



**POTENTIAL HEALTH IMPACTS OF THE PROPOSED
FAMILY VIOLENCE STRATEGY**

Safer Families, Safer Communities

**Report of the Rapid Health Impact Assessment
Conducted in October 2003**

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CONTENTS

1.0	INTRODUCTION TO THE REPORT	3
2.0	CONTEXT: THE DAREBIN FAMILY VIOLENCE STRATEGY.....	4
3.0	PROCESS: HEALTH IMPACT ASSESSMENT.....	5
3.1	WHAT IS HIA?	5
3.2	HOW CAN HIA ADD VALUE TO THE POLICY MAKING PROCESS?	5
3.3	HIA PROCESSES	5
3.4	DETAILS ON THE STRUCTURE OF THE DAREBIN RAPID HIA WORKSHOP	6
4.0	OUTCOME: PROPOSED HEALTH AND WELLBEING IMPACTS OF THE PROPOSED STRATEGY.....	8
4.1	INTRODUCTION	8
4.2	SUMMARY OF RECOMMENDATIONS	8
4.3	RECOMMENDATIONS	9
4.3.1	Communications strategy.....	9
4.3.2	Service provision and delivery.....	10
4.3.3	Community consultation model	11
4.3.4	Cultural considerations.....	12
4.3.5	Health outcomes for children.....	13
4.4	BACKGROUND TO THE RECOMMENDATIONS.....	14
	Communications Strategy	14
	Community consultation model	20
	Cultural Considerations	22
	Health outcomes for children.....	24
5.0	CONCLUSIONS: MANAGEMENT AND SUSTAINABILITY OF THE STRATEGY	25
6.0	APPENDICES	26
6.1	APPENDIX 1: KNOWN IMPACTS ON HEALTH OF FAMILY VIOLENCE – THE EVIDENCE.....	26
6.2	APPENDIX 2: DAREBIN FAMILY VIOLENCE STRATEGY DEVELOPMENT – HIA WORKSHOP PARTICIPANTS 24TH JUNE 2003.....	36
7.0	REFERENCES.....	37

1.0 Introduction to the Report

This report draws out the key findings of a Rapid Health Impact Assessment workshop held on the 24th of June 2003 to assess the Darebin Family Violence Strategy. It makes connections between the key concerns and themes that were discussed in the workshop and the potential health impacts of the Family Violence Strategy on both the community and the individuals within the City of Darebin. The report is divided into three sections:

- (1) **Context:** a brief introduction to the Darebin Family Violence Strategy;
- (2) **Process:** a brief overview of both health impact assessment (HIA) and the objectives of the workshop; and
- (3) **Outcome:** the principal focus of the report, including the recommendations, the main findings of the workshop, and links to the relevant research and evidence on health impacts.

The rapid HIA workshop and the HIA process overall has provided some clear insights into the ways that the strategy might positively or negatively impact on the health and wellbeing of residents and the entire Darebin community. The process has drawn out some obvious and not so obvious issues of potential concern to health. These have been supported by some of the available evidence on potential links to health and recommendations have been made about possible changes or mitigation measures that can be used to minimise the negative and maximize the positive impacts of the strategy on health. The researchers have not set out to provide a conclusive case or to undertake an exhaustive critique of the literature, particularly as little exists on the role of policies and strategies on family violence and the links to family violence. A comprehensive review of the literature on the actual health impacts of family violence on indigenous and non-indigenous Australians can be found in Appendix 1.

The researchers are extremely grateful to the strategy development team, the staff of the Darebin Council and participants of the workshop (see Appendix 2. for listing of workshop participants) for allowing Deakin University to undertake this Rapid Health Assessment. They are also grateful to the participants of the Masters in Public Health Short Course in HIA, which was conducted in 2003 at Deakin University, for their input on the proposed process and the potential links between health and family violence.

It is clear that delivery of the Strategy is conditional upon funding from the Commonwealth Department of Family and Community Services but, for the purposes of this report, the assumption has been made that the strategy will be rolled out. As the strategy development process is grounded in best-practice principles, the findings of this HIA will inform future practice whether it is rolled out in its current form or in a modified form.

2.0 Context: The Darebin Family Violence Strategy

In 2002, the Commonwealth 'Stronger Families and Communities Strategy' invited the City of Darebin to develop proposals that could be implemented to address priority needs for the disadvantaged communities of the municipality. The City of Darebin had previously completed the first phase of this strategy; a local mapping project (The Darebin Local Mapping Project: Directions for Action, 2002) based on a scan of existing research and contacts with service providers and community development workers. The mapping project identified a number of key issues and concerns relating to the overall health and well being of families and local communities. Within this, domestic violence and child abuse figured predominately. The project found that:

Drug and alcohol-related domestic violence and the distress in families and relationships as a result, contributes to high levels of stress, anxiety and low self-esteem amongst those affected as well as the broader community. It impacts on the effectiveness of schools and service providers.¹

High levels of reported child abuse (reported to the Department of Human Services) in the municipality were described in this project as being "particularly disturbing". A total of 698 domestic violence incidents were reported across the municipality in 2002, whilst a total of 868 child protection notifications were received in Darebin as a result of family violence in 2002.² The number of intervention orders can also be taken as an indicator of the extent of family violence. Data from Victoria Police show that 957 intervention orders were recorded in Darebin during 2000-01, and 936 for the period July 2001 – May 2002.³

It was decided that a proposal be submitted around the development of a Family Violence Strategy for second phase funding within the Strengthening Families and Communities Strategy. In phase two, a facilitator worked with the community, particularly with service providers, to develop a coordinated community-based response. A multi-faceted model to address violence against women and children was the result of this process.

Whilst acknowledging that strategies for addressing family violence can occur across a continuum, including prevention, early intervention and longer-term intervention strategies, the proposed model focuses specifically on the first of these - prevention and early intervention strategies. Two projects are proposed:

- Project One employs prevention strategies and includes three specific components: community consultation, a community campaign and the design of community information.
- Project Two encompasses early intervention strategies and includes: support and training for service providers, partnership and protocol development, and the implementation of resilience programs.⁴

The overall strategy hopes to achieve an improvement in the coordination of service provision to those at risk of family violence, and an increased knowledge of non-violent ways of dealing with conflict. Ultimately, this strategy has been designed to achieve a reduction in crime due to family violence, with the hope that this reduction will also result in a reduction in child protection notifications due to family violence.

3.0 Process: Health Impact Assessment

3.1 What is HIA?

Health Impact Assessment (HIA) can be defined as a combination of procedures, methods and tools that are applied to policy development processes to assess the potential, and often unanticipated, effects on the health of the population and the distribution of those effects within the population.⁵ It builds on the notion that a community's health is not only determined by its health services but is governed by a range of economic, social, psychological, environmental and policy influences. Health impacts, therefore, refer to potential changes (both positive and negative), which occur to individual and community health, arising from a development project, a program, a policy or the combined effects of multiple policies. The information gained through undertaking an HIA can assist both decision-makers and the people affected to make the appropriate adjustments to a proposal or policy so as to mitigate the negative and maximize the positive impacts.

