Chapter 11
Intimate Partner Violence in Australia and Aotearoa New Zealand

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11.1 Introducing Ourselves

We were drawn to work together on this chapter primarily because of the opportunity that it provided for us to reflect on how intimate partner violence (IPV) prevention efforts have developed in our respective countries. What emerged, however, was a better understanding of our common interests and concerns around how violence can be best prevented and how much we still have to achieve in the countries in which we live and work.

I, Andrew, am a forensic psychologist by training who now works as an academic in the discipline of criminology in the University of Melbourne, Australia. My work has focused on the development and evaluation of interventions offered to those known to have perpetrated IPV. Over time, I have come to appreciate not only the importance of understanding the personal factors and drivers of violence that are so often the focus of prevention efforts but also the broader social and cultural context in which violence occurs – and is maintained over time. I have learned much from those who receive services – and from those who deliver them – about how the choices that are made on a daily basis are so often constrained by the circumstances in which IPV occurs as well, of course, as the persistence that is required to effect meaningful change in this area.

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I, Stuart, am a criminologist with a background in psychology and also works at the University of Melbourne, Australia. A central theme in my involvement in interpersonal violence has been the idea that reforms intended to address this problem need to be based on a foundation of accurate knowledge about its prevalence and distribution. My introduction to this subject came when I worked at the Australian Bureau of Statistics and was involved in the development of the first national survey to measure the extent of violence against women (the Women's Safety Survey, now run every 5 years in Australia as the Personal Safety Survey). In my subsequent academic career, I have maintained a strong interest in the way that policy reform, policing, and court interventions can help to reduce the level of IPV in the community and can improve responses to the needs of victim/survivors.

I, Devon, am a clinical psychologist and, from the beginning of my career, have specialized in working with people with persistent problems with criminal behavior. I started as a correctional psychologist, working with men in prison who were at high risk of future violence and very high risk of ongoing crime. Effective rehabilitation for these men has been a primary focus of my research and teaching since I became a full-time academic at Waikato University, Aotearoa New Zealand (NZ), in 1994. I began to recognize about 5 years ago that there was a need for more academic research in NZ on intimate partner, family, and whānau (the NZ Māori language term for family, referring to a more extended family structure) violence. Since that time, my graduate students and I have been studying people who perpetrate and experience these forms of violence.

11.2 Introduction

Recently, a range of IPV prevention policy and practice initiatives have been developed across both Australia and NZ. These include public education campaigns, legislative reform, and increased funding for a range of new services and programs in both countries which have contributed to much greater public awareness about both the prevalence and harms associated with IPV as well as other forms of domestic and family violence (Webster et al., 2018). In many ways, such developments have paralleled those that have occurred in other parts of world, with similar challenges facing those in both countries who work to prevent and respond to IPV. These challenges are discussed throughout this chapter, although our main aim in writing this chapter is to offer some wider context to how service delivery systems have developed in both Australia and NZ, to allow comparison with other countries, and to draw attention to the ways in which specific social and cultural factors shape IPV prevention responses. Accordingly, we start by providing an overview of both countries and summarizing current knowledge about prevalence, guiding legislation, and the main programs that are currently available.

11.3 Countries in Context

Even though Australia and NZ have much in common with one another, it is important to note from the outset that there are also distinctive jurisdictional and demographic differences that shape service delivery. Perhaps most significantly, Australia – with a population of 25 million people – is a much larger country, with a federal system whereby parliamentary authority for enacting legislation and the delivery of services can differ markedly across each of the seven states and territories. This means that while the federal government's *National Plan to Reduce Violence Against Women and Their Children 2010–2022* remains the principal policy document that coordinates the national response to prevention, most legal, law enforcement, and support service responses to IPV operate at the level of state and territory government. In contrast, NZ has a total population of around five million people, national legislation, a single criminal justice system, and no single document that currently guides government policy and practice. NZ does, however, have a longer history of addressing IPV as a major policy issue at a national level, with the first public education campaigns dating back to 1993 (Donovan & Vlais, 2005) and the government noticeably strengthening its commitment to reducing family violence in 2014: a commitment that has continued with successive governments.

An important point of difference between the two countries is that the indigenous people of NZ (Māori) represent a much larger proportion (16.5%) of the population than those (Aboriginal and Torres Strait Islander peoples) in Australia (3.3%). This is significant in relation to the NZ Treaty of Waitangi – an agreement made between a number of Māori chiefs and the British Crown in 1840 – which contains important principles concerning Crown obligations to Māori that are used to guide government policy and practice. For example, responses to IPV in NZ are typically embedded in a wider approach to reducing harm to family members and whānau (an extended family or community of related families who live together in the same area) than in Australia where the focus has largely been on preventing IPV.

