

Mental Health & Wellbeing Unit
Victorian Health Promotion Foundation



VicHealth
Scoping Report
2003

**Public Health, Mental Health and Violence
Against Women
Report produced for VicHealth**

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BACKGROUND

The Victorian Health Promotion Foundation, VicHealth, is an independent statutory body established in 1987. VicHealth works towards the development of innovative responses to the complex social, economic and environmental forces that influence the health of all Victorians. VicHealth has a particular focus on a flexible, responsive and evidence-informed approach to working with partners from across different sectors in the community to create environments which improve population health.

In 1999, VicHealth established a framework for the development of activity relevant to the promotion of mental health and wellbeing. Central to this framework is a focus on three determinants of mental health: social inclusion, freedom from discrimination and violence and economic participation.

Evidence reviews which progress the understanding of the link between these determinants and mental health are an essential component of VicHealth's work. In reviewing the literature the impact of violence against women has been a constant and recurrent theme. Consequently, in 2003 this scoping paper was commissioned to investigate potential directions for VicHealth's future focus.

EXECUTIVE SUMMARY

Whilst there has been an historic lack of interest in the connection between violence and health, over the past two decades scientific attention has begun to focus on the gradual collection of evidence by nation states, global instrumentalities and non-government organisations of both the incidence and effects of violence, most particularly, violence against women.

This global attention has culminated in the release of the World Health Organisation's World Report on Violence and Health in 2002. The clearly stated purpose of the WHO report 'is to challenge the secrecy, taboos and feelings of inevitability that surround violent behaviour, and to encourage debate that will increase our understanding of this hugely complex phenomenon.'¹

That violence against women is a social disease with critical public health significance has now been recognised on a global scale accords with the increasing attention directed towards this pandemic in Australia. The enormous social, economic and health impact associated with violence against women is increasingly the subject of state and national government attention. Hospital emergency departments, workplaces and schools are some of the many settings that are beginning to focus on the many challenges posed by increased numbers of victims of violence in their midst, both as workers, patients and students, and the social and economic costs associated with treating or protecting them.

These social, human and economic costs are rising and it has been acknowledged that there is an urgent need to ensure that multi disciplinary, cross sector approaches are introduced to reduce this burden at individual and community levels. There is now also clear articulation of the need to not only focus on the management of existing forms of violence against women but also to work toward its prevention. Consequently world health bodies are now urging that all nations combine in an effort to further understand the causes of violence against women, and respond in ways that recognize its effects on the health of individuals and communities.²

This monograph: ***Public Health, Mental Health and Violence Against Women***, has been prepared for the consideration of the Victorian Health Promotion Foundation (VicHealth), because VicHealth has demonstrated a leadership role in health promotion practice in the face of other seemingly intractable health problems such as the burden of mental ill-health across the population. An opportunity now exists for VicHealth to apply health promotion theory and practice to this issue and support innovative work which would make considerable contribution to the development of global health promotion practice in this area.

¹ World Health Organisation 2002, *World Report on Violence and Health*, WHO, Geneva.

² Ibid

This document canvasses the most recent global, national and Victorian research which examines the nature and incidence of violence against women. It also enumerates the costs of this violence, in terms of mental and physical health, the social and economic costs borne by the whole of the community as a consequence of the combination of cultural and individual factors that give rise to violence against women. This document also takes up the challenges made by the WHO Report on Violence and Health and makes recommendations about potential areas of activity that VicHealth may wish to consider for development through the mental health promotion strategy.

Nature and Incidence of Violence Against Women

It is common ground that the issue of power is central to our understanding of violence. Explicit within the 2002 WHO report, the Australian Commonwealth approach and the Victorian Women's Safety Strategy is the acceptance that violence is an abuse of power. The WHO report makes a bold statement about the inclusion of the word "power" in addition to the phrase "use of physical force", 'broadens the nature of a violent act and expands the conventional understanding of violence to include those acts that result from a power relationship, including threats and intimidation.'³ The WHO report adopted the definition accepted by the WHO Global Consultation on Violence and Health in 1996:

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.⁴

There are great difficulties associated with accurately assessing the incidence of violence against women. This is due to a combination of factors including the intimate nature of the behaviours and the difficulty many victims have in speaking about it combined with the variations of definitions across jurisdictions. Despite the debates surrounding these definitions, it is well established that violence affects large numbers of Australian women each year:

- The first Women's Safety Survey by Australian Bureau of Statistics interviewed 6300 women in 1996, and found that 7.1% of those women had experienced physical or sexual violence within the previous twelve months (ABS 1996).

³ Ibid p5.

⁴ World Health Organisation 1996, Global Consultation on Violence and Health: *Violence : a public health priority*, WHO Geneva.

- Despite acknowledgement that only a small percentage of women experiencing violence bring this experience to the attention of the authorities, in Victoria, police attended 21,618 family violence incidents in 2000/2001. Approximately 80% of adult aggrieved family members at these incidents were female. There were also 19,933 children present at family violence incidents attended by police.⁵
- Victorian Centres Against Sexual Assault estimate that over 1886 recent victim/survivors of sexual violence contacted Victorian Centres between 2001 and 2002⁶

Women often face the greatest risk at home and in familiar settings.⁷ Global data indicates that in some countries nearly one in four women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced.⁸

Violence against women, alongside other forms of violence, occurs along a continuum ranging from harassment and bullying to rape and murder. This violence, whilst contained largely within relationships within the home, like other forms of violence can also occur across settings such as workplaces, educational environments and in the social sphere. Research into the varying forms of violence acknowledges this continuum of violent activity and suggests that a culture of violence is now starting to permeate many facets of our culture and society.

There is also mounting evidence identifying alcohol as an important factor in the perpetration of violence. However, the relationship between alcohol and violence against women is not well understood. While this relationship is also the subject of much debate, there is evidence to suggest that alcohol abuse by men is a mitigating circumstance for partner violence that is especially consistent across different settings.

⁵ Victorian Community Council Against Violence 2002, *Victorian Family Violence Database First Report August*, Victorian Community Council Against Violence.

⁶ Victorian CASA Forum, unpublished data for years 2001/2002.

⁷ Office of Women's Policy 2002, *A Policy Framework: A Co-ordinated Approach to Reducing Violence Against Women*, Women's Safety Strategy. OWP, Victorian Government p21; WHO 2002 p 89.

⁸ WHO 2002 p 149.

