of distress, reinforce feelings of self-blame, prolong the person's contact with mental health services and increase their potential to remain in abusive relationships [Trevillion et al., 2014].
- Children who live with domestic and family violence are more likely to have a range of health, development and social problems. *They are also at higher risk of perpetrating or becoming a victim of violence, which perpetuates intergenerational cycles of violence* [Campo, Kaspiew, Moore, & Tayton; Flood & Fergus; Holt, Buckley, & Whelan; Humphreys, Houghton, & Ellis; Kaspiew et al.; Richards; Stith et al. as cited in Webster et al., 2018].

5.6 Supporting women to recover from FDSV can decrease number of children at risk of living within a domestic and family violence environment.

## 6. Cost of health impacts to our community

6.1 The 2016 KPMG report *The Cost of Violence against Women and their Children in Australia* demonstrated that the cost to the Australian economy of domestic and family violence in 2015-16 was (at least) \$22 billion per year.

6.2 In 2019, a Deloitte report *The Economic Cost of Violence against Children and Young People* found childhood abuse cost the Australian economy \$34 billion in one financial year. Nationally, 72,361 children were abused in the 2016-17 financial year.

6.3 ALSWH data and linked Medicare Benefits Scheme data reveal the healthcare costs associated with experiences of adversity (which includes living in a FDSV environment) and abuse in childhood. From 1996 to 2015, the mean annual healthcare costs of women in the 1973-78 cohort who had experienced childhood adversity was generally higher than that of women who had not experienced childhood adversity. This trend was evident for primary, allied, and specialist healthcare use. *For example, in 1996, women who had experienced childhood adversity had mean annual primary healthcare costs of around \$150, compared to \$117 for women who had not experienced adversity.* By 2015, this difference had increased, with women who had experienced adversity in childhood having mean annual primary healthcare costs of around \$360, compared to \$272 for women who had not experienced adversity in childhood [ALSWH, 2019].

## 7. National Women's Health Strategy 2020-2030

7.1 The National Women's Health Strategy 2020-2030 is clear about the relationship between FDSV and women's health, highlighting violence as one of the five priority areas for action.

7.2 The strategy, quoting an Australian Institute of Family Studies report, notes that women in **regional, rural and remote** Australia are more likely than women in urban areas to experience domestic and family violence. In addition, these women may face specific issues related to their geographical location, the availability of services, and the cultural and social characteristics of living in small communities.

7.3 The strategy recommends three key actions to address the health impacts of violence against women and girls:

- Raise awareness of the health impacts of violence against women and girls
- Address health and related impacts of family and sexual violence
- *Co-design and deliver safe and accessible services for women experiencing family, intimate partner and/or sexual violence.*

## 8. Best Practice in FDSV mental health trauma response, and the gaps in services

8.1 ANROWS research on the health service experiences of women with complex PTSD from FDSV reports 'navigating a fragmented service system where the majority of services are funded to address a particular issue or concern—each with their own (formal and informal) rules—while you are in crisis is fraught for women with experiences of complex trauma. This **research demonstrates there is a need for responses to women who have experiences of complex trauma to be sensitive, coordinated and consistent between services and agencies.** It reflects a growing body of evidence that collaboration between agencies is essential to effectively support women who have experienced domestic, family or sexual violence' [Salter et al., 2020].

8.2 The report states that ‘both women with experiences of complex trauma and healthcare professionals pointed to **models of holistic, wrap-around and place-based service provision** that aim to meet the multiple impacts of complex trauma as a blueprint for “best practice”. They gave examples including specialist providers in community health, women’s health, sexual assault, community legal practice and the refugee sector.’

- See Appendix 1 for *Key Points of Best Practice*, as identified by the research.
- A key recommendation was to **ensure trauma-informed care was embedded within a holistic wellbeing framework that integrates mental, physical and psychosocial wellbeing – and has sustained and long-term funding for specialist trauma programs and services** [Salter et al., 2020]

8.3 Similarly, research by Hegarty et al., (2012) demonstrated the need for a holistic service model for addressing complex needs of women who experience sexual violence in tandem with other structural oppression and marginalisation. Women interviewed for this study emphasised the importance of being able to *easily access appropriate ongoing trauma-informed services* that share information, provide referrals, and support women in accessing help for their complex **issues at all times, not only during crises**.

