Australian Government
Australian Institute of Health and Welfare

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Family, Domestic and Sexual Violence

Population groups

Population groups

These topic pages explore the different experiences of FDSV for certain population groups. While this reporting provides useful high-level insights, it is based on a single characteristic and conceals diversity within the group. It is important to note that there are many factors that can combine to create a risk and experience of violence that is unique to each person (see the Factors associated with FDSV topic for more information).

- Aboriginal and Torres Strait Islander people
- Children and young people
- Young women
- Pregnant people
- Mothers and their children
- Older people
- People with disability
- LGBTIQA+ people
- People from culturally and linguistically diverse backgrounds
- Veteran families

Aboriginal and Torres Strait Islander people

Key findings

- 2 in 3 (67%) First Nations people aged 15 and over who had experienced physical harm in the last 12 months reported the perpetrator was an intimate partner or family member
- Almost 3 in 4 (74%) assault hospitalisations involving First Nations people were due to family violence

Aboriginal and Torres Strait Islander (First Nations) people are overrepresented as both victim-survivors and perpetrators of family and domestic violence (that is, violence that occurs within family or intimate relationships) (Cripps 2023). 'Family violence' is the preferred term for family and domestic violence within First Nations communities, as it covers the extended families, kinship networks and community relationships in which violence can occur (Cripps and Davis 2012). Family violence can lead to severe social, cultural, spiritual, physical and economic impacts for First Nations communities, especially for women and children (HRSCSPLA 2021).

The *National Plan to End Violence against Women and their Children 2022–2032* (The National Plan) has recognised First Nations people as a priority group in their efforts to address, prevent and respond to gender-based violence in Australia (DSS 2022). The National Plan supports measures designed to achieve Target 13 in the National Agreement on Closing the Gap, which is to reduce the rate of all forms of family violence against First Nations women and children by at least 50% by 2031, as progress towards zero (DSS 2022).

The Australian Government has released a dedicated action plan aimed at reducing the rate of First Nations child abuse and neglect and its intergenerational impacts, namely the *Safe and Supported: Aboriginal and Torres Strait Islander First Action Plan 2023–2026* (DSS 2023). The Government has also committed to developing a standalone First Nations National Plan for Family Safety in recognition of the disproportionately high rates of violence against First Nations women and children (NIAA 2023a).

This topic page focuses on the prevalence, nature, responses to, and outcomes of, family and sexual violence among First Nations people. For information on these issues for all people in Australia and other population groups, see relevant topic pages across this report.

Box 1: Indigenous identification in data collections

The Australian Government defines Aboriginal and Torres Strait Islander people as people who: are of Aboriginal or Torres Strait Islander descent; identify as being of Aboriginal or

Torres Strait Islander origin; and are accepted as such in the communities in which they live or have lived. In most data collections, a person is considered to be First Nations if they identified themselves, or were identified by another household member, as being of Aboriginal or Torres Strait Islander origin.

The AIHW uses 'non-Indigenous Australians' when describing people who are not identified as being of Aboriginal or Torres Strait Islander origin, except where people whose Indigenous status is 'not stated' have been included with the non-Indigenous group. In this case, 'other Australians' will be used.

Capturing accurate data on First Nations people is essential for improving policy formulation, program development and service delivery. The Australian Government is working with First Nations organisations and people to improve the access, relevance and governance arrangements relating to First Nations data (NIAA 2023b).

What do we know?

Colonisation, which involved the removal from land and cultural dispossession has resulted in social, economic, physical, psychological and emotional problems for First Nations people across generations. Family violence against First Nations people must be understood as both a cause and effect of social disadvantage and intergenerational trauma (Closing the Gap Clearinghouse 2016).

Factors associated with family violence

There are many factors that may contribute to the risk and experience of family violence. They can include gendered drivers of violence (such as rigid gender norms), demographic factors (such as age and socioeconomic background), mental health history, incarceration, alcohol and other drug use, and access to support (DSS 2022; WHO 2010). Meanwhile, factors such as cultural identity, family and kinship, country and caring for country, knowledge and beliefs, language and self-determination are protective towards First Nations people's health and wellbeing (AIHW 2023a).

First Nations people can face unique risk factors that contribute to their high levels of family violence, with the main underlying drivers intersecting and cumulative.

See also **Factors associated with FDSV**.

Ongoing impacts of colonisation

The ongoing impacts of colonisation for First Nations people include personal, collective and intergenerational trauma, individual and systemic racism and oppression, and the disruption of traditional cultures, relationships and community norms about violence. For non-Indigenous Australians, the history of dispossession has contributed to racialised structural inequalities of power and the normalisation and perpetration of racist social norms and practices. These risk factors can contribute to and be exacerbated by socioeconomic disadvantage, poor physical and mental health, and destructive coping behaviours among First Nations people (Our Watch 2018; Cripps and Davis 2012; DSS 2022; Langton et al. 2020).

Gendered factors

The gendered drivers of violence against First Nations women include the intersection of racism and sexism, and the impacts of colonial patriarchy on gender roles, and interpretation of what constitutes violence against women that can differ from western norms (Our Watch 2018; Langton et al. 2020).

Barriers to reporting or seeking assistance for family violence

Estimates suggest that around 90% of violence against First Nations women and most cases of sexual abuse of First Nations children are undisclosed (Willis 2011). First Nations people can face a range of barriers to reporting violence and accessing formal support, including:

- a lack of understanding of legal rights and options and how to access support
- a lack of cultural competency and discriminatory practices across the support sector
- a lack of awareness and knowledge in what constitutes violence
- a lack of access to transportation and/or communication channels, especially for those living in rural and remote areas
- fear of child removal if disclosing family violence
- fear that parental separation will threaten cultural connection and community cohesion
- fear of reprisal by perpetrator or 'payback' – a form of First Nations customary law aimed at resolving grievances that could lead to violent retribution against the victim-survivor
- fear of losing their home in social or community-controlled housing settings
- fear of not being believed and misidentification of victim-survivors as perpetrators due to defensive violence
- mistrust of mainstream legal and support services to understand and respect the needs, autonomy and wishes of victim-survivors
- mistrust of First Nations-run service providers to maintain client confidentiality
- community pressure not to report violence to avoid increased incarceration of First Nations men
- communication barriers
- racism and discrimination
- poverty and social isolation
- shame and embarrassment
- belief that they should seek support from kin or people within their inner circle, and/or that the incident is a private matter (Fiolet et al. 2019; Backhouse and Toivonen 2018; Willis 2011; Langton et al. 2020).

Other than kin and people within the victim-survivor's inner circle, community-led informal support that prioritise cultural healing also play an important role in First Nations family violence response. Cultural healing processes acknowledge culture as a key protective factor for First Nations people's health and wellbeing (Backhouse and Toivonen 2018; AIHW 2023a). For example, the cultural practices of storytelling and 'Dadirri' ('deep listening') allow victim-survivors to share their stories in a culturally safe setting, while others are encouraged to listen deeply by connecting with their story, reflecting on silence, understanding their pain and respecting their strength (Cripps 2023).

See also **How do people respond to FDSV?**.

What data are available?

Data about the prevalence of family violence among First Nations people come from national surveys and administrative datasets. Some administrative data are available to report on the responses to and impacts of family violence.

The current leading source of data for First Nations people is the National Aboriginal and Torres Strait Islander Social Survey. However, as the survey is designed to collect data on a broad range of topics, it is unable to produce the breadth of data on family violence available in the Australian Bureau of Statistics (ABS) Personal Safety Survey. Information on Indigenous status is not collected in the ABS Personal Safety Survey.

The terminology used for First Nations people in this topic page can vary depending on what is used within the data source.

Box 2: Collecting family violence data for First Nations children

It is difficult to obtain robust data on experiences of family violence for First Nations children. Due to the sensitive nature of the subject, most large-scale population surveys focus on adults.

The Australian Child Maltreatment Study (ACMS) was a cross-sectional survey on the experience of child maltreatment conducted in 2021. While the ACMS did not exclude First Nations people, it was determined that it was not ethically or methodologically appropriate to disaggregate data by Indigenous status for the survey (Haslam et al. 2023).

As part of the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*, the Australian Government has committed to conducting a second wave of the ACMS. This will include specific methods to capture representative data for First Nations people, with a focus on ages 16–24 to produce estimates for recent (past 12 months) child maltreatment (National Office for Child Safety 2021).

Data sources for measuring family violence among First Nations people

- Aboriginal Families Study
- ABS Criminal Courts

- ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
- ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
- ABS Recorded Crime, Offenders
- ABS Recorded Crime, Victims
- AIC National Homicide Monitoring Program
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services (SHS) Collection
- ANROWS Technology-facilitated Abuse study
- Child Protection National Minimum Data Set
- Longitudinal Study of Indigenous Children (LSIC)
- Suicides of Aboriginal and Torres Strait Islander people in Victoria

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

What do the data tell us?

Physical assault by a family member

First Nations people aged 15 and over in 2018-19 who had experienced physical harm in the last 12 months reported the perpetrator was an intimate partner or family member

2 in 3

The latest National Aboriginal and Torres Strait Islander Health Survey (NATSIHS, 2018–19) showed that 2 in 3 (67% or 20,800) First Nations people aged 15 and over who had experienced physical harm in the 12 months before the survey reported the perpetrator was a family member (a former or current intimate partner or other family member) (ABS 2019a).

Box 3: Family violence data in ABS Recorded Crime collections

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

- the relationship of offender to victim falls within a specified family or domestic relationship (spouse or domestic partner, parent, child, sibling, boyfriend/girlfriend or other family member to the offender) and/or

- a family and domestic violence flag has been recorded, following a police investigation and does not contradict any recorded detailed relationship of offender to victim information (see **Data sources and technical notes**).

The ABS Recorded Crime collections refer to these crimes as "family and domestic violence-related", while this topic page refers to these crimes as perpetrated "by a family member".

Recorded Crime – Victims data included in this topic page are only available for New South Wales, South Australia, the Northern Territory, and sometimes Queensland; while Recorded Crime – Offenders data included are available for the four jurisdictions as well as the Australian Capital Territory. As of 30 June 2021, the proportion of First Nations people living in these jurisdictions include:

- 4.2% (or 340,000) in New South Wales
- 2.9% (or 52,100) in South Australia
- 31% (or 76,500) in the Northern Territory
- 5.2% (or 273,000) in Queensland
- 2.1% (9,500) in the Australian Capital Territory (ABS 2023b).

Across jurisdictions with published data (New South Wales, South Australia and the Northern Territory) in 2022, police-recorded crime data indicated that the First Nations victimisation rate of assault by a family member was:

- 1,700 per 100,000 (or 5,100) First Nations people in New South Wales
- 4,800 per 100,000 (or 2,300) First Nations people in South Australia
- 7,700 per 100,000 (or 6,100) First Nations people in the Northern Territory (ABS 2023c) (Figure 1).

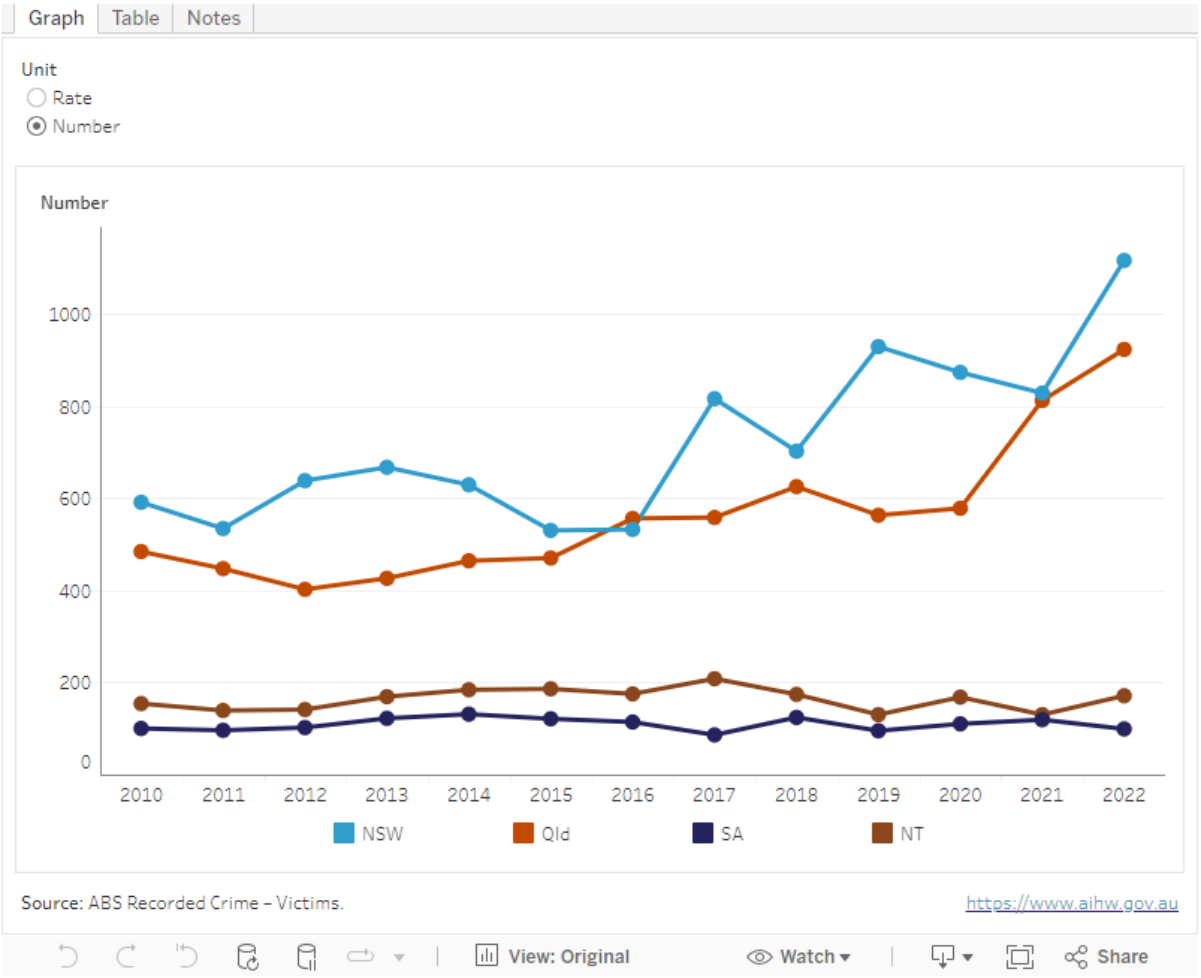
Figure 1: First Nations victims of crimes perpetrated by a family member, for selected states and territories, 2014–2022

Police-recorded sexual assault

Across jurisdictions with published police-recorded crime data (New South Wales, Queensland, South Australia, and the Northern Territory) in 2022, the victimisation rate of sexual assault ranged from 209 per 100,000 (or 100) First Nations people in South Australia to 375 per 100,000 (or 1,100) First Nations people in New South Wales (ABS 2023c).

Between 2010 and 2022, First Nations victimisation rates for sexual assault varied between states and territories and over time (Figure 2; ABS 2023c).

Figure 2: First Nations victims of sexual assault, for selected states and territories, 2010–2022



For sexual assault by a family member, the victimisation rate ranged from 89 per 100,000 (or 70) First Nations people in the Northern Territory to 156 per 100,000 (465) First Nations people in New South Wales. Between 2014 and 2022, these rates varied between states and territories and over time. Since 2018, the First Nations victimisation rate for sexual assault by a family member was lowest for the Northern Territory, compared with New South Wales, Queensland and South Australia (Figure 1) (ABS 2023c).

The use of technology

Increasingly, mobile and digital technologies are utilised by perpetrators to facilitate family violence. When interpersonal harms are conducted via technology, such as online harassment, image-based abuse and monitoring behaviours, they are considered technology-facilitated abuse (TFA).

Data on the prevalence of TFA among First Nations people are available from a nationally representative survey of about 4,600 adults in 2022. The survey used random probability-based sampling methods and weighting to allow results to be generalisable

to the adult population in Australia (Powell et al. 2022). The survey found that among First Nations respondents:

- 7 in 10 (70%) reported experiencing TFA at least once in their lifetime, compared with 1 in 2 (51%) for all respondents
- 2 in 5 (42%) reported having engaged in TFA perpetration in their lifetime, compared with about 1 in 4 (23%) for all respondents (Powell et al. 2022).

For more information on TFA, see **Stalking and surveillance**.

What are the responses to family violence?

Responses to family violence include a mix of informal responses (such as contact with friends and family) and formal responses (such as assistance from police, legal services, specialist crisis services, child protection services or health professionals). This section focuses on formal responses due to data availability. For more information on responses to family violence for the general population, see **How do people respond to FDSV?**.

Despite the lack of data on the effectiveness of First Nations-specific family violence responses, existing research have identified effective specialist family violence responses should include:

- community involvement, engagement and acceptance
- cultural competency
- integrated service delivery
- planning for long-term sustainability
- holistic, flexible and trauma-informed approaches
- building on existing culturally appropriate initiatives and community capabilities (Closing the Gap Clearinghouse 2016; SNAICC et al. 2017).

Police

The ABS collates national statistics on crimes recorded by the police relating to victims and offenders of family violence (see Box 3 and **Data sources and technical notes** for details). Although information on family violence is available from these administrative data sets, a high proportion of family violence is not disclosed to police for a range of reasons, see **Barriers to reporting or seeking assistance for family violence**. The fear of the consequences of seeking help from police was highlighted in the Parliamentary Inquiry into family, domestic and sexual violence, as it is known that some First Nations victim-survivors were previously criminalised due to misidentification as perpetrators or unrelated offences (such as unpaid fines) when police attended the family violence situation (HRSCSPLA 2021).

A large proportion of assault victims are victims of family violence

Across jurisdictions with published data (New South Wales, South Australia and the Northern Territory) in 2022, the ABS Recorded Crime – Victims data collection found that First Nations assault victims:

- were commonly victims of family violence-related assault (54–70%), and
- most commonly identified perpetrators of the assault as partners or ex-partners (32–52%) (ABS 2023c).

Sexual assault victims are most likely to be female and under 18 years old

Most First Nations victims of sexual assault were female (70–93%) in 2022

Across jurisdictions with published data (New South Wales, Queensland, South Australia, and the Northern Territory) in 2022, First Nations victims of sexual assault were predominantly female, ranging from 70% in New South Wales to 93% in South Australia (ABS 2023c).

Except for South Australia, the rate of sexual assault was higher for First Nations people aged under 18 than those aged 18 and over (based on age at report), ranging from 1.3 times as high in the Northern Territory to 1.8 times as high in Queensland. This is consistent with the pattern for all people in Australia, but with higher rate ratios, where the rate of sexual assault was 1.6 to 3.6 times as high for people aged under 18 than those aged 18 and over (based on age at report) (ABS 2023c).

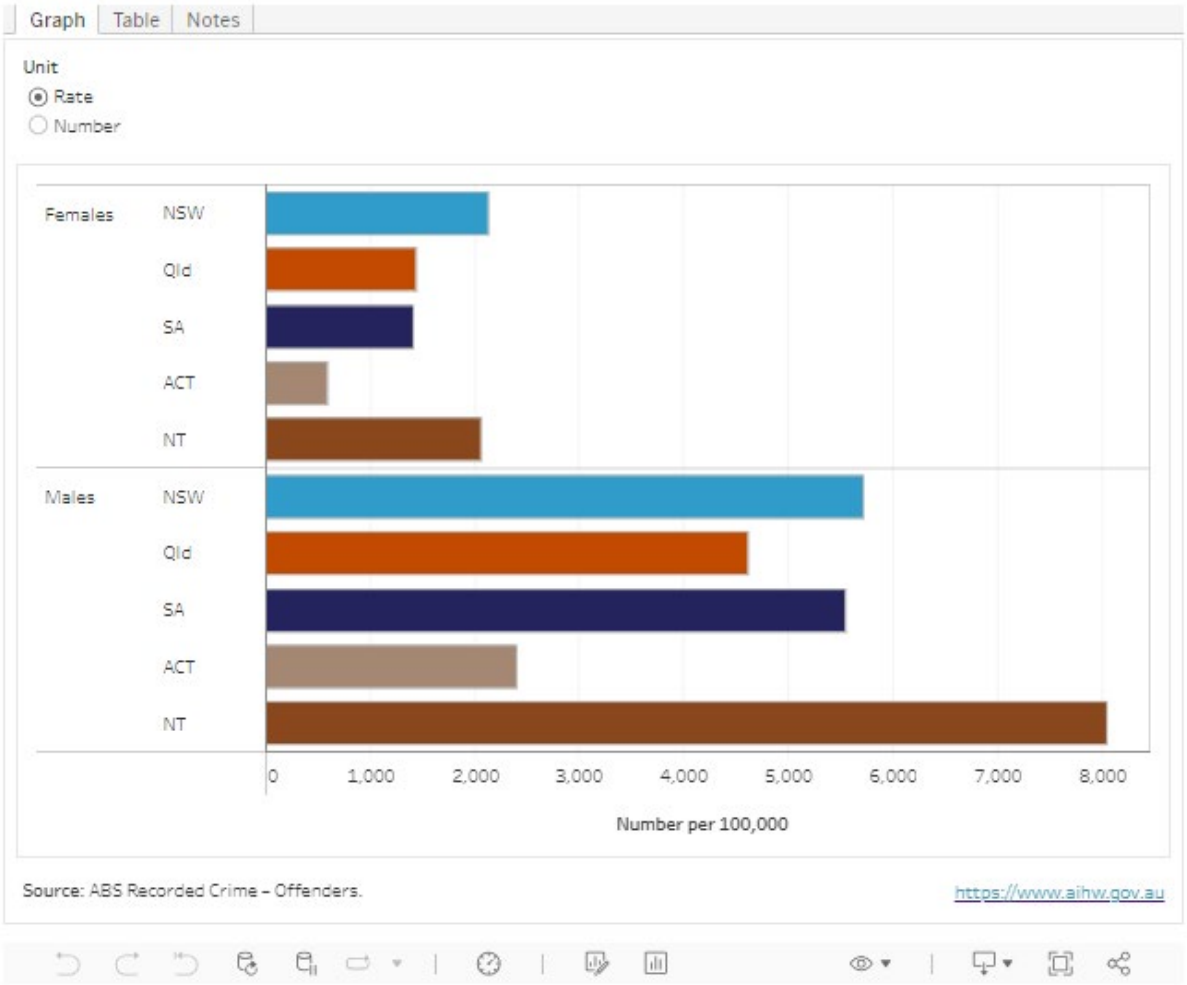
Perpetrators of family violence are most likely to be male

The ABS Recorded Crime – Offenders 2022–23 data collection also contains information about people committing offences related to family violence. Data for First Nations offenders are available for New South Wales, Queensland, South Australia, the Northern Territory and the Australian Capital Territory only. First Nations offender rates are expressed per 100,000 of the population aged 10 years and over (for more information on this collection, see **Data sources and technical notes**.

The offender rate for offences related to family violence was higher for First Nations males than females, ranging from 2.7 times higher in New South Wales to 4.1 times higher in the Australian Capital Territory (Figure 3; ABS 2024).

The Indigenous status of perpetrators of violence against First Nations women is not available for reporting. Note that such violence is perpetrated by men of all cultural backgrounds, not just First Nations men (Our Watch 2018).

Figure 3: First Nations offenders of family violence, for selected state and territories, by sex, 2022–23



Perpetrators of sexual assault are usually known to the victim

First Nations victims of sexual assault are likely to know the perpetrator. The proportion of First Nations victims who knew their perpetrators ranged from 57% in the Northern Territory to 88% in New South Wales in 2022 (ABS 2023c).

Legal

Family and domestic violence protection orders

A common legal response to family violence in Australia is to obtain a personal safety intervention order (PSIO) or family and domestic violence protection order (DVO). First Nations people are over-represented within the DVO system as both applicants and respondents (see Box 4).

Box 4: Impacts of the domestic violence protection order system and the criminal justice system on First Nations people

A domestic violence order (DVO) is a civil order issued by a court that forbids a perpetrator of family violence from committing further abuse against the victim-survivor. It is a criminal offence to breach a DVO. A Queensland study analysed the DVOs that were established in civil courts and those that were referred to criminal courts during 2013–14. The people named as perpetrators in these DVOs were offered the opportunity to self-report their Aboriginal and Torres Strait Islander status.

In 2013–14, almost 23,500 people were named as perpetrators in DVOs issued in Queensland, of whom 1 in 5 (21%) identified as First Nations people. First Nations women were slightly more likely to be named as perpetrators than non-Indigenous women (23% of First Nations perpetrators and 20% of non-Indigenous perpetrators).

DVOs taken out against First Nations people were more likely to have been lodged by the police. Of all DVOs lodged in Queensland, 79% were initiated by the police, and in cases where the perpetrator identified as First Nations, 90% were initiated by the police. In 2013–14, about 6,900 people were defendants facing criminal charges for contravening a DVO in Queensland, of whom 1 in 3 (34%) identified as First Nations people. The proportion of defendants found guilty was similar for First Nations defendants (89%) and all defendants (88%). However, a higher proportion of First Nations defendants received a custodial order (43%), compared with all defendants (27%).

For more information on DVOs, see **Legal systems**.

Source: Douglas & Fitzgerald 2018.

Most First Nations defendants who go to court for family violence offences are found guilty

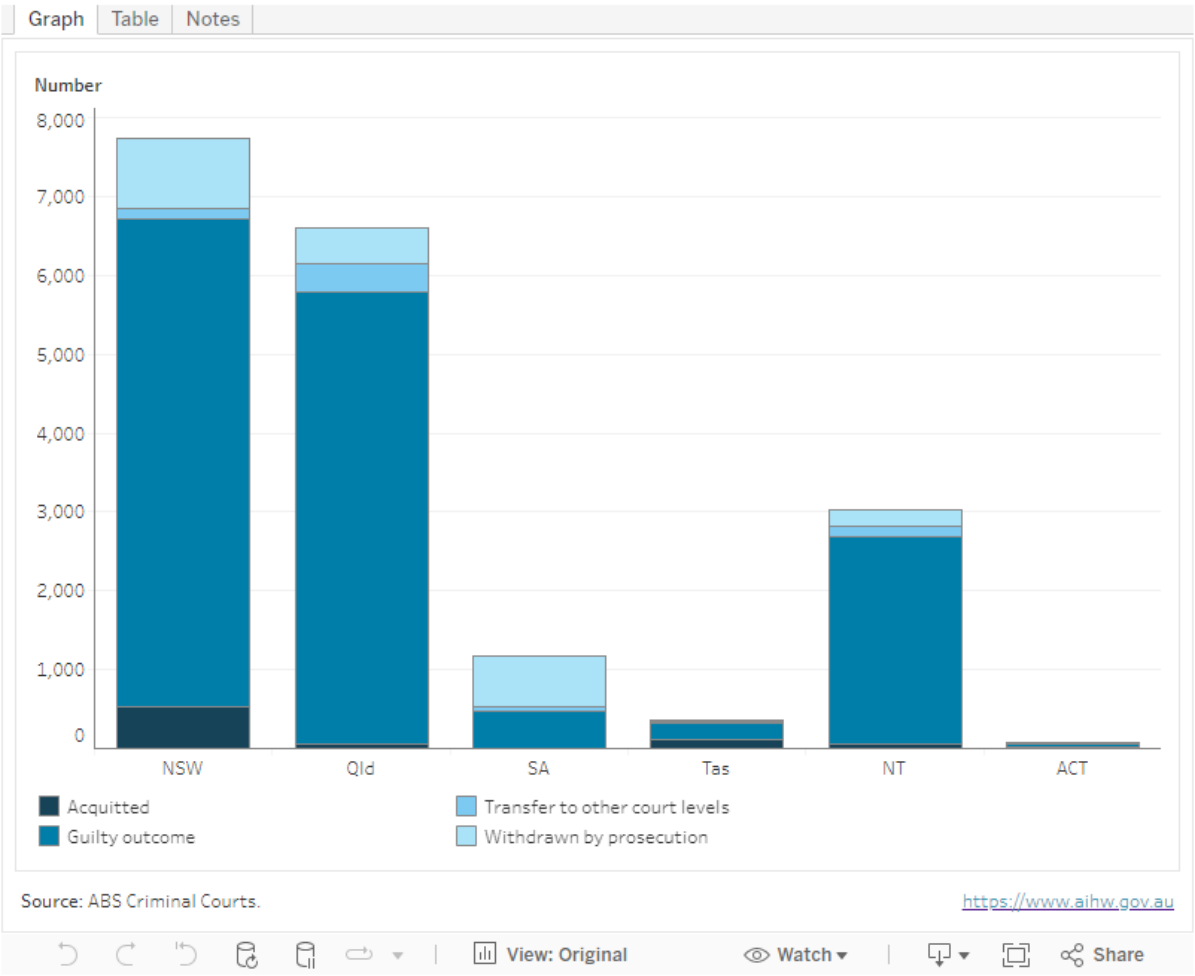
Data from the ABS Criminal Courts, Australia, 2021–22 data set are available for First Nations defendants who had one or more family violence cases finalised in criminal courts in New South Wales, Queensland, South Australia, Tasmania, the Northern Territory and the Australian Capital Territory. Finalised defendants include all individuals for whom charges have been formally completed by a court. These defendants may be acquitted, found guilty, or had their cases withdrawn or transferred. To avoid double counting of defendants who were transferred and subsequently finalised by another method, transfers are excluded in the calculation of proportions (ABS 2023a).

The proportion of First Nations defendants who were found guilty were:

- 92% (5,700) in Queensland
- 91% (2,600) in the Northern Territory
- 81% (6,200 defendants) in New South Wales
- 76% (59 defendants) in the Australian Capital Territory
- 66% (230 defendants) in Tasmania
- 42% (470 defendants) in South Australia (Figure 4) (ABS 2023a).

The proportion of First Nations defendants who were found guilty was similar to the proportion for other Australian defendants (that is, non-Indigenous defendants, including people whose Indigenous status was not stated for the ACT) who were found guilty. This ranged from 40% in South Australia to 89% in Queensland (ABS 2023a).

Figure 4: First Nations defendants of family violence offences finalised in criminal courts, by method of finalisation, for selected states and territories, 2021–22



Acts intended to cause injury is the most common principal offence among First Nations family violence defendants

Acts intended to cause injury are acts intended to cause non-fatal physical injury or mental harm to another person and where there is no sexual or acquisitive element. This includes behaviours such as physical assault and stalking (ABS 2011).

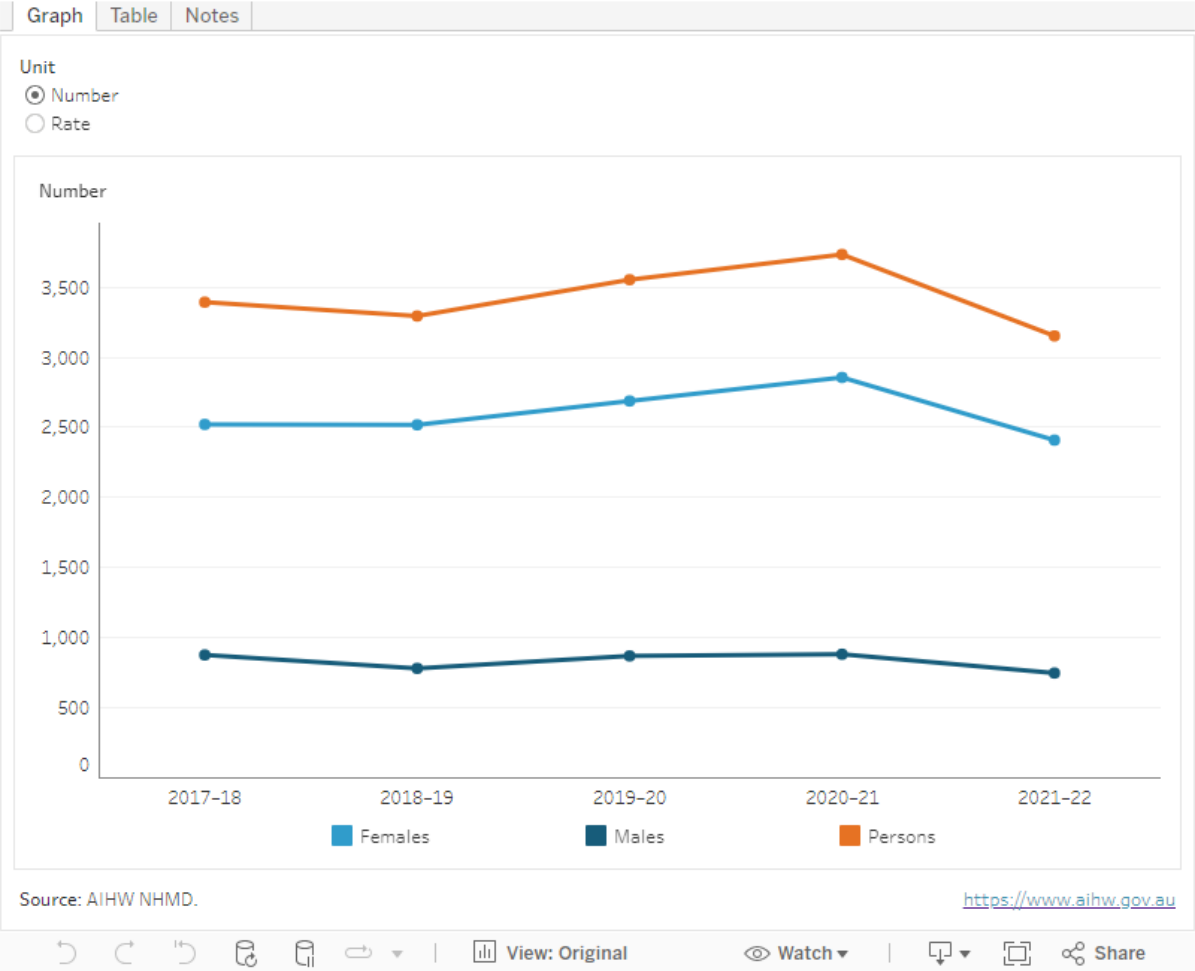
Across jurisdictions with published data, the most common principal family violence offence among First Nations defendants was acts intended to cause injury in 2021–22, ranging from 50% in Tasmania to 73% of all family violence offences in South Australia. The exception was Queensland, where 2 in 3 (67%) First Nations family violence defendants finalised had a principal offence of breach of violence orders (ABS 2023a).

Hospitalisations

Data on hospitalisations for injury from assault come from the AIHW National Hospital Morbidity Database. In 2021–22, there were about 3,100 hospitalisations for injuries related to family violence involving First Nations people (2,400 females and 740 males) (AIHW 2023b) (Figure 5).

As information on cause of injury (such as assault) is not available in national emergency department data, family violence hospitalisations do not include presentations to emergency departments and underestimate overall hospital activity related to family violence. These hospitalisations also relate to more severe (and mostly physical) experiences of family violence (AIHW 2022c). See **Health services** for more information on how family violence hospitalisations are measured.

Figure 5: Family violence hospitalisations among First Nations people, by sex, 2017–18 to 2021–22



Most hospitalisations for assault are a result of family violence

Almost 3 in 4 (74%) assault hospitalisations involving First Nations people in 2021–22 were due to family violence

In cases where a perpetrator was specified, almost 3 in 4 (74%, or 3,100) assault hospitalisations involving First Nations people were due to family violence in 2021–22. Specifically, 47% were due to assault by a spouse or domestic partner, 2.8% by a parent and 24% by another family member (AIHW 2023b).

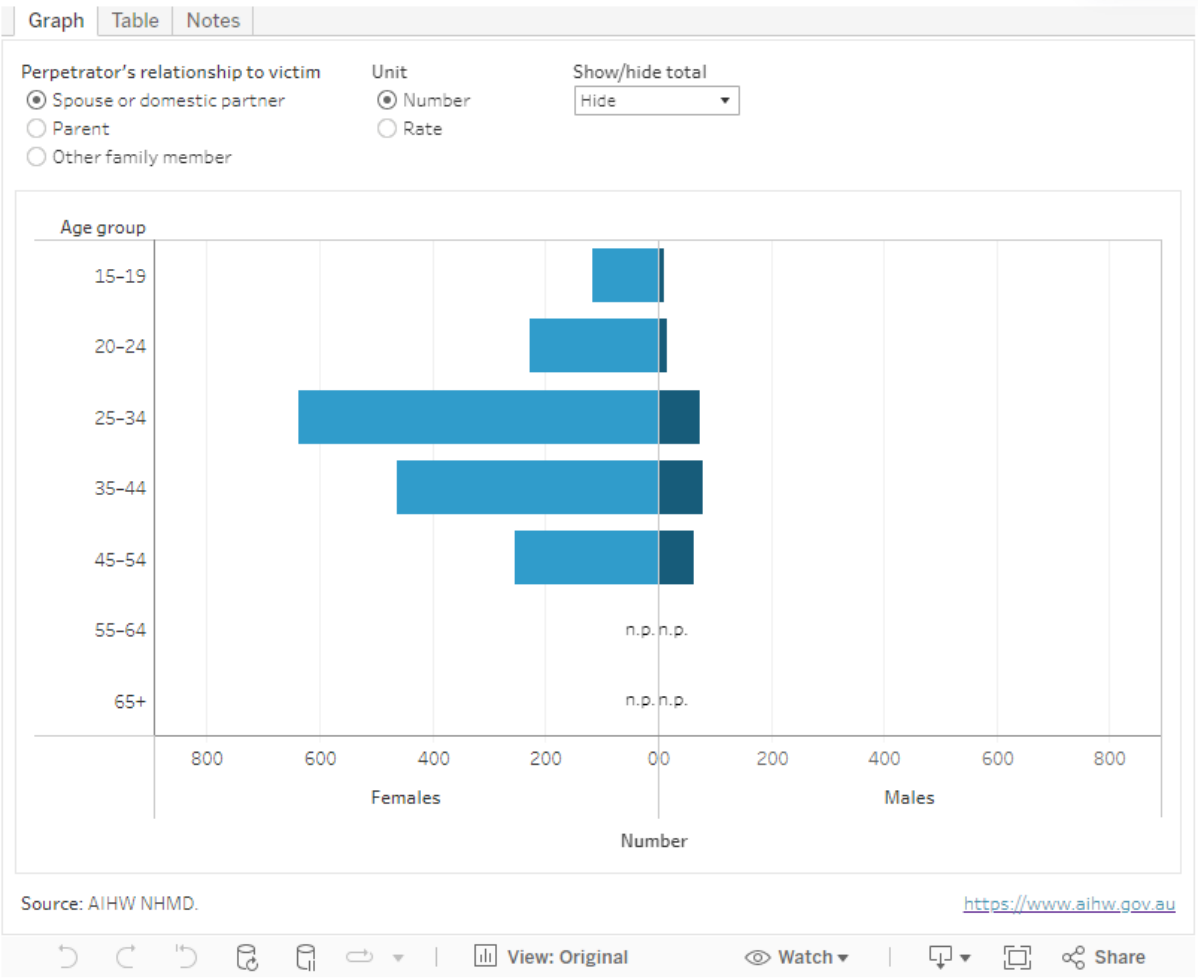
First Nations people aged 25–34 were most likely to be hospitalised for assault by their spouse or domestic partner (53%) or another family member (21%). Meanwhile, First Nations children aged 0–14 were most likely to be hospitalised for assault by a parent (46%) (AIHW 2023b).

For First Nations women aged 15 and over, a spouse or domestic partner was most commonly reported (62%, or 1,700) as the perpetrator for hospitalisations due to assault among all cases where a perpetrator was specified. The hospitalisation rate due to

assault by a spouse or domestic partner was highest for women aged 35–44 (977 per 100,000 hospitalisations) (AIHW 2023b).

For First Nations men aged 15 and over, a family member other than a spouse, domestic partner or parent was most commonly reported (30%, or 405 cases) as the perpetrator for hospitalisations due to assault. The hospitalisation rate due to assault by another family member (226 per 100,000 hospitalisations) was highest for men aged 35–44 (Figure 6) (AIHW 2023b).

Figure 6: Family violence hospitalisations among First Nations people, by relationship to perpetrator, 2020–21 to 2021–22



Most family violence involves bodily force

Among First Nations males and females aged 15 years and over hospitalised for family violence-related injuries in 2021-22:

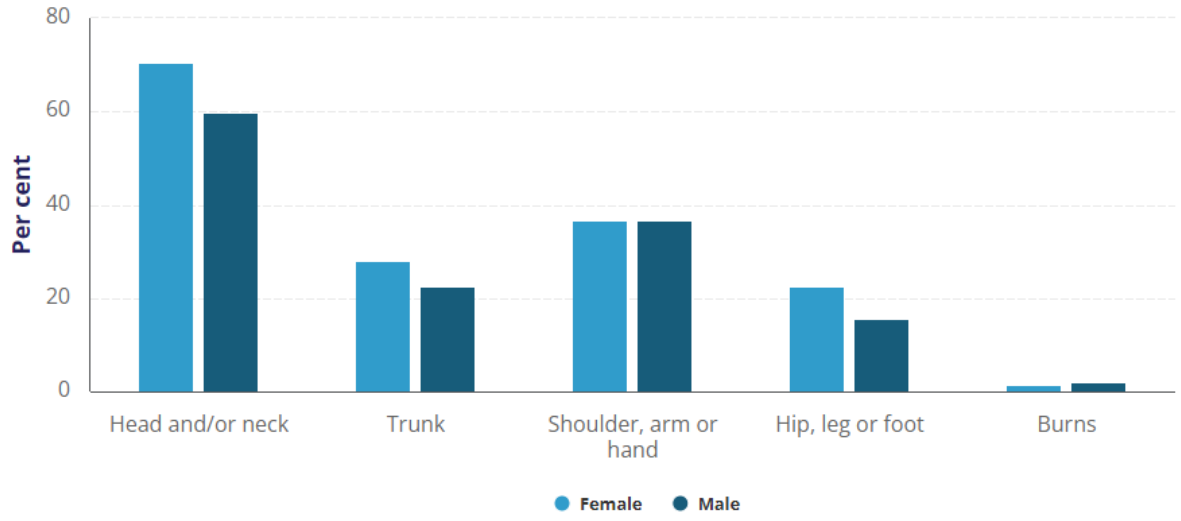
- about 56% (1,300) of females and 42% (290) of males were assaulted by bodily force (excluding sexual assault by bodily force)
- almost one-third (32%) of females were assaulted with an object: 22% (510) with a blunt object and 10% (250) with a sharp object

- more than half (52%) of males were assaulted with an object: 27% (185) with a sharp object and 25% (170) with a blunt object
- hanging, strangulation and suffocation was specified as the cause of injuries for 91 (3.8%) females (AIHW 2023b).

Head and/or neck injuries are the most common injuries inflicted by a family member

Among hospitalisations of First Nations people for assault-related injuries perpetrated by a family member, 70% (1,700) females and 60% (415) males experienced injuries to the head or neck in 2021–22. This included 235 females and 66 males hospitalised for brain injury (Figure 7) (AIHW 2023b).

Figure 7: Family violence hospitalisations among First Nations people, by type of injury and sex, 2021–22



Source: AIHW NHMD | Data source overview

First Nations people living in *Remote and very remote* areas are more likely to be hospitalised due to family violence

In *Remote and very remote areas* in 2021–22, the hospitalisation rate for family violence was:

- about 2,500 per 100,000 (or 1,400) for First Nations females aged 15 and over, compared with 405 per 100,000 (or 520) for those living in *Inner and outer regional* areas and 330 per 100,000 (or 385) in *Major cities*
- 780 per 100,000 (or 420) for First Nations males aged 15 and over, compared with 135 per 100,000 (or 170) for those living in *Inner and outer regional* areas and 83 per 100,000 (or 93) in *Major cities* (AIHW 2023b).

First Nations people are more likely to be hospitalised for family violence than non-Indigenous Australians

Among those aged 15 and over, First Nations people were 31 times as likely to be hospitalised for family violence as non-Indigenous Australians.

In 2021–22, the age-standardised hospitalisation rate for family violence for First Nations people aged 15 and over (500 per 100,000) was 31 times the rate for non-Indigenous Australians (16 per 100,000). First Nations females aged 15 and over were 33 times as likely to be hospitalised for injuries from family violence as non-Indigenous females, with 760 per 100,000 (2,400) First Nations females hospitalised, compared with 23 per 100,000 (2,200) non-Indigenous females. The age-standardised hospitalisation rate for family violence-related injuries for First Nations males was 27 times as high as for non-Indigenous males, with 240 per 100,000 (690) First Nations males hospitalised, compared with 8.9 per 100,000 (870) non-Indigenous males (AIHW 2023b).

Specialist homelessness services

Specialist homelessness services (SHS) provide assistance to people who are experiencing or at risk of homelessness, including clients who have experienced family violence. Data on people seeking support from SHS agencies are drawn from the AIHW Specialist Homelessness Services Collection (SHSC). The SHSC reports on clients experiencing family violence of any age, including both victim-survivor and perpetrator services provided. The AIHW Specialist homelessness services annual report includes additional details on **Clients who have experienced family and domestic violence**.

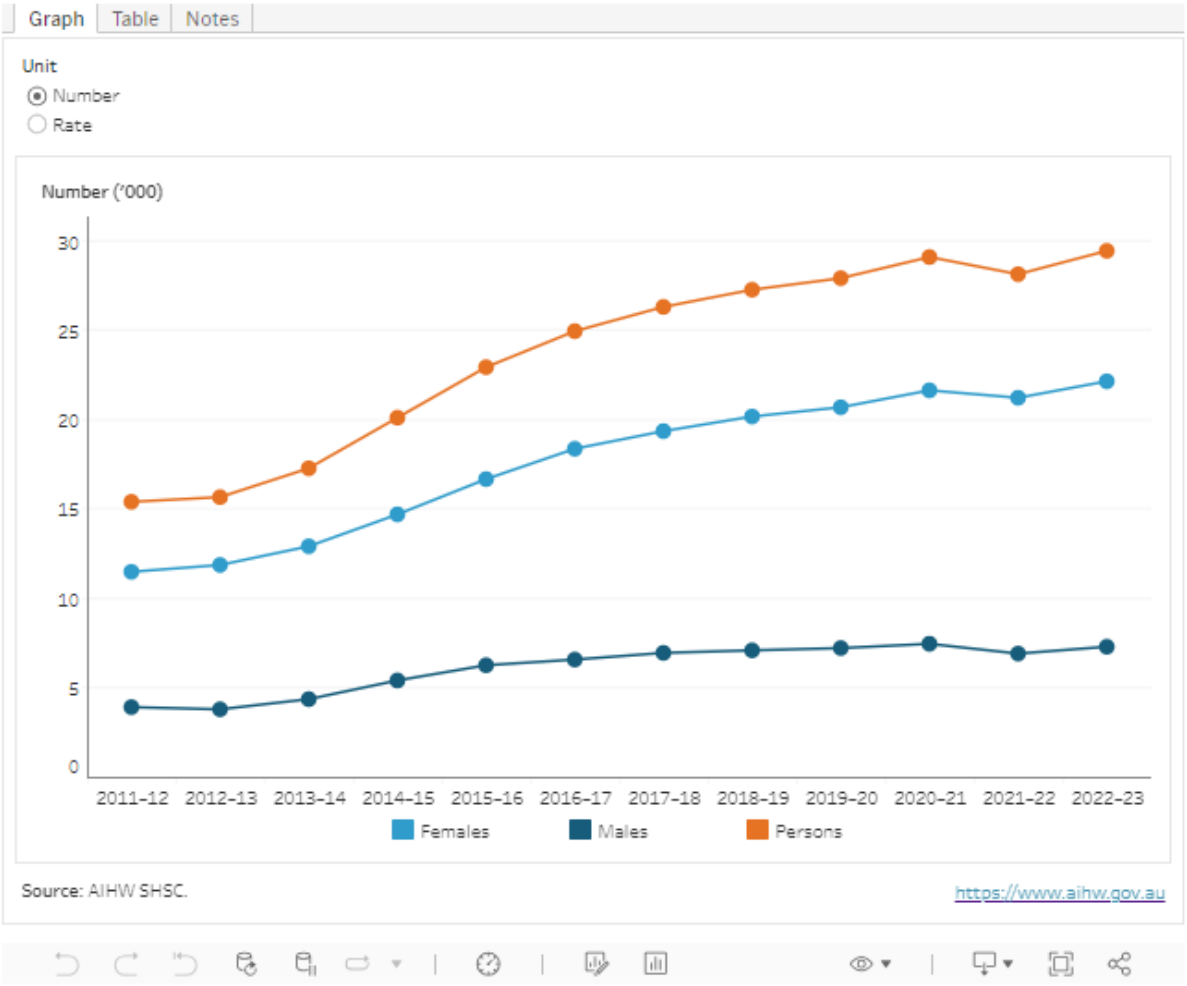
Family violence is one of the main reasons First Nations clients seek assistance

Of the 259,000 clients who accessed SHS in 2022–23 and whose Indigenous status was known, about 74,700 (29%) were First Nations people. Of these First Nations clients:

- 24% (17,800) cited family violence as their main reason for seeking assistance
- 26% (19,400) requested assistance for family violence (AIHW 2023d).

