Submission on Women's Health Strategy from The Backbone Collective

March 2023

Backbone would like to thank Manatū Hauora Ministry of Health for the opportunity to make our submission. Our organisation is committed to ensuring that the insights of women who have experienced violence and abuse (and their children) inform the continuous improvement of the way New Zealand responds to family and sexual violence. Our submission is based on the experiences of hundreds of New Zealand women who have taken part in our online surveys and shared their experiences via email and Facebook messages.

Backbone would also like to acknowledge and thank The Gender Justice Collective[1] for their incredible work to gather the views of women, wāhine, trans women, non-binary & intersex people about the need for a women's health strategy and their tireless advocacy that made this submission process possible.

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About Backbone

The Backbone Collective (Backbone) was launched in March 2017 to enable women to safely and anonymously tell the Government, others in authority, and the public about how the 'system' responded to them when they experienced violence and abuse, and how they need it to respond for them to be safe and rebuild their lives.

Backbone is an independent organisation and a registered charity with the New Zealand Charities Commission. Our purpose is to contribute to the continuous improvement of the response system in Aotearoa New Zealand so that it works well to support and protect women and their children when they experience violence and abuse. We run online surveys to collect anonymous feedback from women victim-survivors (service users) about different parts of the response system. We share reports about the findings of these surveys with recommendations for how the system can work more safely. Our ability to give victim-survivors the opportunity to share their experiences is reliant on donations, philanthropic grants and other contracts.

Our vision, in the context of a Women's Health Strategy, is for a health sector that non-judgementally, safely and cohesively identifies and responds to violence against women and children and provides both emergency and long-term responses to the harm and distress that they experience as a consequence of intimate partner, other family violence and sexual violence.

You can read our reports here: https://www.backbone.org.nz/reports.

In 2020 the Backbone Collective released a report about victim-survivor perspectives on help seeking and longer-term support after experiencing violence and abuse. This found that:[2]

> many women who are victim-survivors of family violence are not accessing or using formal support services... When they do use services, it is more likely to be from a G.P, mental health services, and other health professionals (65%) followed by Police (60%) than other types of support (p47).

This highlights one of the many reasons why men's violence against women and children must be a priority issue in a women's health strategy. In a nutshell: There are significant barriers to help-

[1] https://www.genderjustice.nz/

[2] The Backbone Collective. (2020). *Victim-survivor perspectives on longer-term support after experiencing violence and abuse: A report prepared for the Ministry of Social Development.* The Backbone Collective.

seeking after experiencing violence and abuse. When women do seek system help, they are most likely to engage with health services. Abuse and violence are correlated with virtually all poor health and life outcomes. Abuse and violence against women and children is widespread and chronic – that means many women experience it and that some women experience a lot of it. A health strategy that prioritises violence and abuse can have an enormous impact on improving the health and life outcomes of women and children.

Wellbeing

Backbone asked some victim-survivors to explain what wellbeing meant to them in an online survey in 2019.[3] We heard from 528 victim-survivors of family violence who lived throughout Aotearoa New Zealand. For many of the survey participants their sense of wellbeing and that of their whānau was deeply connected to their ability to be safe from the abuser and to be supported in a range of ways that were informed by a comprehensive understanding of family violence (the dynamics and tactics abusers use). Wellbeing is achieved by the right support and services being available at the right time and for as long as it takes to be safe and recover. The health system has an important role to play in supporting safety and wellbeing for women victim-survivors and their children.

Wellbeing needs

What health means to women and/or specific groups of women.

In Aotearoa New Zealand, men's violence against women and children is variously called domestic violence, intimate partner violence (IPV), family violence, child abuse, elder abuse, family harm and sexual violence. This submission is primarily about violence against women and children in the context of a man's intimate partner violence.

This submission is particular to women,[4] as women have significantly higher prevalence and are more likely to experience adverse health effects from violence and abuse than men.[5] Women who experience higher prevalence, and therefore an increased burden of disease and harm include: Māori women, Pacific women, Asian women, women from migrant and refuge communities, trans women and disabled women.[6] These are the communities of women who often report poorer outcomes in the health service and who have less resources to escape violence and access support services.

[3] The Backbone Collective. (2020). *Victim-survivor perspectives on longer-term support after experiencing violence and abuse: A report prepared for the Ministry of Social Development.* The Backbone Collective. https://www.backbone.org.nz/s/Victim-Survivor-Perspectives-on-Longer-Term-Support-Backbone-report-for-MSD-2020-FINAL.pdf

[4] In a health context this includes both women who are cis-gender female (their sex and gender identities correlate) and those who are 'female' embodied but who do not identify as women or who do identify as women and have diverse sex characteristics.