8.4 Yet, currently there is **nowhere** in the public health system, or across the community service sector, where women can access integrated, comprehensive long-term support to recover from the health impact of this violence. There is a limited range of short-term programs provided by different services (government and non-government) which are largely siloed and only available piecemeal to women, often at different times depending on the waiting lists, and their capacity to pay for services.

8.5 More generally, there is a chronic lack of long-term FDSV services across the sector, particularly for non-housing related support. FDSV impacts on all aspects of a woman’s (and her children) lives, the most critical being health, legal and financial.

8.6 **There is an urgent need for a dedicated service to provide a coordinated and comprehensive response to FDSV and to break the intergenerational cycle of trauma and violence.**

## 9. A Women’s Trauma Recovery Centre: a best practice response

9.1 In response to this complex and urgent need, and in line with best practice recommendations outlined above, the Illawarra Women’s Health Centre in partnership with UNSW is working to establish a **Women’s Trauma Recovery Centre**. A website which includes supporting document is located <https://womenstraumacentre.wordpress.com>.

9.2 This Centre of Excellence will offer a whole-of-organisation trauma sensitive approach that enables recovery from FDSV trauma and helps to break the intergenerational cycle of violence. A range of holistic, and free, **health, legal and psychosocial services** will be provided.

9.3 To ensure that the development and implementation of the initiative is informed by high quality evidence and in response to national, state and local priorities we will embed

systematic evidence-based co-design processes throughout the establishment of the service model. The NSW Government has provided \$50,000 to fund this research and establish the first stage of the business case.

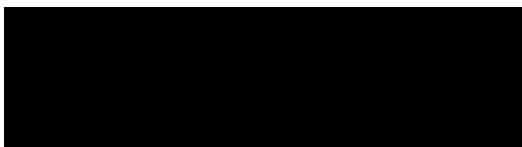
- 9.4 Strategically, the concept of the Women's Trauma Recovery Centre aligns closely with the Fourth Action Plan for the National Plan to Reduce Violence against Women and their Children 2010–2022. Specifically, National Priority Five: improve support and service systems responses and its associated action to **'collaborate across services, sectors and workforces to ensure responses to women affected by domestic, family and sexual violence are coordinated, meet women's needs, avoid women having to retell their story and promote their recovery'**.
- 9.5 It also speaks directly to the National Women's Health Strategy 2020-2030, and the key measures of success to 'reduce the gap in mental and physical health trajectories between women who have and have not experienced violence' and 'increase in number of services available, and women accessing these services'.
- 9.6 The principles of the Centre incorporate the *Key Points of Best Practice* as outlined by the ANROWS research referred to above.
- 9.7 The Centre has the potential to be a circuit breaker not only in an individual woman's life but also for governments seeking to support a common sense, cost saving and compassionate service response.
- 9.8 We expect the model to be both **cost effective and efficacious** and designed to be rolled out across Australia. It is a unique and innovative proposal.
- 9.9 The concept is community led, has extensive community, professional, private sector and local political support, a high-level Consultative Working Group (Appendix 2) and separately, a Professional Advisory Group (Appendix 3). It has the support of, amongst others, **Wollongong and Shellharbour City Councils, the Royal Australian and New Zealand College of Psychiatry, DVNSW, Women's Health NSW, Waminda - South Coast Women's Health and Welfare Aboriginal Corporation, and Jean Hailes for Women's Health** (refer to separate Inquiry submissions). The Illawarra Women's Health Centre has also established working partnerships with **Blue Knot Foundation, Lifeline South Coast and King & Wood Mallesons** which is providing services on a pro bono basis.
- Refer Appendix 4 for a joint letter of support from Senator Concetta Fierravanti, Sharon Bird MP and Stephen Jones MP, and letters of support from the Royal Australian New Zealand College of Psychiatry, University of Newcastle (Australian Longitudinal Study on Women's Health).

