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Inquiry into Domestic and Family Violence—Policy approaches and responses

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Domestic and Family Violence – Policy Approach and Responses

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MAIN POINTS

Prevention is a National Priority Area ONE for the current Third Action Plan of the National Plan to Reduce Violence Against Women and Children;

1 in 5 mothers experienced emotional and/or physical abuse by an intimate partner in the first 12 months postpartum;

Over recent years in the ACT - TWO women with infants were murdered;

1 in 4 mothers experienced family violence in the first four years after having their first child;

The birth of an infant is a 'critical life stage that is often experienced as overwhelming';

Early years health practitioners are key touchstone between women their families and the health and welfare systems;

There is a common expectation of equal or egalitarian family while there are continuing trends towards gendered roles.

Substantial eight nation study conducted by the European Commission *Transitions* (2006) concluded that the Transition to Parenthood was a 'critical tipping point on the road to gender equality';

RECOMMENDATIONS

Expand and develop Baby Makes 3 program - need for practitioners to strengthen core couple relationship during the early years after the birth of an infant so as to facilitate communication and cooperation;

Need for professional development training for midwives, Maternal and Child Health Nurses and GPs so practitioners might assist women and men to identify and alleviate violence within families;

ACT Primary Health Network to coordinate communication and collaboration and to deliver information across the health sector;

Need for funding to run volunteer peer support programs for young families in the ACT (for example: Family Connect (NSW), Good Beginnings, Benevolent Society).

Overview

Couples are under significant pressure particularly during the early years after the birth of an infant. There has been evidence since the 1990s of a spike in violence during pregnancy and early parenthood, an outcome that has been backed up by more recent research conducted by the Murdoch Children's Research Institute (2015). This study found that 1 in 5 mothers (20%) experience emotional and/or physical abuse by an intimate partner in the first 12 months postpartum, and one in four mothers (25%) experience family violence in the first four years after having their first child.[1] Figures such as these highlight the need for **Prevention** programs which are the National Priority Area ONE for the current Third Action Plan of the National Plan to Reduce Violence Against Women and Children.

There is a need for the ACT government to catch-up in this regard. The *Garfield Report* identified early intervention and **prevention**, including the need for training of frontline workers, supported playgroups, home visiting, social support programs and the role of maternal health workers. However, the report's emphasis was on early intervention in terms of DV Crisis Services and victim support. This trend was highlighted in the following *Domestic Violence Service System Final Gap Analysis Report*, which described the ACT services as 'fragmented and crisis driven'.

The ACT *Safer Families Report* highlighted the use a public health model that focused on universal support for all families with more intensive or targeted responses for families that need additional support. In this regard the *Final Gap Analysis Report* recommended the training of front line workers including: midwives and maternal and child health nurses; practitioners who can promote communication and cooperation within families. An extensive body of research demonstrates that the strength of the core couple relationship during the early years significantly contributes to positive outcomes for all. These are skills that are delivered through evaluated programs such as **Baby Makes 3.**[2] This program has been expanding over recent years throughout Victoria; you can see an overview here. Furthermore, the current program manager, Ania Thomas at Carrington Health, said that they have been developing the program to apply a cultural and safety lens to the material. The focus has been on Aboriginal families and specific CALD communities (Arabic speaking and South Asian).

The ACT program *Relaxing into Parenting* program includes a version of Baby Makes 3. Over a two year period the program serviced 195+ clients but the past director of the program Emma Baldock commented that there was a need to include a great diversity of families, including CALD, indigenous and those from the disability sector.

Interventions by health and welfare practitioners can be supported by a Volunteer Family Connect program to assist struggling families. Programs along these lines have been operating in Queensland and recently expanded in New South Wales. The evaluation found a positive outcome for families, for volunteers and in terms of community building.[3]

The ACT Primary Health Network has the potential to promote cross-sector cooperation, by both circulating information and program details.

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[1] Murdoch Children's Research Institute, 2015. *Policy Brief 2: Health consequences of family violence – Translating evidence from the Maternal Health Study to inform policy and practice*, Melbourne.
[2] Keleher H & Hutcheson E, 2016. *Baby Makes 3: Final Report*, Keleher Consulting for Carrington Health, Vic.
[3] Rebekah Grace et al., 2016, *Volunteer Family Connect: Strengthening families and communities through Volunteering Pilot Study Findings* (joint university and NGO project).