[5] Mellar B, Gulliver P, Selak V, Hashemi L, McIntosh T, Fanslow J. (2022) Association Between Men's Exposure to Intimate Partner Violence and Self-reported Health Outcomes in New Zealand. *JAMA Network Open*. 2023;6(1)e2252578. doi:10.1001/jamanetworkopen.2022.52578 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800729

[6] Hager, D. (2017). *Not inherently vulnerable: An examination of paradigms, attitudes and systems that enable the abuse of dis/abled women.* The University of Auckland. https://researchspace.auckland.ac.nz/handle/2292/36826

The current health strategy

The New Zealand Health Strategy (2000),[7] had, as one of its priorities, reducing violence in interpersonal relationships, families, schools and communities. It says:

> In many countries violence is recognised as a key public health issue. Child abuse, sexual violence, family violence, school bullying and elder abuse are all preventable forms of harm and social disruption. To reduce violence in those areas, health professionals and providers require protocols and training to allow them to recognise and respond to the family violence and abuse. Public health campaigns are also important (p 17).

Also named as priorities were:

- reducing the rate of suicides and suicide attempts
- reducing smoking
- minimising harm caused by alcohol and illicit and other drug use to individuals and the community reducing the incidence and impact of cancer
- reducing the incidence and impact of cardiovascular disease
- improving the health status of people with severe mental illness
- ensuring access to appropriate child health care services including well child and family health care and immunisation (p 13).

Listed under reducing inequalities in health status are Māori advancement in health (p18) and improving Pacific peoples' health (p 19).

The short term and cumulative effects of all of these health issues could be addressed, and prevalence reduced, by focusing on the prevention of, and a robust, victim-survivor-led response to violence against women and children.

The physical, emotional and mental health effects of men's violence against women and children

Men's violence against women and children creates huge, long lasting health effects.[8] New Zealand research tells us:[9]

> To adequately address the increased likelihood of adverse health outcomes associated with women's exposure to IPV [intimate partner violence], health professionals need to be engaged in nuanced understanding of IPV identification and appropriate responses and should be well supported to provide robust referral options within proactive and dynamic health care systems. Given the higher rates of violence exposure for Māori

[7] Ministry of Health. (2000). *New Zealand Health Strategy.* Wellington. MoH.
[8] Mellar BM, Hashemi L, Selak V, Gulliver PJ, McIntosh TK, Fanslow JL. (2022). Association Between Women's Exposure to Intimate Partner Violence and Self-reported Health Outcomes in New Zealand. *JAMA Netw Open.* 2023;6(3):e231311. doi:10.1001/jamanetworkopen.2023.1311
[9] Ibid.

> women and women who were food insecure, health and referral services also need to be equipped to address these disparities. Development of these responsive health care systems must be underpinned by well-designed and comprehensive IPV curricula in medical and health training. (para 26)

In 2021 the World Health Organisation (WHO) stated that violence against women is a global epidemic.[10] The New Zealand Women's Health Strategy must recognise the severity of this epidemic and respond to it as it would to other health and life-threatening situations.

Family related violence includes coercive control, emotional/psychological violence, physical violence, financial abuse and sexual violence perpetrated against a person that one has a family relationship with. The Family Violence Act 2018 defines family violence as:

> (1) In this Act, *family violence*, in relation to a person, means violence inflicted—
>
> **(a)** against that person; and
>
> **(b)** by any other person with whom that person is, or has been, in a family relationship.
>
> (2) In this section, *violence* means all or any of the following:
>
> **(a)** physical abuse:
>
> **(b)** sexual abuse:
>
> **(c)** psychological abuse.
>
> (3) Violence against a person includes a pattern of behaviour (done, for example, to isolate from family members or friends) that is made up of a number of acts that are all or any of physical abuse, sexual abuse, and psychological abuse, and that may have 1 or both of the following features:
>
> **(a)** it is coercive or controlling (because it is done against the person to coerce or control, or with the effect of coercing or controlling, the person):
>
> **(b)** it causes the person, or may cause the person, cumulative harm.
>
> (4) Violence against a person may be dowry-related violence (that is, violence that arises solely or in part from concerns about whether, how, or how much any gifts, goods, money, other property, or other benefits are—
>
> **(a)** given to or for a party to a marriage or proposed marriage; and
>
> **(b)** received by or for the other party to the marriage or proposed marriage).

