



## **9. MEMBERS OF CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES WHO HAVE EXPERIENCED FAMILY VIOLENCE**

According to the 2006 census, 23.8 per cent of the Victorian population was born overseas and 25.6 per cent spoke a language other than English in their home (ABS, 2008). In addition, 13 per cent were born in a non-English speaking country (VOMA 2002). The diversity of the Australian population is extensive.

As part of the Victorian Government's commitment to multicultural communities, the Department of Justice released the *Cultural Diversity Plan 2006-2008*. The research informing this plan identified a need for culturally appropriate education programs providing culturally and linguistically diverse (CALD) communities with information about laws and issues relating to family violence, the safety of women and children, and development of appropriate support mechanisms.

In addition, the 2002 Victorian Law Reform Commission *Review of Family Violence Laws* identified the need among migrant communities for culturally specific education programs on the justice system, including information on accessing intervention orders.

To inform the development of programs and policies surrounding family violence in migrant communities, the Victorian Family Violence Database has sought to report on the rates of family violence in CALD communities. This section of the report begins by outlining the issues related to monitoring and identifying family violence among CALD communities, and then provides an analysis of the groups able to be identified through the data providers included in this report.

### **9.1 Identifying CALD status among victims of family violence**

#### *Victoria Police family violence incident reports*

Victoria Police have recently revised the Family Violence Incident Report form to include a data field where the attending officers can identify family violence risk factors including the category *sensitive cultural issues*. In addition, more information will be gathered in relation to use of interpreters and language spoken. These data fields are not mandatory, and information generally will be collected only if the ethnicity and/or language issues are apparent to the officer, or disclosed by one of the parties present. This updated form came into widespread usage in January 2005 and since undergone several revisions.

The VFVD collects data for full financial years (eg 1 July to 30 June), the first full set of data based on the new forms would be for 2005-2006. At the time of writing, a request has been made to Victoria Police for future access to data extracts including information on CALD.



### *Victorian Courts' intervention order applications*

At the time of writing, cultural background and language-spoken information is not routinely collected in the Court link database.<sup>74</sup>

### *Victorian Emergency Minimum Dataset (VEMD)*

The VEMD currently collects information about country of birth and preferred language of the patient presenting at the hospital. This information is available for the two years of VEMD data sets included in this report (2004-05 and 2005-06).

### *Victorian SAAP agencies providing assistance to clients experiencing family violence*

SAAP currently collects data on country of birth and English language proficiency. This information is available for six of the seven years of data sets included in this report (2000-01 through to 2005-06).

## **9.2 Defining culturally and linguistically diverse communities**

Measuring culture, language, ethnicity and their respective affects on individuals and communities within Australia is complex. Although culture and language can be measured through self-reported community identity, language spoken at home and /or country of birth, this does not measure the more subjective experience of various cultural identities, exposure to English as a second language and ability to merge with the dominant Anglo-based Australian culture.

Since the late 1990s there has been a shift away from measuring CALD communities on the basis of country of birth and language spoken, to a constructed scale of English language proficiency. The English language proficient scale combines self-reported proficiency with country of birth to create a standardised scale (ABS, 2001, DIMA).<sup>75</sup> It is thought that English language proficiency is reflective of a person's ability to mix with the dominant Australian culture, and access English language support services. It may also be reflective of the length of time a community has been living in Australia with newly arrived communities demonstrating a lower level of English language proficiency.<sup>76</sup>

However, English language proficiency will have varying impact upon individuals and families migrating to Australia depending on other influencing cultural issues including:<sup>77</sup>

- the length of time a person has been living within the dominant cultural community;
- the length of time other members of the community have been living within Australia and subsequently whether there is an existing cultural network to assist re-settlement through collective experience;<sup>78</sup>



- the degree to which a person is able to immerse themselves within the dominant cultural community;
- the social and political climate of the country a person has migrated from;
- other common co-contributing factors including<sup>79</sup>
  - low socio-economic status,
  - alcohol and illicit drug use,
  - unemployment,<sup>80</sup>
  - previous exposure to violence,
  - challenge to identity,
  - mental health issues due to prior trauma, and
  - isolation from social networks.

English language proficiency has also been identified as a risk factor for family violence as inadequate English language skills can exacerbate social isolation from the wider community. Lack of English skills is also a perceived barrier to learning about Australia and social and government support systems, as well as gaining access to these systems.<sup>81</sup>

Family violence among CALD communities has more recently been targeted for research and assistance. When approaching and discussing issues among various communities it becomes increasingly important to separate out the issues affecting long-standing and large CALD communities from those of the newly arrived and very small minority communities. While long-standing communities of larger CALD populations have had the opportunity to form cultural networks and obtain support for translating support service material into their respective languages, newly arrived communities have not yet formed these connections.<sup>82</sup>

In addition, members of newly arrived communities (and particularly refugee groups) may experience higher rates of family violence due to “cumulative risk factors”.<sup>83</sup> That is, these groups have experienced, and may be experiencing, complex, inter-related risk factors that may result in a greater risk for family violence such as:

- unemployment
- lack of English skills
- low socio-economic status
- loss of community and family networks
- trauma and alienation
- social isolation
- lack of education
- transition of gender and cultural roles
- lack of appropriate information for re-settlement in Australia

In addition, social support services to assist re-settlement of migrants are often not as familiar with the cultural, social and community needs for newly arrived communities. Support services therefore may not have sufficient knowledge or resources to respond effectively to reports of family violence among newly arrived communities.<sup>84</sup>



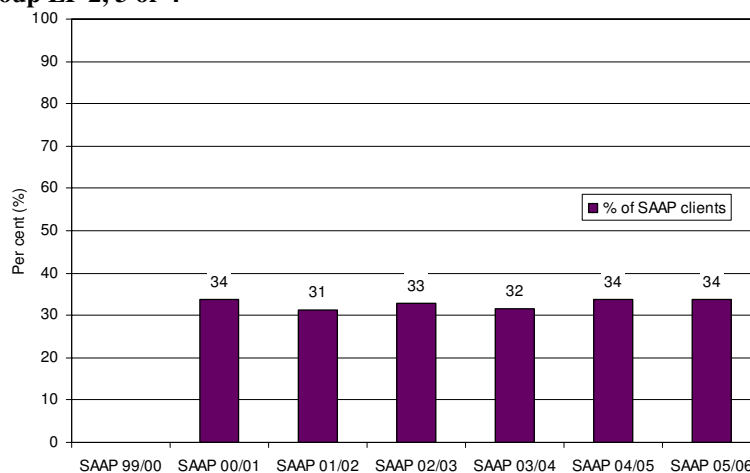
The complex overlay of cumulative risk factors among CALD communities is difficult to assess within the limited data collection capacity of the family violence data providers included in this report.

### 9.3 Communities from non-English speaking backgrounds – SAAP data

#### *Proportion of SAAP family violence clients with EP2, 3 or 4*

Approximately one third of SAAP clients were classified with a language other than English and were categorised as EP2+ (Figure 59).<sup>85</sup>

**Figure 59: Proportion of SAAP clients experiencing family violence where client belongs to a language group EP 2, 3 or 4**

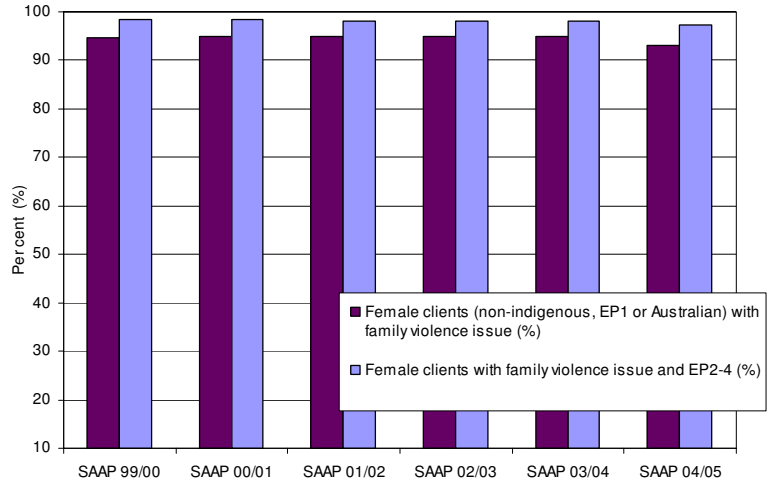


Note: SAAP data represents support periods and are weighted for agency non-participation and client non-consent

Overall, whether a SAAP client comes from a cultural background with typically lower rates of English language proficiency (EP 2, 3 or 4) or not, the majority of family violence clients are female – 95 per cent and higher (Figure 60). It is also the case that women who have an EP score of 2-4 have consistently higher rates of representation as SAAP clients for family violence.



Figure 60: Proportion of female SAAP clients experiencing family violence (excludes Indigenous clients)



Note: SAAP data represents support periods and are weighted for agency non-participation and client non-consent

Across all years, there is a slightly larger proportion of female SAAP clients experiencing family violence *and* who have an EP score of 2-4.



#### 9.4 Country of birth – VEMD data

Hospitals collect information on country of birth and the preferred language spoken by the patient. However information on language does not indicate English language proficiency.

Table 10 presents the broad range of countries where human intent injury patients were born.

**Table 10: VEMD human intent injury patients and country of birth (2004/05 and 2005/06 combined, including males, females, adults and children)**

|                            | Combined 2004/05 & 2005/2006 |     |
|----------------------------|------------------------------|-----|
|                            | N                            | %   |
| Australia                  | 1077                         | 81  |
| Oceania                    | 44                           | 3   |
| North West Europe          | 51                           | 4   |
| Southern & Eastern Europe  | 45                           | 3   |
| North Africa & Middle East | 14                           | 1   |
| South East Asia            | 38                           | 3   |
| North East Asia            | 15                           | 1   |
| Southern & Central Asia    | 13                           | 1   |
| Americas                   | 11                           | 1   |
| Sub-Saharan Africa         | 17                           | 1   |
| Total                      | 1325                         | 100 |

As illustrated, very small numbers of patients born outside of Australia were admitted to the emergency department for human intent, family violence related injuries within the two years of data included in this report.

One-fifth of the VEMD patients were born in Australia compared with nearly one-quarter of Victorians reported as born outside of Australia in the 2006 Census (ABS catalogue 1367.2).



## **10. ABORIGINAL AND TORRES STRAIT ISLANDERS (ATSI) WHO HAVE EXPERIENCED FAMILY VIOLENCE**

In 2003 the Victorian Indigenous Family Violence Taskforce<sup>86</sup> released a final report highlighting the disproportionately high rate of family violence within the ATSI community as compared with the non-ATSI community. The difficulty in documenting the extent of family violence was highlighted as one of the primary barriers to understanding and acting to protect community members from the violence.

### **10.1 Identifying ATSI status among victims of family violence**

ATSI classification among victims of family violence is available from the Victoria Police, VEMD and SAAP data sets. While changes are being made to data collection programs within the Magistrates' and Children's Courts to enable better classification of victim demographics, these changes had not been implemented at the time of data collection included in this report.

Problems in recording ATSI background are similar in nature to those for CALD communities and women with disabilities. Disclosure can often engender fear of discrimination, and therefore members of the ATSI communities may feel uncomfortable relating this information to a person in authority. In addition, members of the wider community are often uncomfortable with asking questions about sensitive demographic questions and therefore may make assumptions based on physical appearance, which are often incorrect.

#### *Victoria Police family violence incident reports*

Victoria Police include data fields to identify ATSI classification on their Family Violence Incident Report. These data fields are not mandatory, and information generally will be collected only if disclosed by the victim or perpetrator.

Indigenous persons often experience greater fear of discrimination in the criminal justice system as compared to other service sectors and may be more likely to withhold their ATSI background. Therefore, because this data field is not mandatory and considered highly unreliable it is not analysed in this report.

#### *Victorian Courts' intervention order applications*

At the time of writing, Indigenous status, cultural background and language-spoken information is not routinely collected in the Court link database.



