

**Victorian Royal
Commission into Family
Violence:
LAVAWN submission**

ENQUIRIES

Judith Lumley Centre
La Trobe University
215 Franklin Street
Melbourne Vic 3000

T: +61 3 9479 8800
E: jlc@latrobe.edu.au

latrobe.edu.au/jlc

Table of contents

VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE: LAVAWN SUBMISSION	1
1. DEFINING AND UNDERSTANDING FAMILY VIOLENCE: OVERARCHING CONCEPTUAL CONCERNS	2
2. CURRENT EVIDENCE FROM LAVAWN RESPONDENTS	3
2.1 Reducing alcohol-related intimate partner violence	3
The role of alcohol in domestic violence	3
Alcohol-related domestic violence in Australia	4
The need for policy and prevention efforts focusing on problem alcohol use	4
Better Australian data on alcohol's involvement in domestic violence	5
2.2 Children, parenting and family violence, peer support and responses in Victoria's primary care health system	5
Introduction	5
Prevalence of partner violence among parents and families	5
Effects of family violence on children	5
Parenting and family violence	6
Home visiting and peer support responses to women experiencing violence	6
The importance of a primary health care response	6
Early identification and support	7
The Victorian Maternal and Child Health Service	7
Need for improved response — MOVE: improving maternal and child health nurse care for vulnerable mothers	8
2.3 Primary and tertiary prevention among gender-diverse communities	9
3. RECOMMENDATIONS	11
Reframing conceptual understandings and language use	11
Parenting, mentoring and primary health care system responses	11
Health systems	12
Alcohol	12
Coordinated policy	13
Opportunities for early intervention	13
Primary and tertiary prevention	13
REFERENCES	14

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Victorian Royal Commission into Family Violence: LAVAWN submission

Violence against women is a public health and human rights issue affecting the health and well-being of women across the globe. The **La Trobe Violence Against Women Network (LAVAWN)** has been established to draw together the breadth of expertise across La Trobe University working on this important issue. The aims of the network are to encourage collaboration and partnerships, and to foster innovation in violence against women research, evaluation and knowledge translation.¹

This submission is a collaborative contribution from LAVAWN researchers and their colleagues.

It is organised into commentary regarding:

- Defining and understanding family violence and how to respond in gender diverse communities
- Evidence based family violence interventions, including alcohol, parenting, mentoring and peer support, primary health system responses, and primary and tertiary prevention for gender diverse communities
- Recommendations for action.

Authors

Professor Angela Taft, Director, Judith Lumley Centre (auspice for LAVAWN), La Trobe University

Ingrid Wilson, Coordinator, LAVAWN, Judith Lumley Centre, La Trobe University

Dr Gillian Fletcher, Institute of Human Security and Social Change, La Trobe University

Leesa Hooker, Judith Lumley Centre, La Trobe University

Karen Parker, Centre for Research on Language Diversity, La Trobe University

Dr Mridula Shankar, Research Fellow, Judith Lumley Centre, La Trobe University

Kylie Lloyd, No To Violence and Men's Referral Service

¹ For a list of LAVAWN researchers, including contributors to this submission, see: www.latrobe.edu.au/ilc/research/reducing-violence-against-women-and-children

For more information about the network, contact Angela Taft [REDACTED] or Ingrid Wilson, LAVAWN coordinator, by telephone on 03 9479 8805 or by email at [REDACTED]

1. Defining and understanding family violence: overarching conceptual concerns

The Royal Commission into Family Violence Terms of Reference and *Issues Paper* reflect the broader focus on the family violence arena in Victoria, in that the central issue is seen as being about men and women (in other words, about sex).

Family violence can include intimate partner abuse, elder abuse and child abuse. It also exists within same-sex and gender diverse relationships [1–6]. If only conceptualised between men and women the *processes* of gender that are socially constructed, the role that power and coercion plays across all genders can be overlooked.