3.2 How can HIA add value to the policy making process?

Conventionally policy makers draw on policy analysis and evaluation to determine whether or not policies are meeting their objectives. HIA can complement this process by applying tools to provide information on the unintended consequences and side effects on health, before and after implementation of the proposal or policy. HIA can specifically add value in policy making through identifying both harmful and favourable factors that would not otherwise have been identified and quantifying the magnitude of their impacts more precisely than could otherwise be done. Subsequent trade-offs in policy making are more easily clarified through the better identification and description of the elements involved, and more appropriate and potentially effective measures for ameliorating harmful factors and enhancing beneficial ones can be identified. HIA can also assist policy makers in their pursuit of transparent decision making processes and increasing participation by stakeholders. More broadly, HIA can contribute to changing cultures so that health and wellbeing are always taken into account in policy making, particularly in contexts where they would otherwise not be considered.

3.3 HIA Processes

There are six steps in an HIA: screening, scoping, identification of impacts, assessing impacts, decision-making, monitoring and evaluation. As the goal is essentially to produce a set of evidence based recommendations about the proposal, the HIA should ideally be undertaken during the development of the policy or strategy. The HIA can be completed at a range of levels, with varying degrees of consultation, using a variety of methods. One method that is increasingly used for policy and strategy development processes is the rapid HIA workshop. This involves a meeting with a group of people who have specialist expertise in health, policymaking and/or the specific policy or strategy. The workshop forms part of the broader HIA steps and is augmented by the collection of relevant evidence of associated health impacts.

3.4 Details on the structure of the Darebin Rapid HIA workshop

The workshop included seventeen people from a variety of organisations and services who had been involved in the development and consultation processes associated with the strategy. The workshop began with an initial review of the strategy and progress to date, followed by a brief explanation of the rapid appraisal workshop process.

Participants were then divided into two groups with care being taken to ensure that a reasonable mix of backgrounds and professional experience were represented in each group. Each group had a facilitator who recorded the collected information on large sheets of paper, and the following steps of the workshop process were undertaken within these groups. In concluding the workshop participants joined together again as one large group to debrief/review/give feedback on the experience.

Step one: Gaining consensus on an appropriate definition of health

This involved discussion of what health and the determinants of health mean to the participants. The degree to which a health impact can be accurately identified and foreseen, is dependent upon the underlying definition of health used, thus it is necessary to gain consensus on an appropriate definition of health and the factors that are ultimately going to determine health in the context of this strategy.

Both groups expressed a clear consensus that they operate on a very broad, holistic, social model of health and within this understanding some very specific components of health were acknowledged and targeted to particular elements of the strategy.

Step two: Identifying barriers and conflicts

This step involved identifying any barriers, threats or conflicts around the implementation of the strategy. This process is important as any difficulties surrounding the implementation of a proposal that are not recognised, acknowledged and managed may actually prevent the potential positive health impacts of the strategy being realised.⁶ Identifying difficulties during the workshop ensures that they are both recognised and taken into account when considering changes that could be made to the strategy to protect and improve health.

Participants initially identified a number of concerns focussed on frustrations with the process of strategy development itself and changes to funding requirements during the development stage, however overall discussion quickly moved onto the identification of broader impact identification.

Step three: Identification and appraisal of Impacts

The main question to be answered at this stage is:

What are the potential impacts on health, positive and negative, arising from the implementation of this strategy?

Groups focused on answering this question using a series of focused sub-questions. The facilitators used the determinants of health: individual; personal/family/lifestyle; social; physical; access to services; and public policy as the basis for consideration. Groups were also given the option of working within the stages of the strategy (for example, early intervention, long-term strategies as an alternative for identifying impacts). Throughout the process participants were encouraged to recap on which of the identified broader impacts had health and well-being impacts, and what these might be. As the impacts were identified the groups were asked to assign them a classification of positive, negative or neutral. Participants were keen to identify any impact that the 'Safer Families, Safer Communities' strategy may have and also to discuss best practice in relation to their professional role as service providers to family violence survivors.

After the workshop, the findings were collated, linked to evidence and negotiated with the Darebin Family Violence Working Group. Section 4.4 explores this process in detail. The Working Group discussed the final recommendations as provided by Deakin University, and felt that these recommendations were appropriate and set priorities for action.

4.0 Outcome: Proposed Health and Wellbeing Impacts of the Proposed Strategy

4.1 Introduction

This section details the recommendations. These recommendations were developed after the Rapid Health Impact Assessment Workshop and arose out of the discussion with the participants in the workshop. This discussion indicated certain key areas of concern in relation to the potential health impacts of the Darebin Family Violence Strategy. A more detailed examination of these potential health impacts, and the supporting evidence from family violence and health literature, follows on from the recommendations.

4.2 Summary of Recommendations

- ***Communications strategy***

Strategies must be adopted to ensure that messages about family violence are very carefully constructed and their impact monitored. It should also be ensured that information dissemination is handled carefully.

- ***Service provision and delivery***

It is recommended that strategies be adopted to minimise the potential for problems of excess demand for services, which may occur as a result of the rolling out of the family violence strategy. Excess demand may impact negatively on both the victims of family violence and on the service providers themselves who may not be specialised in dealing with family violence.

- ***Community consultation model***

That careful consideration should be given to the way that issues of personal safety and sensitivity are handled within the strategy and the way in which the strategy is pitched within the community. Support mechanisms should be built into the consultation process.

- ***Cultural considerations***

To be effective the strategy needs ownership by cultural groups and needs to be grounded in cultural sensitivity. At the same time, it needs to access those individuals most at risk.

- ***Health outcomes for children***

Strategies should be adopted to ensure that the key messages about domestic violence are made accessible to children also. This information should be well researched and designed specifically for children.

4.3 Recommendations

4.3.1 Communications strategy

Strategies must be adopted to ensure that messages about family violence are very carefully constructed and their impact monitored. It should also be ensured that information dissemination is handled carefully.

- ***The content of the message***

The definition of family violence and the key messages about family violence that are communicated should be very carefully researched and constructed. Any visual material must be designed with sensitivity. Inadequate or badly communicated information may exacerbate already harmful and stereotypical views of family violence. This may result in the social exclusion or stigmatisation of those in the community who are most at risk. It may also result in an increased sense of vulnerability across the community as a whole and a perception that Darebin is unsafe.

- a. Any communication should emphasise the importance of shifting away from the notion that family violence, or violence that occurs in a domestic situation, is a 'private' matter; and therefore not the concern or responsibility of neighbours, friends or the wider community. Rather, the message should emphasise that family violence is a critical social issue that must be owned by the community and brought out into the public realm.
- b. Consideration is given to shifting the focus of some aspects of the strategy away from a visual campaign about family violence to a grass roots approach that involves working with peers and representatives in the community to disseminate the information.