### *Victorian Emergency Minimum Dataset (VEMD)*

The VEMD currently collects information about Indigenous status and this information is available for the two years of VEMD data sets included in this report (2004-05 and 2005-06).

As the Victorian Public Hospital system is funded partially based on the mix of case-load they therefore have well-developed data collection systems and staff training which encourages reporting of demographic background information such as ATSI status.

### *Victorian SAAP agencies providing assistance to clients experiencing family violence*

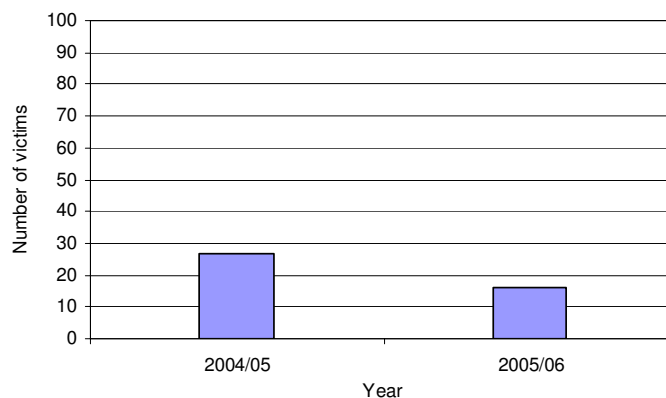
SAAP currently collects data on Indigenous status and this information is available for six of the seven years of data sets included in this report (2000-01 through to 2005-06). SAAP services may have access to ATSI specific funding / services and therefore staff may be trained and comfortable with obtaining information about ATSI status.

## **10.2 Aboriginal and Torres Strait Islander communities and family violence - VEMD**

The discussion below combines cases from both 2004-2005 and 2005-2006 data sets due to the small number of cases reported in each year.

In 2004/2005 there were 27 cases of human intent injuries among individuals identifying themselves as *Indigenous - Aboriginal but not Torres Strait Islander* within the VEMD dataset, and 16 cases in 2005-2006.

**Figure 61: Number of Indigenous victims - VEMD**





The actual number of Indigenous patients was quite small and encompassed three per cent of the overall VEMD human intent injury patients. Figure 62 illustrates that the clear majority of these patients, in both years, were adults rather than children.

**Figure 62: Age grouping of Indigenous victims - VEMD**

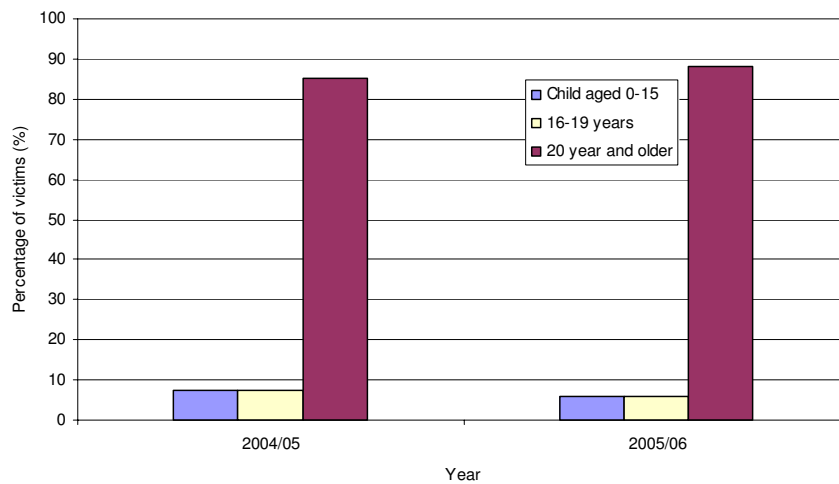
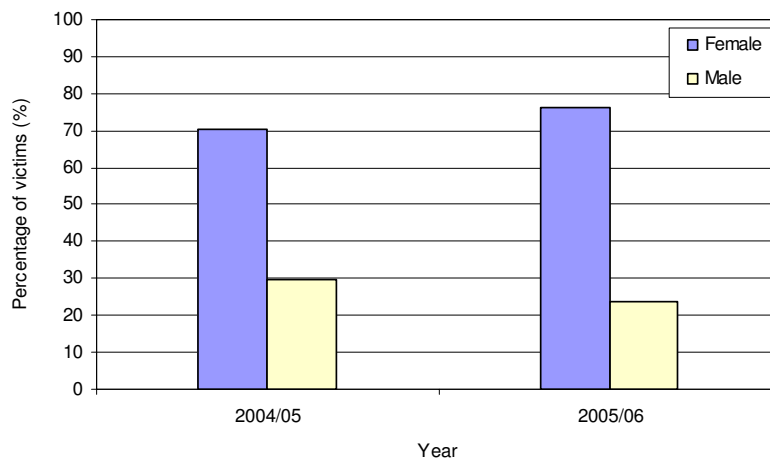


Figure 63 shows that, similar to other data sets, the majority of Indigenous victims of family violence presenting to the emergency department were female. The result is similar across the two years of the data included here.

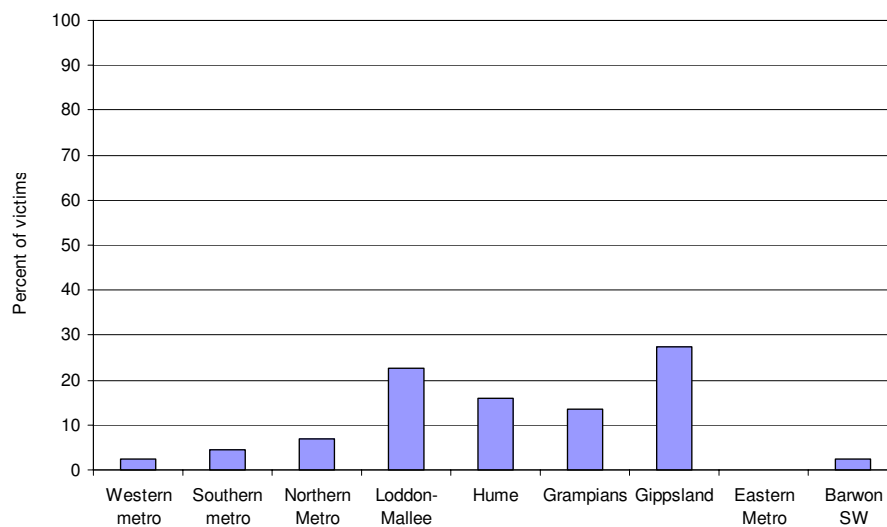
**Figure 63: Gender of Indigenous victims - VEMD**





Small proportions of Indigenous victims of family violence presenting to the hospitals resided in most regions (Figure 64). Due to the small number of cases, the movement of a single patient from one region to another can have a large impact on percentage rates. Therefore the primary finding is that the largest proportions were located in regional and rural communities as compared with the metro regions. This is opposite to the spread of adult female victims in the VEMD population more generally (Figure 29).

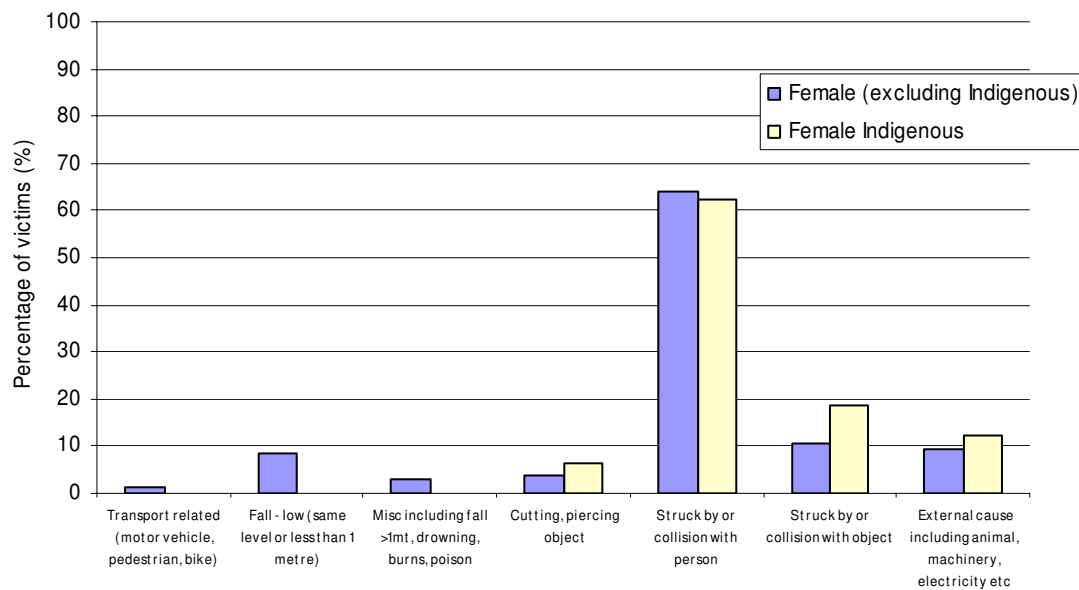
**Figure 64: Indigenous victims by region - VEMD (2004/05 and 2005/06 combined, including males, females, adults and children)**



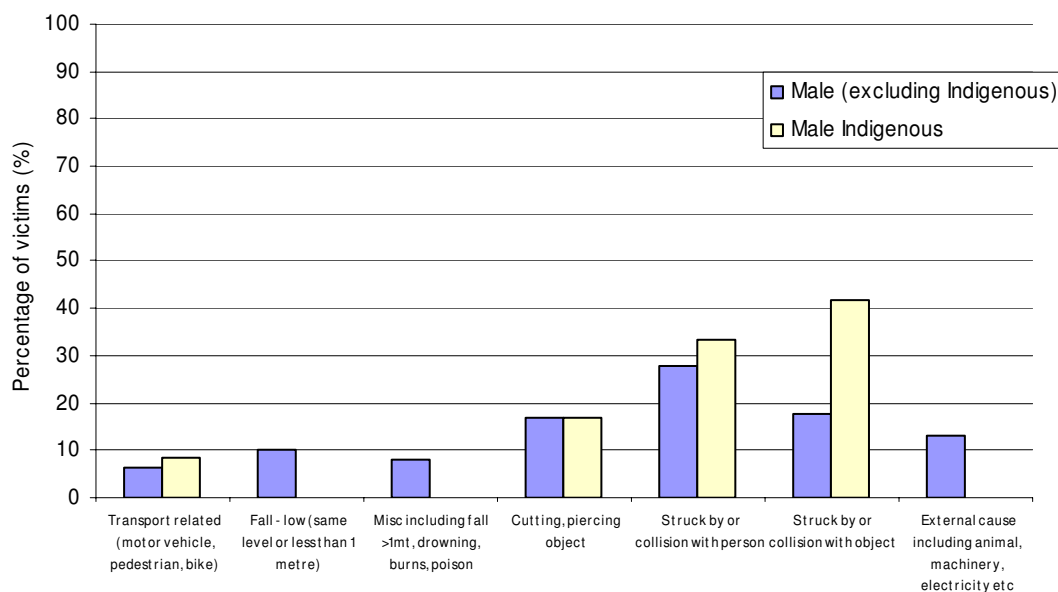


Most of the injuries associated with human intent were classified as being “struck by or collision with another person” (Figures 65 and 66) and this was similar for both the Indigenous and non-Indigenous populations. The main difference between the two patient samples can be seen in the category of being “struck by or collision with an object” which was more frequently diagnosed among the Indigenous community. This was the case for both female and male patients.