We submit that the focus on men/women, rather than on processes of gender, has serious implications for primary prevention practice (see below). Gender inequality is a symptom of processes of gender. It is not a cause.

2. Current evidence from LAVAWN respondents

We argue that this understanding is important to inform inclusive discourse so that all forms of family violence are represented to the Commission. We also recognise that the overwhelming majority of intimate partner abuse (the major form of family violence) is perpetrated by men on their female or male partners. This impacts detrimentally at all levels of family, community and society.

The responses and recommendations outlined below represent current evidence from studies conducted by LAVAWN respondents.

2.1 REDUCING ALCOHOL-RELATED INTIMATE PARTNER VIOLENCE

Note: This section addresses Questions 6 and 7 of the *Issues Paper*:

- What circumstances, conditions, situations or events, within relationships, families, institutions and whole communities, are associated with the occurrence or persistence of family violence?
- What circumstances and conditions are associated with the reduced occurrence of family violence?

The role of alcohol in domestic violence

Domestic violence is a complex phenomenon, with a myriad of factors operating at the individual, relationship, community and societal levels.[7]

There has been resistance to paying attention to the role of alcohol within the service sector due to concerns that men will blame their choice to be violent on being drunk, rather than taking responsibility for their own actions. It is important that we view this issue through the lens of ‘responsible disinhibition’; that is, of men exercising the choice to drink and to use violence.[8] We should not miss the opportunity to learn more about the complex role that alcohol plays in perpetration of violence and victimisation within intimate relationships.

Alcohol use ‘makes things worse’ for female partners of violent spouses not only in terms of risk and severity of violence,[9] but also in terms of the broader impacts on women’s lives. For example, partners of male alcoholics experience higher levels of verbal and physical abuse, and sexual coercion, in addition to other aspects such as financial abuse associated with the partner’s drinking, and taking on the burden of caring and work. [10] Therefore, it is important that we include a focus on alcohol as a contributing factor within any domestic violence prevention framework.[11, 12]

Decades of research the world over has shown that problem alcohol use is a risk factor for domestic violence.[13–20] Heavy drinking and binge drinking increase the likelihood of male-to-female partner violence in intimate relationships.[21] The risk of violence is between 8 and 11-times higher on days of men’s drinking.[22] Alcohol is involved in a significant proportion of violent incidents.[23–25]

Alcohol use also increases the severity of violence in relationships.[26] In relationships where the man or both partners drink heavily, there are higher odds of male-to-female violence.[27, 28] However, men and women may drink for different reasons. Women who are victims of domestic violence are more likely to self-medicate, which can lead to problematic drinking levels. Many studies show that increased levels of alcohol problems

among women can increase their vulnerability to intimate partner violence.[29] However, women's drinking alone is not strongly associated with men's perpetration, compared to the male partner's drinking.[30]

Alcohol is a risk factor for violence across the lifespan of intimate relationships, although particularly in the early years. High levels of alcohol use are associated with dating violence in youth populations.[31] Alcohol use has also been identified as a risk factor in young adult relationships (studies in college populations)[32], in early relationships (newlyweds),[33] and established adult relationships.

Higher levels of domestic violence are found in populations with more severe alcohol problems, such as alcoholics seeking treatment,[34] and Indigenous populations.[35]

Alcohol-related domestic violence in Australia

Alcohol-related domestic violence is highly prevalent in Australia; it is estimated that alcohol contributes to 50.3 per cent of all partner violence, and 73 per cent of physical assaults by a partner.[36] A national survey of Australian women conducted in 2004 found that 1 in 3 (35%) of recent domestic violence incidents were alcohol-related.[37]

In Victoria, there was a steady rise between 2003/4 to 2012/3 in the rate of alcohol-related family violence incidents attended by police, from approximately 15 to approximately 23 incidents per 10,000 people.[38] The data that are available show that a large proportion of domestic violence incidents involve alcohol. It should be noted that these figures under-represent the full extent of alcohol-related domestic violence in the community as incidents reported to police are often the more severe cases and domestic violence incidents are under-reported.

