



Public Health Association
AUSTRALIA

Public Health Association of Australia
*Submission to the National Children's
Commissioner for the Report on the Effects of FDV
on children*

National Children's Commissioner
Australian Human Rights Commission
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Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes. PHAA has a vision for a healthy region, a healthy nation and healthy people living in a healthy society and a sustaining environment based on prevention, the social determinants of health and equity principles.

Public Health

Public health seeks equitable health for all and goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support.

The Public Health Association of Australia

PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups concerned with the promotion of health at a population level.

Key roles of the organisation include the development of policy, capacity building and advocacy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA is an active participant in a range of population health alliances including the *Australian Health Care Reform Alliance*, the *Social Determinants of Health Alliance*, the *National Complex Needs Alliance* and the *National Alliance for Action on Alcohol*.

PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. In addition to these groups the PHAA is responsible for an outstanding peer review journal - the *Australian and New Zealand Journal of Public Health* (ANZJPH).

Advocacy and capacity building

In recent years PHAA has further developed its advocacy role to achieve the best possible health outcomes for the community, both through working with all levels of governments and agencies, and promoting key policies and advocacy goals through the media, public events and by other means.

Preamble

PHAA welcomes the opportunity to provide input to the Australian Human Rights Commission on the examination of children affected by family and domestic violence.

Response to Examination of children affected by family and domestic violence (FDV)

1) What are the definitional issues in relation to family and domestic violence affecting children?

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 of any gender.[1] Domestic violence involves such abuses between people who have been or are in an intimate relationship (also called intimate partner violence/abuse), people who are co-habiting (e.g. housemates) or friends.[1] Abuse can be physical (including rape), verbal, psychological, spiritual, economic or social and can include threats to the injured party, those they love, pets or property.[2-4]

There is large body of evidence that children, especially younger children, are frequently witnesses of FDV in affected families. [5, 6] Overwhelmingly, FDV is perpetrated by men against women and children.[7, 8] Reducing violence against women would reduce the number of children affected by FDV.

FDV and violence against women more broadly are human rights violations, significant public health issues and key determinants of women's and children's health.[8-11]

2) What do we know about the prevalence and incidence of family and domestic violence (FDV) affecting children, including who is involved in FDV events?

Factors that contribute to violence against women at a social and structural level stem from women's lower social, political and economic status than men's and include broader cultures of violence, including attitudinal support for violence against women.[8, 12-14] The determinants of FDV include inequitable power relationships between women and men, adherence to harmful gender stereotypes and social disadvantage.[14-17]

FDV occurs in all groups in society, including culturally and linguistically diverse (CALD) communities, among gay, lesbian, bisexual, transsexual, transgender, intersex and queer (LGTBIQ) people, 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.[1, 18-20]

The prevalence of FDV in Australia is unacceptably high, with one in four women reporting experiencing FDV. [21] Family and domestic violence is also known to be under-reported and under-recorded.[1] A longitudinal study with 1,507 first time mothers found that 29% of women experienced FDV in the first four years post partum. Twelve per cent of women reported abuse at both one and four year post partum questionnaire time points and their children at age four were more likely to demonstrate emotional or behavioural difficulties than those whose mothers did not report experiencing FDV. [22]

Victorian studies have found that 23 per cent of children and young people aged 12 to 20 years have witnessed an act of physical violence against their mother or stepmother. [23] Around one-third of women experiencing violence by a current partner and 40 per cent of women experiencing violence by a previous partner report that their children witnessed the violence. [24] Children were present in an average of 65 per cent of FDV incidents recorded by Victoria Police from 1999 to 2006. [4]

Factors such as alcohol and drug use or childhood exposure to violence, while not causative, can exacerbate the frequency or severity of violence and evidence about effective interventions to reduce alcohol-related family violence are scarce.[4, 25] Nevertheless, evidence suggests that alcohol is implicated in a substantial proportion of incidents.[26] Women's exposure to violence is associated with the adoption of risk behaviours detrimental to health, such as drug and alcohol abuse, physical inactivity and cigarette smoking. [27]

3) What are the impacts on children of family and domestic violence (FDV)?