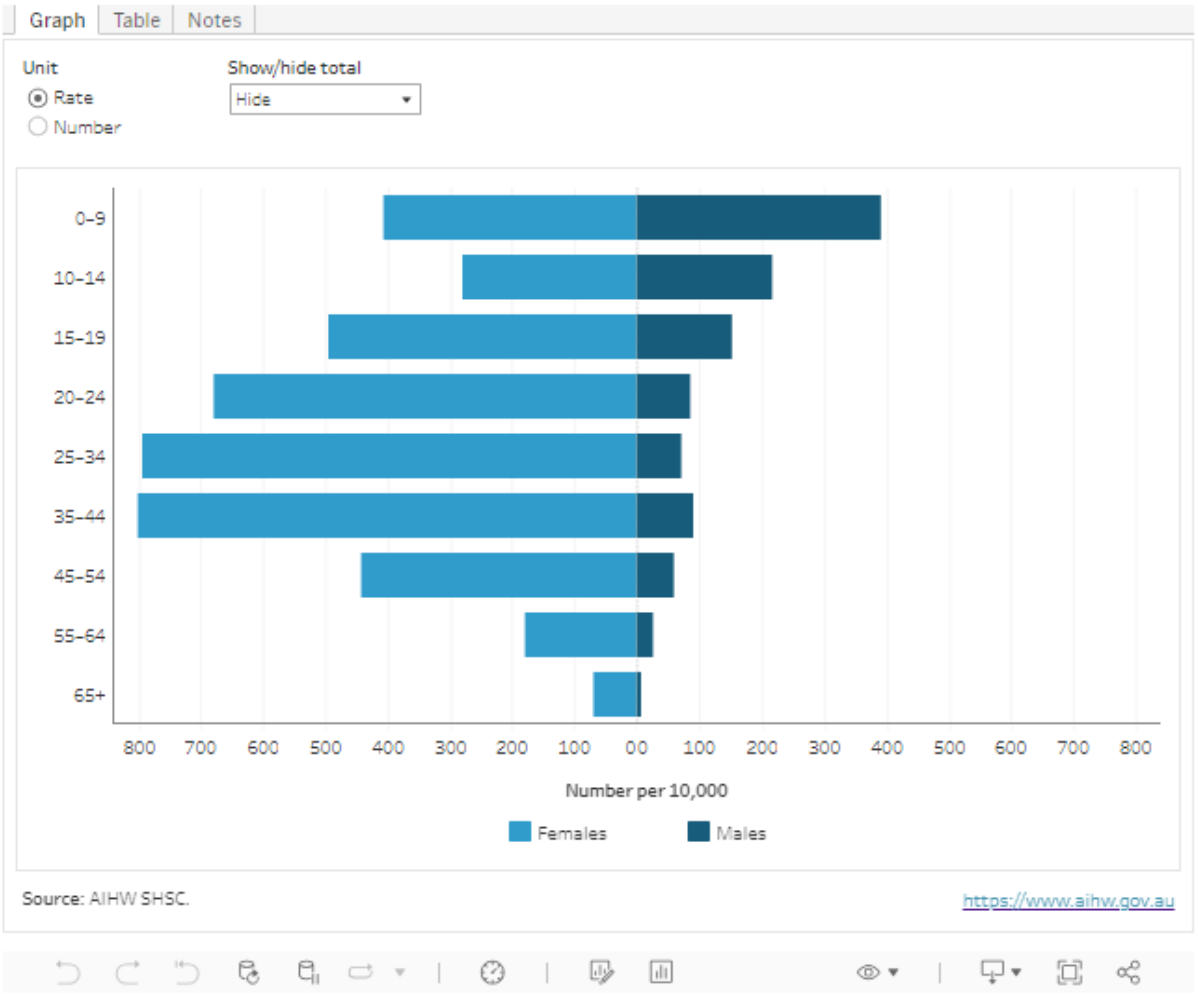
Between 2011–12 and 2022–23, the rate of First Nations SHS clients who have experienced family violence was higher for females than males. The rate has increased over time from 214 per 10,000 people in 2011–12 to 328 per 10,000 people in 2022–23 (Figure 8). Changes in the number of First Nations clients over time may reflect improved Indigenous status data among people receiving SHS support (AIHW 2024).

Figure 8: First Nations specialist homelessness services clients who have experienced family violence, by sex, 2011–12 to 2022–23



In 2022–23, the rate of First Nations SHS clients who have experienced family violence was highest for females aged 35–44 (802 per 10,000 people) across all age groups. Among First Nations male SHS clients, those aged 0–9 had the highest rate (392 per 10,000 people) (Figure 9; AIHW 2024).

Figure 9: First Nations specialist homelessness services clients who have experienced family violence, by age group, 2022–23



For more information on family violence among SHS clients, see **Housing**.

Child protection

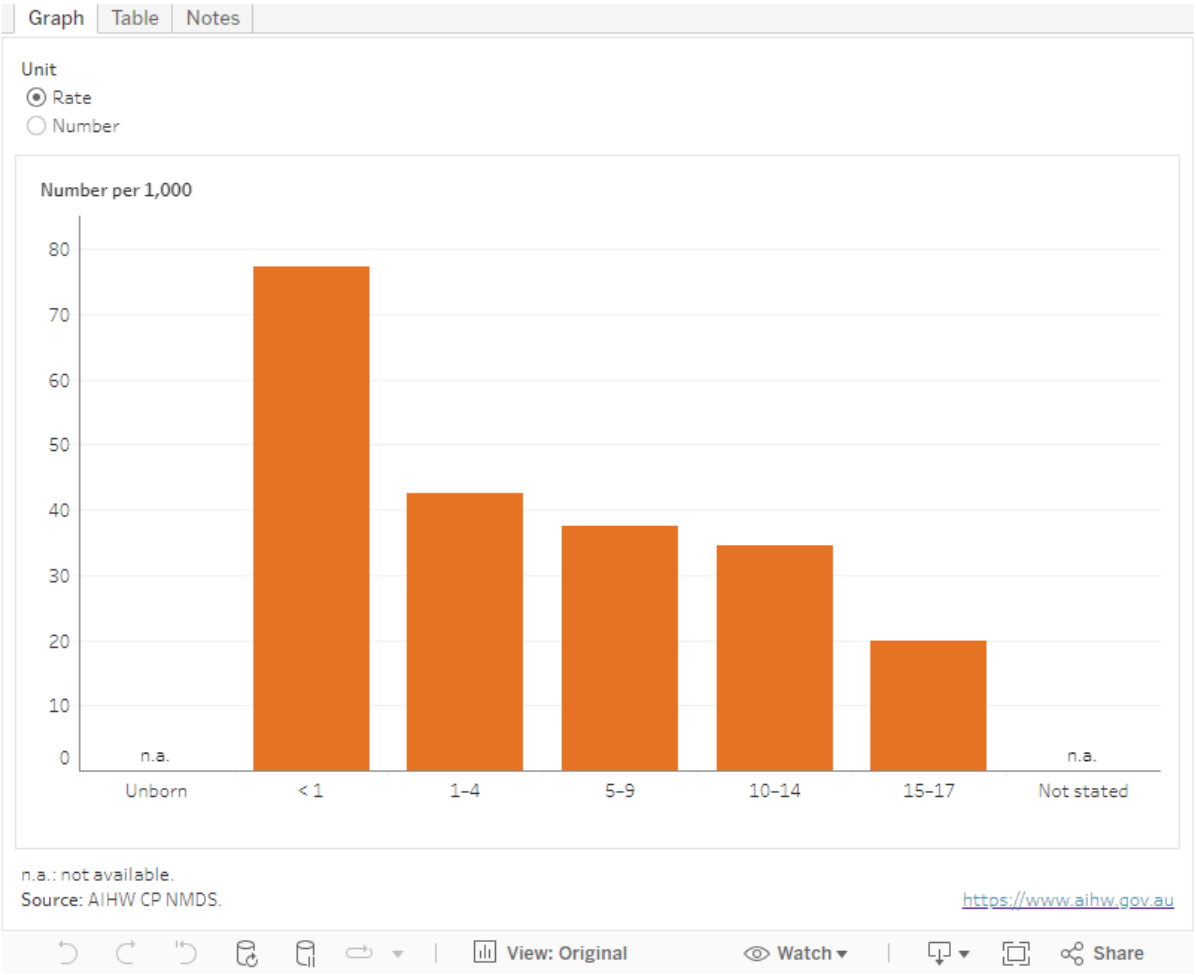
First Nations children are particularly at risk of experiencing the direct and indirect impacts of family violence, which contributes to the over-representation of First Nations children in Australia's child protection system (SNAICC et al. 2017). First Nations children and young people may face additional challenges as a result of multiple disadvantages, such as loss of culture, racism and discrimination (ACYP 2018).

In 2021–22, almost 58,000 (170 per 1,000) First Nations children came into contact with the child protection system. This rate has increased over time from 155 per 1,000 in 2018–19. First Nations infants aged less than one (200 per 1,000) were most likely to come into contact with the child protection system, and adolescents aged 15–17 were the least likely (135 per 1,000) (AIHW 2023c).

Of the 45,500 children who were the subjects of substantiations of maltreatment in 2021–22, 13,600 were First Nations children (40 per 1,000) and 30,500 were non-

Indigenous children (5.7 per 1,000) (Figure 10). Emotional abuse was the most common primary type of abuse substantiated for First Nations children (50%), followed by neglect (30%), physical abuse (13%) and sexual abuse (6.8%) (AIHW 2023c).

Figure 10: First Nations children who were the subject of substantiations, by selected characteristics, 2018–19 to 2021–22



The higher rate of First Nations children in child protection substantiations is complex, and may have been affected by:

- the legacy of past policies of forced removal
- intergenerational effects of previous separations from family and culture
- a higher likelihood of living in the lowest socioeconomic areas
- perceptions arising from cultural differences in child-rearing practices (HREOC 1997).

At 30 June 2022, around 2 in 5 children on care and protection orders or in out-of-home care were First Nations people (40% or 24,600 children and 43% or 19,400 children, respectively) (AIHW 2023c).

See **Child protection** for more information.

What are the impacts and outcomes of family violence?

Family violence has been associated with a range of negative health impacts, including higher rates of miscarriage, pre-term birth and low birthweight, as well as other long-term health consequences for women and children (WHO 2011). See **Health outcomes**, **Behavioural outcomes** and **Economic and financial impacts** for more information.

There are limited national longitudinal data on the impacts and outcomes of family violence in First Nations communities, particularly for children.

Burden of disease

Burden of disease measures the impact of living with illness and injury and dying prematurely. According to the First Nations component of the 2018 Australian Burden of Disease Study (ABDS, see Box 5), child abuse and neglect contributed to 5.1% of the total disease burden and around 80 deaths for First Nations people. Among First Nations women, intimate partner violence (IPV) contributed to 2.1% of the total disease burden and around 30 deaths (AIHW 2022a).

Box 5: Australian Burden of Disease Study

The Australian Burden of Disease Study (ABDS) 2018 estimated the impact of various diseases, injuries and risk factors on total burden of disease for the Australian and First Nations population. It combines health loss from living with illness and injury (non-fatal burden, or YLD) and dying prematurely (fatal burden, or YLL) to estimate total health loss (total burden, or DALY) (see **Glossary**).

The ABDS includes estimates of the contribution made by selected risk factors on the disease burden in Australia, including intimate partner violence (IPV) and child abuse and neglect. The disease burden due to IPV is currently only available for females, as there is not sufficient published research indicating a causal link between disease burden and the risk of IPV for males.

Source: AIHW 2021

For more information on how burden of disease is determined, see Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018, Summary.

Diseases that were causally linked to IPV

The ABDS 2018 estimated the amount of disease burden that could have been avoided if all First Nations women aged 15 and over in Australia were not exposed to IPV. In estimating this burden, 6 diseases were causally linked to exposure to IPV in females:

- depressive disorders (contributing to 20% of depressive disorders total burden in females)

- anxiety disorders (26%)
- early pregnancy loss (28%)
- homicide and violence (injuries due to violence) (62%)
- suicide and self-inflicted injuries (32%)
- alcohol use (10%) (AIHW 2022a).

The burden attributable to IPV for First Nations women (age-standardised DALY rate of 14 per 1,000 people) was 6.1 times the rate for non-Indigenous women (age-standardised DALY rate of 2.3 per 1,000 people). IPV contributed to 5.8% of the total health gap (as measured by the DALY rate difference between First Nations and non-Indigenous women) (AIHW 2022a).

Diseases that were causally linked to child abuse and neglect

Child abuse and neglect among First Nations people was causally linked to:

- anxiety disorders (contributing to 35% of anxiety disorders burden)
- depressive disorders (31%)
- suicide and self-inflicted injuries (41%) (AIHW 2022a).

The burden attributable to child abuse and neglect for First Nations people (age-standardised DALY rate of 16 per 1,000 people) was 3.9 times the rate for non-Indigenous people (age-standardised DALY rate of 4.0 per 1,000 people). Child abuse and neglect contributed to 5.2% of the total health gap (as measured by the DALY rate difference between First Nations and non-Indigenous people) (AIHW 2022a).

Family violence is associated with high psychological distress in First Nations mothers

The Aboriginal Families Study (see Box 6) identified high rates of social health issues affecting Aboriginal women and families in South Australia during pregnancy, and high levels of associated psychological distress after the birth of their babies. One in 4 Aboriginal women (25%, or 83) reported high to very high psychological distress after the birth of their baby, which is higher than estimates of maternal psychological distress among the general population (Weetra et al. 2016).

More than 1 in 2 (56%) Aboriginal women had experienced 3 or more stressful events and social health issues during pregnancy, and more than 1 in 4 (27%) had experienced 5–12 issues. A large number of Aboriginal women reported experiences of family or community conflict during pregnancy:

- 1 in 3 (30%, or 100) had been scared by other people's behaviour
- 1 in 4 (26%, or 90) had left home due to a family argument
- 1 in 6 (16%, or 53) had been physically assaulted (Weetra et al. 2016).

The average age of participating mothers in the study was 25, with an age range of 15–43 (Weetra et al. 2016). First Nations mothers are, on average, younger than non-Indigenous mothers. Of all the mothers who gave birth in 2021, the average maternal

age for First Nations mothers was about 27 years, compared with about 31 years for non-Indigenous mothers. A higher proportion of First Nations mothers were teenagers (10%), compared with 1.1% of non-Indigenous mothers (AIHW 2022b).

Box 6: The Aboriginal Families Study

The Aboriginal Families Study investigates the health and wellbeing of 344 Aboriginal children born between July 2011 to June 2013 and their mothers living in South Australia. It is being conducted as a partnership between the Murdoch Children's Research Institute, the Aboriginal Health Council of South Australia and the South Australian Health and Medical Research Institute. An Aboriginal Advisory Group has been guiding the development and conduct of the study. The study is expected to be completed in December 2023.

As part of the study, the mothers completed a questionnaire in the first year after the birth of their children about experiences of family and community violence during pregnancy. The questionnaire included measures of stressful events (such as serious illness or injury) and social health issues (such as housing problems, trouble with police, and drug and alcohol problems) during pregnancy, and maternal psychological distress were assessed using the Kessler-5 scale. They completed a follow-up questionnaire focused on experiences of intimate partner violence when the children were aged 5–8 years, which were measured using a culturally adapted version of the Composite Abuse Scale.

For more information on the experiences of mothers and children, see **Mothers and their children**.

Source: ANROWS 2023; Weetra et al. 2016.

Preliminary findings from the follow-up questionnaire (based on 170 of the women) found that about 2 in 5 (37%) had experienced any violence from a current or former partner in the previous 12 months (partner violence):

- 1 in 3 (30%) had experienced psychological violence
- 1 in 4 (25%) had experienced physical violence
- about 1 in 4 (26%) had experienced financial abuse
- about 1 in 5 (19%) had experienced all three types of partner violence (Brown et al. 2021).

A higher proportion of women who were single (59%) reported partner violence compared with women who were living with a partner (20%) (Brown et al. 2021).

Witnessing family conflict is associated with social and emotional difficulties among First Nations children

The Longitudinal Study of Indigenous Children (LSIC) is a study among First Nations children of how a child's early years affect their development. The study has interviewed participating families every year since 2008 and includes a sizeable population of First Nations children and their families across Australia; however, it is not based on a representative sample (DSS 2020). The primary carers were asked about their

relationship with their partners in Wave 3 (2010) and again in Wave 6 (2013) (Kneebone 2015).

Among the surveyed families of between 1,200 and 1,700 First Nations children, 1 in 5 (20%) reported that their children had been upset by family arguments in the last year, with this proportion consistent over time. These children were significantly more likely to experience social and emotional difficulties (as measured by a Strengths and Difficulties Questionnaire), compared with children whose parents did not report them being upset by family arguments (Kneebone 2015).

Children whose parents have had violent arguments were also more likely to experience social and emotional difficulties compared with those whose parents did not report violent arguments; however, the difference was only statistically significant in Wave 3 (Kneebone 2015).

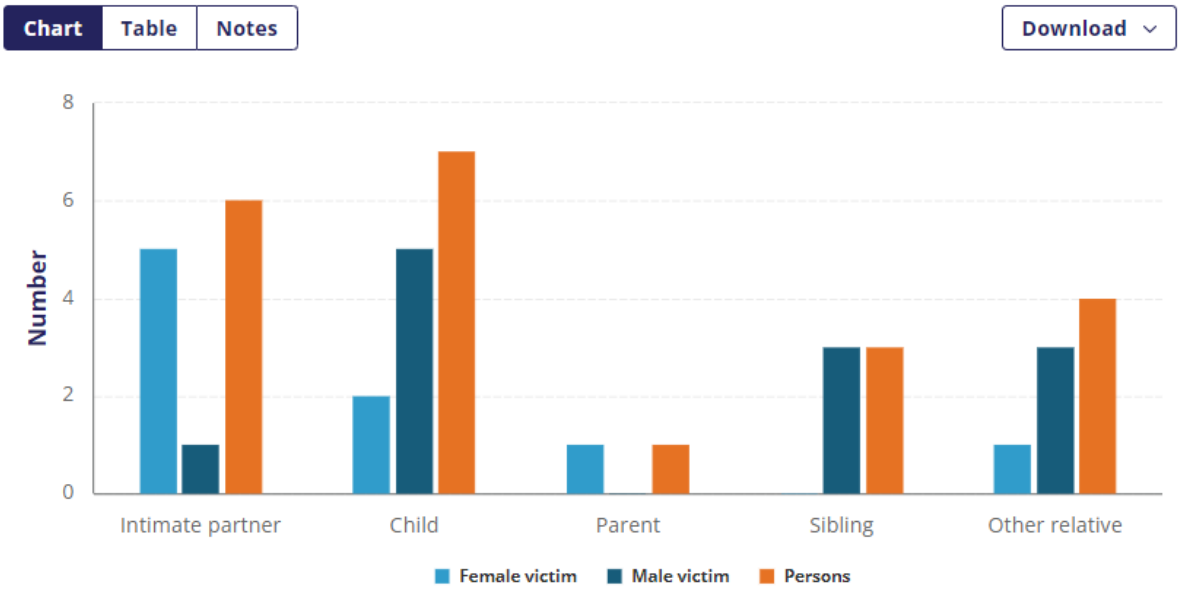
More First Nations women are killed by partners than First Nations men

The National Homicide Monitoring Program recorded 21 First Nations victims of domestic homicide in 2022–23. There were:

- 6 victims killed by an intimate partner
- 7 victims killed by a parent
- 1 victim killed by a child
- 3 victims killed by a sibling
- 4 victims killed by other relatives (Miles and Bricknell 2024).

Over half (56%) of First Nations female victims of domestic homicide were killed by an intimate partner. Meanwhile, 1 in 12 (8.3%) First Nations male victims of domestic homicide were killed by an intimate partner. First Nations male victims of domestic homicide were more commonly killed by parents (42%) (Miles and Bricknell 2024; Figure 11). These data should be interpreted with caution due to small numbers.

Figure 11: First Nations domestic homicide victims, by type of homicide and sex of victim, 2022–23



Source: AIC NHMP | **Data source overview**

Data used by the Australian Domestic and Family Violence Death Review Network, which only includes intimate partner homicides that had a history of violence between the offender and victim, indicate that:

- of the 240 female victims of homicide by a male intimate partner, 1 in 4 (25%) were First Nations women
- of the 65 male victims of homicide by a female intimate partner, 2 in 5 (40%) were First Nations men (ADFVDRN and ANROWS 2022).

For more information, see **Domestic homicide**.

Across jurisdictions with published data (New South Wales, Queensland, South Australia and the Northern Territory) in 2022, police-recorded crime data indicated that the victimisation rate of homicide by a family member was:

- 1.0 per 100,000 First Nations people in New South Wales
- 1.6 per 100,000 First Nations people in Queensland
- 6.3 per 100,000 First Nations people in South Australia
- 10 per 100,000 First Nations people in the Northern Territory (ABS 2023c; Figure 1).

Family violence is a risk factor for suicide

Violent behaviour is a risk factor for suicide, regardless of the presence of other mental health conditions or substance use (Cripps 2023). The Coroners Court of Victoria identified experience of abuse (85%), conflicts with family members (55%), conflicts with a partner (49%) and experiences of family violence with a partner (49%) as some of the

major interpersonal and contextual stressors among First Nations people who died by suicide from 2018 to 2021. The court also found that 1 in 3 (34%) First Nations people who died by suicide had a childhood history of exposure to family violence, including witnessing and/or experiencing family violence during childhood (Coroners Court of Victoria 2023).

Is it the same for everyone?

The risk and experience of family violence among First Nations people can vary. Different aspects of a person's identity (such as gender, socioeconomic status and disability) can expose the individual to overlapping and/or increased sources of discrimination and marginalisation, which can lead to increased risk and severity of family violence (Victoria State Government 2019).

Although national data on the experiences of family violence among First Nations people who also belong to other population groups are limited, some data are available for First Nations people with disability and lesbian, gay, bisexual, transgender, intersex, queer, Sistergirl or Brotherboy (LGBTIQASB+) First Nations people.

See **Factors associated with FDSV** for more information on intersecting risk factors associated with family violence.

First Nations people with disability

First Nations people are more likely to have disability than non-Indigenous Australians. Almost 1 in 4 (24%, or 140,000) First Nations people living in households (excluding those in very remote areas and discrete First Nations communities) reported having disability in 2018, compared with 18% in the total population (ABS 2019b, 2021).

The latest National Aboriginal and Torres Strait Islander Social Survey (NATSISS, 2014–15) showed that First Nations people who reported experiencing physical violence by a family member in the past 12 months were more likely to have disability. Among First Nations people who reported physical violence from a family member, more than half (54%, or 17,700) had a disability. More than half (56%, or 12,800) women and just under half (49%, or 4,800) men who experienced physical violence from a family member in the last 12 months had a disability. However, this result should be interpreted with caution due to small sample sizes (ABS 2016).

For more information on family violence among people with disability, see **People with disability**.

Lesbian, gay, bisexual, transgender, intersex, queer, asexual, Sistergirl or Brotherboy (LGBTIQASB+) First Nations people

Brotherboy and **Sistergirl** are terms used by First Nations people to describe gender diverse people who have a male and female spirit that take on male and female roles within the community respectively.

There are no national data on the prevalence of family violence among LGBTIQASB+ First Nations people. However, it is known that First Nations LGBTIQASB+ communities experience a range of significant and intersecting points of discrimination and marginalisation (DSS 2022). A qualitative study on First Nations LGBTIQASB+ people's experiences of family violence found a high prevalence of violence experienced by LGBTIQASB+ people, where intimidation, bullying and threats of violence were commonly used to make the victim-survivor feel unsafe or excluded and/or force the victim-survivor to hide their gender identity and sexual orientation. The study also found that negative reactions and behaviours were reported more within extended families, older generations and rural or remote communities (Soldatic et al. 2023).

For more information on family violence among LGBTIQA+ people, see **LGBTIQA+ people**.

Related material

- Family and domestic violence
- Intimate partner violence
- Sexual violence
- Who uses violence?
- How do people respond to FDSV?

More information

- Child Protection, Australia.
- Family violence prevention programs in Indigenous communities.
- First Nations people.
- Injury in Australia.
- Specialist Homelessness Services, annual report.
- Suicide & self-harm monitoring.

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Children and young people

Key findings

- 13% of adults in 2021–22 had witnessed partner violence against a parent before the age of 15.
- About 3 in 5 (59%) recorded sexual assault victims had an age at incident under 18 years in 2022.
- Among hospitalisations for FDV-related injuries in 2021–22, the most common perpetrator was parents among children aged 0–14, domestic partners for females aged 15–24 and other family members for males aged 15–24.

Children and young people are particularly at risk of experiencing the effects of family, domestic and sexual violence (FDSV). Violence to children and young people often occurs in homes and family settings. For children and young people who experience or are exposed to FDSV, the harm caused can be serious and long-lasting, affecting their health, wellbeing, education, and social and emotional development (Boxall et al. 2021; Campo 2015; DSS 2022; Toivonen and Backhouse 2018).

Experiences and exposure to FDSV can also increase the probability of the child or young person using violence in their home and later in life (Fitz-Gibbon et al. 2022; Ogilvie et al. 2022). This process can be referred to as the intergenerational transmission of violence, for further discussion, see **Family and domestic violence**.

This page presents the available national data and research on violence and abuse experienced by children and young people in the context of FDSV in Australia.

Box 1: How do we define children and young people?

In AIHW reporting, 'children' are generally defined as people aged 0–12 and 'young people' as those aged 12–24. However, definitions can vary between legal frameworks, government policies and data sources. In some cases, data may not be available for certain age groups or the numbers may be too small for robust reporting. Therefore, different age groups may be used in reporting on children and young people, with children most commonly referring to people aged 0–14 years or 0–18 years and young people referring to people aged 15–24 or 19–24. Regardless of the age groups used for these terms, it is important to acknowledge that children develop at different rates and the term child can diminish the differences among young people's capacity for and desire for self-determination (AIFS 2018).

What forms of FDSV affect children and young people?

In AIHW reporting FDSV refers to all forms of violence that occur in the context of family and intimate partner relationships, and sexual violence in any context (see **What is**

FDSV?). Child abuse and neglect or child maltreatment includes any direct and indirect experiences of violence or neglect among young people aged under 18 years by a person in a position of responsibility, trust or power over the child or young person. This may involve violence used by related or unrelated adults, young people or other children (AIFS 2018; WHO 2022).

Direct forms of FDSV

Direct forms of FDSV include those in which the child or young person is the direct target of FDSV, which may be through neglect, physical, sexual and emotional violence or abuse, and sexual harassment (see Box 2).

Box 2: Broad definitions of direct forms of FDSV

A person may experience multiple and overlapping forms of FDSV including:

- **Physical violence or abuse** – the intentional attempt, use or threat of physical force with the intent to harm or frighten a person (ABS 2023d).
- **Sexual violence or abuse** – any act or attempted act of a sexual nature without consent or threat of sexual acts. Any sexual acts with a person under the age of consent are considered sexual abuse. Note that the age of consent varies between jurisdictions (see **Consent**) (ABS 2023d; DSS 2022).
- **Sexual harassment** – unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated, where a reasonable person would anticipate that reaction in the circumstances (ABS 2023d; DSS 2022).
- **Emotional violence or abuse** – behaviours or actions that are perpetrated with the intent to manipulate, control, isolate or intimidate, and which cause emotional harm or fear (ABS 2023d).
- **Neglect** – any serious acts, omissions or patterns of behaviour, intentional or not, that result in a dependent child or young person not receiving essentials for healthy physical and emotional development (AIFS 2018).

See also **What is FDSV?**.

Technology can be misused to support the perpetration of different forms of violence, such as harassment, stalking, and sexual violence. The term, technology-facilitated abuse, is used to refer to any abusive behaviours and activities that also involve the use of technology such as phones, internet-enabled devices and online platforms (Dragiewicz et al. 2020; Powell et al. 2022).

Indirect forms of FDSV

Indirect forms of FDSV (or **exposure to FDSV**) occur among children and young people when they are exposed to the obvious and/or subtle acts of violence directed at people around them, most commonly someone they live with. Exposure to FDSV can include:

- seeing and/or hearing acts of physical and sexual violence and/or its effects

- witnessing patterns of non-physical controlling behaviours, for example, a parent belittling, disregarding or limiting the freedom of another parent (see also **Coercive control**) (Campo 2015; Katz et al. 2020).

What do we know?

Factors related to experiencing FDSV

Many factors that are more common among people who have experienced FDSV than those who have not **(risk factors**) are also associated with experiences of FDSV among children and young people, see **Factors associated with family, domestic and sexual violence**. While there is a statistical association between risk factors and experiences of FDSV, this does not mean these factors cause FDSV. Risk factors that are unique to or may have a stronger association among children and young people include:

- parental/caregiver factors – including a parent's substance abuse, parental separation or divorce, poor mental and physical health and low levels of education or income
- family factors – including large size, economic hardship, patterns of conflict or violence, involvement in criminal behaviour and actual or intended separation of parents
- individual factors – including low birth weight, disability, pregnancy or birth complications (AIFS 2017; CDC 2022; Fazel et al. 2018; Higgins et al. 2023; Toivonen and Backhouse 2018).

As is the case for people in most age groups, FDSV among young people is more likely to be experienced by young women than young men. This gendered pattern, while present, is less apparent among children, with no gendered pattern evident for exposure to domestic violence (DSS 2022; Mathews et al. 2023b). For a discussion of FDSV centred on the experiences of young women, see **Young women**.

There are some factors that have been associated with a decreased likelihood that children and young people will have experienced FDSV (**protective factors**), including, but not limited to:

- strong parent/child relationships
- family cohesion and support networks
- parental education, employment, resilience and understanding of child development (AIFS 2017; CDC 2022).

Barriers to accessing help

Children and young people may experience many barriers to accessing help that are shared with the general population including, but not limited to, the fear of not being believed, restrictive cultural norms and previous negative experiences with the police and legal systems (AIFS 2015; Coumarelos et al. 2023; RCIRCSA 2017). Some surveys have found that many people in Australia hold attitudes that discredit or distrust

children and young people's disclosures of abuse and violence (Tucci and Mitchell 2021; Coumarelos et al. 2023). For example, an online survey with a sample of about 1000 people aged 18 years and over in Australia that was weighted to be nationally representative found that 67% of respondents believed that children make up stories about being abused or are uncertain whether to believe children when they disclosed being abused (Tucci and Mitchell 2021).

Barriers that are specific to children and young people or may have a larger effect among them include:

- fear of withdrawal of support
- perceived or actual reliance on the perpetrator of violence (for example, when abuse is perpetrated by a parent)
- a lack of understanding or recognition of the abuse or its seriousness
- being unable to express or communicate the abuse
- a lack of appropriate institutional (for example, schools) or child and young people-specific supports (AIFS 2015; Alaggia et al. 2019; Humphreys and Healey 2017; RCIRCSA 2017).

For a further discussion of barriers, see **How do people respond to FDSV?**, and for a discussion of community attitudes to FDSV, see **Community attitudes**.

Negative effects on health and wellbeing

Experiences of and exposure to FDSV as a child or young person can have both immediate and life-long negative effects on the health, wellbeing, development and life satisfaction of victim-survivors. Experiences of FDSV can negatively impact everyone connected to the victim-survivor through physical, emotional, financial, social and psychological effects. Both victim-survivors and their connections can be affected by a loss of trust in people, hyper-vigilance and a loss of connection to their communities. Interactions with services can often be re-traumatising, especially in cases of inadequate justice and support service responses (C3P 2017; DSS 2022; Jones et al. 2021).

Maternal experiences of and exposure to FDSV as a child or young person are statistically associated with adverse pregnancy outcomes. These include low birth weight and pregnancy or birth complications, which in turn, are risk factors for experiencing FDSV among children and young people. This demonstrates the intergenerational impacts of FDSV (see also **Family and domestic violence** and **Pregnant people**) (Mamun et al. 2023).

For information related specifically to the outcomes of child sexual abuse, see **Child sexual abuse**.

How does FDSV affect children long-term?

'Children from families experiencing family violence end up having to recover from their childhood in their adult years. The unaddressed trauma from navigating an unhealthy, abusive parent gets carried into their own relationships often leading to unhealthy coping behaviours, and the continuation of the intergenerational cycle of violence.'

Lily

WEAVERs Expert by Experience

Measuring the extent of violence against children and young people

It is difficult to obtain robust data on children's experiences of FDSV. Due to the sensitive nature of this subject, most large-scale population surveys focus on adults. However, estimates of adults from surveys are likely to underestimate the true extent of FDSV due to some people's reluctance to disclose information and reliance on participants' recollections of events, which may have changed over time.

The Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) asks people aged 18 and over (adults) about experiences of FDSV within specified timeframes (such as before and since the age of 15, in the last 12 months, and in the last 2 years). Data related to experiences of physical and sexual abuse perpetrated by an adult before the age of 15 and experiences of witnessing parental violence before the age of 15 do not provide estimates of the current prevalence of abuse experienced by children (ABS 2023c). For more information about the PSS, please see **What is FDSV?** and **Data sources and technical notes**.

The 2021 Australian Child Maltreatment Study (ACMS) was a cross-sectional survey of people aged 16 and over about their experiences of child sexual abuse and child maltreatment from a parent or caregiver. It also assessed some other childhood adversities and associations with aspects of health and wellbeing later in life. These data provide information about those who responded to the survey and we have restricted our discussion to this group. We have not used these data to draw conclusions about the Australian population given the response rate (see Box 3). However, the survey does provide important information about the survey respondents, which can inform the work of researchers, advocates, and policy makers.

Due to differences in the methods used, findings from these sources are not comparable. For more information about the differences in design and scope, concepts, and definitions for these sources, please refer to the ABS Technical note: Personal Safety Survey and the Australian Child Maltreatment Study.

What national data are available to report on FDSV among children and young people?

Data are available across a number of surveys and administrative data sources to look at the experience, service responses and outcomes of FDSV among children and young people.

Data sources for measuring FDSV among children and young people

- ABS Personal Safety Survey
- ABS Recorded Crime – Victims
- AIC National Homicide Monitoring Program
- AIHW Australian Burden of Disease Study
- AIHW Child Protection National Minimum Data Set
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services (SHS) collection
- Australian Child Maltreatment Study
- The Longitudinal Study of Australian Children
- The National Survey of Secondary Students and Sexual Health

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

How common are experiences of FDSV among children and young people?

The PSS asks respondents about whether they had witnessed violence towards their own parents when they were children. These data are collected from adults 18 years and over about the violence they witnessed before the age of 15.

According to the 2021–22 PSS, about 1 in 8 (13% or 2.6 million) people, aged 18 years and over, witnessed violence towards a parent by a partner before the age of 15. A higher proportion of people had witnessed partner violence against their mothers (12%, or 2.2 million) than their fathers (4.3%, or 837,000). Of people who had witnessed violence towards their mother, almost 3 in 4 (72% or 1.6 million) had witnessed the violence on more than 2 occasions (ABS 2023a). See also **Family and domestic violence** and **Intimate partner violence.**

The PSS also collects data on experiences of physical and/or sexual abuse (abuse) before the age of 15 among females and males aged 18 and over (women and men) and whether perpetrators were known or strangers. The PSS found that about 1 in 6 women (18%, or 1.7 million) and 1 in 9 men (11%, or 1.0 million) in 2021–22 had experienced abuse before the age of 15 (ABS 2023a).

Of the 989,000 women and 788,000 men who had experienced childhood physical abuse, the most common perpetrator of the first incident was a family member, with the majority involving a parent:

- 89% for women, with 52% perpetrated by their father or step-father and 36% by their mother or step-mother
- 87% for men, with 56% perpetrated by their father or step-father and 32% by their mother or step-mother (ABS 2023a).

For the available data on the experiences of sexual abuse before the age of 15, see **Child sexual abuse.**

Estimates from the 2021–22 PSS indicate that people who had witnessed parental violence or experienced childhood physical and/or sexual abuse were more likely to have experienced violence since the age of 15 when compared with those who had not had childhood experiences of violence or abuse.

The experience of partner violence (physical and/or sexual violence, emotional abuse or economic abuse by a partner they lived with, or had lived with, in a married or de facto relationship), occurred among:

- 43% (or 1.1 million) of people who had witnessed parental violence before the age of 15, compared with 18% (or 3 million) of people who had not witnessed parental violence
- 43% (or 1.2 million) of people who had experienced physical and/or sexual abuse before the age of 15, compared with 17% (or 2.8 million) of people who had not experienced childhood abuse (ABS 2023a).

See also **Intimate partner violence**.

Experiences of maltreatment as a child

The 2021 ACMS collected data on experiences of maltreatment as a child (person under 18 years) (see Box 3). The study indicated for surveyed people aged 16 years and over in 2021:

- about 3 in 10 (29%) had experienced **sexual abuse** from any person – about 1 in 12 (8.7%) people experienced forced sex (rape) in childhood

- about 3 in 10 (31%) had experienced **emotional abuse** from a parent/caregiver, with 80% of these people reporting the abuse occurred over years
- about 1 in 11 (8.9%) had experienced **neglect** from a parent/caregiver, with 75% of these people reporting the neglect occurred over years
- 2 in 5 (40%) had experienced **exposure to domestic violence (EDV)** between a parent/caregiver and their partner, with 32% of these people reporting more than 50 incidents (Haslam et al. 2023c; Higgins et al. 2023; Mathews et al. 2023b).

The most recent ACMS report does not provide data about specific perpetrators, however, analyses related to this and other topics are expected in future ACMS reports. See **Child sexual abuse** for a discussion of the ACMS findings about perpetrators of child sexual abuse.

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

Box 3: Australian Child Maltreatment Study (ACMS)

The ACMS was a cross-sectional survey of just over 8,500 participants aged 16 years and over between 9 April and 11 October 2021. People were considered to be eligible for participation if they were aged 16 years or more, in an age group for which participants were required when contacted and had sufficient English language proficiency for participation. The final response rate was 4.0% when based on the estimated number of eligible participants (about 210,370 people) and 14% when based on eligible participants contacted (about 60,800 people) (Haslam et al. 2023a).

Retrospective self-report data was collected exclusively via computer assisted mobile phone interview using a well-validated questionnaire that was adapted to measure child maltreatment in an Australian cultural context (see **Data sources and technical notes**). While the ACMS did not exclude First Nations people (Aboriginal and Torres Strait Islander people), it was determined that it was not ethically or methodologically appropriate to disaggregate data by Indigenous status for this survey (Haslam et al. 2023a, 2023b; Mathews et al. 2021).

The ACMS defines a child as a person aged under 18 years (Haslam et al. 2023a). The ACMS measured five types of child maltreatment with the following definitions:

- **Physical abuse** – experiences of physical force used by an adult against a child that result, or have a high likelihood of resulting, in injury, pain, or a breach of dignity.
- **Sexual abuse** – any contact and non-contact sexual act, or attempted act, inflicted on a child by a person where the child either lacks capacity to give consent, or has capacity but does not give full, free, and voluntary consent. Sexual harassment was excluded from estimates of sexual abuse.
- **Emotional abuse** – non-physical interactions between a child and parent or caregiver that make the child feel worthless, flawed, unloved, unwanted, endangered or only of value in meeting another's needs. Emotional abuse was considered to have occurred if such experiences occurred over a period of at least weeks.

- **Neglect –** involves the failure by a parent or caregiver to provide a child with the basic necessities of life. Neglect was considered to have occurred if such experiences occurred over a period of at least weeks. Neglect has several dimensions: medical, educational, supervisory, physical, nutritional, and environmental.
- **Exposure to domestic violence** – occurs when a child sees or hears one parent/caregiver behave in certain ways towards their partner including: physical acts of violence; serious threats of harm; intimidating, controlling and isolating behaviours; and damage to property and pets during an argument (Mathews et al. 2023a).

The ACMS also conducted assessments for other childhood adversities including corporal punishment, internet sexual victimisation, generalised sexual harassment, peer bullying, sibling victimisation, out of home care, and family-related adversities (Haslam et al 2023a).

Figures presented from the ACMS have been rounded. For exact figures, please see the cited primary source.

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

Partner violence experienced by young people

The PSS defines a partner as a person the respondent lives with or lived with at some point in a married or de facto relationship (ABS 2017b, 2023a).

The latest available estimates of experiences of partner violence among women aged 18–24 are provided by the 2021–22 PSS. Estimates are not available for men aged 18–24 as 2021–22 data are not sufficiently statistically reliable for reporting. The 2016 PSS (which had estimates for both men and women) showed that among people aged 18–24, most partner violence is experienced by women (AIHW 2022a).

Among women aged 18–24, in the 2 years prior to 2021–22:

- about 22,700* (2.2%*) experienced **partner physical and/or sexual violence**
- about 29,200* (2.9%*) experienced **emotional abuse by a partner**
- about 26,100* (2.6%*) experienced **economic abuse by a partner** (ABS 2023b).

Note that estimates marked with an asterisk (*) should be used with caution as they have a relative standard error between 25% and 50%. For the PSS definitions of physical or sexual violence and emotional abuse, see **Data sources and technical notes.**

Box 4: Intimate partner violence among people aged 18-19

Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC) is an ongoing national study following the development of 10,000 children and their families from all parts of Australia. The sample was nationally representative of all Australian children at recruitment. The Australian Institute of Family Studies examined intimate partner violence (IPV) victimisation among people aged 18-19 in Australia using data from the LSAC K cohort at Wave 8, which were collected in 2018. The report found that among the 3,000 participants

aged 18-19 who completed the Wave 8 survey, around 3 in 10 (29%) reported at least one experience of IPV in the year before the survey. Specifically:

- 1 in 4 (25%) experienced emotional abuse
- 1 in 8 (12%) experienced physical violence
- 1 in 12 (8%) experienced sexual abuse in the previous year.

Women aged 18-19 (11%) were more likely to be victim-survivors of sexual abuse than men of the same age (4%). The rates of emotional abuse and/or physical violence victimisation were similar between young women and men.

The report also identified supportive friendships and high trust and good communication with parents during adolescence as protective factors that reduce the risk of IPV.

Please see **Data sources and technical notes** for more information on the LSAC.

Source: O'Donnell et al. 2023.

Sexual violence experienced by young people

The latest available estimates of sexual violence and sexual harassment among women aged 18–24 are provided by the 2021–22 PSS, while the latest estimates for men aged 18–24 are provided by the 2016 PSS.

About 1 in 10 (11%, or 113,000) women aged 18–24 experienced sexual assault in the 2 years prior to 2021–22, more than any other age group.

People aged 18–24 are more likely than other age groups to have experienced sexual violence and sexual harassment (ABS 2017b, 2023h, 2023i).

Based on the latest PSS data (2021–22) on experiences of **sexual violence and harassment among women aged 18–24**:

- about 126,000 (12%) women aged 18–24 experienced sexual violence in the 2 years prior to 2021–22, with about 113,000 (11%) women experiencing sexual assault (ABS 2023i)
- about 356,000 (35%) women aged 18–24 experienced sexual harassment in the 12 months prior to 2021–22 (ABS 2023h).

Based on the latest PSS data (2016) on experiences of **sexual violence and harassment among men aged 18–24**:

- about 26,400* (2.3%) men aged 18–24 experienced sexual violence in the 12 months prior to 2016, which compares with 65,100 (5.9%) women aged 18–24 during the same period
- about 185,000 (16%) men aged 18–24 experienced sexual harassment in the 12 months prior to 2016, which compares with 421,000 (38%) women aged 18–24 during the same period (ABS 2017b).

Note that estimates marked with an asterisk (*) should be used with caution as they have a relative standard error between 25% and 50%. For the PSS definitions of sexual violence and sexual harassment, see **Data sources and technical notes**.

Sexual violence experienced by university and secondary school students

Data about sexual harassment and sexual assault at Australian universities are available from the National Student Safety Survey (NSSS) (see **Data sources and technical notes** for the NSSS definitions of sexual harassment and assault). The 2021 NSSS included a sample of about 43,800 students aged 18 and over from 38 universities who volunteered to respond to the online survey. The sample was weighted to be representative of students studying at Australian universities aged 18 years and over. The NSSS found that, in the 12 months prior to 2021, in an Australian university context, younger students (aged 18–21) were more likely to have experienced:

- **sexual harassment** (12%), when compared with those aged 22–24 years (8.4%), 25–34 years (5.5%) or older, with those aged 18–21 also more likely to report incidents in student accommodation or residences (16%)
- **sexual assault** (1.9%) compared with those aged 22–24 years (1.1%), 25–34 years (0.5%) or older (Heywood et al. 2022).

For further discussion of the NSSS, see **Sexual violence**.

The 7th National Survey of Secondary Students and Sexual health in 2021 investigated some key issues related to sexual harassment and violence among secondary school students including experiences of unwanted sex and the sharing of sexual images, video and messages (sexting) (see Box 5).

Box 5: The 7th National Survey of Secondary Students and Sexual Health

The 7th National Survey of Australian Secondary Students and Sexual Health (SSASH survey) conducted in 2021 surveyed about 6,800 secondary school students aged 14–18 years. The SSASH survey is not considered representative of all secondary school students aged 14–18 as it used a convenience sample based on voluntary survey completion and online recruitment and completion.

For definitions and other technical details about this data source, please see **Data sources and technical notes**.

Experiences of unwanted sex by secondary school students

The SSASH survey asked students about whether they had ever had sex when they did not want to, the context and circumstances of the experience/s and whether they sought help.

About 2 in 5 (40%) respondents who had ever experienced sex had also experienced unwanted sex during their life. Experiences of unwanted sex were more common among respondents that were:

- trans and non-binary young people (55%) and young women (45%) than young men (21%)

- LGBQ+ young people (48%) than heterosexual young people (34%).

