



## Public Health Association of Australia:

### Policy-at-a-glance – Domestic/Family Violence Policy

- Key message:**
1. Domestic/family violence is a significant public health problem and a key determinant of women's and children's health.
  2. PHAA advocates cross-portfolio action to prevent and reduce the incidence, prevalence, impact and severity of family and domestic violence.
  3. PHAA also advocates the development of an alliance of other professional and non-government groups, to develop, publicise, disseminate and implement policies which recognise the public health significance and impact of family/domestic violence.
  4. PHAA is seeking additional legislative measures at both Federal and jurisdictional levels to address domestic/family violence in line with broader policy and program measures.

**Summary:** This policy seeks to outline a series of principles and tangible actions designed to achieve these goals.

**Audience:** Australian, State and Territory Governments, policy makers and program managers. Other professional and non-government groups.

**Responsibility:** PHAA's Women's Health Special Interest Group (SIG)

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## DOMESTIC/FAMILY VIOLENCE POLICY

***Public Health Association of Australia recognises that:***

1. Domestic/family violence is a significant public health problem and a key determinant of women's and children's health [1-3].
2. The terms family violence and/or domestic violence are used in different jurisdictions and by different groups of people. Family violence involves the abuse of power between immediate and extended family members, including all relatives by blood, marriage/de facto or kinship, both adults and children, and also includes intimate partners both current and past [4]. Domestic violence involves such abuses between people who have been or are in an intimate relationship (also called intimate partner violence), people who are co-habiting (e.g. housemates) or friends [4]. Overwhelmingly, family and domestic violence acts are perpetrated by men against women and children [5]. Abuse can be physical, verbal, psychological, economic or social and can include threats to the injured party, those they love, pets or property [5-7].
3. Inequitable power relationships between women and men exist beyond the individual and family to communities, societies and institutions [8, 9] and are reproduced in the context of gendered familial, social, political, cultural and institutional norms that implicitly or explicitly include an acceptance of family and domestic violence, and/or ignore the gendered nature of family and domestic violence [10-12].
4. Determinants of domestic or family violence include gender, age, socio-economic disadvantage, disability, location (urban, rural or remote) previous exposure to or experience of family violence and abuse, use of alcohol, being pregnant or having young children and the availability of weapons [11, 13].
5. Family and domestic violence occurs in culturally and linguistically diverse (CALD) communities, among gay, lesbian, bisexual, transsexual and transgender (GLBT) and people with disabilities, the elderly (including elder abuse where younger family members abuse their elder relatives), the homeless and people from Aboriginal and Torres Strait Islander communities. Yet family and domestic violence data relating to these groups is extremely limited [4, 14-18].

6. The 2005 ABS Personal Safety Survey found that 15% of women had experienced violence from former partners; 36% experienced violence during pregnancy with 17% experiencing violence for the first time during pregnancy. Sixty-one percent of people experiencing violence from a previous partner had children in their care at the time and 36% reported their children witnessing the violence. Two percent of women reported experiencing violence at the hands of their current partner and of these, 10% had violence orders issued against their partners and of these, 20% continued to experience violence perpetrated by their partners. Forty-nine percent of those who experienced violence from a current partner reported they had children in their care and 27% said that their children had witnessed the violence [19].
7. Murder within the family is the most frequent category of homicide in Australia, constituting approximately half the total. Women victims of homicide are most likely to be killed as a result of domestic violence, and domestic violence is also a common context for filicide [20-24]. Women from marginalised groups, particularly Indigenous women, experience higher rates of domestic violence and domestic or family violence related deaths [25, 26]. In the 2006-07 period, 53% of female homicide victims in the general population were killed by their intimate partners, compared to 59% of Indigenous female victims [26]. The number of homicides that occur in the context of pre-existing family or domestic violence are likely underestimated because a large proportion of domestic violence goes unreported [17, 20].
8. Domestic violence deaths are increasingly recognised as the culmination of a predictable pattern of violent behaviour rather than one-off tragic events. Evidence from fatality reviews established in the USA, Canada, the UK, as well as limited evidence from some Australian states and New Zealand, suggest that domestic violence deaths are preventable [20, 27-32].
9. Domestic violence is usually cyclic and often escalates from verbal to physical violence. It seriously affects the mental and physical health of victims and can cause long-term, mental and physical illnesses [2, 33]. Children who witness violence suffer in similar ways and some have been found to exhibit similar physical, mental and emotional problems as children who have been directly abused [34, 35].
10. Professional practices, (legal, medical, social and spiritual) frequently uncritically reflect dominant social values [36]. This is particularly evident in Government and professional responses to Indigenous family violence [12, 37]. Consequently, professionals' responses to family and domestic violence may not be appropriate to the needs of either victims or perpetrators [11, 38].
11. Women are subject to inconsistent terms and conditions of protection orders and strength of sentencing for breaches across the different States/Territories. Internationally and in Australia stronger domestic violence laws, while welcome, have had the unintended effect of increasing the number of dual arrests in some jurisdictions where the perpetrator and the victim are arrested

because of injuries being sustained by both parties [39, 40]. Dual arrests undermine efforts to increase reporting of domestic violence and ignore gender-power inequity between women and men [39, 41, 42]. Canadian evidence shows that women who seek assistance from the justice system frequently experience further trauma because of indifference or discriminatory attitudes from the system that they previously thought should protect them [43].