**Figure 65: Female Indigenous victims and overall human intent injury female patients by condition associated with injury - VEMD (2004/05 and 2005/06 combined)**



**Figure 66: Male Indigenous victims and overall human intent injury male patients by condition associated with injury - VEMD (2004/05 and 2005/06 combined)**

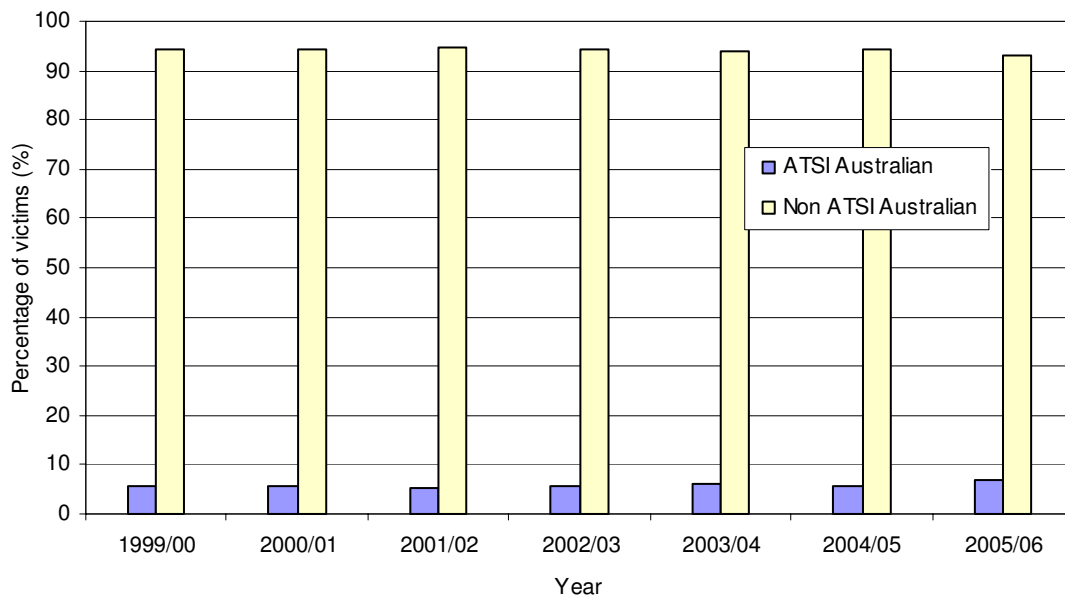




### 10.3 Aboriginal and Torres Strait Islander communities and family violence - SAAP

SAAP data includes combined analysis for members of the Australian population disclosing either Aboriginal or Torres Strait Islander background. Although numbers are small, this population represented between five to seven per cent of the women seeking SAAP services for family violence. This comprised between 568 women in 2000/2001 through to 1081 women in 2005/2006.

**Figure 67: Proportion of adult female SAAP clients disclosing an ATSI background and those without.**





## **11. FAMILY VIOLENCE PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT OF THE VICTORIAN HOSPITAL SYSTEM**

As discussed in Section 4.3, this is the first time that emergency department data has been included in a volume of the Victorian Family Violence Database. In 1998 the Australian Medical Association issued a position statement about the recognition of family violence within medical settings in 1998, however, it is a group of victims not traditionally included in family violence analysis. In research as early as 1993, the prevalence rate of family violence victims presenting to the Australian metropolitan emergency departments was one in seven (Roberts et al 1993).

In addition, earlier studies (Dobash and Dobash 1979 and Dobash et al. 1985) illustrate that victims of family violence are more likely to attend a medical facility due to the violence and associated problems than they are to consult with police or other professionals. However, research in a Queensland emergency department revealed that family violence went largely undetected, unreported and unaddressed (Roberts 1995). Medical professionals in the emergency department were focused primarily on injury treatment and did not know how to address the psycho-social issues related to the abuse. Reasons for a lack of address and detection included (see Roberts 1995 for additional discussion);

- lack of knowledge to detect injuries related to family violence
- lack of knowledge about how to question a patient if family violence abuse is suspected (eg separating the patient from other family members when discussing injury cause if abuse is suspected)
- lack of knowledge about community resources available
- four fifths (80 %) of the family violence related injuries presented between five pm and eight am when social work staff were not available
- caseload pressure to attend to multiple urgent cases, and therefore limited time available to spend with any one patient.

### **11.1 Gender comparisons and injury event or circumstance**

Preliminary analysis earlier in this report indicates that this group of family violence victims is compositionally different than other victim groups. A larger proportion of the patient group is male (Table 4) as compared with other data sets included in this report.

The most likely reason for a greater proportion of males to appear with injuries sustained from family violence is most likely because of the mix of circumstances and events in which patients sustain injury.



Information about the relationship between perpetrator and victim is not recorded in the hospital data and therefore it is sometimes unclear whether the patient is:

- a victim who sustained an injury
- a victim who injured themselves when fighting back against a perpetrator
- a perpetrator who sustained injury from a victim attempting to defend themselves
- a perpetrator who sustained a self-inflicted injury while attempting to inflict injury on another.

It is therefore useful to explore further the VEMD data to try to better understand the type of people and injuries presenting to the hospitals.

Gender analysis commenced with an exploration of the event or circumstance associated with the injury, as well as the age of patient. Across the three graphs (Figure 68 through Figure 70), clear differences can be seen and these differences increase along with patient age.

The total number of patients aged less than 20 was small, and therefore care must be taken with interpretation of the graphs for these age groups. A small increase or decrease in number of patients injured from any event / circumstance category could change the proportions dramatically. Therefore, rather than commenting on per cent differences in the younger age groups, it is the indicative proportional differences which are of interest. The value of this information increases in the context of viewing the three graphs together.

#### *Injury events among children aged between 0 – 15 years*

Girls and boys in the youngest age group (0-15 years) sustained similar rates of injury across similar circumstances / events (Figure 68). Variations to this were around events where a child was struck by an object and external causes. Boys were struck by an object at twice the rate which girls experienced this event, and this proportional difference continued across the age groups (see Figures 68 through Figure 70). Girls were injured through *external causes* at twice the rate as that for boys, however the proportions reversed in older age groups and the difference between adults was proportionally smaller.

#### *Injury event of being struck by another person*

Across all three age groups, struck by or collision with a person was the most frequently reported injury event and females were over-represented among patients with this injury event, and in all age groupings. While differentiation was slight among children, the proportional difference between females and males increased with age. Sixty-four per cent of adult females were struck by another person compared with 28 per cent of adult males (Figure 70).



### *Injury events inflicted by an object*

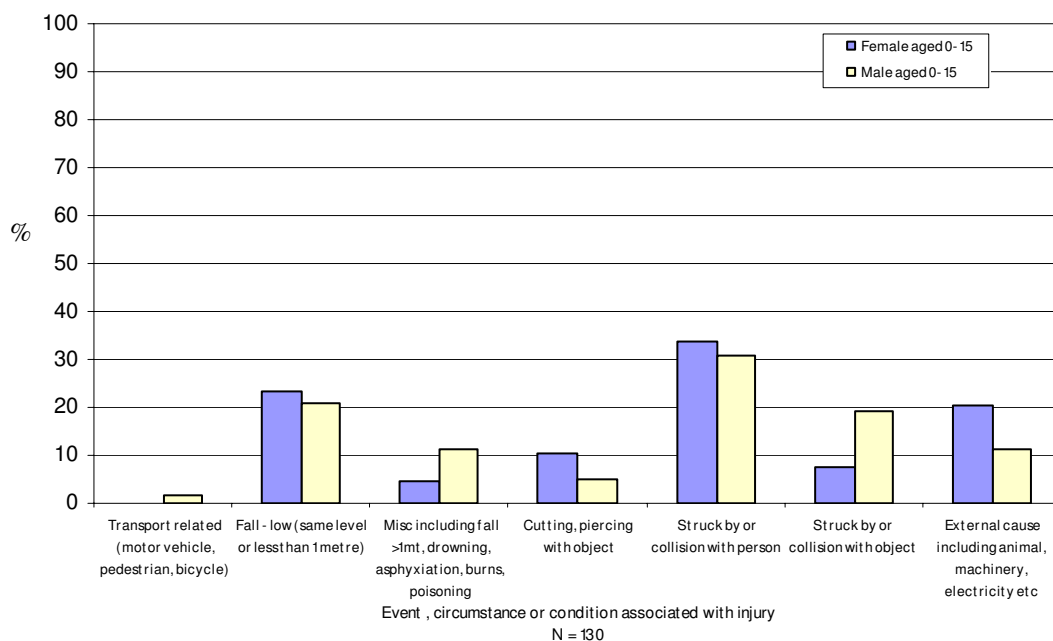
Males were proportionally more likely to experience an injury event where they were either *injured* or *cut by an object*. While female children were over-represented with injury events of being *cut by an object*, the proportions reversed in the 15-19 year old age group. Among adults there was a substantial difference between females and males being *cut or pierced by an object*.

Across all age groups males were more likely to be *struck by an object* than were females, and the injury rate remained relatively static across age groupings.

### *Injury from low fall*

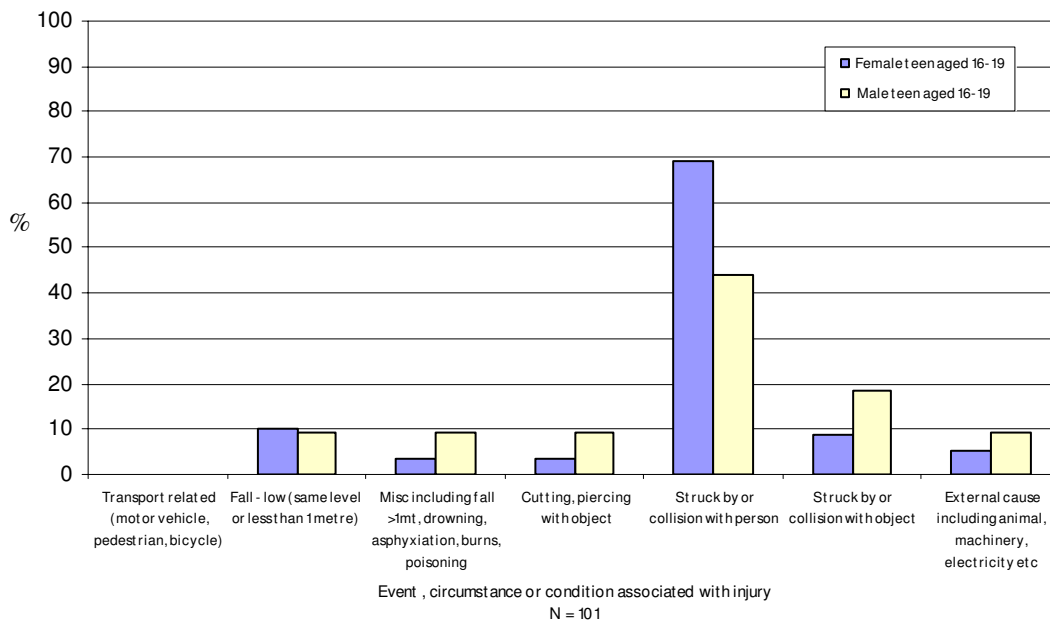
The rate of patients who experienced a low fall injury event decreased noticeably with age. While low falls were a common injury circumstance among one fifth of children (Figure 68), this declined to a rate of less than one in ten among adults.