## 10. Recommendation

- 10.1 The next National Plan to Reduce Violence against Women and their Children include **investment in the establishment of a Womens Trauma Recovery Centre** – as a pioneering and evidence-based response to the health impacts of family, domestic and sexual violence.
- 10.2 Strongly aligned with priorities in both **the National Plan and the National Women's Health Strategy 2020-2030** [25] the Centre will address the trauma arising from FDSV to improve long-term health and psychosocial outcomes for women and families.
- 10.3 This initiative will address the *psychosocial, physical and mental impacts of complex trauma, including breaking the cycles of ongoing exposure to violence and intergenerational trauma*.
- 10.4 It will be an **integrated service providing multisectoral wrap around support** with medical and health care (including non-clinical support such as group therapy and peer support), with legal, financial counselling and ongoing individual casework and advocacy.
- 10.5 The Centre will respond to the need for **continuity of care at all levels** (i.e. an integrated service system), including the coordination of care for women who have undiagnosed permanent disability and complex trauma (Bevis et al., 2020; Salter et al., 2020).
- 10.6 The cost of **a three-year pilot project** to design, implement and evaluate the Centre will cost an estimated \$10 million. After three years, we expect to demonstrate the model is both cost effective and efficacious and can be rolled out across Australia.

The Centre represents an investment that will provide significant financial and social returns to both the Commonwealth and NSW Governments, and the community.

As a first of its kind in Australia, it will transform domestic, family and sexual violence response and recovery services.



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## Appendix 1: Key Point of Best Practice

Australia's National Research Organisation for Women's Safety. (2020). *Constructions of complex trauma and implications for women's wellbeing and safety from violence: Key findings and future directions* (Research to policy and practice, 12/2020). Sydney: ANROWS.

### Key points of best practice

- **No wrong door with "soft" and low entry points:** Women who present with experiences of complex trauma should be able to enter into health, legal and other systems through multiple pathways that are supportive and helpful, with low or no barriers to entry.
- **Focus on self-determination and recovery:** The explicit task of services and agencies should be to support the client to be self-determining, autonomous and thriving.
- **Safety first:** Women's safety needs are assessed and addressed, including safety from perpetrators and their housing and security needs. The service also needs to feel safe for women, including in its physical design and culture of clear boundaries.
- **Flexibility:** Within those clear boundaries, services are flexible and able to accommodate the needs of women with experiences of complex trauma, which may include difficulties attending sessions or after-hours crises.
- **Continuity and predictability of care:** Women are able to establish a connection and a safe relationship with a key staff member that endures over time, and decisions about the woman's care are ultimately made with the woman.
- **A "whole of life", "whole of person" perspective:** Current presentation and need is framed by a holistic view of women's experiences and selves that addresses how women's histories influence their expectations of and interactions with the service.
- **Stepped care within services:** Women receive more intensive care when/if their needs escalate and are referred back to lower threshold care when stabilised (i.e. retained in care rather than being dropped out of treatment because they are no longer "acute"). Stepped care should be available within services where possible or else through close collaborations between services.
- **Multi-disciplinary teams offering multiple modalities of treatment:** Services address physical, psychosocial and mental health needs, as well as practical life challenges, incorporating cultural knowledge and expertise where necessary.
- **Psychoeducation:** Women have the opportunity to learn about the impact of trauma on their lives.
- **Welcoming physical environments, including spaces for recovery after treatment:** Women are often disorientated after trauma-related service, and it may not be safe for them to travel, hence it is important that the physical environments of services are welcoming and can provide rest spaces.
- **Case management and advocacy:** Clients are supported to navigate complex and challenging systems, including police and the NDIS.
- **Supporting parenting:** Services can accommodate parenting and also promote good parenting as part of the service.
- **Practical accommodation of clients' needs:** Services have brokerage or provisions in place to address women's problems with childcare and transport.
- **Investment in staff care, support and vicarious trauma prevention, and the promotion of vicarious resilience:** A culture of care should be evident among and between workers and extended to clients.