Family violence is a gendered crime, primarily perpetrated by men against female partners and their children. However, there is also violence against same sex partners, some female partners abuse men, and children of all genders may abuse their siblings and parents.

[10] World Health Organisation. (2021). *Violence against women: Key facts*. Newsroom fact sheets. https://www.who.int/news-room/fact-sheet

Prevalence data tells us that one in three New Zealand women experience domestic violence (physical or sexual) from their male partner during their life-time.[11] 2023 research[12] says that 54.7% of women report experiencing at least 1 of the 5 types of IPV (physical, sexual, coercive/controlling, psychological and/or economic abuse). For some populations of women these statistics are even higher. In the same study, 64.1% of Māori women reported all forms of IPV.[13] Pacific women and children experience high rates of physical and sexual violence[14] and non-Western ethnic minorities are also at risk, and while there is no standardised data collection, efforts have been made to determine prevalence using disaggregated data.[15] Socioeconomic circumstances also indicate risk. Mellar et. al.,[16] report that "[c]ompared with all other sociodemographic subgroups, women who reported food insecurity had the highest prevalence for any IPV (69.9%) and all specific types."

Some measure of risk is indicated from family violence death statistics. Findings from the *Learning from Tragedy* report include:[17]

- The average annual mortality rate from family violence for Māori was nearly three times that for the average total NZ population.
- The average annual mortality rate from family violence for Pacific peoples was over twice that for the average total NZ population.
- Asians had a very slightly elevated risk of family violence compared with the average total NZ population, [although data collected from different sources in 2013 suggests that the risk is much higher[18]]. Asian victims tended to be younger, new to New Zealand, and more at risk from a couple-related homicide (p 22).

[11] Fanslow, J., & Robinson, E. (2004). Violence against women in New Zealand: prevalence and health consequences. *New Zealand Medical Journal, 117*(1206), 1-12.

[12] Mellar BM, Hashemi L, Selak V, Gulliver PJ, McIntosh TK, Fanslow JL. (2023). Association Between Women's Exposure to Intimate Partner Violence and Self-reported Health Outcomes in New Zealand. *JAMA Network Open.* 2023;6(3):e231311. doi:10.1001/jamanetworkopen.2023.1311 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2801941

[13] Mellar BM, Hashemi L, Selak V, Gulliver PJ, McIntosh TK, Fanslow JL. (2023). Association Between Women's Exposure to Intimate Partner Violence and Self-reported Health Outcomes in New Zealand. *JAMA Network Open.* 2023;6(3):e231311. doi:10.1001/jamanetworkopen.2023.1311

[14] Le Va. (2018). https://www.leva.co.nz/our-work/violence-prevention/resources-research

[15] Paulin, J., & Edgar, N. (2013). *Towards freedom from violence: New Zealand family violence statistics disaggregated by ethnicity*. Wellington. Office of Ethnic Affairs. Retrieved from: http://ethniccommunities.govt.nz/sites/default/files/files/Towards%20Freedom%20from%20Violence%20-%20NZ%20Family%20Violence%20Statistics%20Disaggregated%20by%20Ethnicity%20-%20Office%20of%20Ethnic%20Affairs%202013.pdf. Office of Ethnic Affairs.

[16] Mellar BM, Hashemi L, Selak V, Gulliver PJ, McIntosh TK, Fanslow JL. (2023). Association Between Women's Exposure to Intimate Partner Violence and Self-reported Health Outcomes in New Zealand. *JAMA Network Open.* 2023;6(3):e231311. doi:10.1001/jamanetworkopen.2023.1311

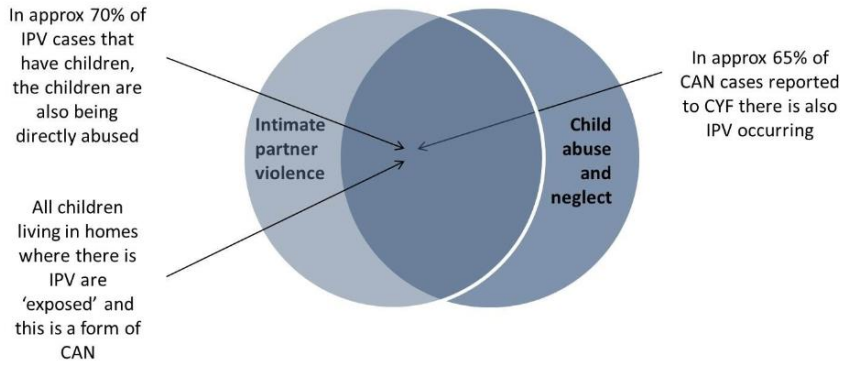
[17] Martin, J. & Pritchard, R. (2010*). Learning from Tragedy: Homicide within Families in New Zealand 2002-2006*. Working Paper April 2010. Wellington: Ministry of Social Development. ISBN 978-0-478-32364-1 (online). http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/learning-from-tragedy