**Figure 68: Injury type by age and gender – children aged between 0-15 years (VEMD 2004/05-2005/06 combined)**

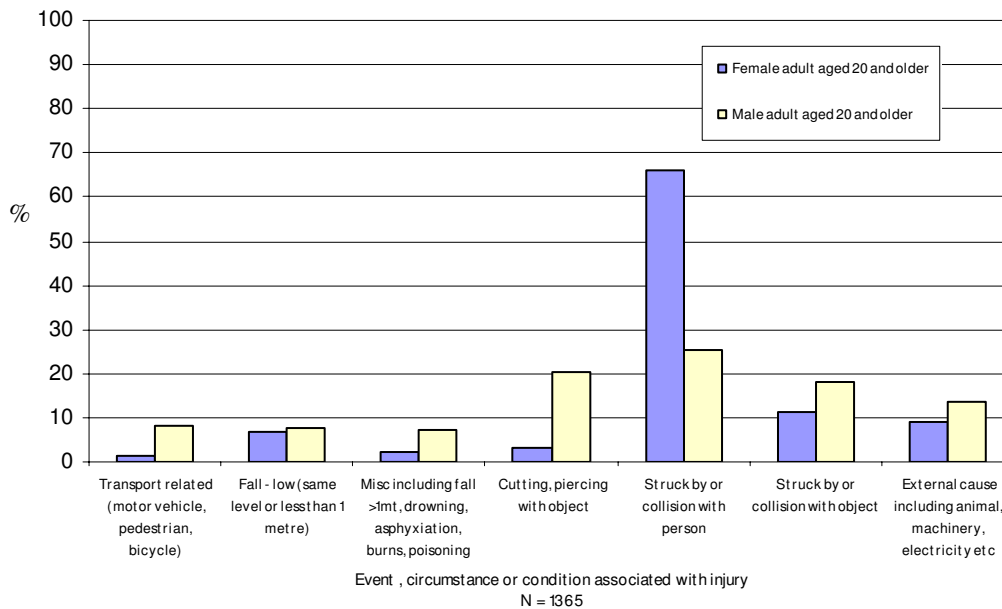




**Figure 69: Injury type by age and gender – teens aged between 15-19 years (VEMD 2004/05-2005/06 combined)**



**Figure 70: Injury type by age and gender – adults aged 20 years and older (VEMD 2004/05-2005/06 combined)**





## 11.2 Description of injury events

It appears that male victims more often experience injuries inflicted by a form of ‘weapon’ other than hands / fist than do females.

Men are typically more adept at fighting with their hands / fist and are more likely to cause serious injury to a female victim through this mode of violence. Women on the other hand are usually physically less strong than men and may be inclined to pick up an item in self-defence to shield / protect themselves, or actively fight back. Therefore it seems possible that women will present to the emergency department with injuries caused by circumstances of being *struck by another person*, and men may be recipients of injuries caused by *being struck by an object*.

In order to better understand the events or circumstances associated with injury classifications, long-hand descriptions of injuries are explored through the descriptive notes in the Public Hospital emergency data (Table 11).

Descriptions of injury are consolidated into six broad categories, which are listed below alongside some detailed examples of the range and type of injury which may appear within the description. Examples have been chosen simply to illustrate the range of descriptions presented for men and women.

While conclusions about victims / perpetrator relationships can not be drawn from these limited descriptions, they do offer some small insights to gender differences either based on the perception of the person entering the information on the file, or real differences in the gendered nature of the event. An overview of differences identified includes:

- Description of injury events among male patients more often includes mention of alcohol / intoxication
- Many notes include mention that injury occurred ‘during domestic’ which denotes language minimising the event
- Injury to female patients more often includes mention of ‘alleged assaulted’ as compared with descriptions of injuries to males



**Table 11: Examples of injury descriptions included in injury event classifications (VEMD 2004-2006 only)**

| Category description   | Female, Adult patients<br>Sample of injury descriptions  | Male, Adult patients<br>Sample of injury descriptions  |
|--|--|--|
| Transport related (motor vehicle, pedestrian, bicycle)             | <ul style="list-style-type: none"> <li>leg abrasions, arm in seatbelt &amp; dragged from car &lt;10kms by ex husband, multiple grazes to body</li> <li>Struck with car equipment</li> <li>Struck by slow car</li> </ul>  | <ul style="list-style-type: none"> <li>Fell off back of moving trailer</li> <li>Fall from motor bike – high speed, no neck pain, deformed L wrist</li> <li>During argument, big toe run over by car</li> <li>Painful right shoulder, 20kmh hit car door</li> <li>Partner pushed off bike – both drunk</li> <li>Hit by car at 40kmh – grazes to back and L wrist</li> </ul>   |
| Fall - low (same level or less than 1 metre)                       | <ul style="list-style-type: none"> <li>Alleged assault, pushed down stairs, injury R ankle</li> <li>Allegedly assault by partner, pushed over and fell on shoulder</li> <li>Assaulted and fell over onto outstretched hand</li> <li>Fight with boyfriend, fell off bed, painful lower back</li> <li>Hit head when thrown on floor</li> <li>During domestic at home, fell onto outstretched arm</li> <li>Location in park, while walking, pulled to ground by husband</li> <li>Arguing with boyfriend, pushed over couch</li> <li>In domestic, pulled down stairs, laceration to occipital, painful neck</li> <li>Pushed by husband suspect broken wrist, sent for x-ray</li> </ul> | <ul style="list-style-type: none"> <li>? domestic minor head injury</li> <li>Fall from bicycle with shoulder pain</li> <li>Fall on broken glass</li> <li>Fall off motorbike</li> <li>Fall while intoxicated and dislocation to ankle</li> <li>Laceration to back of head after fall</li> <li>Twisted ankle, back pain</li> <li>Laceration head, intoxicated</li> <li>Painful hip</li> <li>Neck pain</li> <li>Was pushed, hit head on concrete</li> <li>Twisted L knee</li> </ul> |
| Misc including fall >1mt, drowning, asphyxiation, burns, poisoning | <ul style="list-style-type: none"> <li>Alleged assault, attempted strangling, numerous bite marks, nausea</li> <li>Beaten by partner, punched her, tried to strangle her, nose swollen</li> <li>Burn to hand</li> <li>Laceration to lip</li> <li>Left arm pain at shoulder joint, elbow and wrist</li> <li>Spilt boiling coffee to upper R thigh</li> </ul>  | <ul style="list-style-type: none"> <li>Alleged assault facial lacerations</li> <li>Attacked – R &amp; L temporal &amp; occipital</li> <li>Clothes caught fire 2 / 7 ago right chest and flank</li> <li>In kitchen, during argument with wife, caused by boiling water was allegedly thrown</li> <li>Fall 2/12 ago with subdural haematoma</li> <li>Poisoning / overdose allegedly took x8 clozapine given to him by girlfriend</li> </ul>  |
| Cutting, piercing with object                                      | <ul style="list-style-type: none"> <li>Laceration to head, ? domestic</li> </ul>   | <ul style="list-style-type: none"> <li>Chest wall injury, stabbed in LT lower</li> </ul>   |



| Category description               | Female, Adult patients<br>Sample of injury descriptions  | Male, Adult patients<br>Sample of injury descriptions  |
|------------------------------------|--|--|
|                                    | <p>abuse, thrown into car by husband</p> <ul style="list-style-type: none"> <li>• 1 cm stab wound to lower L leg</li> <li>• History of being involved in argument with partner who was strangling patient and stabbed her in throat . . .</li> <li>• Stabbed right through right lower leg with kitchen knife</li> <li>• Laceration to eyebrow</li> <li>• Lacerations to L forearm</li> <li>• Laceration to lip with broken glass</li> <li>• Self inflicted, post domestic abuse</li> <li>• Patient allegedly had chair thrown at her</li> <li>• Multiple stab wounds to upper body</li> </ul>   | <p>chest with long bladed knife, 1-2 cm laceration</p> <ul style="list-style-type: none"> <li>• Alleged assault with scissors</li> <li>• Alleged stabbing to the L/side of the chest using steak knife after domestic argument, patient states awoke with knife in chest</li> <li>• Allegedly cut with razor blade by girlfriend</li> <li>• Assaulted by wife with fish knife lacs to neck</li> <li>• Stab wound to back, penetration 4-5 cm</li> <li>• Cut arm on glass</li> <li>• Cut tip of finger off with broken jug</li> <li>• Fell onto rose bush, large laceration to L neck</li> <li>• Hit in head with glass bottle, hit with phone receiver in face, lac to R cheek</li> <li>• Domestic argument, stabbed with knife in arm</li> <li>• Penetrating injury to abdo and L/hand from nail gun</li> </ul> |
| Struck by or collision with person | <ul style="list-style-type: none"> <li>• Alleged assault by husband bruises to face requiring crisis accom</li> <li>• Fracas with defacto</li> <li>• Alleges assault by husband, injury to the nose, the R/wrist and the R/occipital region</li> <li>• Swelling to R eye after altercation with husband and being pushed into door handle</li> <li>• Allegedly punched by boyfriend, impact to nose</li> <li>• PT states she was assaulted the other night and again tonight</li> <li>• Struck by partner at home</li> <li>• R/eye h/toma, punch to face, dragged down stairs- back injury</li> <li>• Alleged assault by fist to head, now dizzy, vague. Headaches</li> <li>• 9 weeks gestation, kicked in stomach</li> <li>• Alleged assault by b/friend injury to</li> </ul> | <ul style="list-style-type: none"> <li>• Chest wall struck by wife's fist to chest during fight.</li> <li>• Alleged assault - bruise jaw, lac head</li> <li>• Alleged assault by wife lac under L/ eye, swollen eye, loss of consciousness for a couple of secs lac to tip of fingers L) hand</li> <li>• Alleged assault to face</li> <li>• Arm pulled by partner 2/7 ago heard a crack now difficulty sleeping at night</li> <li>• Disloc 2 fingers</li> <li>• Assaulted sustained human bite to L hand, multiple abrasions hand/arm/knee</li> <li>• Injury - chest wall states wife hit him in left chest this am, sharp pain on inspiration</li> <li>• PT alleges that his partner hit and kicked him in the head</li> <li>• Was hit by girlfriend with closed fist</li> </ul>                                |



| Category description               | Female, Adult patients<br>Sample of injury descriptions   | Male, Adult patients<br>Sample of injury descriptions   |
|------------------------------------|---|---|
|                                    | <ul style="list-style-type: none"> <li>R ribs</li> <li>• Alleged assault by ex partner inj to head L arm</li> <li>• Alleged assault by husband 1/7 ago PT states punched in face, arms, pushed to floor.</li> <li>• Punches, kicks to upper body</li> <li>• Alleged assault by husband after wedding, bruises to face scratches</li> <li>• Dental problems punched in mouth by boyfriend</li> <li>• Alleged assault by partner- punched in chest</li> <li>• Alleged assault, injury to R big toe, PT 7 months pregnant</li> <li>• Bottle to head by domestic partner superficial scalp wound</li> </ul> | <ul style="list-style-type: none"> <li>• R hand injury &amp; bridge of nose injury post alleged assault by partner &amp; hitting hand on fence</li> </ul>   |
| Struck by or collision with object | <ul style="list-style-type: none"> <li>• Right arm outstretched towards door which was forcefully pushed other side</li> <li>• Alleged assault hit L elbow with cup, cup was thrown at her, has bruised cheek</li> <li>• Alleged assault by boyfriend head slammed into concrete wall</li> <li>• Attacked by defacto hit with fists and screw driver, several superficial lacs, swelling to hand and face, distressed</li> <li>• Boyfriend threw PT through a window apparently, Lac to underside of left forearm</li> <li>• Claims partner hit patient head with metal teapot</li> </ul>               | <ul style="list-style-type: none"> <li>• Alleged assault/ blow to R ribs with cricket bat</li> <li>• Allegedly hit in the face by a metal cosmetic case by ex girlfriend</li> <li>• Alleged assault by partner hit across forehead with champagne bottle, lac to bridge of nose</li> <li>• Alleged assault hit with broom R) thumb was caught, skin also split, sutures required</li> <li>• Assaulted by wife with steel kettle, hit to head</li> <li>• Laceration to lateral aspect skull after being hit when wife threw object at him after arguing</li> <li>• Ft laceration to L wrist post being hit by wife with a plate</li> <li>• Had a fight with his girlfriend last pm and she allegedly struck pt with photo frame</li> <li>• Hit with phone, lac R eyebrow</li> <li>• Injury - open wound – head, glass cut to head, scratch to face following fight with partner</li> </ul> |

**Key to abbreviations:** abdo = abdomen, Dislo = dislocation, h/toma = haematoma, L = left, lac = laceration, PT = patient, R = right, 1/7 = 1 day ago, 1/12 = 1 month ago

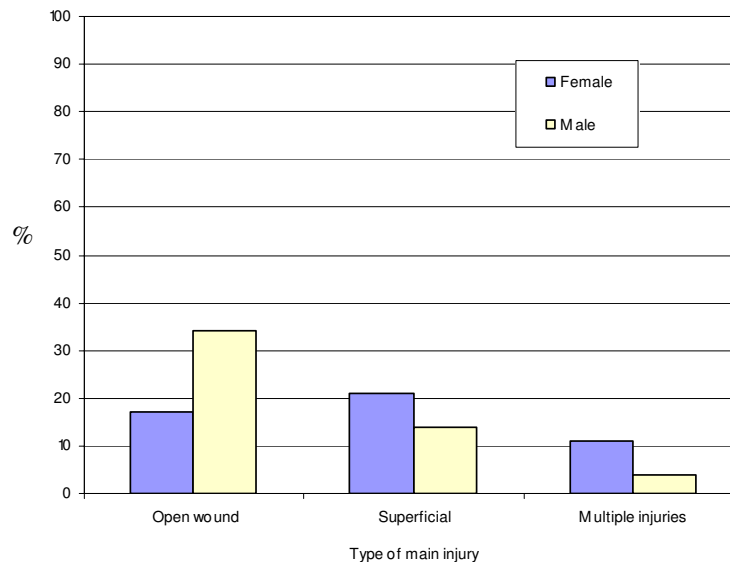


### 11.3 Gender comparisons and type of injury

The main injury of the patients is classified into categories according to the pathological nature of the injury primarily responsible for the patient's presentation at the Emergency Department. There were 26 different categories to which injuries were categorised ranging from sprain, crushing, bite - venomous, asphyxiation, traumatic amputation, burns / corrosion etc. Most categories contained too few cases to allow meaningful comparison among the human intent injury cases.