- ***The delivery of the message***

Consideration must be given to the ways that information about the strategy is disseminated. It is especially important that the strategy is released in coordination with the broader agendas and agencies in Darebin that deal with violence. Particular focus should be on the coordination of the family violence strategy with the Darebin Safety Plan.

4.3.2 Service provision and delivery

It is recommended that strategies be adopted to minimise the potential for problems of excess demand for services which may occur as a result of the rolling out of the family violence strategy. Excess demand may impact negatively on both the victims of family violence and on the service providers themselves who may not be specialised in dealing with family violence.

- It is recommended that mechanisms be included in the strategy that monitor the impact of the strategy on service providers. These mechanisms could include:
 - (i) working with services to develop appropriate protocols and processes before the strategy is implemented;
 - (ii) tracking unmet service demands as the strategy rolls out.
- It is recommended that the family violence strategy runs parallel with other measures to support people who want to leave violent situations. For example, there should be a link between the strategy and refuge programs.
- It is recommended that appropriate support mechanisms be available to service providers. Discussion with service providers should be held to investigate ways of meeting the increased demand on services without creating negative health outcomes for the providers themselves. Some suggestions include improved mechanisms for networking and a pilot project linked to crisis response. These should be investigated and positioned next to the implementation of the strategy.

4.3.3 Community consultation model

That careful consideration should be given to the way that issues of personal safety and sensitivity are handled within the strategy and the way in which the strategy is pitched within the community. Support mechanisms should be built into the consultation process.

- Consideration should be given to the structure and management of the proposed focus groups.
- It is recommended that there be an investigation of ways in which those participants who are vulnerable and at risk can be part of the consultation process in safety and without further damage to their physical and psychological health.
- It is recommended that, as part of the consultation process, a facilitator be included who has counselling skills, a depth of understanding and specific expertise on issues surrounding family violence.

4.3.4 Cultural considerations

To be effective the strategy needs ownership by cultural groups and needs to be grounded in cultural sensitivity. At the same time, it needs to access those individuals most at risk.

- Consideration needs to be given to the ways in which the strategy can reach the most vulnerable and isolated individuals of the different cultural groups. The strategy must take into account that often the cultural leaders of any given community may act also as cultural gatekeepers. That is, the leaders may filter any new information coming in and create a situation where those individuals most at risk of family violence do not actually have access to this information or the agencies which may be able to help them. A series of strategies are needed to overcome this potential problem. These may include:

- that existing groups (for example women's groups) within the different cultural communities be used as a vehicle for disseminating information about the strategy.
- Consideration could be given to facilitating informal support networks for culturally diverse groups.
- that the strategy involves the participation of multicultural agencies.

4.3.5 Health outcomes for children

Strategies should be adopted to ensure that the key messages about family violence are made accessible to children also. This information should be well researched and designed specifically for children.

- It is recommended that the needs of children run as a thread throughout the strategy.
- It is recommended that the information which children have access to include a clear definition of family violence. In addition there should be information on where the child can get help. Any information should aim to communicate to the child:
 - that violence is not a 'normal' part of family life;
 - that violence is not the child's own fault;
 - that seeking help is appropriate.

The twofold aim of the strategy should be to improve knowledge of family violence amongst children and to increase the rates of help seeking amongst children.

4.4 Background to the Recommendations

The following section details the actual discussion that was held with the participants at the Rapid Health Impact Assessment Workshop. It combines a summary of the key themes that arose in this discussion with evidence taken from the relevant literature on family violence and health issues. Italics are used to indicate the main points raised in the workshop. The recommendations were developed out of this discussion.

The findings centre around five broad areas of potential impact and within each a number of aspects, both positive and negative, are discussed. Readers should note that this report does not focus on the health impacts of family violence per se but on the likely health impacts of the proposed family violence strategy. The actual direct health impacts of family violence have been collated and included in Appendix 2.

Communications Strategy

Four potential impacts were identified in this area, two with a potential positive impact and two with a potential negative impact.

Increased community knowledge through open discussion was recognised as being an important potential outcome of the development and implementation of the strategy and workshop participants identified a variety of ways that this may impact at individual and wider community levels.

Workshop participants felt that increasing community knowledge, encouraging open discussion and therefore making the issue of family violence more visible, may result in building both individual and community capacity, through de-stigmatising family violence and leading people to feel better about discussing family violence more openly. This was recognised as providing possible opportunities for personal empowerment.

In their paper “Going Public” A shift in the culture of practice’ (2002) the Northern Domestic Violence Service identified the benefits of making their service, and therefore the key issue of family violence, more visible within the community through telling women that there is an alternative to living with violence.

A study by Keys Young (1998) which looked at how women survive family violence shows that one of the main turning points for women in seeking help or taking action is linked to their experiences outside the home and results in the realisation that their situation is neither ‘normal’ nor acceptable; effectively supporting an increase in confidence to take action on the issue.⁷

The Northern Domestic Violence Service believe, specifically in regard to DV services, that if they continue to maintain a veil of secrecy about their existence and the nature of their work, they run the risk of inadvertently colluding to keep domestic violence a ‘private or ‘personal’ matter. They recognise that this only works to reinforce victim’s feelings of isolation, embarrassment, shame, betrayal, hopelessness and despair.⁸

At the community level, the outcomes of increasing community knowledge of both family violence and its presence in Darebin were considered to have positive benefits and result in increased community capacity.

The notion of community capacity is linked to the broader concept of social capital, which is defined as “the features of social life – networks norms and trust – that enable participants to act together more effectively to pursue shared objectives”.⁹ The Australian Bureau of Statistics Discussion Paper ‘Social Capital and Social Wellbeing’ (2002) recognises a body of evidence that suggests a positive correlation between social capital and health. Research suggests that a link exists between social capital and lower morbidity, with people who have higher levels of social interaction and participation being more likely to enjoy better health and thus lower risks of premature morbidity”.¹⁰

Similarly, studies by Kawachi have found that areas low in social capital as measured by high-income inequalities and low levels of trust, also had higher death and disease rates.¹¹

It was also felt that at the community level, an increased acceptance of people asking for or seeking help in respect to issues of family violence, could lead to an increase in overall safety and/or perceptions of safety for individuals and the community. This would result in side benefits of improved health outcomes for both individuals and the community as a whole.

The Darebin Community Safety Plan 1999/2000 - 2002/2003 recognises a safe community as adding to one’s sense of personal well being and enables people to feel safe in their everyday lives. This plan also recognises that community safety is not only about crime but is also about *fear* of crime, accidents and injuries, many of which can be prevented. It promotes the idea that:

... achieving a safe community is more than solving and reducing crime; it is about achieving a society where people participate fully in community and public life, anywhere and anytime, without being constrained by the fear of violence and crime.¹²

DAREBINsafe identifies a number of community safety priorities with clear links to health outcomes for both individuals and the community. These cover a broad spectrum of aspects of community well-being including social connectedness, community participation in decision making, reduction in accidents and injuries, prevention of crime, and perceptions of fear. All of these impact directly and indirectly on physical and psychological health.