The average age at which unwanted sex was first experienced was 14.9 years, lower for respondents that were trans and non-binary young people (14.0 years) compared with young women (15.0 years) and men (15.4 years). About 1 in 5 (21%) were younger than 14 years of age.

Most respondent's first experience of unwanted sex occurred in an intimate relationship (60%). About 1 in 5 (21%) were in familial or friendship relationships and for about 1 in 10 (9.9%) it was perpetrated by someone known but not a friend or family member. Respondents described the context in which their most recent experiences of unwanted sex occurred:

- about 2 in 3 (65%) young people described experiencing verbal pressure
- about 2 in 5 (41%) said they agreed to sex as they were worried about the negative outcomes of not having sex
- about 1 in 3 (32%) were physically forced to have sex
- about 3 in 10 (28%) indicated they were too drunk or high at the time to consent to sex.

About 1 in 4 (23%) respondents who had experienced unwanted sex had talked to someone or sought help about their experience.

The percentage of respondents in year 10 and year 12 with unwanted sexual experiences has varied between 25% and 29% between 2002 and 2018, increasing to 41% in 2021. It is currently unclear why the percentage increased, although it may reflect an increasing awareness of sexual violence and consent among young people.

Experiences of sexting and image-based abuse

Sharing sexual images, video and sexually suggestive messages (sometimes collectively referred to as 'sexting') can be a part of sexual communication and relationships. It can also put someone at risk of abuse, including the non-consensual sharing of images (image-based abuse) and pressure through threats of image-based abuse (eSafety Commissioner 2022).

The SSASH survey found that many respondents had experienced sexting, with over 4 in 5 (86%) reporting that they had received sexual messages or images and over 2 in 3 (71%) that they had sent them before. In questions related to consent and sexting:

- about 1 in 3 (29%) reported that they had been sent a sexual or nude image that they had not asked for and did not want to receive on at least one occasion
- about 1 in 5 (18%) reported that sexual photos of them had been shared without their permission on at least one occasion (unwanted sharing) – young women (21%) and trans and non-binary young people (19%) were more likely to report this than young men (11%).

Most respondents agreed or strongly agreed that you have to be careful about sexting (96%) and that sending photos may have serious negative consequences (92%). However, many felt there were positive aspects to sexting such as being more open about sex and sexuality (65%) and that 'sexting is a regular part of a relationship' (63%)

See **Consent** for further discussion of consent.

Source: Power et al. 2022.

Sexual harassment in the workplace

Data related to experiences of sexual harassment in workplaces are available from the 2022 Australian Human Rights Commission's national survey on sexual harassment in workplaces (see Box 6).

Box 6: The Australian Human Rights Commission's national survey on sexual harassment in workplaces

The Australian Human Rights Commission's national survey on sexual harassment in workplaces sampled about 10,200 people aged 15 and over using non-probability, quota sampling methods and weighting to obtain a sample representative of the population aged 15 and older by sex, age and area of residence.

In this survey, sexual harassment also included behaviours more commonly reported as sexual violence, such as rape or sexual assault. There was only a small number of respondents aged 15–17 (n<50) so results should be interpreted with caution.

Source: AHRC 2022.

More people aged 15–17 (47%) or 18–29 (46%) in 2022 had been sexually harassed in their workplace in the previous 5 years when compared with the total population (33%). Young women were more likely than young men to report sexual harassment:

- 60% of women and 25% of men aged 15–17 years
- 56% of women and 35% of men aged 18–29 years (AHRC 2022).

For more information on sexual harassment and sexual violence, see **Sexual violence** and for a discussion of FDSV centred on the experiences of young women, see **Young women**.

Technology-facilitated abuse among children and young people

Most Australian children and young people have ready access to the internet and digital technology. However, there is no nationally-representative data on the prevalence of technology-facilitated abuse among children.

A non-representative national survey in 2019 of 515 professionals who work on family and domestic violence (FDV) cases asked some questions related to experiences of technology-facilitated abuse **among children**. This found that:

- about one-quarter (27%) of FDV cases the professionals dealt with involved technology-facilitated abuse of children
- common forms of abuse included monitoring and stalking, threats and intimidation and blocking communication
- everyday technologies were used in abuse such as mobile phones, texting and Facebook

- many of the children experienced mental health issues (67% of cases), fear (63%), and negative impacts on their relationship with the non-abusive parent (59%) (Dragiewicz et al. 2020).

72% of surveyed people aged 18-24

in 2022 had experienced **technology-facilitated abuse** in their lifetime, more than any other age group

Data on the prevalence of technology-facilitated abuse among young people aged 18–24 are available from a nationally representative survey of about 4,600 adults in 2022. The survey used random probability-based sampling methods and weighting to allow results to be generalised to the adult Australian population (Powell et al. 2022). This survey estimated that **among young people aged 18–24 years**:

- about 5 in 7 (72%) have experienced technology-facilitated abuse in their lifetime, the highest proportion of any other age group
- young women (74%) are more likely than young men (68%) to have experienced technology-facilitated abuse in their lifetime
- about 2 in 5 (38%) young people have perpetrated technology-facilitated abuse in their lifetime, the second highest proportion of any age group (Powell et al. 2022).

While the increased use of mobile dating apps and websites over the past 10 years has allowed many people to build relationships, studies have suggested that experiences of technology-facilitated sexual violence are common for people who use these online spaces, particularly women and members of LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer, asexual people, or people otherwise diverse in gender, sex or sexual orientation) communities (Wolbers et al. 2022). However, there is no research that specifically relates to prevalence among young people. For further discussion, see **Stalking and surveillance**.

Technology-facilitated abuse also includes the possession, production and distribution of pictures and video that capture child sexual abuse (child sexual abuse material [CSAM]). With increases in the global availability of the internet, CSAM has continued to grow as a global issue. However, there is limited information on its effects on children and young people in Australia (see **Child sexual abuse**).

Corporal punishment

About 3 in 5 (58%) surveyed young people aged 16–24 in 2021 self-reported experiencing corporal punishment 4 or more times in childhood.

Corporal punishment is the use of physical force with the intention of causing a child or young person to experience pain or discomfort to change or punish their behaviour. Research has shown that corporal punishment can negatively impact children and

young people's development, health and wellbeing in both the short- and long-term and is minimally effective in the short-term and not effective in the long-term (Sege and Siegel 2018; Poulsen 2019).

The 2021 ACMS found that about:

- 3 in 5 (58%) young people aged 16–24 self-reported experiencing corporal punishment 4 or more times in childhood
- 1 in 2 (54%) parents surveyed had used corporal punishment with their own children
- 1 in 4 (26%) people believe corporal punishment is necessary to raise children, with a higher proportion of older people than younger people holding this belief – the highest proportion was among those aged 65 and over (38%) and the lowest among those aged 16–24 (15%) (Haslam et al. 2023b).

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

There are no national data available on the use of other aversive disciplinary strategies such as yelling at and shaming children.

What are the responses to FDSV for children and young people?

There are many formal and informal responses and supports which may be used by people who experience family and domestic violence, including family and friends, health professionals and helplines. However, national data related to children and young people is not available for all responses.

The First National Action Plan for the *National Strategy to Prevent and Respond to Child Sexual Abuse* includes an action for the AIHW to develop a scoping study for and establish an Australian Child Wellbeing Data Asset, a national, child-focused, linked data set. The data asset would support the analysis of children and young people's pathways through government services (for example, education, health services, child protection, youth justice, mental health services, hospitals, police services) for which there is currently no national data (DPMC 2021).

On this topic page we present the available national data on responses to FDSV for children and young people.

Helplines and related support services

There are a number of general and specialised helplines in Australia that provide information, advice and support to children and young people who are experiencing or at risk of FDSV. See **Helplines and related support services** for a discussion of such services including but not limited to:

- Kids Helpline, a free national helpline that provides support for children and young people aged 5 to 25
- Bravehearts, a support service for people affected by child sexual abuse and a National Redress Scheme service provider (Bravehearts 2021)
- Blue Knot Foundation, a support service for people affected by complex trauma and a National Redress Scheme service provider (Blue Knot Foundation 2021).

Help seeking behaviours

Apart from data related to helplines and support services, there is no national data on help seeking behaviours among children currently available.

The PSS collects data for young people aged 18–24 on advice or support (help) sought and received after the most recent experience of family and domestic violence. However, there are data quality issues and limitations in reporting for this age group due to the number of people sampled in the survey. Only data of a sufficient quality is reported below.

Based on data from the 2016 PSS, in response to their most recent incident of violence perpetrated by an intimate partner or family member the proportion of **women aged 18–24** who:

- sought help was over half (54% or 49,100) of those sexually assaulted by a male*
- sought help was about two-thirds (64% or 102,000) of those physically assaulted by a male
- did not seek help was about 1 in 4 (27% or 13,700) of females physically assaulted by a female (ABS 2017a).

Noting that statements marked with a * have a 95% margin of error greater than 10 percentage points, which should be considered when using this information.

The ACMS collected data about people aged 16 and over who had experienced child maltreatment and their contact with health providers over the 12 months before the survey. People who had experienced child maltreatment were more likely than those who had not to have engaged all types of health service professionals assessed in the survey and to be admitted to hospital with mental health problems (Pacella et al. 2023). In the 12 months before the survey, people who had experienced child maltreatment were more likely than those who had not to have:

- seen a psychiatrist (3.0 times)
- consulted a mental health nurse (2.7 times)
- had 6 or more visits to a GP (2.4 times)
- been admitted for a mental disorder (2.4 times)
- had 24 or more visits with any health practitioner (2.3 times)
- had 12 or more visits with any health practitioner (1.8 times)
- had an overnight hospital admission (1.4 times) (Haslam et al. 2023c).

Even higher associations were present for people who had experienced multi-type maltreatment (Haslam et al. 2023c).

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

Child protection services

In Australia, states and territories are responsible for providing child protection services to anyone aged under 18 who has been, or is at risk of being, abused, neglected or otherwise harmed, or whose parents are unable to provide adequate care and protection.

The latest data on child protection services in Australia show that:

- about 1 in 32 (3.1% or about 178,000) children came into contact with the child protection system in 2021–22
- almost 3 in 5 (57% or about 25,900) children who were the subject of a child protection substantiation in 2021–22 had emotional abuse recorded as the primary type of abuse or neglect (AIHW 2023b).

See **Child protection** for an in-depth discussion.

Police responses

To report on the police response to FDSV this report uses the ABS Recorded Crime collections, which are based on crimes that are reported to police in each state and territory (see Box 7 for key data considerations).

Box 7: FDSV data for police responses

Recorded Crime – Victims data do not represent a count of individual people as one person can be counted multiple times if they experience multiple incidents of a specific crime and/or multiple different crime offences. Counts are also randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals (ABS 2023g).

Not all offences are reported to police, which means recorded crime data underestimate FDSV in Australia. The PSS collects data on reporting levels to police and reasons for not contacting police after instances of FDSV, see **FDV reported to police** and **Sexual assault reported to police** for further discussion.

Generally, the age of victims is reported as the age victims were when they first became known to the police (**age at report**), however, some sexual assault data are explored by **age at incident**. For sexual assault, there can be more variability in the time to report crimes to police than other crimes. This means the age at incident for sexual assault can differ from age at report (ABS 2023g).

Offences are described as **FDV-related** where the relationship of offender to victim, as stored on police recording systems, falls within a specified family or domestic relationship,

or where a FDV flag has been recorded following a police investigation. Relationship of offender to victim data for Western Australia is not of a sufficient quality for national reporting (ABS 2023g).

Changes in recorded crime data over time may be due to changes in reporting behaviour, increased awareness about forms of violence, changes to police practices, an increase in incidents and/or a combination of these factors. For detailed technical notes, see **FDV reported to police** and **Sexual assault reported to police**.

Also, refer to the **ABS Recorded Crime – Victims methodology website** for further information.

It is not possible to summarise data for all recorded crimes related to FDSV as recorded crime data are collected based on specific criminal offences and there is variability in the collection methods and classification of offences and FDV between states and territories. This means that some data are not available for all states and territories (see **Data sources and technical notes**). In this section we discuss the available data by offence type.

Recorded sexual assault offences

3 in 5 recorded sexual assault victims had an **age at incident under 18 years** in 2022

Based on national data, about 3 in 4 (74%) recorded **sexual assault** victims had an **age at incident** under 25 years in 2022:

- most were aged under 18 years (59% of all victims, or about 18,900 victims)
- about 1 in 7 were aged 18–24 years (15% of all victims, or about 4,900) (ABS 2023e).

Among recorded sexual assault victims with an age at incident under 25 years:

- about 5 in 6 were female (82%, or about 19,500)
- over half were aged 10–17 years (56%, or about 13,400)
- fewer than 2 in 5 were victims of **FDV-related sexual assault** (36%, or about 8,500) (ABS 2023e).

Most recorded **FDV-related sexual assault** victims in 2022 with an age at incident under 25 years were female (87%, or about 7,400). Among those aged 0–24, the most common age group for:

- female victims was 10–17 years (49%, or about 3,700)
- male victims was 0–9 years (61%, or about 680) (see Supplementary tables).

Based on 2022 data (excluding Western Australia), offenders of sexual assault crimes were known to most recorded victims with an age at incident of 0–9 years (87%), 10–17 years (79%) and 18–24 years (63%). In between 3.9% and 6.9% of cases, a perpetrator

wasn't able to be identified or a relationship was not specified (ABS Recorded Crime – Victims, unpublished).

The most **common relationship of offender to victim** by age at incident were:

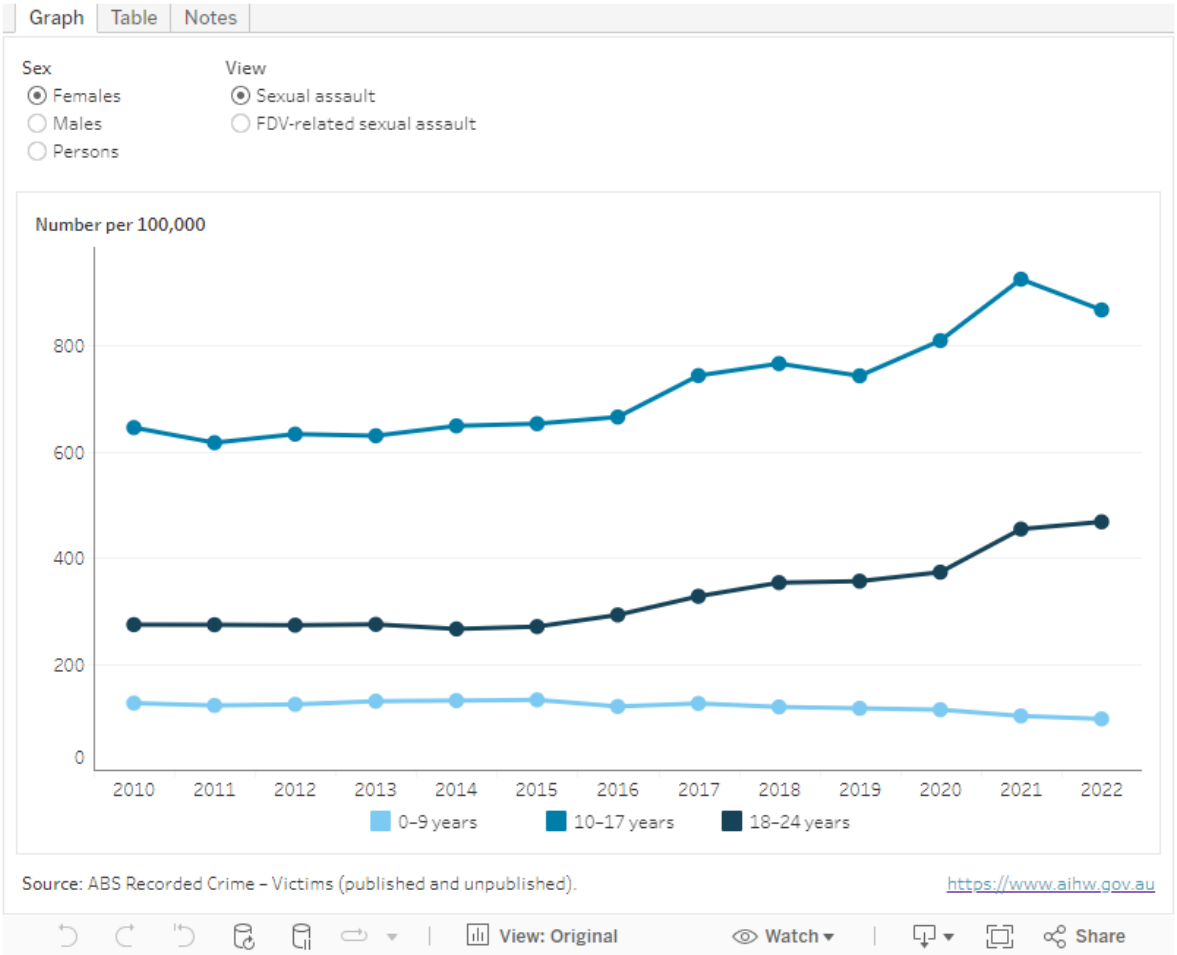
- family for victims aged 0–9 years (57%), with 21% involving parents
- people who were known but not family members for victims aged 10–17 years (49%) and 18–24 years (37%) (ABS Recorded Crime – Victims, unpublished).

Strangers accounted for 3 in 10 (31%) offenders of victims with an age at incident of 18–24 years, with smaller proportions among younger age groups (ABS Recorded Crime – Victims, unpublished).

Changes over time in the rate of both recorded sexual assault and FDV-related sexual assault victims have varied by age at report:

- among victims aged 10–17 years and 18–24 years, the rate has increased
- among victims aged 0–9 years, the rate decreased among sexual assault victims and remained similar among FDV-related sexual assault victims (Figure 1).

Figure 1: Rate of recorded sexual assault and FDV-related sexual assault victims, by sex and age at report, 2014–2022



Recorded victims of other FDV-related offences

FDV-related assaults

Based on data on recorded FDV-related assault victims by age at report in 2022 (excluding Victoria and Queensland, see **Data sources and technical notes**):

- over 1 in 4 (27% or about 20,900) were under 25 years, with most aged 18–24 (about 12,300)
- there were over 3 times as many female victims (about 9,300) as male victims (about 2,900) for those aged 18–24
- there were more male victims (about 1,200) than female victims (about 820) for those aged 0–9 (ABS 2023e).

In states and territories where data are available (see **Data sources and technical notes**), the **most common relationship** of offender to victim in 2022 by age at report was:

- parent for male and female victims aged 0–9, except male victims in the Northern Territory for whom family other than parents was more common
- parent for male and female victims aged 10–17, except female victims in Tasmania and the Northern Territory for whom intimate partner was more common and male victims in the Northern Territory for whom family other than parents was more common
- intimate partner for male and female victims aged 18–24 (see Supplementary tables).

FDV-related kidnapping/abduction

In 2022, about 54% (or about 275) of all kidnapping/abduction offences involved victims with an age at report of under 25 years. Among victims under 25 years, over 1 in 4 (27% or about 75) are victims of FDV-related kidnapping/abduction. Based on data excluding Western Australia, the **most common relationship** of offender to victim of FDV-related kidnapping/abductions in 2022 by age at report was:

- parents for victims under 18 years
- intimate partners for victims aged 18–24 (ABS Recorded Crime – Victims, unpublished).

Recorded FDV-related kidnapping/abduction victims have varied year to year with no apparent trend over time (ABS Recorded Crime – Victims, unpublished). Due to the low number of offences, any change year to year can result in a large proportional change in the victimisation rate making changes over time difficult to interpret.

See **FDV reported to police** and **Sexual assault reported to police** for a discussion of the general population.

Hospitalisations

Children aged 0–14 years in 2021–22 had the highest proportion of hospitalisations for injuries caused by physical and sexual assault and maltreatment (injury hospitalisations) that were FDV-related compared with any other age group (AIHW 2023a).

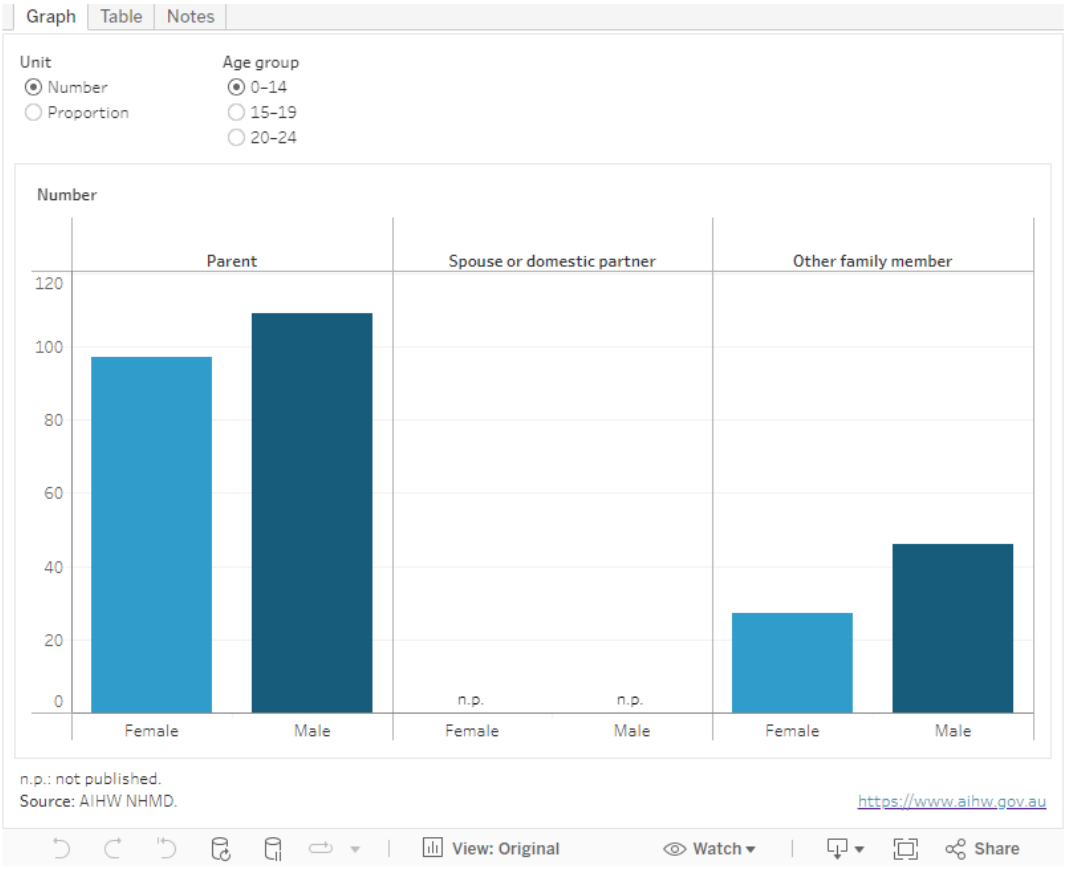
Among injury hospitalisations in 2021–22 where the perpetrator was specified, the injury was FDV-related for:

- **over half** (55%, or about 285) **of children aged 0–14 years**, with about 130 girls and 155 boys
- **over 1 in 3** (35%, or about 385) **young people aged 15–19 years**, with about 275 females and 110 males
- **over 2 in 5** (44% or about 710) **young people aged 20–24 years**, with about 530 females and 180 males (AIHW 2023a).

Relationship to perpetrator

Among hospitalisations for FDV-related injuries in 2021–22, the most common perpetrator was parents (72% or about 205) among children aged 0–14, domestic partners (74% or about 600) for females aged 15–24 and other family members (58% or about 165) for males aged 15–24 (Figure 2).

Figure 2: FDV-related hospitalisations for injuries due to abuse, by age group, sex and perpetrator of abuse, 2021–22



Method of FDV-related injury

The most common methods of assault in hospitalisations for FDV-related injuries in 2021–22 were classified as:

- assault by bodily force (37% or 105) or other maltreatment (31% or about 90) for people aged under 15 years
- assault by bodily force (59% or about 640) for people aged 15–24 years (AIHW 2023a).

The most common methods of assault were similar for males and females in both age groups.

Principal injury diagnosis

The most common principal diagnosis in hospitalisations for FDV-related injuries in 2021–22 was injuries to the head for both children under 15 years (46% or about 130) and people aged 15–24 years (36% or about 400) (AIHW 2023a).

Among FDV-related injury hospitalisations in 2021–22:

- a higher proportion involved injuries to the head for males aged under 15 years (51% or about 80) than females (40% or about 50)

- 1 in 15 (6.7% or about 20) children under 15 years experienced intracranial injuries and no intracranial injuries were recorded for people aged 15–24 years
- more than 1 in 5 (22% or about 240) people aged 15–24 years experienced injuries to limbs compared with 15% (or about 40) for children under 15 years (AIHW 2023a).

See **Health services** for further discussion of FDSV-related hospitalisations.

Specialist homelessness services

Specialist homelessness services (SHS) can provide assistance to people who are experiencing homelessness, or who are at risk of homelessness, including clients who have experienced FDV.

Children experiencing FDV may seek SHS support with other family members, or independently. For children in particular, SHS support is critical to reduce the likelihood of a long-term experience of homelessness (Kaleveld et al. 2018).

In 2022–23, FDV was the main reason for seeking SHS assistance among 2 in 5 (40%) children aged 0–14 and around 1 in 6 (17%) young people aged 15–24 (AIHW 2024).

Irrespective of their main reason for seeking support, a large proportion of children and young people supported by SHS in 2022–23 had experienced FDV, with:

- over half (55%, or about 23,800 of 43,200) of children aged 0–9 years
- about half (48%, or about 8,300 of 17,400) of children aged 10–14 years
- about one-third (35% or about 18,200 of 52,300) of young people aged 15–24 years, with over three times as many females (about 13,800) as males (4,400) (AIHW 2023c).

From 2011–12 to 2022–23, the proportion of clients assisted by SHS services who had experienced FDV has generally increased for children aged 0–9 years (from 42% to 55%) and 10–14 years (from 36% to 48%) and young people aged 15–24 years (from 29% to 35%) (AIHW 2024).

In 2022–23, the majority (70%, or about 12,700) of young people aged 15–24 years who had experienced FDV **presented to a SHS agency alone**, with nearly 4 times as many females (10,000) as males (2,700). One in 10 (9.9% or about 3,200) children aged 0–14 years presented to a SHS agency alone (AIHW 2024).

Housing outcomes

Fewer clients aged 0–14 and 15–24 years were homeless by the end of their support in 2022–23

Many clients who are supported by SHS have achieved or progressed towards a more positive housing situation by the end of their support. **Among SHS clients who have experienced FDV** and whose ongoing SHS support ended in 2022–23:

- fewer clients were homeless at the end of support (about 4,600 clients aged 0–14 years and 4,000 clients aged 15–24 years) compared with their first period of support in 2022–23 (7,100 and 5,400, respectively)
- more clients were housed at the end of support (13,500 clients aged 0–14 years and 6,700 clients aged 15–24 years) compared with their first period of support in 2022–23 (10,900 and 5,600, respectively) (AIHW 2024).

For information about all people who use SHS services and have experienced FDV, see **Housing**.

Impacts and outcomes of FDSV

Experiences of violence before the age of 15 are associated with many negative outcomes in adult life, including experiences of violence as an adult

At the time of writing, the latest available data from the PSS (2016) showed that adults who had experienced violence before the age 15 years, when compared to those who had not, were:

- more likely to have lower levels of educational attainment, income and life satisfaction, and to report poor health
- twice as likely to experience any violence as an adult (71% compared with 33%)
- three times as likely to experience partner violence as an adult (28% compared with 8.9%)
- more likely to report a disability or long-term health condition at the time of the interview (46% compared with 29%) (ABS 2019a).

For a discussion among the general population, see **Health outcomes** and **Behavioural outcomes**.

Burden due to child abuse and neglect

The Australian Burden of Disease Study 2018 estimated the amount of burden that could be avoided if no one in Australia had experienced child abuse and neglect.

Burden due to child abuse and neglect estimates the mental health and injury outcomes experienced at all ages that are attributable to exposure during childhood. Three diseases were causally linked to child abuse and neglect: depressive disorders, anxiety disorders and suicide and self-inflicted injuries (AIHW 2021).

Child abuse and neglect was 1 of the top 3 leading contributors to total disease burden for females and males aged 0–14 years and 15–44 years in 2018

Compared with other risk factors that contribute to total burden, in 2018, child abuse and neglect was:

- the 2nd leading risk factor for females and males aged 0–14
- the leading risk factor for females aged 15–44
- the 3rd leading risk factor for males aged 15–44 (AIHW 2021).

Females aged under 15 experienced 44% more burden from child abuse and neglect than males aged under 15 (AIHW 2021).

Overall, child abuse and neglect contributed to:

- about 810 deaths (0.5% of deaths)
- 2.2% of the total burden of disease and injury in Australia in 2018 (AIHW 2021).

Associations between child maltreatment and mental health disorders

The ACMS determined associations between child maltreatment and 4 mental health disorders identified using widely used and validated diagnostic instruments (Lawrence et al. 2023b). These disorders included lifetime major depressive disorder (MDD), current generalised anxiety disorder (GAD), current severe alcohol use disorder (SAUD) and current post-traumatic stress disorder (PTSD). Childhood maltreatment was strongly associated with experiences of each mental health disorder. Among surveyed people who experienced child maltreatment:

- the proportion who had a mental disorder (48%) was over twice as high as people who had not experienced maltreatment (22%)
- 1 in 4 (25%) experienced lifetime MDD, about 1 in 6 (16%) current GAD, about 1 in 13 (7.8%) current PTSD and over 1 in 16 (6.1%) current SAUD
- the strongest association was with current PTSD, with people who experienced maltreatment about 5 times more likely than those who had not
- early and persistent negative effects on mental health were evident, with people at each of three age spans in life (16–24, 26–44 and 45 and over) about 3 times more likely to have a mental disorder than those who had not experienced child maltreatment (Haslam et al. 2023c; Scott et al. 2023).

Experiences of mental disorders were most strongly associated with experiences of emotional abuse, sexual abuse and multi-type maltreatment even after adjusting for the experience of other forms of child maltreatment (Haslam et al. 2023c).

These findings show that child maltreatment has both an early and lasting impact on people's mental health throughout their lives. It is likely child maltreatment could have an even larger impact than currently shown as some types of mental disorders (for example, eating disorders and personality disorders) and symptoms that impaired an individual's functioning but did not meet clinical thresholds were unable to be included in this study (Haslam et al. 2023c).

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

Associations between child maltreatment and health risk behaviours

The ACMS determined associations between self-reported experiences of child maltreatment and six health risk behaviours: cannabis dependence, suicide attempts, non-suicidal self-injury, smoking, binge drinking and obesity (see **Data sources and technical notes**). People who had experienced child maltreatment were more likely than those who had not to report each health risk behaviour in the 12 months prior to the survey.

The strongest associations between experiences of child maltreatment and health risk behaviours were for:

- cannabis dependence at the time of the interview (6.2 times more likely), reported by 3.7% of those who had experienced child maltreatment
- suicide attempt in the past 12 months (4.6 times more likely), reported by 1.5% of those who had experienced child maltreatment
- self-harm in the past 12 months (3.9 times more likely), reported by 4.7% of those who had experienced child maltreatment (Haslam et al. 2023c).

The occurrence of these risk behaviours was higher among surveyed young people aged 16–24 who had experienced child maltreatment than other age groups, whereas binge drinking, recent cigarette smoking and obesity were more common in other age groups (Table 1).

Table 1: People aged 16 and over who self-reported experiences of child maltreatment and certain health risk behaviours or conditions, by age group, 2021

Health risk behaviour	People aged 16–24	People aged 25–44	People aged 45 and over
Current cannabis dependence	5.9%	3.7%	1.4%
Recent suicide attempt	5.2%	1.7%	0.4%
Recent self-harm	14%	5.6%	1.5%
Binge drinking	8.8%	13%	13%
Recent cigarette smoking	20%	25%	18%
Current obesity	14%	24%	29%

Notes:

1. Current refers to at the time of the interview and recent refers to any occurrence in the past 12 months.

2. Binge drinking refers to having six or more drinks for men or five or more drinks for women in a single session at least weekly over the past 12 months.

Source: Lawrence et al. 2023a, 2023b.

Child maltreatment was associated with an increased risk of all assessed health risk behaviours among **young people aged 16–24** except binge drinking, which was common in both groups (8.8% for those with and 7.6% for those without experiences of child maltreatment) (Lawrence et al. 2023a).

Some health risk behaviours associated with child maltreatment were more common among either females or males aged 16–24 who had experienced maltreatment:

- more females reported self-harm (18% compared with 7.5% of males)
- more males reported current smoking (23% compared with 17% of females) and binge drinking (11% compared with 6.8%) (Lawrence et al. 2023a).

The increased likelihood of health risk behaviours among all age groups were found to be primarily driven by experiences of emotional abuse, sexual abuse and multi-type maltreatment as a child (Haslam et al. 2023c).

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

Criminal justice involvement

Analysis of the ACMS data examining associations between child maltreatment and criminal justice involvement found that over 1 in 7 (15%) participants who experienced maltreatment reported ever being arrested. This compares with 8.1% of participants who reported no maltreatment and having ever being arrested (Mathews et al. 2023c).

The proportion of participants who experienced maltreatment and reported ever being arrested was higher for men (23%) and gender diverse participants (23%) compared with women (8.6%) (Mathews et al. 2023c).

Compared with non-maltreated participants, participants who experienced any maltreatment were:

- 2.3 times more likely to have ever been arrested
- 1.9 times more likely to have ever been convicted
- 1.4 times more likely to have ever been imprisoned (Mathews et al. 2023c).

There were statistically significant differences in arrest, conviction and imprisonment rates between male participants who reported and did not report maltreatment. For female participants, these differences were only statistically significant for arrest rates among those aged 25-44 (Mathews et al. 2023c).

There are stronger associations between child maltreatment and criminal justice involvement for those who experienced chronic multi-type maltreatment (that is, three

or more types of maltreatment). One in 5 (20%) participants who experienced chronic multi-type maltreatment reported ever being arrested, compared with 10% of participants who reported no maltreatment or less than three types of maltreatment (Mathews et al. 2023c).

For more information about this study, see **Children and young people: Measuring the extent of violence against children and young people** and **Data sources and technical notes**.

Homicide

According to the National Homicide Monitoring Program (NHMP), in 2022–23 there were 16 people killed by a parent or parent-equivalent (filicide), with 3 females and 13 males. There were also 16 people killed by their child, with 7 females and 9 males (Miles and Bricknell 2024). Note that these data relate only to the relationship between people and does not indicate age.

About 3 in 5

victims of **homicide and related offences** aged under 18 years in 2022 were the victim of a family member or intimate partner

According to the ABS 2022 Recorded Crime – Victims data collection, among all recorded victims of homicide and related offences (including murder, attempted murder and manslaughter):

- about 3 in 5 (59%, or 37) of those aged under 18 years were the victim of a family member or intimate partner, with a similar number of females and males
- about 1 in 4 (27%, or 12) of those aged 18–24 years were the victim of a family member or intimate partner, with a similar number of females and males (ABS 2023f).

The rate of recorded FDV-related homicide and related offences among:

- victims aged under 18 years decreased from 0.7 to 0.4 per 100,000 from 2014 to 2020, and increased to 0.6 per 100,000 in 2022
- victims aged 18–24 has varied year to year (between 0.1 and 0.8 per 100,000), with 0.5 per 100,000 in 2022 (ABS 2023f).

Due to the low numbers of offences, any change year to year can result in a large proportional change in the victimisation rate.

Characteristics of filicide

Homicides in which a parent kills a child most commonly involve custodial mothers

To analyse the characteristics of filicide (a parent killing a child) it is necessary to combine data from multiple years due to the relatively small number of incidents year to

year. The latest available data from the NHMP for this purpose covers the period between 2000–01 and 2011–12. These data show that in Australia, there were about 240 incidents of filicide (a parent killing a child) involving about 285 victims:

- Almost all (96%, or about 275) of the victims were aged under 18; the remaining 4% (10) were aged 18–33.
- There were more male victims (56%, or about 160) than female victims (44%, or 125).
- The filicides were committed by 260 offenders (Brown et al. 2019).

The most common relationship between offender and victim was:

- custodial mother (46%, or about 135)
- custodial father (29%, or 82)
- stepfather (14%, or 41)
- non-custodial father (10%, or 27) (Brown et al. 2019).

A known history of domestic violence between the offender and an intimate partner was a characteristic in almost 1 in 3 (30%, or 57) filicide incidents (Brown et al. 2019).

Characteristics of FDV homicide types other than filicide

For all family and domestic homicide types other than filicide, most victims were aged over 25 years. Based on NHMP data between 2002–03 and 2011–12:

- about 1 in 4 (23% or 9) victims of homicides committed by a sibling were aged 15–24 years, with less aged 0–14 years (5.0% or 2)
- about 1 in 5 (20% or 18) victims of homicides committed by family members other than parents or siblings were aged 15–24, with a lower proportion of victims aged 0–14 years (7.6% or 7)
- about 1 in 7 (15% or 95) victims of intimate partner homicide were young people aged 15–24, with a lower proportion among people aged 0–14 years (0.2% or 1) (Cussen and Bryant 2015).

Noting that all family relationships include biological, adoptive and step relatives (Cussen and Bryant 2015).

Has it changed over time?

There are limited data on how the rate of experiences of FDSV among children and young people has changed over time. PSS data on the rate of experiences of sexual harassment and assault among women aged 18–24 in the 12 months prior to the survey (the 12-month prevalence rate) can be used to report on changes over time. Based on the latest available data, the 12-month prevalence rate of:

- sexual harassment was similar in 2021–22 (35%) and 2016 (38%) (ABS 2017b, 2023h)
- sexual assault increased from 2012 (2.2%*) to 2016 (4.5%) (ABS 2013, 2017b).

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

Is the experience of FDSV the same for everyone?

Some children and young people who share individual, socio-demographic and cultural characteristics may experience higher rates and/or different types of FDSV. However, there are limited data and research that investigates experiences of FDSV among children and young people in many population groups. Available national data show that:

- about 1 in 11 (9.4%) First Nations females and about 1 in 18 (5.5%) First Nations males aged 15–24 years in 2014–15 experienced physical family and domestic violence in the previous 12 months (ABS 2019b)
- a higher proportion of injury hospitalisations in 2021–22 were FDV-related for First Nations people compared with non-Indigenous people for people aged 0–14 (67% compared with 51%), 15–19 (59% compared with 24%), and 20–24 (74% compared with 30%) (AIHW 2023a)
- in 2016:
  - nearly twice as many adults with disability (10%) as adults without disability (5.4%) had experiences of physical and/or sexual abuse before the age of 15 perpetrated by a parent/step-parent
  - about 1 in 9 (12%) adults with disability had experiences of sexual abuse before the age of 15 compared with 1 in 17 (5.8%) adults without disability (AIHW 2022b).

For further discussions, see **Population groups.**

Related material

- Child sexual abuse
- Young women
- Mothers and their children
- Pregnant people
- Who uses violence?
- Helplines and related support services

More information

- Australian Burden of Disease Study 2018: Interactive data on risk factor burden
- Specialist Homelessness Services annual report 2021–22
- Child protection Australia 2021–22

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Young women

Key findings

- The 2021-22 PSS estimated that 1 in 8 (12%) women aged 18-24 experienced sexual violence in the 2 years before the survey
- In 2022, younger women were more likely to be victims of sexual assault than older women (56% were under 18 years old and 30% were aged 18-34)

Family, domestic and sexual violence (FDSV) affects people of all ages and from all backgrounds, but predominantly perpetrated by men against women and children. There are also differences in the experience of FDSV across age groups for women. Young women are more at risk of experiencing physical and sexual intimate partner violence (IPV), sexual violence and harassment compared to older women, while non-physical forms of violence (such as emotional abuse) are similar across age groups in many countries (Stöckl et al. 2014; ABS 2023a, 2023b; Pathak et al. 2019).

Definitions for what constitutes the age range for young women vary across data collections and reporting. This topic page defines young women as aged 15–34 to reflect age groups used in key data sources. However, the following sections will illustrate that the nature of violence can still vary within this broad age group.

What do we know?

There are several reasons why physical and sexual IPV may be less common among older women. One potential explanation is that the decrease is part of the general trend that criminal activity reduces with age, another is that couples who form early unions may face unique relationship stressors that can contribute to IPV, such as early pregnancies, employment instability, and financial difficulties (Stöckl et al. 2014). It is important to note that FDSV prevalence among older women are often underreported, due to various factors such as:

- generational differences in cultural norms (e.g. normalisation of violent behaviours, conservative attitudes that women should play a passive role)
- fear of retaliation, abandonment, institutionalisation or ostracisation
- health (e.g. functional dependence/disability, cognitive impairment)
- age-related shame in disclosing and/or seeking help (Qu et al. 2021; Beaularier et al. 2008; Pathak et al. 2019; WHO 2018).

For more information on FDSV among older women, please refer to the **Older people** topic page.

Impacts of FDSV victimisation among young women

Existing research indicates FDSV victimisation among young women can lead to adverse and/or long-lasting health impacts. Women who have experienced childhood abuse or household dysfunction can have higher long-term primary, allied and specialist healthcare costs, compared with women without these childhood experiences (Loxton et al. 2018). Women who had experienced childhood sexual abuse were also more likely to report poor general health and experience depression and bodily pain during adulthood than those who had not (Coles et al. 2018).

Associations also exist between childhood abuse and the experience of violence in adulthood. The 2016 ABS Personal Safety Survey (PSS) found women who experienced childhood abuse were about 3 times as likely to experience sexual violence and partner violence as an adult than those who did not experience childhood abuse (ABS 2019a). In addition, an ANROWS study found that people aged 16–20 who had both witnessed violence between other family members and been subjected to child abuse were 9.2 times more likely to use violence in the home than those who had not experienced any child abuse (Fitz-Gibbon et al. 2022).

What do the data tell us?

Data are available across several surveys and administrative data sources to look at the prevalence, service responses and outcomes of FDSV among young women.

What national data are available to report on FDSV among young women?

- ABS Personal Safety Survey
- ABS Recorded Crime, Victims
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services (SHS) Collection
- ANROWS Adolescent Family Violence in Australia study
- ANROWS Technology-facilitated Abuse study
- Australian Longitudinal Study on Women's Health
- National Aboriginal and Torres Strait Islander Social Survey
- National Student Safety Survey

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

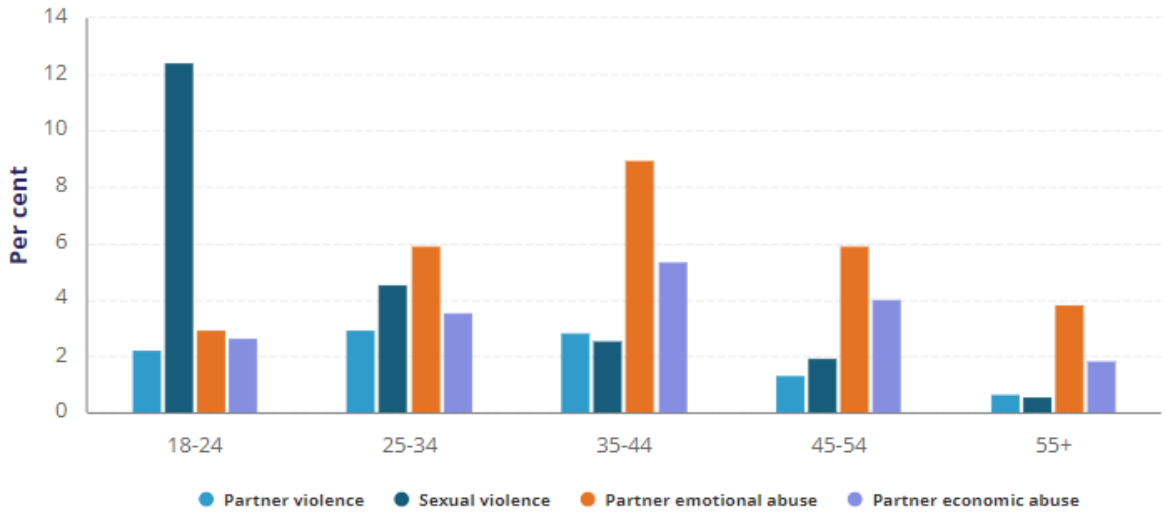
Young women experience more cohabiting partner violence and sexual violence than older women

Women's exposure to violence differs across the age groups. The 2021-22 PSS found that the prevalence of physical and/or sexual violence by a cohabiting partner (partner violence) among women declined with age. One in 39 (2.6%) women aged 18-34 experienced partner violence in the 2 years before the survey, compared with 2.2% for those aged 35-54 and 0.6% for those aged 55 and over (ABS 2023a).

The prevalence of sexual violence by any perpetrator among women also decreased with age. One in 8 (12%) women aged 18-24 experienced sexual violence in the 2 years before the survey, compared with 4.5% of those aged 25-34, 2.5% of those aged 35-44, 1.9%* for those aged 45-54 and 0.5%* of those aged 55 and over (ABS 2023e).

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

Figure 1: Women who experienced cohabiting partner violence, sexual violence, partner emotional abuse and partner economic abuse in the 2 years before the survey, by age group, 2021-22



*: estimate has a relative standard error (RSE) between 25% and 50% and should be used with caution.

Source: ABS PSS 2021–22 | **Data source overview**

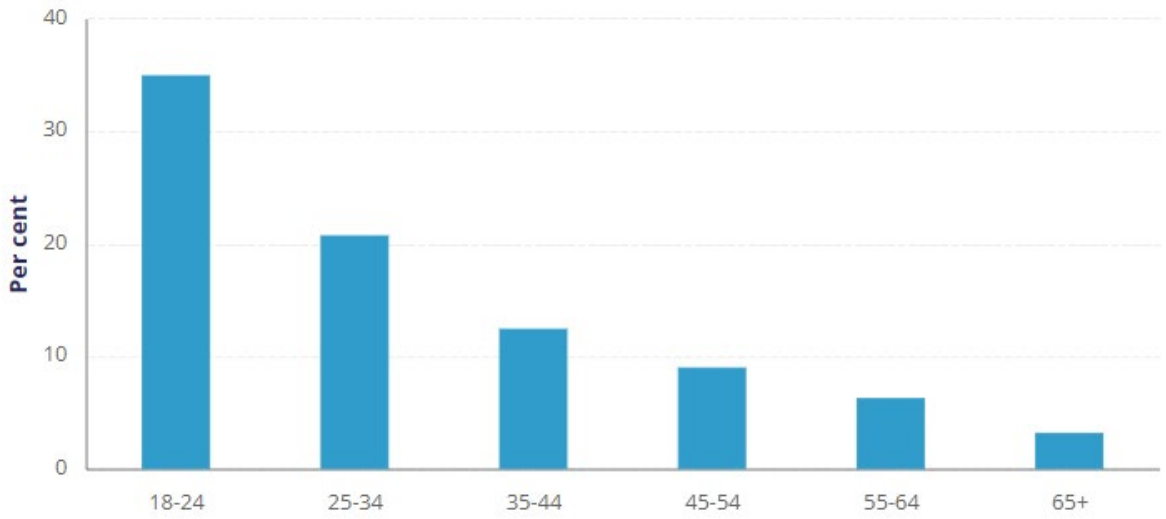
The Australian Longitudinal Study on Women's Health asked 3 cohorts of women about their experiences of unwanted sexual activity in the 12 months prior to several time points during the study (recent sexual violence). Almost 4% of women aged 18–23 in 1996 experienced recent sexual violence, with the proportion maintaining at less than 2% once the cohort reached ages 22–27 in 2000. Similarly, almost 6% of women that were aged 18–24 in 2013 experienced recent sexual violence, with the proportion dropping to below 4% when the cohort reached ages 24–30 in 2019 (Townsend et al. 2022).