However comparisons were able to be made between injuries which were considered *superficial* and those that were *open wounds* (Figure 71). Women's injuries were proportionally more likely to be classified as *superficial* and men's injuries as *open wounds*. This makes sense in conjunction with description of injury event as discussed above in Sections 11.1 and 11.2. If adult male patients are more likely than females to be injured in an event where they are *struck by an object* or *cut by an object*, then they will also be more likely to have an open wound. Female patients are more likely to be injured by being *struck by a person* as compared with males and therefore more often will experience superficial wounds, such as bruising, where the skin is not broken.

**Figure 71: Main injury type by gender – adult patients aged 20 years and older (VEMD 2004/05-2005/06 combined)**



Note: Per cent does not equal 100% as only three of the 26 main injury categories are included in this graph.

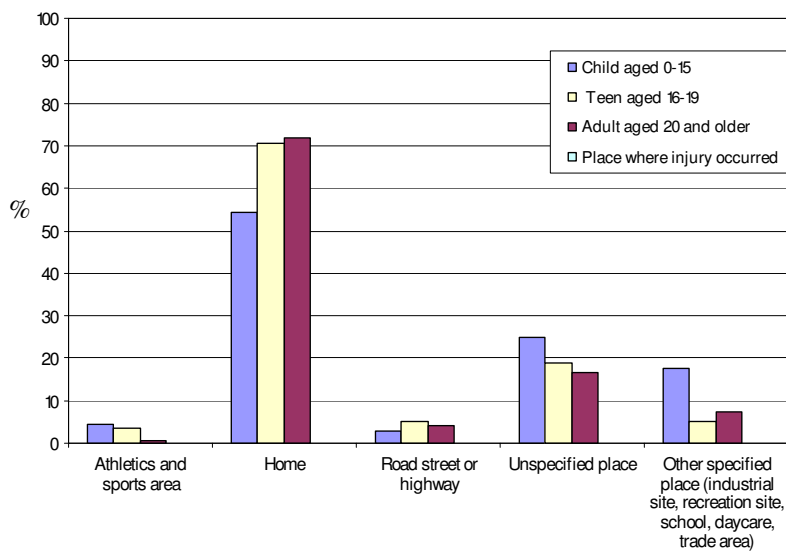
It is also interesting to note that female patients are twice as likely to be reported with multiple injuries as are male patients.



## 11.4 Gender and age comparisons and location when injury occurred

Part of the injury description for patient analysis includes information on the location where the injury took place. While the majority of injuries occurred in the *home*, regardless of age and gender, some interesting differences do appear across age groups of male patients.

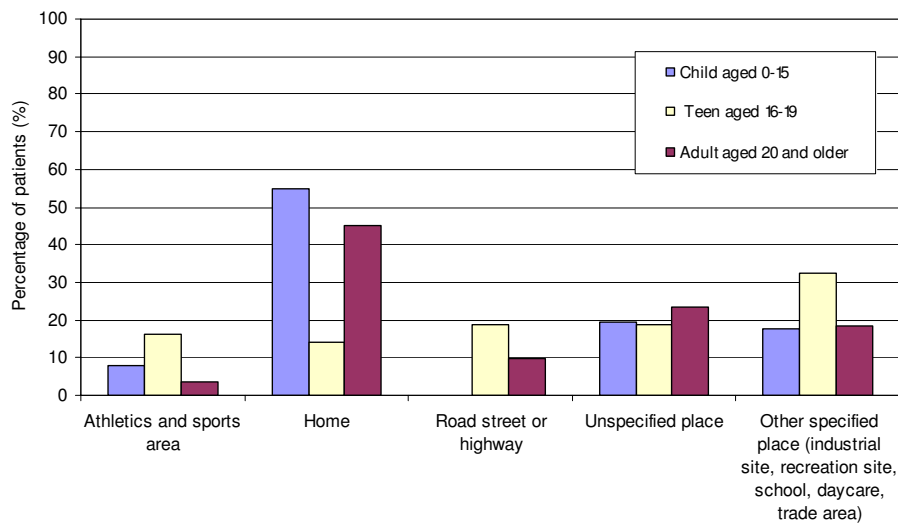
**Figure 72: Location of where injury sustained by age – female patients (VEMD 2004/05-2005/06 combined)**





Male patients aged between 16-19 years (Figure 73) experienced injuries across a more diverse range of locations. In particular, this group is over-represented in obtaining injuries on the *road, street or highway* (as a single specified location) as compared with other age groups and females. Males in this teenage group are the least likely to experience a human intent injury in the home.

**Figure 73: Location of where injury sustained by age – male patients (VEMD 2004/05-2005/06 combined)**







## 12. CONCLUSION

This seven year trend analysis report clearly illustrates the impact of change to Victorian policy and practice in relation to violence against women and children. A complete picture of family violence reform will be illustrated at the end of 2009, once the new *Family Violence Protection Act* and Victorian Police Safety Notices have been in place for 12 months.

Based on system reform over the past four years, ongoing training across the sector and improved systems are implemented – including improved data collection to assist in measuring change – we will continue to see increased reporting of family violence and increased accountability of perpetrators.

While it's still unknown how many families are experiencing family violence, it is the case that increased reporting, awareness of the complexity of family violence and improved support services all assist to improve the safety for women and children affected by family violence.

The findings of Volume 3 of this report continue to confirm existing research and discourse about the extent and nature of family violence. Throughout Victoria, as across Australia, family violence is a significant social problem that continues to be predominantly perpetrated by men against women in intimate personal relationships. While family violence against children is also likely to be highly under-reported, we do know that extensive numbers of children are present at family violence incidents.

The large scale of the impact of family violence on victims and future generations highlights the need for services that ensure the immediate safety of women and children, as well as policy initiatives that focus on the prevention of family violence in the future.

To this end, the Victorian Government has recently committed to a Family Violence Prevention framework through collaboration between the Office for Women's Policy and VicHealth.

The Victorian Family Violence Database is the first project of its kind in Victoria with a unique capacity to examine trends and patterns across sectors responding to family violence. The ongoing development of the Database reflects the recognition of the need for improved information about trends and patterns in family violence to provide evidence based policy and practice. Data collection and analysis are also important for monitoring and measuring the impact of changes in policies and practice over time.

The collaboration of key sectors responding to family violence in bringing together the information in the Database demonstrates a shared commitment to improving responses to family violence in Victoria.

The recent combined efforts of government and nongovernment organisations through partnerships such as the Statewide Advisory Committee to Reduce Family Violence



has supported government investment in family violence reform in Victoria, and acknowledged the importance of integrated responses to effectively address this issue.

In analysing the data for this report, it was apparent that while the data are a highly valuable source of information, there are significant gaps and limitations with the data sources. For instance, information about cultural background and preferred language of victims and perpetrators, location of the family violence incidents, and risk factors such as pregnancy and disability have not been collected in a reliable or comparable way across the data sources. For the purpose of implementing integrated responses to family violence, it is essential that organisations collect data in a way that is comparable with other service providers. The more access we have to reliable data, the more effective these responses will be. The Victorian Family Violence Database project will continue to work with data providers to seek to improve data collection, and to broaden the range and scope of information held in the Database through the inclusion of additional data sources.



## GLOSSARY

|                                |   |
|--------------------------------|---|
| <b>Accompanying child</b>      | A person aged 17 years and under who receives support or supported accommodation from a SAAP agency and whose parent or guardian is a client of the same agency.  |
| <b>Adult</b>                   | A person aged 18 years and over.  |
| <b>Aggrieved family member</b> | The family member whose person or property is the subject of the complaint–application for an intervention order or who is the subject of a family violence report (see also <i>victim</i> ).   |
| <b>Application refused</b>     | An application for an intervention order that was refused by the court.   |
| <b>Application struck out</b>  | An application for an intervention order that was struck out by the court usually/generally due to the non-appearance of the applicant at court for the final determination of the application.   |
| <b>Application withdrawn</b>   | An application for an intervention order that was withdrawn as a result of the aggrieved family member or complainant, where the complainant is not the aggrieved family member(eg the police) requesting that the application not proceed. |
| <b>Carer</b>                   | Within the scope of the <i>Family Violence Protection Act</i> , carers of persons with disabilities are defined as persons in a family-like relationship, whether paid or not.  |
| <b>Child</b>                   | Defined variously by age (16 years and under; 17 years and under, according to data source, and as indicated in text) or in relationship to a parent (including an adult child), and may include step-child.                                |
| <b>Children present</b>        | Children recorded by police as ‘present’ at a family violence incident; included as victims of family violence.   |



|                                       |  |
|---------------------------------------|--|
| <b>Client</b>                         | A person aged 18 years or older, or a person of any age not accompanied by a parent or guardian, who receives support or assistance from a SAAP agency or is accommodated by a SAAP agency (see also <i>victim</i> ).                              |
| <b>Complaint</b>                      | The grounds for an application for an intervention order.  |
| <b>Defendant</b>                      | The person against whom a complaint for an intervention order is made.   |
| <b>Intervention order</b>             | An order made by the Magistrates' or Children's Courts of Victoria that restricts a person's behaviour in relation to another person, or prohibits a person from undertaking specific activities.  |
| <b>Intimate personal relationship</b> | Includes same-sex relationships that have not been classified as domestic partner/former domestic partner, and includes girlfriend/boyfriend who are/have been in an intimate relationship but are not domestic partners/former domestic partners. |
| <b>Other party</b>                    | The person involved in a family violence incident as recorded by police, other than the aggrieved family member.   |
| <b>Region</b>                         | Department of Human Services region; (see Figure 30).  |
| <b>SAAP agency</b>                    | An organisation that receives Supported Accommodation Assistance Program funding to provide services.  |
| <b>Support</b>                        | Assistance, other than supported accommodation, provided to a client as part of an ongoing support relationship between a SAAP agency and a client.  |
| <b>Supported accommodation</b>        | Accommodation paid for, or provided directly by, a SAAP agency.  |
| <b>Support period</b>                 | The period during which a client receives support and/or supported accommodation from a SAAP agency.   |
| <b>VEMD</b>                           | Acronym for the Victorian Emergency Minimum Dataset.   |



|                         |  |
|-------------------------|--|
| <b>Victim</b>           | A generic term to refer to an <i>aggrieved family member, patient, applicant</i> or a <i>client</i> who has sought assistance as a result of family violence.  |
| <b>Victorian courts</b> | Magistrates' or Children's Courts of Victoria.   |
| <b>Weighting</b>        | Formulae applied by the SAAP National Data Collection Agency to adjust for agency non-participation and client non-consent. For consistency, in this report, weighting has been applied where required to SAAP agencies' data. |





## COUNTING RULES

In this report, the counting rules outlined below apply.