The contrast or flip side of increasing community knowledge and discussion about FV was also recognised by workshop participants. Concerns were expressed that the strategy may result in Darebin being perceived as unsafe. One unintended consequence of the strategy development process was that it would draw attention to FV and thus risk an increase in fears for personal safety, security, anxiety and even suspicion.

Perceptions of safety are recognised as having the potential to impact on health outcomes as much as actual tangible experiences. The DAREBINsafe community consultation process identifies, amongst a number of concerns raised by participants, ‘fear about the issues identified’, rather than direct experience. For instance, when talking about theft in the street or violence, people tended to speak of their *fear* of being robbed or attacked – with *fear*

being the factor likely to impact on an ongoing or long-term basis. The City of Darebin's 1996 Safer Communities Policy statement acknowledges the importance of perception when it states:

... all aspects of personal safety affected by council business and activity, including perceptions of personal safety and perceptions of crime in addition to actual crime rates and victimisation rates.

Workshop participants also expressed concerns about the potential negative impacts that perceptions about safety in Darebin could have on relationships outside the immediate family including on friendships and neighbours.

Approximately 50% of responses to the DAREBINsafe Community Safety Survey identified 'being able to call on my neighbours/friends for help' as being important. This issue ranked amongst the most important solutions identified in that report on community safety. Social cohesion, or the existence of mutual trust and respect in the community and wider society, has been shown to help to protect people and their health. For example, one study of a community with high levels of social cohesion showed low rates of coronary heart disease. The study also reported that rates increased when social cohesion in the community declined.¹³

Participants carefully considered the impacts of the dissemination of the strategy and they tend to focus on the perspective taken and long-term visions of promoting safety for all in Darebin. It is harder to identify the nature of the impacts and whether they will occur in the short term or long-term.

The nature of language used in the strategy, in the dissemination of information relating to the strategy, and in the production of any materials to be used as part of the strategy, was a recurring concern expressed within the workshop. In the first instance, the use of the term family violence was a key point of discussion. Participants felt that defining this type of violence as 'family' retained the problem within the family rather than working to encourage its recognition as a broader community issue. An obvious result of this was recognised as being its assignment as being 'not as bad' as perhaps street assault, or similar acts of violence within the community. It was also felt that information created for dissemination within the broader community could, if not sensitively developed, work to further exacerbate already established community views about family violence and reinforce specific perceptions and stereotypes of Darebin which can be harmful to both those experiencing family violence and to the larger community as a whole.

Kordvani (2002) draws attention to the dangers of separating violence off from the rest of social relationships between men and women, or similarly, to attempts to abstract physical violence out of its social settings. He recognises that in focusing on violence to women as a social problem it effectively places individuals in a wider context and makes it possible to see the nature of violence as a much broader dynamic process.¹⁴ Douglas (2002), in recognising family violence as continuing to be perceived as a private social issue rather than as a public matter and a concern for criminal law, warns of potential dangerous outcomes or risks for women especially if the defining of the issue continues to result in many violent perpetrators being subject to minimal public sanctions for their inappropriate and often dangerous behaviour.¹⁵ The links to women's health arising out of this ongoing problem are clear and well documented.

Service provision and delivery

Three potential impacts were identified in this section. All had the potential to be both positive and negative depending on how the strategy is delivered.

The area of increased demand on services was consistently identified throughout the workshop as being a key concern. It was felt that if services were unable to deal appropriately with or cope with the magnitude of demand, and if service users expectations were not readily met, then individuals attempting to access assistance might experience adverse health outcomes. These include increased levels of anxiety and stress, and even increased exposure to risk.

Continuing anxiety, insecurity, low self esteem, social isolation and a feeling of lack of control over one's life have been shown to have powerful effects on health. Such psychosocial risks increase the chances of poor mental health and premature death. Prolonged periods of stress can lead to health problems such as susceptibility to infection, diabetes, high blood pressure and an elevated risk of heart attack and stroke.¹⁶ In addition, the emotional and psychological issues already faced by women experiencing FV women may also be exacerbated. These have been shown to include such things as, diminished self-esteem¹⁷ risks of self-harm and suicide¹⁸ feelings of shame, self blame and guilt¹⁹, eating disorders and somatic and stress complaints such as gastrointestinal symptoms, bodily aches and pains, insomnia and other sleep disorders.²⁰

Of particular interest also to Darebin, are the findings of preliminary research accessed within the Cities of Darebin and Moreland's "Misuse of Pharmaceuticals Project" which suggests that:

Many women who first presented to their doctors with anxiety are currently in violent relationships or have a history of abuse. What began, as inappropriate, regular use of medications becomes self-harming misuse as the feelings of hopelessness from regular sedative use takes hold.²¹

Darebin and Moreland local government areas currently have overdose rates higher than the Melbourne average. Of these 66 percent of people presenting at hospital emergency departments with intentional medication poisoning, are women.

Workshop participants also suggested that the increased demand on services has the potential to increase demand on other services and that these services may be unable or incapable of meeting the increased demand. Negative health outcomes were recognised for both service users and providers in this instance, with service users potentially experiencing a reduced sense of personal capacity or/increased powerlessness if they are unable to get what they expect from services.

Keys Young (1998) found that in reporting incidents of family violence, most women were more likely, in the first instance, to approach friends, family members or various helping professions rather than specialist FV services. These included GP's, counsellors, child specialists, maternal and child health centre staff, teachers, clergy, or solicitors. They found that a perceived inability

of services to help generated feelings of further entrapment in an abusive situation because people felt that no one could help, nor did they feel able to help themselves. In other cases, however, the realisation that it was ultimately going to be up to the individual to deal with the issues, hardened their resolve to find their own resolution to the problem, sometimes reflecting the women's preferred coping and problem-solving skills resulting in personal empowerment.

Participants were also extremely concerned about the potential health impacts for service providers who were not specialised in dealing with family violence.

The possible health implications for professionals affected in this way is illustrated through the outcomes identified by health professionals participating in a training course on family violence. The Domestic Violence and Incest Resource Centre conducted the training. Participants at the training were concerned that by asking questions about violence that: they may offend a woman and lose her trust or confidence; that their response may not be adequate; and, that they were unsure about the limitations of their role in relation to FV.²² The implications of these concerns for the health outcomes of allied professionals include: a diminished sense of personal capacity or ability to deliver appropriate services; reduced self-confidence; and, the potential to experience disillusionment in their work and in the nature of their work. Physical health outcomes may be linked to increased workplace stress and anxiety.

The impacts of the strategy development and implementation processes on service provision and delivery was recognised as potentially producing a number of health outcomes.