The Physical and Mental Health Effects of Violence Against Women

The World Health Organisation emphasizes that:

‘women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related symptoms, pain syndromes, phobias, chemical dependency, substance use suicidality, somatic and medical symptoms, negative health behaviours, poor subjective health and health service utilization.’⁹

The 2002 WHO Report also describes the direct health consequences to women including:

- Depression, anxiety and phobias
- Suicide attempts
- Chronic pain syndromes
- Psychosomatic disorders
- Physical injury
- Gastrointestinal disorders
- Irritable bowel syndrome
- A variety of reproductive health consequences¹⁰

The report also indicates that:

- The influence of abuse can persist long after the abuse has stopped;
- The more severe the abuse, the greater its impact on the woman’s physical and mental health; and
- The impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative;
- The consequences of violence against women, both on the women themselves and on their children who witness such violence, can be profound and life-long.¹¹

The economic consequences of violence against women are also increasingly recognized:

- Australian businesses are losing at least \$500 million per year because of the effects of family violence on their employees.¹²

⁹ WHO 2002 p 101

¹⁰ WHO 2002 p 101

¹¹ Partnerships Against Domestic Violence 2001, *Working Together Against Violence: The First Three Years of Partnerships Against Domestic Violence* p 24

¹² Henderson M (PP Henderson and Associates), *Impacts and Costs of Domestic Violence on the Australian Business/Corporate Sector –Report to the Lord Mayor’s Women’s Advisory Committee, Brisbane City Council, May 2000.*

- Victims of domestic violence were estimated to take just under \$30 million in sick leave and days off each year, while \$6 million is spent on staff turnover.
- Data collected by the Women's Domestic Violence Crisis Service (Victoria) shows that the majority of women accessing their crisis service are not in the paid workforce (86%), whereas a majority of women (80%) were also accessing some type of financial support from the State. Those receiving sole parents' benefits (39%) were also highly represented among callers to the crisis service.¹³

Victorian Health Promotion Foundation: Potential Roles

VicHealth has established a conceptual framework to guide mental health promotion activity and has successfully developed and implemented a full program of activity which is acknowledged at a global level. However, external stakeholders and VicHealth staff are cognizant of the need to further develop a gender focus in this area of activity.

Consequently, during 2000 the VicHealth mental health promotion panel 1) acknowledged the relevance of a focus on violence against women to the current mental health promotion conceptual framework and 2) endorsed a focus on violence against women as a potential key area for future action.

The evidence supporting a mental health promotion approach towards the elimination of violence against women is clear. The case is made by the World Health Organisation and the Commonwealth, State and Territory governments and is documented in this report.

At the state level the Women's Safety Strategy, endorsed through a whole of government approach, lays fertile ground for implementation of mental health promotion activity which supports and adds to this emerging agenda.

¹³ Victorian Women's Domestic Violence Crisis Service 2003, *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02* p 25.

Recommendations

After reviewing the current literature and research, and consultation with a small number of key stakeholders, it is recommended that VicHealth consider support for:

- Research, conducted in conjunction with DHS, which identifies the burden of disease, associated with violence against women;
- Community forums which facilitate bottom-up, planning, activity and advocacy at the local level;
- The development of an advocacy project which 1) undertakes research and reports on media management of Violence Against Women over a two year period, 2) increases media attention on this issue, 3) responds to inappropriate media coverage as required and 4) makes recommendation for future activity in this area;
- A scoping / consultation exercise to determine research, interventions and communications and marketing strategies which focus on the connection between alcohol and escalation of violence against women.

1 INTRODUCTION

The World Health Organisation World Report on Violence and Health (WHO 2002) argues that for most of the past century, scientific interest in the problem of violence perpetrated against women has been negligible and that this violence must be understood as a significant public health issue requiring immediate response. The report states that:

“Violence represents a crucial violation of women’s rights as human beings. The experience of violence necessarily violates women’s rights to liberty and security of person and to freedom from fear. The presence of violence is incompatible with the enjoyment of the highest attainable standard of physical and mental health”.

Whilst there has been an historic lack of interest in this issue, over the past two decades scientific attention has begun to focus on the gradual collection of evidence by nation states, global instrumentalities and non-government organisations (“NGOs”) of both the incidence and effects of violence against women.

That violence against women is a social disease with critical public health significance has now been recognized on a global scale. The enormous social, economic and health impacts associated with violence against women have also been acknowledged as has the urgent need to ensure that multi disciplinary, cross sector approaches are introduced to reduce this burden at individual and community levels. Likewise there is now clear articulation of the need to not only focus on the management of existing forms of violence against women but also to work toward its prevention. Consequently world health bodies are now urging that all nations combine in an effort to further understand the causes of violence against women, and respond in ways that recognize its effects on the health of individuals and communities.¹⁴

This document canvasses the most recent global, national and Victorian research which examines the nature, incidence of violence against women. It also enumerates the costs of this violence, in terms of mental and physical health, the social and economic costs borne by the whole of the community as a consequence of the combination of cultural and individual factors that give rise to violence against women. This document also takes up the challenges made in the WHO Report on Violence and Health and makes recommendations about potential areas of activity that VicHealth may wish to consider for development through the mental health promotion strategy.

In the context of the WHO World Report on Violence and recognising VicHealth’s leadership role in health promotion and in particular mental health promotion, an opportunity now exists for VicHealth to apply health promotion theory and

¹⁴ World Health Organisation 2002

practice to this issue and support innovative work which would make considerable contribution to the development of global health promotion practice in this area.

2 VIOLENCE IN A GLOBAL CONTEXT: THE WHO REPORT ON VIOLENCE AND HEALTH

Violence is now acknowledged as a vital determinant in the health of individuals and communities. It is widely recognised that women and children are particularly affected. The Secretary-General of the World Health Organisation (WHO) has stated that there is an urgent 'need for more research on the connection between human rights, legal and economic issues, and the public health dimensions of violence' and that 'a rapidly growing body of evidence shows that women's experience of violence has direct consequences not only for their well-being, but also for that of their families and communities [which in turn] has intergenerational repercussions'.¹⁵ There is considerable evidence that many world bodies have now accepted that violence against women requires global efforts and that it is no longer regarded as a simple issue which is confined to the circumstances of any particular country, race or group.¹⁶ This recognition has given rise to international collaboration to achieve a focus on violence as a public health issue requiring urgent attention.

