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Queensland Mental Health Commission

Consultation paper:

Development of a whole-of-government Trauma Strategy for Queensland

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The nature and extent of trauma and its impacts on adult and child victim-survivors in the context of domestic and family violence

What is this research about

Domestic and family violence (DFV) is a global public health issue which can have lasting effects on victim-survivors' physical, emotional and social wellbeing [1, 2]. While not exclusively male-to-female perpetrated, DFV remains a gendered issue that disproportionately affects women and children [3, 4]. We therefore examine the nature, extent and impacts of DFV-related trauma affecting women and children as the primary victim-survivors of this form of trauma. We further discuss opportunities for and the effectiveness of trauma-informed interventions and recovery work for women and/ or children affected by DFV.

Evidence reviewed for the purpose of this paper identified high prevalence rates of trauma-related mental health impacts, including an increased risk of anxiety, depression, Post Traumatic Stress Disorder (PTSD), self-harming and suicidal behaviours among adult and child victim-survivors of DFV. These can be successfully addressed through immediate and long-term recovery support, which recognises both women and children as victim-survivors in their own right. Effective interventions include Trauma-Focused Cognitive Behaviour Therapy (TF-CBT), modified dialectical behaviour therapy (DBT), Eye Movement Desensitisation and Reprocessing (EMDR), integrated interventions focused on mother-child relationships, trauma-informed educational settings and holistic recovery support approaches.

The context for this research

Prevalence of DFV for women and children

One in four women in Australia experience emotional abuse by a current or former partner after the age of 15 years old and one in six women experience physical and/ or sexual abuse by a current or former partner [3], and it is well-established that First Nations women are overrepresented as victim-survivors [5]. Indeed, two in three First Nations people report experiences of physical harm by an intimate partner or family member in the past 12 months [6]. Violence against women is the single biggest contributing factor to the disease burden affecting women aged 18-44 years old in Australia, including premature death, injury and chronic illness. It is further the biggest contributing factor to women and children's housing instability in Australia[7]. Women experiencing DFV are more likely to develop anxiety, depression and PTSD [8,9]. However, the impacts of DFV-related trauma and thus recovery needs often reach beyond women's physical and mental health and extent to financial insecurity and social isolation, which can further exacerbate victims-survivors poor physical and mental health outcomes [10-12]. A number of clinical interventions have proven to be effective in reducing the adverse health outcomes associated with DFV. However,

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victim-survivors broader recovery from DFV-related trauma requires a holistic approach to supporting women's social, financial, emotional and physical recovery [7].

The majority of adult female victim-survivors further have children in their care at the time of the abuse, making the experiences and impacts of DFV-related trauma an intergenerational public health issue [13]. Prevalence data on children's experiences of DFV between parents or carers remains scarce. In Australia, latest nationally representative evidence shows that 43.8% of young Australians (16–24-year-olds) report childhood experiences of DFV (CEDFV) between parents or carers [14]. The intergenerational effects of DFV on children's physical, social and emotional wellbeing are increasingly well documented, including elevated levels of behavioural problems, anger and aggression, depression and anxiety, self-harm and suicide [15-17]. The short- and long-term consequences of childhood trauma, including DFV, are estimated to cost Australia A$34 billion each year [18]. Yet, latest Australian research shows that access to timely recovery support for children experiencing DFV, including psychosocial and clinical mental health interventions, remains scarce [16, 19].

The key findings

The impacts on DFV related trauma on children as victim-survivors

Broader impacts of DFV-related trauma

Longitudinal research by Gartland and colleagues [15]shows that CEDFV is associated with a 90% increased risk of displaying behavioural problems in the clinical range along with being more than twice as likely to develop sleep problems by the age of 10 years old, compared to children growing up without CEDFV. Some research further shows that early CEDFV (at 30 months old) is associated with decreased memory function at the age of 5 years old and further highlights that the effects of CEDFV on children's cognitive functioning can be more severe and persistent where CEDFV occurs in early childhood (under the age of 6 years old) compared to middle childhood (6-12 years old) and adolescence (13 years and older) [17]. However, the evidence around CEDFV at different points during childhood and varying effects has been inconsistent [15, 20]. Research appears to be more consistent regarding the cumulative effects of different forms of child maltreatment. Studies examining the impact of CEDFV and other forms of child maltreatment show strong evidence that while each form of child abuse can have detrimental effects on children's social, emotional, and physical development, multi-type abuse experiences significantly increase the risk of adverse short and long-term outcomes, including mental health concerns [20-22].