### **Victoria Police**

Each incident of family violence recorded by Victoria Police is counted as one aggrieved family member. However, one aggrieved family member may have been recorded as having sought police assistance on more than one occasion in any given year. Information on multiple incidents is not available to the Victorian Family Violence Database so it is not possible to determine how many incidents of family violence relate to the same victim.

### **Victorian courts**

One application for an intervention order may include multiple aggrieved family members. For the purposes of this report, each aggrieved family member who was the subject of a finalised intervention order application is counted.

An aggrieved family member may have applied for an intervention order on more than one occasion in any given year, or in more than one year. Information on multiple finalised intervention order applications is not available to the Victorian Family Violence Database and therefore it is not possible to determine how many applications relate to the same aggrieved family member.

### **SAAP agencies**

Each support period is counted. However, in any one year, a client of a SAAP agency may receive more than one support period. The Victorian Family Violence Database does not receive data on clients presenting to SAAP agencies on multiple occasions and, therefore, it is not possible to determine how many of the support periods relate to the same client. Previous research indicates that some SAAP clients do receive more than one support period in a given year. For example, in 1998–1999, across clients of all SAAP agencies targeting women and children escaping family violence, 65.3 per cent had one support period, 19.1 per cent had two support periods, and 7.9 per cent had three support periods (Chung et al. 2000, p. 40).

### **VEMD (extracted directly from Sections 1 and 2 of the VEMD users guide – will be rewritten in plain language for the final report)**

The Victorian Emergency Minimum Dataset (VEMD) contains de-identified demographic, administrative and clinical data detailing Emergency Department presentations at Victorian Public Hospitals that receive Non-Admitted Emergency Services Grant funding.

The majority of data items and codesets utilised in the VEMD have been based on, or taken from definitions and codesets specified in the National Health Data Dictionary (NHDD).



An Emergency Department Presentation should be reported even if the patient leaves the Emergency Department before the treatment has commenced, or if the registration was commenced but not completed.

If a patient attends the Emergency Department for the treatment of two or more conditions concurrently, only one episode should be recorded in the VEMD. For example, a patient attends the Emergency Department with foreign body of the eye and otitis media, even though the two injuries are independent, and may be treated as such by the clinicians, the patient is considered to have only presented at the Emergency Department once. Up to three diagnoses and thirty procedure codes can be recorded in the VEMD, this allows sites to differentiate between different complaints and the applicable treatment. (Modified extract from the VEMD Manual)



## REFERENCES

- Access Economics 2004, *The Cost of Domestic Violence to the Australian Economy*, Office of the Status of Women, Commonwealth Government.
- Alexander, Renata, 2002 *Domestic Violence in Australia: The Legal Response*, Third Edition. Federation Press.
- Australian Bureau of Statistics 1996, *Women's Safety Australia*, Catalogue No. 4128.0, Australian Commonwealth Government.
- Australian Bureau of Statistics 2006, *Personal Safety Survey*, Catalogue No. 4906.0, Australian Commonwealth Government.
- Australian Bureau of Statistics 2008, 2006 Census Quickstats: Victoria, Australian Commonwealth Government.
- Australian Bureau of Statistics 2006, National Regional Profile, 2000 to 2004, cat no. 1379.0.55.001, Australian Commonwealth Government.
- Australian Bureau of Statistics 2004, *Sexual Assault in Australia: A Statistical Overview*, Catalogue No. 4523.0.
- Australian Bureau of Statistics 2003, *Disability, Ageing and Carers, Australia: Summary of Findings, State Tables for Victoria*, Catalogue No. 4430.0.
- Australian Institute of Health and Welfare 2000, *SAAP National Data Collection, Annual Report 1999-2000, Victoria*, Catalogue No. HOU 52.
- Australian Institute of Health and Welfare 2001, *SAAP National Data Collection, Annual Report 2000-2001, Victoria, Supplementary Tables*, Catalogue No. HOU 63.
- Australian Institute of Health and Welfare 2005, "Female SAAP Clients and Children escaping domestic and family violence", *Bulletin*, Issue 30, September.
- Bagshaw, D. and Chung, D. 2000, *Women, Men and Domestic Violence*, University of South Australia.
- Bagshaw, D., & Chung, D. 2000, 'Reshaping responses to domestic violence: The needs of children and young people', in *The Way Forward: Children, Young People and Domestic Violence, National Forum Proceedings*, Partnerships Against Domestic Violence.
- Bhandari, M. et al 2008, "(Mis)Perceptions about Intimate Partner Violence in Women Presenting for Orthopaedic Care: A Survey of Canadian Orthopaedic Surgeons" in *The journal of Bone and Joint Surgery (American)*, vol. 90, pp.1590-7.
- Bobic, N. 2004, *Adolescent Violence Towards Parents*, Australian Domestic and Family Violence Clearinghouse Topic Paper.



- Brown, D. and Endekov, Z. 2005, *Childhood Abused: The Pandemic Nature and Effects of Abuse and Domestic Violence on Children in Australia*, The Alannah and Madeline Foundation.
- Brownridge, D. A. 2006, 'Violence against Women Post-separation', *Aggression and Violent Behavior*, vol 11, no. 5, pp. 514-530.
- Campbell, A. 1993, *Out of Control: Men, Women and Aggression*, Pandora, London.
- Carcach, C. & James, M. 1998, 'Homicide between intimate partners in Australia', *Trends and Issues in Crime and Criminal Justice*, No. 90, Australian Institute of Criminology.
- Carlson, B. E. 1997, "Mental retardation and domestic violence: an ecological approach to intervention" *Social Work* 42(1): 79-89.
- Chung, D., Kennedy, R., O'Brien, B. and Wendt, S. 2000, *Home Safe Home: The Link Between Domestic and Family Violence and Women's Homelessness*, Partnerships Against Domestic Violence.
- Cockram, J. 2003, *Silent voices: Women with Disabilities and Family and Domestic Violence*, Women with Disabilities Australia.
- Cohen, M. M., T. Forte, et al. 2005, "Intimate partner violence among Canadian women with activity limitations." *Journal of Epidemiology and Community Health*, vol 59, no. 10, pp. 834-9.
- Commonwealth of Australia, Women with Disabilities 1997, *More than just a ramp- : a guide for women's refuges to develop Disability Discrimination Act action plans*, ACT Australia, pp. 4-5.
- Crime Prevention Victoria 2002, *Safer Streets and Homes: A Crime and Violence Prevention Strategy for Victoria, 2002-2005*, Victorian Government.
- Cunneen, C. & Stubbs, J. 2002, 'Migration, political economy and violence against women: the post immigration experiences of Filipino women in Australia' in J Freilich, G Newman, S Shoham & M Addad (eds) *Migration, Culture Conflict and Crime*, Dartmouth, Ashgate.
- Curry, M. A., D. Hassouneh-Phillips, et al. 2001, "Abuse of women with disabilities: an ecological model and review." *Violence Against Women* vol. 7 no. 1 pp. 60-79.
- Department of Premier and Cabinet 2001, *Growing Victoria Together*, Victorian Government.
- Distaff Associates 1991, *Costs of Domestic Violence*, Sydney, New South Wales Women's Co-ordination Unit.
- Dobash and Dobash, 1979, *Violence against Wives*, Open Books, London.



- Dobash, R.E., Dobash, R.P. and Cavanagh, K., 1985, 'The contact between battered women and social and medical agencies', in *Private Violence and Public Policy*, Pahl, J. (ed), Routledge and Kegan Paul, London.
- Edleson, J.L. 1999, 'Children's witnessing of adult domestic violence', *Journal of Interpersonal Violence*, vol.14, no.4, pp.839-870.
- Ferrante, A., Morgan, F., Indermaur, D. & Harding, R. 1996, *Measuring the Extent of Domestic Violence*, Hawkins Press.
- Fantuzzo, J., Boruch, R., Beriama, M., Atkins and Marcus, S. 1997, 'Domestic Violence and Children: Prevalence and Risk in Five Major US cities', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 36, no. 1, pp 162-122.
- Frank, J. B., and Rodowski M. F. 1999, 'Review Of Psychological Issues in Victims of Domestic Violence Seen in Emergency Settings', in *Emergency Medicine Clinics of North America*, vol. 17, issue 3, pp. 657-677.
- HEROC 1997, *Bringing them Home* (National Inquiry into the separation of Aboriginal and Torres Strait Islanders (ReF))
- Gilson, S. F., E. P. Cramer, et al. 2001a, "Redefining Abuse of Women with Disabilities: A Paradox of Limitation and Expansion" *Affilia* vol. 16, no. 2, pp. 220-235.
- Indermaur, D. 2001, 'Young Australians and domestic violence', *Trends and Issues in Crime and Criminal Justice*, No. 195, Australian Institute of Criminology.
- James, K. 1999, 'Men as Victims of Domestic Violence' in *Challenging Silence: Innovative responses to sexual and domestic violence*, Breckenridge, J. and Laing, L. (eds), Allen and Unwin, St Leonards, NSW.
- Jennings, C. 2007, 'The use of Sole Occupancy Orders in Supporting Women with Disabilities', *DVIRC Quarterly*, 4, Summer.
- Keel, M, 2004, *Family Violence and Sexual Assault in Indigenous Communities*, Australian Centre for the Study of Sexual Assault, Briefing No. 4, September.
- Kimm, J. 2004, *A Fatal Conjunction: Two Laws, Two Cultures*, Federation Press.
- Laing, L. 2000, 'Progress, trends and challenge in Australian responses to domestic violence', *Issues Paper 1*, Australian Domestic and Family Violence Clearinghouse.
- Laing, L. 2000, 'Children, young people and domestic violence', *Issues Paper 2*, Australian Domestic and Family Violence Clearinghouse.
- Laing, L. and Bobic, N. 2002, *Economic Costs of Domestic Violence: Literature Review*, Australian Domestic and Family Violence Clearinghouse, UNSW Sydney, Australia.
- Lievore, D. 2003, *Non-reporting and Hidden Recording of Sexual Assault: An International Literature Review*, Australian Institute of Criminology.



- McGregor, H. 1990, 'Conceptualising male violence against female partners: political implications of therapeutic responses', *ANZ Journal of Family Therapy*, vol. 11, no. 2, pp. 65-70.
- Sherrard, J., Ozanne-Smith, J., Brumen, I.A., Routley, V. Williams, F. 1994, *Domestic Violence: Patterns and Indicators*, Report 63, Monash University Accident Research Centre, Melbourne.
- Stark, E. and Flitcraft, A. 1991, "Spouse Abuse", in *Violence in America: A Public Health Approach*, M.L. Rosenberg and M.A. Fenley (eds), Oxford University Press, New York.
- Mouzos, J. 1999, *Femicide: The Killing of Women in Australia 1989-1999*, Australian Institute of Criminology, Canberra.
- Mouzos J. 2001, *Homicidal Encounters: A Study of Homicide in Australia 1989-1999*, Research and Public Policy Series No. 28, Australian Institute of Criminology, Canberra.
- Mouzos, J. & Makkai, T. 2004, *Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey*, Research and Public Policy Series No. 56, Australian Institute of Criminology.
- Mulroney, J. 2003, *Australian Statistics on Domestic Violence*, Australian Domestic & Family Violence Clearinghouse, Topic Paper.
- Nosek, M. A., C. C. Foley, et al. 2001, "Vulnerabilities for abuse among women with disabilities", *Sexuality and Disability* vol. 19, no. 3 pp. 177-89.
- New South Wales Women's Coordination Unit 1991, *New South Wales Domestic Violence Strategic Plan: Costs of Domestic Violence*, New South Wales Government.
- Office of the Status of Women, Department of Prime Minister and Cabinet 1995, *Community Attitudes to Violence Against Women*.
- Office of the Status of Women, Department of Prime Minister and Cabinet 2001, *Working Together Against Violence: The First Three Years of Partnerships Against Domestic Violence*, Commonwealth of Australia.
- Office of Women's Policy 2001, *Key Directions in Women's Safety*, Victorian Government.
- Office of Women's Policy 2001, *Northern Territory Government Domestic Violence Strategy Data Collection Project Report*, Northern Territory Government.
- Office of Women's Policy 2002, *Women's Safety Strategy: A Policy Framework*, Victorian Government.
- Putt, J. & Higgins, K. 1997, *Violence Against Women in Australia: Key Research and Data Issues*, Australian Institute of Criminology, Research and Public Policy Series, No. 6.