Overall the strategy development and implementation processes were recognised for their potential positive impacts and associated health outcomes. Obvious health benefits for people accessing services (specialist and general) would be derived from two potential improvements, both arising from the implementation of the strategy. First, the identification of gaps in service delivery could result in streamlining of services. Second, improvements in service networks and the enhancement of joined up service provision might encourage take up of a range of services and remove the need for clients to replicate sensitive information to service providers. Additionally, service deliverers that are not currently linked to family violence might be keen to take a more active role if an enlightened community encouraged it. This might mean that in the future such service providers might capture some of the family violence issues before they reach crisis point.

Keys Young (1998) found that mainstream service providers and professionals potentially have an important role to play in identifying relationships in which family violence is occurring and often at an earlier stage than specific family violence service providers and in providing appropriate assistance or information. The study found that often the response of these services to a victim's disclosure was significant in determining the subsequent help-seeking behaviour. For example, at worst, a poor or negative response deterred or delayed the victim from seeking help elsewhere, thus effectively exacerbating the known health consequences of remaining in an abusive relationship and adding to feelings of despair, loneliness and sense of helplessness. They were able to gain information, awareness and support necessary to enable them to deal with the abuse in their own way and in their own time which positively impacted upon feelings of support, control and empowerment).

Positive impacts at a public policy level were also identified, specifically in regard to the potential for resources to be more appropriately matched to policy requirements. Additionally, potential benefits were recognised by the strategy being based within Darebin Council rather than the within the protective services or community based service sector. It was felt that this could allow for a greater sphere of influence on other services which the council provides, thereby resulting in the better integration of services overall.

Evans (2003) recognises greater visibility of the issue of family violence not only in health policy but also across government, as enabling interventions that are more respectful of the dilemmas experienced by people in their efforts to live in relationship with each other.²³

Concerns were expressed about personal safety through increased risk of vulnerability and violence. One unintended consequence of the strategy might be that awareness of the availability of services creates a false sense of security for women. If they feel that there is increased support, yet choose to stay in a violent situation; they may be at increased risk of injury.

Women's Safety Australia (ABS) found that 73% of a sample of 6,300 women, who often experienced violence from a current male partner, identified that they live in fear.²⁴ Waugh & Bonner (2002) identified possible health risks if the woman stays in the relationship compared with the possible risks if she leaves the relationship. These health risks include physical and psychological, risks to children, financial disadvantage, risks to family and friends, relationships, and legal status. In addition 'life-generated risks' include: financial limitations; home location; physical and mental health issues; inadequate responses by major social institutions; and discrimination.²⁵

Community consultation model

Five potential impacts were identified, three potentially positive and two potentially negative.

The use of a community consultation model in the strategy development was a major focus of discussion amongst the workshop participants. The positive benefits for health of such community engagement were broadly considered. The health impacts of such outcomes were recognised at an individual level as being, in the first instance, increased opportunities for personal empowerment. It was recognised that participation increases opportunities for the development of support for individuals.

Participation has been shown to have developmental outcomes when participating citizens gain greater self-esteem or experience a change in their identity. Their capacity to act, and to make a difference, can also be enhanced when they broaden their practical and analytical skills.²⁶

Keys Young (1998) found that many participants reported outcomes of improved self-esteem and confidence resulting from their participation in socially linked activities outside the home. They reported that being able to break out of physical and social isolation appears to open women's eyes to other possibilities and enable them to realise their own sense of worth, their own capabilities and confidence, and thus improve their health.

Similarly, positive support from family and friends is identified within the 'Partners Against Domestic Violence' study 'Home safe Home' (2000) as a key factor in reducing the impacts of family violence for women. This study identified a number of aspects, in particular: having their experiences of family violence validated; having emotional support; and having a level of practical support available to them through, for example, childcare or assistance with accommodation.²⁷

A potential positive impact for the community of an increased sense of control over the process of strategy development and the possible establishment of informal support networks could result in greater community cohesion with associated health outcomes.

The World Health Organisation report 'The Solid Facts' (1998) identifies social support as being one of ten key determinants of health. This document recognises that support operates on the levels of both the individual and the community and it discusses the association between social isolation and exclusion and poor health outcomes. People who get less emotional support from others are more likely to experience less wellbeing, more depression, and higher levels of disability from chronic disease.²⁸

Social support and good social relations make an important contribution to our health. Social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health (WHO, 1998).

The outcomes of the DAREBINsafe: Community Consultation process mirrors these research findings. Of a number of major solutions proposed in response to the most important concerns about community safety, a strong sense of community was ranked first. Increased participation in the community, either through direct involvement in community groups, or through more contact with neighbours, was clearly the most important factor identified to increase people's sense of safety thus developing a strong sense of community. Being actively involved in the community, accepting and acting on civic responsibility, good relationships and friendships with neighbours, are all crucial to good health.²⁹

Positive outcomes were also recognised for broader policy development. The community consultation process was recognised as providing policy makers with the opportunity to talk with the community in appropriate ways, allowing them to tap into the feelings of the community, and to attune their policy formulation more appropriately. This opportunity was recognised for its potential positive health outcomes for the community.

Evidence has shown that in a situation where people feel that their opinions and needs are being disregarded by those in authority, feelings of powerlessness and lack of confidence are engendered which impact negatively on their health.³⁰

Participants also identified a number of key concerns regarding the community consultation process. At an individual level it was felt that there is the possibility of expectations being raised through this process that could be difficult to meet, leading once again to feelings of disempowerment/disillusionment and decreased personal capacity.

Similarly, it was felt that personal issues could come to the forefront of discussion in the Forum that may not be appropriately accommodated within that public arena, thereby exacerbating issues of personal safety, both physical and psychological. It was also noted that if the process itself was not truly democratic and participatory, then those participants whose level of participation may be affected by ongoing issues in their own communities might experience stigmatisation or social exclusion.

The difficulties relating to disclosure for many women and the associated health impacts linked to these may be potentially exacerbated through some aspects of the strategy. Fear is a major deterrent to women telling anyone about their experiences of family violence. These fears include: fear for their own physical safety or that of their children or other family members; fear that they will not be believed or taken seriously or of being judged; or fear for social and psychological wellbeing.

Many of the women involved in the Partnerships Against Domestic Violence Study 'Against the odds: How women survive domestic violence' felt very much under threat if they either told anyone about the abuse or if they took any action to escape the abusive relationship. Similarly, shame and embarrassment arose largely from a fear that disclosure would reflect back on them and resulted in associated feelings of guilt and responsibility for the abuse perpetrated against them. They were concerned that people would condemn them or think them stupid for staying in the relationship.

Cultural Considerations

Darebin is a municipality that is rich in cultural diversity. The 2001 census shows Darebin's total population is approximately 130,000 people. Of these almost two thirds (61%) are either first or second generation migrants and at least 51% of the population are first or second generation migrants of non-English speaking backgrounds.³¹ The largest groups of overseas born in Darebin are Italian, Greek, British, Chinese, Vietnamese and Lebanese. Darebin also has the largest indigenous population of any city in metropolitan Melbourne, with over 1000 people identified as being of Aboriginal or Torres Strait Islander descent in 1996.³²

Consideration of this diversity and the potential issues that the development of a FV strategy could raise were at the forefront of discussions in the workshop.