Mental health outcomes associated with the impacts of DFV-related trauma

Research suggests that children experiencing DFV have a higher risk of receiving a mental health diagnosis across multiple mental health sub-categories [16]. For example, Orr and colleagues' [16]study based on linked Australian health data of over 60,000 children in Western Australia showed that children with CEDFV had a significantly increased risk of being diagnosed with mental health disorders, including a 36% increased risk of depressive disorder, 39% increased risk of schizophrenia, 49% increased risk of anxiety disorder, 59% increased risk of self-harm and 99% increased risk of substance use disorder. Longitudinal Australian research conducted by Gartland and colleagues [15] identified similar adverse effects on children's mental health when experiencing DFV. Children growing up with DFV were twice as likely as children without CEDFV to be diagnosed with a mental health disorder by the age of 10 years old, including a 70% increase of being diagnosed with anxiety disorder.

DFV and youth suicide

Suicide is a complex phenomenon and the leading cause of death for young people aged 16 to 24 years in Australia [23]. Suicide is associated with an interaction between psychological, biological, and sociocultural factors[24]. Adverse childhood experiences (ACEs), including CEDFV, constitute one such factor that increases the risk of suicidal behaviours among young people [25]. While Australian evidence on the role of CEDFV in youth suicide remains scarce [26], international literature suggests that CEDFV can contribute to the increased risk of suicidal behaviour in young people [27, 28] . Emerging findings from an Australian jurisdiction support this evidence [29]. In a representative sample of over 600,000 young people (aged 15-25 years old), 14.2% had CEDFV documented in police records. This increased to 32.8% among young people who experienced at least one episode of suicidal behaviour leading to acute health services contact. Further, the impact of CEDFV on suicidal behaviours was gendered, with risk almost tripling for males.

Intergenerational transmission of violence associated with impact of DFV-related trauma

In addition to the diverse effects of CEDFV on children's social and emotional wellbeing, a growing body of Australian and international work has identified a clear link between CEDFV and use of violence later in life, including adolescence and adulthood. While outcomes vary, research shows a strong link between CEDFV and victimisation and/ or perpetration of DV in adolescent dating and adult intimate partner relationships, as well as adolescents' use of violence in the home towards other family members [22, 30, 31]. Australia's first prevalence study on young people's self-reported use of violence in the home up to the age of 20 years old, for example, showed that 1 in 2 children with CEDFV and other forms of child maltreatment also reported using violence in the home during adolescence. More importantly, among those who reported frequent use of violence towards other family members, 9 out of 10 reported CEDFV [22].

The impacts on DFV related trauma on women as victim-survivors

Physical health and broader social impacts

Findings from a recent systematic literature review indicate that women who have experienced DFV face a significantly increased risk of various adverse physical health outcomes, including the development of chronic diseases and pain, cardiovascular problems, worsening of menopausal symptoms, an elevated risk of developing diabetes, contracting sexual transmitted infections, and poorer human immunodeficiency virus outcomes [2]. DFV is often related to hospitalisations, with an elevated risk for First Nations women. For example, in 2021-22, First Nations women were 33 times as likely to be hospitalised for DFV-related injuries as non-Indigenous Australian women [32]. DFV victimisation is also associated with premature death. From all 310 intimate partner homicides that occurred between July 2010 and June 2018 in Australia, the majority (77%) involved a male killing a current or a former female partner [7].

DFV not only impacts the direct well-being of victim-survivors but also extends to experiences of housing and financial security. Indeed, DFV is the leading cause of homelessness for women with children in Australia, with a significant proportion of all Specialist Homelessness Services (SHS) users (38%) reporting DFV [33]. Aside from housing stability of victim-survivors, DFV is associated with experiences of financial hardship more broadly, which can persist long after the end of the abusive relationship [34].

