Public Health Association of Australia:  
Policy-at-a-glance – Domestic and Family Violence Policy 

Key message: PHAA will:

1. Advocate for full implementation and resourcing of the *National Plan to Reduce Violence against Women and their Children 2010-2022.*

2. Advocate for cross-portfolio action to prevent and reduce the incidence, prevalence, impact and severity of domestic and family violence.

3. Support the introduction of legislative measures at both federal and jurisdictional levels to address domestic and family violence in line with broader policy and program measures.

Summary: Domestic and family violence is a significant public health issue and a key determinant of women’s and children’s health. This policy sets out PHAA’s position and actions on this issue.

Audience: Federal, State and Territory Governments, policy makers and program managers, other professional and non-government groups.

Responsibility: PHAA’s Women’s Health Special Interest Group.

Date policy adopted: September 2013

Contacts: Catherine Mackenzie and Louise Johnson, Co-convenors, Women’s Health Special Interest Group –
catherine.mackenzie@flinders.edu.au  ljohnson@varta.org.au
The Public Health Association of Australia (PHAA) notes that:

1. The terms domestic violence and family 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. 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. Abuse can be physical, verbal, psychological, economic or social and can include threats to the injured party, those they love, pets or property.

2. Domestic and family violence is a significant public health issue and a key determinant of women’s and children’s health.

3. Overwhelmingly, domestic and family violence is perpetrated by men against women and children. Factors that contribute to violence against women at a social and structural level include broader cultures of violence, including attitudinal support for violence against women. The determinants of domestic and family violence include inequitable power relationships between women and men and adherence to harmful gender stereotypes.

4. Domestic and family violence occurs in all groups in society, including culturally and linguistically diverse (CALD) communities, among gay, lesbian, bisexual, transsexual, transgender and queer (LGBTIQ) and people with disabilities, the elderly (including elder abuse where younger family members or carers abuse their elder relatives), homeless people and people from Aboriginal and Torres Strait Islander communities.

5. High rates of family and domestic violence in Aboriginal and Torres Strait Islander communities are associated with the ongoing impact of colonisation. Indigenous women are more likely to be killed than non-Indigenous women as a result of domestic or family violence.

6. The 2005 Australian Bureau of Statistics 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. Being pregnant, having young children, and the availability of weapons have been linked to domestic and family violence.
7. Domestic and family violence is often an escalating pattern of behaviour. Once the pattern has commenced there is a clear risk of the behaviour being repeated. Female victims of homicide are most likely to be killed as a result of an escalating pattern of domestic violence. 29,30,31,32

8. Domestic and family violence affects the mental and physical health of victims and can cause long-term, mental and physical illnesses. 33,34 Women experiencing severe combined physical, emotional and sexual abuse from intimate partners experience poorer quality of life and mental health than women experiencing other types of abuse. 35

9. Exposure to domestic violence has serious, and often long-term, negative effects on children’s physical and social development. Children who witness violence have been found to exhibit physical, mental and emotional problems similar to those experienced by children who have been directly abused. 36,37 The safety and wellbeing of a protective parent (usually the mother) is linked to children’s health and wellbeing after a history of living with domestic violence. 38 Disconnect between federal family court and state child protection systems been implicated in perpetuating violence against women and their children. 39,40,41

10. A recent Cochrane Collaboration systematic review found that screening in various healthcare settings has shown little promise in reducing or preventing domestic and family violence and does not lead to increased referrals. 42

11. There is limited evidence that non-professional mentor mother support may improve safety as well as physical and mental wellbeing among mothers experiencing intimate partner violence referred from primary care. 43

12. Factors such as alcohol and drug use, or childhood exposure to violence, while not causative, can exacerbate the frequency or severity of violent bevhaviours. 44

13. Victims require 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, childcare, legal and housing options. 45,46

*The Public Health Association of Australia affirms the following principles:*

14. Domestic and family violence can be reduced through primary, secondary and tertiary strategies. Primary prevention strategies focus on the determinants of domestic and family violence including gender inequality and adherence to harmful gender stereotypes. Secondary prevention focuses on early intervention, particularly with at risk groups. Tertiary prevention focuses on working with victims and perpetrators of domestic and family violence. 47 Work must take place at all three levels.

15. Women’s refuges and other family and domestic violence support services are vital and must be adequately resourced. Affordable counselling and outreach services for women who do not
choose to go into refuges, and initiatives for women to remain in the home, must also be in place.

16. The safety of the victim(s) should be the primary consideration and police and justice interventions with the perpetrator should be tailored to considerations of victim safety based on a risk assessment. The onus should not be on the victim to find a place of safety but for society to keep the victim safe from the perpetrator.

17. Children and young people require support such as affordable and age appropriate counselling.\footnote{48}

18. Legislative systems affect the incidence and impact of domestic and family violence against women and their children.

The Public Health Association of Australia believes that the following steps should be undertaken:


20. Domestic violence death review teams should be established in all Australian states and territories should be linked to share information and increase understanding of patterns of violence preceding deaths so that these deaths can be prevented.

21. Regular community-wide violence reduction education campaigns should be implemented, together with action to introduce, resource, and evaluate intervention programs, particularly for those women in high risk groups, such as Indigenous, pregnant, young, separated/divorced women, especially those with dependent children.

22. Continue legislative reform, particularly in relation to federal family court and child protection systems, to address persistent problems with legislative management of domestic and family violence.

The Public Health Association of Australia resolves to undertake the following actions:

The PHAA Board and Branches, with advice from the Women’s Health Special Interest Group, will:


24. Monitor the effectiveness of legislative reform and continue advocacy work to ensure the safety of women and their children.

25. Monitor the effectiveness of domestic and family violence programs.

26. Advocate to increase the status of women in Australian society (see PHAA Gender and Health Policy).
ADOPTED 2010, REVISED AND RE-ENDORSED IN 2013

First adopted at the 2010 Annual General Meeting of the Public Health Association of Australia. The latest revision has been undertaken as part of the 2013 policy review process.

References:


8 Evans, I., Battle-scars: long-term effects of prior domestic violence. 2007, Centre for Women’s Studies and Gender Research, Monash University: Melbourne.


12 UN Secretary-General. Background documentation for: 61st session of the General Assembly; Item 60(a) on advancement of women; Secretary-General’s study on violence against women. Geneva: United Nations; 2006

13 Sen, G., P. Ostlin, and A. George, Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health: Why it exists and how we can change it., in Final Report to the WHO Commission on Social Determinants of Health. 2007, Institute of Management, Bangalore and Karolinska Institute, Sweden.


20 Bonar, M. and D. Roberts, A Review of the Literature relating to Family and Domestic Violence in Culturally and Linguistically Diverse Communities in Australia. 2006, Department for Community Development, Government of Western Australia, Family and Domestic Violence Unit.


33 Evans, I., Battle-scars: long-term effects of prior domestic violence. 2007, Centre for Women’s Studies and Gender Research, Monash University: Melbourne. p. 60 p.


38 Wilcox, K, Family Law and Family Violence: Research to Practice, Good Practice Officer, Australian Domestic and Family Violence Clearinghouse, January 2012