The 2010 *National Drugs Strategy Household Survey* shows that women are disproportionately affected by a partner's drinking. A survey of Australians' alcohol consumption and harm found that women are more likely to experience alcohol-related abuse from a spouse or partner, whereas men are more likely to report alcohol-related abuse from a stranger. Over 21 per cent of women reported being put in fear by a partner's drinking compared with 6.3 per cent of men; almost 40 per cent of women reported experiencing alcohol-related physical abuse within an intimate relationship compared with 11 per cent of men.[39]

The need for policy and prevention efforts focusing on problem alcohol use

We urgently need policy development on alcohol-related intimate domestic violence, developed and coordinated between the alcohol policy field and the domestic violence sector.

We systematically reviewed the evidence base over the last 20 years,[40] and found a significant lack of attention to interventions that reduce alcohol-related intimate partner violence through reducing harmful drinking.

Historically, alcohol has been given little attention in national and state domestic violence frameworks, although much focus has been on strategies to reduce alcohol-related violence affecting Indigenous communities.[41] Yet the data show that alcohol-related domestic violence is not confined to Indigenous Australians. Hence, policy and intervention frameworks should look to reduce alcohol-related violence across the whole Australian community.

There is limited attention given to alcohol in the *National Plan to Reduce Violence against Women and their Children 2010–2022*. The associated actions focus on harm in Indigenous communities. Gaps exist in the *National Drug Strategy 2010–2015* regarding domestic violence.

At the state level, Victorian policy responding to alcohol-related domestic violence is also scant. Reducing the Alcohol and Drug Toll: Victoria's Plan 2013–2017 cross-references Victoria's Action Plan to Address Violence

against Women and Children. This plan acknowledges the role of alcohol as a risk factor in men's perpetration and women's victimisation. However, the potential for effective interventions to reduce alcohol-related domestic violence has not been actively pursued within the domestic violence prevention field.

Better Australian data on alcohol's involvement in domestic violence

There is a need for better Australian data on alcohol's role in domestic violence — we need this to measure and inform policy intervention and prevention. For example, the *Personal Safety Survey* from the Australian Bureau of Statistics should ask questions about the involvement of offender alcohol and/or other drug use specifically for partner violence.

The Royal Commission should consider actions to reduce harmful drinking; although the factors that contribute to the perpetration of violence against an intimate partner are many and complex, alcohol misuse is one of the few risk factors that we have the ability to change at the individual, community and societal level.[42]

2.2 CHILDREN, PARENTING AND FAMILY VIOLENCE, PEER SUPPORT AND RESPONSES IN VICTORIA'S PRIMARY CARE HEALTH SYSTEM

Note: This section addresses Questions 8 and 11 of the *Issues Paper*.

Introduction

Family violence is a significant social and public health issue that particularly affects many mothers and their children.[43] Witnessing family violence is now defined as a form of child abuse and neglect.[44, 45] Children are most vulnerable when parents have mental health issues, are substance abusers or when children are exposed to family violence.[45]

Prevalence of partner violence among parents and families

The prevalence of family violence amongst parents and subsequent child exposure rates are difficult to estimate, as national and state systems that collect data on violence and children are limited, spread throughout sectors and not easily accessible.[46] Within the wider academic literature, research study samples, definitions of family violence and measures used also vary. Family violence measures based on conflict may not capture the coercive and controlling psychological violence that is so detrimental to women and children.[47]

Within Australia, research suggests that children are frequently exposed to parental aggression and family violence.[48, 49] Households where a violent parent is present are significantly more likely to have children in attendance, especially children under 5 years.[50–52] Victoria Police data (2013–2014) report children present in approximately 34 per cent of households attended by police related to family violence incidents.[53] There are limited studies on prevalence of family violence amongst diverse parent populations (culturally and linguistically diverse, disabled, lesbian, gay, bisexual, transgender and intersex) including rural and remote parents and children.[54, 55]