[18] Paulin, J., & Edgar, N. (2013). *Towards freedom from violence: New Zealand family violence statistics disaggregated by ethnicity*. Retrieved from Wellington:

Between 60 – 90% (depending on the research population) of all disabled women are sexually, emotionally and/or physically abused.[19] International research indicates that LGBTI+ communities are also at higher risk.[20]

There is a high correlation between violence against women and harm to children. See the Figure below which has copied from *The Way Forward* report:[21]

Figure 5: The co-occurrence of IPV and CAN



Sexual violence is "any act (verbal or physical) which breaks a person's trust and/or safety and is sexual in nature. The term sexual violence includes: rape, incest, child sexual assault, marital rape, sexual harassment, exposure and voyeurism".[22] Sexual violence occurs primarily between people who know each other, and there are high rates of sexual violence in domestically abusive, intimate partner relationships. It is a gendered crime experienced disproportionately by female victims. Victims are aged from birth to very old age. Perpetrators are overwhelmingly male.[23]
The New Zealand Law Commission describes the harms, complexities and victim responses to sexual violence in an intimate partner relationship: [24]

> Most perpetrators of sexual violence are known to their victim and many are in a personal or family relationship with their victim. The victim may be reliant on the perpetrator for social or economic support… Sexual violence can occur in an ongoing, long-term relationship, often in concert with other kinds of violence and abuse (physical, emotional and psychological). In such cases, sexual violence is a form of intimate partner violence perpetrated in the context of a pre-existing domestic relationship, which is also likely to be characterised by economic dependence and emotional manipulation.

[19] Hager, D. (2017). *Not inherently Vulnerable: An examination of paradigms, attitudes and systems that enable the abuse of disabled women*. A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Health Science, University of Auckland.
[20] Carlton, J. M., Cattaneo, L. B., & Gabhard, K. T. (2015). Barriers to help seeking for lesbian, gay, bisexual, transgender and queer survivors of intimate partner violence. *Trauma Violence Abuse.* (May 15). DOI: 10.1177/1524838015585318
[21] Herbert, R. and Mackenzie, D. (2014). *The way forward - an Integrated System for Intimate Partner Violence and Child Abuse and Neglect in New Zealand.* Wellington, The Impact Collective.
[22] Auckland Sexual Abuse Help. *Sexual Violence and Prevention.* Accessed from www.sexualabusehelp.org.nz
[23] https://toah-nnest.org.nz/what-is-sexual-violence/who
[24] Law Commission. (2015). *The justice response to victims of sexual violence: Criminal trials and alternative processes.* NZLC R136; Law Commission (2016). *Understanding family violence: Reforming the criminal law relating to homicide*. NZLC R139.

A related point is that, although sexual violence can have a number of distinctive impacts on its victims, there is no "typical" victim response. Victims may behave in many different ways to cope with the psychological impact of offending both at the time of the incident and afterwards. Some of these may appear counter-intuitive, yet they are established by research to be common responses.

The harms of violence and abuse

Men's violence against women causes a great deal of harm to women, much of it long term.[25, 26] This includes:[27]

- Fear, including hyper-vigilance
- High rates of injury - broken bones, head injury, cuts, stab wounds, other wounds from weapons, burns, strangulation, traumatic brain injury, bruising, internal injuries and unconsciousness
- Physical illness from stress and lack of medical care
- High rates of sexually transmitted infections, including HIV
- Pregnancy complications
- Unwanted pregnancy
- Abortions
- Delays in pre-natal care
- Miscarriage
- Effects of rape including: gynaecological problems, STDs, HIV, sexual problems, and problems related to unwanted pregnancies as above
- Psychological effects of trauma and sexual violence including traumatic stress symptoms such as nightmares, depression, an inability to concentrate, sleep and eating disturbances and feelings of anger, humiliation and self-blame

[25] Law Commission. (2015). *The justice response to victims of sexual violence: Criminal trials and alternative processes.* NZLC R136; Law Commission (2016). *Understanding family violence: Reforming the criminal law relating to homicide*. NZLC R139; Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi & Rafael Lozano (eds). (2002). *World report on violence and health.* World Health Organisation.