Young women are more likely to experience sexual harassment and stalking than older women

The 2021–22 PSS estimated that over 1 in 8 (13%, or 1.3 million) women and 1 in 22 (4.5%, or 427,000) men aged 18 and over had experienced sexual harassment in the 12 months before the survey. Of all age groups, women aged 18–24 were most likely to

have experienced sexual harassment, with over 1 in 3 (35%, or 356,000) having experienced sexual harassment in the 12 months before the survey (ABS 2023b, 2023d) (Figure 2).

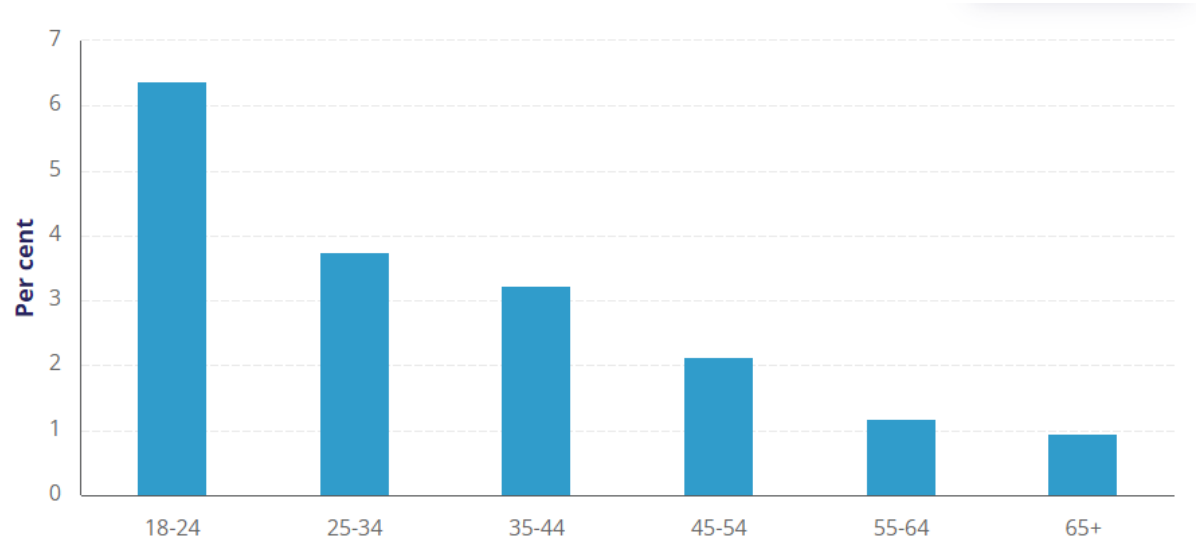
Figure 2: Women who experienced sexual harassment in the 12 months before the survey, by age group, 2021-22



Source: ABS PSS 2021–22 | **Data source overview**

The 2016 PSS estimated that 1 in 16 (6.4%, or 69,900) women aged 18–24 experienced stalking from a male in the 12 months before the survey, with this proportion decreasing with age (ABS 2017) (Figure 3).

Figure 3: Women who experienced stalking by a male in the 12 months before the survey, by age group, 2016



Source: ABS PSS 2016 | **Data source overview**

Box 1: Sexual assault and harassment in Australian universities

A survey administered by the Australian Human Rights Commission in 2016 found that sexual violence was prevalent in universities across Australia. In 2021, Universities Australia funded the National Student Safety Survey (NSSS) as part of its *Respect. Now. Always.* initiative to further understand the extent and nature of the problem. The NSSS sampled over 43,800 Australian university students and found that compared to male respondents, female respondents were:

- more likely to have experienced sexual assault (6.0% compared with 2.1%) or harassment (21% compared with 7.6%) in a university setting, and
- more likely to have been sexually assaulted by a male perpetrator (97% compared with 44%).

The study also found that respondents aged 18–21 were most likely to report sexual harassment by a stranger or a student from their place of residence in their most impactful incident of harassment in a university context compared to older students. Meanwhile, respondents aged 22–24 were more likely to report sexual assault in a university context than other age groups.

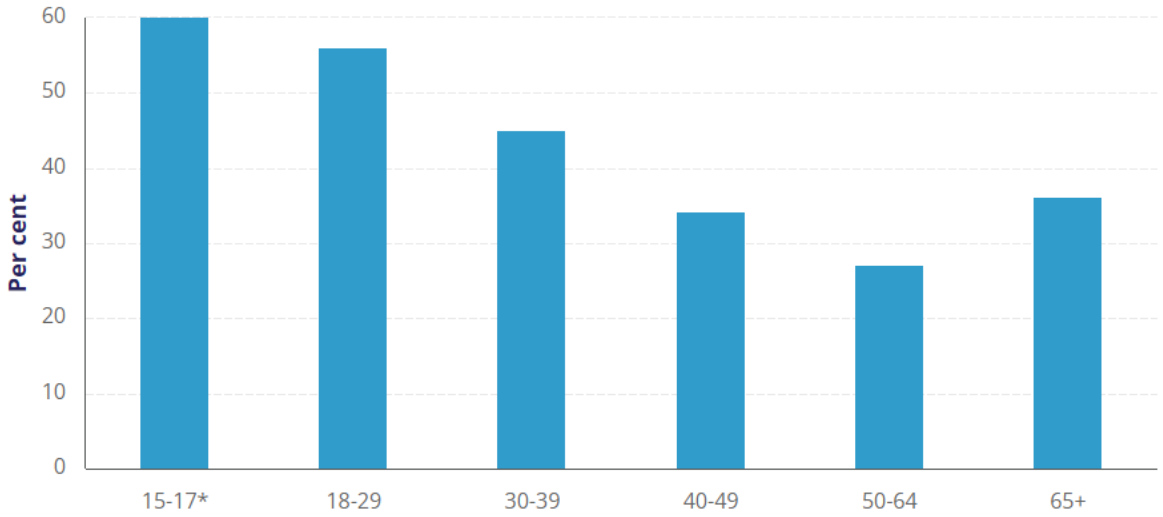
For more information on sexual violence in Australia, please refer to the **Sexual violence** topic page.

Source: Heywood et al. 2022

Young women are more likely to experience sexual harassment at their workplace

The Australian Human Rights Commission conducted the fifth national survey on sexual harassment in Australian workplaces in 2022. The nationally representative study of over 10,000 respondents found that the proportion of women that had been sexually harassed at work in the last 5 years decreased with age between age group 15–17 and 50–64. Sixty per cent of women aged 15–17 had been sexually harassed at work in the last 5 years compared with 27% of those aged 50–64 (AHRC 2022) (Figure 4).

Figure 4: Women that experienced workplace harassment in the last 5 years, by age group, 2022



*: small sample size and the data should be interpreted with caution.

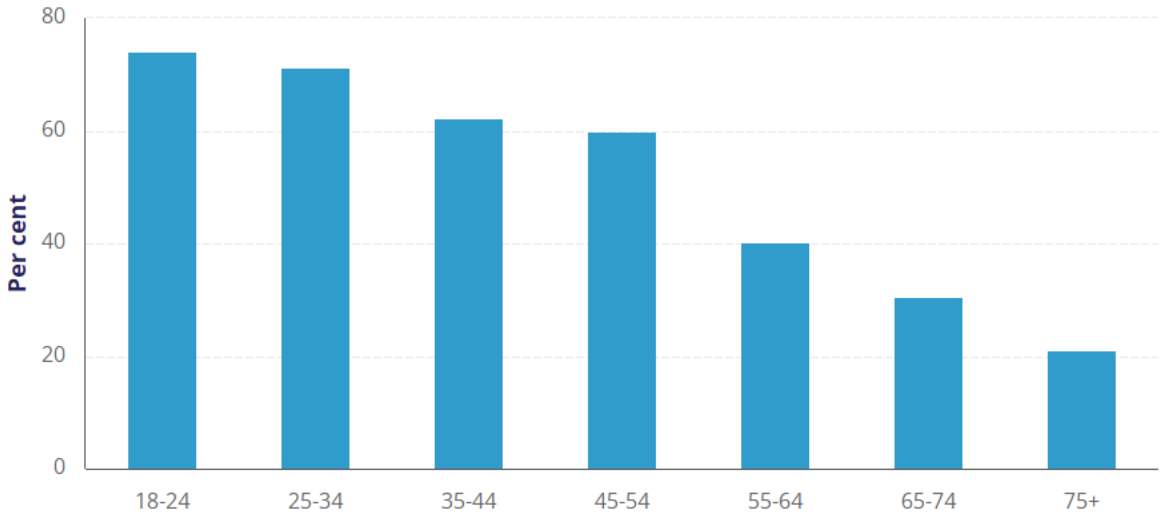
Source: AHRC National survey on sexual harassment in Australian workplaces | **Data source overview**

For more information on sexual harassment in Australian workplaces, please refer to Time for respect: Fifth National Survey on Sexual Harassment in Australian Workplaces.

Young women are more likely to experience technology-facilitated abuse than older women

Technology-facilitated abuse (TFA) involves the use of mobile and digital technologies in interpersonal harms, such as online harassment, image-based abuse, and monitoring behaviours (Powell et al. 2022). A nationally representative study of about 4,600 respondents on TFA found that younger women were more likely to report lifetime TFA victimisation compared to older women. Almost 3 in 4 (74%) female respondents aged 18–24 and 7 in 10 (71%) of those aged 25–34 reported having experienced TFA in their lifetime, with this proportion decreasing with age (Figure 5) (Powell et al. 2022).

Figure 5: Lifetime victimisation of technology-facilitated abuse for female respondents, by age group, 2022



Source: ANROWS Technology-Facilitated Abuse Survey | **Data source overview**

For more information on TFA, please refer to the **Stalking and surveillance** topic page.

What are the responses to FDSV for young people?

Young women are more likely to seek informal support for sexual assault than older women

The ABS PSS 2021-22 collected data on police contact and support-seeking behaviours among young women after experiencing sexual assault. In response to their most recent incident of sexual assault perpetrated by a male in the last 10 years, women aged 18–34 were:

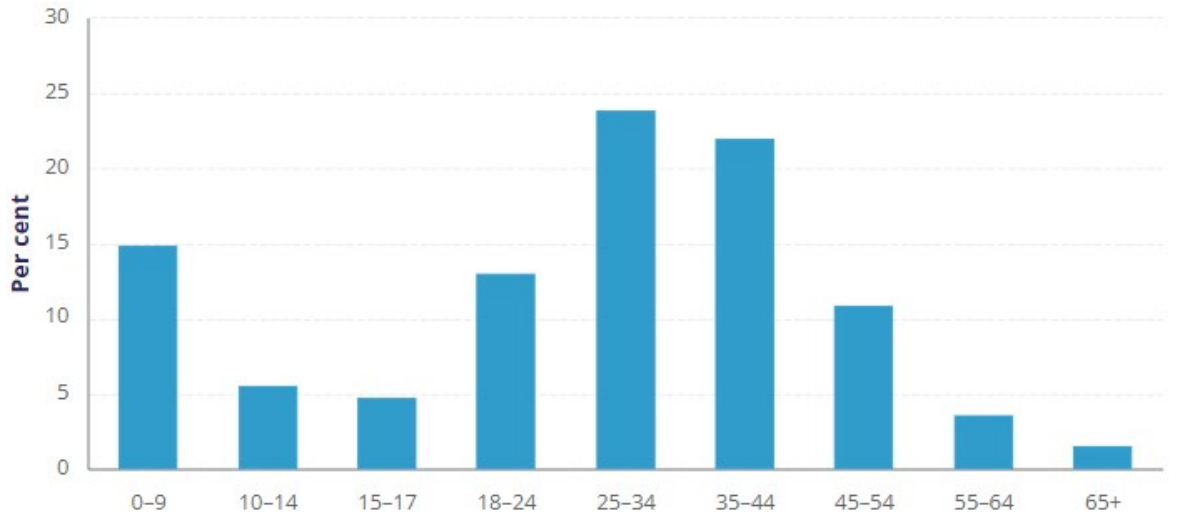
- less likely (5.5%*) to contact police than those aged 35 and over (12%)
- more likely (52%) to seek informal support (including friends, family, people at work and spiritual advisors) than those aged 35 and over (35%) (ABS 2023e).

Please note that data marked with an * have a relative standard error of 25% to 50% and should be used with caution.

Young women are more likely to use specialist homelessness services due to family and domestic violence than older women

Specialist homelessness service (SHS) agencies receive government funding to deliver services to support people experiencing or at risk of homelessness. The AIHW Specialist Homelessness Services collection reported that in 2022–23 the proportion of female SHS clients who have experienced FDV was highest for those aged 25–34 (24%) and decreased with age for age groups from 35–44 onwards (Figure 6; AIHW 2023b).

Figure 6: Specialist homelessness services female clients who have experienced family and domestic violence, by age group, 2022–23



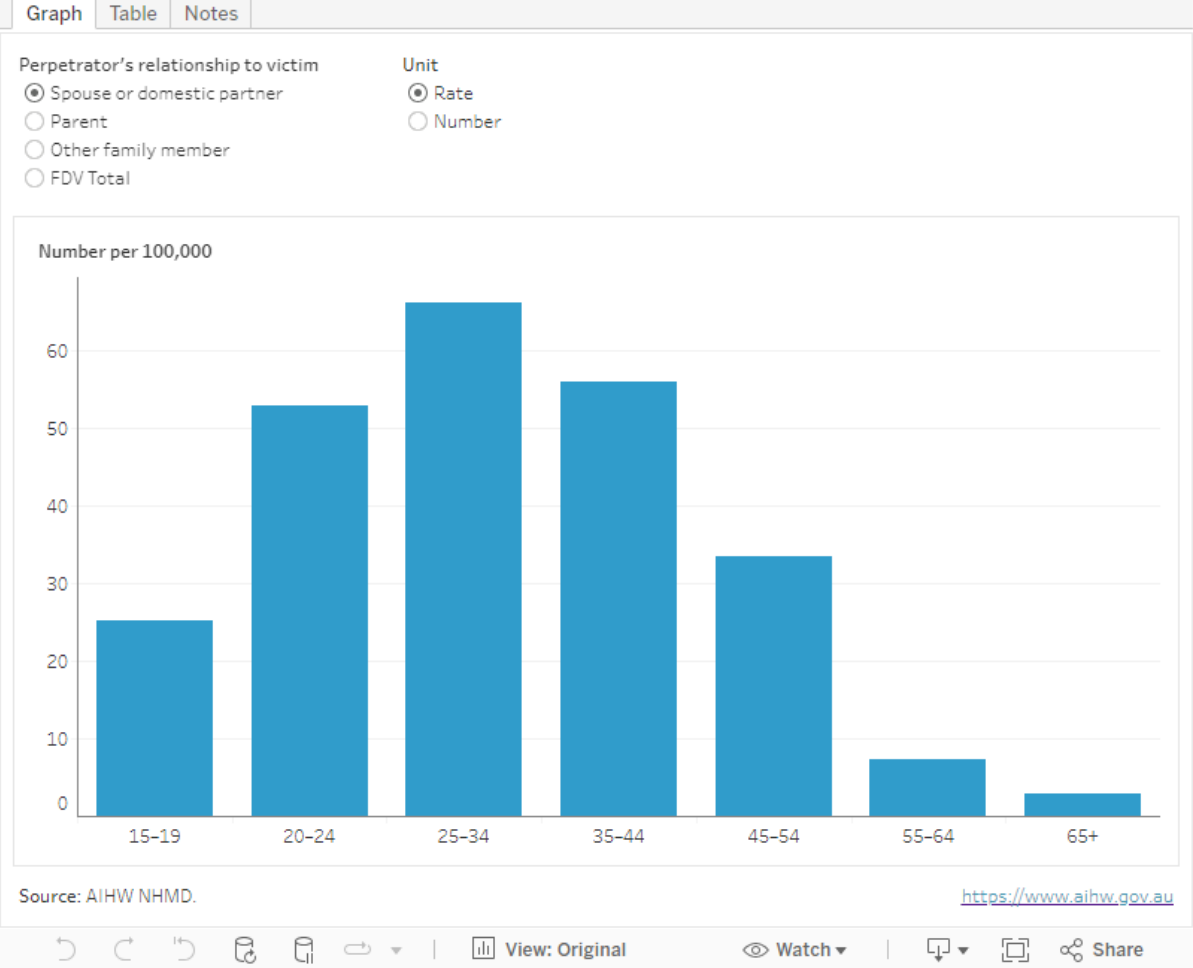
Source: AIHW SHSC | **Data source overview**

In 2022–23, almost 1 in 4 (23%) women aged 18 and over who experienced FDV presented as single with child/ren (of any age). Proportions were highest for women aged 25–34 and 35–44 (27% for both age groups), compared with 20% for women aged 18–24 and 13% for women aged 45 and older (AIHW 2024).

Younger women are more likely to be hospitalised for FDV-related injuries than older women

In 2021–22, the rate of hospitalisations for FDV-related injury was highest for females aged 25–34 (80 per 100,000 females), with this age group most likely to be hospitalised due to injury from spouse or domestic partner (66 per 100,000 females). Meanwhile, females aged 0–14 had the highest rate of hospitalisation due to injury from parents (4.2 per 100,000 females) (Figure 7) (AIHW 2023a).

Figure 7: Family and domestic violence hospitalisations for females, by relationship to perpetrator, 2021–22



The proportion of hospitalisations for injuries related to sexual assault was also highest for females aged 25–34 (28%), compared with 18% for those aged 15–19 and 16% each for those aged 20–24, 35–44 and 45 and above (AIHW 2023a).

These data relate to people admitted to hospital and do not include presentations to emergency departments for FDV-related injury. Please refer to the **Health services** topic page for more information on FDSV hospitalisations.

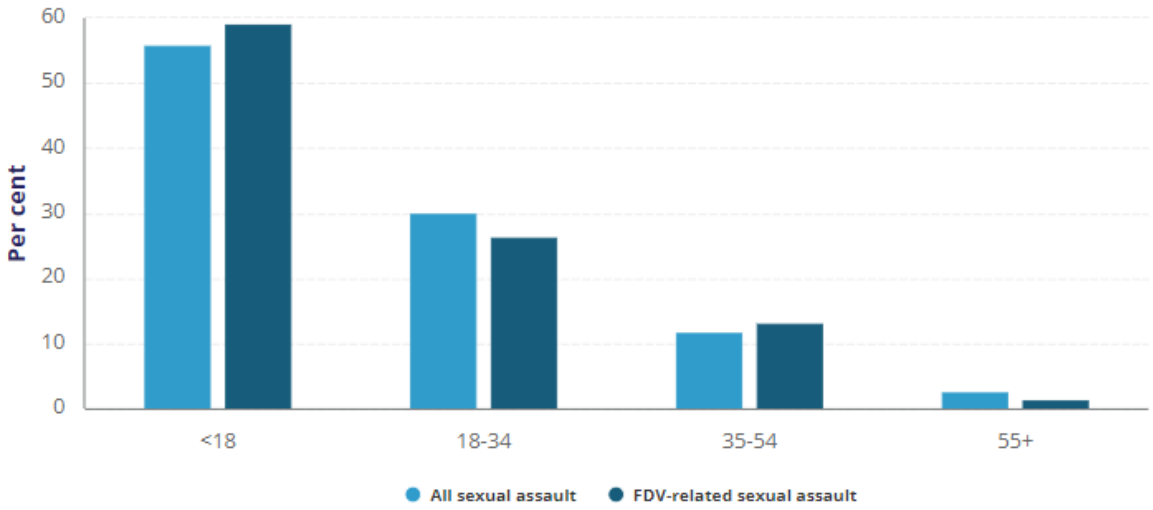
Police responses

Younger women are more likely to be victims of sexual assault than older women

In 2022, police-recorded crime data showed younger women were more likely to be victims of sexual assault than older women. The most common age group at incident for victims was under 18 years (56%, or 15,000), compared with 30% (or 8,100) of females aged 18-34, 12% (or 3,100) of females aged 35–54, and 2.4% (or 650) of females aged 55 years and over (ABS 2023c).

Younger women were also more likely to be victims of FDV-related sexual assault than older women. The most common age group at incident for victims was under 18 years (59%, or 6,100), compared with 26% (or 2,700) of females aged 18–34, 13% (or 1,400) of females aged 35–54, and 1.2% (or 130) of females aged 55 years and over (ABS 2023c) (Figure 8).

Figure 8: Female victims of sexual assault, by age group, 2022



Source: ABS Recorded Crime – Victims | **Data source overview**

Please refer to **FDV reported to police** and **Sexual assault reported to police** for data on offences. For more information on adolescent family violence, please see Box 2 and **Children and young people**.

Box 2: Adolescent family violence in Australia

Adolescent family violence (AFV) is the use of family violence by a young person against their parent, carer, sibling or other family member within the home, which can include physical, emotional, psychological, verbal, financial and/or sexual abuse (RCFV 2016).

ANROWS administered a non-representative survey on 5,021 young people aged 16–20 living in Australia to evaluate their sociodemographic characteristics, current living arrangements, and their experiences of:

- witnessing violence between other family members
- being subjected to direct forms of abuse perpetrated by other family members
- their use of violence against other family members.

The study found that 1 in 5 (20%) respondents reported ever using violence against a family member, with verbal abuse (15%) and physical violence (10%) as the most common types of AFV used. Respondents assigned female at birth (23%) were more likely to report using violence in the home than those assigned male at birth (14%). Nine in 10 (90%) respondents

assigned female at birth and 6 in 7 (86%) respondents assigned male at birth who had used AFV also reported they had experienced child abuse.

For more information on AFV in Australia, please refer to the Children and young people topic page.

Source: Fitz-Gibbon et al. 2022

Impacts of COVID-19

We continue to learn about the impact of the emergency phase of the COVID-19 pandemic on FDSV, with some different patterns observed between research and national population prevalence data (Diemer 2023). As the methodologies differ, these data cannot be directly compared.

The 2021–22 ABS Personal Safety Survey, which was conducted from March 2021 to May 2022, found that intimate partner violence in the last 12 months for women aged 18 years and over decreased from 2.3% in 2016 to 1.5% in 2021–22. Results for 2021–22 were also lower than 2012 (2.1%) and 2005 (2.3%) (ABS 2023b). Comparable data for 2016 and 2021-22 are not available for younger women.

Between 16 February 2021 and 6 April 2021, the Australian Institute of Criminology (AIC) conducted an online survey of about 10,100 women aged 18 and over who had been in a relationship in the preceding year. Results found that in the 12 months before the survey, the pandemic coincided with first-time and escalating domestic violence in Australia for some women (Boxall and Morgan 2021a). Further analysis of these data found that younger women were more likely than older women to report having experienced physical and sexual violence and/or coercive control in the 3 months prior to survey. Women aged 18–24 were 8 times more likely to experience physical/sexual violence and 6 times more likely to experience coercive control than women aged 55 and over (Boxall and Morgan 2021b).

Please refer to the **FDSV and COVID-19** topic page for more information.

Is it the same for everyone?

Young women are a diverse group, and experiences of violence and abuse can differ for various reasons. Although age and sex-specific data are limited for different population groups, they generally show that younger women are still more likely to experience FDSV than older women within sub-groups.

Aboriginal and Torres Strait Islander young women

There are limited national data on FDSV prevalence among Aboriginal and Torres Strait Islander (First Nations) young women. It is known that in 2014-15, First Nations women in the age groups 25–34 years and 35–44 years were most likely to have experienced FDV-related physical violence (14% for both groups), compared with 9.4% of those aged 15–24 and 5.4% of those aged 45 years and over (ABS 2019b). Similarly, a higher

proportion of First Nations women hospitalised for FDV-related injury were aged 25–34 (34%) and 35–44 (25%) compared with those that were aged 24 years and under (21%) and 45 years and over (19%) (AIHW 2023a).

Please refer to the **Aboriginal and Torres Strait Islander** people topic page for more information.

Lesbian, gay, bisexual, transgender, intersex, queer or asexual (LGBTIQA+) young women

There are no national data on the prevalence of FDSV among LGBTIQA+ young women. However, LGBTIQA+ people experience identity-based abuse in addition to all forms of violence that affect cisgender women (DSS 2022). Identity-based abuse includes any act that uses how a person identifies to threaten, undermine or isolate them, such as pressuring a person to conform to gender norms or undertake conversion practices (Gray et al. 2020; DSS 2022).

Data from the Australian Longitudinal Study on Women's Health shows women aged 25–30 that did not identify as exclusively heterosexual were at increased risk of interpersonal violence, when compared with their exclusively heterosexual counterparts. Interpersonal violence includes physical abuse, emotional abuse, sexual abuse, harassment and being in a violent relationship (Szalacha et al. 2017).

Please refer to the **LGBTIQA+** topic page for more information.

Young women with disability

Women with disability or illness are more likely to experience IPV and sexual violence than those without disability or illness (Brownridge 2006; Royal Commission in Violence, Abuse, Neglect and Exploitation of People with Disability 2021). Younger women with disability are also more likely to experience sexual violence than older women with disability. Data from the Australian Longitudinal Study on Women's Health shows 73% of women aged 24–30 living with disability or illness have reported experiencing sexual violence in their lifetime, compared with 55% of women aged 40–45 and 34% of women aged 68–73 (Townsend et al. 2022).

Please refer to the **People with disability** topic page for more information.

Culturally and linguistically diverse young women

There are limited national data on the prevalence of FDSV among young women from culturally and linguistically diverse (CALD) backgrounds in Australia. A non-representative national study on migrant and refugee women's safety and security found that, among the 1,400 respondents, those aged under 30 (16%) were more likely to report having experienced physical and/or sexual violence compared with 14% of those aged 30–44, 12% of those aged 45–64, and 10% of those aged 65 and over (Segrave et al. 2021).

It is also known that IPV can affect CALD girls as young as 12 years old and result in hospitalisation (MYSA 2017). Some CALD young women are in arranged marriages

where leaving an abusive relationship could lead to ostracism from their support systems (MYSA 2017). Moreover, many CALD women do not recognise forms of IPV outside of physical violence that causes injury, particularly financial abuse and reproductive coercion (El-Murr 2018).

Please refer to the **People from culturally and linguistically diverse backgrounds** topic page for more information.

Pregnant young women

Young women are at higher risk of experiencing IPV during pregnancy and in early motherhood. The Australian Institute of Family Studies found that young women aged 18–24 are more likely to experience FDV during pregnancy than older women (Campo 2015). Taft et al.'s (2004) study of 14,800 women aged 18–23 found that 27% of the women who had ever had a pregnancy reported having experienced IPV, compared with 8% of the women who had never been pregnant. However, it is unclear whether young women in Taft et al.'s (2004) study became pregnant as an outcome of violence or that becoming pregnant increased their likelihood of experiencing violence.

Please refer to the **Pregnant people** topic page for more information.

Related material

- Children and young people
- Health outcomes
- Intimate partner violence
- Modern slavery
- Sexual violence
- Stalking and surveillance

More information

- Specialist Homelessness Services, annual report.
- Child Protection, Australia.

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Pregnant people

Key findings

- 1 in 7 women who experienced violence by a current partner and were pregnant during the relationship, experienced the violence during their pregnancy
- Pregnant women assaulted by a partner were more likely to experience injury to their trunk than other women (48% compared with 29%)

People can experience violence specific to reproductive health and/or pregnancy. This violence can occur in the context of family violence, commonly intimate partner violence, or sexual violence by any perpetrator (see Box 1 for a discussion of the terms used). There can be a range of negative health impacts associated with this violence, including lack of autonomy in reproductive choice, unintended pregnancies, abortions, higher rates of miscarriage, delayed prenatal care, pre-term birth (before 37 completed weeks of gestation) and low birthweight (less than 2,500 grams) (Marie Stopes Australia 2020, WHO 2011, WHO 2021). Previous experience of trauma, including exposure to family and domestic violence during childhood, may also be associated with pregnancy complications, pre-term birth and low birthweight (Mamun et al. 2023) and could contribute to a birth being experienced as traumatic (Highet et al. 2023).

Pregnancy, and the early post-natal period, is a time of heightened risk for the onset or escalation of partner violence (ANROWS 2020, State of Victoria 2016). The experience of violence before, during and after pregnancy has been associated with physical and psychological health problems for both the mother and child (Bayrampour et al. 2018, Brown et al. 2015, Campo 2015, Moore et al. 2017, WHO 2021, Yang et al. 2022).

This section mostly focuses on violence perpetrated by intimate partners but it can also be perpetrated by family members (particularly in relation to reproductive coercion and abuse) or strangers (in relation to sexual violence).

In AIHW's family, domestic and sexual violence (FDSV) reporting, specific terms are used when reporting from certain data sources. The terms 'women' and 'mothers' are used throughout this topic for consistency with sources. However, it should be noted that some people may not identify with these terms (see Box 1).

Box 1: Reporting on the experience of FDSV in relation to pregnancy

'Pregnant people' is a gender-neutral term that may be used to refer to all people who are or have been pregnant, regardless of their gender identity (including for example, people who identify as women, transgender or non-binary). The mechanisms for collecting data on sex and/or gender vary across data collections. In most cases, 'male' and 'female' are used, however it is not always known whether the data refer to sex at birth or to gender identity and some people may not identify with these terms. AIHW FDSV reporting uses the terms

used in the data source, including the terms 'women' and 'mothers' which some people may not identify with.

The following FDSV-related terms are used in the reporting for this topic:

Intimate partner violence includes both **dating violence** (violent or intimidating behaviours perpetrated by a current or previous boyfriend, girlfriend or date) and **partner violence** (violent or intimidating behaviours perpetrated by a current or former cohabiting partner).

Partner violence is reported in the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) for:

- 'current partner' – a person who, at the time of the survey, was living with the respondent in a marriage or de-facto relationship.
- 'previous partner' – a person who lived with the respondent at some point in a marriage or de facto relationship, but who was no longer living with the respondent at the time of the survey.

Sexual violence includes sexual assault, sexual threat, sexual harassment, child sexual abuse, street-based sexual harassment and image-based abuse. However, the ABS PSS uses a narrower definition of sexual violence, including only sexual assault and sexual threat. Sexual violence in its broadest form can occur in the context of family or domestic violence or be perpetrated by other people known to the victim or by strangers.

Sexual assault is a type of sexual violence that involves any physical contact, or intent of contact, of a sexual nature against a person's will, using physical force, intimidation or coercion.

Reproductive coercion and abuse is any interference with a person's reproductive autonomy that seeks to control if and when they become pregnant, and whether the pregnancy is maintained or terminated. It may include pregnancy coercion, birth control sabotage or controlling the outcome of a pregnancy. Intimate partner violence, including sexual violence, may be a mechanism through which reproductive coercion and abuse is perpetrated. However, perpetrators may also be a family member or a family member of the partner.

Data sources for reporting on the experience of FDSV in relation to pregnancy

- ABS Personal Safety Survey
- Mothers' and Young People's Study
- AIHW Burden of disease
- AIHW National Hospital Morbidity Database
- Australian Longitudinal Study on Women's Health
- Longitudinal Study of Australian Children

What do we know about the experience of FDSV in relation to pregnancy?

How many people experienced violence by a partner during their pregnancy?

The World Health Organisation estimated a prevalence rate for intimate partner violence during pregnancy of around 2% for Australia (WHO 2011). This was based on a secondary analysis of data from the International Violence against Women Survey 2002, which explored the experience of physical and sexual intimate partner violence for 6,700 women who had ever been pregnant (Devries et al. 2010).

A review of studies on the prevalence of intimate partner violence in pregnancy indicated a lack of reliable data for Australia (Román-Gálvez et al. 2021). As a proxy, the ABS Personal Safety Survey (PSS) can be used to report on whether women who experienced partner violence were ever pregnant during the relationship and if violence occurred during pregnancy.

1 in 7 women who experienced violence by a current partner and were pregnant during the relationship, experienced violence during their pregnancy.

According to the 2021–22 PSS, an estimated 124,000 women, who had experienced violence by a current partner since the age of 15, were pregnant during the relationship. Of these women, about:

- 1 in 7 (15%*, or 18,000*) experienced violence during their pregnancy
- 1 in 8 (13%*, or 15,900) experienced violence for the first time during pregnancy (ABS 2023).

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

17% of women who experienced violence by a previous partner, experienced the violence for the first time during pregnancy.

Of the estimated 791,000 women who had experienced violence by a previous partner since the age of 15 and were pregnant during the relationship about:

- 2 in 5 (42%, or an estimated 329,000 women) experienced violence during their pregnancy
- 1 in 6 (17%, or an estimated 132,000 women) experienced violence for the first time during pregnancy (ABS 2023).

15% of clients of pregnancy counselling and reproductive health services in Australia reported reproductive coercion and abuse.

Reproductive coercion and abuse may include behaviours that are pregnancy promoting or pregnancy preventing (including coerced abortion) (Sheeran et al. 2022). A study of around 5,100 clients who sought counselling support for pregnancy from 2 specific providers in Australia between January 2018 and December 2020 investigated the reporting of reproductive coercion and abuse. Fifteen per cent of clients reported reproductive coercion and abuse:

- 6% to promote pregnancy
- 7.5% to prevent pregnancy
- 1.9% to promote and prevent pregnancy (Sheeran et al. 2022).

What are the health service responses to intimate partner violence during pregnancy?

Many pregnant people have regular contact with health-care professionals during pregnancy, which presents an opportunity to identify and respond to violence (AIHW 2015, ANROWS 2020). Perinatal, maternal and child health services are specifically targeted to pregnant people and their children and can play a critical role in early intervention by identifying family and domestic violence (FDV) and providing appropriate referrals (AIHW 2015).

Evidence suggests that screening by health professionals during pregnancy can lead to higher rates of disclosure of, and increases the identification of, domestic violence (O'Reilly et al. 2010). Screening for FDV during pregnancy occurs in most states and territories, however, a variety of FDV screening approaches are used (AIHW 2015). National perinatal data on screening for FDV is not yet available for reporting and little is known about the supports and services provided to people who experience, or are at risk of experiencing, violence during pregnancy (AIHW 2022b).

Box 2: Screening for family and domestic violence during pregnancy

The National Pregnancy Care Guidelines recommend that all people are asked about FDV during pregnancy and that this should only be asked when alone with the person (Department of Health 2020). The 2023 National Perinatal Mental Health Guideline also recommends that enquiry about FDV is included as part of psychosocial assessment of factors influencing mental health (Highet et al. 2023).

A variety of FDV screening approaches are used in Australia, including routine and targeted screening and other mechanisms that prompt screening questions, and the use of a variety of screening tools (AIHW 2015). Screening for intimate partner violence typically occurs when a client is asked a series of questions that seek to determine if that person is experiencing, or is at risk of, violence in their intimate relationship (AIHW 2015).

The AIHW National Perinatal Data Collection (NPDC) is a national population-based cross-sectional collection of data on pregnancy and childbirth. In 2020, a voluntary family violence screening question (which is defined as including "Violence between family members as well as between current or former intimate partners") was introduced into the NPDC through the

Perinatal National Best Endeavours Data Set (NBEDS) to identify whether screening for FDV was conducted. Due to the time lag between development, implementation and collection of data by the state and territory perinatal data collections and their inclusion in the NPDC, data are not yet available for reporting (AIHW 2023).

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

What are the outcomes of violence in relation to pregnancy?

Pregnancy loss or termination

17% of the burden of disease due to early pregnancy loss was attributable to intimate partner violence in 2018.

Intimate partner violence is a major health risk factor for women aged 15 to 44 years, ranking as the fourth leading risk factor for total disease burden in 2018 (see Box 3) (AIHW 2021a).

Box 3: Burden of disease

Burden of disease refers to the quantified impact of living with, or dying from, a disease or injury. Attributable burden is the reduction in burden that would have occurred if exposure to a specific risk factor had been avoided or reduced to its lowest level (AIHW 2021b).

Early pregnancy loss (including termination of pregnancy and miscarriage) is one of the six outcomes linked to intimate partner violence (Ayre et al. 2016).

It was estimated that intimate partner violence contributed to 1.4% of the total burden of disease and injury among Australian women in 2018. Seventeen per cent of the burden due to early pregnancy loss was attributable to IPV (AIHW 2021b). These estimates reflect the amount of disease burden that could have been avoided if all women aged 15 and over in Australia were not exposed to intimate partner violence, including emotional, physical and sexual intimate partner violence by a cohabiting current or previous intimate partner (AIHW 2021b).

The proportion of burden due to early pregnancy loss attributable to IPV was similar between 2015 (18%) and 2018 (17%) (AIHW 2020, 2021b).

Women who experienced violence were twice as likely to terminate a pregnancy.

Associations are made between unintended pregnancy, intimate partner and sexual violence, reproductive control and abuse, and forced termination of pregnancy (Campo 2015, Grace and Anderson 2018, Tarzia and Hegarty 2021). Some international research suggests there may be a repetitive cycle of pregnancy termination in the context of intimate partner violence (Hall et al. 2014). However, there are no nationally representative data available to inform about the extent or impacts of reproductive coercion and abuse in Australia (Carter et al. 2021, Price et al. 2022) or on the incidence or prevalence of abortion (Taft et al. 2019).

The Australian Longitudinal Study on Women's Health was used to examine factors associated with abortions undertaken for non-medical reasons. The analysis focused on data from the 1973–1978 birth cohort after five surveys and included data for 9,021 women (Taft et al. 2019). Findings indicated that:

- women who reported recent intimate partner violence were twice as likely to terminate a pregnancy than women who did not experience intimate partner violence
- the experience of any interpersonal violence, including recent or past partner violence, and non-partner violence, significantly increased the likelihood of terminating a pregnancy (Taft et al. 2019).

Two studies of Queensland women provide some limited information about intimate partner or sexual violence and unintended pregnancy:

- 12% of first contacts with the service disclosed domestic violence and 3% disclosed sexual assault in a study of 6,200 women seeking information regarding termination of unintended pregnancies in Queensland between July 2012 and June 2017 (Sharman et al. 2019).
- reproductive coercion was reported among 5.9% of women at first contact and 18% of the repeat contacts in a study of 3,100 Queensland women who contacted a telephone counselling and information service regarding an unplanned pregnancy between January 2015 and July 2017 (Price et al. 2022).

Health and wellbeing outcomes

Intimate partner violence may result in unintended pregnancies (Gartland et al. 2011) and the risks (medical conditions) associated with these pregnancies may be greater than those for planned pregnancies (Keegan et al. 2023). Medical conditions as a result of pregnancy may be short-term conditions experienced during pregnancy or conditions that develop after pregnancy and continue in the longer-term. For example, heart conditions, diabetes, high blood pressure, infections, anemia, bleeding, nausea/vomiting, and severe morning sickness (Keegan et al. 2023; NICHD 2020). People who are denied reproductive autonomy and are forced to continue a pregnancy are also denied the right to accept the risks that may be associated with pregnancy.

Violence experienced during pregnancy may result in physical and psychological health problems for both the mother and fetus including low birth weight, premature labour and miscarriage, injuries, fetal stress and trauma, maternal depression, anxiety, and post-traumatic stress disorder (Bayrampour et al. 2018, Brown et al. 2015, Campo 2015, WHO 2021, Yang et al. 2022).

According to the Mothers' and Young People's Study (formerly the Maternal Health Study), women who experienced family violence were around twice as likely to give birth to babies with low birthweight (less than 2,500 grams), compared with women who did not experience violence (12% and 4.7%, respectively). Babies born with low birthweight are at higher risk of developing a range of health conditions such as diabetes and hypertension earlier in their life, compared with babies born in the normal weight range (Brown et al. 2015).

People who were afraid of an intimate partner during pregnancy were also more likely to experience vaginal bleeding during pregnancy, urinary and faecal incontinence, and depressive and/or anxiety symptoms (Brown et al. 2015).

Intimate partner violence during pregnancy is also associated with adverse health behaviours during pregnancy, including maternal smoking, alcohol and substance use, and delayed prenatal care (Suparare et al. 2020, WHO 2011). Difficulties or lack of attachment between the mother and child and lower rates of breastfeeding may also be associated with intimate partner violence (WHO 2011).

See also: **Children and young people; Mothers and their children.**

Following birth, people are generally advised to abstain from sexual intercourse for 4–6 weeks, or until they have a medical check (Piejko 2006). However, some people may be pressured by their partner to resume sexual intercourse before they are physically or emotionally ready (Jambola et al. 2020). Incomplete healing following birth may cause sexual discomfort, infection and tears (Gadisa et al. 2021). This and other common maternal health problems such as tiredness and fatigue may result in sexual dysfunction (Piejko 2006). If birth control has not been resumed, there may also be a shorter interval between pregnancies (Gadisa et al. 2021).

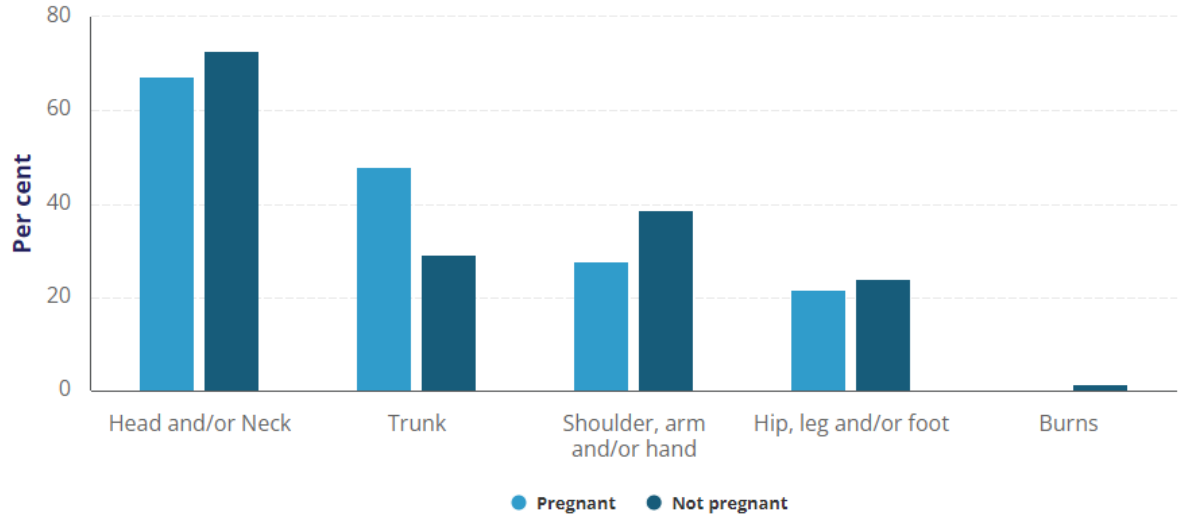
Shorter intervals between pregnancies have commonly been considered to be intervals of less than 18 months from the end of one pregnancy to the start of the next pregnancy. Adverse outcomes that have been associated with shorter intervals between pregnancies include placental abruption, placenta praevia, uterine rupture (for people who previously delivered by caesarean section), gestational diabetes, increased risk of stillbirth, small size for gestational age, preterm delivery and neonatal death (Dorney et al. 2020).

Hospitalisations

People who experience intimate partner violence during pregnancy are likely to be hit in the abdomen, which not only harms them but also has the potential to endanger the pregnancy (WHO 2011).

In 2021–22, the victim was pregnant in 7% (or about 250) of hospitalisations of women for injuries from assault by a spouse or domestic partner. Two-thirds (67%) of these pregnant women were admitted with injuries to their head and/or neck, and 48% were hospitalised with injuries to their trunk (that is, the thorax, abdomen, lower back, lumbar spine and pelvis). Trunk injuries were more common among pregnant women than among women who were not pregnant (29%) (Figure 1).

Figure 1: Physical assault hospitalisations where perpetrator was spouse or partner, females aged 15 and over, by type of injury, by pregnancy status, 2021–22



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

Analysis of linked hospital and death data from the National Integrated Health Services Information Analysis Asset found that about 1 in 10 (11%) hospitalisations in which FDV was identified between 2010–11 to 2018–19 had a principal diagnosis of *Pregnancy, childbirth and puerperium*. For these hospitalisations, *Pregnancy, childbirth and*

puerperium was the diagnosis considered to be mainly responsible for occasioning the hospitalisation (AIHW 2021c).

Intimate partner homicide

The risk of intimate partner homicide may be greater for people who experience violence during pregnancy (Boxall et al. 2022, WHO 2011). Of the 240 female intimate partner homicide victims between 2010 and 2018, five (2.1%) were pregnant at the time that they were killed (ADFVDRV and ANROWS 2022).

Are some pregnant people at greater risk of experiencing FDSV?

Some studies have indicated that certain groups of people are at greater risk of experiencing FDSV during pregnancy and following birth (Campo 2015, Suparare et al. 2020, Toivonen and Backhouse 2018).

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander (First Nations) people experience higher rates than non-Indigenous people of medical complications in pregnancy, perinatal deaths, preterm birth and babies born with a low birth weight (Weetra et al. 2016). Twenty-eight per cent of the burden due to early pregnancy loss was attributable to intimate partner violence in 2018 for First Nations women (AIHW 2022a). This compares with 15% for non-Indigenous women (AIHW 2021b).

The Aboriginal Families Study examined the social health issues and psychological distress experienced by 344 mothers of Aboriginal babies born in South Australia between July 2011 to June 2013. Findings indicated high rates of social health issues affecting Aboriginal women and families during pregnancy, including issues related to family or community conflict. More than 1 in 3 (36%) women who experienced 3 or more social health issues in pregnancy reported high or very high psychological distress (Weetra et al. 2016). A follow up questionnaire when the children were aged 5-8 years focused on experiences of intimate partner violence, see **Mothers and their children**.

See also: **Aboriginal and Torres Strait Islander people**.

Younger people

People aged 18–24 are at greater risk than older people of experiencing intimate partner violence during pregnancy and in early motherhood (Campo 2015). They may also be at greater risk of experiencing reproductive control from an intimate partner, unintended pregnancy and/or forced termination (Campo 2015).

See also: **Young women**.

People with severe mental illness

Analysis of data extracted from hospital records of around 300 women with severe mental illness (including schizophrenia and related psychotic disorders and Bipolar Disorder) from 1 hospital in Western Australia found that:

- around 48% of pregnant women with severe mental illness had experienced intimate partner violence and were 3 times the risk when compared with the general pregnant population in Australia
- there was no difference in rates of intimate partner violence in women with psychotic disorders when compared with bipolar disorder
- rates of smoking and illicit substance use were significantly higher in pregnant women with severe mental illness who experienced intimate partner violence compared with those who had not experienced IPV (Suparare 2020).

Migrant and refugee people

Migrant and refugee people may have visa restrictions that prevent access to health services, including sexual health, maternal health or abortion services (Marie Stopes Australia 2020). People on a temporary or partner visa may be reliant on a violent partner financially and/or for residency and threats related to deportation may also be used to control them (AIJA 2022, Tarzia et al 2022).