In late 2002, the WHO Report on Violence and Health was published ("the report"). This report comprehensively mapped the aetiology of violence across all population groups. It noted the dimension of the problem, commenting that in surveys from around the world, 10-69% of women report being physically assaulted by an intimate partner at some point in their lives.¹⁷ In some countries one in four women report sexual violence by an intimate partner and up to one third of girls report forced sexual initiation. Hundreds and thousands more are forced into prostitution or subjected to violence in other settings such as schools,

¹⁵ World Health Organisation 2002

¹⁶ In 1993 the UN General Assembly passed the Declaration on the Elimination of Violence Against Women, (UN Resolution 48/104 (444). Proceedings of the 85th Plenary Meeting, Geneva, Dec. 20, 1993. United Nations General Assembly). The new level of urgency to respond to the deleterious effects of violence was affirmed in May 1996 when the Forty-ninth World Health Assembly had also noted with great concern a dramatic worldwide increase in the incidence of intentional injuries to people of all ages and both sexes, but especially women, and endorsed the urgency of tackling the problem of violence against women and girls and understanding its health consequences. (World Health Organization (WHO). Violence against women: A priority health issue. WHO/FRH/WHO/97.8, Geneva, WHO, Jul. 1997. Fact sheets). This endorsement of the recommendations of the Fourth World Conference on Women (Beijing 1995) and the International Conference on Population and Development (Cairo 1994. in September 1998, the Interagency Development Bank brought together 400 experts from 37 countries to discuss the causes and costs of domestic violence, and policies and programs to address it.(WHO Fact Sheet, *ibid*). In 1999, the United Nations Population Fund declared Violence Against Women a "public health priority" (United Nations Population Fund (UNFPA). Violence against girls and women. New York, UNFPA, 1999. p24)

¹⁷ WHO 2002, p 17.

workplaces and healthcare institutions.¹⁸ The report argues that violence is now a priority public health issue and that WHO must urgently develop appropriate public health guidelines to address the problem.¹⁹ The report claims to be an authoritative global statement on violence, and:

....is the first comprehensive review of the problem of violence on a global scale - what it is, whom it affects and what can be done about it. Three years in the making, the report benefited from the participation of over 160 experts from around the world, receiving both peer review from scientists and contributions and comments from representatives of all the world's regions.²⁰

3 NATURE AND INCIDENCE OF VIOLENCE AGAINST WOMEN

There is much debate about the use of different terms and categories to describe violence against women. Implicit within the 2002 WHO report, the Women's Safety Strategy and the Commonwealth approach is the acceptance that violence is an abuse of power. The WHO report makes a bold statement about the inclusion of the word "power" in addition to the phrase "use of physical force", 'broadens the nature of a violent act and expands the conventional understanding of violence to include those acts that result from a power relationship, including threats and intimidation.'²¹

The definition of violence contained in the WHO report is adopted from the definition accepted by the WHO Global Consultation on Violence and Health in 1996:

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.²²

Reference is made to the importance of 'intentionality' with committing the acts themselves, irrespective of the outcome it produces.²³ This approach builds on the important work undertaken in health settings and described as 'injury prevention' at the same time distinguishing it from injury prevention because it needs to address the motive of the *injurer*.

¹⁸ Ibid p 18.

¹⁹ WHO 2002

²⁰ WHO 2002, p 2

²¹ Ibid p5.

²² WHO 1996.

²³ Ibid p 5

The 2002 WHO report also uses the term 'intimate partner violence' and defines this violence as 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.'²⁴

A spectrum of degrees of force is covered by the definition of coercion:

Apart from physical force, it may involve psychological intimidation, blackmail or other threats - for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent - for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.²⁵

The Victorian Government's Women's Safety Strategy adopts the approach taken in earlier work by the National Committee on Violence Against Women, using the catch-all phrase of violence against women, which 'includes sexual and physical violence as well as emotional and psychological violence. It includes all types of violence regardless of whether it occurs in the home, workplace or a public place and regardless of the relationship between the perpetrator and the woman who has experienced the violence'.²⁶

Importantly, the Victorian Government's approach allows for the development of policy across a range of settings, recognising that there are a core set of determinants identified for all forms of violence against women. For the purposes of this document, the term 'violence against women' is adopted to assist compatibility with trends in Australian policy in this regard.

The Commonwealth Government also acknowledges that domestic violence is generally understood as gendered violence, and 'is an abuse of power within a relationship or after a separation when one partner in an intimate relationship attempts by physical or psychological means to dominate and control the other. It is generally understood as gendered violence, and is an abuse of power within a relationship or after a separation'.²⁷ This understanding of the centrality of an abuse of power has formed the basis of definitions adopted within Australia.²⁸ It has therefore been a central focus for Commonwealth and State policy development. Accordingly, it is assumed to be a central element in a public health approach to the prevention of violence.

²⁴ WHO 2002, p 89.

²⁵ Ibid.

²⁶ Office of Women's Policy 2002, *A Policy Framework: A Co-ordinated Approach to Reducing Violence Against Women*, Women's Safety Strategy, OWP, Victorian Government, p 9.

²⁷ Partnerships Against Domestic Violence 2002, *Annual Report 2000-2001: A Substantial Beginning to a new Commitment*, p 1.

²⁸ See for example, the AMA position statement on Domestic Violence (1998) which 'deplores all forms of domestic violence...an abuse of power'. <http://www.ama.com.au/web.nsf/doc/SHED-5FK5FQ>

3.1 Incidence/evidence of violence against women

The difficulties associated with collecting accurate data on the incidence of violence against intimate partners are widely acknowledged by researchers and policy makers.²⁹ They may be easily summarized. The inconsistencies in the way violence is defined, variations in selection criteria for studies; differences in sources of data and the willingness of respondents to talk have each been noted.³⁰ The 2002 WHO report also makes the critical point that a focus on 'acts alone can also hide the atmosphere of terror that sometimes permeates violent relationships' and cites research from a range of qualitative studies which 'suggest that some women find the psychological (mental) abuse and degradation even more intolerable than the physical violence'.³¹

Arising from these definitions and the need for a public health approach, the 2002 WHO report divides violence into three broad categories: self-directed violence; interpersonal violence and collective violence. These typologies also capture the form of the violence, which can be physical, sexual or psychological or involve deprivation or neglect. Also considered within this approach is the relevance of the setting, the relationship between the perpetrator and the victim, and in the case of collective violence - the possible motives for the violence. Measurement of the violence and its extent are seen as critical to determining future policy direction, as is the measurement of the impact of the violence - lives lost, health harmed and money spent.³²

Women often face the greatest risk at home and in familiar settings.³³ Global data indicates that in some countries nearly one in four women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced.³⁴ Exact numbers are hard to come by due to lack of reporting. It is also the case that empirical studies have been under-resourced in the past. Where such research has been undertaken, it is often criticized for a range of reasons including variations in laws across regions or countries; the fear and shame felt by many potential research subjects and diverse definitions used by different writers³⁵. Almost half the women who die as a result of homicide are killed by their current or former husbands or boyfriends, while in some countries the figure can be as high as 70%. Most victims of physical aggression are subjected to multiple acts of violence over extended periods of time. A third to over half of these cases are accompanied by sexual violence.³⁶

²⁹ WHO 2002 p 92; PADV 2001 p11, OWP 2002 p 25.