Effects of family violence on children

Child exposure to family violence has been associated with an increased risk of emotional, physical and child sexual abuse.[56, 57–60] The psychological, health and socio-economic impacts on children witnessing or exposed to family violence indicate that holistic care is required, with a focus on prevention, early identification,[61] and interventions to support the disrupted mother-child relationship.[62, 63]

Parenting and family violence

There is limited research on the parenting behaviours of fathers who abuse their partners.[64] Women as victims have been researched extensively to the point where women are pathologised, rather than focussing on the perpetrator and his methods to undermine women's parenting.[65, 66] The evidence about the impact of violence on mothering in the context of family violence is mixed, and women's responses are heterogeneous.[67] Some women have reported finding strength in their mothering role,[68] and make every attempt to protect their children; however, the majority of studies find evidence of a deficit parenting style where the effects of family violence overwhelm mothers.

Negative health consequences and trauma from the abuse, along with undermining tactics by perpetrators influence women's ability to function and parent effectively.[69, 70, 71] Significant parenting stress can follow with altered attachment of mothers to their children,[72] and harsher parenting styles.[73] Women and children affected by violence benefit from early identification and support.[74]

Home visiting and peer support responses to women experiencing violence

In the *Personal Safety Survey* (ABS)² women say that they disclose first and seek support from family and friends, and after this, their health care providers. Family and friends, and health care providers, can be supportive or judgmental, and we need strategies to support a better and more effective response from these first-line supporters.

There is good evidence that social support (from family, friends or others) improves women's mental health irrespective of the level of violence that their partner perpetrates.[75] One growing evidence-based method to improve women's social support has been tested twice in Melbourne and replicated abroad: the support of peer or mentor mothers to improve women's health and wellbeing.[76,77] In Victoria, there are two studies that have evaluated care provided to women by peer support, which have proved to be effective and could be expanded at the local government area level.

MOSAIC was a study undertaken in north west Melbourne that aimed to reduce partner abuse and depression among women who were pregnant or had infants under 5 years.[78, 79] MOSAIC 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 weak evidence for other outcomes, but a trend was evident favouring MOSAIC-mentored women: lower levels of depression (22%) in the MOSAIC group compared with 33% in the un-mentored group, and better levels of physical health; 82 per cent of women mentored said they would recommend mentors to friends in similar situations.

Non-professional mentor mother support can improve the safety and enhance the physical and mental wellbeing of mothers and children experiencing partner violence.

Mentoring Mums implemented a similar program with mothers in a range of vulnerable situations and argued that the 'befriending' role straddled a half-way point between kith and kin and the professional home visitor.[F] There is a growing attempt to strengthen the role of the nurse home visitor in cases where there is family violence.[G, H, I]

The importance of a primary health care response

² Australian Bureau of Statistics. *Personal Safety Survey 2012*. In: ABS, editor. Canberra: ABS; 2013.

The health impacts of intimate partner violence especially on mothers' mental health can be short or long-term, remain after the violence has ceased, or continue to present repeatedly if the underlying cause of intimate partner violence is left undiagnosed.

Healthcare providers are often the first or only professionals that abused women come in contact with, providing an important opportunity for early intervention. In Australia [84, 85] and elsewhere [86, 87] due to the impact of abuse on ill health, survivors of violence are over-represented in clinic and hospital populations, and their use of healthcare services is much more frequent.[88] For example, female patients in general practice reported more than three times the rate of partner abuse in the previous 12 months compared to women in the general Australian population,[89] and abused women saw general practitioners (GPs) twice as many times as non-abused women.[90]

While patients who are abused are not likely to disclose violence to their clinicians voluntarily, studies with female patients indicate that they find it acceptable for providers to inquire sensitively about violence, if responses are non-judgmental, nondirective and individually tailored to suit their needs and situations.[91] In Victoria, GPs are the provider of choice for many family members, and GPs see perpetrators, survivors and children.[92] Maternal and child health (MCH) nurses provide services to 99 per cent of mothers of newborns and continue with this care until school age. The childbearing period is a time when women may be more vulnerable to violence and this can not only impact on the mother's health, but also her ability to parent effectively.