Mental health impacts/ outcomes

A wide range of mental health disorders and symptoms have been found to be associated with experiences of DFV, including mood disorders, anxiety disorders, engagement in risk-taking behaviours such as harmful substance use

(including alcohol, licit and illicit drug use) and PTSD. These impacts are even more elevated among women that experience complex abuse [35]. Internationally, findings from a meta-analysis show that women exposed to DFV have two to three-fold increased risk of major depression disorder and 1.5-2-fold increased risk of depressive symptoms and postpartum depression compared to women who have not been victimised [36]. According to Australian data from 2018, DFV contributed to 15% and 20% of the total burden of depressive disorders among non-Indigenous and First Nation women, respectively [32, 37]. Further, evidence suggests that women with a history of DFV are approximately twice as likely to experience symptoms of anxiety compared to those who had not experienced DFV [38, 39]. In 2018, 11% of anxiety disorders among non-Indigenous women and 26% among First Nations women in Australia were attributable to DFV [37]. Finally, meta-analysis findings show that women with PTSD are more than seven times as likely to report lifetime DFV compared to those without a PTSD diagnosis [40].

DFV and suicide

Australian longitudinal data suggests that recent experiences of multiple instances of DFV directly contribute to women's suicide attempts [41], which is consistent with international evidence [42]. In 2019, DFV was identified as the second greatest contributor to premature death due to suicide and self-inflicted injuries among women in Australia, and the highest among women aged 85 years and over [43]. Additionally, DFV contributed to 32% to the suicides and self-inflicted injuries among First Nations women [32]. In 2022, 'problems in spousal relationship circumstances' was the third most prevalent risk factor for death by suicide, identified in 25.1% of suicides [44]. In Queensland, from July 2015 to 30 June 2021, 44 DFV-related suicide deaths of women were recorded [45].

Interventions for child-victim-survivors

Psychotherapeutic interventions for children: Evidence from control trials

Different clinical interventions have been explored and tested with regards to their effectiveness in reducing the adverse effects associated with DFV-related trauma. For example, evidence indicates that community-provided TF-CBT improves children's DFV-related PTSD and anxiety compared to CCT [46]. Additionally, EMDR has been shown to effectively reduce symptoms of children's PTSD, anxiety, depression, and behavioural problems [47]. However, findings from a meta-analysis on child emotional and behavioural outcomes of DFV interventions revealed that treatments without a specific trauma focus contributed to lager intervention effects than trauma-focused approaches (i.e., treatments that specifically targeted children's individual trauma experiences) [48]. Overall, intervention effects vary by treatment type, with play therapy having the largest effect size, followed by child-parent psychotherapy, psychoeducation, multicomponent interventions, and TF-CBT [48].

Other therapeutic interventions for children

Randomised control trials offer a robust approach to investigating the effectiveness of complex interventions [49]. However, it is essential to evaluate outcomes that align with the priorities and expectations of those using the interventions. Integrated approaches that enhance the relationship between mothers and children following abusive experiences are promising in this area. For example, programmes based on the Ontario model where parallel groups of women and children are held in the community have been shown to be effective in other countries, like in the UK. Examples of such programs include the Children Experiencing Domestic Abuse Recovery (Cedar) [50] and the Domestic Abuse, Recovering Together (DART) programmes [51]. These groupwork interventions focus on enhancing the mother-child relationship and facilitate dialogue about experiences and feelings associated with victimisation experiences. In addition to improving the mother-child relationship, Ontario-based programmes

reduce the child's emotional distress, conduct problems, difficulties in peer relationships, while also increasing their self-esteem and developing a greater understanding of DFV and safety planning [50, 51].

It is important to note here that child-centred interventions to mitigate the impacts of DFV-related trauma require children to have a space for recovery. Many child-victim-survivors have ongoing contact with the adult perpetrator of DFV, even where adult survivors can physically separate from an abusive partner and co-parent. This ongoing contact is frequently associated with ongoing experiences of DFV-related trauma, along with a limited space for recovery [52, 53]. It is therefore important for policy and practice to recognise the unique recovery needs of child-victim-survivors and the protective measures required to ensure the adult perpetrator of DFV has limited opportunity to minimise the recovery space and hinder access to recovery support [7, 52, 53].