11.4 Prevalence

The Australian component of the International Violence Against Women Survey (Mouzos & Makkai, 2004) and three national Personal Safety Surveys (Australian Bureau of Statistics; ABS, 2005, 2012, 2016) provide the most commonly cited Australian incidence and prevalence data. The results of the most recent Personal Safety Survey (ABS, 2016) reveal that approximately 1 in 4 women (23% or 2.2 million people) and 1 in 13 men (8% or 703,700) self-report experiencing violence from an intimate partner at some point in their life. One in 6 women (16% or 1.5 million) and 1 in 17 men (6% or 528,800) reported that they had experienced *physical violence*, with women eight times more likely to have reported sexual violence

by a partner than men. In the previous 12-month period, 1.7% of women and 0.4% of men self-reported an incident. These rates are comparable with those in NZ where the primary measure of IPV is derived from the New Zealand Crime and Victims Survey (NZCVS, Ministry of Justice [New Zealand]). The 2018–2019 survey reported similar lifetime prevalence rates to Australia (22% for women, 9% for men), with higher rates for bisexual (37%) and gay/lesbian (33%) people. The 2017–2018 NZCVS also reported 12-month IPV prevalence estimates of 1.7% for women and 0.5% for men. Although survey data is thought to underestimate the true extent of IPV (Heward-Belle, 2018), these figures nonetheless provide some indication of the size of the issue in Australia and NZ and draw particular attention to the level of harm that is likely to result. The New Zealand Violence Against Women Study, for example, has reported that half of IPV victims have been injured at least once in their lifetime (Fanslow & Robinson, 2011).

11.5 Impact of IPV

The negative impact of IPV on a range of health outcomes is well established, with IPV known to contribute to poor quality of life, chronic mental health issues, and increased use of health services and medication (e.g., Hegarty et al., 2013). In addition, there is evidence that IPV has direct and indirect impacts on employment and productivity, housing, and homelessness, as well as contributes to the systemic costs associated with justice and law enforcement responses (KPMG Management Consulting, 2009). NZ data suggest that of those victimized by IPV in the previous 12 months, around half (51%) will report anxiety, panic attacks, or depression as a consequence (NZCVS Y2 core report). In addition, one in four occurrences of family violence (i.e., aggregated across all relationship types) led to injury, with medical attention sought in 12% of incidents. The estimated economic costs in 2014 of IPV victimization in NZ, depending on the prevalence rates used in the model, were between NZ$2.7 and NZ$5.4 billion (Kahui & Snively, 2014), with estimated costs to employers in lost productivity in the year to June 2014 in the range of NZ$368 million (Kahui et al., 2014). Webster (2016) has estimated that IPV contributes around 5% to the disease burden of all Australian women aged 18–44 years and just over 2% of the burden in women of all ages. It is also the third leading risk factor for death for Australian women aged 25–44 years (AIHW, 2019).

11.6 Guiding Legislation

Since the 1980s, the primary statutory and legal mechanism that provides for the immediate and future safety for victims of IPV in Australia has been *civil domestic violence protection orders*. Referred to variously as “restraining,” “family violence,”

"intervention," "protection," or "apprehended violence" orders, these can be applied for by the victim (or by police on behalf of the victim) to protect against future violence by an intimate partner (Women's Legal Service Tasmania, 2020). Such orders also consider the safety of children and, in most jurisdictions, include a mandatory condition that prohibits (or allows only conditional access to) firearms. There is also the provision for magistrates to make perpetrator exclusion orders to enable women and children to remain safely in their homes – although Breckenridge et al. (2015) have reported that these are rarely used.

With regard to those behaviors that constitute criminal offenses, it is important to note that legal definitions vary between the federal jurisdiction and the states and territories. An example of this is the legal response to incidents of coercive control. At the federal level, for example, the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth) contains a broad definition of family violence which includes coercive and controlling behavior, whereas at the state and territory level, criminal offences such as assault, damage to property, and stalking are not included in the scope of behaviors that are captured by coercion and control orders. In addition, these latter offenses are defined by single incidents and thus fail to capture patterns of coercion and control that can be associated with IPV.

NZ introduced similar legislation in 1982. The most recent legislation is the *Family Violence Act 2018*, which, along with other law changes made at the same time, broadened the types of violence that are grounds for making a protection order, included new offences (e.g., strangulation), changed bail decision-making, enhanced provisions for victims to have their statements recorded on video at the scene of the event, led to the labeling of convictions as family violence, improved information sharing between agencies, and required responses for Māori to reflect traditional values and practices. The *Domestic Violence-Victims' Protection Act 2018* also introduced the right for victims of IPV and other family violence to take up to 10 days' leave a year and made provision for short-term flexible working arrangements for victims of IPV.