Both of these clinicians therefore have a valuable role to play in sensitively identifying, caring for and referring survivors of violence to specialist services. Only a minority of women are asked about domestic violence by their healthcare providers.[93] Providers' reported barriers to identification, including a lack of training and knowledge about support services, discomfort with raising the topic, language and cultural differences, presence of partners in consultations, absence of a supportive working environment and time constraints.[94, 95] Two studies in Victoria, one with MCH nurses (MOVE) and another with GPs (WEAVE) have tested promising interventions by health professionals to improve identification and support of abused women.[96] We briefly describe the interventions and key findings here.

Early identification and support

The Victorian Maternal and Child Health (MCH) service has been recognised as a cornerstone of Victoria's preventative services in addressing and preventing vulnerability. The Cummins Report (from the Protecting Victoria's Vulnerable Children Inquiry) suggests a strong universal and enhanced MCH service is needed for vulnerable families and that more evidence is required into interventions to reduce vulnerability.[97] Improvements are required in the way nurses and services care for families with additional needs.[98, 99] Improving MCH nurses' capacity to identify and support vulnerable women and children experiencing violence is one way to address this need.

The Victorian Maternal and Child Health Service

The Victorian MCH service is a 'universal health service for children from birth to school age, focusing on promotion of health and development, prevention, early detection and intervention for physical, emotional and social factors affecting young children'.[100] MCH services, governed by the Victorian Department of Education and Training are located within local government and are provided by registered nurses who are qualified midwives with further postgraduate qualifications in MCH. MCH nurses are community-based health professionals, with existing links and working knowledge of local allied health professionals and other services to support vulnerable families.

In 2009, the DEECD (now Victorian Department of Education and Training) introduced a new 'Key Age and Stage' practice framework to the Victorian MCH service.[100] This policy change involved a comprehensive evidence-based primary health care program, with the aim of improving child health outcomes. The new framework included the introduction of mandatory, routine family violence screening.[100] Whilst nurses have always been cognisant of family violence in the community, previous practice was to ask women about their exposure to violence based on risk assessment rather than routine asking.

Need for improved response — MOVE: improving maternal and child health nurse care for vulnerable mothers

Earlier family violence research with MCH nurses identified barriers to nurses' identification of abused women.[101] MCH nurses also felt underprepared to address family violence with women.[102] 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 had been carefully developed within a theoretical model to improve sustainability with 6 months of active involvement of MCH nurse consultants to ensure the model responded to nurses' concerns as well.[103] It consisted of focussed maternal health visits, a self-completion, maternal health and wellbeing checklist, which included maternal health and family violence screening questions, and a family violence clinical practice guideline and pathway.[104] Enhanced contacts with local family violence services were also included in the model. A designated family violence liaison worker was appointed to nurse teams, and nurse mentors acted as change agents to support MCH nurse family violence work and implement the model.

MOVE was implemented for 12 months in eight 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.[105] At 2-year follow-up, results indicated an increased and sustained practice change with a fourfold increase in safety planning.

Process evaluation identified that the MOVE maternal and health and wellbeing checklist (completed by mothers) was the most helpful resource for nurses, facilitating identification, nurse-client interaction and supportive care. Use of this checklist at a specific maternal health visit allowed nurses more time to address women's health needs including around family violence. However, workloads, privacy issues, lagging knowledge and limited reflective practice continue to be barriers to family violence screening.[106]

The MOVE intervention enhances nurse-mother interactions and increases the amount of safety planning discussions with women and children at risk of abuse. Interventions such as MOVE that offer women pathways to safety may ultimately reduce children's exposure to family violence.