## Appendix 2: Illawarra Women's Trauma Recovery Centre

### High Level Consultative Working Group Membership

Gordon Bradbury AM	Lord Mayor, Wollongong City Council
Marianne Saliba	Mayor, Shellharbour City Council
Margot Mains	Chief Executive, Illawarra Shoalhaven Local Health District
Caroline Langston	Executive Director Integrated Care, Mental Health, Planning, Information & Performance Illawarra Shoalhaven Local Health District
Clinical Associate Professor Katherine Brown	Medical Director, Ambulatory and Primary Health Care Illawarra Shoalhaven Local Health District
Nicky Sloan	CEO, Illawarra Community Industry Group, representative Regional Development Australia, Illawarra
Superintendent Dean Smith	Commander Lake Illawarra Local Area Command
Kim McMullan	Director, Community Services, FACs
Truda Gray	Centre Coordinator, Illawarra Legal Centre
Dr Arunima Gupta	Managing Director, Wollongong Diagnostics
Craig Nealon	Communications and Community Manager, BlueScope
Vicki Tiegs	Marketing Group Director, Waples
Helen Simpson	Lived Experience. PhD Candidate, UOW
Libby Lloyd AM	Special Advisor

## Appendix 3: Illawarra Women's Trauma Recovery Centre

### Professional Advisory Group Membership

Margherita Basile	Manager, Sydney Womens Counselling Centre, Chair, WHNSW
Dr Loyola McLean	Associate Professor, Brain & Mind Research Institute, Sydney Medical School
Jackie Bourke	Registered Consultant Psychologist
Dr Cathy Kezelman AM	Medical practitioner, mental health consumer advocate, President of Blue Knot Foundation National Centre of Excellence for Complex Trauma
Associate Professor Rowena Ivers	Academic GP and public health physician
Dr Karen Williams	Psychiatrist South Coast Private Hospital
Roberta Allen	Senior Associate Lawyer at Foye Legal, specialises in Family Law
Dr Nithya Reddy	Psychiatrist
Sue Dignan	Domestic and Family Violence caseworker, Illawarra Women's Health Centre
Denika Thomas	<ul style="list-style-type: none"> <li>– Social Worker, Illawarra Women's Health Centre</li> <li>Specialist Young Women's Counsellor</li> </ul>

## Appendix 4: Letters of Support



**Senator the Hon Concetta  
Fierravanti-Wells**  
Liberal Senator for New South Wales

**Hon Sharon Bird MP**  
Federal Member for Cunningham

**Stephen Jones MP**  
Federal Member for Whitlam

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Senator the Hon Marise Payne  
Minister for Women  
M1 49, Parliament House  
Canberra ACT 2600

Senator the Hon Anne Ruston  
Minister for Families and Social Services  
MG 60, Parliament House  
Canberra ACT 2600

Dear Ministers,

We are writing to support the Illawarra Women's Health Centre's proposal to establish a community-led first-in-Australia Domestic and Family Violence Trauma Recovery Centre.

We strongly support this proposal. The Centre, an evidence based multi sectoral integrated service will transform domestic and family violence support services.

Domestic and family violence is a major public health issue. Approximately one in six women in Australia have experienced physical and/or sexual violence by a current or previous partner. The Australian Institute of Health and Welfare reports that domestic violence is the greatest health risk factor for women aged 25 to 44.

The impact of violence is substantial and long-lasting. Experiences of family and domestic violence are linked to poor mental and physical health outcomes, which can persist long after the violence has ceased. Moreover, women affected by family and domestic violence often face legal and financial challenges, which can lead to poverty and homelessness. Post-Traumatic Stress Disorder and Complex PTSD are a very real outcome for women and children who have been exposed to family and domestic violence and abuse. Analysis from the Australian Longitudinal Study on Women's Health shows that women who have untreated trauma or PTSD spend a minimum of 10% more per year on General Practitioners alone.

Indeed, the cost to individuals, our community and our health systems is enormous. Adding to this the impact of lost productivity and the cost to the criminal justice system, in 2018 KPMG estimated domestic and family violence cost Australia a conservative \$22 billion per year. This equates to \$280 million per year in the Illawarra alone.

Women recovering from domestic and family violence may require a range of support services depending on their circumstances: counselling, social support, parenting support, financial advice and support and/or legal support. These services are most efficiently and effectively provided in one safe place, from a case managed team of professionals. And yet, this is currently not available anywhere.