11.7 Services and Programs

Specialized services for women and children experiencing IPV first became available in Australia in the mid-1970s when women's refuges were established to provide crisis accommodation and counseling. They were founded on a feminist understanding of violence against women and relied on voluntary funding and support and collective organizational arrangements. The period since can be characterized by a steadily increasing role of state and federal government in policy, funding, and service delivery and a continued focus on tertiary (crisis) responses to IPV. Some of the key national initiatives have been the establishment of the Office for the Status of Women (in 1983), the Partnerships Against Domestic Violence (PADV) initiative (in 1997), the Women's Safety Agenda in July 2005, and the National Plan

to Reduce Violence Against Women and Their Children – endorsed by the Council of Australian Governments in February 2011 (Phillips et al., 2015). State government responses have tended to focus on reforms to child protection and homelessness services (Phillips et al., 2015), as well as law enforcement and judicial system reforms, including mandatory arrest policies, specialist policing and codes of practice (Diemer et al., 2017), and access to protection orders and specialized domestic violence courts (Murray & Powell, 2009). The mid-late 1980s and early 1990s also saw a dramatic growth in the availability of men's behavior change programs. These were originally provided by nongovernment agencies but increasingly through service contracts with state government departments. These programs typically involve between 12 and 24 rolling group work sessions which follow an individual assessment, with partner engagement and support also offered. For example, the Queensland Professional Practice Standards stipulate a minimum program length of 32 h, with most programs around 32–40 h duration spread over 13–16 weeks (see Day et al., 2018).

In contrast to the explicitly gendered approach to IPV service delivery in Australia (e.g., perpetrator programs are often called "*men's* programs" in Australia), the NZ government approach is less explicit about the assumed gender of aggressors and focuses on family/whānau violence, with no exclusive approach to IPV. Most service and program provision comes from community-based nongovernmental organizations (NGOs) with very similar historical roots to those described in Australia (i.e., 1980s women's refuges, pro-feminist men's movements), reflected in the national network of family violence services *Te Kupenga Whakaoti Mahi Patunga* which originates from men's stopping violence services. Specialist NGOs are contracted by the Ministry of Justice to provide most of the programs and services for IPV, particularly in association with the granting of protection orders. The New Zealand Ministry of Justice (NZMOJ) closely monitors program standards for their contracted providers. They have adopted a code of practice rather than a highly prescriptive approach, which has allowed diversity of service development, including a number of Kaupapa Māori (indigenous) providers. Agencies may contract to provide programs for men, women, or children and for perpetrators or victims, but attendance is only mandated for perpetrators on correctional sentences or respondents of protection orders. Programs may be individually based or provided to groups. The Ministry of Social Development also provides a small amount of funding for providers to work with perpetrators (sometimes women) referred through other pathways, such as self-referrals or child protection, but is more involved in community prevention frameworks including partnerships with Māori and Pasifika.

Two distinct coordinated crisis response models for family violence have been running in pilot forms in NZ since 2016, based mainly around police calls for service. The Integrated Safety Response (ISR) brings together representatives from all relevant government departments and NGO providers to triage recent police calls for service and refer them onto suitable Kaupapa Māori or family violence services, based on assessed risk and need. An alternative initiative, Whāngaia Ngā Pā

Harakeke, is a partnership between police and iwi (a Māori language word meaning "people" or "nation," which is often translated as "tribe" or "a confederation of tribes") who work alongside NGOs and other relevant government departments. In both pilots, aggressors and victims can be referred for help even though in perhaps two-thirds of calls, no criminal offence is detected. Help provided through this referral pathway is quite diverse but is mainly individually based. There are early indications that both approaches are having positive effects (Mossman et al., 2019; Walton & Brookes, 2019).

11.8 Challenges and Opportunities

In both Australia and NZ, the prevention of IPV is an area that has evolved over time, with legislative reform, policy and regulation measures, and funding initiatives subject to continual amendment and review. Momentum for change does, however, vary – with bursts of activity often followed by some hiatus and loss of progress. In this section, we identify three challenges facing the sectors in both countries: workforce development; responding to diversity; and program evaluation and standard setting. This list is by no means exhaustive, as many other challenges – and associated opportunities – are faced by providers. For example, a particular issue arises in Australia where the federal system leads to problems in relation to the cross-boundary enforcement of protection orders because women cannot be automatically assured that their order will be enforceable across state and territory boundaries without going through a formal application or court process (Heward-Belle, 2018).