1. Need for early intervention and prevention

Though there are recognised difficulties in determining the frequency of domestic violence in pregnancy[4] and further to the earlier referenced study by the Murdoch Children's Research Institute the first major report by the Australian Bureau of Statistics, *Women's safety Australia* (1996) found that nearly one half of women who had disclosed they had experienced abuse within a relationship, experienced violence during pregnancy; the violence began during pregnancy for one half of this group. Evidence also indicates that homicide was the cause of death during pregnancy and childbirth for 5% of women.[5] A paper by Angela Taft'[6] said that between 4 to 8 or 9 in every 100 pregnant women are abused. Though, she added, there are difficulties around disclosure and screening. She also noted the existence of overseas evidence on a link between pregnancy and homicide.

Links between motherhood and domestic violence are made clear by **Elspeth McInnes**.[7] Two important sources McInnes drew on were the Australian Bureau of Statistics and a study conducted by the National Council of Single Mothers and their Children, which included interviews with 36 respondents. The 1996 ABS figures showed that 42% of women who had experienced violence by a former partner were pregnant at the time; of these 20% experienced violence for the first time when they were pregnant. Forty-six percent of women who had experienced violence by a former partner had children in their care; furthermore 61% of women who had experienced violence by a current partner during the relationship, had children in their care. She found that violence was a critical factor impacting on the population of single parents in South Australia. The **Spark Resource Centre** (working with single mothers) identified 70 to 80% of their clients as survivors of violence and these families had to deal with a Family Court that granted child access to fathers who were the perpetrators of violence.

Anne Morris[8] identified a process which she labelled 'maternal alienation' that can be used by violent men within their families so as to alienate children from their mother. Women can become isolated from sources of support. These men become skilled at convincing her family, the neighbours, the children's school, and any professionals involved with the family that she is mad or bad. People and services involved with the mother and/or children can make a positive difference in this regard if they support the mother to help her rebuild her relationships with her children. This enables her to support and protect her children in the future, as well as helping her overcome the effects of violence and abuse herself. The latest research points out that good practice for better child protection should be built on supporting the mother, not blaming or punishing. Morris concluded that maternal alienation became possible because of a privileging of the male voice and extensive mother blaming within cultural discourses and in families.

Noel Cazenave and M. Zahn[9] drew on a study of 83 homicide cases; 42 male and 41 female victims. The authors refer to a quote from Del Martin in *Battered wives* which stated that the

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[4] - due to problems with working definitions and lack of medical screening - Walsh, Deborah, 2000, 'Domestic violence in pregnancy', Domestic Violence and Incest Resource Centre Newsletter, no. 1

[5] Murdoch Children's Research Institute, et al.

[6] Taft, Angela, 2002, 'Violence against women in pregnancy and after childbirth: current knowledge and issues in health care responses', Domestic and Family Violence Clearinghouse, Issues paper, no. 6

[7] McInnes, Elspeth, 2001, 'Single mothers, social policy and gendered violence', paper presented to 'Seeking Solutions' domestic violence and sexual assault conference, Gold Coast

[8] Morris, Anne, *'Maternal Alienation: the use of mother blaming in abuse'*

[9] Cazenave, Noel, Zahn, M., 1992, 'Women murder and male violence', in Intimate Violence: interdisciplinary perspectives, (ed) E. C. Viano, Hemisphere Publishing Corp., Washington

ultimate cause of wife beating is sexual inequality. Wife beating will persist as long as there are unequal power relations between men and women and violence can be used to further tip the scale in favour of male supremacy. Male homicide was a result of self-defence in 18 of the 41 cases and female homicide the result of women attempting to end a relationship in 12 out of the 41 cases. The main findings were that 53 out of 58 of the cases (91%) were initiated by male physical violence. The researchers concluded that many of the murders were gender specific, males tending to be the initial aggressor and female homicide tended to be the result of male offenders' desire for the maintenance of the gender-based status quo. Interestingly, the study did not directly report on whether there were children in the family but all of the specific reports included references to children being present.