There is potential for the strategy to impact at an individual level because of cultural differences. There is the possibility that individuals may become ostracised from their communities as a result of participating in aspects of the strategy or in actions recommended in the strategy. This may occur because of cultural differences in perceptions of what constitutes family violence and associated barriers that may stem from these diverse cultural understandings. The subsequent impacts on these people include social exclusion and loss of social and community networks which were recognised for their potential to result in adverse health outcomes.

Research into attitudes to family violence undertaken by 'Partnerships against Domestic Violence' (2000) drew on consultations drawn from more than 280 people from various cultural and linguistic backgrounds. It was found that whilst most people considered family violence to be unacceptable, there are values held within communities that impact on people's willingness to judge or intervene. Throughout the discussions family and friends were recognised as an important source of support. Study participants mentioned that ideally a person's first point of contact if seeking assistance for family violence should be 'trusted family and friends'; however many of the participants felt that disclosing violence would disgrace both the victims and their families. Indeed, a common theme emerging from the Keys Young study (1998) was the issue for some non-English speaking women in respect to disclosing family violence. Talking about family violence was said to be taboo in some cultures and several women felt they would face ostracism or chastisement if they attempted to try and talk to people or services within their own communities. They feared that their stories could be turned back on them.

Research has shown that specifically in regard to CALD communities, many women already have limited social networks. In this instance, negative health outcomes can be linked to fear - fear of being alone without support, especially if children are involved, fear of being deported, and fear of loneliness and isolation. In a situation where a woman feels the only support she has is from an abusive partner, there may be increased or continuing ill health impacts of physical and emotional abuse.

At a community level similar concerns were recognised as potential if it was felt by specific cultural communities that confidences, belief systems and social

relationships were in jeopardy if the issue of family violence was made more visible or viewed as a crime.

Focus groups held in Darebin in 2000 with newly arrived Iraqi/Caldean and Mainland Chinese women identified issues around the notion of shame related to the reporting of family violence. To report family violence to the police or someone outside of the family brings shame to the family, therefore women tended to keep the abuse secret and to blame themselves. In these groups women also spoke about cultural and traditional perceptions and expectations of a women's role, for example one participant related how "A woman is like a rock – she receives all the tough stuff of life and yet she stays solid like a rock and doesn't break". The issue of isolation was raised with this group and participants felt that there was no place they could go to talk about their problems because of their inability to communicate outside of the family.³³

At a broader social level, it was cautioned that an overall shift in societal perceptions of family violence as being unacceptable by the broader community may also work to marginalise any cultural groups perceived as being more tolerant of it. In this case the potential for negative health outcomes would be linked to issues of social exclusion and stigmatisation.

Migrants from other countries, ethnic minority groups and refugees are particularly vulnerable to social exclusion. They are generally at risk of exclusion from citizenship and the opportunity to work and to obtain an education. The racism, discrimination and hostility that they face in these circumstances will often result in adverse outcomes for their health. The harm to health can emanate from material deprivation, as well as social and psychological problems of living on the margins.³⁴

Research undertaken by the 'Partnerships Against Domestic Violence' identified a significant number of participants who felt that family violence issues should be dealt with inside their own communities because of racism, lack of cultural understanding, an 'uncaring and selfish attitude' within the Australian community, and a fear of condemnation by the general community.

Braaf (2002) recognises a significant challenge to prevention work as being the widespread perception that violence is confined to 'other', as opposed to mainstream cultural groups. She recognises this stereotyping of cultural groups as diminishing women's rights to safety and justice and men's responsibility for perpetrating violence. She also makes explicit a link between how violence is framed and the resultant distancing of some groups of women from prevention strategies, thereby further exacerbating potential negative health outcomes.³⁵

Workshop participants also identified positive health benefits for culturally diverse groups within Darebin in relation to the strategy. The strategy may serve to reinforce and support naturally occurring networks within these communities, thereby resulting in positive health outcomes through the benefits of inclusion and social support.

Health outcomes for children

Children were repeatedly identified as a specific group who may be particularly vulnerable to potential health outcomes resulting from a number of identified possible impacts of the strategy development and implementation.

It was felt by workshop participants that an unintended impact of increased community knowledge and open discussion on family violence arising out of the strategy was that children could suffer anxiety and stress because of fear that violence such as this may happen to them or their family.

Evidence shows that children have a tendency to develop a sense of responsibility for family violence³⁶ and certainly the perception that this may happen in their own families should be recognised for its potential to lead to other adverse health effects linked to increased levels of anxiety and distress.

Similarly, the risk of adverse health outcomes for children was highlighted in regard to potential broad outcomes of the strategy. It was suggested that if the strategy results in increased family separations due to increased reporting of family violence, then children are placed at greater risk by moving them from the family home to an unfamiliar environment.

Sudden rushed upheavals and changes in accommodation impact upon children in a variety of ways including: loss of home; loss of friendships, pets, toys, surroundings, and sports; disruption of schooling; adjustment to refuge living; and, an increased risk of becoming homeless. Subsequently, homelessness exposes young children to an increased risk of victimisation including physical and sexual assault and to other risk factors such as substance abuse, self-harm, neglect and unsafe sexual practices.

Participants felt that as long as the strategy worked to create a safer environment for children in the long run by increasing understanding that seeking help is appropriate, then the potential for long-term negative impacts on children were reduced.

Research provides evidence that in general family violence has adverse effects on children's behaviour, their cognitive and problem-solving abilities, as well as their coping and emotional functioning. The potential for this strategy to alleviate such outcomes thereby providing the opportunity to improve overall psychological and physical health outcomes for children involved in violent situations, is consistent with positive health goals.

5.0 Conclusions: Management and Sustainability of the Strategy

A number of issues regarding the long-term impacts of the strategy linked to management of its goals and long-term sustainability were discussed as they link to potential health outcomes. It is not possible to provide evidence of the likely impacts here as the issues are speculative and contextualised to Darebin and will only be understood in the fullness of time.

It was acknowledged by workshop participants that it is very difficult to measure change in this sphere both sympathetically and realistically. Measurement issues linked to change were identified for their potential to shape community and social perceptions. If measurement inappropriately portrays only statistical data indicating that there is less violence in the family, an unintended impact might be that there is reduced community tolerance or an increased tendency towards victim blaming resulting in feelings of self-blame for those experiencing family violence. This might result in diminished self-confidence, self-esteem and an associated reduced sense of capacity to take action within this community.

Also of concern was the possibility that the strategy may be too broad and seeking to achieve too much. It was felt that as a result of boundaries being somewhat unclear from the Commonwealth government, that resources may be diluted, and that time for implementation would be limited and thus the ability to provide an adequate strategy would be reduced. The potential health outcomes for service providers were specifically highlighted as emanating from perceptions and feelings of confidence around their capacity to have any impact on the issue of family violence within Darebin.