³⁰ WHO 2002 p 92.

³¹ WHO 2002 p 93.

³² Beverley Raphael *Domestic Violence: The healthcare sector could become agents of change* in MJA 2000; 173:513-514.

³³ OWP 2002 p 21; WHO 2002 p 89.

³⁴ WHO 2002 p149.

³⁵ Women's Domestic Violence Crisis Service, *What's Love Got To Do With It? Victorian Women Speak out about domestic violence. Annual Report 2002-2003* (2003).

³⁶ WHO 2002 p 93.

In Australia, the most comprehensive survey of violence against women was undertaken by the Australian Bureau of Statistics in 1996. Interviews were carried out with 6300 women and showed that 7.1% of those women had experienced physical or sexual violence within the previous twelve months. The survey found that

- 'younger women were more at risk than older women: 19% of women aged between 18-24 had experienced an incident of physical violence in the previous 12 month period, compared to 6.8% of women aged 35-44 and 1.2% of women aged 55 and over'.³⁷
- 36.4% of women had experienced some violence since the age of 15 - 30.1% physical and 17.6% sexual violence. 45% of sexual violence and 55% of physical violence was committed by a current partner, a previous partner or a boyfriend/girlfriend or date.³⁸

The ABS survey has been criticised on the basis that it under-represented women in rural and remote areas, and as a result under-represents indigenous women. It has also been argued that it does not accurately represent the experiences of women born in particular countries, though data relating to women born in English speaking and non English speaking countries is more reliable because of the methodology adopted in the survey.³⁹

In another study of homicides between intimate partners, conducted between 1989 and 1996, one quarter of the killings were of spouses (or former spouses) and 77% of these were committed by men on their then current or former female partners.⁴⁰ In another study of reported homicides in Australia between 1989 and 1998, 14.6% of women victims were killed by strangers, and 'almost 60% were killed by an intimate partner.' Aboriginal and Torres Strait Islander women were even more likely to be killed by an intimate partner - 74% compared to 54% of Caucasian victims. Overall, Aboriginal and Torres Strait Islander women accounted for approximately 15 per cent of the femicide victims, although comprising only about 2 % of the total female population.⁴¹

In Victoria, police attended 21,618 family violence incidents in 2000/2001. Approximately 80% of adult aggrieved family members at these incidents were

³⁷ Australian Bureau of Statistics 1996, *Women's Safety Australia*, Cat No 4128.0.

³⁸ These figures have been recalculated by Graycar and Morgan in *The Hidden Gender of Law* from the ABS table 3.18. The rationale for this being that the ABS, when reporting total levels of violence, only counts a woman once if she experienced violence from more than one perpetrator whereas Graycar and Morgan have counted *incidents* of violence: Regina Graycar and Jenny Morgan, *The Hidden Gender of Law* (2nd ed, 2002).

³⁹ *Ibid* p 303.

⁴⁰ Carach, C. & James, M. 1998, *Homicide Between Intimate Partners in Australia* (Australian Institute of Criminology, Trends and Issues Paper No 90, cited in Graycar and Morgan, p 304.

⁴¹ Mouzos, J. 1999, *Femicide: An overview of Major Findings* (Australian Institute of Criminology, Trends and Issues Paper No 124) cited in Graycar and Morgan, p 304.

female. There were also 19,933 children present at family violence incidents attended by police.⁴²

Victorian Centres Against Sexual Assault estimate that over 1886 recent victim/survivors of sexual violence contacted Victorian Centres between 2001 and 2002.⁴³

Clinical studies in emergency departments and antenatal clinics indicate that between 19.3% and 25.7% of women will be subjected to domestic violence over their lifetimes.⁴⁴

Violence against women also frequently involves violence against children. Violence perpetrated against women while they are pregnant⁴⁵, in the presence of their children, against children in the presence of their mothers, and against children, trying to defend their mothers or to stop the violence has increasingly come to the attention of researchers.⁴⁶ While violence against children is not the focus of this paper, it is common ground that prevention of violence against women has significant benefit for the growth and development of children.

3.2 Where does violence against women occur?

Violence against women occurs within a range of settings. Much of the research, for example, distinguishes between 'domestic violence' which occurs in the home and 'sexual harassment', which occurs often within the context of service provision or the workplace.⁴⁷ Bullying in a range of settings is now also being recognized as violence. For example, bullying in schools has become a focus for curricula and there is now important research which links bullying behaviour to a culture of violence. It goes on to suggest this can ultimately lead to violence against women.⁴⁸

Bullying and sexual harassment in the workplace are also key contributors to a culture of violence. Bullying has also been found to be strongly connected to the health of Victorians.⁴⁹ In 1998, a Morgan Poll was conducted which indicated that 46% of Australians experienced either verbal or physical abuse from a co-

⁴² Victorian Community Council Against Violence 2002, *Victorian Family Violence database First Report* August, cited in Women's safety strategy pg 21

⁴³ Victorian CASA Forum, unpublished Data for years 2001/2002.

⁴⁴ Hegarty, K., Hindmarsh, E., & Gilles, M.T. *Domestic violence in Australia: definition, prevalence and nature of presentation in clinical practice MJA 2000; 173:363-367.*

⁴⁵ Taft, A 2002, *Violence against women in pregnancy and after childbirth: Current knowledge and issues in health care responses.* Australian Domestic Violence Clearinghouse Issues paper number 6. PADV and UNSW p 4-5

⁴⁶ Laing, L. 2000 *Children, young people and domestic violence* in Australian Domestic Violence Clearing House, PADV, UNSW, Issues Paper 2, 2000, p 2.

⁴⁷ Australian Bureau of Statistics 1996, *Women's Safety Australia*, Cat No 4128.0, ABS, Canberra.

p24 -25

⁴⁸ Wallis Consulting Group, *Victorian Attitudes Towards Bullying* (September 2001)

⁴⁹ Ibid p iv

worker or manager sometime in their working lives and 7% of Australians who have been in paid employment have experienced some kind of physical abuse from someone employed in the same workplace.⁵⁰

In 2001, formal complaints of sexual harassment in the workplace lodged with the Victorian Equal Opportunity Commission outnumbered complaints based on any other attribute including complaints of disability, race and sex discrimination in employment.⁵¹ In 2000/2001 there were 550 complaints of sexual harassment lodged with the Commission. Eighty three per cent of these complaints were from women.⁵²

3.3 The relationship between violence against women and alcohol

There is much debate about the relationship between violence against women and alcohol. There is evidence to suggest that alcohol abuse by men is a mitigating circumstance for partner violence that is especially consistent across different settings. However, there is considerable debate about the nature of the relationship between alcohol abuse and violence and whether it is truly causal.