12. The original aim of the Family Law Reform Act (1995) was to ensure that Family Court decisions consider, in the best interests of children, how much time they spend with each parent. However, evidence is mounting that as most separating families who go through the Family Court of Australia are those in which domestic violence has been a factor, many of these decisions have forced children to spend time with (usually) fathers who have perpetrated domestic violence [44]. Sanctioning children's contact with a parent who has perpetrated domestic violence, in spite of the Family Law Amendment (Shared Parental Responsibility) Act (2006) including that the safety of children is paramount, has resulted in perpetuating violence against women and children [45, 46]. This has been occurring at the same time as public policy moves to improve child protection and reduce violence against women and children [47]. Part of the reason for this is that domestic violence has been dealt with in the family law system as conflict between parents that is different from, or does not include, child abuse [22, 35, 48].
13. The reduction of \$100 million funding to legal aid services from 1997/98 to 2000/01 was particularly detrimental to the ability of women to protect and defend themselves and their children in the Australian court system. The capping of legal aid funding may also have had a detrimental effect on difficult and complex cases, (e.g. those involving families from non-English speaking backgrounds) [22, 35, 48].
14. Evidence suggests that a human rights approach to family and domestic violence is more effective than current legal frameworks which often work to further marginalise women who are fearful of, or not comfortable with the justice system [43, 49].
15. Victims require external validation of their rights and support with the emotional and practical consequences of the breakdown of the relationship. Women's refuges are a critical part of the emergency response for victims, but women also require earlier intervention and support. Such support includes affordable counselling, income support, child care, legal and housing options. [43, 49].
16. Children and young people also require affordable and age appropriate counselling and other support in to enable them to cope with post-traumatic stress, achieve their potential and develop positive and non-violent relationships [5, 34, 47, 50].

17. Victims of domestic violence have been identified in health services, antenatal clinics, general practice and accident and emergency departments. However, the majority have not disclosed the abuse or been asked about it, thereby missing many opportunities for early intervention and further prevention of violence [51].
18. There is limited evidence that men who have been abusive or violent in the past and who demonstrate a commitment to learn non-violent behaviour can benefit from available, closely monitored and high standard behaviour change programs [52, 53]. There is substantial evidence, however, of high rates of recidivism of domestic violence perpetrator program participants [54]. There needs to be further evaluation in order to understand attributes of effective perpetrator programs. [15].

***The Public Health Association of Australia resolves that:***

19. The National Office/Board will write to State/Territory health and community services authorities seeking publication of cross-portfolio action that has been undertaken to prevent and reduce the incidence, prevalence, impact and severity of family and domestic violence.
20. The National Office/Board will write to research funding bodies seeking them to sponsor further national research into effective intervention and prevention strategies for family and domestic violence in Australia, particularly projects that focus on under-researched groups, for example women with disabilities, the elderly, GLBT and CALD. In this context, PHAA supports use of the Australian Bureau of Statistics (ABS) Conceptual Framework so that statistical collections are more consistent.
21. The Women's Health Special Interest Group will work to develop an alliance with other professional and non-government groups, to develop, publicise, disseminate and implement policies which recognise the public health significance and impact of family/domestic violence. Further, the Alliance would seek to commit these groups to continuing action to strengthen the skill base in family and domestic violence issues amongst their members.
22. The Women's Health Special Interest Group will lobby professional health bodies to ensure that training for all under-graduates, post-graduates and continuing education for doctors and nurses includes effective core education components on the identification and effective management of family and domestic violence.
23. The Women's Health Special Interest Group will call on these bodies to develop, disseminate, implement and evaluate guidelines and effective resources on the identification and management of family and domestic violence and ethical practice in family and domestic violence management.

24. The Women's Health Special Interest Group will support Domestic Violence Death Review advocacy groups in their endeavour to establish domestic violence death review panels in all Australian states and territories.
25. The National Office/Board will write to the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) seeking them to: implement regular community wide violence reduction education campaigns, and to support action to introduce, resource, and evaluate effective intervention programs targeted to those in high risk groups, such as pregnant, young, separated and divorced women, particularly those with dependent children.
26. The National Office/Board will write to the Commonwealth Attorney General's Department seeking restoration of the level of funding provided to State/Territories for legal aid so that persons experiencing domestic violence are not disadvantaged. The Board will also seek the development of national guidelines for the granting of legal aid in cases that involve domestic violence.
27. The Women's Health Special Interest Group will support the continuing role of women's refuges and other family and domestic violence support services, especially the funding of affordable counselling and outreach services for women who do not choose to go into refuges and initiatives for women to remain in the home.
28. The National Office/Board will write to the Commonwealth and State/Territory Departments of Attorneys General seeking the strengthening of legal measures, in particular
  - the funding of research into new forms of defence for the domestic murder of an abusive spouse, e.g. a variation of self-defence, which avoids pathologising the woman's response;
  - the development of consistent terms and conditions for inter-state protection orders (including strengthening of the portability of protection orders via the development of a national data-base), and more rigorous and escalating sentencing applications for their breaches; and
  - reviewing family law and child protection systems so that they operate together to prevent violence against women and children.
29. The Women's Health Special Interest Group will advocate at the State/Territory level for the extension of training to police, court staff, magistrates and other personnel, which extends beyond law and policy to include a greater understanding of the social and other consequences of domestic violence for victims and includes awareness of and sensitivity to other cultures.
30. Further, the Women's Health Special Interest Group will advocate at the State/Territory level for the introduction of human rights approaches to family and domestic violence policy-making to highlight the central role that

inequitable gender-power relations play in perpetuating family and domestic violence.

31. The National Office/Board will write to the relevant national authority/authorities seeking improvements in, and the development of, national standards and evaluation of services for persons who want to change their abusive behaviour and learn non-violent relationships and parenting.
32. The Women's Health Special Interest Group will advocate at the State/Territory level for the development and implementation of community based and integrated court support projects for victims of family and domestic violence (Aggrieved Family Members) to obtain protection orders.

### **ADOPTED 2010**

***This policy was adapted from a previously archived policy as part of the 2010 policy review process and endorsed in its current form at the Public Health Association of Australia Annual General Meeting in September 2010.***

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