Studies suggest that the harmful effects of witnessing FDV (including physical, psychological and verbal violence) are equal to direct child abuse and neglect. [5] Harmful effects include poorer health and developmental outcomes than children not exposed to FDV. [6] Children who witness FDV are at higher risk of mental health problems, poorer academic achievement, aggression and other forms of anti-social behavior. [4, 28] Children and young people who have experienced or been exposed to abuse are more likely to attempt or complete suicide than those who have not. [29]

Domestic and family violence impacts on mothers' (or non-offending parents') capacity for parenting, which also affects children's psychosocial development and wellbeing.[28] Mothers/non-offending parents tend to try to protect their children from witnessing or experiencing the perpetrators' violence, however it is not always possible.[28] Pre-school aged children are more at risk than school-aged children because they spend more time with the parents/family and do not have the buffer provided by time spent at school. [28]

FDV is often an escalating pattern of behaviour. Once the pattern has commenced there is a clear risk of the behaviour being repeated. Women and children who are victims of homicide are most likely to be killed as a result of an escalating pattern of domestic violence.[30-32]

4) What are the outcomes for children engaging with services, programs and support?

Community-based domestic violence services, state-based child protection services and police, and the federal family law system demonstrate different understandings of FDV and children's exposure to FDV. [33-40]

Children's exposure to FDV has been recognised by child protection agencies as being detrimental to children's health and wellbeing. When children are exposed to FDV, mothers tend to be blamed for failing to protect their children rather than the perpetrators being held to account for being violent [28, 38, 39].

Federal family court magistrates tend to draw on dominant, patriarchal ideals about the family with narrow understandings of FDV and the effects on children, ignoring or downplaying violence except when it is of an extreme physical nature. [35, 37] Further, children are viewed as incompetent witnesses who may have been coached by their mothers regarding FDV or their own experience of abuse. [41] The construction of the 'best interest of the child' differs from that of children's rights. [42] The best interest concept prioritises opportunities to spend time with the non-residential parent, regardless of any history of FDV. [41] A human rights approach would emphasise the right of the child to live free from all forms of violence, including exposure to violence.[42]

5) What are the outcomes for children of public policy approaches and educational campaigns targeting family and domestic violence (FDV)?

A public health approach to reducing violence against women and children would mean preventing violence in the first place.[4, 9] A public health approach includes primary prevention (before any violence has occurred), secondary prevention (support and services for at-risk populations) and tertiary prevention (support to reduce effects of violence and prevent recurrence).[43] The ideal is primary prevention, which aims to bring about a cultural shift toward gender equality, changing cultural norms toward non-acceptance of violence against women and redistributing resources to promote access to services for all.[43] Public health education campaigns may be useful, but other public health approaches that lead to structural change are needed to support attitudinal change. Improving the status of women in Australia requires multiple strategies, for example equalising men's and women's pay and changing gender roles and expectations via strategies such as paid parental leave, access to child care services, changes in the ways in which courts deal with women who have been raped and women who are victims of FDV.

Studies suggest that older children fare better than younger children, potentially because of the buffering effect of their lives outside the family, for example peers, sports, school.[28] A strong

relationship with the protective parent or other caregiver/s may also mitigate the effects of FDV. The duration of violence also influences the effects, with longer duration being more detrimental.[28]

Interventions focussing on mothers and children to improve their safety and wellbeing

There is limited but growing evidence of what works to reduce abuse or improve the safety of women. [44] These include peer support or nurse home visiting or other studies in primary care. [45] Several Australian studies have shown promise for replication in reducing abuse and promoting safety of women and children. [46] MOSAIC was a mentor mother randomised trial that provided 12 months of weekly home visiting from trained and supervised local mentor mothers, (English and Vietnamese speaking) offering non-professional befriending, advocacy, parenting support and referrals. Mothers supported by MOSAIC mentors showed a significant reduction in mean abuse scores at follow-up compared with un-mentored mothers (15.9 vs 21.8). There was a trend favouring MOSAIC mentored women: lower levels of depression (22%) in the MOSAIC group compared with 33% un-mentored group and better levels of physical health (SF36). 82% of women mentored would recommend mentors to friends in similar situations. Similar results have been found in other peer-support models for vulnerable mothers.[45]

The Victorian Maternal and Child Health (MCH) service has been recognised as a cornerstone of Victoria's preventative services in addressing and preventing vulnerability as they see 99% of mothers with a new baby and follow children at regular intervals until they are 6 years old. The Cummins report into protecting Victoria's vulnerable children suggests a strong universal and enhanced MCH service is needed for vulnerable families and that more evidence is required into interventions to reduce vulnerability.