11.8.1 Workforce Development

A lack of a sufficiently sized and skilled workforce of practitioners qualified to provide programs that respond to IPV is a major constraint on service delivery. As such, an important issue going forward is practitioner training. There is very little foundational training for practitioners available in either Australia or NZ, although specialist graduate certificates are now slowly being introduced that aim to equip practitioners with the skills to work competently and safely with those who perpetrate IPV. Such qualifications are limited in their capacity to offer training to the wide range of practitioners who have a role to play in prevention, and recruiting sufficient skilled staff is an ongoing challenge (e.g., Paulin et al., 2018). Significant national support for knowledge transfer and exchange in policy and practice is, however, provided by Australia's National Research Organisation for Women's Safety Limited (ANROWS) in Australia and by the New Zealand Family Violence Clearinghouse, based at the University of Auckland.

11.8.2 Responding to Diversity

The impact of IPV is especially severe in indigenous communities, with indigenous Australian women as many as 35 times more likely to sustain serious injury and require hospitalization than non-indigenous women as a result of IPV and more likely to require emergency or refuge accommodation (Morgan & Chadwick, 2009). There is a clear need to develop culturally based services. In addition, refugees and migrant groups have been identified as particularly unlikely to seek help or report IPV and to require specialist support when they do report (Simon-Kumar, 2019). These programs are slowly becoming more available in Australia, although some are still in the concept or development phase (Fisher et al., 2020; Putt et al., 2017). In NZ, Māori are also at increased risk of IPV victimization (NZCVS, 2018). Māori- and Pasifika-led approaches focus more explicitly on building well-being and share the goals of restoring traditional cultural beliefs, values, and practices regarding family and community life that should protect against violence, using processes that are themselves part of the culture (e.g., Fa'alau & Wilson, 2020). Indigenous programs often share a recognition that the experience of IPV is in no small part due to a combination of as follows: (a) multigenerational trauma resulting from the active suppression and destruction of culture that is the process of colonization – resulting in "loss of cultural identity, isolated and fragmented family systems, weakened traditional mechanisms for support, loss of land, language and self-determination" (Dobbs & Eruera, 2014; p. 23) – and (b) the imposition or adoption by peoples that formerly revered and respected women of colonizing western belief systems that denigrate them (see also Stubbs & Wangmann, 2017).

The challenges in delivering services to diverse rural and geographically remote areas in Australia are also obvious. To illustrate, the largest Australian state, Western Australia, while having a population of only 2.3 million people, covers a geographical area of nearly one million square miles (roughly twice the size of Western Europe). While the majority (75%) of the Western Australian population reside within one metropolitan area (the city of Perth), IPV services have to be provided across the entire state, including to remote areas.

With regard to sexual and gender diversity, there are still few specialist providers of IPV services. The emphasis from support organizations to date has largely been on advising "mainstream" providers on how to meet the needs of members of the Rainbow Community (e.g., Dickson, 2016; see kahukura.co.nz), although this area is now receiving some attention (Gray et al., 2020). Similarly, the service needs of women with disability are also being increasingly explored (Maher et al., 2018).

11.8.3 Evaluation and Standards of Practice

There is clearly much work to be done in the area of evaluation and quality assurance in service delivery in IPV services and programs. Despite widespread recognition of the need for more robust evaluation, very little data on outcomes are available

in both countries – a number of qualitative, service user, and provider evaluations have been undertaken, but methodologically strong evaluations of intervention effects are largely absent. This is, in part, because of difficulties with accessing necessary data and in part due to the substantive ethical and practical challenges involved with this type of work (see Paulin et al., 2018; Walton & Brookes, 2019).

The lack of robust evidence base for practice creates particular challenges in setting standards of practice for the sector. A lack of compelling empirical evidence to suggest that any one type of intervention is more effective than any other has, for example, led to a lack of consistency in service delivery in Australia (Mackay et al., 2015), although work in this area is underway (Day et al., 2018).

11.9 Next Steps

Even though IPV (and family violence more generally) can be viewed as a significant public health and criminal justice problem, government responses have typically not provided the level of resourcing that is commensurate with the level of need, and it is often the community or nongovernment sector that provides the most impetus for service reform. Both Australia and New Zealand are at a point where their respective governments are, however, more committed to preventing IPV than ever before, and the next step is to move current interventions beyond crisis responses to target primary, secondary, and tertiary levels of prevention. Addressing the challenges associated with workforce development, diversity, and the evidence base for service delivery will be essential if integrated prevention programs are to be developed that adequately respond to the complexity of the issue.

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