Despite these conflicting opinions, the evidence is that women who live with heavy drinkers run a far greater risk of being the victims of physical partner violence, and that men who have been drinking inflict more serious violence at the time of the assault. According to a survey of violence against women in Canada, for example, women who lived with heavy drinkers were five times more likely to be assaulted by their partners than those who lived with non-drinkers.⁵³

The presence of alcohol has also been found to be relevant in the Australian context. The Women's Safety Survey conducted by the ABS in 1996 found that in 40% of violent incidents alcohol was involved. However, in this survey, there was no additional data which indicated which partner had consumed the alcohol⁵⁴.

The Victorian Women's Domestic Violence Crisis Service (WDVCS) makes the point that violence against women is a particular feature of family life at times of national celebration, such as at the time of the Grand Prix, the AFL Grand Final, Christmas and New Year periods and most school holidays, and Christian Easter. In a report published in 2003, the WDVCS noted that in 166 cases of

⁵⁰ Morgan Poll (1998) Finding No.3091 9 June 1998, cited in Women's Safety Survey at 25.

⁵¹ Victorian Equal Opportunity Commission, *An overview of the Nature, Causes and Impact of Systemic Discrimination in Employment* (Unpublished paper, 2002).

⁵² Victorian Equal Opportunity Commission, *The Way Forward, Annual Report 2001/2002* (2002).

⁵³ WHO 2002 p 98.

⁵⁴ Australian Bureau of Statistics 1996, *Women's Safety Australia*, Cat No 4128.0, ABS, Canberra.

domestic violence, in 18.5% of circumstances in which women were assaulted, alcohol or drugs, were involved.⁵⁵

Clearly, alcohol and drugs are important factors in the behaviour of offenders, but it should also be noted that there is also considerable evidence that women who are in situations of violence resort to drugs and alcohol to 'dull the pain'.⁵⁶

In a study conducted in 1993 for the National campaign Against Drug Abuse, the relationship between violence and alcohol and domestic violence as causal was roundly dismissed. However, the study noted that alcohol was frequently used as an excuse for violence, although and noted that other forms of violence - psychological, emotional and verbal abuse, financial or economic abuse and social abuse, abuse are generally far less likely to be regarded as being linked to alcohol use in any significant way.⁵⁷

4. VIOLENCE — A PUBLIC HEALTH ISSUE

The report urges that nation states consider violence within a global context and that they adopt a public health approach to the prevention and elimination of violence. Broadly, a 'public health approach' is identified by WHO as an approach which defines and monitors the extent of the problem, identifies the causes, formulates and tests ways of dealing with the problem and applies widely the measures that are found to work.⁵⁸ The report builds on what is called an 'ecological model', which is used to explain the myriad causes of violence. This model takes into account the multitude of biological, social, cultural, economic and political factors that influence violence at four levels: the individual, the relationship, the community and the societal. The features of this model provide the basis for a public health approach to the analysis of violence and its prevention.

Taking each level in turn, the individual level takes into account the biological and personal history factors that increase the likelihood of an individual becoming a victim or perpetrator of violence. At the relationship level, the model explores how relationships with families, friends, intimate partners and peers influence violent behaviour. At the community level, the report considers the context in which social relationships occur (eg in schools, workplaces and neighbourhoods) and seeks to identify characteristics of these settings that increases the risk of violence. Finally, the broader societal level examines social norms that create a

⁵⁵ Victorian Women's Domestic Violence Crisis Service, *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02* (2003).

⁵⁶ Partnerships Against Domestic Violence, *Against the Odds: How Women Survive Domestic Violence* (Office for the Status of Women, May 1999).

⁵⁷ National Symposium on Alcohol Misuse and Violence: *Violence Against Women in the Home* Report No.4. 1-3 December 1993. p iii.

⁵⁸ *Ibid* p 3.

climate in which violence is encouraged. At this level, health, economic, educational and social policies that maintain economic or social inequalities between groups are also taken into account.

In adopting a public health response to violence, the report argues at the outset that 'violent behaviour and its consequences can be prevented'.⁵⁹ Further, it maintains that a public health approach does 'not replace criminal justice and human rights responses to violence, rather, it complements their activities and offers additional tools and sources of collaboration'.⁶⁰ To this end, a public health approach advocates accurate definitions of violence, identification of the causes, formulation and testing of ways of dealing with the problem and wide application of the measures that are found to work.

The Australian Public Health Association has also recognised family violence as a significant public health problem. In December 2001 it called for a prevention effort that:

... must proceed from a recognition of the human rights and dignity of women, children and the elderly and an understanding of the social, economic, emotional and psychological factors which entrap them in violent situations.⁶¹

A useful contrast has recently been drawn between the public health response and the criminal justice system approach to social problems:

The public health approach uses a consistent model regardless of the problem: whether it is the eradication of a communicable disease like smallpox or the reduction in morbidity and mortality from a non-communicable disease like diabetes ... contrasted with the traditional approach of the criminal justice system, which has traditionally dealt with problems after they have already occurred.⁶²

4.1 The physical and mental health effects of failing to prevent violence against women

The World Health Organisation emphasizes that women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related symptoms, pain syndromes, phobias, chemical dependency, substance use suicidality, somatic and medical symptoms, negative

⁵⁹ Ibid p 4

⁶⁰ WHO, World Report on Violence and Health—A Summary (2002) p 4.

⁶¹ PHA Violence Against Women: A priority Public Health Issue Second draft for comment 19/12/01.

⁶² McDonald D *Violence as a Public Health Issue* in Australian Institute of Criminology: Trends and Issues in Criminal Justice (July 2000).p2-3

health behaviours, poor subjective health and changed to health service utilization.⁶³

The 2002 WHO Report describes the direct health consequences to women as injury and the increased risk of future ill-health.⁶⁴ There is also considerable evidence that suggests that women who have experienced physical or sexual abuse in childhood or adulthood experience physical and psychological ill-health more frequently than other women. They are also likely to adopt further risk behaviour, including smoking, physical inactivity and alcohol and drug abuse. A history of being the target of violence also puts women at increased risk of:

- Depression
- Suicide attempts
- Chronic pain syndromes
- Psychosomatic disorders
- Physical injury
- Gastrointestinal disorders
- Irritable bowel syndrome
- A variety of reproductive health consequences⁶⁵

The mental health consequences are particularly significant, with abused women suffering from a much higher rate of depression, anxieties and phobias than non-abused women.⁶⁶ There is also evidence that the relationship between violence and depression is causal, with a number of studies identifying the significant variables associated with this. Firstly, significant reductions have been found in the levels of depression and anxiety once women stop experiencing violence.⁶⁷ This can be compared to increases in depression and anxiety when the violence is on-going.⁶⁸

Importantly, the 2002 WHO report makes the following comments about the general research about the health consequences of abuse:

- The influence of abuse can persist long after the abuse has stopped;
- The more severe the abuse, the greater its impact on the woman's physical and mental health; and
- The impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative.