[26] Black, M. C. (2011). Intimate partner violence and adverse health consequences. *American Journal of Lifestyle Medicine, 5*(5), 428-439.

[27] Fanslow, J., & Robinson, E. (2004). Violence against women in New Zealand: Prevalence and health consequences. *New Zealand Medical Journal, 117*(1206), 1-12; Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (2011). *Family violence across the lifespan: An introduction.* (3rd ed.). Thousand Oaks, CA: Sage; Gulliver, P., & Fanslow, J. (2013). Exploring risk factors for suicidal ideation in a population-based sample of New Zealand women who have experienced intimate partner violence. *Australian and New Zealand Journal of Public Health*, http://dx.doi.org/10.1111/1753-6405.12110; Heise, L., & Garcia-Moreno, C. (2002). Violence by intimate partners. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano, (Eds.), *World report on violence and health* (pp. 87-121). Geneva, Switzerland: World Health Organisation; Heise, L. L., Pitanguy, J., & Germain, A. (1994). *Violence against women, the hidden health burden*. (Discussion Paper No. 255). Washington DC, WA: The World Bank; Powers, L. E., & Oschwald, M. (2004). *Violence and abuse against people with disabilities: Experiences, barriers and prevention strategies*. Centre on Self-Determination, Oregon Institute on Disability and Development, Oregon; Radford, J., Harne, L., & Trotter. J. (2006). Disabled women and domestic violence as violent crime. *Practice: Social Work in Action, 18*(4), 233-246; VicHealth. (2004). *The health costs of violence: Measuring the burden of disease caused by intimate partner violence: A summary of findings*. Melbourne, Australia: Victorian Health Promotion Foundation; World Health Organisation. (2016). *Violence against women: Intimate partner and sexual violence against wo*men. Fact sheet No. 239 (Updated January 2016). Geneva, Switzerland: World Health Organisation. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/.

- Suicide and suicide attempts (IPV victimisation is implicated in 73% of Māori maternal suicides, and childhood exposure to family violence is implicated in one-fifth of youth suicides)
- A variety of mental health problems including depression, anxiety, substance abuse, self-harming behaviours and very low self-esteem.

Children experience a great deal of immediate and developmental harm not only from being physically, sexually and emotionally abused, but from being exposed to abuse against women in their families and homes and from related neglect. This harm, and consequent developmental problems, can occur in-utero and from the moment children are born. The harm children experience is developmental, cognitive, physical, sexual and emotional.[28]

Physical harm includes:

- Abdominal/thoracic injuries
- Brain injuries
- Bruises and welts
- Burns and scalds
- Central nervous system injuries
- Disability
- Fractures
- Lacerations and abrasions
- Ocular damage
- A range of long-term chronic health problems as adults

Sexual and reproductive harm includes:

- Reproductive health problems
- Sexual dysfunction
- Sexually transmitted diseases, including HIV/AIDS
- Unwanted pregnancy

Psychological and behavioural harm includes:

- Alcohol and drug abuse
- Cognitive impairment
- Delinquent, violent and other risk-taking behaviours
- Depression and anxiety
- Developmental delays
- Eating and sleep disorders
- Feelings of shame and guilt
- Hyperactivity or difficulty in concentrating
- Poor relationships
- Poor school performance
- Poor self-esteem

[28] Graham-Bermann, S. A., & Edleson, J. L. (2001). *Domestic Violence in the Lives of Children: The future of research, intervention and social policy*. Washington D.C.: American Psychological Association; E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano, (Eds.), *World report on violence and health.* Child abuse and neglect by parents and other caregivers (pp. 57-85). Geneva, Switzerland: World Health Organisation

- Post-traumatic stress disorder
- Psychosomatic disorders
- Suicidal behaviour and self-harming behaviours

Added stress, such as not being believed and validated in health systems, by Police and in the Family Court (particularly ongoing, court ordered unwanted interaction with the abuser) adds to women and children's distress and confusion and results in long term damage to women and children's health and wellbeing.[29] Such systemic responses have been described as secondary abuse.