- Roberts, G., 1988 Domestic Violence: Costing of Service Provision for Female Victims – 20 case histories, in Queensland Domestic Violence Task Force (eds), *Beyond these Walls: Report of the Queensland Domestic Violence Task Force to the Honourable Peter McKechnie, MLA, Minister for Family Services and Welfare Housing* (pp. 429-503). Brisbane, Australia.
- Roberts, G.L., O'Toole B.I., Raphael, B., Lawrence, J.M. and Ashby, R. 1996, 'Prevalence Study of Domestic Violence Victims in an Emergency Department', in *Annals of Emergency Medicine*, vol 27, Issue 6 pp. 747-753.
- Roberts, G., 1995, 'Domestic Violence Victims in Emergency Departments', in *Australian Violence: Contemporary Perspectives II*, Chappell, D. and Egger, S.J. (eds), Australian Institute of Criminology, Canberra.
- Roberts, G.L., O'Toole B.I., Lawrence, J.M. and Raphael, B. 1993, 'Domestic Violence Victims in a Hospital Emergency Department', in *Medical Journal of Australia*, vol 159, pp. 307-310.
- Salthouse, S. & Frohmader, C. 2005, Real Trouble in the Home: the Domestic Violence Reality for Women with Disabilities, DVIRC Newsletter Issue No 4 2004/2005 summer edition.
- Strang, H. 1996, 'Children as victims of homicide', *Trends and Issues in Crime and Criminal Justice*, No. 53, Australian Institute of Criminology.
- Strauss, M., Gelles, R. and Steenmetz, S. 1980, *Behind Closed Doors: Violence in the American Family*, Anchor/Doubleday, New York.
- Strauss, M. 1993, 'Physical Assault by Wives' in *Current Controversies on Family Violence*, Gelles, R. and Loseke, D. (eds), Sage, California.
- Taft, A. 2002, 'Violence against women in pregnancy and after childbirth', *Issues Paper, 6*, Australian Domestic and Family Violence Clearinghouse.
- VicHealth 2004, *The Health Costs of Violence: Measuring the burden of disease caused by intimate partner violence*, Victorian Government.
- Victorian Community Council Against Violence (VCCAV) 2002, *Victorian Family Violence Database: First Report*, Victorian Government.
- Victorian Community Council Against Violence (VCCAV) 2006, *Victorian Family Violence Database: Five Year Report 1999-2004*, Victorian Government.
- Victorian Indigenous Family Violence Task Force Final Report 2003, Department for Victorian Communities: Melbourne.
- Victoria Police 2002, *A Way Forward: Violence Against Women Strategy*, Victoria Police, Victorian State Government, Australia.



- Victoria Police 2004, *Victoria Police Code of Practice for the Investigation of Family Violence*, Victoria Police, Victorian State Government, Australia.
- Victorian Law Reform Commission 2004, *Defences to Homicide Options Paper*, Melbourne Australia.
- VOMA 2002, *Valuing Cultural Diversity*, Victorian Office of Multicultural Affairs, Melbourne.
- Walsh, D. 2000, 'Domestic violence in pregnancy', *Domestic Violence and Incest Resource Centre Newsletter*, vol. 1.
- Walsh, D. and Weeks, W. 2004, *What a Smile Can Hide: A Study on the Violence Against Women During Pregnancy*, Royal Women's Hospital, Melbourne Australia.
- Office of Women's Policy, Melbourne 2002, *Women's Safety Strategy: A Policy Framework*.
- Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano (eds) 2002, *World Report on Violence and Health*, World Health Organisation, Geneva.
- Young, M. E., M. A. Nosek, et al. 1997, "Prevalence of abuse of women with physical disabilities." *Archives of Physical Medicine and Rehabilitation* vol. 78, no. 12 pp. S34-S38.



## ENDNOTES

- 1 Results are based on reports from women who have ever experienced an intimate partner relationship, and experienced an episode of physical violence in any of those relationships over their lifetime (since the age of 16).
- 2 Queensland based report including severe family violence assessed through the Conflict Tactics Scale, disclosed abuse only (Roberts 1988).
- 3 New South Wales based report including: emotional, physical and sexual abuse; both disclosed and undisclosed estimates; at three stages of service usage (Distaff Associates 1991).
- 4 The committee recently has been reformed into the Statewide Advisory Committee to Reduce Family Violence.
- 5 Best practice models such as the Duluth Model, implemented in Minnesota, USA, demonstrate that coordinated and integrated responses to family violence, together with measuring, monitoring and tracking, result in a reduction of family violence and a reduction in victimisation.
- 6 Subsequent changes included ten new positions for regional Family Violence Advisory Officers (including two in each of four regional areas and one across the metro area).
- 7 Updates available on Victoria Police website <[www.police.vic.gov.au](http://www.police.vic.gov.au)>.
- 8 It should be noted that these statistics are based on the number of times police have recorded on the family violence incident form that they sought a complaint and warrant for an intervention order. This may differ to Magistrates' and Children's Court of Victoria statistics regarding the number of police applications for an intervention order as courts count both complaint and summons for an intervention order, and complaint and warrant for an intervention order.
- 9 See Victoria Police statistical highlights and media release of August 2, 2005 at <[www.police.vic.gov.au](http://www.police.vic.gov.au)>
- 10 The Database project has also provided approximately 20 reports to individual agencies that requested LGA-specific family violence data. For instance, data were provided to Werribee Legal Service on the Wyndham LGA data that were used to create a profile of family violence in Wyndham. These informed local policy development in that area.
- 11 Developed by the Victorian Community Council Against Violence and the Project Reference Group. Adapted from Deborah Walsh 2000, 'Domestic violence in pregnancy', *Domestic Violence and Incest Resource Centre Newsletter*, vol. 1, pp. 12–17.
- 12 The Victorian Law Reform Commission Review of Family Violence Laws Report recommends that the definition of family violence be expanded and articulated in new family violence legislation. In particular, the definition of 'family' is recommended to be amended to include relationships where: a) "a relative according to Aboriginal tradition or contemporary social practice"; b) "a relative according to any other traditional or contemporary social practice"; and c) "a person who has or has had a relationship with the original person involving the original person's dependence or partial dependence on that person for paid or unpaid care" (pp. xxix-xxx).
- 13 Women with disabilities may experience a relationship power imbalance in an intimate relationship, but not necessarily a sexual one, if she is dependent on a carer who undertakes personal tasks essential for her daily needs.

---

14 Australian Institute of Criminology, International Violence Against Women  
Survey (IVAWS) 2002–03 weighted data. We wish to acknowledge and thank  
15 Jenny Mouzos for extracting this figure for this report.

16 Over-representation of indigenous children within the welfare system has been  
noted in relation to a) previous policies of removing Aboriginal children from  
17 their families, b) intergenerational effects of family separation, c) lower socio-  
economic status and d) poor perceptions of cultural differences in child rearing  
18 practices (HEROC 1997).

19 Term used by Denise Lievore (2003) to describe violence against women  
reported to police.

20 The single exception is that Victorian courts are able to report on the number of  
complaints for intervention orders that were made by police.

21 Due to the nature of the data and limitations on data collection, it is difficult to  
ascertain appropriate confidence levels and error rates for statistical significance  
22 testing. With this qualification, based on the ABS estimated resident population  
of Victorian adults aged 18 years and older being 3,814,912 as of 30 June 2004  
(excluding those located in unincorporated Victoria), to obtain a confidence  
level of 95 per cent and a confidence interval of  $\pm 3$  percentage points, our  
sample size would need to be 1067. All of our data sets meet this sample size  
across all of the years of analysis.

23 The family violence risk assessment asks questions about the length of time the  
violence has continued, how many previous police visits there have been, the  
intervals between violence, victim's level of fear and specific risk indicators (eg  
and in addition to others, pet abuse, pregnancy, controlling behaviour, recent  
separation and isolation).

24 See section 5 of the *Crimes (Family Violence) Act 1987* for a list of restrictions  
that can be included in an intervention order.

25 At the time of writing this report, new stalking legislation was under review.

26 These figures have been obtained from the *Statistics of the Magistrates' and  
Children's Courts of Victoria, Intervention Order Statistics 1998/1999–  
2002/2003* (Court Statistical Services Victoria 2004, p. 63). They are based on  
finalised applications for the principal aggrieved family member.

27 In section 4 of the *Crimes (Family Violence) Act 1987*.

28 The *Magistrates' Court (Family Violence) Act 2004* allows the court to make  
intervention orders for children on its own initiative. The Act introduces a  
procedure where the court must inquire into the welfare of children when  
making an intervention order. Before making an intervention order, the court  
must consider whether there are any children are family members of the  
defendant or the aggrieved family member. If so, the court must consider  
whether they have been subjected to family violence or seen or heard family  
violence, and whether they are likely to do so again. If there are such children  
who have not been included as aggrieved family members on the complaint for  
an intervention order, the court may, on its own initiative, include the  
child/children on the adult's intervention order, or make a separate intervention  
order for the child/children. (See section 4A of the *Crimes (Family Violence)  
Act 1987*.)

29 For more information see *SAAP National Data Collection, Data Dictionary,  
Version 2, November 2001*, pp. 3-6.

- <sup>26</sup> See Australian Institute for Health and Welfare, *SAAP National Data Collection, Annual Report 1999–2000, Victoria*, Catalogue No. HOU 52, 2000, p. xviii; Australian Institute of Health and Welfare, *SAAP National Data Collection, Annual Report 2000–2001, Victoria, Supplementary Tables*, Catalogue No. HOU 63, 2001, p. 7; Australian Institute of Health and Welfare, *Homeless People in SAAP, SAAP National Data Collection, Annual Report 2001–2002, Victoria, Supplementary Tables*, Catalogue No. HOU 74, 2002, p. 19; Australian Institute of Health and Welfare, *Homeless People in SAAP, SAAP National Data Collection, Annual Report 2002–2003, Victoria, Supplementary Tables*, Catalogue No. HOU 93, 2003, p. 19; Australian Institute of Health and Welfare, *Homeless People in SAAP, SAAP National Data Collection, Annual Report 2003–2004, Victoria, Supplementary Tables*, Catalogue No. HOU 115, 2005, p. 21.
- <sup>27</sup> The Australian Institute of Health and Welfare recommends rounding estimates and numbers other than percentages to the nearest 50 to allow for any errors inherent in the weighting process. Australian Institute of Health and Welfare, *Homeless People in SAAP, SAAP National Data Collection Annual Report 2003–04*, p. 91.
- <sup>28</sup> The VEMD records details of injuries treated at the Emergency Departments of the 38 Victorian Public Hospitals with 24-hour emergency departments. The 38 hospitals currently contributing data to the collection include: Austin and Repatriation Medical Centre, Ballarat Base Hospital, The Bendigo Hospital, Box Hill Hospital, Echuca Base Hospital, The Geelong Hospital, Goulburn Valley Base Hospital, Maroondah Hospital, Mildura Base Hospital, Northern Hospital, Royal Children's Hospital, St Vincent's Public Hospital, Northeast Health Wangaratta, Warrnambool Hospital, Western Hospital (Footscray), Sunshine Hospital, Williamstown Hospital, Wimmera Base Hospital, Dandenong Hospital, Royal Victorian Eye and Ear Hospital, Frankston Hospital, Latrobe Regional Hospital, Alfred Hospital, The Angliss Hospital, Monash Medical Centre, Royal Melbourne Hospital, Werribee Mercy Hospital, Rosebud Hospital, Sale Hospital, Warragul Hospital Bairnsdale Hospital, Swan Hill Hospital, Wodonga Hospital, Hamilton Hospital, Sandringham Hospital, Royal Women's Hospital, Mercy Women's Hospital, Casey Hospital.
- <sup>29</sup> Victorian Injury Surveillance System data was collected between 1988 and 1996 and was limited to four major metropolitan hospitals and one large rural hospital (Western Hospital Footscray and Sunshine, Royal Children's Hospital, Preston and Northcote Community Hospital, Latrobe Regional Hospital and Royal Melbourne Hospital).
- <sup>30</sup> The results of two controlled studies conducted through the University of Queensland at the Royal Brisbane Hospital Emergency Department, between 1990 and 1993, revealed that one per cent of patients were accompanied by partners / parents who refused to leave their side and therefore could not be questioned about family violence (Roberts et al 1996).
- <sup>31</sup> Of 2454 calls to the Helpline in 2004-05, the most frequently reported crime for which victims sought assistance was 'general assault' (n=964) followed by 'domestic violence and child physical abuse' (n=232).
- <sup>32</sup> Helpline data is not available prior to 2006 due to changes in data collection models. IRIS data collection commenced in 2005 with adequate agency involvement by the end of 2006-2007 for inclusion in the Database.