Related material

- Intimate partner violence
- Sexual violence
- Coercive control
- Children and young people
- Mothers and their children
- Young women

More information

- Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2018
- Australia's mothers and babies
- Hospitals

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Mothers and their children

Key findings

- 1 in 3 mothers experienced intimate partner violence between the birth of their first child and their child turning 10 years of age.
- Mothers who experienced intimate partner violence were 3–4 times as likely to report mental health symptoms.
- Almost half (47%) of adult female clients who presented to specialist homelessness services as single with child/ren identified FDV as the main reason for seeking assistance

Intimate partner violence is the main preventable risk factor contributing to illness and death in women of childbearing age in Australia (AIHW 2021). The experience of violence has been associated with short- and long-term negative outcomes for women, including poorer physical and mental health, alcohol use disorders and economic insecurity (Bayrampour et al. 2018, Brown et al. 2015, Brown et al. 2020, DSS 2022, WHO 2021, Yang et al. 2022). Women's parenting capacity and relationships with their children can also be affected by intimate partner violence (Hooker et al. 2016, Kaspiew et al. 2017, Lapierre 2021).

This section focuses on the specific challenges for mothers who experience intimate partner violence. For more general information about the impacts and outcomes of violence, see also **Health outcomes, Economic and financial impacts**. For information about pregnancy-related issues, see **Pregnant people**.

Reporting on the experience of FDSV for mothers

In AIHW's Family, Domestic and Sexual Violence (FDSV) reporting, specific terms are used when reporting from certain data sources. The terms 'women' and 'mothers' are used throughout this topic for consistency with sources and to improve readability. However, it should be noted that some people may not identify with these terms (see Box 1).

Box 1: Terms used for reporting

The mechanisms for collecting data on sex and/or gender vary across data collections. In most cases, 'male' and 'female' are used, however it is not always known whether the data refer to sex at birth or to gender identity and some people may not identify with these terms. AIHW FDSV reporting uses the terms from the data source, including the terms 'women' and 'mothers' which some people may not identify with.

The following FDSV-related terms are used in the reporting for this topic:

Intimate partner violence includes both **dating violence** (violent or intimidating behaviours perpetrated by a current or previous boyfriend, girlfriend or date) and **partner violence** (violent or intimidating behaviours perpetrated by a current or former cohabiting partner).

Partner violence is reported in the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) for:

- 'current partner' – a person who, at the time of the survey, was living with the respondent in a marriage or de-facto relationship.
- 'previous partner' – a person who lived with the respondent at some point in a marriage or de facto relationship, but who was no longer living with the respondent at the time of the survey.

Data are available across several surveys and administrative data sources to look at the experience of violence, service responses and the impacts and outcomes of FDSV for mothers and their children.

What national data are available to report on FDSV for mothers and their children?

- ABS Personal Safety Survey
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services Collection
- Australian Domestic and Family Violence Death Review Network (ADFVDRN) National Minimum Dataset
- Longitudinal Study of Australian Children
- Mothers' and Young People's Study

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

What do we know about the experience of FDSV in relation to mothers?

How many mothers experience intimate partner violence?

1 in 3 mothers

experienced intimate partner violence between the birth of their first child and their child turning 10 years of age

The Mothers' and Young People's Study (see Box 2) followed a cohort of women to assess their experience of intimate partner violence and their mental and physical health in the 10 years following the birth of their first child.

Box 2: The Mothers' and Young People's Study

The Mothers' and Young People's Study is an ongoing study initially designed to investigate women's health after childbirth (formerly known as the 'Maternal Health Study'). The focus of

the study has expanded to investigate the health and wellbeing of children and young people, including the link between the health of mothers and their children.

More than 1,500 first-time mothers were recruited in early pregnancy from 6 Melbourne metropolitan hospitals between 2003 and 2005. Data have been collected on a range of physical and psychological health problems, including depression, anxiety, domestic violence, and child health and developmental outcomes. The mean age of women in the study when their first baby was born was 31 years (age range 18–50).

The study incorporated a validated measure of intimate partner violence, the Composite Abuse Scale (CAS), in follow-up questionnaires at 1 year, 4 years and 10 years after their child was born. The CAS includes items to ask women about their experience of emotional abuse and physical abuse by a current or previous partner and how frequently specific behaviours had happened in the previous 12 months.

Although the obstetric characteristics of the women in the study were largely representative of first-time mothers, women aged under 25 years and women born overseas or of non-English speaking background were under-represented.

Sources: Brown et al. 2020, Murdoch Children's Research Institute 2022.

Over 1 in 3 (35%) women had experienced intimate partner violence in any of the 3 follow-up periods (at 1 year, 4 years and 10 years after the birth):

- almost 1 in 5 (19%) women reported *recent* intimate partner violence (in the 12 months prior to the 10-year follow-up)
- 16% of women reported *past* intimate partner violence (during the first and/or fourth year after giving birth but not in the 12 months prior to the 10-year follow-up) (Brown et al. 2020).

Two in three (65%) women who reported *recent* intimate partner violence had also reported *past* intimate partner violence (Brown et al. 2020).

Threats to remove children is a common form of emotional abuse

According to the 2021–22 PSS, about 1 in 5 women (22% or 425,000) and 1 in 4 men (24% or 251,000) who experienced emotional abuse from a previous partner reported that the abuse involved threats to take their child/ren away. About 1 in 11 (8.7% or 167,000) women reported that the abuse involved threats to harm their child/ren (ABS 2023).

About 3 in 10 women (27% or 515,000) and men (29% or 313,000) who experienced emotional abuse from a previous partner reported that the abusive partner lied to their child/ren with the intent of turning them against the victim-survivor (ABS 2023).

In an online survey conducted in 2021 (see Box 3), of women who had children living with them and reported verbally abusive and threatening behaviours:

- just under 1 in 3 (30%) reported their partner had threatened to have their child/ren taken away

- 1 in 5 (21%) reported their partner had threatened to hurt their children (Boxall and Morgan 2021).

Box 3: National survey of female carers

An online survey conducted by Roy Morgan Research Solutions between 16 February and 6 April 2021 (using their Single Source panel and panels managed by PureProfile and Dynata) included a sample of women in Australia aged 18 years and over who had been in an intimate relationship with another person in the past 12 months. Proportional quota sampling was used, based on the Australian adult female population stratified by age and usual place of residence. Data were weighted by age and jurisdiction to reflect the spread of the Australian population using data from the ABS. The effective sample size (for the weighted sample) was just under 10,200 respondents.

For findings from studies included in this topic page, the sample was limited to women who had at least one child living with them in the 12 months prior to completing the survey.

Source: Boxall and Morgan 2021

Perpetrators may involve children in technology-facilitated abuse directed at their mothers

Technology-facilitated abuse refers to abusive behaviours that occur through contact with another person using a device, service or app (Dragiewicz et al. 2020). A non-representative national survey of 515 domestic violence professionals in 2019 found that children were involved in technology-facilitated abuse in about 1 in 3 domestic violence cases:

- Monitoring and stalking were the most common forms of technology-facilitated abuse involving children. In 45% of cases, perpetrators used technology to learn or try to learn about a new home location or asked a child about the adult victim's location or activities.
- Technology was also used to publicly insult the adult victim where the child could see it (38% of cases), send the child messages insulting the adult victim (38% of cases) and to tell the child they would take them away from the other parent (26% of cases).
- 1 in 3 (33%) cases involved the perpetrator prohibiting or blocking phone and/or online communication between an adult victim and child (Dragiewicz et al. 2020).

See also **What is FDSV?, Stalking and surveillance** and **Children and young people**.

Mothers may be the target of adolescent family violence

Family violence used by an adolescent within the home (adolescent family violence) may be more commonly directed at siblings or mothers. This may reflect who is seen as the weakest or 'safest' target, be due to conflict arising from attempts to establish boundaries and/or be a learned behaviour (Fitz-Gibbon et al. 2022). See also **Who uses violence?** for a discussion of the intergenerational transmission of violence.

In a non-representative survey of over 5,000 young people aged 16-20 years living in Australia in 2021, 1 in 5 (20%) reported they had used violence against a family member:

- 2 in 3 (68%) had used violence against a sibling
- 1 in 2 (51%) had used violence against their mother
- less than 2 in 5 (37%) had used violence against their father (Fitz-Gibbon et al. 2022).

What are the outcomes for mothers who experience intimate partner violence?

Health issues

Mothers who experienced intimate partner violence were 3–4 times as likely to report mental health symptoms.

According to the Mothers' and Young People Study, 39% of women who experienced physical and emotional violence from an intimate partner, in the first 12 months after giving birth, reported depressive symptoms, compared with 12% of women who did not experience violence (Brown et al. 2015). Similarly, 40% of women who had experienced recent intimate partner violence (in the 12 months prior to the 10-year follow-up) reported depressive symptoms compared with 12% of women who did not experience violence (Brown et al. 2020).

Recent and past experience of intimate partner violence were both associated with mental health problems. Mothers who reported intimate partner violence in any of the three follow up periods (1, 4 and/or 10 years) were 3–4 times as likely to report depressive, anxiety or post-traumatic stress symptoms than women who did not report intimate partner violence:

- 30% compared with 12% for depression
- 23% compared with 7.4% for anxiety
- 31% compared with 9.3% for post-traumatic stress (Brown et al. 2020).

Mothers who experienced intimate partner violence were more likely to have poor physical health

The Mothers' and Young People Study also found that mothers who had experienced intimate partner violence were more likely to report poorer physical health and chronic health conditions at the 10-year follow-up (Brown et al. 2020).

Mothers who had experienced intimate partner violence in any of the three follow up periods (1, 4 and/or 10 years) were more likely to have poor functional health status (self-reported quality of life) at the 10-year follow-up when compared with those who had not experienced violence (44% and 21%, respectively). They were also more likely to report common physical health problems (extreme tiredness, back pain, severe

headaches or migraines, severe period pain, and urinary incontinence) and chronic health conditions (asthma, heart disease and/or diabetes) (Brown et al. 2020).

Mothers with recent experience of violence were more likely to report common health problems than those with a past experience of violence. However, chronic health conditions were more likely to be reported by mothers who reported past experience of violence (Brown et al. 2020).

Parenting issues

Mothers who experience intimate partner violence are more likely than those who do not to report negative experiences of motherhood, including parenting difficulties and attachment issues (Hooker et al. 2016, Kaspiew et al. 2017). Family violence perpetrators use a range of strategies to control women, which may in turn affect their parenting capacity and relationships with children. This can include controlling financial and material resources and decision-making, undermining their authority, limiting interactions and communication with their children and the use of violence directed towards, and/or perpetrated in front of, children. These strategies can undermine women's confidence in their ability to provide adequate care and protection for their children (Hooker et al. 2016, Kaspiew et al. 2017, Lapierre 2021).

Analysis of data on inter-parental conflict from Growing Up in Australia: The Longitudinal Study of Australian Children (see Box 4) found that mothers who reported persistent (past and current) conflict were significantly more likely than mothers who reported no conflict to report:

- psychological distress (ranging from 24% to 33%, compared with 6.2% to 7.0%)
- low efficacy as a parent (25% to 27% compared with 9.0% to 13%)
- high irritability (24% to 27% compared with 11% to 12%)
- low consistency (32% to 35% compared with 12% to 13%) (Kaspiew et al. 2017).

Box 4: Inter-parental conflict – Growing Up in Australia: The Longitudinal Study of Australian Children

A study using data from Growing Up in Australia: The Longitudinal Study of Australian Children explored the associations of conflict between parents, psychological distress, parenting styles and child outcomes for families where the primary caregiver was a mother (including biological, step or adopted mothers). Data were analysed and proportions presented as a range across three distinct times in the child's development: preschool, when children were aged 4–5 years (3,300 families); primary school, when children were aged 8–9 years (3,400 families); and pre-adolescence, when children were aged 12–13 years (3,100 families).

The analysis was based on mother-reported inter-parental conflict which refers to conflict with fathers or father-figures, either in the same household or living elsewhere. It includes verbal and physical conflict, such as arguments, tension, and violence. Kaspiew et al. (2017) noted that such conflict is likely to be common in couples experiencing family and domestic

violence, but it is not necessarily indicative of abusive behaviour where one partner is seeking to exert power and control over the other.

Source: Kaspiew et al. 2017

Strategies used to control women may prevent them from leaving a violent relationship (State of Victoria 2016). Mothers may not feel that they are able to leave due to: concerns about being able to support themselves and their children; the fear of ongoing or escalating violence; partners threatening to kill or harm the children or to have children removed from the victim-survivor's care through family court or child safety systems; and disruptions to children's education and social participation (Kaspiew et al. 2017, Lovatt 2020, State of Victoria 2016).

What are some of the hidden costs of FDSV for mothers?

'If you manage to hold on to your job, you lose out on opportunities for career advancement. Like everyone, I have bills to pay and need to keep a roof over our heads. I go to work for a 'break' – for eight hours I get to pretend I have some semblance of a normal life. I am stuck in a casual role because of the ongoing post-separation abuse that I continually must navigate. Because of the relentless stress I'm not the mother I could and should be to my children. My kids have a mum whose parenting capacity is crippled by the ongoing abuse, while the perpetrator plays Disney Dad. The hidden costs of leaving a violent situation are multidimensional and multilayered.'

Lily

WEAVERs Expert by Experience

Women who had experienced partner violence or abuse were more likely to be living as single mothers

Analysis of the 2016 PSS showed that women who had experienced violence or abuse from a partner (since the age of 15) were more likely to be living as a single parent of children under the age of 18 ('single mothers') when compared with women who had not experienced partner violence or abuse:

- 11% of women who had experienced physical or sexual violence from a partner since the age of 15 compared with 2.1% for women who had not
- 10% of women who had experienced emotional abuse from a partner since the age of 15 compared with 1.7% for women who had not (Summers 2022).

Financial impacts

Family and domestic violence is the main reason women and children leave their homes in Australia (AHURI 2021) and it is often the people who have experienced violence who bear the costs for leaving (HRSCSPLA 2021). The substantial financial costs can include deposits, rental bonds and furniture for a new home, legal and medical costs, travel or moving costs, and for mothers, costs associated with providing for the needs of their children (HRSCSPLA 2021). These costs may prevent women from leaving an abusive

relationship and may be a reason some women return to a previous violent partner (HRSCSPLA 2021, Summers 2022). See also **Economic and financial impacts**.

A range of services are available to support people who have to leave their home due to violence, including crisis payments and accommodation, subject to eligibility criteria (see also **Services responding to FDSV** and **Financial support and workplace responses**). People who are in severe financial hardship and have experienced changes in their living arrangements due to family and/or domestic violence, and are receiving, or are eligible to receive, an income support payment or ABSTUDY Living Allowance, may receive a one-off crisis payment. Half (50% or around 10,500) of the women who were granted family and domestic violence crisis claims in 2021-22 were receiving Family Tax Benefit (FTB) at the end of the 2021–22 financial year, meaning they had dependent children in their care (AIHW 2022).

Homelessness

Women and children affected by family and domestic violence are one of the national priority homelessness cohorts identified in the National Housing and Homelessness Agreement (CFFR 2018). Specialist homelessness services (SHS) provide a crisis response for people who are homeless or at risk of homelessness, including people experiencing domestic and family violence (AIHW 2023). However, the limited supply of long-term affordable housing makes it difficult for women and children affected by family and domestic violence to move into permanent, independent housing (HRSCSPLA 2021). The 2021 Parliamentary inquiry into family, domestic and sexual violence also recommended that the Australian Government and state and territory governments should consider funding emergency accommodation for perpetrators to prevent victim-survivors being forced to flee their homes or continue residing in a violent home (HRSCSPLA 2021). See also **Housing**.

Around 58,600 female clients aged 18 and over who sought SHS assistance in 2022–23 had experienced family or domestic violence (see Box 5). Of these clients, over 1 in 5 (23% or 13,400 clients) presented to specialist homelessness services as single with child/ren (AIHW 2024).

Box 5: Specialist Homelessness Services collection

The AIHW Specialist Homelessness Services (SHS) collection includes clients who have experienced family and domestic violence (that is, the client sought assistance because of family and domestic violence or required family or domestic violence assistance as part of any support period).

The data allows for analysis by presenting unit type at the beginning of support (that is, the group of people with whom the client presents to the SHS agency). This includes the category ‘single with child/ren’. However, all clients in the presenting client group, including children, are assigned the same presenting unit type. The analysis in this topic page has been restricted to female clients aged 18 and over who presented as ‘single with child/ren’ to provide a closer representation of single mothers. However, it should be noted that the

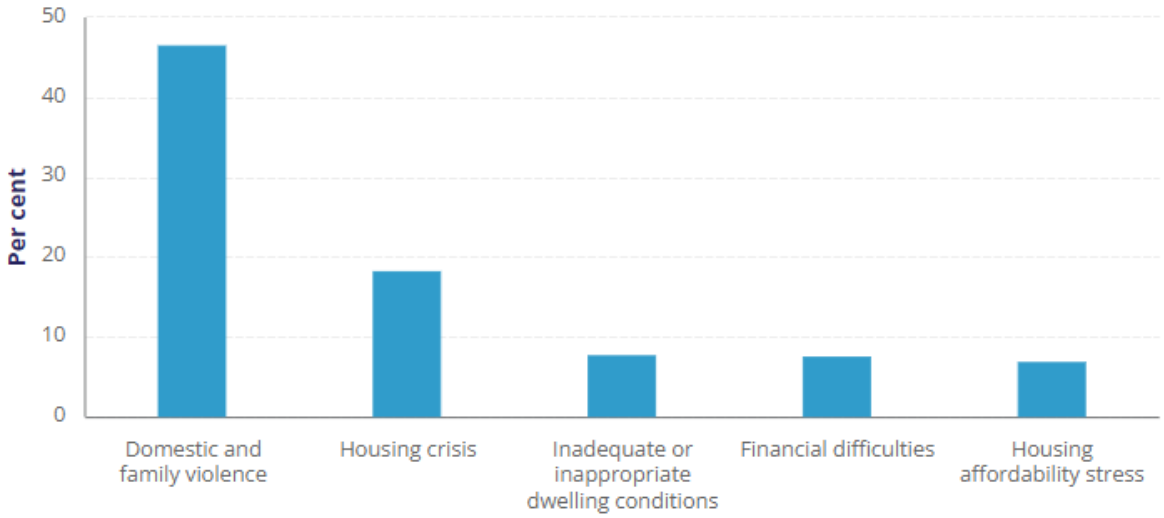
analysis may include some female children who were aged 18 and over and excludes mothers who were aged under 18 years.

Source: AIHW 2023.

Almost half (46%) of adult female clients who presented to specialist homelessness services as single with child/ren identified FDV as the main reason for seeking assistance

In 2022–23, 31% of adult female SHS clients identified FDV as the main reason for seeking assistance (AIHW 2023). The proportion was higher for female clients aged 18 and over who presented to specialist homelessness services as 'single with child/ren' – almost half (46%) of these clients identified FDV as the main reason for seeking assistance. Other main reasons nominated by these clients were housing crisis (18%), inadequate or inappropriate dwelling conditions (7.7%) and financial difficulties (7.6%) (Figure 1).

Figure 1: Female clients aged 18 and over who presented to specialist homelessness services as single with child/ren – main reasons for seeking assistance (top 5), 2022–23

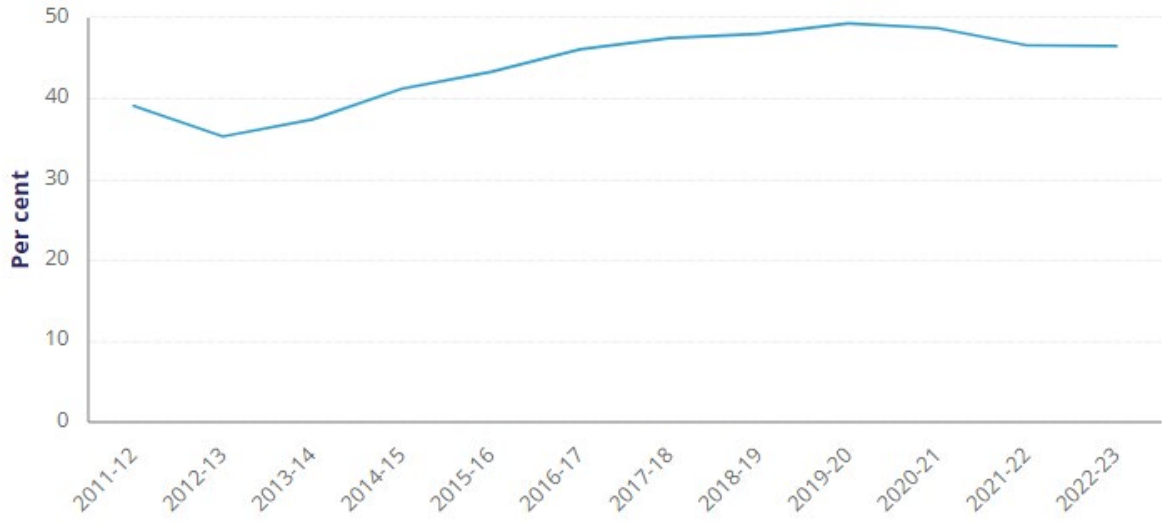


Source: AIHW SHSC | **Data source overview**

Figure 2 shows the proportion of female clients aged 18 and over who presented to specialist homelessness services as single with child/ren and identified FDV as the main reason for seeking assistance from specialist homelessness services declined from 39% in 2011–12 to 35% in 2012–13 before increasing to 49% in 2019–20. There was a slight decrease to 46% in 2022–23.

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

Figure 2: Female clients aged 18 and over who presented to specialist homelessness services as single with child/ren and identified FDV as the main reason for seeking assistance, 2011–12 to 2022–23



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

See also **Housing**.

Experience of violence following separation

Separation has been identified as a time of increased risk for family violence (DSS 2022, State of Victoria 2016). Financial abuse (for example denied or misused access to financial or material resources) may escalate or occur for the first time after separation and for some women this can result in periods of homelessness or housing instability and poverty (Kaspiew et al. 2017).

Shared parenting or maintaining contact between children and their father can also be challenging for women who have experienced violence (Lapierre 2021). Some perpetrators may use contact or child support arrangements to engage in violence and control victim-survivors and/or their children after separation (Lovatt 2020, State of Victoria 2016).

Almost half of single mothers experienced violence while temporarily separated from a previous violent partner

The Summers (2022) analysis of the 2016 PSS showed that an estimated 46,700 women who were living as 'single mothers' at the time of the survey had moved out of the home during a temporary separation from a previous violent partner. Of single mothers who

have moved out of the home during a temporary separation from a previous violent partner:

- almost half (49%) experienced violence from the previous partner while temporarily separated
- 14% reported that the violence increased while temporarily separated (note, estimate has a relative standard error of 25% to 50% and should be used with caution).

Almost 2 in 5 (37%) 'single mothers' who had experienced violence by a previous partner more than once while living together reported that violence by the previous partner increased after the relationship finally ended (Summers 2022). Separation is an identified risk factor for intimate partner homicide (Boxall et al. 2022).

Intimate partner homicide

The Australian Domestic and Family Violence Death Review Network (ADFVDRN) identified 311 cases of intimate partner homicides (homicides that were preceded by a reported or anecdotal history of domestic and family violence) between July 2010 and June 2018. The majority (77%, or 240) of these homicides involved a male killing a current or former female intimate partner (ADFVDRN and ANROWS 2022).

Of the 311 intimate partner homicides, the offenders and victims were parents of at least 172 children under 18 at the time of the homicide. Across 4 of these cases, 8 children were killed along with their mother (ADFVDRN and ANROWS 2022).

See also: **Domestic homicide**.

What are the impacts of FDSV for children and young people?

Experience of, or exposure to FDSV, can affect children and young people's health, wellbeing, education, and social and emotional development (see **Children and young people** for more information).

According to the 2021–22 PSS, many parents who reported experiencing violence from a partner also reported their child/ren had seen or heard the violence, with:

- more than 2 in 3 (69%, or about 483,000) women and about 1 in 2 men (48%, or about 57,600*) saying their child/ren had seen or heard the violence used by a **previous partner**
- about 1 in 2 (49%, or an estimated 44,400) women saying their child/ren had seen or heard the violence used by a **current partner** (ABS 2023).
- Note that estimates marked with an asterisk (*) should be used with caution as they have a relative standard error between 25% and 50%.

In a survey of around 3,800 female carers living in Australia during 2021 (see Box 3), 1 in 3 (35%) women who had experienced intimate partner violence in the past 12 months indicated that a child in their care had been exposed to the violence (Wolbers et al. 2023).

The Mothers' and Young People's Study found that children whose mothers experienced family violence in the 12 months following birth were 3 times as likely (27%) to have emotional and/or behavioural difficulties at age four as children with no abuse reported (9%) (Brown et al. 2015).

Studies have also indicated there is a relationship between domestic violence and poor maternal attachment and aggressive behaviours at school (Moore et al. 2017) and that experiences of, and exposure to, FDSV can increase the probability of the child or young person using violence in their home and later in life (Fitz-Gibbon et al. 2022; Ogilvie et al. 2022).

How are services working for children?

'Services for children are very limited and are very difficult to access. I sought counselling for my daughter and faced six month waitlists for children's counselling services that I had to hunt down and make sure I was eligible for. Once in those services I could only access them within work hours and they offered very little options in terms of types of therapy, days or hours available. It was so heartbreaking. I felt like a failure of a mother juggling the impossible.'

Jasmine

WEAVERs Expert by Experience

Is it the same for everyone?

Mothers of Aboriginal children

Preliminary findings from 170 mothers of Aboriginal children (see Box 6 for details of the Aboriginal Families Study) from the follow up questionnaire indicated that 37% had experienced violence from a current or former partner in the previous 12 months. A higher proportion of women who were single (59%) reported the experience of partner violence in the previous 12 months when compared with women who were living with a partner (20%) (Brown et al. 2021).

Box 6: The Aboriginal Families Study

The Aboriginal Families Study is an ongoing study investigating the health and wellbeing of 344 Aboriginal children and their mothers living in South Australia. A questionnaire completed in the first year after the birth of the children (2011-2013) asked about experiences of family and community violence during pregnancy (see **Pregnant people**). A follow up questionnaire when the children were aged 5-8 years focused on experiences of intimate partner violence.

See also: **Aboriginal and Torres Strait Islander people**.

Migrant and refugee women

Analysis of data from the Mothers' and Young People's Study (see Box 2) found that a higher proportion of migrant mothers (women born overseas in countries where English is not the national language) experienced physical or emotional violence from a partner in the first 12 months following birth when compared with women born in Australia (22% compared with 17% respectively) (Navodani et al. 2019). Of particular note, migrant mothers were more likely to report the experience of emotional abuse only and it is thought that isolation from extended family and the additional challenges of having a baby in a new country may have contributed to this finding (Navodani et al. 2019).

Visa restrictions may prevent access to health services, including sexual and maternal health services, for migrant and refugee women (Marie Stopes Australia 2020). Women on a temporary or partner visa may be reliant on a violent partner financially and/or for residency and threats related to deportation or the removal of children may also be used to control them (AIJA 2022).

Related material

- Intimate partner violence
- Economic and financial impacts
- Services responding to FDSV
- Financial support and workplace responses
- Children and young people
- Pregnant people

More information

- Australia's mothers and babies
- Hospitals
- Specialist homelessness services annual report 2021–22

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Older people

Key findings

- 1 in 6 (15% or 598,000) older people in Australia experienced elder abuse in the past year.
- Psychological abuse is the most common form of elder abuse.
- 1 in 2 people who perpetrate elder abuse are a family member.
- 1 in 3 people who experienced elder abuse sought help from a third party.

People in Australia are at increased risk of abuse in their later years. This abuse can take many forms, including psychological or emotional abuse, financial abuse, physical abuse, sexual abuse, and neglect (ALRC 2017).

Elder abuse that occurs in families differs from other types of family and domestic violence because it often involves abuse of parents by adult children (Kaspiew et al. 2015; Qu et al. 2021). Abuse can also occur outside of the family, such as in aged care facilities and health care services (Joosten et al. 2017). Elder abuse can cause a range of physical, psychological, financial and social harms to older people (WHO 2022).

The number of older people in Australia experiencing abuse is likely to increase over time with Australia's ageing population. While 17% of people in Australia were aged 65 and over in 2021, projections indicate that this group will make up around 21% of the population by 2066 (ABS 2018; 2021).

This page presents data on all forms of elder abuse, but focuses on elder abuse in the context of family, domestic and sexual violence where data are available.

What is elder abuse?

While there is no agreed definition for elder abuse, the definition most commonly used in Australia is from the World Health Organization:

> *Elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person* (WHO 2022).

A key aspect of the definition is that elder abuse occurs in relationships where there is 'an expectation of trust'. Such relationships include those with family members, friends, neighbours, and some professionals such as paid carers.

In Australia, 'older people' are generally defined as those aged 65 and over. However, Aboriginal and Torres Strait Islander people are often included among 'older people' from the age of 50 (Kaspiew et al. 2015). These age groups are used to define older people in this page, unless stated otherwise.

What do we know?

Measuring elder abuse

Prevalence estimates of elder abuse vary according to setting, and by who is reporting the abuse. Evidence from international studies show that abuse estimates are higher for older people in institutional settings than in the community. Estimates are also higher where abuse is reported by institutional staff than by older people themselves (Box 1) (WHO 2022; Yon et al. 2018).

Box 1: Elder abuse around the world – international evidence

A 2017 meta-analysis showed an overall international prevalence rate of 16% for self-reported elder abuse in community settings (Yon et al. 2017). The prevalence was highest for psychological abuse (12%), followed by financial abuse (6.8%), neglect (4.2%), physical abuse (2.6%) and sexual abuse (0.9%).

In institutional settings, Yon et al. (2018) found that a third (33%) of older adults had experienced psychological abuse. The next most common types of abuse were physical and financial abuse (both 14%), neglect (12%) and sexual abuse (1.9%). Notably, 2 in 3 institutional staff (64%) reported perpetrating some form of abuse against an older person in the past year (WHO 2022; Yon et al. 2018).

Prevalence estimates are likely to underestimate the true extent of elder abuse. This is because victim-survivors can be reluctant to disclose ill-treatment by a family member, or because they are dependent on the abuser for care (Qu et al. 2021). Older people with cognitive impairment (for example, dementia) or other forms of disability may also be unable to report abuse.

What are the risk factors?

While elder abuse can happen to anyone, certain factors can exacerbate a person's risk of experiencing or perpetrating elder abuse (Box 2).

Box 2: Risk factors for elder abuse

International literature provides evidence about risk factors for experiencing and perpetrating elder abuse.

Factors which heighten the risk of experiencing elder abuse include:

- poor physical or mental health
- substance misuse
- functional dependence/disability
- problems with stress and coping
- attitudes such as self-blame and stoicism

- previous experiences of abuse
- high-conflict relationships
- social isolation (Schofield and Mishra 2003; Storey 2020; WHO 2022).

Factors associated with perpetrating elder abuse include:

- poor physical and mental health
- substance misuse problems
- dependency on the victim
- holding negative attitudes such as ageism or resentment of the older person
- a history of conflictual or violent relationships
- social isolation
- experience of stressful events
- a history of family violence (Storey 2020; WHO 2022).

Elder abuse follows similar gendered patterns as other forms of family and domestic violence, albeit to a lesser extent. A 2017 review found that there is a greater likelihood for women being abused (17%) than men (11%) (Ho et al. 2017). Sons are also more likely to perpetrate abuse than daughters (Kaspiew et al. 2015).

Long-term health impacts

Elder abuse can have serious physical and mental health, financial, and social consequences. These include physical injuries, premature mortality, depression, cognitive decline, financial devastation and placement in nursing homes (WHO 2022).

A 2017 systematic review demonstrated that older people who experience abuse are at higher risk of:

- physical health problems such as bodily pain, diabetes, weight problems, digestive problems, incontinence, allergies and disability
- psychological problems such as depression, negative emotions, anxiety, stress, suicidal ideation, attempted suicide and sleeping problems
- social dysfunction
- increased hospitalisation, visits to emergency department and use of behavioural health services (Yunus et al. 2017).

What national data are available to report on elder abuse?

Data are available across a number of surveys and administrative data sources to look at the prevalence, consequences and outcomes of elder abuse, and the responses to it.

Data sources for measuring elder abuse

- ABS Personal Safety Survey (PSS)

- ABS Recorded Crime – Victims
- AIFS National Elder Abuse Prevalence Study
- AIHW National Hospital Morbidity Database
- AIHW Specialist Homelessness Services (SHS) data collection
- ANROWS Technology-Facilitated Abuse National Survey
- Serious Incident Response Scheme

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

What do the data tell us?

1 in 6 older people in Australia experience elder abuse

Box 3: National Elder Abuse Prevalence Study

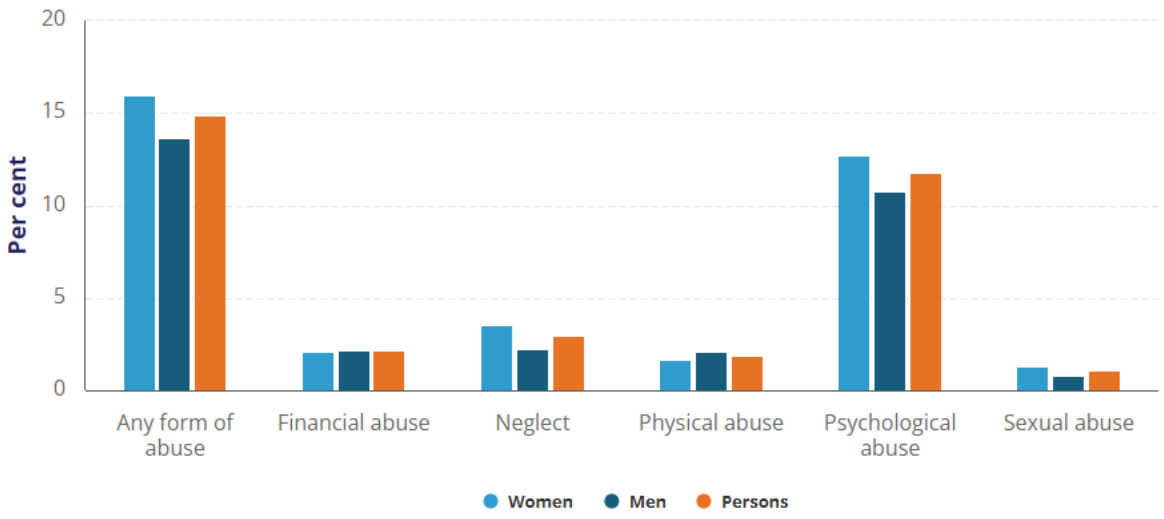
The 2021 AIFS National Elder Abuse Prevalence Study collected information about elder abuse experienced by older people who live in the community in Australia. This nationally representative prevalence study surveyed 7,000 older people in 2020 who were living in the community and had the capacity to engage in telephone interviews. Aged care residents or those with cognitive impairment were excluded. However, this is the best national data source at present.

For further information, see National Elder Abuse Prevalence Study.

The AIFS National Elder Abuse Prevalence Study (see Box 3) estimated that, in 2020:

- around 1 in 6 (598,000 or 15%) older people living in the community had experienced elder abuse in the past year
- 471,300 (12%) had experienced psychological abuse in the past year
- 115,500 (2.9%) had experienced neglect in the past year
- 83,800 (2.1%) had experienced financial abuse in the past year
- 71,900 (1.8%) had experienced physical abuse in the past year
- 39,500 (1.0%) had experienced sexual abuse in the past year
- a slightly higher percentage of women than men had experienced any form of elder abuse in the past year. This pattern was also evident for psychological abuse and neglect (Figure 1; Qu et al. 2021).

Figure 1: Prevalence of elder abuse in the past year



Source: AIFS National Elder Abuse Prevalence Study | **Data source overview**

More than 1 in 4 older people have experienced technology-facilitated abuse

Elder abuse can take many forms. When abuse is conducted via mobile, online and/or digital technologies, it is called technology-facilitated abuse (Powell et al. 2022). Technology-facilitated abuse can encompass many subtypes of abuse, including harassing behaviours, sexual violence and image-based sexual abuse, monitoring and controlling behaviours, and emotional abuse and threats (Powell et al. 2022).

Box 4: Technology-facilitated abuse data

Data on technology-facilitated abuse are available in a study from the Australian National Research Organisation on Women's Safety which was released in 2022. This research study involved a nationally representative study of about 4,600 people, of whom about 1,200 were aged 65 years and older.

For further information, see Technology-facilitated abuse: Extent, nature and responses in the Australian community.

The Australian National Research Organisation on Women's Safety (Box 4) estimated that:

- 1 in 3 (33%) people aged 65–74 years have experienced technology-facilitated abuse in their lifetime
- 1 in 4 (25%) people aged 75 years and over have experienced technology-facilitated abuse in their lifetime

- in both age groups (65-74 years and 75 years and over), men were more likely than women to have experienced technology-facilitated abuse in their lifetime (Powell et al. 2022).

For more information on technology-facilitated abuse, please see **Stalking and surveillance**.

3% of older women and 2% of older men had experienced sexual harassment in the last 12 months

Box 5: Personal Safety Survey

The Australian Bureau of Statistics Personal Safety Survey (PSS; ABS 2023a) collects information on experiences of physical and sexual assault, family and domestic violence, economic and emotional abuse, stalking, sexual harassment and childhood abuse.

For further information, see Personal Safety, Australia.

The 2021-22 PSS (Box 5) estimated that:

- 69,600 women aged 65 years and over (3.2%) had experienced sexual harassment in the last 12 months (ABS 2023c).
- 75,500 men aged 55 years and over (2.2%) had experienced sexual harassment in the last 12 months. This estimate should be used with caution as it has a relative standard error of 25% to 50% (ABS 2023c).
- 17,300 women aged 55 years and over (0.5%), had experienced sexual violence in the last 2 years. This estimate should be used with caution as it has a relative standard error of 25% to 50% (ABS 2023d).

The latest available data for reporting on stalking experienced by older people is from the 2016 ABS Personal Safety Survey (ABS 2017). This survey estimated that 17,000 older women (0.9%) and 11,400 older men (0.7%) had experienced stalking in the last 12 months. These estimates should be used with caution as they have a relative standard error of 25% to 50%.

Perpetrators differ depending on the type of abuse

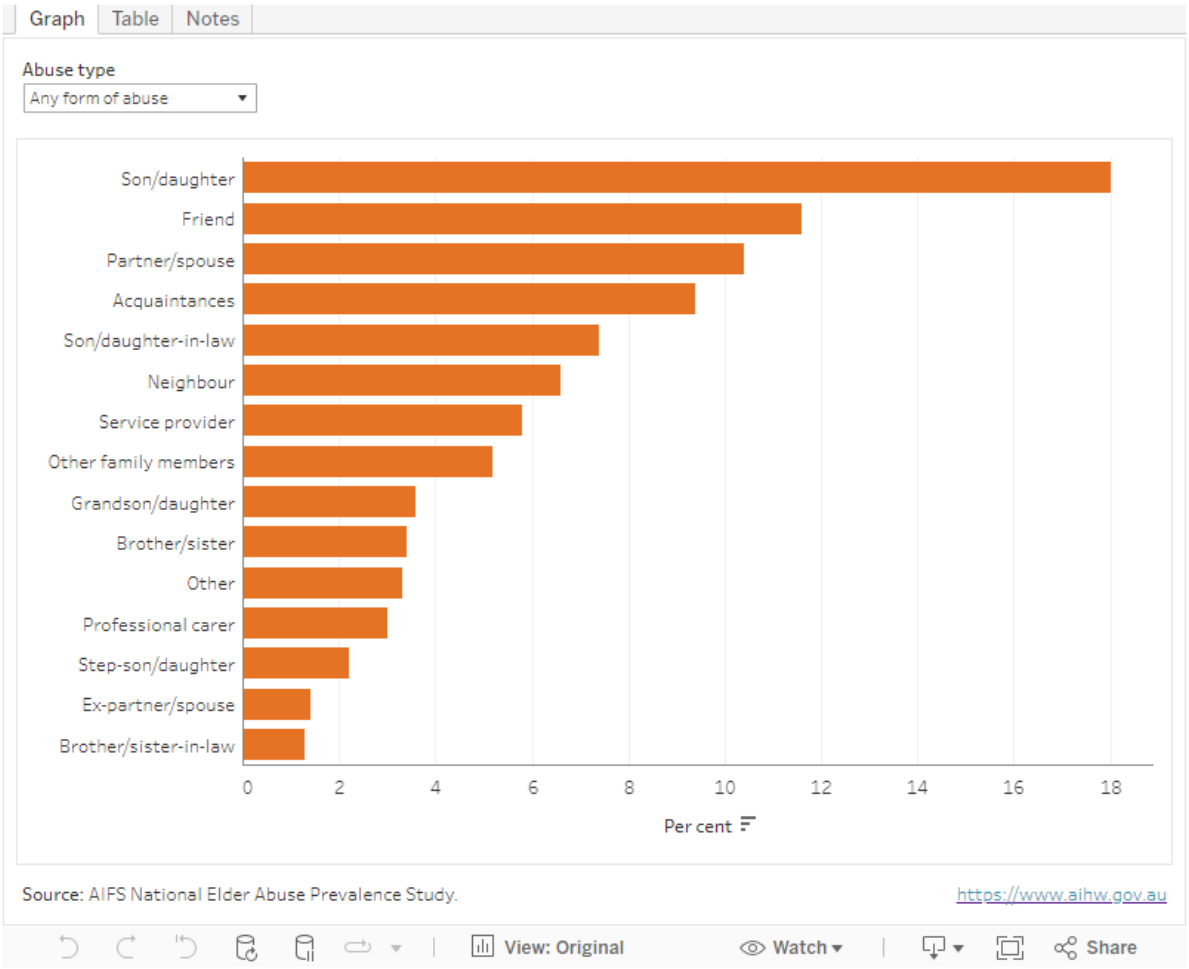
The 2021 AIFS study collected information on the perpetrators of elder abuse (Figure 2). While children were the most common perpetrators overall, patterns varied substantially depending on the type of abuse. For instance, psychological, financial and physical abuse were most often perpetrated by children of the older person, but there were almost no reports of sexual abuse perpetrated by children. A similar proportion of perpetrators of neglect were children (24%) and spouse/partners of the older person (25%) (Qu et al. 2021).

Around 1 in 2 (53%) perpetrators of elder abuse were family members (includes ex-partner/spouses). Perpetration by family members was highest for financial abuse (64%) then neglect (60%), psychological abuse (55%), physical abuse (50%) and sexual abuse

(15%). Sexual abuse of older people was primarily perpetrated by friends (42%), acquaintances (13%) and neighbours (9%) (Qu et al. 2021).

Figure 2 explores the perpetrators of each type of elder abuse.

Figure 2: Relationship of perpetrators to older person (as % of perpetrators)



Perpetrators were more likely to be male than female

Box 6: Perpetration of elder abuse

The National Elder Abuse Prevalence Study (Qu et al. 2021) collected information about the characteristics of people who perpetrate elder abuse. This information was collected about the 'main' perpetrator for each older person who had experienced abuse, which was defined as the perpetrator who affected the older person the most. Note that these data include family as well as non-family perpetrators.

The AIFS study (Box 6) showed that main perpetrators were:

- more likely to be male (55%) than female (45%)
- more likely to be aged 65–74 (23%) or 45–54 years (20%) than any other age

- more likely to be unemployed (53%) than employed (47%)
- more likely to live apart from the older person (77%) than to live with them (23%) (Qu et al. 2021).

The majority (72%) of elder abuse victim-survivors indicated that their main perpetrator had one or more problems. The most common problems were mental health issues (32%), followed by financial problems (21%) and physical health problems (20%) (Qu et al. 2021).

What are the responses to elder abuse?

People who experience elder abuse may access many types of informal and formal supports such as family and friends, health professionals, and helplines. Information on how victim-survivors seek help can assist understanding and improvement of response strategies. It can also provide information about the extent of under-reporting of elder abuse in data collected as a by-product of service delivery.

Help seeking

1 in 3 people

in 2021 who had experienced **elder abuse** had sought help from a third party

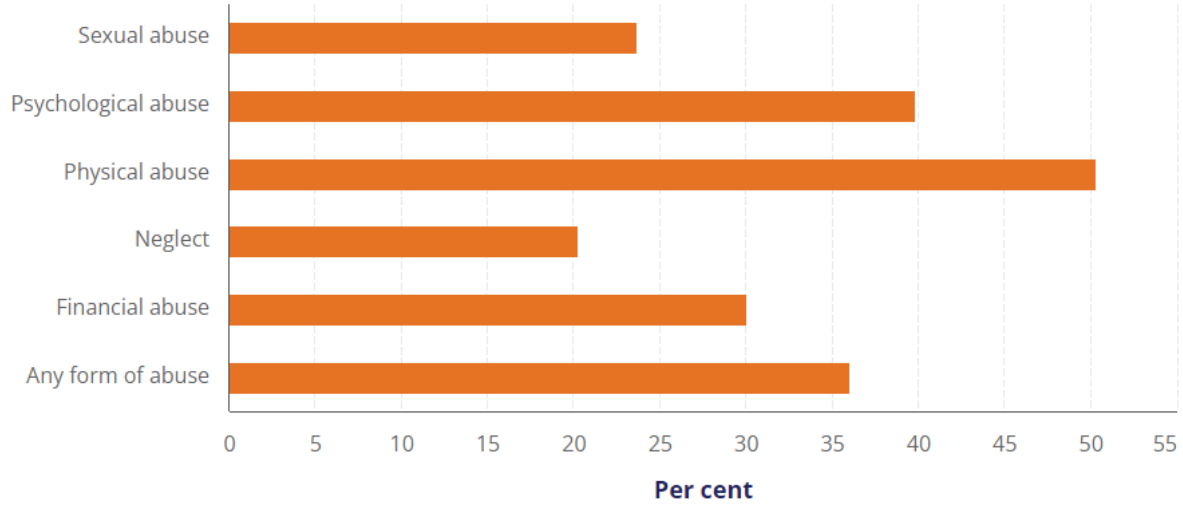
Data on advice or support sought after elder abuse are available from the AIFS study. The study estimated that:

- 1 in 3 (36%) older people in Australia who experienced abuse sought help or advice from a third party such as a family member, friend or professional
- help seeking was most common after physical abuse, followed by psychological abuse, financial abuse, sexual abuse and then neglect
- of those seeking help, the most common sources of help were family members (41%) and friends (41%), followed by a GP or nurse (29%), a professional carer (24%), the police (17%) and lawyers (15%). Around 1 in 20 (5.3%) contacted a helpline (Qu et al. 2021).

Around 8 in 10 (82%) older people who experienced abuse had taken action to stop the abuse from happening again. These actions included informal actions (such as speaking to the person) and formal actions (such as seeking legal advice). The most common actions were speaking to the person or breaking contact with them.

Figure 3 explores help seeking or advice for each type of elder abuse.

Figure 3: Whether help or advice was sought by people who experienced elder abuse



Source: AIFS National Elder Abuse Prevalence Study | **Data source overview**

Helplines contacts

Each state and territory in Australia has a telephone helpline for elder abuse (Box 7). These helplines are delivered by a government or non-government organisation in each jurisdiction, and provide confidential information, advice and referrals. Some states and territories publish data about the support services they provide, and these data can provide insight into instances in which elder abuse is identified or suspected.

