Domestic and Family Violence against Women

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KEY STATEMENT

Domestic and family violence (DFV) is a major public health and welfare issue in Australia and around the world. It affects people across all ages, gender, race, religion, ethnicity, culture and socioeconomic and demographic groups, but predominantly affects women and children.

Globally, the World Health Organization (WHO) estimates that 1 in 3 (30%) women who have been in a relationship have experienced physical or sexual violence from an intimate partner since the age of 15 (WHO, 2013). In Australia, about 1 in 6 (17%, or 1.6 million) women and more than half a million men (6.1%) have experienced violence from a current or previous cohabiting partner since the age of 15 (Australian Bureau of Statistics, 2017). Family violence also affects children, who may be victims or witness violence against family members. Children witnessing, or being exposed to, domestic violence is increasingly being recognised as a form of child abuse. DFV is also a human rights issue and is preventable. Nurses have an important role to play in mitigating, managing, and preventing DFV in the community as they engage with those affected by violence when they seek health care services.

The Australian College of Nursing (ACN) supports nurses to better understand the complexities that surround DFV, whether it affects them personally or professionally. Nursing is a female dominated profession, and as such ACN recognises that nurses may experience domestic violence in their own lives. Nurses provide non-judgemental, compassionate care to women and families, and deserve the same respect. ACN encourages nurses who are experiencing DFV to seek support and assistance.

The Australian College of Nursing (ACN) views DFV as unacceptable under any circumstances. Access and equity to support and care for those affected by DFV should be provided.

BACKGROUND

Definitions and Scope of the Problem

The WHO defines violence as 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 (Krug, Mercy, Dahlberg, & Zwi, 2002). In this definition, intentionality is the main determinant of violence which likely results in health effects or death whether the person who commits the act, or perpetrators, may not perceive it as such.

Family violence refers to violence that occurs among people who share kinship, through birth or marriage, or who share a home (Herzberger, 2019). Family violence is the preferred term for violence between Aboriginal and Torres Strait Islander people, as it covers the extended family and kinship relationships in which violence may occur (Council of Australian Governments [COAG], 2011; Kuskoff & Parsell, 2020).

For this report, **domestic violence** is considered a subset of family violence. It refers to violent behaviour between current or former intimate partners—typically, where one partner tries to exert power and control over the other, usually through fear. It can include physical, sexual, emotional and psychological abuse (Barocas, Emery, & Mills, 2016; Van Gelder et al., 2020). Behaviour towards the victim can include limiting their access to finances, preventing them from contacting family and friends, demeaning and humiliating them, threatening them or their children with injury or death, and acts of physical violence (COAG, 2016; Stanford, 2016). Domestic violence is sometimes called ‘intimate partner violence’.

Sexual violence is a broader concept covering a range of behaviours of a sexual nature, carried out against a person's will using physical force or coercion (or any threat or attempt to do so). Sexual violence can be perpetrated by partners in a domestic relationship, former partners, other people known to the victims, or strangers (COAG, 2011; Kuskoff & Parsell, 2020). This also includes child sexual abuse when an adult, adolescent or child uses their power or authority to involve a child in sexual activity.

In this document, domestic and family violence includes:

- Child abuse – any type of abuse that involves physical, emotional, sexual, or economic abuse or neglect of a child under 18 years of age (16 years of age in New South Wales, 17 years of age in Victoria) (Royal Australian College of General Practitioners, 2014).
- Sexual violence – any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting (WHO, 2013).
- Elder abuse – any type of abuse (physical, emotional, sexual, economic) or neglect of a person 65 years of age or over, either in a residential aged care facility (RACF), in private care, or living independently (WHO, 2008).
- Intimate partner violence – behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours (WHO, 2017).
- Carer abuse to a person living with a disability or with complex medical and or social needs.

International and local facts

Globally, 30% of women have experienced physical and/or sexual violence by an intimate partner in their lifetime and up to 38% of murders of women are committed by intimate partners (WHO, 2017). One billion children, over half of all boys and girls aged 2–17 years, experience some form of emotional, physical or sexual violence every year (WHO, 2017).

In Australia, one in six women have been subjected, since the age of 15, to physical and/or sexual violence by a current or previous cohabiting partner (Australian Institute of Health and Welfare, 2018). Family, domestic and sexual violence happens repeatedly—more than half (54%) of the women who had experienced current partner violence, experienced more than one violent incident (Australian Bureau of Statistics, 2017). However, between 2005 and 2016, rates of partner violence against women have remained relatively stable (WHO, 2020). People who, as children, witnessed partner violence against their parents were 2–4 times as likely to experience partner violence themselves (as adults) as people who had not (Australian Institute of Health and Welfare, 2018).