⁶³ WHO 2002 p 101

⁶⁴ WHO 2002 p 100.

⁶⁵ WHO 2002 p 101

⁶⁶ WHO 2002 p 102.

⁶⁷ Bennett, L., Manderson, L. & Astbury, J. 2000, *Mapping the Global Pandemic: Review of Current Literature on Rape, Sexual Assault and Sexual Harassment of Women*. p9

⁶⁸ Sutherland, C, Bybee, D and Sullivan, C *The long-term effects of battering on women's health*. *Women's Health* 4:41-70, cited in Bennett, Manderson and Astbury; *Ibid* p9.

Indeed, the consequences of violence against women, both on the women themselves and on their children who witness such violence, can be profound and life-long.⁶⁹

The economic consequences of violence against women are also increasingly recognized, although it should be noted that there is currently no national data measuring the cost. In 1991, the NSW Women's Coordination Unit commissioned a report on the costs of domestic violence. It found that the total estimated cost to NSW over one year was over \$1.5million. This included direct economic costs to women, economic costs to government and indirect costs to others.⁷⁰ Other evidence suggests that Australian businesses are losing at least \$500 million per year because of the effects of family violence on their employees.⁷¹ In the same study, victims of domestic violence were estimated to take just under \$30 million in sick leave and days off each year, while \$6 million is spent on staff turnover. The Victorian Women's Domestic Violence service suggests that the relationship between employment and domestic violence is a critical factor in women's capacity to leave and to create a safe place for her and her children. They suggest that because of this link, domestic violence is a key contributor to the poverty of women, citing research which supports the view that 'women are fired simply because their employer determines that it cannot have a domestic violence victim in the workplace.'⁷² They go on to cite research which indicates that the loss of a job due to domestic violence, 'teamed with regular domestic violence, leads many women to lose their sense of self-esteem which may then be followed by problems with depression, anxiety and anger. Taken together this greatly decreases a woman's chances of regaining employment or undertaking job training programs that may lead to lower personal income and greater receipt of personal assistance.'⁷³

Data collected by the WDVCS shows that the majority of women accessing their crisis service are not in the paid workforce (86%), whereas a majority of women (80%) were also accessing some type of financial support from the State. Those receiving sole parents' benefits (39%) were also highly represented among callers to the crisis service.⁷⁴

⁶⁹ Partnerships Against Domestic Violence 2001, *Working Together Against Violence: The First Three Years of Partnerships Against Domestic Violence* p 24

⁷⁰ Ibid p 14.

⁷¹ Henderson M (PP Henderson and Associates), *Impacts and Costs of Domestic Violence on the Australian Business/Corporate Sector – Report to the Lord Mayor's Women's Advisory Committee*, Brisbane City Council, May 2000.

⁷² R. Runge 1998, 'Victims of Domestic Violence face twice the Abuse' in *Human Rights Spring* pp19-24, cited in Victorian Women's Domestic Violence Crisis Service *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02* (2003).

⁷³ S. Lloyd, 'The Effects of Domestic Violence on Women's Employment' 19(2) (April 1997) *Law and Policy* p 153, cited in Victorian Women's Domestic Violence Crisis Service, *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02* (2003).

⁷⁴ Victorian Women's Domestic Violence Crisis Service, *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02* (2003) p 25.

5. PREVENTION AND ELIMINATION OF VIOLENCE AGAINST WOMEN

The critical role of criminal sanctions in the process of prevention is widely acknowledged⁷⁵. Criminalisation has long been accepted as performing a function that is both highly symbolic as well as enforcing legal and social norms.⁷⁶ Historically, those committed to violence prevention have made considerable efforts to reform the justice system to ensure that it applies the same standards of non-violence in public places into people's private and domestic relationships.

However, the criminal justice system is also limited in its capacity to respond to the growing numbers of complaints of violence. Moreover, it does little to assist women to leave violent men or to fundamentally shift cultural practices that reinforce and educate citizens toward non-violent, more democratic relationships and cultural practices.

In recognising that the criminal justice system has its place, but does not constitute the sole approach to prevention, it is appropriate to consider what a public health approach has to offer. Significant efforts also need to be made in the areas of primary and secondary prevention, testing what works and evaluating programs rigorously. This includes programs for perpetrators, appropriate health service responses, outreach programs, coordination across communities to ensure the monitoring and improvement of responses; the development of communication strategies and school programs.

The 2002 WHO report acknowledges the need for support for those who are the victims of violence, noting that battered women's shelters and women's crisis centres have been important cornerstones of the support for women who have experienced violence.⁷⁷ Women's refuges and Centres Against Sexual Assault also operate throughout Australia. Predominantly, these services were set up in response to the perceived failures of the major institutions - the police, hospitals and the courts, to respond adequately to women in situations of violence, or who had survived sexual assault. It must be recognised, however, that these services have never had sufficient resources to respond to the cultural and linguistic diversity of women seeking refuge, or the diversity of needs of women and their children who require support. This document supports the expansion of these services to ensure that the safety of women and their families remains a paramount value.

⁷⁵ See for example Office of Women's Policy 2002, *A Policy Framework: A Co-ordinated Approach to Reducing Violence Against Women*, Women's Safety Strategy; WHO 2002 p 106.

⁷⁶ Holder, R. *Domestic and Family Violence: Criminal Justice Interventions*, Australian Domestic and Family Violence Clearing House, PADV, UNSW, Issues Paper 3 2001.

⁷⁷ WHO 2002 p 104.

However, the purpose of this document is to consider a public health approach and to explore the dimensions of a preventative approach. A secondary purpose of this document is to explore an Australian application of the WHO approach to violence and health and how prevention strategies suggested by the World Health Organisation might be applied to a Victorian setting. Specifically, how would a public health approach, such as that taken with other social phenomena - smoking, drink driving, or the spread of HIV/AIDS, be applied to the problem of violence, most particularly men's violence? What can the Victorian Health Promotion Foundation contribute to this effort, given that violence impacts on most of the areas in which it invests, many of its priority population groups, and ultimately has a major impact on an area which VicHealth has identified as a major cause of disease amongst Victorians: mental health?

The 2002 WHO report proposes a set of principles of 'best practice' to underpin prevention. They are that prevention responses will:

- Take place at both national and local level;
- Involve women in their development and implementation;
- Reform the responses of institutions and change their cultures; and
- Cover and be coordinated by a range of different sectors.⁷⁸

These principles are useful in considering an Australian approach to violence prevention and are suggested as useful points of reference in developing Australian approaches.