Box 7: 1800 ELDERHelp

1800 ELDERHelp was established in 2019 as a national, free call number which directs callers to a state or territory telephone service. The helplines are an important entry point into the service system for those in need of assistance. Callers may access the helplines via 1800 ELDERHelp or in other ways such as contacting the service directly.

Callers can be the victim-survivors of elder abuse or other people who are concerned about an older person. Currently, data are collected differently across states and territories in accordance with different definitions and operational processes. For this reason, data from helplines are not comparable between states and territories.

In 2021–22:

- the New South Wales helpline received 3,072 reports about abuse of older people (NSW ADC 2022)
- the Victorian helpline received 3,487 calls (COTA Victoria 2022)

- the Queensland helpline received 3,841 calls about abuse of older people. This included 2,338 abuse notifications and 1,503 enquiry calls (Gillbard and Leggat-Cook 2022).
- the Western Australian helpline received 1,330 calls (Advocare 2022)
- the South Australian helpline received 1,463 calls relating to older people (SA Health 2022).

Work is currently underway to harmonise the data collected across 1800 ELDER Help helplines to improve comparability. For more information about this work, see **Key information gaps and development activities.**

Police

Box 8: ABS Recorded Crime – Victims data

Data on assaults which occur within the context of family and domestic violence in Australia are drawn from the ABS Recorded Crime – Victims collection. Note that these data do not include violence in non-family or domestic relationships such as that committed by a carer, service provider or stranger.

The ABS Recorded Crime – Victims collection also provides information on sexual assault crimes committed by family members, non-family members known to the victim, and strangers.

For further information, see Recorded Crime – Victims.

Some forms of elder abuse that are considered criminal offences under legislation are reported to, and recorded by, police. Data on crime rates make it possible to examine how police are engaged following incidents of violence, such as sexual assault, and violence that occurs in a family and domestic context.

In some cases, there is a delay in the reporting of a crime to police. Crime data can therefore be presented according to the victim's age at the time of report or by their age at the time of the incident. This section presents data for victims of FDV-related assault who were aged 65 years and over at the time of report. Note that it does not necessarily refer to incidents of elder abuse (that is, violence that occurred while the person was 65 years and over).

Family and domestic violence-related assault

According to 2022 ABS Recorded Crime – Victims data (Box 8) (excluding Victoria and Queensland, see **Data sources and technical notes**), 37–51% of all assault victims aged 65 years and over at the time of report, were assaulted by a family member or domestic partner in 2022 (ABS 2023b).

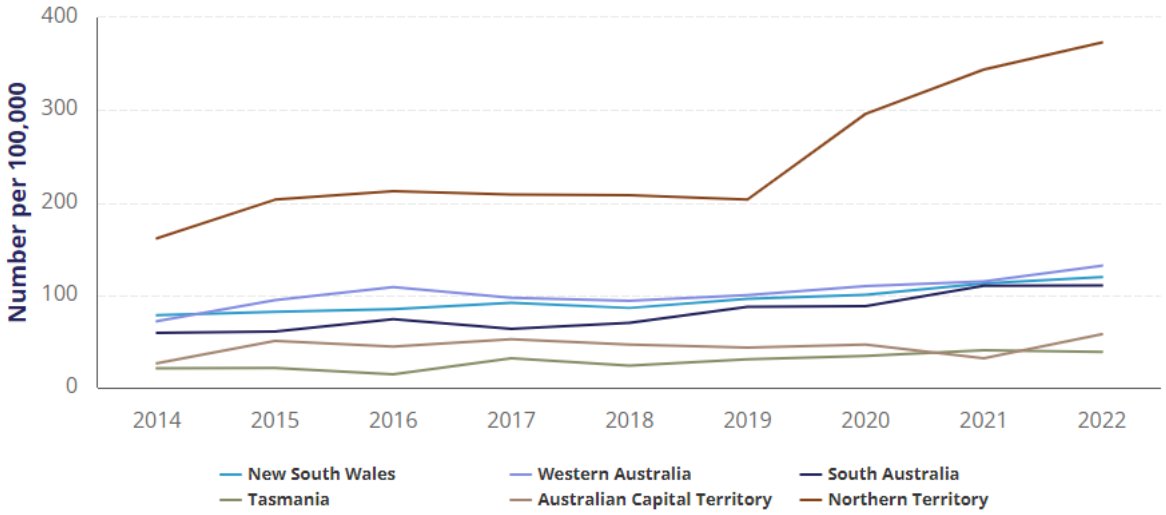
The victimisation rate for family and domestic violence assaults (FDV assaults) in 2022 for those aged 65 years and over at the time of report was:

- around three times as high in the Northern Territory as in other states and territories
- higher for females than males in New South Wales, Western Australia, South Australia and the Northern Territory
- higher for males than females in the Australian Capital Territory and Tasmania (ABS 2023b).

Figure 4 shows the rates of FDV assault since 2014.

- The rate of FDV assaults reported in most states and territories remained relatively stable between 2014 and 2022, at 14–132 per 100,000 persons.
- The Northern Territory had the highest rate of FDV assaults reported to police in every year between 2014 and 2022, while Tasmania and the Australian Capital Territory had the lowest rates.
- The rate of FDV assaults reported in the Northern Territory increased sharply between 2019 and 2022 (ABS 2023b).

Figure 4: Victims of family and domestic violence-related assault, aged 65 years and over, by state, 2014–2022



Source: ABS Recorded Crime - Victims (unpublished) | **Data source overview**

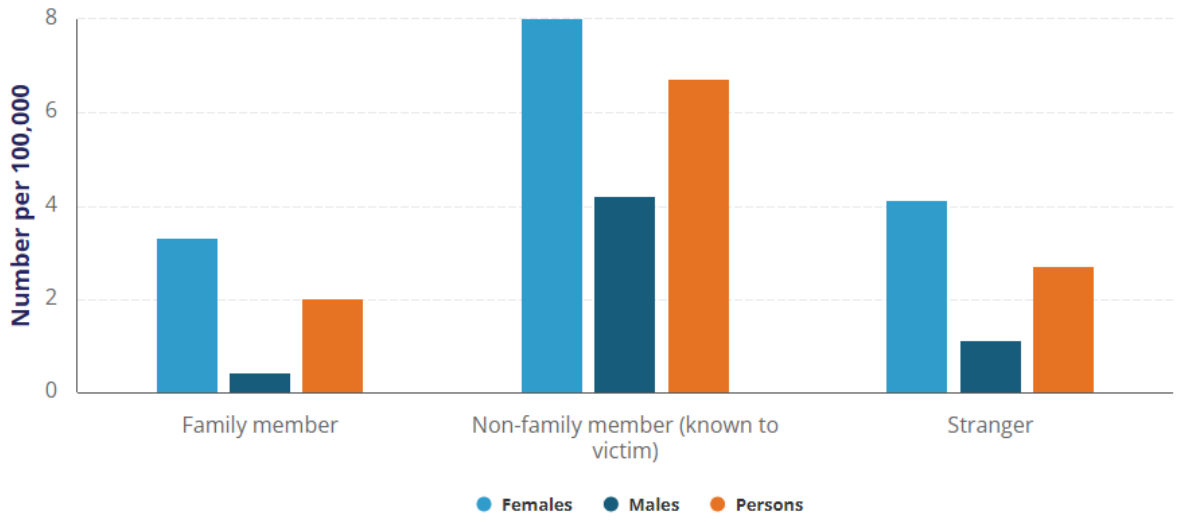
Sexual assault

The 2022 ABS Recorded Crime – Victims data show 114 male (5.5 per 100,000) and 380 (16.1 per 100,000) female victims of sexual assault aged 65 years and over at the time of report in 2022 (ABS 2023b).

Figure 5 presents the victimisation rate for sexual assault of people aged 65 years and older at the time of report in 2022 (excluding Western Australia), by offender type. It shows that:

- the highest victimisation rate (9.1 per 100,000) was for females by a non-family member who was known to them (for example, a neighbour or friend)
- females had a higher victimisation rate than males for each offender type
- for males and females, the victimisation rate for sexual assault perpetrated by non-family members was higher than by family members (ABS 2023b).

Figure 5. Victims of sexual assault aged 65 years and over (excluding Western Australia), by relationship of offender to victim, 2022



Source: ABS Recorded Crime - Victims (unpublished) | **Data source overview**

The victimisation rate for FDV-related sexual assault among people aged 65 years and over at the time of report increased slightly from 0.8 to 1.9 per 100,000 between 2014 and 2022, and was higher for females than males in every year (ABS 2023b).

Specialist homelessness services

Box 9: Specialist Homelessness Services Collection

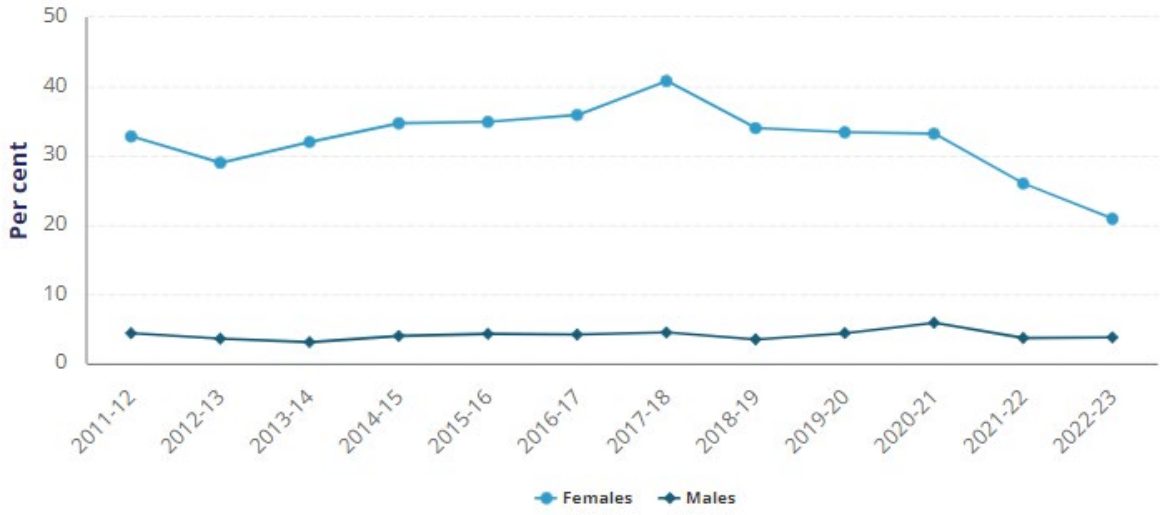
Data on people seeking support from specialist homelessness services (SHS) are drawn from the AIHW Specialist Homelessness Services Collection. These services can provide assistance to people who are experiencing homelessness or who are at risk of homelessness, including clients who have experienced family and domestic violence. Examining the number of SHS clients who have experienced family and domestic violence provides an indication of the level of service response. The AIHW Specialist homelessness services annual report includes additional details on Clients who have experienced family and domestic violence.

Data on assistance provided by specialist homelessness services (SHS) (Box 9) show that:

- 5,400 females and 4,800 males aged 65 years and over accessed SHS in 2022-23

- 21% of females (1,100) and 3.8% (185) of males aged 65 years and over who accessed SHS in 2022–23 had experienced family or domestic violence
- since 2011–12, the proportion of females aged 65 years and over accessing SHS who had experienced FDV decreased from 33% in 2011–12 to 21% in 2022–23 (Figure 6)
- the proportion of males aged 65 years and over accessing SHS who have experienced FDV fluctuated between 2011–12 and 2022-23, ranging from 3.1% in 2013–14 and 5.9% in 2020–21, with 3.8% in 2022–23 (Figure 6; AIHW 2024).

Figure 6. Proportion (%) of male and female specialist homelessness services clients aged 65 years and older who experienced family and domestic violence, 2011-12 to 2022–23



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

Hospitalisations

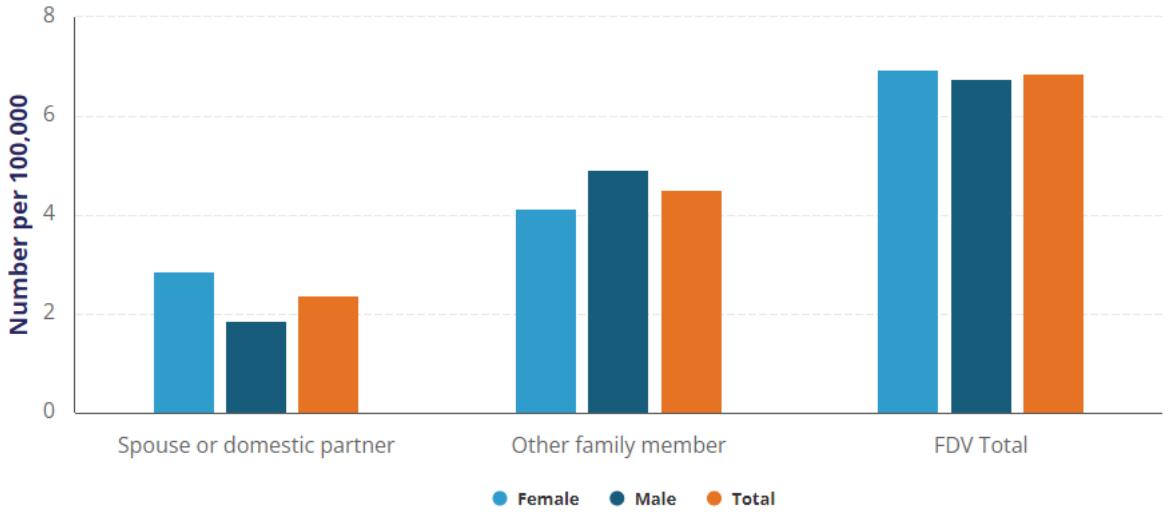
Box 10: Hospitalisations data

Some people who experience family and domestic violence require care from a health professional, and in some cases are admitted to hospital. Examining the hospitalisations for injuries caused by a family member or partner provides an indication of the demand for these services. However these data do not include presentation to emergency departments or primary care and so relate to more severe (and mostly physical) experiences of family and domestic violence. In addition, those who are hospitalised may choose not to reveal their experience of abuse, or the information may not be fully recorded. Data are drawn from the AIHW National Hospital Morbidity Database.

In 2021-22, about 160 women and 135 men aged 65 years and over were hospitalised for injuries related to family and domestic violence. Figure 7 shows that:

- overall, the rate of hospitalisations for injuries caused by a spouse or domestic partners was lower than by other family members
- women were more likely than men to be hospitalised for injuries caused by a spouse or domestic partner
- men were more likely than women to be hospitalised for injuries caused by another family member (AIHW 2023).

Figure 7. Family and domestic violence hospitalisations for people age 65 years and over, by relationship to perpetrator, 2021-22.



Source: AIHW NHMD | Data source overview

Has it changed over time?

Some data are available to show how elder abuse has changed over time. These changes may reflect an actual change in the prevalence of elder abuse, an increase in awareness and propensity to report, or a combination of these factors.

Sexual assault in residential aged care

Box 11: Residential aged care data

When unlawful sexual contact or inappropriate sexual conduct is detected within residential aged care facilities, providers must notify the Aged Care Quality and Safety Commission. The incident notifications are reviewed and assessed within 24 hours to ensure appropriate responses by providers including reporting to the police (Aged Care Quality and Safety Commission 2022c). Quarterly data on these notifications are available via the Serious Incident Response Scheme from October 2021.

Data from the Aged Care Quality and Safety Commission on reports of unlawful sexual contact or inappropriate sexual conduct in residential aged care facilities show:

- 530 reports between 1 October and 31 December 2021
- 485 reports from 1 January and 31 March 2022
- 452 reports between 1 April and 30 June 2022
- 633 reports between 1 July and 30 September 2022
- 565 reports between 1 October and 31 December 2022
- 592 reports between 1 January and 31 March 2023
- 519 reports between 1 April and 30 June 2023 (Aged Care Quality and Safety Commission 2021; 2022a; 2022b; 2022c; 2022d; 2023a; 2023b).

For more information, see Sector performance data | Aged Care Quality and Safety Commission.

Is it the same for everyone?

Older people in Australia are a diverse group, and experiences of violence and abuse can vary for a number of reasons. Data are available for selected groups of older people in Australia, but should be interpreted with caution due to small sample sizes.

Culturally and linguistically diverse (CALD) populations

The AIFS study provides information on the prevalence of elder abuse in Australia's culturally and linguistically diverse (CALD) population. Note that these findings relate to the CALD population as a whole; conclusions about specific cultures or regions could not be drawn due to small sample sizes.

Key findings were that:

- A similar proportion of CALD (14%) and non-CALD (15%) participants had experienced elder abuse in the past year.
- Experiences of each type of abuse (except financial abuse) were similar for CALD and non-CALD participants. Financial abuse was less common for CALD (1.6%) than non-CALD (2.1%) participants.
- The experience of abuse was slightly higher for CALD women (14.2%) than CALD men (13.8%).
- Elder abuse decreased with age among the CALD sample (Qu et al. 2021).

Older people with disability or long-term health conditions

Around 50% of people in Australia aged 65 and over have disability (AIHW 2022). Some studies have suggested that older people with disability may be at increased risk of elder abuse (Storey 2020; WHO 2022). The AIFS study provides estimates of elder abuse for older people in the community who have disability or long-term health conditions. Note

that the study excluded older people living in residential care facilities and those who lacked capacity to complete an interview.

The AIFS study shows that 21% of older people with disability or long-term health conditions had experienced elder abuse in the past 12 months (Qu et al. 2021). Older people with a disability or long-term health conditions experienced higher rates of every type of elder abuse than older people without disability or long-term health conditions (Qu et al. 2021).

Regional and remote areas

The AIFS study provides information on the prevalence of elder abuse in the past 12 months by geographic remoteness. Key findings were that:

- the prevalence of neglect was lower in *Outer regional*, *Remote* and *Very remote areas* (1.0%) than in *Major cities* (3.0%) and *Inner regional areas* (3.4%)
- the prevalence of financial, physical, psychological and sexual abuse were similar across levels of geographic remoteness (Qu et al. 2021).

Related material

- What is FDSV?
- Community understanding and attitudes
- Sexual violence
- Intimate partner violence

More information

- Family, domestic and sexual violence in Australia: continuing the national story 2019
- Family, domestic and sexual violence data in Australia
- National sexual violence responses
- Family, domestic and sexual violence: National data landscape 2022
- Specialist homelessness services annual report 2021–22
- National Hospital Morbidity Database

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People with disability

Key findings

- About 1 in 5 (21% or 1.2 million) adults with disability in 2016 had experienced physical and/or sexual violence from a current or previous intimate partner since the age of 15
- Women with disability (30%) in 2016 were about 3 times as likely as men with disability (11%) to have experienced intimate partner violence since the age of 15
- Adults with severe or profound disability (24%) in 2016 were about 3 times as likely as adults without disability (9.6%) to have experienced sexual violence since the age of 15

People with disability are more likely to be victim-survivors of family, domestic and sexual violence (FDSV) than people without disability (CRE-DH 2021; DSS 2022). People with disability can also be affected by different forms of FDSV and experience additional barriers to getting help. Understanding the experiences of people with disability, as a group, can provide helpful information for organisations providing services to people with disability. This page presents the available national data on FDSV among people with disability.

Box 1: How do we define disability?

In FDSV reporting we present data from a range of sources that, due to varying methods, can define disability differently.

Generally, disability can be considered an umbrella term for a person who, given environmental and personal factors, is experiencing any of the following:

- impairment – problems in body function or structure
- activity limitation – difficulties in executing activities
- participation restriction – problems an individual may experience in involvement in life situations (WHO 2002).

For a detailed discussion of issues related to definitions of disability, see AIHW's People with disability – Defining disability.

Data from the Australian Bureau of Statistics' (ABS) Personal Safety Survey (PSS) is used to report on the prevalence of FDSV. The PSS uses the ABS Short Disability Module, which considers a person to have disability if they had one or more health conditions which have lasted, or are likely to last, for at least 6 months and restrict everyday activities.

The severity of disability is defined by whether a person needs help, has difficulty, or uses aids or equipment, with 3 core activities – self-care, mobility, and communication – and is reported for mild, moderate, severe, and profound limitation. People who always or sometimes need help with one or more core activities are referred to in this section as **people with severe or profound disability**.

What are the forms of FDSV experienced by people with disability?

People with disability can experience the same forms of FDSV as the general population (see **What is FDSV?**). However, they may also experience distinct types of violence, violence across a wider range of settings (for example, in institutions, group homes, and long term hospital stays) and from a greater range of people (for example, carers and support workers), see Box 2. Due to varying definitions of family and domestic violence (FDV) in Australia, violence in some situations may not be recognised as FDV (for example, from a carer or staff in residential settings) and protections and supports related to FDV may not be available (RCVANEPD 2021a). Forms of FDSV that are unique to people with disability or that may be more likely include:

- abuse focused on the disability
- threats of institutionalisation, abandonment, withdrawal of care and health information disclosure
- withdrawal of medication, care and other assistance
- interference with mobility aids, equipment and medication
- medical exploitation, including forced psychiatric interventions and reproductive violence, such as forced sterilisation, abortion and contraception
- restrictive practices such as restraints and seclusion
- a perpetrator controlling aspects of their lives including movement and finances (Australian Government 2022; RCVANEPD 2021a; eSafety 2021a; RCVANEPD 2022).

For further discussion of forms of FDSV experienced by all people, see **What is FDSV?**.

Box 2: Institutional child sexual abuse

Children and adults with disability can be particularly at risk of abuse in institutional settings due to the nature of their disability, the discrimination they experience in response to their disability and their increased likelihood to experience institutional settings (RCIRCSA 2017b).

In contributions to the Royal Commission into institutional responses to child sexual abuse victim-survivors with disability highlighted difficulties disclosing institutional abuse, including their verbal and non-verbal attempts being explained away as a part of their disability, and being disbelieved, ignored or punished. There were also accounts of disclosure to police not being pursued as the victim-survivor was not viewed as a 'credible witness' (RCIRCSA 2017b).

For further discussion of institutional child sexual abuse, see **Child sexual abuse**.

What do we know about FDSV among people with disability?

People with disability are more likely to experience FDSV than people without disability in Australia and can experience greater difficulty getting support (DSS 2022; RCVANEPD

2020a). The economic cost of violence, abuse, neglect and exploitation experienced by people with disability in Australia was conservatively estimated to be at least $46 billion in 2021–22. When considering the gaps in outcomes seen for people with disability the conservative estimate increased to $75 billion (Vincent et al. 2022).

Exposure to FDV as a child or young person with disability

Exposure to FDV among children and young people with disability can have lasting negative effects on their social, emotional and cognitive development and overall health and wellbeing. Exposure to FDV refers to any experiences of FDV apart from being the direct target of abuse, including witnessing patterns of non-physical controlling behaviours between family members (Orr 2020).

There is no national data on the prevalence of exposure to FDV among children and young people with disability. An analysis of state-linked data from Western Australia shows that children with disability are more likely to be exposed to FDV in a variety of ways and that exposure can be associated with an increased risk of mental health conditions or mental health service use, see Box 3.

Box 3: Exposure of children with disability to FDV

Two recent studies used linked administrative data from Western Australia to analyse the exposure of children with disability to FDV. Disability was determined using a medical model based on the NDIS categories of disability and administrative data sources, such as the Hospital Morbidity Data System, the Western Australian Register of Developmental Anomalies, the Mental Health Information System and the Intellectual Disability Exploring Answers database.

Children with disability were over-represented among children who:

- were exposed to FDV (based on police and hospitalisation data) (30%)
- were involved in child protection (32%)
- entered out-of-home care (36%) (Octoman et al. 2022).

Children with disability were also about twice as likely to have a mother hospitalised due to FDV assault (7.8%) compared with all children in the study cohort (4.3%) (Octoman et al. 2022).

Some population groups were over-represented among children with disability who had a mother hospitalised due to FDV assault when compared with all children in the study cohort. These population groups include:

- Aboriginal and Torres Strait Islander children (36% compared with 8%)
- Children living in socio-economically disadvantaged areas (1st and 2nd quintiles, see **Methods**) (63% compared with 42%)
- Children living in outer regional, remote or very remote areas (see **Methods**) (36% compared with 17%) (Octoman et al. 2022).

Among children who were exposed to FDV, disability was found to increase the chance of mental health conditions or service use. Among children exposed to FDV, having disability was associated with:

- 41% increased risk of mental health service contact
- a significant increase in the risk of a diagnosis in 9 of the 10 mental disorder subcategories, including substance use disorder (80% increase), psychological development disorder (167%) and personality disorder (149% increase) (Orr et al. 2022).

Among children who were not exposed to FDV, disability was associated with an even higher increased risk in mental health service contact (88%). This suggests that exposure to FDV may be acting as a barrier to mental health service contact for children with disability (Orr et al. 2022).

Certain characteristics of children with disability who were exposed to FDV also increased their risk of mental health service contact, including:

- being born to a father aged over 40 years (78% increase) compared with those born to a father aged 30–39 years
- being born pre-term (23% increase) compared with those born at term (Orr et al. 2022).

Factors related to experiencing FDSV among people with disability

People with disability can be more likely to experience FDSV than people without disability due to a range of factors including:

- discrimination and marginalisation
- reliance on the perpetrator of violence, for example, for care, mobility, and/or income
- insufficient safeguards in institutional and group living situations
- not fully understanding the abuse or its seriousness
- reduced impulse control and help seeking behaviour
- social isolation
- communication challenges
- barriers preventing them from getting help (Australian Government 2022; eSafety 2021b; RCVANEPD 2022).

Risk factors that can increase the likelihood that people in the general population will experience FDSV may also have greater effects among people with disability, see **Factors associated with FDSV**.

Barriers to seeking help

While people with disability can experience the same barriers to seeking help for FDSV as the general population, some are distinct to people with disability or may have greater impact due to disability, including:

- a lack of trust that they will be believed or taken seriously, potentially due to prior experiences of discrimination and minimisation
- feelings of shame or self-blame
- insufficient accessible information about ways to report, rights, and available support
- physical barriers to accessing services
- fear of negative consequences of reporting, including retaliation, criminalisation, ostracisation from family and/or community, and loss of support and/or access to children
- inadequate specialised support services
- normalisation of abuse and/or being controlled (eSafety 2021a, 2021b; Maher et al. 2018; RCVANEPD 2022).

What are some of the barriers to seeking help?

'We still have a long way to go, to make services accessible and inclusive to people with disabilities and/or mental illness escaping family violence. I have been advocating for refuge reforms, to make them more accessible, but unfortunately physical access (which is one type of accessibility) has been the only reform considered.'

Anonymous

WEAVERs Expert by Experience

For further discussion of barriers to getting help experienced by all people, see **How do people respond to FDSV?**.

Impacts of experiences of FDSV

Experiences of FDSV can have dramatic, life-long negative effects on:

- health and wellbeing, through resultant injury, mental illness and loss of life satisfaction, as well as higher rates of health risk factors, including smoking, poor diet, and isolation
- education, employment and financial security (RCVANEPD 2020a; Vincent et al. 2023).

Further research is required to better understand and quantify the negative impacts caused by experiences of FDSV among people with disability.

For a discussion of the impacts and outcomes of FDSV among all people, see **Behavioural outcomes**, **Health outcomes** and **Economic and financial impacts**.

Measuring FDSV among people with disability

There are no nationally consistent data sets available to describe the extent of FDSV experiences among all people with disability (Octoman 2022). While data are available

across a number of surveys and administrative data sources to look at the prevalence, service responses and outcomes of FDSV among people with disability, the majority are restricted to particular states or territories.

This page focuses mainly on data from the Australian Bureau of Statistics' (ABS) Personal Safety Survey (PSS, see **Data sources and technical notes**), which is currently the best source of population level estimates of adults with disability who have experienced FDSV. However, the PSS has limitations in its ability to estimate experiences of FDSV among people with disability (see Box 4).

Importantly, it is not possible with data from the PSS to determine if a person had disability at the time they experienced violence as the PSS collects information about disability at the time of the interview and information about experiences of violence in the 12 months prior to the survey, since the age of 15 and before the age of 15 (ABS 2017).

This page mainly reports on experiences of FDSV since the age of 15 and before the age of 15. This type of reporting can help us understand how many people with disability may require access to support, given the long-term effects of experiences of FDSV. However, it cannot show whether disability is a risk factor for, or outcome of, experiencing FDSV. Data on FDSV in the 12 months prior to the survey can be useful to see whether the experience of violence has changed over time (ABS 2017).

Box 4: Limitations with the ABS PSS

There are a number of limitations in using the PSS to estimate the prevalence of FDSV among people with disability:

- participants are selected from private dwellings, thus excluding people who live in institutional and other care settings
- the ABS Short Disability Module is used to identify a 'disability or restrictive long-term health condition'. This module is not as effective as the questions used in the ABS Survey of Disability, Ageing and Carers, and may overestimate the number of people with less severe forms of disability
- it is not possible to determine whether a person had disability at the time of experiencing violence as disability status is determined at the time of the interview, whereas questions on violence relate to past experiences
- information about experiences of violence is not collected in proxy interviews where the selected respondent is incapable of answering for themselves, for instance, due to a communication disability. This results in an underrepresentation of people with a communication disability who are unable to communicate at all (ABS 2021; AIHW 2022; CRE-DH 2021).

In addition, information is only collected from participants aged 18 years and over and there is no mechanism to determine if violence reported is part of a systemic pattern of abuse or an isolated incident (ABS 2017; CRE-DH 2021).

The ABS assess that these limitations do not affect the overall national representativeness of people with disability in the PSS sample (ABS 2021).

What do the data tell us?

How common is the experience of FDSV among people with disability?

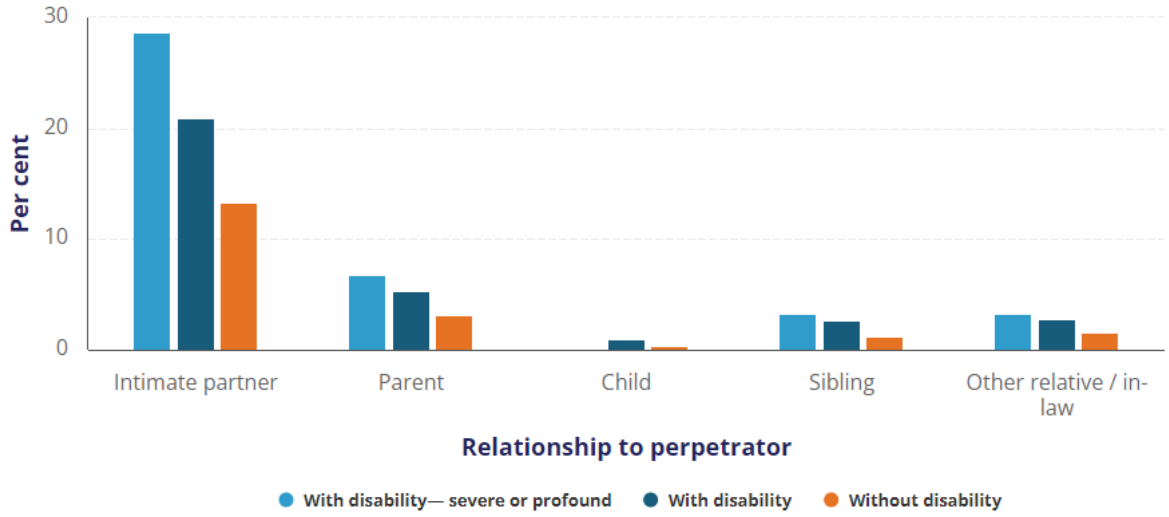
Family and domestic violence

There are limited data from the 2021–22 ABS PSS that are sufficiently statistically reliable to report on patterns in experiences of FDSV among women with disability and no sufficiently statistically reliable data for men with disability. As such, the latest available estimates of experiences of FDV, including intimate partner violence and partner emotional abuse, are primarily sourced from the 2016 ABS PSS.

The perpetrator was known to the majority (81%, or 2.2 million) of people aged 18 years and over (adults) with disability in 2016 who reported that they had experienced physical and/or sexual violence **since the age of 15** (hereafter referred to as violence). The most common perpetrators of violence were intimate partners (21% of all adults with disability in 2016 or 1.2 million people) (AIHW 2022).

Experiences of violence from an intimate partner or parent since the age of 15 were more common among adults with disability in 2016 (21% and 5.2%, respectively) than adults without disability (13% and 3.0%, respectively), with the highest proportions among those with severe or profound disability (29% and 6.7%, respectively). Similar patterns were apparent for perpetrators with other family relationship types (Figure 1).

Figure 1: The proportion of adults who experienced physical and/or sexual violence since age 15, by disability status and relationship to perpetrator, 2016



*: estimate has a relative standard error (RSE) between 25% and 50% and should be used with caution.

Source: ABS PSS 2016 | **Data source overview**

Box 5: Key ABS PSS terms and definitions for FDSV reporting

Intimate partner – Includes boyfriend or girlfriend or date, current partner, previous partner, and ex-boyfriend or ex-girlfriend or ex-date.

Cohabiting partner – Includes someone the person lives with or lived with in a married or de facto relationship.

Emotional abuse – Emotional abuse occurs when a person is subjected to certain behaviours or actions aimed at preventing or controlling their behaviour, causing them emotional harm or fear. These behaviours are intended to manipulate, control, isolate or intimidate the person they are aimed at. They are generally repeated behaviours and include psychological, social, economic and verbal abuse.

Disability group – A broad categorisation of disability. It is based on underlying health conditions and on impairments, activity limitations and participation restrictions. It is not a diagnostic grouping, nor is there a one-to-one correspondence between a health condition and any disability group.

Physical violence – An act using physical force with the intent to harm or frighten a person since the age of 15, such as physical assault or threat of physical threat.

Physical abuse – Any deliberate physical injury (including bruises) inflicted upon a child (under the age of 15 years) by an adult. Excludes discipline that accidentally resulted in injury, emotional abuse, and physical abuse by someone under the age of 18.

Sexual violence – A behaviour of a sexual nature carried out against a person's will since the age of 15, such as sexual assault (for example, rape, indecent assault and attempts to force a person into sexual activity) or threat of sexual assault.

Sexual abuse – Any act by an adult involving a child (under the age of 15 years) in sexual activity beyond their understanding or contrary to currently accepted community standards. Excludes emotional abuse and sexual abuse by someone under the age of 18.

Sexual harassment – Behaviours of a sexual nature that make a person feel uncomfortable and that the person finds offensive.

Source: ABS 2017.

A higher proportion of adults with disability in 2016 (20% or 1.1 million) experienced abuse **before the age of 15** than adults without disability (11% or 1.3 million), with about 3 in 10 (28% or 198,000) adults with severe or profound disability (AIHW 2022).

For both adults with and without disability in 2016, the most common perpetrators of abuse **before the age of 15** were:

- parents/step-parents (10% of all adults with disability, 16% of all adults with severe or profound disability and 5.4% of all adults without disability)
- known people who are not family members (8.2% of all adults with disability, 9.9% of all adults with severe or profound disability and 4.0% of all adults without disability) (AIHW 2022).

Intimate partner violence and partner emotional abuse

Analysis of the 2016 PSS shows that the proportion of adults who had experienced **intimate partner violence** since the age of 15 was higher among:

- adults with disability (21%, or 1.2 million) than adults without disability (13%, or 1.7 million)
- women with disability (30%, or 892,000) than men with disability (11%, or 303,000)
- women with severe or profound disability (36%, or 163,000) than men with severe or profound disability (16%, or 41,300) (AIHW 2022).

The available data from the 2021–22 PSS shows that violence by a cohabiting partner was experienced in the 2 years prior to the survey by 2.2% (68,600) of women with disability and 1.5% (99,400) of women without disability (ABS 2023a).

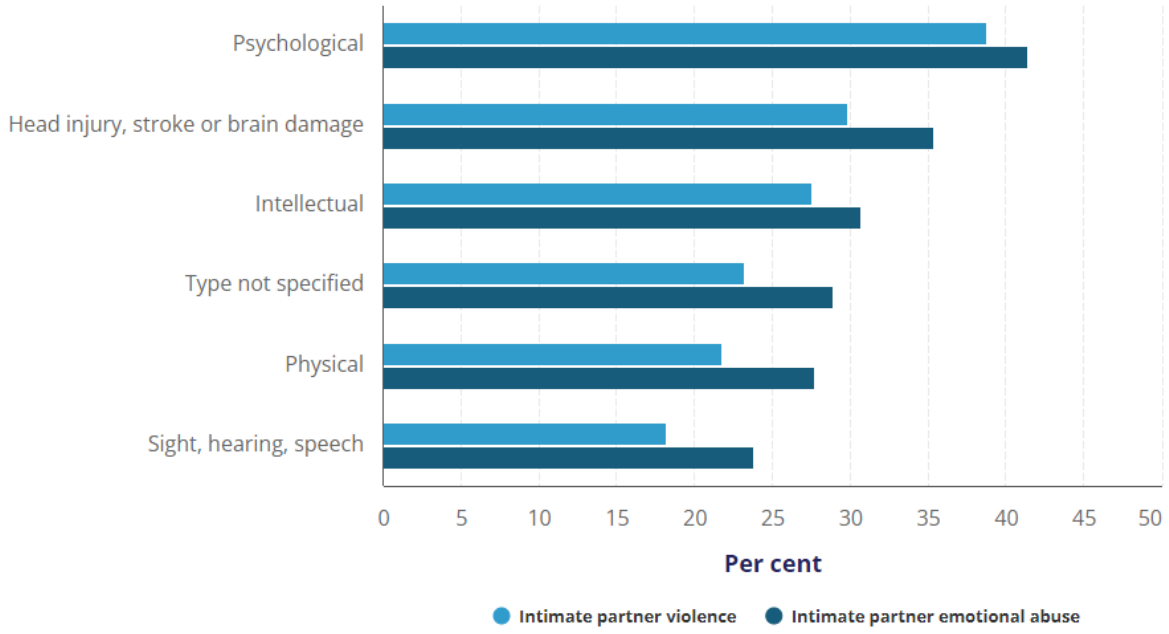
The proportion of adults in 2016 who had experienced **partner emotional abuse** since the age of 15 was higher among:

- adults with disability (26%, or 1.5 million) than adults without disability (17%, or 2.1 million)
- women with disability (32%, or 929,000) than men with disability (20%, or 556,000)
- women with severe or profound disability (39%, or 179,000) than men with severe or profound disability (27%, or 69,900) (AIHW 2022).

Adults with psychological disability (39%) or head injury, stroke or brain damage (30%) in 2016 were the most likely to have experienced intimate partner violence since the age of 15

Some adults with disability in 2016, such as those with psychological disability, were more likely than other adults with disability to have experienced **intimate partner violence** and **partner emotional abuse** since the age of 15 (Figure 2).

Figure 2: The proportion of adults with disability who experienced intimate partner violence and partner emotional abuse since age 15, by type of disability, 2016



Source: ABS PSS 2016 | **Data source overview**

Similarly, the available data from 2021–22 shows that a higher proportion of women with psychosocial disability (6.1% or 37,200) than other women with disability or women without disability (1.5% or 99,400) experienced violence by a cohabiting partner in the 2 years prior to the survey (ABS 2023a).

Types of emotional abuse

The latest available PSS data (2016) shows that adults with disability were more likely than adults without disability to report some types of emotional abuse from their most recent previous partner that was emotionally abusive, including:

- insults intended to cause shame or humiliation (56%, or 668,000 compared with 46%, or 707,000)
- financial abuse (50%, or 591,000 compared with 37%, or 579,000)
- deprivation of basic needs such as food, shelter, sleep or assistive aids (14%, or 172,000 compared with 8%, or 124,000) (AIHW 2019).

Note that more than one type of emotional abuse could be selected thus proportions sum to more than 100% (AIHW 2019).

Adults with disability in 2016 were more likely than adults without disability to report that they had experienced emotional abuse from more than 1 previous partner (24%, or 282,000 compared with 16%, or 244,000) (AIHW 2019).

Sexual violence

The latest available estimates of lifetime experiences of sexual violence and harassment among adults with disability are available from the 2016 PSS. Data from the 2021–22 PSS provide some additional insights into recent experiences of sexual violence and harassment among women with disability.

Adults with severe or profound disability (24%) in 2016 were about 3 times as likely as adults without disability (9.6%) to report they had experienced sexual violence since the age of 15

The proportion of adults in 2016 who had experienced **sexual violence since the age of 15** was higher among:

- adults with disability (16%, or 935,000) than adults without disability (9.6%, or 1.2 million)
- women with disability (25%, or 748,000) than men with disability (6.6%, or 187,000)
- women with severe or profound disability (30%, or 140,000) than men with severe or profound disability (13%, or 32,300) (AIHW 2022).

The proportion of adults in 2016 who had experienced **sexual harassment since the age of 15** was higher among:

- adults with disability (43%, or 2.5 million) than adults without disability (37%, or 4.7 million)
- women with disability (57%, or 1.7 million) than men with disability (28%, or 799,000)
- women with severe or profound disability (58%, or 264,000) than men with severe or profound disability (38%, or 96,400) (AIHW 2022).

The available data on recent experiences from the 2021–22 PSS showed a higher proportion of women with disability reported experiences of:

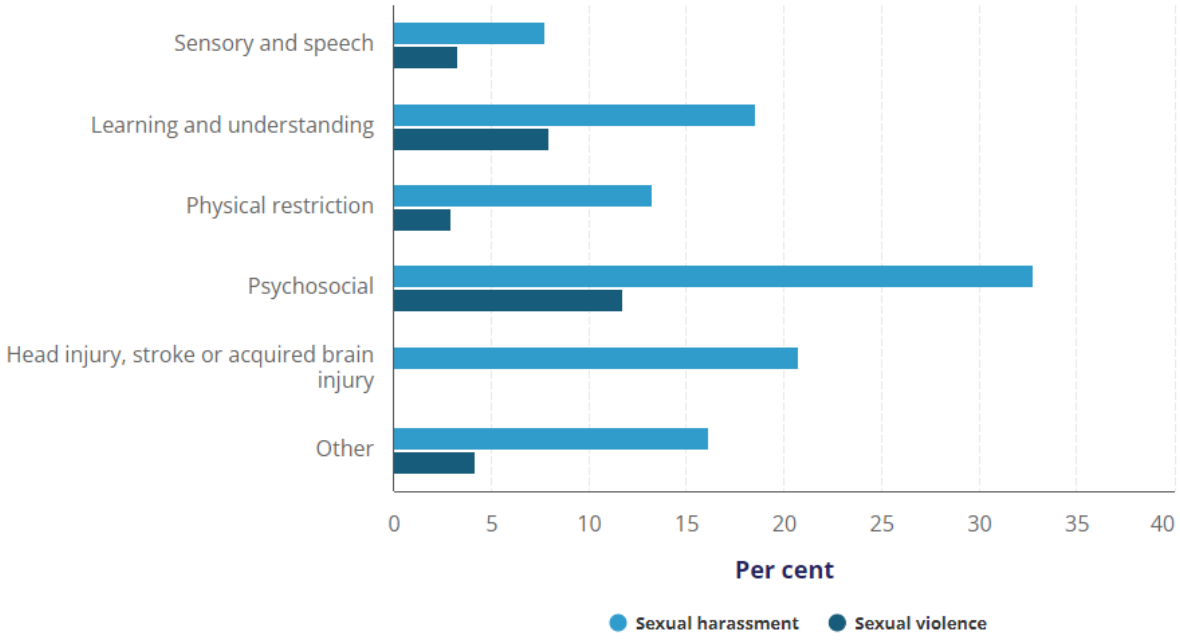
- sexual violence in the last 2 years (4.0%, or 127,000) compared with women without disability (2.5%, or 167,000) (ABS 2023c)
- sexual harassment in the last 12 months (14%, or 459,000) compared with women without disability (12%, or 793,000), with even higher proportions for women with only schooling/employment restrictions (25%, or 98,700) or severe or profound disability (19%, or 78,000) (ABS 2023b).

Data were not available for men with disability (ABS 2023b, 2023c).

Women with psychosocial disability (12%) in 2021–22 were the most likely to have experienced sexual violence in the last 2 years.

Some women with disability in 2021–22, such as those with psychosocial, head injury, stroke or acquired brain injury, or learning and understanding disability, were more likely than other women with disability to have experienced **sexual violence in the last 2 years** or **sexual harassment in the last 12 months** (Figure 3).

Figure 3: The proportion of women with disability who experienced sexual violence in the last 2 years or sexual harassment in the last 12 months, by type of disability, 2021–22



*: estimate has a relative standard error (RSE) between 25% and 50% and should be used with caution.

Source: ABS PSS 2016 | **Data source overview**

While 2021–22 PSS data for men with disability was not available, data from the 2016 PSS shows a similar pattern for men – men with psychological disability were more likely

than other men with disability to have experienced either sexual violence or sexual harassment since the age of 15 (AIHW 2022).

Experiences of sexual abuse before the age of 15

The latest available PSS data (2016) shows that the proportion of adults who had experienced sexual abuse before the age of 15 was higher among:

- adults with disability (12%, or 671,000) than adults without disability (5.8%, or 738,000)
- women with disability (16%, or 477,000) than men with disability (6.9%, or 194,000)
- women with severe or profound disability (22%, or 98,600) than men with severe or profound disability (9.8%*, or 25,200) (AIHW 2022).

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

Adults with psychological disability (21%, or 186,000) or head injury, stroke or brain damage (18%, or 33,500) in 2016 were the most likely to have experienced sexual abuse before the age of 15 (AIHW 2022).

Types of sexual harassment

The latest available PSS data (2016) shows that adults with disability were more likely than adults without disability to report that they had ever experienced some types of sexual harassment, including:

- unwanted touching, grabbing, kissing or fondling (25%, or 1.5 million compared with 20%, or 2.5 million)
- inappropriate comments about body or sex life (24%, or 1.4 million compared with 21%, or 2.7 million)
- indecent exposure (18%, or 1.1 million compared with 14%, or 1.8 million)
- indecent phone call (15%, or 882,000 compared with 10%, or 1.3 million) (AIHW 2022).

Note that more than one type of sexual harassment could be selected thus proportions may sum to more than 100% (AIHW 2022).

Sexual harassment in the workplace

The 2022 Australian Human Rights Commission's national survey on sexual harassment in workplaces (the AHRC national survey) asked people aged 15 and over about their experiences of sexual harassment in workplaces in the previous 5 years. The AHRC included behaviours more commonly associated with sexual violence in their definition of harassment, for example, rape or sexual assault, and determined disability through self-identification.

Nearly half (48%) of people with disability had been sexually harassed in their workplace in the previous 5 years (compared with 32% of people without disability) with:

- over half (54%) of women with disability and nearly 2 in 5 (38%) men with disability

- an increase since 2018 (44% of people with disability, with 52% of women and 35% of men with disability) (AHRC 2022).

See **Sexual violence** for more information.

Technology-facilitated abuse

People with disability were 1.4 times more likely to have experienced technology-facilitated abuse in their lifetime than those without disability in 2022

A nationally representative study of around 4,600 people aged 18 years and over in 2022 investigated experiences of technology-facilitated abuse (TFA) (see **Glossary**) among people who self-identified as having disability. This study estimated that about 3 in 5 (57%) people with disability had experienced any TFA in their lifetime (TFA lifetime victimisation):

- Having disability was a significant predictor of TFA lifetime victimisation, with those with disability 1.4 times more likely than those without.
- A higher proportion of women with disability (59%) than men with disability (55%) reported lifetime TFA victimisation (Powell et al. 2022).