There are many reasons why people perpetrate domestic violence; they include gender inequality and social norms that condone violence, childhood experiences of abuse or exposure to violence and coercive control growing up, harmful use of alcohol, and stressful situations such as those being experienced during pandemic and economic instability (WHO, 2017). Crises and times of unrest have been linked to increased interpersonal violence, including incidence of violence against women and children (Peterman et al., 2020). Men can also become victims of domestic violence by their female partners (Entilli & Cipolletta, 2017). Same-sex couples are also not immune from violence with evidence indicating that the violence rate may be comparable if not higher than for heterosexual couples (Rollè, Giardina, Caldarera, Gerino, & Brustia, 2018).

The different types of violence share many underlying risk factors and important inter-relationships. For example, economic inequality, alcohol misuse and inadequate parenting all increase the likelihood of child abuse, youth violence and intimate partner and sexual violence against women. Children who suffer rejection, neglect, harsh physical punishment and sexual abuse or witness violence at home or in the community are at greater risk of engaging in aggressive and antisocial behaviour at later stages in their development, including violent behaviour as adults (Münger & Markström, 2018).

Violence against women

Violence against women (VAW) is the largest problem with regard to public health and violated human rights all over the world. Factors contributing to VAW include lower levels of women's education, gender inequality and norms on the acceptability of violence against women, male controlling behaviours towards their partners, ideologies of male sexual entitlement and low levels of women's access to paid employment. Some groups of women who are most at risk of VAW are Aboriginal and Torres Strait Islander women, young women, pregnant women, women with disabilities, women experiencing financial hardships and women who experienced abuse or witnessed domestic violence as children (WHO, 2020).

VAW can have health, social and economic consequences (WHO, 2017). Some major health problems from VAW are suicide, injuries, unintended pregnancies which result in various health reproductive issues, human immunodeficiency viruses (HIV), increased likelihood of miscarriage and still-birth, various mental health issues, gastrointestinal disorders, increased drug and alcohol misuse, and risky sexual behaviours in later life. The social and economic costs of VAW can widely affect society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

RATIONALE

The Role of Nurses in Managing Domestic and Family Violence

Readiness to help

As frontline health professionals, nurses are the major group to whom patients want to disclose any health problems caused by domestic and family violence. Nurses are key persons for intervention for DFV. However, literature shows that they often have a problem with 'readiness' to mitigate DFV. When patients do disclose, there is evidence that health professionals often lack the essential skills and experience to respond appropriately (Hegarty et al., 2020). As a result, only a minority of women, men and/or children exposed to DFV are recognised in health care settings.

Literature shows that readiness to address DFV is also influenced by having a personal commitment to the violence issue. This commitment could arise through having a personal experience of DFV in their home life or family or through adopting a feminist-like or human-rights-informed ideological conceptualisation of DFV (Entilli & Cipolletta, 2017). Further, a commitment can arise through possessing a strong belief that the best interests of patients must be held as paramount.

It is a professional mandate for nurses to care for the wellbeing of patients. The Code of Conduct of Nurses in Australia requires nurses to provide safe, person-centred, evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals (Nursing and Midwifery Board of Australia, 2018). Furthermore, the International Council of Nurses (ICN) Code of Ethics for Nurses gives nurses the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations (ICN, 2012). All nurses should observe their professional code of conduct and ethics in their practice, which also include to be ready to mitigate DFV at all times when they engage with people who have experienced violence (Ali & McGarry, 2018).

On the other hand, evidence has focused on barriers to patients disclosing (shame, being judged or not believed, and confidentiality concerns) or barriers for health practitioners' identification (insufficient time or skills, feeling overwhelmed by the emotional nature of the work or their own DFV experience) (McLindon, Humphreys, & Hegarty, 2018) or facilitators to identification (information, screening tools, skills training, support) (Entilli & Cipolletta, 2017). All these barriers need to be well addressed in order to enable nurses to identify and manage patients experiencing DFV.

A Routine Procedure

Asking about DFV should be part of a normal assessment process for nurses and other health professionals. This is important especially if nurses recognise and witness signs of patients experiencing abuse and violence. Patients suffered from DFV often present psychological and physical indicators (Royal Australian College of General Practitioners, 2014). Psychological indicators can be insomnia, depression, suicidal ideation, anxiety symptoms and panic disorder, somatic symptom disorder, post-traumatic stress disorder, eating disorders, and drug and alcohol abuse. While physical indicators can involve obvious injuries (especially to the head and neck), bruises in various stages of healing, sexual assault, sexually transmitted infections, chronic pelvic pain, chronic abdominal pain, chronic headaches, chronic back pain, numbness and tingling from injuries, and lethargy.