The MOVE randomised controlled trial included implementation of a best practice model of nurse screening and supportive care for women attending the MCH service. The MOVE model was carefully developed within a theoretical model to improve sustainability [47] with six months active involvement of MCH nurse consultants to ensure the model responded to nurses' concerns as well. It consisted of focussed maternal health visits, a self-completion, maternal health and wellbeing checklist, which included maternal health and FV screening questions, and a FV clinical practice guideline and pathway. [48] Enhanced contacts with local FV services were also included in the model. A designated FV liaison worker was appointed to nurse teams and nurse mentors acted as change agents to support MCH nurse FV work and implement the model.

MOVE was implemented for 12 months in 8 MCH teams in Melbourne's North West metropolitan regions. Extensive trial evaluation identified improved asking and safety discussions with women. Intervention nurse teams screened more women using the MOVE checklist and completed three times more safety planning[49]. At two year follow-up, results indicate an increased and sustained practice change with a fourfold increase in safety planning. [50]

The effectiveness of safety planning with children is unknown and there are a number of difficulties entailed when involving children. The emphasis on keeping safety plans a secret from the perpetrator and from those outside the home who do not recognise the violence being two key problems.[5]

6) What are the surveillance and data gaps/needs in relation to children affected by family and domestic violence (FDV)?

In spite of definitional problems regarding FDV, there is now a reasonable evidence base regarding women's experiences of FDV. There is very limited research that has sought the impacts of FDV on children from their perspective. More research that seeks to understand the experiences and views of children affected by FDV is needed. Undertaking such research requires ethical considerations because of the nature of the research and the distress that children may experience in the research process. [51].

There is little evidence of the effectiveness of health service screening reducing FDV except where there is a strong theoretical basis (e.g. MOVE program outlined above). There is some evidence that non-professional mentor mother support improves safety as well as physical and mental wellbeing among mothers experiencing intimate partner violence referred from primary care.[52]

Recommendations

- FDV can be reduced through primary, secondary and tertiary prevention strategies.[4] PHAA recommends that all three strategies be implemented in the following ways:
 - 1) Primary prevention should include efforts to improve the status of women in Australian society, for example by reducing the gendered pay gap and promoting and improving paid parental leave, in addition to current campaigns that aim to reduce violence against women. Approaches to the prevention of FDV should promote policies to reduce alcohol misuse, especially binge drinking among young people and include evaluation to measure their impact on FDV prevalence.
 - 2) Secondary prevention should use a social determinants approach to reduce risk among at-risk sub-groups, for example by reducing women's poverty by improving income-support measures and reducing women's homelessness by re-instating and resourcing peak housing and homelessness bodies. It should also include strategies in universal health services, such as maternal and child health services, using effective models such as MOVE to support providers to better identify and support vulnerable women and children.

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3) Tertiary prevention should focus on funding and access to women's refuges and other FDV support services. Affordable counselling and outreach services should be available for women who do not choose to go into refuges, and initiatives for women to remain in the home, must also be in place. This should include implementing peer support and mentor mother models at local government area level. The safety of victims should be the primary consideration and 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. Children and young people require support such as affordable and age appropriate counselling. [7]

- Legislative reform should continue, particularly in relation to state-based child protection services and police, and the federal family law system, to address persistent problems with legislative management of FDV.
- Those working in the federal family law system, including those working in family mediation services, should be educated regarding the effects of FDV on children.
- Support services for mothers/non-offending parents must be established and resourced (e.g. MOSAIC and MOVE).
- Those working in child protection services should be educated regarding the effects of FDV on protective parents' and work with domestic violence services to increase the safety of protective parents as well as their children.
- Appropriate counselling services, using counsellors trained in FDV, should be made available to protective parents and their children.
- Child care services should be made accessible to protective parents to provide a buffer from witnessing/experiencing FDV.
- Research and evaluation of programs designed to prevent, reduce and mitigate the effects of FDV is crucial, with MOSAIC and MOVE offering excellent examples.
- Based on the evidence to date, supporting and strengthening relationships between the protective parent or protective caregiver/s may be helpful. Reducing the impact of FDV on the protective parent may also increase their capacity to parent and also reduce the likelihood of the protective parent engaging in risk-taking behaviour such as alcohol and drug misuse.
- Research funding bodies should include FDV research as a priority to increase research in this under-researched area.
- Human research ethics committees should be educated regarding what constitutes ethical research with children in the context of FDV.
- Domestic violence death review teams should be established in all Australian states and territories and these should be linked to share information and increase understanding of patterns of violence preceding deaths so that these deaths can be prevented.
- All services involved in FDV should share their data with each other and with domestic violence death review panels.

Conclusion

PHAA appreciates the opportunity to make this submission.

Please do not hesitate to contact PHAA should you require additional information or have any queries in relation to this submission.



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