TFA among all people was most commonly perpetrated by intimate partners and was associated with high levels of psychological distress in victim-survivors (Powell et al. 2022).

People with disability (25%) and those without (22%) were similarly likely to have ever perpetrated TFA in their lifetime (lifetime TFA perpetration). Among the whole population, TFA perpetration was much more common when there had been TFA victimisation (39% compared with 6.0%) (Powell et al. 2022).

For information on TFA among all people, see **Stalking and surveillance**.

People with disability as perpetrators of FDSV

There is limited data and research related to the use of FDSV by people with disability. Research about harmful sexual behaviours and the use of family violence among children and young people has indicated that there may be a larger representation of people with disability among people displaying these behaviours in Australia (Fitz-Gibbon et al. 2022; RCIRCSA 2017a). However, more research is required to further investigate these findings. For a discussion of harmful sexual behaviours and adolescent family violence among the general population, see **Child sexual abuse** and **Family and domestic violence**, respectively.

FDSV-related homicide among people with disability

There is limited data available on homicides related to FDSV among people with disability.

The Australian Domestic and Family Violence Death Review Network and Australia's National Research Organisation for Women's Safety collaborated to analyse cases of intimate partner homicides preceded by a reported or anecdotal history of violence between the offender and victim (IPV homicides) between July 2010 and June 2018 (ADFVDRN and ANROWS 2022).

A smaller proportion of both males and females with disability were IPV homicide offenders or victims than the representation of people with disability in the general population (18%). People with disability were only identified among:

- about 1 in 15 female IPV homicide victims of males (or 6.7%)
- about 1 in 11 female IPV homicide offenders who killed a male (or 9.2%)
- about 1 in 12 male IPV homicide victims of females (or 8.5%)
- about 1 in 10 male IPV homicide offenders who killed a female (or 9.3%) (ADFVDRN and ANROWS 2022).

Note that people with disability may have been under-reported in this analysis (see **Data sources and technical notes**).

See **Domestic homicide** for further discussion of homicides related to FDSV.

What are the responses to FDSV for people with disability?

Helplines and related support services

There are a number of general and specialised helplines in Australia that provide information, advice and support to people with disability who are experiencing or at risk of FDSV. See **Helplines and related support services** for a discussion of such services including but not limited to:

- the National Counselling and Referral Service, which provides counselling, information, support and referrals to services for people with disability who have witnessed or experienced violence, abuse, neglect and exploitation
- the Blue Knot Foundation, a support service for people affected by complex trauma and a National Redress Scheme service provider (Blue Knot Foundation 2021).

The National Disability Abuse and Neglect Hotline is a service for reporting any abuse and neglect, not limited to FDV, of people with disability, see Box 6 for further discussion.

Box 6: The National Disability Abuse and Neglect Hotline

The National Disability Abuse and Neglect Hotline is a free, independent and confidential reporting service. The Hotline enables anyone to report instances of abuse and neglect among people with disability in any circumstance (not limited to FDV). The Hotline works with callers to find appropriate ways of dealing with reports of maltreatment (for example, referring cases to complaints handling bodies). Between 2017 and 2022:

- reports have generally increased, from 249 in 2017 to 480 in 2020, with 413 in 2022
- reports of sexual abuse ranged between 8 in 2019 and 23 in 2021, with 15 in 2022

Multiple reports can relate to a single victim–survivor and data are not available on whether reports are related to FDV (DSS 2023).

Police responses

The Royal Commission into violence, abuse, neglect and exploitation of people with disability received reports that people with disability are disproportionately represented as victims, offenders and witnesses in the criminal justice system (Dowse et al. 2021).

However, due to long standing challenges and gaps in the collection of disability status in existing data collections, there is limited data available on FDSV-related recorded crimes among people with disability (Ringland et al. 2022a). One method to fill these gaps in data is to link data related to recorded crimes with data that identifies people with disability. Data linkage has recently been used in a test pilot of the National Disability Data Asset to investigate recorded crime among people with disability in NSW, see Box 7.

Box 7: Recorded crime victimisation and offending among people with disability in NSW

The National Disability Data Asset pilot Justice Test Case used victim and offending data held by the NSW Bureau of Crime Statistics and Research linked with other State and Commonwealth administrative data collections to examine the interaction between people with disability and the NSW crime and justice system (CJS). Disability was defined using administrative records of disability-specific service use. People with disability may have been included in the study but not identified as having a disability if they did not have records of disability-specific service use. This may result in an under-representation of people with disability that interact with the NSW CJS in this study.

Among recorded domestic violence-related crimes in NSW:

- people with disability were about 3 times as likely to be victims as the general population for every year between 2009 and 2018, with age and sex standardised rates among people with disability ranging between around 1,800 to 2,000 per 100,000 people compared with between 660 to 710 per 100,000 for the general population (Ringland et al. 2022b)
- about 1 in 23 (4.4%) people with disability were victims between 2014 and 2018, with a higher proportion of Aboriginal females with disability (19%) than Aboriginal males with disability (8.6%), non-Aboriginal females with disability (5.0%) and non-Aboriginal males with disability (2.6%) (Ringland et al. 2022a)
- persons of interest were proceeded against in a lower proportion of incidents involving people who had both cognitive and physical disability (51%) than people without disability (58%) between 2014 and 2018, with a smaller difference for people with disability in general (56%) (Ringland et al. 2022a)

- a higher proportion of people with disability (25%) experienced revictimisation within 12 months than those without disability (20%) between 2014 and 2018, with people with psychosocial disability the most likely (29%) to experience revictimisation (Ringland et al. 2022a)
- people with disability were more than 3 times as likely to be offenders than the general population every year between 2009 and 2018, with age and sex standardised rates increasing over time from around 630 to 1,100 per 100,000 compared with 200 to 340 per 100,000 in the general population (Ringland et al. 2022b).

Specialist homelessness services

Specialist homelessness services (SHS) can provide assistance to people who are experiencing or at risk of homelessness, including clients who have experienced FDV. The SHS Collection identifies disability using a shortened version of the AIHW Standardised Disability Flag module. This enables reporting on SHS use and outcomes among people with disability (AIHW 2024).

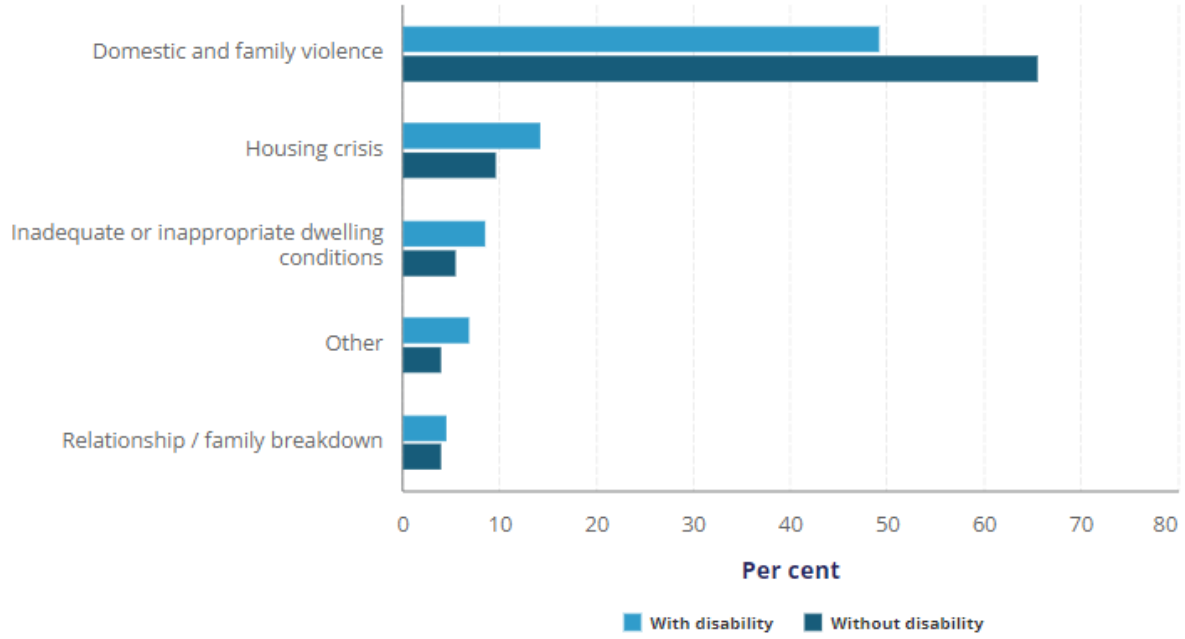
About 25,900 people with disability were SHS clients (9.5% of all SHS clients) in 2022–23 (AIHW 2023b). Of these, about 1 in 3 (31% or about 8,100) SHS clients with disability had experienced FDV, representing:

- 43% (or 5,900) of female SHS clients with disability
- 18% (or 2,200) of male SHS clients with disability (AIHW 2023b).

A smaller proportion of SHS clients with disability had experienced FDV (31%) than SHS clients without disability (38%) (AIHW 2023b).

The main reason that SHS clients with disability who had experienced FDV sought SHS support was domestic and family violence (49%) followed by housing crisis (14%). People with disability who had experienced FDV were less likely than those without disability to report domestic and family violence as their main reason but more likely to report other main reasons (Figure 4).

Figure 4: Top 5 main reasons SHS clients with and without disability who have experienced domestic and family violence sought support, 2022–23



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

From 2013–14 to 2022–23, the proportion of SHS clients who have experienced FDV who had disability has varied between 5.9% in 2013–14 (or about 5,000 clients) and 8.3% in 2016–17 (or 9,500), with 7.7% in 2022–23 (or 8,100) (AIHW 2023b).

Housing outcomes

Fewer specialist homelessness services clients with disability who have experienced FDV were homeless by the end of support (about 1,500) compared with at the start of support (about 2,000) in 2022–23

Many clients who are supported by SHS have achieved or progressed towards a more positive housing situation by the end of their support. Among SHS clients with disability who have experienced FDV and whose ongoing SHS support ended in 2022–23:

- fewer clients were homeless at the end of support (about 1,500) compared with their first period of support in 2022–23 (about 2,000)
- more clients were housed at the end of support (about 2,800) compared with their first period of support in 2022–23 (about 2,300) (AIHW 2023b).

For information about all people who use SHS services and have experienced FDV, see **Housing**.

Has it changed over time?

PSS data on the rate of experiences of FDSV among people with disability in the 12 months prior to the survey (the 12-month prevalence rate) can be used to report on changes over time. Comparing 2012 with 2016, among people with disability, the 12-month prevalence rate of:

- **sexual violence** was stable (1.3% and 1.4%, respectively), with a lower rate among adults without disability in 2012 (0.6%) and a similar rate in 2016 (1.2%)
- **sexual harassment** increased from 12% to 15%, with lower rates among adults without disability (10% in 2012 and 13% in 2016)
- **intimate partner violence** was relatively stable (1.9% and 2.4%, respectively), with a similar rate among adults without disability in 2012 (1.4%) and a lower rate among adults without disability in 2016 (1.4%)
- **emotional abuse by a partner** increased from 4.5% to 5.6%, with lower rates among adults without disability (3.4% and 4.0%, respectively) (ABS 2021).

Data for the 12-month prevalence rate of sexual harassment among women with disability was also available for 2021–22. The prevalence rate remained similar between 2012 (17%) and 2016 (19%) and decreased in 2021–22 (14%). This is consistent with results for the general population (ABS 2021, 2023b). Data for the 12-month prevalence rate of intimate partner violence and emotional abuse by a partner among women with disability are not available for 2021–22 (ABS 2023a).

These changes over time may be due to a number of reasons. The most recent PSS was conducted between March 2021 and May 2022, during the COVID-19 pandemic. We are continuing to learn about the effects of the COVID-19 pandemic on FDSV, which first occurred in Australia between March to April 2020. The 2-year period following the onset of the pandemic involved many changes to people's living circumstances. These changes, and the potential flow-on effects to a person's likelihood of experiencing violence, are discussed in more detail in **FDSV and COVID-19**.

Is it the same for everyone?

People from diverse sociodemographic and cultural groups can have disability, and experiences of violence can occur in intersecting ways (see **Factors associated with FDSV**). National data on these intersections are limited, for example there are no national data on violence among people with disability who live in institutional and/or other care settings. The Royal Commission into violence, abuse, neglect and exploitation of people with disability (the Royal Commission) collected recent research about FDSV among diverse population groups and heard from people and organisations about these issues.

For a general discussion of FDSV among specific population groups, see **Population groups**.

First Nations people with disability

While there is limited national data specific to experiences of FDSV among First Nations people (Aboriginal and Torres Strait Islander people) with disability, available research shows that:

- there is a higher proportion of people with disability or a restrictive long-term health condition among First Nations people (estimated to be 45% in 2014–15) compared with the general population (18%) (ABS 2016)
- it is likely that First Nations people with disability experience intersectional discrimination and disadvantage, which can increase the risk of experiencing FDSV and restrict access to support (AHRC 2020; RCVANEPD 2020b)
- First Nations women with disability are likely to experience high rates of emotionally abusive, harassing and controlling behaviours and are more likely than non-Indigenous women with disability to experience domestic physical or sexual violence, and coercive control (Boxall et al. 2021).

Culturally and linguistically diverse people with disability

Respondents to a public hearing for the Royal Commission highlighted the following about experiences of FDV among culturally and linguistically diverse people with disability:

- There can be many barriers to reporting violence, including lack of knowledge about processes in Australia, fear of authority and discrimination, and entrenched attitudes towards women and their roles in families (RCVANEPD 2021b).
- a lack of specialised, trauma-informed staff, support workers and processes can prevent people from engaging with the criminal justice system or influence the outcomes received (RCVANEPD 2021b).
- a survey of recent violence during the pandemic found that women with disability from non-English speaking backgrounds were more likely than those from English speaking backgrounds to have experienced domestic physical or sexual violence, and coercive control (Boxall et al. 2021).

LGBTIQA+ people with disability

A report commissioned by the Royal Commission in 2019 used data from 2 national non-representative surveys of LGBTIQ (lesbian, gay, bisexual, transgender, intersex, queer, asexual people, or people otherwise diverse in gender, sex or sexual orientation) young people and adults, *Private Lives 3* and *Writing Themselves In 4, to* provide some insights into violence, abuse, neglect and exploitation among LGBTIQ people with disability. There was not a sufficient number of participants with disability with an intersex variation in either survey for the data to reflect their experiences. *Private lives 3* included about 2,600 people identified as having disability through the AIHW Standardised Disability Flag module and *Writing Themselves in 4* included 2,500 people who self-identified as having disability or a long-term health condition (Hill et al. 2022). The report found that:

- about 1 in 3 (32%) respondents with disability aged 14–21 experienced sexual harassment or assault in the previous 12 months due to their sexual orientation or gender identity
- a higher proportion of adult respondents with severe (16%) or moderate (11%) disability reported experiencing sexual assault in the previous 12 months than respondents without disability (6.7%)
- most adult respondents with severe (73%), moderate (69%) or mild (67%) disability reported experiencing violence from an intimate partner in their lifetime, compared with 55% of respondents without disability
- most adult respondents with severe (81%), moderate (78%) or mild (69%) disability reported experiencing violence from a family member in their lifetime, compared with 55% of respondents without disability
- FDSV was experienced by a higher proportion of adult respondents with disability from multicultural backgrounds, living in rural or remote areas, or who were trans or gender diverse compared with other groups (Hill et al. 2022).

Younger and older people with disability

Children, young people and older people can experience higher rates of FDSV than people of other ages and are additionally affected by particular forms of FDSV. Studies have shown that those with disability are at an even greater risk than those without:

- Twice as many people aged 65 years or over who self-identified as having disability or long-term health conditions (21%) experienced any form of **elder abuse** in the previous 12 months in 2020 compared with those without disability or long-term health condition (9.8%) (Qu et al. 2021).
- About twice as many adults with disability in 2016 had experienced sexual abuse by any perpetrator (12%) or physical and/or sexual abuse by a parent/step-parent (10%) **before the age of 15** compared with those without disability (5.8% and 5.4%, respectively) (AIHW 2022).

The second wave of the Australian Child Maltreatment Study aims to collect representative data for people with disability in Australia to allow estimates of child maltreatment to be reported for this group. The second wave should run from 2024 to 2025 (DPMC 2021).

Children who are considered unable to live safely with their families may be placed in out-of-home care. Children, and in particular children with disability, can be at risk of abuse in care (RCIRCSA 2017b). While there is limited data related to children with disability available, children with disability are thought to be significantly over-represented in out-of-home care. Disability status was only recorded for 71% (32,300) of children in out-of-home care in 2021–22. Among these children, 29% (9,300) were recorded as having disability (AIHW 2023a). For a discussion of child protection data related to the general population, see **Child protection**.

Related material

- Children and young people
- Older people
- Sexual violence
- Who uses violence?
- Helplines and related support services

More information

- People with disability in Australia – Violence against people with disability
- Family, domestic and sexual violence in Australia: continuing the national story 2019
- Family, domestic and sexual violence data in Australia
- National sexual violence responses
- Family, domestic and sexual violence: National data landscape 2022
- Specialist Homelessness Services, annual report 2021–22
- National Hospital Morbidity Dataset

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LGBTIQA+ people

Key findings

Of respondents to the 2019 Private Lives 3 survey:

- 1 in 2 (49%) had ever experienced sexual assault
- 3 in 5 (61%) had ever experienced violence from an intimate partner
- 8 in 10 (81%) with severe disability had ever experienced family violence.

The term LGBTIQA+ is used to refer to lesbian, gay, bisexual, transgender, intersex, queer, asexual people, or people otherwise diverse in gender, sexual orientation and/or innate variations of sex characteristics. Alternative abbreviations may be used in data sources when discussing specific groups within LGBTIQA+ populations.

Research indicates that most LGBTIQA+ people experience some form of violence in intimate partner and/or family relationships in their lifetime. The impacts of these experiences are profound, far-reaching and compounded by stigma, prejudice and discrimination towards LGBTIQA+ people. The drivers of violence are often the same as those identified for violence against women (AHRC 2015; Campo and Tayton 2015; DSS 2022; Hill et. al 2020).

LGBTIQA+ people are recognised as population groups that experience health and wellbeing disparities due to stigma and discrimination. The *National Plan to End Violence against Women and their Children 2022–2032* (the National Plan) recommends increased attention to LGBTIQA+ populations to address the high prevalence of violence against LGBTIQA+ people (Campo and Tayton 2015; DSS 2022; Hill et al. 2020).

LGBTIQA+ language

People may use a wide range of terms to describe gender, sexual orientation and innate variations of sex characteristics, and some people may not identify with or use certain terms (Box 1). The terms and language used by LGBTIQA+ people to define their identity are influenced by many factors, including their age, ethnicity, socioeconomic position, and their lived experiences and relationships with others (AIHW 2018).

While reporting on LGBTIQA+ people together provides useful high-level insights, it conceals diversity within the group. It is important to note that there are many factors that can combine to create a risk and experience of violence that is unique to each person, and an individual included in the term LGBTIQA+ may not identify as being part of any single group.

Box 1: LGBTIQA+ terminology

Asexual: A sexual orientation that reflects little to no sexual attraction. People who identify as asexual can still experience romantic attraction.

Bisexual/bi: A sexual orientation that reflects sexual and/or romantic attraction towards 2 or more genders. Bisexuality is not exclusive to binary genders.

Brotherboy/brothaboy: A term used by some Aboriginal and Torres Strait Islander (First Nations) communities to describe gender diverse First Nations people who have a male spirit and take on male roles within the community.

Cisgender: The cisgender (cis) experience of gender is defined for persons whose gender is the same as what was presumed for them at birth.

Gay: A sexual orientation that describes sexual and/or romantic attraction towards people of the same gender. This term is most commonly applied to men, although some women use this term.

Gender/gender identity: Gender is a social and cultural concept. It is about social and cultural identity, expression and experience as a man, woman or non-binary person. Gender identity is about who a person feels themself to be. Gender expression is the way a person expresses their gender; person's gender expression may also vary depending on the context, for instance expressing different genders at work and home. Gender experience describes a person's alignment with the gender presumed for them at birth, i.e. a cis experience or a trans experience.

Heterosexual: A sexual orientation towards people of a different gender.

Intersex: Intersex refers to people with innate genetic, hormonal or physical sex characteristics that do not conform to medical norms for female or male bodies. This is also called 'variations of sex characteristics'. Intersex does not refer to a particular gender identity or sexual orientation; intersex people old enough to freely express an identity may be heterosexual or not, and cisgender or not.

Lesbian: A sexual orientation most often used by women whose primary sexual and/or romantic attraction is to other women.

Non-binary: Non-binary is an umbrella term describing gender identities that are not exclusively male or female.

Pansexual: A sexual orientation not restricted by gender. Pansexuality can include sexual and/or romantic attraction towards any person, regardless of their gender.

Queer: A term used to describe a range of sexual orientations and gender identities. For some it is a reclaimed derogatory term and represents a political movement that celebrates difference, although it is still sometimes used against non-heterosexual and non-cisgender people in a derogatory manner and considered derogatory by many older LGBTIQA+ people.

Sex: A person's sex is based upon their sex characteristics, such as their chromosomes, hormones and reproductive organs. While typically based upon the sex characteristics observed and recorded at birth or infancy, a person's sex can change over the course of their lifetime and may differ from their sex recorded at birth.

Sexual orientation: An umbrella concept that encapsulates: sexual identity (how a person thinks of their sexuality and the terms they identify with), attraction (romantic or sexual interest in another person), and behaviour (sexual behaviour). It is a subjective view of oneself and can change over the course of their lifetime and in different contexts.

Sistergirl/sistagirl: A term used by some First Nations communities to describe gender diverse First Nations people who have a female spirit and take on female roles within the community.

Trans and gender diverse (trans): The trans and gender diverse (trans) experience of gender is defined for persons whose gender is different to what was presumed for them at birth.

Variations of sex characteristics: See 'Intersex'.

Sources: ABS 2021; AIFS 2022; DSS 2022; IHRA 2021.

What do we know?

Measuring violence experienced by LGBTIQA+ people

National reporting on the health and wellbeing of LGBTIQA+ people is often limited by a lack of data on gender, sexual orientation and innate variations of sex characteristics in data collections. Where data are available, it most often refers to people who identify as gay, bisexual, or heterosexual. Certain groups such as trans, asexual and intersex people remain under-researched and -reported; and current data do not fully describe the complexities and diversities among LGBTIQA+ people (AIHW 2018; Campo and Tayton 2015; DSS 2022).

The Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020 was developed by the Australian Bureau of Statistics (ABS) to standardise the collection and dissemination of data relating to sex, gender, variations of sex characteristics and sexual orientation. Work to implement the standard in national surveys has commenced and will improve the availability of data on LGBTIQA+ people (ABS 2021). In particular, the 2021–22 ABS Personal Safety Survey (PSS) collected data on sexual orientation for the first time to support understanding of the prevalence of FDSV among people with different sexual identities (ABS 2023b; see Box 3). Implementation of the standard is also being considered in national administrative data collections. For example, there was national agreement to collect and supply data on the gender of people admitted to Australian hospitals from 2022–23 (see Admitted Patient Care National Minimum Data Set).

The terms and abbreviations used to describe LGBTIQA+ people can vary depending on the groups or topics being discussed, and the ways in which data are collected. Unless otherwise stated, the AIHW's FDSV reporting uses the terms and abbreviations used by the data source – for example, where data sources have data only for LGBT people, this terminology has been used within this topic page.

Similarly, the terms used to describe a person's sex or gender will depend on how this information is collected in a particular data source. This means that binary language is often used in the AIHW's FDSV reporting to describe data. The AIHW recognises that binary language does not represent the experiences of all people, and that some people, particularly gender diverse people, may not identify with these terms. Specific

information about how sex and/or gender are collected in each data source, is included in **Data sources and technical notes**, where available.

What distinct forms of violence are experienced by LGBTIQA+ people?

Discrimination against LGBTIQA+ people may increase their risk of experiencing distinct forms of family, domestic and/or sexual violence (FDSV) when compared with other population groups. However, some LGBTIQA+ people can experience distinct forms of violence that may be referred to as identity-based abuse. Identity-based abuse may include behaviours such as:

- pressuring a person to conform to gender norms or stop them from accessing gender affirming care
- corrective rape (a hate crime in which the victim is raped because of their perceived sexual orientation)
- threatening to 'out' the person's gender, sexuality, HIV status or intersex status
- exiling a person from family due to their sexuality or gender
- forcing a family member into conversion therapy (DSS 2022).

Intersex people may also experience body shaming, along with forced and coercive medical interventions and body modifications in childhood and adulthood, as a result of stigma and misconceptions about intersex variations (DSS 2022).

Additionally, a lack of understanding of these issues by support services may present unique barriers to accessing support for LGBTIQA+ people (Cullen et al. 2022; DSS 2022).

What do the data tell us?

The main data source used in this topic page is the La Trobe University Private Lives 3 survey (see Box 2).

Box 2: How did the Private Lives 3 survey ask respondents about FDSV?

La Trobe University's research series, Private Lives, is currently the largest national survey focussed on the health and wellbeing of LGBTIQ people. In 2019, Private Lives 3 collected FDSV data from 6,835 LGBTIQ respondents aged 18 to 80+ years from a wide range of gender identities and sexual orientations. As the survey uses a non-probability convenience sample, the results may not be representative of the Australian LGBTIQA+ population and cannot be generalised to this population group. Comparative data was not available for all groups due to data limitations (Hill et al. 2020).

Whilst this survey included participants with an intersex variation/s, the data are not able to be disaggregated by this category and, therefore, the acronym LGBTQ+ is used when referring to the Private Lives 3 results. For more information see **Data sources and technical notes**.

The survey included questions about family violence and intimate partner violence. Family violence was described as abuse by a family member(s), including both birth and chosen family. Intimate partner violence was described as abuse by a partner(s) in an intimate relationship, noting that intimate relationships may be either sexual or not sexual in nature (Hill et al. 2020).

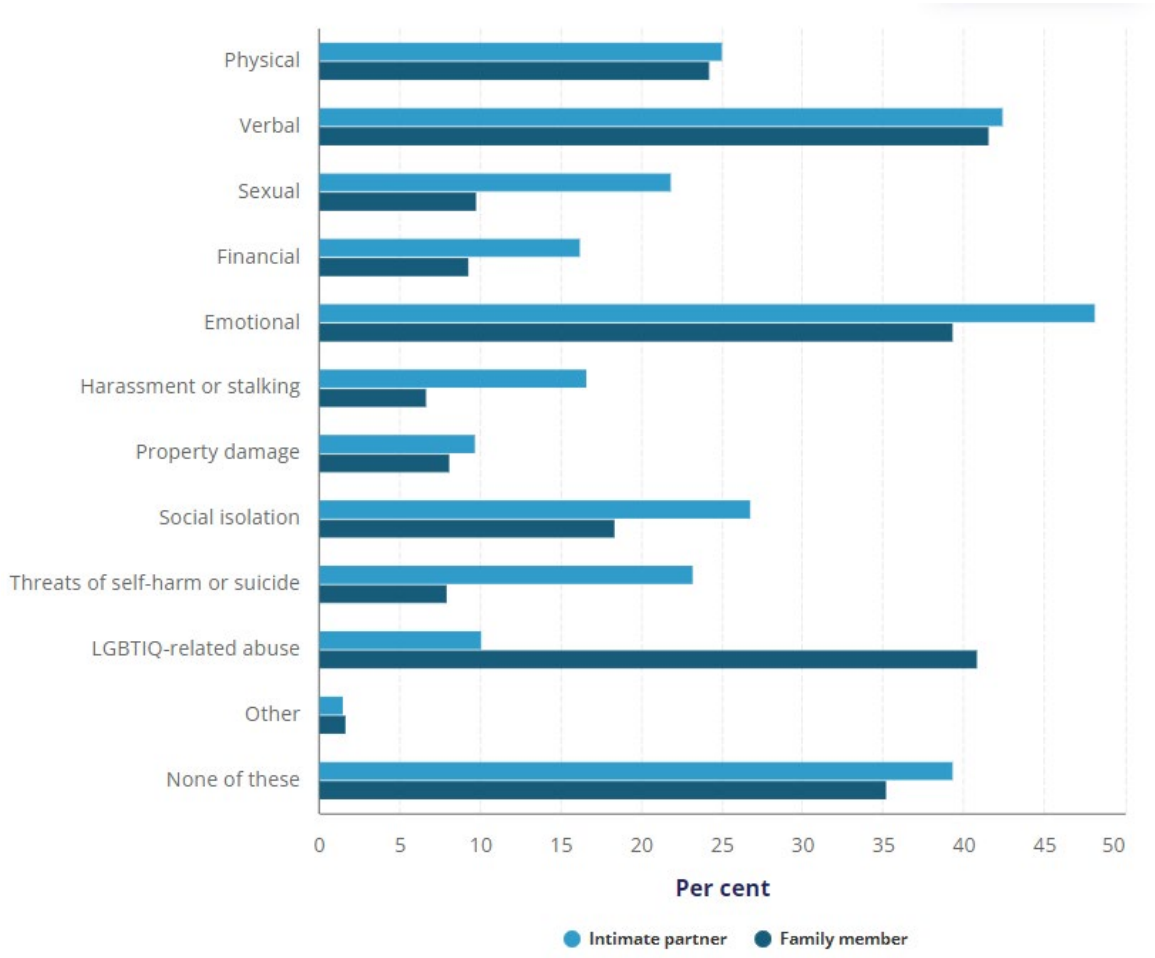
Respondents were provided with a list of specific violent behaviours and asked to indicate whether they had ever experienced them from intimate partners or family members. This included: physical violence, sexual assault, verbal abuse, emotional abuse, financial abuse, harassment or stalking, damage to property, social isolation, threats of suicide and self-harm, LGBTIQ-related abuse, and other. 'LGBTIQ-related abuse' included: shamed you about being LGBTIQ, threatened to 'out' you or your HIV status, or withheld hormones or medication (Hill et al. 2020).

Compared to when asked more generally if they had ever experienced violence, when these specific forms of violence were explicitly listed, the proportion of people who reported having ever experienced violence increased from 42% to 61% for intimate partner violence, and from 39% to 65% for family violence (Hill et al. 2020). FDSV is often a highly personalised experience and may not be recognised or reported as abuse by the individual.

Intimate partner violence and family violence

In 2019, 3 in 5 (61%) respondents to the Private Lives 3 survey had ever experienced intimate partner violence. Emotional abuse (48%), verbal abuse (42%), and social isolation (27%) were the most commonly reported types of intimate partner violence experienced (Figure 1). Cisgender men (57%) were the most common perpetrator, followed by cisgender women (35%) (Hill et al. 2020).

Figure 1: Types of intimate partner and family violence ever experienced by LGBTQ+ people, by perpetrator type, 2019



Source: La Trobe University Private Lives 3 survey | **Data source overview**

Similarly, 2 in 3 (65%) respondents had ever experienced family violence, not including intimate partner violence. Verbal abuse (42%), LGBTIQ-related abuse (41%), and emotional abuse (39%) were the most common types of violence experienced from a family member (Figure 1). Almost 3 in 4 (73%) indicated the perpetrator of family violence was a parent (including guardian, foster carer, step-parent, or adoptive parent (Hill et al. 2020).

Respondents overall were more likely to experience violence from intimate partners than family members for all forms of violence, except LGBTIQ-related abuse, where 41% indicated abuse occurred from a family member, compared with 10% from an intimate partner (Hill et al. 2020).

There was some variation in experiences of violence by gender:

- Non-binary respondents consistently indicated higher proportions of violence by any perpetrator when compared to other gender identities. This was consistent across

all types of violence except for verbal violence perpetrated by a family member, which was highest for transgender men.

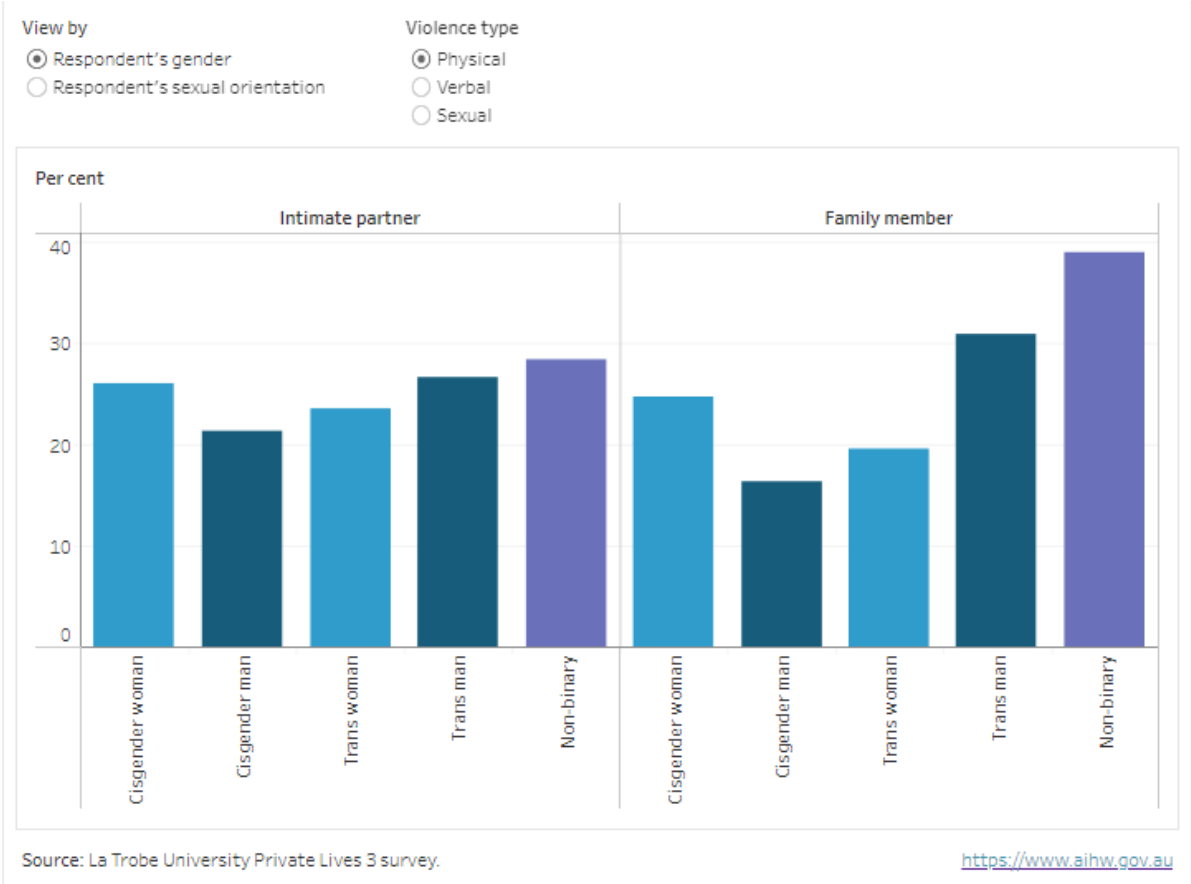
- Transgender men had the second highest proportion of violence by type of violence and perpetrator, followed by cisgender women, trans women and cisgender men.
- Cisgender men reported the lowest rates of violence across all types of violence by any perpetrator (Figure 2).

Overall, experiences of violence by sexual orientation varied depending on the type of violence:

- Verbal violence was the most common type of violence experienced for all sexual orientations, regardless of perpetrator type.
- All types of violence, regardless of perpetrator, were most commonly experienced by pansexual and queer respondents (Figure 2).

Broadly speaking, respondents who identified as lesbian or gay were more likely to experience physical or verbal violence from an intimate partner than from a family member. Conversely, respondents who identified as bisexual, pansexual, queer, asexual or something else experienced physical and verbal violence at higher levels from family members than intimate partners (Hill et al. 2020).

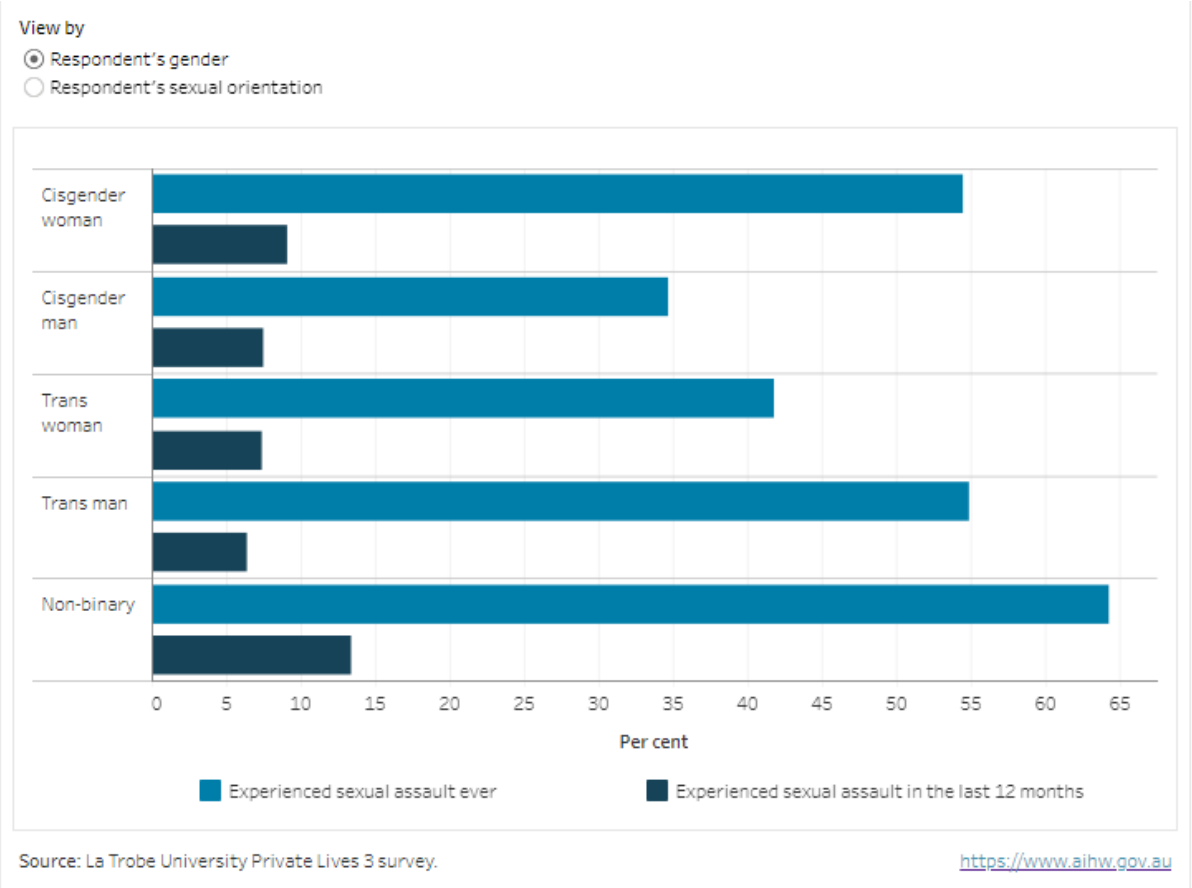
Figure 2: Types of intimate partner and family violence ever experienced, by gender, sexual orientation and perpetrator type, 2019



Sexual assault

Almost half of all respondents (49%) to the Private Lives 3 survey indicated having ever experienced sexual assault and 8.9% had experienced sexual assault in the past 12 months (Hill et al. 2020).

Figure 3: Experience of sexual assault, by gender and sexual orientation, 2019



The majority of queer, pansexual and bisexual identifying respondents had experienced sexual assault in their lifetime. Additionally, a large proportion of lesbian (46%), asexual (45%) and gay (34%) respondents had experienced sexual assault at some point in their life (Figure 3).

The majority of non-binary, cisgender women and trans men had experienced sexual assault in their lifetime. Additionally, many trans women (42%) and cisgender men (35%) had experienced sexual assault at some point in their lifetime (Figure 3).

For the most recent sexual assault, the perpetrator was most commonly identified as a former intimate partner (22%), current intimate partner (19%), friend (19%), casual encounter (19%) or stranger (18%).

The most common gender of perpetrator of the most recent incident of sexual assault were cisgender men (84%). Perpetrators were also identified as cisgender women (14%), non-binary people (1.8%), trans women (1.3%) and trans men (1.2%).

Box 3: Data available from the Personal Safety Survey

For the first time, the 2021–22 PSS collected data on sexual orientation. Some 2021–22 data were available on women aged 18 years and older who had experienced sexual violence (which includes sexual assault and sexual threat), and cohabiting partner violence and

emotional abuse (which includes any violence from someone the person lives with or lived with in a married or de facto relationship). Data for other groups of people were not sufficiently statistically reliable for reporting (ABS 2023a, 2023c).

The 2021–22 PSS estimated that:

- LGB+ women were over 5 times more likely than heterosexual women to have experienced sexual violence in the past 2 years (13% compared with 2.4%)
- for the vast majority of LGB+ and heterosexual women who had experienced sexual violence in the last 2 years (98% for both groups), the perpetrator was male (ABS 2023c).

There were no statistically significant differences between LGB+ and heterosexual women in the experience of violence or emotional abuse by a cohabiting partner in the last 2 years:

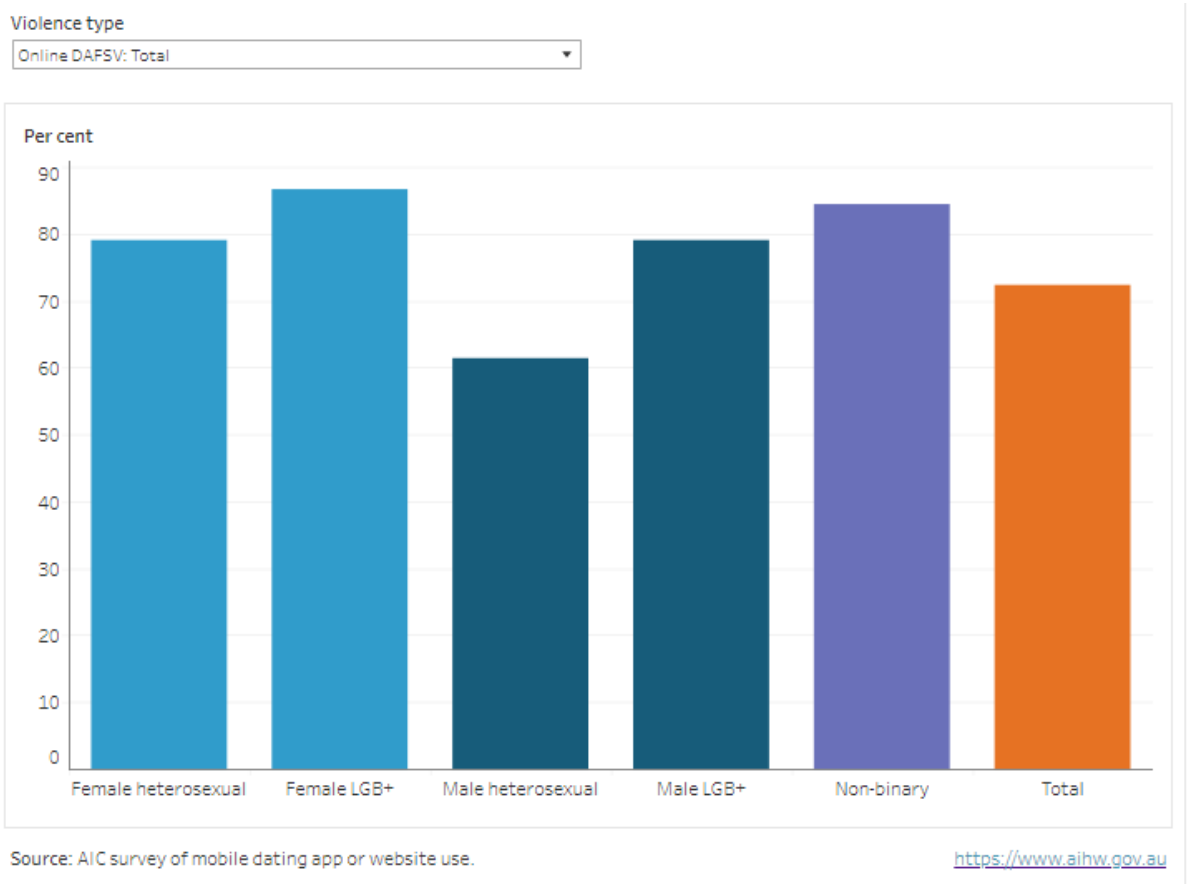
- violence by a cohabiting partner in the last 2 years was experienced by 3.9%* of LGB+ women and 1.6% of heterosexual women (* indicates the estimate has a relative standard error of 25% to 50% and should be used with caution)
- emotional abuse by a cohabiting partner in the last 2 years was experienced by 7.1% of LGB+ women and 5.2% of heterosexual women (ABS 2023a).

Technology-facilitated violence

The Office of the eSafety Commissioner surveyed more than 3,700 Australian adults aged 18 to 65 on general online safety. The report from eSafety identified LGBTQI+ people as an at risk group for serious online abuse. One in 3 (36%) lesbian, gay and bisexual people reported experiences of image-based abuse compared with 1 in 5 (21%) heterosexual people in Australia. The survey concluded that cyber abuse, image-based abuse and homophobic or transphobic abuse disproportionately affected young LGBTQI+ people (eSafety 2020).

Additionally, a series of research papers from the Australian Institute of Criminology (AIC) examined dating app-facilitated sexual violence (DAFSV), and the disproportionate impact this has on non-heterosexual people. DAFSV is described as sexual harassment, aggression and other violence that occurs online, or facilitates in-person violence. In 2021, almost 10,000 people aged 18 and older who had used a mobile dating app or website in the last five years were surveyed, of which 1,613 identified as lesbian, gay, bisexual, pansexual or not heterosexual (LGB+) (Lawler and Boxall 2023; Teunissen et al. 2022; Wolbers et al. 2022). Among all respondents, almost 3 in 4 (73%) had experienced at least one form of online and/or in-person DAFSV within the last 5 years, and around half (45%) said they had experienced both. The occurrence of violence was especially high for LGB+ women and men, followed by non-binary people and heterosexual women, when compared with heterosexual men. LGB+ respondents were more likely to experience violence online than in-person, and sexual harassment was the most commonly reported type of online violence (Figure 4) (Wolbers et al. 2022). See also **Stalking and surveillance**.

Figure 4: Experience of online and in-person dating app-facilitated sexual violence (DAFSV) in the last 5 years, by gender and sexual orientation, 2021



Source: AIC survey of mobile dating app or website use. https://www.aihw.gov.au

The survey also found:

- Despite disproportionate levels of DAFSV, LGB+ women and men had much lower rates of reporting their most recent experience to police when compared with heterosexual men.
- When DAFSV was reported to police, LGB+ men and women were more likely to report negative experiences than their heterosexual counterparts. See also **FDV reported to police** and **Sexual assault reported to the police**.
- Across all groups, LGB+ men were most likely to report they had received requests for child sexual exploitation materials while using dating apps/websites. Inappropriate requests may include asking for photos of children, questions about children of a sexual nature or offering payment for image-based content of children. This does not mean that these respondents perpetrated child sexual exploitation. The gender of the person requesting content cannot be determined from the data provided (Lawler and Boxall 2023; Teunissen et al. 2022; Wolbers et al. 2022).