Current Australian state and territory laws on mandatory reporting of children exposed to family violence vary across jurisdictions.[107] Legislation that mandates health care professionals to report children within violent families may cause an overloaded child protection system,[108] and significant damage to mother-child relationships, further alienating women from their children. This causes a double victimisation effect where mothers and children are victims of the perpetrator abuse and also abuse from the 'system'. [109] Silo operations where women are offered assistance through family violence services that offer a woman-centred approach differ from child protection services that are child-centred. Feminist researchers argue for interventions to help heal the mother-child relationship rather than offer separate child and parent therapies.[110] Unfortunately, previous group work (in Melbourne) with mothers and children has not been sustained due to lack of funding.[111, 112] More research and intervention work is needed to support the mother-child bond in the aftermath of family violence.[113]

2.3 PRIMARY AND TERTIARY PREVENTION AMONG GENDER-DIVERSE COMMUNITIES

Violence occurs within family or domestic spaces, regardless of who is the victim. The use of terms such as ‘violence against women’ and ‘women victims’ are inappropriate and reduces family violence to a term which excludes the gender-diverse experience of others. All violence occurring within family or domestic spaces is wrong. Much of this violence (regardless of the sex of the perpetrator or victim) is gendered— the underlying issues are ones of power. A young man who is abused by his mother because he is ‘not manly enough’ is also a victim of gender-based violence.

Primary prevention work needs to move away from a focus on men/women towards open discussion of gender processes, using processes that are flexible, discursive, locally owned, genuinely participatory, and that use ‘critical questioning’.[114]

Examples of the value of adopting such approaches in primary prevention of violence against women already exist within VicHealth’s Respect, Responsibility and Equality program, although there does not appear to have been any process-related learning arising from these examples. Baby Makes 3, delivered by Whitehorse Community Health Service, developed an innovative program for heterosexual first-time parents, believed to be the first of its kind anywhere in the world. The program is ‘discussion-based’ and ‘work[s] with the insights and challenges that the participants raise’.[115] The project evaluation found that participants in the program made particular mention of the value of being able to share and discuss experiences in a group setting and of the way in which this in turn led to clearer and more open communication between couples outside of the program.[116]

The Northern Interfaith Respectful Relationships project was adapted partway through by the addition of a one-to-one ‘peer mentoring approach’ that ‘allowed for sustained levels of discussion and reflection in ways that training did not’.[117] The program’s mentors were encouraged to engage with mentees in discussion on gender-related topics, ‘in relation to personal life, faith community, and society’.[118]

The experiences of lesbian, gay, gender diverse and transgender people are rendered all but invisible throughout the *Issues Paper* and the Terms of Reference, with their consistently unqualified references to violence occurring within a man/woman framework. One specific reference to non-heteronormative people occurs in the section ‘particular groups and communities’, defined as ‘children, older people, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, gay, lesbian, bisexual, transgender and intersex communities, regional and rural communities, and people with disabilities and complex needs’.

Violence can and does occur in relationships between same-sex attracted and/or gender diverse³ and intersex people [119–126]. Indeed, Leonard et al. [127] found that 42 per cent of lesbian-identified respondents to their *Coming Forward* research reported having been in a same-sex relationship where they were subjected to abuse by their partner. This needs to be considered against the 2012 Australian Bureau of Statistics *Personal Safety* survey data (cited in the *Issues Paper*), which reported 25 per cent of women and 14 per cent of men had experienced emotional abuse (which incorporates a range of manipulative and coercive behaviours) in an intimate relationship. There does not appear to be any way of disaggregating data by sexual or gender identity. Nor are data collected on the multiple forms of family violence defined in the *Issues Paper* in the Terms of Reference. Where are the data on violence by young people against parents or siblings, elder abuse, and violence by carers in a domestic setting?

³ By ‘gender diverse’, we are referring both to people who have transitioned from the sex into which they were born, and people who do not conform to man/woman categorisation. Such people may identify by a variety of terms, including gender non-binary, gender-queer and a-gender.