The immediate impacts of sexual and family violence are detailed *The Way Forward Report*, as shown in the Figure below copied from that report.[30]

Figure 7: Immediate effects of IPV

Physical Health	Personal and Social Wellbeing	Intimacy and Relationships	Mental and Emotional Health	Other Impacts
• death • physical injury • permanent disability (blindness, deafness, epilepsy, loss of mobility) • hospitalisation for physical injuries of gynaecological problems • sexually transmitted infections (STIs) • unwanted pregnancies • chronic, long-term illness • losing an unborn baby, or having a baby with birth defects • infertility • treatment for broken teeth, cuts, headaches, concussion • bruises, pain, trauma	• feeling worthless • loss of community and culture • self-blame • hurting others that are close • copying controlling and violent behaviour • withdrawing from family and friends • bad relationships with children • feeling whakama/shame, guilt or embarrassment • feeling out of control • a distorted sense of reality • low self-esteem and loss of confidence • loss of energy, feeling apathetic • isolation (staying home so people don't see the bruises; being avoided by others) • hating or being ashamed of your body • sexual promiscuity	• living in constant fear • not being able to have healthy sexual relationships	• mental illness • anxiety and worry • eating and sleeping disorders • depression • feeling suicidal/ committing suicide/self-harm • violent thoughts or actions • Post Traumatic Stress Disorder (PTSD)	• alcohol and drug abuse • inability to hold down work

A consequence of leaving an abusive relationship is that many women will be poorer. The wider literature about gender and poverty concurs that after separation most women will experience lower income and higher debt. This is exacerbated for women leaving abusive/violent relationships.[31] Women's Refuge (New Zealand) identify that women leaving abusive relationships will have difficulty maintaining employment and will frequently have poorer quality housing, including for some being reliant on friends and family for accommodation.[32]

[29] Salter, M. (2012). Invalidation: A neglected dimension of gender-based violence and inequality. *International Journal for Crime and Justice, 1*(1), 3-13.
[30] Herbert, R. and Mackenzie, D. (2014). *The way forward - an Integrated System for Intimate Partner Violence and Child Abuse and Neglect in New Zealand*. Wellington, The Impact Collective.
[31] Eldin Fahmy, Emma Williamson and Christina Pantazis, (2015). *Evidence and policy review: Domestic violence and poverty. A Research Report for the Joseph Rowntree Foundation*. University of Bristol School for Policy Studies
[32] Jury, A., Thorburn, N., & Weatherall, R. (2017). *Women's Experiences of Economic Abuse in Aotearoa New Zealand*. Women's Refuge.

Women's Aid UK, from their 2019 client survey, say: [33]

- A third of respondents had to give up their home as a result of the abuse or leaving the relationship and nine found themselves homeless as a result of leaving
- 43.1% of respondents told us they were in debt as a result of the abuse and over a quarter regularly lost sleep through worrying about debt
- 56.1% of our sample who had left a relationship with an abuser felt that the abuse had impacted their ability to work and over two fifths of all respondents felt the abuse had negatively impacted their long-term employment prospects/earnings.

Financial abuse significantly increases women's stress, leading to physical and mental health problems, and reduces women's access to health services, to safe and secure housing, adequate nutrition and other necessities/determinants of life.

Patterns and trends

Women's lifetime exposure to physical and sexual intimate partner violence has not changed between 2003 and 2019 (still about 1 in 3 women) and there is evidence that lifetime rates of sexual IPV have not changed substantially over the last century.[34] Lifetime rates of controlling behaviours and economic abuse, however, appear to be increasing. This increase has implications for health, as experience of controlling, coercive behaviours, physical and sexual violence and economic abuse are associated with often long-term illness, disability, substance abuse and mental health problems.

Lifetime rates of experience of intimate partner violence have not changed because we have not invested in, and implemented, evidence-based prevention strategies. Effective evidence based IPV prevention efforts exist but need to be implemented to address perpetration of intimate partner violence. These need to engage men and boys and needs to be informed by international evidence as well as local knowledge.

Priorities for system change

1. **The health system must prioritise the identification and response to violence against women and children, recognising that helping victims escape violence and live lives free from control, harm and fear, will alleviate many of the long-term health complaints associated with IPV, sexual violence, elder abuse, abuse of LGBTI+, and abuse of disabled people.**

[33] UK Women's Aid. (2019) *The nature and impact of domestic violence*. https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-nature-and-impact-of-domestic-abuse/. See also: Marilyn Howard & Amy Skipp, (2015). *Unequal, trapped & controlled Women's experience of financial abuse and potential implications for Universal Credit: Exploratory research by Women's Aid for the TUC*. England. TUC

[34] Fanslow, J., Hashemi, L., Gulliver, P., McIntosh T. (2021). A century of sexual abuse victimisation: A birth cohort analysis. *Social Science & Medicine*, Volume 270,113574, https://doi.org/10.1016/j.socscimed.2020.113574

Prioritising this response is both preventative (reduces the incidence of long-term illnesses, mental health problems and disability) and proactive (reduces the potential for more complex comorbidities by early identification and response).