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C/- PO BOX 387, WOLLONGONG NSW 2500

4 December 2019

The Hon. Brad Hazzard  
Minister for Health and Medical Research  
GPO Box 5341  
SYDNEY NSW 2001



New South Wales Branch

Dear Minister,

**Re: Support for proposal to establish a Domestic and Family Violence Trauma Recovery Centre in the Illawarra**

I am writing to you on behalf of the NSW Branch of the Royal Australian and New Zealand College of Psychiatrists regarding the funding proposal for a Trauma Recovery Centre (TRC) which one of our Fellows, Dr Karen Williams, presented to you on 22 November.

The NSW Branch strongly supports the proposal to establish this Centre.

Domestic and family violence (DFV) is one of the leading causes of death, illness and injury for women aged under 45 years. The impact of DFV on women and their children is profound, traumatic and has long term implications. It is the leading cause of trauma and child protection related concerns and interventions, and homelessness for women and their children in NSW. It is intergenerational in its impact and complexity; linked and leading to drug and alcohol addiction and abuse, long-term mental health and disability issues including post-traumatic stress disorders, poverty, homelessness, family and relationship breakdown. The cost of DFV to the state's economy is estimated to be \$4.5 billion each year.

The TRC will be an integrated, comprehensive, long-term treatment service to enable women and their children to recover from the manifold impacts of this violence. The proposal seeks a modest investment of \$60,000 initially (stage one) to establish a co-design research agenda involving cross-disciplinary collaboration and relevant stakeholders to map existing services and gaps. Although the case for such a centre is obvious, its stakeholders want the development driven by research and evidence. We also recommend additional funding for impact modelling of the design options. The initial estimates for stage two (establishment and staffing of the TRC) is for \$10 million over 3 years, but this figure will be informed by the results of the Stage One outcomes. Once fully established, the TRC will serve as a model for other locations in Australia to replicate.

The Centre has strong community and professional support including from two of our Fellows, Associate Prof. Loyola McLean and Dr Karen Williams, who have extensive experience in trauma focused therapy, and who with other experts in DFV, will lend their expertise in overseeing the research and development of an appropriate model of care. The NSW Branch supports their involvement in this important project. As highlighted in the proposal, the research project will also involve the collaborative support of leading and internationally renowned public health researchers such as, Professor Rebecca Ivers and Dr Patricia Cullen, as well as Dr Marlene Longbottom who has extensive experience working with Aboriginal and Torres Strait Islander communities.



24 February 2020

The Hon. Brad Hazzard  
Minister for Health and Medical Research  
GPO Box 5341  
SYDNEY NSW 2001

Dear Minister,

**LETTER OF SUPPORT  
ILLAWARRA WOMEN'S HEALTH CENTRE  
TRAUMA RECOVERY CENTRE**

I am writing to you regarding the funding proposal for a Trauma Recovery Centre in the Illawarra region. I strongly support the proposal to establish a Domestic and Family Violence Trauma Recovery Centre.

Domestic and family violence is a major public health issue. Approximately one in six women in Australia have experienced physical and/or sexual violence by a current or previous partner. The Australian Institute of Health and Welfare reports that domestic violence is the greatest health risk factor for women aged 25 to 44.

The impact of violence is substantial and long-lasting. Experiences of family and domestic violence are linked to poor mental and physical health outcomes, which can persist long after the violence has ceased. Moreover, women affected by family and domestic violence often face financial difficulties, which can lead to poverty and homelessness.

Currently, there are no dedicated services which address the ongoing needs of women affected by family and domestic violence in Australia. The proposed Trauma Recovery Centre will fill this gap by providing trauma-informed support for women's long-term health and wellbeing, while simultaneously addressing the financial and legal impacts of violence. Importantly, the integrated service design will prevent further burden on women affected by violence, who are often required to recount their stories to multiple organisations.

In receipt of the proposed funding, the Trauma Recovery Centre will be informed by high quality evidence, through the support and collaboration of leading public health researchers. This is essential for developing an effective model of care to facilitate women's recovery from violence.

The Illawarra Trauma Recovery Centre will serve as a model for other locations, to be rolled out state- and Australia-wide as a comprehensive response to this public health issue. I strongly believe that funding the proposal to establish the centre is a crucial step in addressing the issue of family and domestic violence in our nation.

Please contact me if you would like to discuss my support for the initiative further.

Yours sincerely,

Professor Deborah Loxton  
University of Newcastle

WOMEN'S TRAUMA