While family violence and intimate partner violence in non-heterosexual relationships share a number of key identifying characteristics with violence in heterosexual relationships, there are also a number of forms which are unique to GLBTIQ community:

- i. Threat of being 'outed' or outing a partner or family member to family, friends, work colleagues
- ii. Using homophobia as a tool to control a partner; for example, telling a partner that services won't believe them, police are homophobic so won't help them, they will lose custody of their children
- iii. Threatening to or revealing HIV status or won't care for them if they are unwell with HIV-related illness
- iv. Telling their partner or family member that they 'deserve it' because they are GLBTIQ and linking in to their own internalised homophobia.[128]

3. Recommendations

Reframing conceptual understandings and language use

Urgent work is needed to reframe our conceptual understandings and the language used around 'family violence' so that the term is gender-diverse and inclusive of all forms of abuse in family settings

Parenting, mentoring and primary health care system responses

Current action:

- Support local government councils to provide mentor support for vulnerable mothers in their communities
- Include Maternal and Child Health data into the proposed Family Violence Index
- Improve data collection methods to accurately measure and monitor trends among the proportion of families with children exposed to family violence
- Improve capacity to link data with other systems (e.g. police and hospital data)
- State-wide implementation of the MOVE model into the current Department of Education and Training, Maternal and Child Health service practice guidelines to support the current family violence work completed by nurses, including all aspects of the model:
- Maternal and Child Health nurse teams to provide a later (ideally 3-month) focussed mother's health consultation to address women's health needs, including asking about family violence
- All MOVE clinical resources including the crucial maternal health and wellbeing checklist to be made available to Maternal and Child Health teams state-wide
- Link teams with individual regional family violence service workers to support nurse work and improve inter-sectoral collaboration
- Increase funding for family violence services, allowing improved collaboration with nurses and other early intervention work instead of crisis-only services
- Improve data collection methods within Maternal and Child Health services to measure family violence in the Maternal and Child Health client population and the family violence work of nurses and the ability to link/compare with other Family Violence Index data sources
- Increase State Government support for/monitoring of accreditation in undergraduate and postgraduate education and skill development for health care professionals responding to victims of abuse

Further research on:

1. Whether Maternal and Child Health nurse family violence routine screening or risk assessment methods are effective in the longer term for improving outcomes for women and children
2. The impact/outcomes of nurse safety discussions with women attending Maternal and Child Health services
3. How enhanced Maternal and Child Health services respond to high-risk families experiencing violence
4. An effective model for Maternal and Child Health nurses to engage with migrant/refugee and Aboriginal families experiencing family violence
5. Greater understanding of how the mother-child relationship is altered due to family violence
6. Lived experience of abused women as parents and the mother-child relationship
7. Parenting behaviours of abusive men and the father-child relationship
8. Intervention aimed at programs to support the mother-child bond and heal relationships

Health systems

To improve responses to intimate partner violence within primary care:

1. Development of healthcare policy acknowledging and addressing the health impacts of family, particularly intimate partner violence and the role of the health system in early intervention; to provide the basis for a systematic health systems response
2. Formation of a working party of representatives of healthcare associations and field experts to develop clear and specific protocols, standard operating procedures and referral networks for health providers to assist survivors of violence (including children), and also to identify and manage men who use violence, including those with comorbid substance use and mental health disorders
3. The Victorian Government to commence dialogue with the Royal Australian College of General Practitioners (based in Melbourne) about mandatory training in the accreditation program for the college (Fellowship of the RACGP) in responding to family violence
4. The Victorian Government to discuss with the University of Sydney Bettering the Evaluation and Care of Health (BEACH) sentinel data collection about the potential for family violence codes, so that survivor and perpetrator identification and referral can be monitored in sentinel GP practices in Victoria and other states, as it is for infectious and chronic diseases and reproductive health
5. The Victorian Government to advocate for accredited ongoing training for identifying and responding to intimate partner violence for doctors and nurses including in the curriculums of Victorian medical and nursing programs as a leader and model of good practice
6. The Victorian Government to fund provider time for improved inter-sectoral collaboration between the health system and specialist family violence services for all members of the family to strengthen referral networks, including ethno-specific services
7. Government-funded standard resources to be developed in a diversity of Victorian languages to encourage development of a supportive environment within healthcare services that acknowledges intimate partner violence as a health concern
8. Increased budget allocation for specialist family violence services including for rural and remote populations, survivors with disabilities, and same sex and trans survivors of intimate partner violence; identification and addressing of barriers to supportive clinical care and referral for rural and remote populations, survivors with disabilities, and same sex and trans survivors of intimate partner violence