The role of educational settings

Australian data on young people's support needs around their use and experiences of violence in the home highlights young people's expectations for trauma-informed responses to disclosures or effects of CEDV [54]. International systematic review evidence highlights that few studies have examined the effectiveness of the growing implementation of trauma-informed approaches in educational settings, including trauma-informed professional development for staff and trauma-screening for students [55]. The limited evidence suggests that US-based programs like the *The Heart of Teaching and Learning (HTL): Compassion, Resiliency, and Academic Success Model* [56], *The Healthy Environments and Response to Trauma in Schools (HEARTS) Model* [57], *The Trust-Based Relational Intervention (TBRI) Model* [58] and *The New Haven Trauma Coalition (NHTC)* [59] have all achieved positive outcomes across intervention objectives, including increased self-esteem and behavioural change, a reduction in other trauma symptoms, and increased staff knowledge and understanding of trauma and its presentations. While Australian research evidence around trauma-informed educational settings remains scarce, the Australian *National Guidelines for Trauma-Aware Education* [60] provide a blueprint for the consistent implementation of trauma-informed practice in education.

Interventions for adult victim-survivors

Mental health interventions for DFV adult victim-survivors

Evidence from different meta-analyses reveals that interventions for DFV victim-survivors are effective at reducing PTSD, depression, anxiety, general distress and increasing self-esteem among adult victim-survivors [61, 62]. Specifically, short-term DFV-tailored interventions, including CBT and interpersonal therapies, have demonstrated to be most effective when compared to non-tailored interventions, resulting in an overall symptom improvement of 69% versus 29% [61]. In addition, modified DBT has shown to reduce depressive symptoms, hopelessness, and general psychiatric distress among women victims of DFV [63]. Empirical evidence regarding the effectiveness of EMDR for victim-survivors of sexual violence and DFV indicates a decrease of 36% in anxiety symptoms, 44% in depression symptoms and 34% of PTSD symptoms following treatment [64]. Additionally, trauma-informed treatments have demonstrated efficacy in reducing symptoms of PTSD, depression and anxiety, showing a superior effect on psychological health improvement compared to usual care groups [65]. Importantly, evidence indicates that safety and presence of social support are prerequisites for long-term recovery [66], thus the adoption of a holistic approach is essential for victim-survivors' recovery.

Holistic interventions including DFV adult victim-survivors' psychological recovery

Recovery frequently relies on addressing the legal, financial, and security issues resulting from DFV. However, the evidence base regarding holistic recovery support is still emerging. For example, the Department of Health and Aged Care has provided the Primary Health Networks (PHN) funding to pilot the Supporting Recovery program in 2024 [67]. The goal of this program is to promote sustained recovery and address the mental health impacts related to trauma among victim-survivors of DFV and sexual violence. The program has been designed to minimise touchpoints and guarantee that victim-survivors can access integrated and coordinated services, ensuring their safety and ability to engage in DFV and sexual violence trauma-informed mental health therapies that facilitate long-term recovery [67].

What does this research mean for policymakers

The National Plan to End Violence against Women and their Children 2022-2032 (the National Plan) identifies several key recovery objectives, including access to trauma-informed and culturally safe services that support sustained recovery, specialist recovery services tailored to diverse populations, and the recognition of children and young people as victim-survivors of DFV in their own right [7]. Considering the substantial body of evidence showing the multifaceted and long-lasting impacts of DFV on both adult and child-victim-survivors, it is imperative to adopt a holistic approach that addresses the different recovery needs necessary for sustainable healing and recovery. Thus, service responses to victim-survivors should extend beyond DFV specialist services to encompass support services concerning child and family welfare, as well as physical and mental health of both children and adults. This broader approach should integrate trauma-informed crisis responses, early interventions and long-term, holistic recovery support. Further, the National Plan has recognised First Nations people as a priority group in their efforts to prevent and respond to DFV in Australia [7]. Accordingly, considering the overrepresentation of First Nations women and children as victim-survivors and their increased risk to experience DFV-related impacts, responses to DFV and related impacts must not only be trauma-informed but also culturally safe and sensitive.