Lesbian and bisexual women

There are often complex ways in which the drivers of violence against women and the drivers of violence against LGBTIQA+ people intersect; particularly regarding the binary and rigid constructions of gender (DSS 2022). Previous studies of FDSV in the general

population have largely focused on heterosexual women and pose challenges for making valid comparisons with LGBTIQA+ communities.

A comparative analysis of almost 9,000 women from the 2003 Australian Longitudinal Study on Women's Health (ALSWH, see **Data sources and technical notes**) provides some insight into experiences of violence for lesbian, bisexual and mainly heterosexual women compared with exclusively heterosexual women. The data do not indicate the gender of perpetrators of violence (AIHW 2019; Szalacha et al. 2017).

One in 4 (25%) women who identified as bisexual or mainly heterosexual, and roughly 1 in 6 (15%) women who identified as lesbian, reported that they had ever been in a violent relationship, compared with 1 in 10 (10%) women who identified as exclusively heterosexual (AIHW 2019; Szalacha et al. 2017).

Bisexual women reported higher proportions across all types of violence (emotional, physical, sexual abuse and sexual harassment) and were more likely to experience stress, anxiety, depression and poor mental health, when compared with women who identified as lesbian, mostly heterosexual, or exclusively heterosexual (AIHW 2019; Szalacha et al. 2017).

Regardless of sexual orientation, emotional abuse was the most commonly reported type of violence. When compared with exclusively heterosexual women, women who identified as bisexual, lesbian or mostly heterosexual were:

- 2 to 3 times as likely to have been in a violent relationship in the past 3 years
- twice as likely to report physical abuse by a partner (AIHW 2019; Szalacha et al. 2017).

Gay, bisexual, transgender, intersex and queer men

In 2017–18, University of Western Sydney and ACON, surveyed almost 900 gay, bisexual, transgender, intersex and queer men on sexual and gender identity; experiences of intimate partner violence; attitudes to violence; and bystander awareness and willingness to intervene.

Of the men surveyed in 2017-18, 3 in 5 (62%, or 556) reported that they had experienced physical, verbal or emotional abuse in a relationship, and almost 1 in 4 (26%, or 138) had experienced abuse within the last year (Ovenden et al. 2019).

Respondents most commonly reported that they had discussed their abusive relationship with:

- a friend or neighbour (35%)
- counsellor or psychologist (18%)
- family or relative (17%).

However, 1 in 6 (17%) did not discuss their experience of abuse with anyone (Ovenden et al. 2019).

Around 2 in 5 (43%) respondents reported witnessing violence or abuse between men in a relationship, of which, over three quarters intervened in some way. The form of

intervention was most commonly verbal (41%), followed by physical (14%), and sought help (13%). About 1 in 4 (23%) did not know what to do while 1 in 8 (13%) did not intervene (Ovenden et al. 2019).

Services and support seeking-behaviour among LGBTIQA+ people

FDSV specialist services

The 2020 Australian Government House of Representatives inquiry into FDSV identified a variety of barriers to LGBTIQA+ people reporting FDSV and seeking help, including homophobia, transphobia and a fear of discrimination (HRSCSPLA 2021).

LGBTIQA+ people are far less likely than the general population to find support services that meet their distinct needs (DSS 2022). Additionally, a national survey by the University of New South Wales Social Policy Research Centre of 1,157 workers in specialist family, domestic and sexual violence services indicated:

- A majority of workers wanted more training on how violence is experienced by LGBTQ+ people.
- Workers felt there was a lack of training and capacity to support LGBTQ+ communities.
- A general lack of societal knowledge and awareness more broadly of how violence occurs in gender diverse and same-sex relationships (Cullen et al. 2022).

Additionally, service providers may not recognise violence in LGBTQ+ relationships (Campo and Tayton 2015; Cortis et al. 2018; Cullen et al. 2022).

What are some of the barriers to seeking help?

'As I was in a lesbian relationship and my abuser was female, access to resources at the time was limited. Luckily, things have significantly improved in the last ten years and there is much more support available for those in LGBTIQA+ relationships who are experiencing family violence.'

Martina

WEAVERs Expert by Experience

Help seeking

The Private Lives 3 Survey asked respondents who had ever experienced violence from an intimate partner or family member about support-seeking behaviour from various services such as police, doctors, counselling services, sexual assault services or FDV services (see Table 1). Of respondents who reported having ever experienced family or intimate partner violence, 28% reported the most recent incident to a support service (Hill et al. 2020). The respondents who indicated that they had reported it to a service were also asked whether they felt supported by that service. Of the 886 respondents

reported who the violence to a counselling service or psychologist, the vast majority (89%) felt supported, whereas of the 279 who reported the violence to police, less than half (45%) felt supported (Table 1).

Table 1: Service type to which intimate partner or family violence was reported the most recent time it occurred, by perceived support, 2019

Service to which violence was reported the most recent time	Number	%	Felt supported (%)
Counselling service or psychologist	886	18.7	89.4
Police (including LGBTIQ liaison officers)	279	5.9	45.0
Doctor or hospital	210	4.4	68.4
Lawyer, legal service, court system	119	2.5	57.1
Telephone helpline	117	2.5	58.6
Domestic or family violence service	109	2.3	65.1
Employer	80	1.7	71.3
Teacher or educational institution	84	1.8	69.9
Sexual assault service	44	0.9	79.6
LGBTIQ organisation	46	1.0	73.9
Religious or spiritual community leader or elder	37	0.8	64.9
Other	206	4.4	84.3
I did not report this abusive behaviour	3,406	72.0	Not applicable

Source: Hill et al. 2020.

Is it the same for everyone?

LGBTIQA+ people are a diverse group, and experiences of violence can occur in intersecting ways. National data are limited and data development is required to fully capture the scope of lived experience for LGBTIQA+ people, for example those who are also culturally and linguistically diverse people, or people with disability. Although limited, some data are available for people with disability, First Nations people, and people who live in rural Australia, which are discussed below.

LGBTIQA+ people with disability

Analysis of the Private Lives 3 study to examine the experience of FDSV among LGBTIQ adults with disability was performed with funding from Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Hill et al. 2022). There was not

a sufficient number of respondents with disability with an intersex variation for the survey data to reflect their experiences.

The analysis found experiences of intimate partner or family violence were more common for LGBTQ+ adults with disability when compared with LGBTQ+ adults without disability. The proportion of LGBTQ+ adults with disability who had ever experienced intimate partner or family violence increased with the severity of disability:

- 73% of those with severe disability, 69% of those with moderate disability, and 67% of those with mild disability had ever experienced intimate partner violence, compared with 55% of LGBTQ+ adults without disability.
- 81% of those with severe disability, 78% of those with moderate disability, and 68% of those with mild disability had ever experienced violence from a family member (excluding their partner) compared with 56% of LGBTQ+ adults without disability (Hill et al. 2022).

Overall, family violence was more common among non-binary people (85%), trans men (84%) and trans women (78%) with disability, compared with cisgender women (77%) and cisgender men (70%) with disability. Broadly speaking, the proportion of LGBTQ+ adults with disability who had ever experienced intimate partner violence was similar across different gender identities (Hill et al. 2022).

First Nations LGBTIQA+ people

Significant diversity exists in gender identity, sexual orientation, sexual expression and lived experiences amongst First Nations LGBTIQA+ people. Brotherboys, Sistergirls and other First Nations LGBTIQA+ people may experience a number of significant and intersecting points of discrimination in Australia (HRSCSPLA 2021).

The Australian Human Rights Commission (AHRC) acknowledged First Nations LGBTI people may face specific difficulties in:

- maintaining cultural ties and family support which may contribute to FDSV
- gendered cultural initiation processes that are unable to accommodate an individual's gender expression
- the gap between Aboriginal-specific service provision and service provision that accommodates for broader LGBTI populations and FDSV (AHRC 2015).

Additionally, there is a lack of research that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how this may affect the individual, individual expression, and experiences of FDSV. See also **Aboriginal and Torres Strait Islander people**.

LGBTIQA+ people in regional and remote areas

Data are not currently available at a national level for LGBTIQA+ experiences of FDSV in regional and remote communities, but the particular risk and lack of support services for regional and remote communities and LGBTIQA+ people has been acknowledged (HRSCSPLA 2021).

Regional and remote communities face particular challenges as a whole, which may be heightened for LGBTIQA+ people experiencing FDSV. Access to LGBTIQA+ specific services that intersect with FDSV support is a critical area of development, particularly for regional and remote communities (DSS 2022).

The Private Lives 3 survey found that LGBTQ+ people residing in inner suburban locations experience lower levels of psychological distress, and better self-rated health than respondents in outer suburban areas, regional cities or towns or rural/remote locations (Hill et al. 2020). Further, a higher rate of respondents in urban areas accessed mental health services that were specifically LGBTIQ-inclusive compared with their peers in rural communities, which may reflect levels of availability (Hill et al. 2020).

For more information see **Health services** and **Health outcomes**.

Related material

- Stalking and surveillance
- Coercive control

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People from culturally and linguistically diverse backgrounds

Key findings

- Some people from culturally and linguistically diverse (CALD) backgrounds may experience vulnerability due to temporary and dependent visa status, language barriers, and/or lack of community support and networks. These factors may increase their risk of exposure to family, domestic and sexual violence (FDSV), be exploited by perpetrators, and heighten barriers to seeking help.
- Cultures can differ in their attitudes towards gender roles, relationships, and family dynamics, which can impact the way FDSV is perceived and tolerated.
- Some forms of violence are more likely to be influenced by a person's visa status and/or by religious, cultural or community contexts, for example visa abuse, dowry abuse and female genital mutilation/cutting.

Family, domestic and sexual violence (FDSV) occurs across Australia, and impacts people from many different communities and cultures. While cultural and linguistic diversity is not an explicit indicator of disadvantage or risk, many people from culturally and linguistically diverse (CALD) backgrounds may experience increased exposure to risk factors or heightened barriers to seeking support. Contributing factors may include recent displacement, temporary and dependent visa status, language barriers, or lack of community support and networks (El-Murr 2018; HRSCSPLA 2021; Webster et al. 2022; Vaughan et al. 2016).

Australia is a nation diverse in cultures and ethnicities, with more than 1 in 4 (28%) of the population born overseas and more than 1 in 5 (23%) speaking a language other than English at home (ABS 2022). Understanding patterns of FDSV experienced by people from CALD backgrounds is important for identifying and responding to the specific needs of CALD populations. Box 1 describes how CALD is defined for this topic page.

Box 1: How is CALD defined?

The Australian Bureau of Statistics (ABS) *Standards for Statistics on Cultural and Language Diversity* (SSCLD) outline a nationally consistent framework for the collection and analysis of data representing people from CALD backgrounds. The SSCLD includes a minimum core set of four indicators:

- Country of birth of person – the following categories are often used in reporting:
  - Born in Australia
  - Born overseas in Main English-speaking countries (MESC) – a term used to describe the main countries from which Australia receives, or has received, significant

numbers of overseas settlers who are likely to speak English. This includes Canada, Republic of Ireland, New Zealand, South Africa, United Kingdom and United States of America.

  - Born overseas in Non-main English-speaking countries (N-MESC) – a term used to describe countries other than main English-speaking countries. It is important to note that being from N-MESC does not imply a lack of proficiency in English (ABS 2021).
- Main language other than English (LOTE) spoken at home
- Proficiency in spoken English
- Indigenous status.

However, there is considerable variation in how CALD status is collected and reported across data sources. Most national data collections do not have the measurement of CALD as a primary focus, so may collect information on only one or 2 of the SSCLD measures. CALD may be defined in different ways for different purposes, and other measures of cultural diversity may be collected additionally, or alternatively, to those under the SSCLD. For reporting, in some cases a specific group is defined as having 'CALD status', while in other cases the measures of cultural diversity are presented without CALD/non-CALD categorisation. Measures may be reported separately, or combined to provide a richer understanding of the diversity that exists within CALD groups.

The 2 key data sources used in this topic page (see Data sources for measuring FDSV experienced by people from CALD backgrounds) have data available on country of birth and/or main language spoken at home. The terminology used in this page reflects that used in the published data sources, noting that for one source a specific group has not been defined as having 'CALD status'.

It is important to note that while Aboriginal and Torres Strait Islander people are diverse in language and culture, their experiences and needs as First Australians are unique and are therefore considered distinct from the CALD population for the purposes of this report. See more at **Aboriginal and Torres Strait Islander people** and Data sources for measuring FDSV experienced by people from CALD backgrounds.

What do we know?

It is important to recognise that people from CALD backgrounds in Australia are not a single homogenous group, however there are several factors that can increase the risk of FDSV for some CALD people and/or impact their perceptions and understanding of violence, and help-seeking behaviours.

Cultural attitudes towards women and understanding of violence

Cultures can differ in their attitudes towards gender roles, relationships, and family dynamics, which can impact the way domestic violence is perceived and tolerated (Webster et al. 2017; Le et al. 2020). For example, some cultures may expect women to submit to husbands and fathers, stay in a violent relationship, and avoid bringing shame to themselves and their family (Vaughan et al. 2016).

Why is it sometimes difficult to recognise FDSV?

'As a survivor from a migrant community, a broader recognition of family violence is crucial. My perpetrators were my father, my uncle, my aunt and my grandmother. I also witnessed the abuse against my mother by the same perpetrators (her husband and her in-laws). Due to the lack of conversation around non-IPV perpetration, our experiences were first, hard to recognise, and later, hard to seek appropriate help for.'

Heshani

WEAVERs Expert by Experience

For information on community attitudes and understanding of violence against women among people from CALD backgrounds, see Box 2.

Box 2: Findings from the National Community Attitudes towards Violence Against Women Survey (NCAS)

The NCAS is a national survey that measures community knowledge of, and attitudes towards, violence against women and gender inequality. The 2021 NCAS surveyed 19,100 people, of whom 21% spoke a LOTE at home, 10% were born overseas in MESC and 24% were born overseas in N-MESC (see Box 1; Coumarelos et al. 2023).

Respondents who spoke English at home were significantly more likely than those who spoke a LOTE at home to demonstrate ”advanced”:

- understanding of violence against women (48% of respondents who spoke English, compared with 31% of LOTE with good English and 22% of LOTE with poor English)
- rejection of gender inequality (30% of respondents who spoke English, compared with 21% of LOTE with good English and 13% of LOTE with poor English)
- rejection of violence against women (38% of respondents who spoke English, compared with 21% of LOTE with good English and 6% of LOTE with poor English).

Respondents born in Australia were significantly more likely than those born overseas in N-MESC who had been in Australia for up to 5 years to demonstrate “advanced”:

- understanding of violence against women (48% of Australia-born respondents compared with 21% of N-MESC who had been in Australia for up to 5 years).
- rejection of gender inequality (30% of Australia-born respondents compared with 21% of N-MESC).
- rejection of violence against women (38% of Australia-born respondents compared with 13% of N-MESC).

Respondents born overseas in MESC did not significantly differ to Australian-born respondents in their understanding of violence against women, rejection of gender inequality, or rejection of violence against women.

For more information on the NCAS, see **Community understanding of FDSV** and **Community attitudes**.

Pre-migration experience

Immigrants may be particularly affected by recent arrival to an unfamiliar country (HRSCSPLA 2021). Some immigrants, particularly refugees, are also at increased risk of migration-related trauma. For example, some refugees may have experiences of war, torture and other traumatic pre-arrival experiences, including FDSV. These experiences of violence can affect a person's mental health, including their ability to cope in a new environment and developing post-traumatic stress, and can worsen family functioning issues during re-settlement (El-Murr 2018; Vaughan et al. 2016).

Visa status

People from CALD backgrounds on temporary visas may face additional challenges in seeking help for FDSV. Victim-survivors on a temporary visa may be dependent on a violent partner for residency and may not disclose violence due to the fear they may be deported. Conditions of temporary visas can result in social isolation due to, for example, restrictions to accessing employment and housing. Isolation may be further heightened for those who do not speak English or drive (HRSCSPLA 2021; Vaughan et al. 2016). Moreover, temporary visa holders are often unable to access social support such as income support and healthcare (e.g. through Medicare), as eligibility is limited to people with permanent residency or citizenship status (Cullen et al. 2022; NAGWTVEW 2018).

Barriers to support

Aside from visa-related barriers, people from CALD backgrounds may face other difficulties accessing support for FDSV, such as:

- lack of CALD-specific information (for example, related to gender equality and violence, service availability, or legal rights and entitlements)
- language and communication barriers
- fear and distrust of authorities due to pre-settlement experiences
- community norms that discourage disclosure, acknowledgement and intervention of violence within relationships
- community belief that family and domestic violence issues should be dealt with within the family unit (El-Murr 2018; Cullen et al. 2022; NAGWTVEW 2018).

What are some of the barriers to getting help in migrant communities?

'The full extent of the family violence was never acknowledged or discussed explicitly with anyone, not even with my mum or sister, who were also abused by my father. We had an implicit understanding that we couldn't discuss this, as we were protecting ourselves from being overwhelmed with helplessness, as we weren't sure what to do once it was acknowledged. This experience highlights the differences in the tolerance and acceptance levels within different family structures, even within my own community, highlighting that there are differences in the level of comfort survivors have when disclosing their abuse to people of different backgrounds and how a lack of discussion broadly impedes help-seeking.'

Heshani

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Lack of culturally appropriate services

To effectively address FDSV, responses require culturally competent and safe services that take into account the unique experiences and needs of victim-survivors from different backgrounds. This can include providing language interpretation services, training service providers on cultural competency, and involving community leaders and organisations in safety planning for victim-survivors (Cullen et al. 2022; DSS 2022).

A study by Australia's National Research Organisation for Women's Safety (ANROWS) on the FDSV workforce has identified a lack of policy frameworks and specialised support services addressing cultural factors that mediate violence against women (Cullen et al. 2022). However, existing research suggests promising outcomes for culturally appropriate programming and effective violence prevention strategies when community-based involvement is promoted in FDSV responses and workforces (AIHW 2018; El-Murr 2018; HRSCSPLA 2021; Cullen et al. 2022). For more general information see **FDSV workforce**.

Both the national Inquiry into FDSV and the *National Plan to End Violence Against Women and Children 2022–2032* identified the need for distinct policy, specialist services and resources to support FDSV victim-survivors from CALD communities (HRSCSPLA 2021; DSS 2022). However, the diversity in backgrounds and experiences of violence can make it challenging to meet the needs of all CALD victim-survivors, especially in instances where victim-survivors also experience intersecting forms of inequality, such as racism, disability, homelessness or poverty.

Measuring violence experienced by people from CALD backgrounds

While some national data on FDSV experienced by people from CALD backgrounds exist, there is a limited level of disaggregated data available on specific sub-groups, such as refugees, specific migration visa holders or cultural groups. This is either because the range of relevant data items may not be collected, or the data are not of sufficient quality for reporting due to small sample sizes. To overcome this limitation, reporting of broader indicators, for example binary categories based on country of birth or language

spoken at home, are used to provide high-level insights, but can conceal cultural and ethnic variation. In addition, there may be underrepresentation of people from CALD backgrounds in surveys due to language barriers, especially where alternatives to English are not available and self-reported information is required, and/or under-reporting by people from CALD backgrounds due to a reluctance to disclose sensitive information in official government surveys, or variations in how people acknowledge or define violence between different cultures (AIHW 2018).

Data sources for measuring FDSV experienced by people from CALD backgrounds

This page draws on the modest data available across national surveys. The key sources used are: the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS), and the Australian Institute of Family Studies (AIFS) National Elder Abuse Prevalence Study. For more information about these data sources, please see **Data sources and technical notes**.

What do the data tell us about FDSV experienced by people from CALD backgrounds?

Personal Safety Survey

The PSS collects data on the experiences of violence in Australia and captures information on respondents' country of birth and main language spoken at home. See Box 1 for information about the categories used for reporting. The PSS defines sexual violence as the occurrence, attempt or threat of sexual assault; physical violence as the occurrence, attempt or threat of physical assault; and a cohabiting partner as someone the person lives with, or lived with at some point, in a married or de facto relationship.

The 2021–22 PSS estimated that, in the 2 years prior to the survey, of women born overseas:

- 2.1% of those born in N-MESC (non-main English-speaking countries) had experienced sexual violence compared with 2.0%* of those born in MESC and 3.4% of women born in Australia (ABS 2023b)
- 1.0% experienced physical and/or sexual violence by a cohabiting partner (partner violence) compared with 2.1% of women born in Australia (ABS 2023a)
- 4.6% of those born in N-MESC had experienced emotional abuse by a cohabiting partner (partner emotional abuse) compared with 5.4% of those born in MESC and 5.6% of women born in Australia (ABS 2023a).

The PSS also found that a similar proportion of women who mainly spoke a language other than English at home (LOTE), and women who spoke English at home, had experienced:

- sexual violence (2.9%*and 2.9%, respectively) (ABS 2023b, see Box 1)
- partner violence (1.7%* and 1.7%, respectively) (ABS 2023a)

- partner emotional abuse (4.8% and 5.4%, respectively) (ABS 2023a).

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

National Elder Abuse Prevalence Study

The National Elder Abuse Prevalence Study is a nationally representative survey that examined elder abuse among 7,000 people aged 65 and over living in the community (i.e. not in residential aged care settings). Around 1 in 6 (18%) were identified as CALD respondents, based on those who spoke a LOTE at home (AIFS 2021). The study found that the prevalence of elder abuse (financial, physical, sexual, psychological and/or neglect) in the 12 months prior to the survey was similar for CALD (14%) and non-CALD respondents (15%) (AIFS 2022). Among CALD respondents, 1 in 25 (4%) reported experiencing abuse relating to their language and cultural background in the 12 months prior to the survey – for example, not being respected when talked to because of their culture, race or ethnicity; restricting their contact with friends or others from the same cultural background; and restricting their access to culturally familiar activities (such as attending certain events or watching shows in their preferred language) (AIFS 2022).

Box 3: Additional findings from research

This box presents some key additional findings from selected research. While these surveys are not nationally representative, they can provide some high-level insights.

Monash University's **Migrant and Refugee Women in Australia: Safety and Security Study** surveyed around 1,400 migrant and refugee women in 2020 (Segrave et al. 2021). The study found that 1 in 3 (33%) had experienced family and domestic violence (FDV) by a current or previous partner, other family member, and/or in-law, in the 5 years prior to the survey. Among these:

- Around 9 in 10 (91%) had experienced controlling behaviours, for example, limiting contact with family and friends, controlling finances, and/or threatening deportation or withdrawal of sponsorship.
- Almost half (47%) had experienced violence towards others, pets and/or property.
- Around 2 in 5 (42%) had experienced physical and/or sexual violence.

Almost 1 in 4 (24%) indicated they experienced FDV frequently or often. The study also found that FDV was more common among migrant and refugee women on temporary visas (40%) than those who were Australian citizens (32%) or permanent visa holders (28%) (Segrave et al. 2021).

The ANROWS **Migrant and refugee women's attitudes, experiences and responses to sexual harassment in the workplace study** surveyed just over 700 self-identified migrant and refugee women in 2022 (Segrave et al. 2023). Interim findings indicate that of the migrant and refugee women in the study:

- Around 2 in 3 (68%) had experienced at least one form of sexual harassment in any setting in the last 5 years in Australia

- Almost half (46%) had experienced at least one form of sexual harassment in the workplace in the last 5 years in Australia.

Perpetrators of sexual harassment in the workplace were most commonly men in senior positions in the workplace or who were clients or customers (Segrave et al. 2023).

Analysis of the 2019 Private Lives 3 survey to examine **FDSV experiences among lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) adults with disability** was funded by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Hill et al. 2022). There was not a sufficient number of respondents with disability with an intersex variation for the survey data to reflect their experiences. Around 29% of survey respondents (or 700 people) reported their background as multicultural (that is, a cultural background other than Anglo-Celtic). The study found that among respondents with disability from a multicultural background:

- Around 8 in 10 (81%) had ever experienced violence from a family member (compared with 76% of those from an Anglo-Celtic background)
- Around 7 in 10 (72%) had ever experienced violence from an intimate partner (compared with 69% of those from an Anglo-Celtic background)
- 1 in 5 (20%) had experienced sexual assault in the past 12 months (compared with 15% of those from an Anglo-Celtic background)
- Around 1 in 3 (34%) had reported violence from a family member or intimate partner to support services (compared with 32% of those from an Anglo-Celtic background) (Hill et al. 2022).

For more information on these population groups, see **People with disability** and **LGBTIQA+ people**.

What else do we know?

Some forms of violence are more likely to be influenced by a person's visa status, and/or by religious, cultural or community contexts, for example:

- visa abuse
- dowry abuse
- female genital mutilation/cutting
- reproductive coercion and abuse (see **Pregnant people**)
- **modern slavery** (such as forced marriage or human trafficking) (El-Murr 2018; HRSCSPLA 2021).

Further information on some of these forms of violence can be found below.

What is visa abuse?

Over 2 in 5 women

on temporary visas who sought support for family violence in 2015–16 were threatened that sponsorship for their visa application would be withdrawn

Refugees and migrants living in Australia on temporary visas may face unique experiences of FDV. Visa abuse can happen when the victim-survivor's temporary migrant status is used by a perpetrator to control or coerce them or their family member (Safe Steps 2023). For example, a person in Australia on a temporary partner visa may face deportation if they leave the relationship, or a perpetrator with citizenship may threaten to take custody of any children (see also **Coercive control**).

Currently there are no national data on visa abuse. However, some state data from the Victorian family violence service, InTouch, are available to provide insights on responses to incidents of family violence in migrant and refugee communities. A Monash University study on InTouch's case files of 300 women on temporary visas who sought support for family violence in 2015–16 found that:

- over 2 in 5 (44%) were threatened by a partner or family member that sponsorship for their visa application would be withdrawn
- almost 2 in 5 (39%) had been threatened with deportation from a partner or family member (Segrave 2017).

What is dowry abuse?

Dowry and other similar practices are observed in many cultures globally and generally involve the giving of money, property or other goods by one family to another during or any time after marriage (AIJA and AGD 2022). Dowry-related violence or dowry abuse occurs when a victim-survivor and/or their family are coerced into making further or larger gifts by another individual/s, typically in-laws, current or former spouses and fiancés and can be exacerbated by visa status (Parliament of Australia 2019). This coercion can involve:

- psychological, emotional, physical and/or sexual abuse and harassment
- cultural and social isolation
- economic deprivation (see **Economic and financial impacts**)
- threats of cancelling visa sponsorship, marriage annulment or deportation (AIJA and AGD 2022).

There are limited data related to the prevalence of, and responses to, dowry abuse in Australia. However, case studies and stories from victim-survivors that have been shared as a part of the Victorian Royal Commission into Family Violence 2015–16 and the 2019 Senate inquiry into the practice of dowry and incidence of dowry abuse in

Australia (the 2019 Senate Inquiry) indicate that it is a major concern for some communities in Australia (O'Connor and Lee 2022).

Women in Australia who experience dowry abuse-related violence may face a number of barriers to recognising the abuse and seeking help such as:

- feelings of shame and failure
- fear of retribution, cultural and social isolation
- language barriers or a lack of awareness of their rights in Australian society and where to get help (Parliament of Australia 2019).

The 2019 Senate Inquiry recommended that economic abuse should be recognised as a form of family violence, with dowry abuse included as an example of economic abuse. It was also recommended that more data should be collected on both dowry abuse and economic abuse in general. For data related to economic abuse, see **Economic and financial impacts**.

In response to the 2019 Inquiry, the Victorian Government recently legislated for dowry abuse to be an example of family violence in the Family Violence Protection Act 2008 and dowry abuse is mentioned under the definition of family violence in the Western Australian Restraining Orders Act 1997 *(AIJA and AGD 2022).*

What is female genital mutilation/cutting?

The term 'female genital mutilation/cutting' (FGM/C) refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs, for non-medical reasons. FGM/C is mostly carried out on young girls between infancy and adolescence, and occasionally on adult women, and can result in lifelong medical and psychological complications (WHO 2022).

While FGM/C is internationally recognised as a violation of the human rights and abandonment of the practice by 2030 is a United Nations' sustainable development priority, FGM/C is still a common cultural practice in communities in some African, Asian and Middle Eastern regions (United Nations 2022; Matanda and Lwanga-Walgwe 2022). Through migration, there are also many females affected throughout the world, including in Australia (AIHW 2019; WHO 2022).

FGM/C, including sending a person overseas to have a procedure done, or facilitating, supporting or encouraging someone to have it done, is illegal in all Australian states and territories (DSS 2019). Mandatory reporting laws require that selected professional groups (for example, medical practitioners and teachers) report instances where they suspect FGM/C has been conducted, in Australia or overseas, on children normally living in Australia (AIFS 2020). People seeking support for FGM/C in Australia can visit the National Education Toolkit for Female Genital Mutilation/Cutting Awareness website (NETFA 2022).

Available international data suggests there has been an overall decline in the prevalence of the practice over the last three decades. However, this progress has varied between

countries, and it is estimated that at least 200 million girls and women alive today across 31 countries have undergone FGM/C (UNICEF 2022).

There is limited evidence on the extent of FGM/C in Australia. The AIHW estimated that over 50,000 girls and women born elsewhere but living in Australia in 2017 had undergone FGM/C (AIHW 2019). This figure is based on modelled calculations only and should be interpreted with caution. While rudimentary, this estimate provides insight into the potential extent of FGM/C in Australia. For further information on the study's methodology refer to the report, Towards estimating the prevalence of female genital mutilation/cutting in Australia.

Related material

- Coercive control
- Economic and financial impacts
- Modern slavery

More information

- Culturally and linguistically diverse Australians, overview

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Veteran families

Key findings

- Studies of veteran families have reported levels of intimate partner violence (IPV) ranging from 2% to 46%
- In 2015, almost 3 in 10 (29%) recently transitioned Australian Defence Force (ADF) members and more than 1 in 5 (22%) current ADF members reported IPV exposure in their current relationship
- 1 in 4 (25%) clients of specialist homelessness services in 2021–22 who were current or former members of the ADF had experienced family and domestic violence (FDV)

The nature of service in the Australian Defence Force (ADF) affects a range of lifestyle aspects for the serving member and their family and can make it difficult to develop and maintain social connections outside of the military (AIHW 2022b). ADF service increases the likelihood of exposure to trauma (either directly or indirectly) and affects support networks, for example, separation from family during deployment (AIHW 2022a). Veterans (see Box 1) and their families may also experience specific challenges in seeking support for family and domestic violence (FDV) (Fitz-Gibbon et al. 2022).

The *Defence Strategy for Preventing and Responding to Family and Domestic Violence 2023–2028* and *DVA Family and Domestic Violence Strategy 2020–25* are part of the Australian Government's response to FDV. The strategies aim to improve awareness and support for veterans and their families affected by FDV (Department of Defence n.d.; DVA 2020).

This page focuses mainly on intimate partner violence (IPV), rather than FDV, due to the available data. While IPV among veteran families could include violence perpetrated by a veteran or a partner of a veteran, most of the research to date has focussed on IPV perpetrated by veterans. Further research is needed to build the evidence base about the experience of FDV within veteran families (Fitz-Gibbon et al. 2022).

Box 1: Defining veterans

The term 'veteran' traditionally described former ADF personnel who were deployed to serve in war or war-like environments. While veterans may now be considered people who have any experience in the ADF including current, reserve, and former (ex-serving) personnel, there may be different definitions of veterans depending on the available data (AIHW 2022a).

The Australian Bureau of Statistics' (ABS) 2021 Census of Population and Housing included the ADF Service Variable for the first time. This is a standard question about whether a person is currently serving or has previously served in the ADF. The ADF consists of regular service (considered a person's main ongoing job, and most roles are full-time in nature) and reserves service (normally part-time in nature and can include up to 200 days of service per year, depending on the role). The ADF includes:

- Australian Army (including NORFORCE (North-West Mobile Force))

- Royal Australian Navy
- Royal Australian Air Force (ABS 2021).

It also includes people who previously served in the National Service and the Second Australian Imperial Force. It does not include people who have served in non-Australian defence forces and excludes overseas visitors (ABS 2021).

The ABS definition generally applies for the purpose of this topic, noting that the particular cohort of veterans included in the available data may differ.

In the 2021 Census of Population and Housing, 1 in 20 (5.3%) Australian households reported at least one person who had served, or was currently serving, in the ADF (ABS 2022).

What do we know?

There is a lack of research regarding IPV perpetration and victimisation among veteran families (Cowlishaw et al. 2022; Pollard and Ferguson 2020), and FDV within veteran families more broadly.

International research has reported higher rates of FDV within military families when compared with civilian families (Cowlishaw et al. 2022; Hinton 2020; Kwan et al. 2020; Pollard and Ferguson 2020). Specific factors that are unique to military families may contribute to conflict in relationships and increase the risk of IPV – for example: family separation and reintegration due to deployment; frequent geographic moves resulting in social isolation and economic dependence on the serving member; and trauma experienced during service (Daraganova et al. 2018; Gierisch et al. 2013; Pollard and Ferguson 2020; Yu et al. 2021). Similarly, there is a complex interaction between mental health and the experience and use of violence, and research indicates some veterans may also be at increased risk of mental illness following transition out of regular ADF service (Van Hooff et al. 2019).

The male-dominated military environment has been identified as a hypermasculine culture that emphasises operational effectiveness and deployability (Pollard and Ferguson 2020). Members who display characteristics that are considered feminine or weak (such as empathy, fear, sadness) and those who seek help, could be perceived as a liability that should be removed from the group. Cultures like this may influence attitudes, behaviours and social norms that are associated with violence against women (Our Watch 2021) and reinforce the stigma associated with seeking help, contributing to the under-reporting of IPV (Pollard and Ferguson 2020).

Issues with under-reporting of IPV that may be more specific to military families include: financial-, housing- and health-related dependence on the serving member or veteran; the military reputation of the serving member; and the possibility of the serving member being demoted or discharged and losing the benefits associated with service (Fitz-Gibbon et al. 2022; Hinton 2020; Pollard and Ferguson 2020).

Data sources for reporting on veteran families

- Timor-Leste Family Study (see Box 3)
- Vietnam Veteran Families Study (see Box 4)
- Family Wellbeing Study (see Box 5)
- Transition and Wellbeing Research Programme (Box 6)
- Specialist homelessness services collection (see **Data sources and technical notes**).

What do the data tell us?

Data on the experience of FDV within veteran families are currently only available from a limited number of sources and are not routinely reported. However, data development activities are being undertaken to enhance reporting in this area, including the potential use of the ABS ADF Service Variable (see Box 1) to explore data from the ABS 2021–22 Personal Safety Survey.

When examining the available data, it is important to note the available data are not contemporary and only provide part of the picture:

- The studies included in this page are cross-sectional – the data cannot identify causality but may provide an indication of potential associations between IPV and ADF service.
- For the studies included in this page, reporting on IPV was limited to physical and/or sexual violence and some aspects of emotional abuse. The wider range of behaviours and harms that are now understood to be IPV, such as financial abuse, stalking and coercive control, may not have been captured in these studies.
- Findings from the studies included in this page are largely based on male ADF members and their female partners due to the higher proportion of males represented in the veteran population. According to the 2021 Census of Population and Housing, most (86%) veterans (including those currently serving and those who had previously served) were male, and 14% were female. However, there was a higher proportion of females (21%) represented in the currently serving ADF population (ABS 2022).

The studies included in this page used the Woman Abuse Screening Tool (WAST) to measure IPV. However, findings are not comparable across the studies due to differences in the veteran cohort included in the studies and the application of the WAST (refer to Boxes 2–6 for information about the use of the WAST).

Box 2: The Woman Abuse Screening Tool

The Woman Abuse Screening Tool (WAST) comprises 8 items to assess the degree of relationship tension, the amount of difficulty the respondent and partner have in resolving arguments and whether a partner experienced physical, sexual and/or emotional abuse.

The first 2 questions constitute the WAST-Short:

1. In general, how would you describe your relationship? (The response options for this question are: 'a lot of tension', 'some tension' and 'no tension').

2. Do you and your partner work out arguments with: great difficulty, some difficulty or no difficulty?

When used for initial screening for IPV in a validation study, these 2 questions correctly identified 92% of women who had experienced IPV and 100% of women who had not experienced IPV (Brown et al. 2020).

The remaining questions have the response options 'often', 'sometimes' and 'never':

3. Do arguments ever result in you feeling down or bad about yourself?

4. Do arguments ever result in hitting, kicking or pushing?

5. Do you ever feel frightened by what your partner says or does?

6–8. Has your partner ever abused you physically/emotionally/sexually?

Findings across data sources are not comparable due to differences in the WAST items used and the scoring of response options.

There is limited evidence supporting the psychometric properties of the WAST. The WAST:

- does not define the types of IPV being measured and relies on participants' existing understanding of IPV
- does not capture the wider range of behaviours and harms that are now understood to be IPV (such as financial abuse, stalking and coercive control)
- cannot be used to explore past-year prevalence, frequency, duration or impact of IPV.

Source: Brown et al. 2000, Cowlishaw et al. 2023, McGuire et al. 2012.

Timor-Leste Family Study

1 in 10 (10%) current partners of members who were deployed to Timor-Leste between 1999 and 2010 reported the experience of IPV post-deployment

Box 3: The Timor-Leste Family Study

The Timor-Leste Family Study was the first Australian study to investigate the effects of recent deployments on the health and wellbeing of ADF families. Study participants (almost 2,900 ADF members and just over 1,300 current partners) were recruited from ADF members deployed on one or more operation(s) to Timor-Leste between 1999 and 2010 and a comparison group of ADF members who were not deployed to Timor-Leste. Previous partners (referred to as 'former partners' in the study) were also invited to participate, however their responses were not included due to the small number of previous partners who completed the questionnaire.

The questionnaire, completed between May 2011 and January 2012 included the WAST (see Box 2). Participants were classified as screening positively for IPV if they responded in the highest categories ('a lot of tension' and 'great difficulty') for either of the first 2 items. Participants were not required to endorse questions relating to specific types of violence to be screened positively for IPV. Previous research has indicated that the first 2 questions correctly identify more than 90% of women who have experienced IPV.

Source: McGuire et al. 2012.

One in 10 (10%) serving members' partners reported the experience of IPV post-deployment to Timor-Leste (McGuire et al. 2012). There was no statistically significant difference in the reported level of IPV between ADF members who were deployed and those who were not. IPV was significantly associated with poorer mental health scores and symptoms of Post-traumatic Stress Disorder for partners (McGuire et al. 2012).

Spouses and Partners of Vietnam Veterans – findings from the Vietnam Veterans Family Study

Less than 2% of current partners of Vietnam veterans reported experiencing IPV

Box 4: The Vietnam Veterans Family Study

The Vietnam Veterans Family Study aims to understand the impact of deployment on the families of Vietnam servicemen by comparing findings with the families of Vietnam-era personnel (other men who served in the ADF during the Vietnam War between 1962–75, but were not deployed). The data, collected in 2011, were reported for 1,447 current partners (referred to as 'current spouses/partners' in the study) of Vietnam veterans, 852 current partners of Vietnam-era personnel, 67 previous partners (referred to as 'ex-spouses/partners' in the study) of Vietnam veterans and 21 previous partners of Vietnam-era personnel. Male partners were excluded (Yu et al. 2021).

The study examined whether partners had experienced abuse at any stage of the couple relationship using 6 items from the WAST (see Box 2) to determine if there had been physical, sexual or emotional abuse between partners. A 3-point Likert scale of 1 (Never), 2 (Sometimes) and 3 (Often) was used with an average score of 1–3 calculated across the 6 items (WAST scores generally range from 8 to 24, higher scores indicating higher levels of abuse). Findings for previous partners were not considered reliable due to small cell sizes.

Source: Yu et al. 2021

Overall, less than 2% of current partners reported there had been IPV at some stage in the couple relationship. Mean levels of abuse in the couple relationship were higher for the partners of Vietnam veterans (1.4%) compared with partners of Vietnam-era personnel (1.2%) (Yu et al. 2021).

IPV was reported as an underlying reason for the relationship ending by:

- 28% of previous partners of Vietnam veterans
- 17% of previous partners of Vietnam-era personnel (Yu et al. 2021).

Family Wellbeing Study

Around 1 in 20 (4.8%) current partners of ADF members or those who had recently transitioned from service in 2015 reported they had experienced abuse at some stage in their relationship

Box 5: The Family Wellbeing Study

The Family Wellbeing Study is part of the Transition and Wellbeing Research Programme undertaken for the Department of Defence and the Department of Veterans' Affairs.

The Family Wellbeing Study was designed to investigate the health and wellbeing of families of ADF members who were either in full-time active service in 2015, or had left service between 2010 and 2014. Almost 1,400 family members took part, including around 980 partners (referred to as 'spouses/partners in the study) – about 680 were partners of current serving members and about 305 were partners of ex-serving members.

The study examined whether current partners had experienced IPV at any stage of the couple relationship using the 8-item WAST (see Box 2). Responses were scored using a 3-point Likert scale of 1 (Never), 2 (Sometimes) and 3 (Often), with a total score calculated as the sum of the 8 items. This was subsequently categorised as 'there had not been abuse in the relationship' (a score of 0–16) and 'there had been abuse in the relationship' (a score of 17–24).

Source: Daraganova et al. 2018.

Around 1 in 20 (4.8%) partners reported they had experienced abuse at some stage in their relationship. The authors noted that the lower rate in this study compared with the Timor-Leste Family Study may be related to the effects of recent deployment on the participants in the Timor-Leste Family Study. As noted, deployment may increase the risk of conflict in relationships and increase the risk of IPV (Daraganova et al. 2018).

Other findings from the study include:

- A higher proportion of partners of ex-serving ADF members (8.4%) reported the experience of IPV, when compared with partners of current serving members (3.1%).
- Partners with poorer physical health and/or who were psychologically distressed were 3 times as likely to report experiencing IPV than partners who did not have these health issues.
- Partners of members who had served more years in the ADF were less likely to report the experience of IPV (Daraganova et al. 2018).

Partners were asked whether they had ever been without a permanent place to live and the associated reasons – of the almost 205 partners who had ever been without a

permanent place to live, 6.4% reported it was due to violence/abuse/neglect (Daraganova et al. 2018).

Transition and Wellbeing Research Programme Secondary Analyses

In 2015, about 3 in 10 (29%) recently transitioned ADF members and 1 in 5 (22%) current ADF members reported any IPV exposure in their current relationship

Findings from the secondary analyses of data from the Transition and Wellbeing Research Programme indicate high levels of IPV among veteran families. Any IPV exposure in their current relationship (see Box 6) was reported by about:

- 3 in 10 (29%) transitioned ADF members
- 1 in 5 (22%) current personnel
- almost half (46%) of partners of transitioned ADF members
- 1 in 4 (24%) partners of current personnel (Cowlishaw et al. 2023).

These findings should be considered in relation to the limitations of the available data (see Box 2, Box 6 and Cowlishaw et al. 2023).

Box 6: The Transition and Wellbeing Research Programme

The Transition and Wellbeing Research Programme was a large-scale study conducted in 2015 to explore the impact of military service on the health and wellbeing of ADF members and families. Secondary analyses reported in this topic are based on 2 of the components:

- The Mental Health and Wellbeing Transition Study (MHWTS) – surveys of ADF members who had transitioned from the Regular ADF between 2010 and 2014 and a comparison sample of permanent, full-time current serving members in 2015. The survey was completed between June and December 2015.
- The Family Wellbeing Study (FWS) – surveys of family members of transitioned and current serving members who nominated a family member to take part. The survey was completed between September 2015 and February 2016.

The sample included:

- around 2,900 ADF members who had transitioned and around 6,200 permanent, full-time current serving members who reported involvement in an intimate relationship
- around 300 intimate partners of transitioned members and around 660 intimate partners of current serving members
- a sub-sample of transitioned personnel who provided consent for their responses to be linked with data from family members in the FWS (around 265 'couples').

IPV exposure was measured using a subset of items from the WAST (items 4–8, see Box 2), to assess whether physical (items 4 and 6), emotional (items 5 and 7), or sexual violence (item 8) ever occurred in the current relationship. WAST items were only asked of participants in

current relationships and therefore did not capture IPV exposure in previous relationships. Analyses based on the FWS are not fully representative of partners as it only includes partners if the ADF member agreed for them to be contacted, the sample tended to over-represent older participants and previous partners were excluded.

Different response options were used in the MHWTS ('Never' 'Rarely' and 'Sometimes') and the FWS ('Never', 'Sometimes' and 'Often'). Response options for items were collapsed to form binary measures (0 = Never, 1 = Rarely/Sometimes or Sometimes/Often). For most analyses, any IPV exposure was categorised as non-zero scores on any of the items 4–8 from the WAST.

Source: Cowlishaw et al. 2023.

Emotional abuse was the most common type of violence reported by all groups, followed by physical abuse. Rates of self-reported IPV exposure were similar for men and women among both transitioned and current ADF members (Cowlishaw et al. 2023).

Findings also indicated that higher rates of IPV exposure for members and partners were associated with financial hardship and/or exposure to trauma. Conversely, protective factors, such as social connection and resources were associated with lower rates of IPV exposure (Cowlishaw et al. 2023).

The use of IPV by transitioned members was explored for a sub-set of around 265 couples for whom Mental Health and Wellbeing Transition Study (MHWTS) data for the transitioned member was linked with their partner's data from the Family Wellbeing Study (FWS). Findings indicated that high proportions of transitioned members who used IPV reported harmful drinking (69%), suicidal ideation (63%), depression (59%) and PTSD (58%) (Cowlishaw et al. 2023).

What else do we know?

Homelessness is an important aspect to consider in understanding the welfare of veterans (AIHW 2019). In 2022–23, around 1,500 SHS clients were current or former members of the ADF (AIHW 2023). Of these:

- about 1 in 4 (23%) had experienced FDV
  - 1 in 7 (14%) had experienced FDV and had a current mental health issue
  - 1 in 20 (5.0%) had experienced FDV and had problematic drug or alcohol use
  - about 1 in 20 (4.7%) had experienced FDV and both of the additional selected vulnerabilities (current mental health issue and problematic drug or alcohol use)

- 11% reported FDV as the main reason for seeking assistance
- 14% needed assistance for FDV (AIHW 2023).

Analysis of data generated by linking information from the Department of Defence personnel system data with the AIHW's Specialist Homelessness Services Collection (SHSC) explored the use of homelessness services for the contemporary ex-serving ADF population (that is, ex-serving ADF members who had at least one day of service on or after 1 January 2001, who discharged after 1 January 2001 and before 1 July 2017). This analysis included an assessment of women who needed domestic and family violence services (DFV) (AIHW 2019).

53% (or 145) of female ex-serving ADF members who were SHS clients between 1 July 2011 and 30 June 2017 needed DFV services.

Between 1 July 2011 and 30 June 2017, 1.7% (or 274) of the female contemporary ex-serving ADF population had accessed SHS (AIHW 2019).

- 53% (or 145) of female ex-serving ADF SHS clients were assessed as needing DFV services.
- Female ex-serving ADF SHS clients who needed DFV services had a longer length of support than those who did not need DFV services – 43% had a support length of 91 days or longer, compared with 25% of women who did not need this type of service (AIHW 2019).

Related material

- Intimate partner violence
- Housing

More information

- Veterans
- Specialist Homelessness Services annual report

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