Alternately, it was recognised that this may also result in establishing positive inroads into dealing with the issue of family violence. The actions proposed within the strategy require organisations to work together and this could result in a system change more broadly across all levels involved which would ultimately result in better health outcomes for all. Linked to this was the suggestion that at a policy level, policy makers' ability to advocate for such things as better resource distribution may be increased through exposure to, and learning from, other organisations and states, resulting in better overall outcomes for effective policy making and subsequent positive health outcomes.

Sustainability of the strategy past the first year was also discussed. Whilst this was recognised as putting additional pressure on the council and potentially raising expectations, the culture of influencing policy which it could potentially create, was recognised as being most beneficial for the development of partnerships, increasing shared understandings and facilitating positive shifts in overall perceptions in regard to the issue of family violence, which would ultimately positively impact on health for residents of Darebin.

6.0 Appendices

6.1 Appendix 1: Known impacts on health of Family Violence – The Evidence

Developed by Jessica McCormick – 2002

This section summarises findings of research under the following six headings:

MAINSTREAM

Women
Children
Men
Community
Service Providers
Government Response

INDIGENOUS

Men
Women
Children and Young Adults
Communities
Indigenous interaction with Service Providers
Government Response

N.B. Numbers in brackets after each indicate the source of the information. For example (1) indicates the data was derived from Women's Service Network (WESNET). Domestic Violence in Regional Australia: A literature review. Canberra: Commonwealth of Australia; 2000.

The definition of 'domestic violence' underpinning much of the research commissioned by the Commonwealth Government in their Partnerships Against Domestic Violence initiative is:

"...an abuse of power perpetrated mainly (but no only) by men against women in a relationship or after separation. Domestic violence takes a number of forms both physical and psychological. The commonly acknowledged forms of domestic violence are: physical and sexual violence, emotional and social abuse and economic deprivation (1)."

The term 'family violence' seeks to explain the violence that occurs between family members and across generations as well as incorporating violence that occurs between intimate partners. The term refers to:

"...all forms of violence in intimate relationships (such as spousal abuse, child abuse and elder abuse) and covers a diverse range of reciprocal kinship ties of obligation and support (2)."

It is for this reason that Indigenous communities prefer the term 'family violence'.

MAINSTREAM

1. Women

Women experiencing family violence can experience:

Physical injuries/problems (3-6)

Bruises (4)
Concussions (4)
Internal injuries (4)
Homicide (6)
Respiratory conditions (6)
Destruction of property (6)
Sleep deprivation (6)

Emotional and psychological issues

Fear (7, 8)
Self harm & suicidality (7, 9)
Eating disorders (7)
Post-traumatic stress disorder (7)
Diminished self esteem (4, 10, 11)
High levels of anxiety and depression (4, 10-12)
Feelings of shame, self blame & guilt (3, 4, 10, 12)
Somatic and Stress complaints such as irritable bowel syndrome, gastrointestinal symptoms, bodily aches and pains, insomnia and other sleep disorders (3, 5, 10)

Social issues

Social isolation – women tend to dissociate themselves from friends, social life and slowly withdraw from community life (4)
Fear of abuser and of removal of child (ren) may prevent disclosure, resulting in further isolation (4)
Insecurity & mistrust of others (4)
Increased risk of developing substance abuse problems (9)
Reduced quality of life (13)
Increase in restraints on human potential and activities resulting from the violence (13).
Absenteeism from work (13)

Parenting difficulties

Many women who experience violence are mothers who are responsible for the day-to-day tasks central to parenting. The physical, emotional and psychological difficulties and social issues as a direct result of violence as outlined above, combine to impact negatively on parenting capacity.

Diminished mother-child attachment (10)
Raised levels of reactivity to normal child behavior (14)
Parental neglect (4)
Conflict (4, 14)

Family violence during pregnancy

Of particular concern, the Women's Safety Australia survey (15) found that, of all the women who reported an incidence of violence at some time in their lives, 42 % were **pregnant** at the time.

The effects of family violence on health during pregnancy include:

Increased risk of having poor weight gain (11)

Anemia (11)

Infections (11)

Pre-term labour (9, 11, 16)

Low birth weight (11, 16)

Increased risk of postnatal depression (11)

Placental abruption (9)

Foetal death and direct foetal injury (9, 16)

Substance misuse, failure to obtain adequate nutrition, rest and medical care may also be attributed to the stress associated with the violence (9, 16).

2. Children and Young adults

The literature has begun to provide evidence that family violence has effects on children's behavior, their cognitive and problem-solving abilities, as well as their coping and emotional functioning. As a group, children exposed to family violence suffer disadvantage in all of the previously mentioned areas, however there does not appear to be any 'typical' reactions. Rather, numerous variables such as the nature and extent of the violence, the level of socio-economic well-being and the children's individual resiliency and coping mechanisms all influence the effect of such violence.

Children exposed to family violence (that is either experience abuse themselves or witness such abuse) often suffer from a range of issues including:

Physical injuries/problems

Children at times often suffer abuse or are injured themselves when they attempt to intervene (9, 12)

Somatic complaints (4, 10, 11, 16)

Poor appetite (4)

Muscle tension (4)

Homicide (1, 17, 18)

Emotional and psychological issues

Anxiety/Distress (4, 9-11)

Low levels of social competence (19)

Increased incidence of attention deficit hyperactivity disorder (3)

Self-esteem and depression (9-11)

Children may develop a sense of responsibility for the violence (9)

Social issues

Inability to establish health peer relations (4, 9-11)

Abused children tend to demonstrate antisocial behavior (4, 9, 16)

Higher rates of drug and alcohol abuse and criminal behavior reported (4)

Adopt violence as a form of conflict resolution (4, 20-22)

Intergenerational transmission of violence (2, 4, 6, 7, 9, 23-26)

Accommodation and Intervention Issues

Children may experience the effects of police intervention, movement to a refuge or to a relative's house. Sudden, rushed upheavals and changes in accommodation impact upon children in many varied ways including:

Loss of home (9)

Loss of friendships, pets, toys, surroundings, sports (9)

Disruption of schooling (9)

Adjustment to refuge living (9)

Domestic violence is one of a range of factors, which increase the risk that young children will become homeless (9, 27-29).

Subsequently, **homelessness** exposes young people to an increased risk of victimisation including physical and sexual assault and to other issues such as substance abuse, self harm, neglect and unsafe sexual practices (9).

Educational issues

There is a growing body of evidence, which suggests that children from violent homes often demonstrate problems at school and education difficulties such as:

Bullying in school (3, 11)

Below average adaptive skills (3, 11)

Below average reading ages (3, 11)

Difficulty with school work and inappropriate coping strategies (9, 10, 16)

Increased risk of leaving education prematurely (3)

Delayed development and disturbed social functioning (10)

3. Men

Despite overwhelming evidence to suggest that domestic and family violence is mainly perpetrated by men against women, the issue of violence against men is increasingly being recognised (6, 8, 30). Yet despite this, there are concerns that violence by women against their male partners is largely underreported, ignored or covered up (6).