Options for reform

Evidence on the effectiveness of holistic approaches for recovery support, including responses that support holistic social and emotional recovery for adult and child victim-survivors of DFV is still in its infancy, particularly in Australia. Existing evidence highlights the need to invest in pilot interventions to further build this evidence in the Australian context.

Specifically, health-based intervention strategies should aim at improving adult mental health outcomes through the investment in evidence based mental health interventions, such as CBT, EMDR [61, 62]. ***This creates an opportunity for Queensland Health to invest in increased treatment availability and accessibility for victim-survivors in metropolitan, regional, rural and remote healthcare settings.***

Further, evidence highlights the need for investment in models providing holistic recovery support that alleviates DFV-related life stressors (e.g. financial and housing insecurity), which are known to exacerbate victim-survivors' mental health concerns (e.g. anxiety, depression, PTSD)[7, 66, 68]. This is in line with Action item 4 of the first *Action Plan* (2023-2027) under the *National Plan*, which provides a roadmap for all state and territory governments to build the capacity across services and systems to provide trauma-informed, connected and coordinated responses to support sustainable healing and recovery for victim-survivors. ***The Queensland Government should therefore***

consider holistic rather than siloed funding approaches to resourcing DFV-informed responses across its departments, including child safety, education, housing, (mental) health, employment, courts and corrections.

Further, research shows that healthy attachment between adult and child victim-survivors is critical in the recovery of both women and children and has shown to reduce DFV-related mental health impacts for adult and child victim-survivors. The adequate resourcing of interventions that strengthen or rebuild parent-child relationships between adult and child victim-survivors is therefore critical in supporting short- and long-term recovery. Here, Ontaria based models, such as the Cedar [50] and DART programmes [51] have demonstrated effectiveness in reducing children's emotional distress, conduct problems, and difficulties in peer relationships, while increasing self-esteem and awareness/ understanding of DFV. ***The Queensland Government should therefore invest in Queensland-based trials and related process and outcome evaluations to identify a) opportunities for the consistent implementation of these programs into DFV specialist and child and family welfare services and b) any program alterations required to ensure the model is fit for purpose in metropolitan, regional, rural and remote Queensland trial settings.***

In line with the *National Plan's* framing of children as victim survivors in their own right and Action item 8 of the first *Action Plan*, children and young people's mental health should further be targeted through access to child-centred, early, trauma-informed, and evidenced-based interventions that are age-appropriate and culturally safe to support recovery and minimise the risk of adverse short- and long-term outcomes for all children [7, 46, 47]. Such interventions would not only improve young victim-survivors' mental health but also prevent the intergenerational transmission of violence. From a DFV- and trauma-prevention perspective, the latter is crucial given the strong link between CEDFV and further victimisation and/ or perpetration of DFV during adolescence and adulthood [22, 30, 31]. ***The Queensland Government should therefore increase funding across DFV specialist and child and family welfare services to facilitate the consistent implementation and evaluation of child-centred, DFV-informed therapeutic work in metropolitan, regional, rural and remote settings.***

Finally, educational settings have a unique opportunity to recognise and respond to (early) signs of CEDV and counter its impacts [55, 60]. The benefits of building trauma-informed educational settings are multi-layered. Firstly, trauma-aware staff are better equipped to create DFV- and trauma-informed referral pathways for students to support children and young people's short- and long-term recovery from DFV-related trauma [54]. Secondly, trauma-informed educational settings provide opportunities for early interventions that mitigate the documented adverse effects of CEDV on children and young people's educational engagement, progress and outcomes [55, 60]. ***It is therefore recommended that Queensland Education supports professional development of its staff in DFV- and trauma-informed education to support education staff in identifying and responding to indicators and disclosures of CEDV.*** The *National Guidelines for Trauma-Aware Education* should be used as a blueprint here. Further, ***The Queensland Government should fund Queensland Education to implement and evaluate school-based trials of evidence-based programs (e.g. HTL, HEARTS, TBRI, NHTC) [55] to explore their effectiveness in metropolitan, regional, rural and remote Australian settings.***

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