Doing this means ensuring that:

- every woman who enters the health system encounters health and related professionals who understand the dynamics of violence against women and children, including the intersectional nuances of violence for elders, disabled women, rainbow communities, and women from non-western ethnic/cultural backgrounds.
- all health and related professionals understand the risks abusers pose to women's safety and how the system can create further harm if policies and practice are not created and implemented with the safety of women and children as a first priority.
- screening of all women – and their children if required - for violence and abuse, (coercive, controlling, psychological, financial, physical and sexual violence) is undertaken regularly and in circumstances that create safety.
- the screening that occurs screens not just for abusive behaviours, but for the health-related outcomes, including physical illnesses, injury, head injury, sexual violence related harm, anxiety, depression, PTSD and suicide ideation and attempts.
- the social work response to disclosures is well resourced, with staff who have excellent relationships with the specialist violence services in the community and resources within the health service to keep women and children safe while they (women and children) make decisions about their ongoing safety.
- patient records are unable to be accessed by partners, carers and others outside of, and occasionally within, the health system. Women's Refuge National Office[35] report that patient notes are regularly accessed by abusers and used to discredit women (prevent their disclosures being recognised as legitimate), to further abuse them (threaten, ridicule and further control them), and to coerce them into keeping silent in any future interactions with health and related professionals.
- mental health and substance abuse services are fully resourced and trained to respond to the harm caused by men's violence against women and children. This must include providing gender and violence specific services for women *and* children harmed by men's violence.[36] Policy and practice must be developed to ensure that specialist support is easily accessible. This means that women (and their children) who disclose any form of violence or abuse by a current or former partner should be offered immediate support from a specialist well trained workforce.

As part of this policy and practice development, services must ensure that they:

- conduct any consultation in private, and details should not be disclosed to the former partner.

[35] National Office of Women's Refuge (2023). *Health at what risk? Balancing healthcare access and the risks of partner violence in online health notes.* Unpublished report.
[36] Hager, D. (2011). *Finding safety: Provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services.* Winston Churchill Memorial Trust, 2011.

- uphold client confidentiality, (including not sharing patient records or diagnosis with other organisations, schools or the Family Court) while informing women of the limits of this confidentiality particularly when mandatory reporting is necessary.
- are non-judgemental and supportive.
- provide practical care and support that does not intrude and are directed by what the victim-survivor wants.
- increase safety for women and children and do not result in unintended harm.
- support and services should include specialist support for children's mental health and support and advocacy for navigating the necessary social and legal services.

In order for this to occur we need the Manatū Hauora/Ministry of Health's Violence Intervention Programme[37] to receive priority implementation and resourcing. Currently, the Violence Intervention Programme has developed an infrastructure that provides evidence-based strategies for family violence assessment and intervention. However, the programme is not well embedded into the health system, and strong policy, leadership and resourcing is needed for the programme to achieve its potential. Additional resourcing is required to support engagement with referral services, and across agencies in the community, and to ensure robust monitoring (and taking corrective actions) of the staff screening and responses. We hear many anecdotal stories of unsafe screening (for example in front of partners or support people), or doctors and others refusing to screen because it doesn't fit with their priorities/takes up time/they don't understand the need to screen.

2. The Backbone Collective specifically recommend that all health and related service responses and developments must apply an IPV/family/sexual violence lens.[38]

Applying an IPV/family/sexual violence lens means:

- building victim-survivor voices into the design and development of all policy and programmes.
- all health and related sector policies (social work, police, justice and Family Court) should include a specialist IPV/family/sexual violence lens to ensure that they are fit for purpose and will result in safe practice and processes for victim-survivors and their children.
- providing opportunities for victim-survivors, or their advocates, to alert officials to policies or processes that are resulting in harm to victim- survivors and their children.
- ensuring that when these red flags are raised by victim-survivors, or their advocates, they are shared with all relevant government agencies and with the family law system and that corrections to policy and practice occurs across all relevant agencies.
- ensuring government agencies work in collaboration when designing policies or processes in response to family and sexual violence so that information is shared and policies don't work against each other e.g. health policies and family law policies.