5.1 Prevention of Violence Against Women - A global approach

Arising from these principles, the 2002 WHO report recommends an emphasis on the following.

A. Research on individual factors

The report identifies the need for research in a wide range of areas including:

- ✓ Prevalence, consequences and risk and protective factors of violence by intimate partners in different cultural settings, using standardized methodologies;
- ✓ Longitudinal research on:
 - the trajectory of violent behaviour by intimate partners over time, examining whether and how it differs from the development of other violent behaviours;
 - the impact of violence over the course of a person's life, investigating the relative impact of the different types of violence on health and well being and whether the effects are cumulative; and

⁷⁸ WHO 2002 p 109.

- the life histories of adults who are in healthy, non-violent relationships despite past experiences that are known to increase the risk of partner violence;⁷⁹
- ✓ Documenting and evaluating services and interventions that support survivors or work with perpetrators;
- ✓ Determining the most appropriate health sector responses to sexual violence with different basic packages of services being recommended for different settings depending on the level of resources;
- ✓ Determining what constitutes appropriate psychological support for different settings and circumstances;
- ✓ Evaluating programs aimed at preventing sexual violence including community based interventions - particularly those targeted towards men - and school-based programs.⁸⁰

B. *Research on Interventions at community/societal level*

More research is also recommended on interventions, both for the purpose of lobbying policy-makers for more investment as well as to improve the design and implementation of programs. Priority is suggested for the following areas:

- ✓ Documentation of the various strategies and interventions around the world for combating intimate partner violence;
- ✓ Studies assessing the economic costs of intimate partner violence;
- ✓ Evaluation of the short and long term effects of programs to prevent and respond to partner violence — including school education programs, legal and policy changes, services for victims of violence, programs that target perpetrators of violence, and campaigns to change social attitudes and behaviour;⁸¹
- ✓ Community based efforts: prevention campaigns; community activism by men; school-based programs;⁸²
- ✓ The prevention of all forms of sexual violence through programs in communities, school, and refugee settings;
- ✓ Support for culturally sensitive and participatory approaches to changing attitudes and behaviours;
- ✓ Support for programs addressing the prevention of sexual violence at the broader context of promoting gender equality;
- ✓ Programs that address some of the underlying causes of violence, including poverty and lack of education, for example, by providing job opportunities for young people; and
- ✓ Programs to improve child rearing, reduce the vulnerability of women and promote more gender-equitable notions of masculinity.⁸³

⁷⁹ Ibid p12.

⁸⁰ Ibid p 173.

⁸¹ Ibid p 112.

⁸² Ibid p173.

⁸³ Ibid.

C. Strengthening informal sources of support

Programs which place greater emphasis on enabling families, circles of friends and community groups, including religious communities, to deal with the problem of partner violence.

D. Making common cause with other social programs

Programs on partner violence should be integrated with other programs such as those tackling youth violence, teenage pregnancies and substance abuse and other forms of family violence.

5.2 An Australian Approach to Prevention

The Partnerships Against Domestic Violence ("PADV") was established in 1997 as an initiative between the Commonwealth, States and Territories, to work together towards the common goal of preventing domestic violence across Australia. The following areas were identified as the priorities for the period 1997-2003:

- ✓ Working with children and young people to break the cycle of violence between generations;
- ✓ Working with adults to break the pattern of violence: working with victims and violent men;
- ✓ Working with adults to break the cycle of violence between generations;
- ✓ Working with adults to break patterns of violence: working with victims and violent men;
- ✓ Working with the community to educate against violence;
- ✓ Protecting people at risk: reforming legislation and improving responses by police and courts;
- ✓ Information and good practice: finding out what works; researching areas where new information is needed to support violence prevention; and
- ✓ Helping people in regional Australia: overcoming barriers to receiving assistance.

Partnerships Against Domestic Violence (a commonwealth-state initiative) (PADV 1) concluded in September 2001. PADV2, part 2 of the aforementioned initiative commenced at that time, and will continue in 2003 with the following priorities:

- ✓ Community education: a broad national community awareness campaign will emphasize the harm done to children and the need for perpetrators to take responsibility for their violence;
- ✓ Indigenous Family Violence Grants Program;
- ✓ Children-prevention and early intervention; and
- ✓ A national approach to working with perpetrators.⁸⁴

⁸⁴ Partnerships Against Domestic Violence 2001, *Working Together Against Violence: The First Three Years of Partnerships Against Domestic Violence* pp. 24-25.

5.3 A Victorian Approach - The Women's Safety Strategy

There is much in common between the approaches being recommended by the 2002 WHO report and the Victorian Women's Safety⁸⁵ strategy. Each recognizes the preventive approaches inherent in a range of other activities, and that 'prevention of violence against women includes any law, policy program or activity aimed at reducing the level of fear, and the impact of violence against women or changing community perceptions of violence against women.'⁸⁶

Notably, each approach requires intervention at a range of levels and a mix of interventions at primary, secondary and tertiary levels.

The Victorian Government approach advocates seven key directions in its prevention strategy:

- ✓ Support a mix of primary, secondary and tertiary activities including attitudinal change programs (primary); early intervention with at-risk groups (secondary); responding to perpetrators and supporting victims (tertiary);
- ✓ Provide consistent messages across all sectors (eg physical and sexual violence is a crime; responsibility rests with the offender not the victims);
- ✓ Ensure that violence prevention initiatives reflect the differences between women and men's experiences;
- ✓ Conduct targeted communication activities;
- ✓ Enhance community involvement and ownership;
- ✓ Respond in an appropriate and timely manner to people who use violence; and
- ✓ Ensure that what we are doing works.

Current Initiatives - Individual

The Victorian Women's Safety Strategy has also identified the following strategies to tackle Women's Safety at an individual level:

- ✓ The ***crime and violence strategy*** is being developed in a way that is sensitive to gender and cultural differences and will include a focus on the prevention of family violence;
- ✓ The ***Victorian Workcover Authority*** is developing a Code of Practice for the Prevention of Bullying and Violence in the workplace, including specific risk control case studies and examples set in industries or occupations where there is a high proportion of female employees and violence is a workplace hazard;

⁸⁵ Office of Women's Policy 2002, *A Policy Framework: A Co-ordinated Approach to Reducing Violence Against Women*, Women's Safety Strategy.

⁸⁶ Ibid p 40.

- ✓ The **Department of Infrastructure** is continuing to improve safety on public transport and in taxis through the installation of security cameras, emergency call buttons, and better public lighting.