Broaching the subject of violence with women should become part of routine practice to disclose health problems caused by it. This can be part of the general procedure to inquire about mental health, to complete comprehensive patient histories and as part of the intake process (Rollè et al., 2018). The main purpose is to increase awareness of abuse and violence, including addressing the problem more universally or routinely in a clinical setting. If verbal communication is an issue, a questionnaire could be a practical tool (Anderzen-Carlsson et al., 2018). It should be short and easy and the time and place for initiating a talk about this sensitive topic must be carefully chosen.

Lack of education and training

A lack of education and training on DFV are common barriers nurses experience in implementing domestic violence screening. Literature points to an interpersonal or intimate nature to screening for domestic violence that is unique and may require highly interactive training throughout pre-licensure education and work orientation (Wyatt, McClelland, & Spangaro, 2019). Training should assist nurses to provide non-judgemental support to women experiencing domestic violence whether women acknowledge the abusive relationship or not (Di Giacomo, Cavallo, Bagnasco, Sartini, & Sasso, 2017; Francis, Loxton, & James, 2017). Specialised training might be required as there is a need for interpersonal, trusting, and relationship skills between nurses and patients to have a successful screening for domestic violence (Baird, Saito, Eustace, & Creedy, 2018). Training should provide adequate information and guidance for nurses on what to do and who they can refer DFV cases to. For example, contact a hotline number to report DFV cases (Australian Federal Police (AFP), 2020), provide toolkits and/ or applications for organisations and workers in various sectors on how to deal with DFV cases (National Sexual Assault Domestic Family Violence Counselling Service (1800RESPECT), 2020) and provide referral to other DFV support services.

KEY PRINCIPLES

- ACN is committed to supporting nurses to better understand the complexities that surround DFV.
- ACN is committed to working with organisations that employ nurses and support groups to ensure nurses are informed and educated about DFV and aware of the support available within the local community and the referral pathways.
- Nurses should undertake all care and referrals in a timely manner prioritising consent, safety, trust, and choice for women. Best practice is individualised care for the person affected by family, domestic and or sexual violence.

In the workplace, ensure the following principles are addressed:

Culture

- provide a supportive, flexible and safe workplace for staff subjected to or affected by DFV
- be respectful of differences, including gender, sexuality, culture, religion, age and ability
- work to embed a widespread acknowledgement that DFV is unacceptable anywhere at anytime

Communication

- raise awareness of DFV and support of the national strategy.
- provide access to information about DFV including the support options available through external agencies.

Training

- encourage staff to undertake relevant and targeted training to build effective skills to support people subjected to or affected by DFV in a compassionate and culturally appropriate manner.
- Leaders at all levels of nursing should learn how to build engagement and create a department-wide supportive culture around the unacceptable nature of DFV.

Support and Referrals

- maintain and coordinate support services to best meet the needs of people affected by DFV.
- refer those subjected to or affected by DFV to appropriate service providers.
- maintain up-to-date information about external service providers to ensure referrals are appropriate.

Policy

- examine policies regularly to ensure that they are appropriate and flexible and meet the needs of people subjected to or affected by DFV.

INDICATORS OF SUCCESS

- evaluation of success in relation to preventing and responding effectively to domestic and family violence is challenged by the difficulties of ensuring robust and reliable data. Success will be indicated by:
  - whether those subjected to DFV feel supported
  - greater knowledge about the causes and consequences of DFV
  - increased help seeking behaviours by people subjected to or affected by DFV
  - a growing understanding that DFV are unacceptable anywhere.

ACN'S RECOMMENDATIONS

Acknowledging the critical role of nurses in identifying people who are potential victims or victims of DFV.

- Health organisations provide education and training for all nurses and ongoing support to provide them with the confidence and competence to identify and support women experiencing DV or the potential for DV.
- Health organisations must support DV education through four themes: training inclusive of; educational and training experiences, identification of DFV, curriculum and communication skills for nurses (Alshammari, McGarry, & Higginbottom, 2018).
- Health organisations must network with support groups, representative and stakeholders for establishing multi-agency guidelines and awareness.
- Health organisations must develop policies to support an integrated coordinated care approach for patients experiencing DFV requiring support through leadership, clinical protocols, tools, infrastructure/ resources, environments, data systems for feedback and a supportive culture (Rollè et al., 2018).
- Health organisations must provide education for nurses regarding the development and implementation of health services policies and guidelines inclusive of referral pathways for women to community and government agencies.
- The Australian government and non-government stakeholders must formulate and implement national policies and processes that reflect best practice and align with national strategies. A coordinated multi-agency approach is vital to preventing and responding to DFV.
- Government must invest in a digital platform that reliably reports on specific population groups, and to identify key drivers of DFV, such as mental health, drug and alcohol use and vulnerable groups.
- Government must invest in a standardised dataset that enables incidents to be captured across different settings and also to assess the impact and outcomes for victims.
- Government must invest in research into DFV prevention, detection, and management especially within the most vulnerable communities, working with community members.

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