[37] https://www.health.govt.nz/our-work/preventative-health-wellness/family-violence-and-sexual-violence.
[38] The Backbone Collective. (2022). *Shining light on the shadow: The impact of the COVID-19 Pandemic on abuser behaviour*. The Backbone Collective. https://static1.squarespace.com/static/57d898ef8419c2ef50f63405/t/62d8a6978d89d744f0c129dc/1658365603673/Shining+Light+on+the+Shadow+FINAL+Backbone+Collective.pdf

3. Prioritise the provision and funding of health services victim-survivors say they need.

Victim-survivors have clearly articulated via online surveys to Backbone the types of health services and supports they need and are currently lacking in their communities. Many women in Backbone's 2020 survey on longer term support services explained a need for free or subsidised access to healthcare as they struggled to afford the everyday living expenses and were forced to go without healthcare in many cases.[39]

Victim-survivor suggestions for free services included:

- counselling or psychologists and mental health treatment
- health checks for women, their children and whānau
- dentist visits, dental repair due to the abuse
- healthy food or vitamins
- optometrists
- support for weight issues
- prescriptions
- family planning and abortion services.

Some women suggested access to other kinds of health services would help such as:

- women-only health collectives
- services for children that were not Oranga Tamariki (as they feared taking their child to the Dr would result in the child being removed from their care)
- Māori healing practices and support from iwi and hapu
- specialist rehabilitation support and care to recover from injuries related to the violence and abuse.

4. Health care professionals need to understand violence experience as a health issue.

This means health care professionals must provide regular, mandated and specialist training to people who work with victim-survivors and their children – which is all of the health workforce. Training should aim to raise workers' understanding of family violence (including dynamics and impacts of coercive control) sexual violence, abuser dynamics/behaviours and impacts on victim-survivors including children. This can occur through effective, regular training and tertiary education about:

- the dynamics of men's violence against women and children including an understanding of the power and violence implications of intersectional risk and harm (for example, the various intersectional dynamics of violence against Māori women, disabled women, elders, and violence against women identifying people from the LGBQTI+ community).
- the nuances involved in IPV for victim-survivors who are no longer in a relationship with their partners and an understanding that violence and abuse continue post separation

[39] The Backbone Collective. (2020). *Victim-survivor perspectives on longer-term support after experiencing violence and abuse: A report prepared for the Ministry of Social Development.* The Backbone Collective. https://www.backbone.org.nz/s/Victim-Survivor-Perspectives-on-Longer-Term-Support-Backbone-report-for-MSD-2020-FINAL.pdf

and for long periods and victim-survivors have little control in their ongoing experience of violence and abuse.

- the ways abusers use children to continue their abuse post separation.[40]
- the ways the system response enables violence and abuse to continue and can act as a barrier to women and children's safety.[41]
- the prevalence and health consequences of intimate partner violence and sexual violence, to provide a strong basis for health professionals to understand their professional role when (not if) they encounter victims of violence and abuse.[42]

The Manatū Hauora/Ministry of Health needs to foster knowledge about the dynamics and harms of violence through multiple strategies.

- work with universities to get them to recognise the importance of embedding knowledge about the dynamics and harms of violence into their core curricula. This would include all medical training – doctors, psychiatrists, nurses and allied health professionals (for example psychologists, psychotherapists, counsellors, audiology and physiotherapy), all social work training and training of community workers, and all lawyers and allied justice staff.
- support the VIP coordinators to attend specialist postgraduate training on violence - for example https://www.auckland.ac.nz/en/fmhs/about-the-faculty/soph/study-options/subjects/violence-prevention.html
- support wider workforce development efforts for the field, as has been done for development of the Alcohol and Drug workforce. See for example https://pubmed.ncbi.nlm.nih.gov/28499116/.

The Backbone Collective, 17 March 2023.

[40] The Backbone Collective. (2022). *Shining light on the shadow: The impact of the COVID-19 Pandemic on abuser behaviour.* The Backbone Collective. https://static1.squarespace.com/static/57d898ef8419c2ef50f63405/t/62d8a6978d89d744f0c129dc/1658365603673/Shining+Light+on+the+Shadow+FINAL+Backbone+Collective.pdf

[41] The Backbone Collective. (2020). *Victim-survivor perspectives on longer-term support after experiencing violence and abuse: A report prepared for the Ministry of Social Development.* The Backbone Collective. https://www.backbone.org.nz/s/Victim-Survivor-Perspectives-on-Longer-Term-Support-Backbone-report-for-MSD-2020-FINAL.pdf

[42] Ambikile, J. S., Leshabari, S., & Ohnishi, M. (2022). Curricular Limitations and Recommendations for Training Health Care Providers to Respond to Intimate Partner Violence: An Integrative Literature Review. *Trauma, Violence, & Abuse*, 23(4), 1262–1269. https://doi.org/10.1177/1524838021995951