The next step planned by the Victorian Government is to develop models of family violence prevention programs including models for young men building on work in other jurisdictions, particularly developing a model of family violence prevention.

Current Interventions - Community

- ✓ Strengthen capacity of communities to address violence against women (local safety committees in LGAs; family violence networks; community safety activities such as urban planning undertaken by local government; Primary Care Partnerships; the BEST START project; individual workers in relevant agencies who facilitate cooperation between agencies to reduce violence);⁸⁷
- ✓ Support for rural and regional communities;
- ✓ Support ‘communities of interest’ in improving women’s safety (eg lesbians, women with disabilities, sex workers). Move towards and integrated response to family violence (incorporating justice and human services being coordinated multi-agency response);
- ✓ Support best practice and evaluation.

On-going investments in violence prevention

The Women’s Safety Strategy has drawn together a number of programs which describe activity that could be broadly described as capacity-building:

- ✓ **DHS has established family violence** networks in nine regions.
- ✓ Victoria police has established local safety committees in each municipality as part of local priority policing project.
- ✓ **Crime Prevention Victoria** has funded programs which support crime reduction at the local level through safer communities and address key areas of crime concern such as assault and armed robbery. Local safety surveys also contribute to an understanding of women’s perceptions of safety in local areas.
- ✓ **Indigenous Family Violence Strategy**
- ✓ **Office of Housing** is developing a high-rise security strategy to enhance security of public housing tenants.
- ✓ The government’s **Community Building Initiative** aims to improve the social and economic well being of Victorian communities through government and communities working in partnership. Safety and security is one of the issues that communities may choose to focus on. The

⁸⁷ A ‘crime prevention’ project has just commenced that will enhance existing family violence programs, develop innovative responses to boys and young men to break the cycle of family violence, provide a primary/secondary prevention focus to the work of family violence service agencies, and develop a range of prevention initiatives. This pilot project will take place over three years in one each of a rural and metropolitan community.

government as part of this initiative is supporting ten community building demonstration projects.

Identified priorities for the future:

- ✓ Women's safety charter as a tool to promote local collaboration and cooperation to address violence against women;
- ✓ Host a forum for communities to share best practice information and ideas in addressing violence against women.

6. VICTORIAN HEALTH PROMOTION FOUNDATION — A PUBLIC HEALTH APPROACH TO THE PREVENTION OF VIOLENCE AGAINST WOMEN

The Victorian Health Promotion Foundation's leadership in the area of mental health promotion provides a sound basis for the development of strategies that are levelled at the prevention of violence against women. In many respects the issue of violence presents VicHealth with an opportunity to consolidate the conceptual foundations laid by the first three years of the mental health plan.

The evidence supporting a mental health promotion approach towards the elimination of violence against women is clear. The case is made by the World Health Organisation, the Commonwealth, State and Territory governments. Women living in circumstances of violence show poor mental and physical health outcomes, not just because of the violence against them, but because of the secondary effects of violence on their social connectedness with their communities and families, their ability to participate meaningfully in the economy, and their sense of value as citizens in a society which associates their safety and well-being with that of the wider community.

The aetiology of violence results in women being profoundly disconnected from their social and familial networks as both a direct and indirect result of violence.⁸⁸ Poverty and homelessness have been tracked as both direct and indirect consequences of violence, which in turn impact directly and indirectly on their economic participation. The VicHealth Mental Health Promotion Plan acknowledges that there is a link between employment and social status and mental health, noting that 'economic participation is not simply a question of full employment, but access to money necessary to feed, clothe and participate in community life.'⁸⁹ Women in circumstances of violence are limited in their capacity to access money and for these reasons, their mental and physical health is affected, not just by the violence, but by the compounding factors resulting from the violence.

⁸⁸ Victorian Women's Domestic Violence Crisis Service, *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02* p26.

⁸⁹ Victorian Health Promotion Foundation *Mental Health Promotion Plan Foundation Document: 1999-2002* p 8.

Over the last three years, VicHealth has initiated programs which value diversity and work against discrimination in all its forms. In 1999, it explored the relationship between sex discrimination against women in the form of violence and abuse. It found that such discrimination led to higher levels of depression and anxiety, depression, stress, alcohol abuse, chronic tranquiliser use and higher utilization of medical care.⁹⁰ Violence against women is perhaps one of the most pernicious forms of discrimination.

VicHealth adopted the World Health Organization's approach to mental health promotion, and has committed three years to action and advocacy to address the full range of potentially modifiable determinants of health. Commensurate with this approach, is an approach which works not only with the determinants related to the actions of individuals, but factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment.

VicHealth is currently considering its role in violence prevention. After reviewing the current literature and research, and consultation with a small number of key stakeholders, it is recommended that VicHealth supports:

- Research, conducted in conjunction with DHS which identifies the burden of disease associated with violence against women.
- A scoping/consultation exercise to determine research, interventions and communications and marketing strategies which focus on the connection between alcohol and escalation of violence against women.
- Community forums which facilitate bottom-up planning, activity and advocacy at the local level.
- The development of a project which 1) undertakes research and reports on media management of Violence Against Women over a two year period, 2) increases media attention on this issue, 3) responds to inappropriate media coverage as requires and 4) makes recommendation for future activity in this area.

⁹⁰ Raphael and Martinek 1995, cited in Victorian Health Promotion Foundation *Mental Health Promotion Plan Foundation Document: 1999-2002* p 8.

7 CONCLUSION

There are many well-documented benefits of preventing violence towards women. Among them are the most obvious benefits in the improvement of women's mental and physical health and that of their children and in turn, that of the whole community, now and in the future. However, there are other benefits commensurate with the goals of Vic Health's mental health plan. These benefits are more than economic participation and more than those simply achieved through the absence of violence: they are an improvement in productivity across the entire spectrum of women's citizenship. The benefits of preventing violence against women are also commensurate with 'family friendly'⁹¹ approaches to health promotion, recognising that women and men rear healthier children in a context of equality, where both adults are able to reach their full potential as parents and as citizens. The World Health Organisation makes the case for the benefits of prevention in outlining a future where violence is not only prevented, but where health for all is achieved:

Both policy makers and activists in this field must give greater priority to the admittedly immense task of creating a social environment that allows and promotes equitable and non-violent personal relationships. The foundation for such an environment must be the new generation of children, who should come of age with better skills than their parents generally had for managing their relationships and resolving the conflicts within them, with greater opportunities for their future, and with more appropriate notions on how men and women can relate to each other and share power.⁹²

⁹¹ Note Victorian Women's Domestic Violence Crisis Service, *What's Love Got to Do with It? Victorian Women Speak out about Domestic Violence. Annual Report 2001/02*

⁹² WHO 2002 p 113.

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