Research priorities:

1. Investigate good practice strategies for health care providers for their patients from migrant and refugee communities experiencing family violence
2. Better data collection methods to monitor the health care trends for survivors, their children, and perpetrators presenting to primary health care settings
3. Investigate the role of health care providers in Victorian health care settings, such as general practice, mental health, and drug and alcohol services who see perpetrators with and without substance misuse, to identify and better manage or refer the men (or women) for treatment responding to both the comorbid disorders and the abuse.

Alcohol

- Develop policy and programs to reduce harmful drinking (especially among young people) because alcohol misuse is one of the few risk factors that we have the ability to change at the individual, community and societal level.
- Improve data collection on the involvement of alcohol in the perpetration of domestic violence. Specifically, include a specific question regarding the involvement of alcohol & other drugs in the ABS Personal Safety Survey in their data collection on partner violence. Advocate for the inclusion of

questions about perpetrator alcohol use in other population surveys related to experiences of partner violence including the Australian Longitudinal Study on Women's Health.

Fund or support research upon alcohol policy measures that are effective in reducing alcohol consumption and harm; for example:

- pricing and taxation measures— research that specifically models the effect of these strategies on the drinking behaviours of those who perpetrate alcohol-related domestic violence is needed
- at the community level, measures to reduce the availability of alcohol (e.g. restrictions on retail hours; reducing the number and density of alcohol outlets, particularly takeaway alcohol outlets) show promise for reducing rates of domestic violence and require further investigation
- further development of effective treatment options to deal with co-occurring alcohol-use and domestic violence, using a gendered lens
- exploration of different approaches to reduce alcohol-related domestic violence; for example, in the US, a criminal justice response that mandated sobriety in recidivist drink drivers with a history of problem drinking also found a 9 per cent reduction in domestic violence.

Coordinated policy

Focus policy development on prevention actions to address alcohol use and violence at the individual, relationship, community and societal levels, with the goal of improving the safety of women and children at risk.

Opportunities for early intervention

Early interventions that target binge drinking in young adults may present opportunities to prevent and reduce alcohol-related intimate partner violence in later life

Focus prevention strategies focus on reducing harmful drinking behaviour among both young men and women.

Primary and tertiary prevention

- Develop a more inclusive, diverse definition of family violence which includes a full range of gendered diversity (LGBTI) and develop policy, programs and data to reflect this new understanding.
- Support providers of tertiary prevention services (i.e. post-violence services) to move beyond the male/female boundary, to recognise and respond to family violence affecting non-heterosexual and non-gender normative people
- Consider the needs of male victims of family violence (of all ages, from childhood to adulthood). Break down barriers for same-sex-attracted and bisexual men who face a number of homophobic and heteronormative barriers when seeking support from service providers.
- Develop support services responsive to the needs of non-heteronormative or non-gender normative people who experience family violence and lack specialty support services. GLBTI-specific health or other services are not always equipped to offer appropriate services to people experiencing violence.
- Encourage specific education for generalist services who may not apply routine relationship violence assessments to same-sex attracted couples as they would with heterosexual couples, or they may minimise the violence between two men as opposed to a man and a woman.

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