---

33 The Provisional Crime Statistics released by Victoria Police reports the total number of family violence incidents in Victoria for 2006/2007 as 29,652. ([http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media\\_ID=21749](http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=21749))

34 See endnote 33.

35 See endnote 8.

36 The Family Violence Advisers are located at the following police stations: Melbourne, Werribee, Ballarat, Epping, Sunbury, Shepparton, Knox, Benalla, Endeavour Hills and Morwell.

37 See Victoria Police media release of May 29, 2007 and August 24, 2007 at [www.police.vic.gov](http://www.police.vic.gov).

38 See endnote 33.

39 This figure refers to the total number of aggrieved family members included in an application for an intervention order that was finalised during the period. For instance, if a mother and her two children sought an intervention order against the husband/father, this would constitute three aggrieved family members and one complaint for an intervention order.

40 This figure has been obtained from the *Statistics of the Magistrates' and Children's Courts of Victoria, Intervention Order Statistics 1998/1999–2002/2003*, Court Statistical Services Victoria 2004, p. 61. It is based on finalised applications for the principal aggrieved family member.

41 This figure was obtained from the Magistrates' Court of Victoria 2003–04 Annual Report (p. 28), and is based on finalised applications for the principal aggrieved family member.

42 Extract from Ms Christine Nixon's inaugural speech. Sighted 28/4/2008: [http://www.police.vic.gov.au/content.asp?Document\\_ID=44](http://www.police.vic.gov.au/content.asp?Document_ID=44)

43 As noted previously, these numbers are weighted and rounded to the nearest 50, as are the figures and percentages in the following discussion, unless indicated otherwise.

44 Due to the large variation in sample population sizes across agencies included in this report, the majority of graphs have their scales standardised. This allows graphs to provide information not just of the proportions within the agency, but also in relevance to other data sets. The benefit of this standardisation is that small populations are not exaggerated out of proportion; the downside is that some graphs can appear to have a large amount of unused space.

45 Relationship information is not available from the SAAP, VSA or VEMD data sets. The child category includes adult children in relationship to a parent as well as those aged 16 years and under.

46 It should be noted that child refers to the nature of the relationship to the defendant/other party rather than the age of the victim. Therefore, it is possible to have an adult victim who is the child of the defendant/other party.

47 In 2003–2004 there were no children under 12 who were defendants in intervention orders. The police data showed that 2 per cent of the perpetrators were a child/step-child under the age of 12. In 2005–2006 less than 2 per cent (n=39) of perpetrators in the police data were under 12 and only one was a defendant in an intervention order.

48 Currently, we do not have information on the number of cases that involved both parents seeking assistance for violence by their adolescent child.

49 For the purposes of this report, adults are aged 18 years and over.

---

50 See discussion of cross-applications in section 4.3 of this report. Some of the  
male aggrieved family members may have sought cross-applications against  
female aggrieved family members.

51 See discussion in Section 4.3 regarding classification of human intent injuries  
between family members.

52 *Other family member* is comprised of relationships including: sibling, step-  
sibling aunt, uncle, cousin, in-laws (including defacto, sibling, brother, sister  
etc) grandparents, grandchildren, nephew and niece.

53 The age groups used are consistent with those provided by SAAP. SAAP does  
not provide single-year data. Single-year data are available from ABS statistics,  
police, courts and VEMD which have been recoded into age groups compatible  
with SAAP. It must be noted that the numbers of years included in each  
category are not equal.

54 Victorian adult female populations for analysis of both 1999–2000 and 2003–  
2004 data are based on that provided by the Australian Bureau of Statistics.

55 The largest age group of adult female victims was 25-34 years, notably younger  
than male victims (see discussion in Section 6.5).

56 Regions are based on the Department of Human Services regions. Victorian  
regional populations are based on the Australian Bureau of Statistics estimated  
resident population data.

57 It is beyond the scope of this project to examine why changes have occurred in  
regional populations over the period.

58 Population analysis was not included for the SAAP data, as the SAAP data  
relate to the location of the services rather than the address of the victim.

59 Due to the smaller numbers of adult male victims, we have not included analysis  
as a percentage of the regional population.

60 For the purposes of this report, children are classified as aged 17 years and  
under for courts and police when identifying aggrieved family members and  
SAAP clients. Police data for reporting on children *present* identifies children  
aged 16 years and younger. Both the SAAP client forms and police forms  
reporting children present contains pre-determined age categories which can not  
be disaggregated for direct age comparisons. It must be noted that when multiple  
age categories are used, the numbers of years included in each category are not  
equal.

61 The number of children ‘present’ at the time a police member attends a family  
violence incident is likely to be an underestimate of the number of children who  
are regularly present in the home and who potentially experience the effects of  
family violence.

62 The presence of children accompanying an adult into SAAP accommodation is  
noted as “at least one child or more” within each of four age categories.  
Children are not identified individually and therefore we are unable to report an  
accurate number of children or disaggregated age analysis. Accompanying  
children are considered up to 17 years of age.

63 This figure is also likely to be an underestimate and should only be considered  
as a guide.

64 Police do not collect information about the gender of children recorded as  
‘present’ at family violence incidents.

65 As noted, exact numbers of accompanying children have not been provided and  
analysis is based on ‘at least’ one child accompanying the client in the stated age

---

groups. This analysis may be different from SAAP reports that analyse on the basis of exact numbers of children in given age groups.

66 Some institutions also implement strict privacy principles whereby information not required for the specified purpose of the database can not be collected in the view that it may breach the *Privacy Act 2000*.

67 At the time of writing the report, the courts were undergoing review of how they might implement training among workers for supporting women with disabilities, as well as meeting the needs of CALD and indigenous women.

68 Commonwealth of Australia, *Women with Disabilities (1997) More than just a ramp- : a guide for women's refuges to develop Disability Discrimination Act action plans*, ACT Australia, pp. 4-5.

69 Women may not qualify for a disability pension if they are earning an income above the level for means testing; if their disability is not assessed as 'severe'; or if their circumstances have changed and they *are* eligible but undergoing a period of delay before the pension can be accessed.

70 The disability support pension has strict qualifying criteria and will not identify the majority of women with disabilities who are not eligible. This may include women who are marginalised and unable to apply, are dependent on their partner for income, those who are employed, and those who believe the difficulty in meeting requirements is not worth the effort for the benefits they may in turn receive.

71 SAAP data are weighted for agency non-participation and client non-consent, and rounded to the nearest 50 cases.

72 SAAP data represents client support periods. All agencies may include victims who seek assistance on multiple occasions.

73 Information on client residential location is not available for SAAP data and therefore regional comparison is primarily to identify locations of services which can accommodate women with disabilities in comparison to women without disabilities.

74 While the use of interpreters is recorded, it was not available in the data extract. The Courtlink database is expected to be replaced in 2009. The new database will contain additional data fields and a request has been made to include information on CALD and indigenous status.

75 "The EP index is defined as the percentage of recent immigrants (those entering in the five years before the Census) who speak English only or another language and good English. Good English is defined as those who reported at the Census that they spoke 'English Only' or spoke English 'Very Well' or 'Well'"(Department of Immigration and Multicultural and Indigenous Affairs 2003, p. 2).

76 Care should be taken with this assumption, as migrants from some communities have greater contact with English prior to migration and therefore EP may not be accurately reflective of newly arrived and emerging communities. It has also been demonstrated that segments of some communities may be reluctant to learn English regardless of the number of years having lived in Australia (insert reference??).

77 Rees, S. and Pease, B. 2007, *Refuge Settlement, Safety and Wellbeing: Exploring domestic and family violence in refugee communities*, Immigrant Women's Domestic Violence Service and VicHealth, Victoria.

- 
- <sup>78</sup> For further detailed discussion on identifying new and emerging communities see: Jupp, J. 2002, *From White Australia to Woomera – The Story of Australian Migration*, Cambridge University Press, Cambridge.
- <sup>79</sup> Rees, S. and Pease, B. 2007, *Refuge Settlement, Safety and Wellbeing: Exploring domestic and family violence in refugee communities*, Immigrant Women’s Domestic Violence Service and VicHealth, Victoria, p. 23.
- <sup>80</sup> English language proficiency plays a vital role in a person’s employment status. Approximately one quarter of migrants reporting that they speak English “not very well” or “not at all” 18 months after arrival, are unemployed. This compares with only one-fifth or fewer migrants who speak English “well” or “very well” being unemployed 18 months after migration. Australian Government Department of Immigration and Citizenship, 2007, *Migrant Labour Market Outcomes*, Fact Sheet 14 [online], January 30. Available from internet: <URL: <http://www.immi.gov.au/media/fact-sheets/14labour.htm>>. Viewed October 9, 2007.
- <sup>81</sup> Rees, S. and Pease, B. 2007, *Refuge Settlement, Safety and Wellbeing: Exploring domestic and family violence in refugee communities*, Immigrant Women’s Domestic Violence Service and VicHealth, Victoria, p. 31.
- <sup>82</sup> Cultural Perspectives, 2000, *Attitudes to Domestic and Family Violence in the Diverse Australian Community: An Initiative of Partnerships Against Domestic Violence*.  
Pittaway, E., 2004, *The Ultimate Betrayal: An Examination of the Experience of Domestic and Family Violence in Refugee Communities*, University of New South Wales.
- <sup>83</sup> Pittaway, E., 2004, *The Ultimate Betrayal: An Examination of the Experience of Domestic and Family Violence in Refugee Communities*, University of New South Wales, p. 17.
- <sup>84</sup> Rees, S. and Pease, B. 2007, *Refuge Settlement, Safety and Wellbeing: Exploring domestic and family violence in refugee communities*, Immigrant Women’s Domestic Violence Service and VicHealth, Victoria, pp. 22-23.
- <sup>85</sup> Australian Institute of Health and Welfare, 2007, *Homeless People in SAAP, SAAP National Data Collection, Annual Report 2005–2006*, Australia, Canberra. English proficiency relates to people born overseas. The English proficiency status of clients is determined by their country of birth. Four English proficiency groups based on country of birth (excluding Australia) have been specified by the Department of Immigration and Multicultural Affairs (DIMA 2003). These are combined into two groups for the SAAP data:
- English proficiency group 1 countries—Canada, Ireland, New Zealand, South Africa, the United Kingdom, the United States of America and Zimbabwe
  - English proficiency groups 2–4 countries—all other countries (excluding Australia).
- <sup>86</sup> Aboriginal Affairs Victoria, 2003, *Victorian Indigenous Family Violence Taskforce, Final Report December 2003*, Department for Victorian Communities, Melbourne.