Physical injuries/problems

Scratching (8)

Being spat at (8)

Having hair pulled (8)

Threatened with a knife (8)

Being kicked and punched (8)

Verbal and emotional abuse

Constant accusations and interrogation about other women, friends, neighbours (8)

Constant put-downs and ridiculing (8)

Men who perpetrate violence often suffer feelings of guilt and shame (4)

Social and financial abuse

Being denied a social life (8)

The partner spending money irresponsibly in rage (8)

4. Community

Estimating the costs both economically and socially to the community is a constant challenge. Some Australian studies have attempted to calculate the direct costs of domestic violence, although calculating the indirect cost proves more difficult because of the risk of underestimating the costs (13).

Economic impacts (1, 13, 31)

The literature has begun to document and provide evidence of the economic costs of domestic and family violence to society. These costs have been divided into 3 broad categories:

Direct or Tangible – ‘refer to the costs associated with provision of a range of facilities, resource and services to a woman as a result of her being subject to domestic violence (13).’ For example costs of crisis services, accommodation

services, legal services, income support and health/medical services, of which the bulk of such cost are borne by governments (13).’

Indirect or Intangible – ‘refer to the pain, fear and suffering incurred by women and children who live with domestic violence (otherwise termed the social and psychological costs of domestic violence) (13).’ Other indirect costs include the “...the flow on costs that are incurred when a woman leaves a violence relationship such as replacing damaged or lost household items, school uniforms when children change schools... (32).”

Opportunity costs – ‘refer to the costs of opportunities which the participant has lost as a result of being in or leaving the violent relationship such as loss of employment promotion opportunities and quality of life (13).’

Income lost or forgone due to the impact of violence on women’s workforce participation (32)

Social impacts (1)

The impact on the wider community of indirect and opportunity costs as mentioned previously are intrinsically linked to the social impact as is evident in the following comment:

“...the decrease in quality of life experienced by women, communities and society as a result of domestic violence and the increase in restraints on battered women’s **human potential and activities resulting from the violence** (32).”

Miller, Cohen and Wiersema (1996, pp. 21) confirm that:

“The largest cost element for all violent crimes is lost quality of life and related fear, pain and suffering.”

Increased juvenile crime (3)

Increased demand for safe shelters (7, 33)

Perpetuation and continuation of intergenerational violence (Laing, Refer to social issues - children)

Employment issues

It has been reported that the annual cost of domestic violence to the business/corporate sector in Australia is an estimated \$1.5 billion.(13)

Absenteeism from work (13)

Increased staff turnover (13)

Lost productivity (13)

5. Service Providers

Service options

More flexibility in existing service responses (33)

More options available to assist women still living in an abusive relationships (33)

Increase access to domestic violence crisis services which are often limited due to the level of demand (33)

More accommodation options to cater for women who do not need, or want, a high security or communal model of living (33)

More support offered on an outreach basis (33)

Legal responses

No evidence of research in this field has been found.

6. Government and Political responses

The need for multidisciplinary approaches that cut through bureaucratic divides (34)

INDIGENOUS

The boundary between the individual (self), family and community is not as clearly defined as in the mainstream and as such much of the evidence available is broad and interwoven within the various sub-sectors outlined below.

1. Indigenous Women

Indigenous women are much more likely to be victims of violence within the family and to sustain injury compared to non-Indigenous women (35).

Physical Issues (2, 24, 35-39)

Homicide (35)

Violence involving weapons (35)

Physical abuse (2, 17, 24, 35, 37-40), (36)

Bruises (24)

Burns (24)

Black eyes (24)

Welts (24)

Unconsciousness (24)

Miscarriages (24)

Sexual Abuse (2, 17, 24, 35-40)

Rape and related injuries (24)

Infections due to untreated injuries (24)

Social issues (2, 17, 24, 35-40)

Over-representation in police statistics (17, 35)

Increased levels of incarceration (35)

Racism (35)

Difficulty accessing employment (35)

Homelessness (35)

Tendencies towards aggression (35)

Emotional and Spiritual Issues (2, 17, 24, 35-40)

Shame

Extreme anxiety

Cultural abuse

Spiritual abuse

2. Indigenous Men

Emotional and Spiritual Issues

Stress (2)

Emotional trauma (2, 39)

Powerlessness (23)

Hopelessness (23, 38)

Social issues

Increased rates of self harm, mutilation and suicide (35)

Increased levels of incarceration (2, 35)

3. Indigenous Children and Young Adults

Physical issues

Neglect (2, 37, 38, 41)

Incest (2, 37, 38, 41)

Assault (2, 37, 38, 41)

Paedophilia (2, 37, 38, 41)

Rape (2, 37, 38, 41)

Emotional and spiritual issues

Loss of self-esteem (2)

Embarrassment and shame (2)

Feelings of helplessness (2)

Social Issues

Loss of concentration at school (2, 37, 39)

Youth suicide (2, 39)

Transgenerational cycle of violence (37, 38, 42)

Difficulty forming relationships in life (42)

4. Indigenous Communities

Social Issues

Increased levels of criminal behaviour (43)

Shame (35)

Increased levels of mental illness (43)

Increased levels of suicide attempts (37, 38)

Transgenerational trauma (37, 38, 42)

High levels of incarceration rates (2, 35)

High rates of homicides, rapes and suicides

Increased rates of family breakdown and prevalence of single parent families (2)

Diminished community relationships, dynamics and harmony (2)

5. Indigenous interaction with Service Providers

Aboriginal women are often reluctant to use 'white women's' social services:

"In discussions about violence towards women there has been little consideration that the violence, labelled domestic, has alternative dimensions for Aboriginal women, and more particularly, the solutions provided by the narrow feminist response to issues of violence towards women, have been experienced by many Aboriginal women as another form and experience of violence (cited in (43)).

Legal Response and Law enforcement

"The law has been an instrument in the oppression of Aboriginal people far more than it has been a resource for them (35)." This often prevents disclosure of violence.

6. Government Response

No evidence found

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**6.2 Appendix 2: Darebin Family Violence Strategy Development – HIA
Workshop participants 24th June 2003**

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Denise Laughlin	DHS - NMR
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Monika Merkes	City of Darebin, Social Policy Unit
Jane Redfern	SFYS
Joanne Fittock	MCH Darebin Maternal & Child Health (Coordinator)
Jan Black	City of Darebin, Community Services (General Manager)
Voula Pantsis	City of Darebin, Family Support Service
Sally Waddell	City of Darebin, Family Support Service
Donna Karmis	City of Darebin, Family Support Service
David Williamson	City of Darebin, Social Policy Unit
Anne Boscutti	Austin CAMHS
Andrea Hay	DHS – SMR
Veronica Rodenburg	Preston Creative Living Centre
Amber Stevens	Darebin Community Health
Dean Griggs	City of Darebin, Municipal Public Health Planner
Nola Tudball	Community Consultant

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