Joyce McCarl Nielson set out to test a proposition of **Dobash and Dobash**[10] that social isolation is linked to wife abuse. The paper was drawn from two separate studies and she concluded that isolation seemed to both precede and result from battering. The relationship could be explained in two ways – a lack of monitoring relationships (friends and family) and a desire for social control.

The 'Our Watch' campaign argues that gender inequality underlies domestic violence and they highlight the **'Baby Makes Three'** program that works with families during the early years after the birth of a child so as to promote respect, communication and equality within families. Furthermore, the Australian Research Alliance for Children and Youth (ARACY) argues for early intervention and family support.[11] Though the evidence is compelling these early years services remain inadequate and patchy across Australia.

The *National Plan to Reduce Violence Against Women and Children* focused on the significant part played by health professionals, in particular the early years practitioners who work with women and their families. As a means to prevent domestic violence within the relevant literature, there is a recognition of the need to promote communication and respectful relationships within families. Strategies across Commonwealth, States and Territories include an emphasis on the role of health practitioners to:

- support men to take a leading role;
- to challenge discrimination and gender stereotyping;
- build equality and respect between men and women;
- and importantly promote initiatives to support men to engage in caring and unpaid domestic work.

An Australian violence prevention specialist Liz Mulder advocated health promotion as a preventative strategy.[12] Robyn Seth-Purdie also emphasised a need for:

> ... significant changes in attitudes toward partnership in marriage, responsibility for child-care, and support networks, to take the place of the extended family in relieving the stress of child-care and guarding against the development of chronic abuse. [13]

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[10] Dobash, R.E., Dobash, R., 1979, Violence against wives: a case against patriarchy, The Free Press, New York

[11] ARACY, 2015. *Better systems, better* chances: A review of research and practice for prevention and early intervention

[12] Mulder, Liz, 1999, Preventing Violence Against Women, paper presented at the Interdisciplinary Congress on Women, Tromso, Norway; Seth-Purdie, Dr Robyn, 1995, Domestic violence: in search of well-informed policy, (Australian) Parliamentary Library, Canberra

[13] Seth-Purdie, Dr Robyn, 1995, Domestic violence: in search of well-informed policy, (Australian) Parliamentary Library, Canberra

Furthermore, among the strategies suggested to prevent further violence the paper recommended:

> ... the development of a national relationship skills/parenting skills program in a range of culturally appropriate forms, to teach techniques of conflict resolution and stress management, and to raise awareness of basic human rights within the family.

This emphasis was reinforced by W. Kim Halford[14] in a paper prepared for the Department of Family and Community Services, National Families Strategy. Halford recommended the development of skills based relationship education materials and programs that prepare couples for the variety of life transitions including the transition to parenthood.

Nurses and midwives provide universal maternal, child and family health services in Australia. The *National Framework for Universal Child and Family Health Services*[15] emphasises prevention, early intervention, continuity of care, collaboration and integration of services. However, the Australian federation of states and territories has resulted in policy frameworks that differ across jurisdictions and services that are fragmented across disciplines and sectors. The congruence of the research both national and international suggests the time is right to consider the introduction of a national approach to universal maternal and child health services.

Submissions to the Victorian Royal Commission into Family Violence[16] provide for insight and direction. The **La Trobe Violence Against Women Network (LAVAWN)** drew attention to the significant role of alcohol in domestic violence. Alcohol is a factor in 50% of cases of partner violence and 73% of cases of assault. Households with children are significantly more likely to have children under five years of age. They draw attention to the lack of research on domestic violence and in particular within diverse family forms according to ethnicity, disability and sexual orientation. They found good evidence for peer support programs that included mentors, both professional and non-professional. They argued that the nurse home visitor is an important touchstone. There is, however a series of issues for nurses which include: a lack of training; lack of knowledge of support programs; discomfort for health workers; issues with language and cultural difference; there were time constraints; and issues with the presence of the partner (who may be a perpetrator). They argued a need for an improved maternal and child health service for vulnerable women and drew attention to the Vic Health 'Respect, Responsibility and Equality Program'.

2. The experience of women through the Transition to Parenthood

An international body of research on the Transition to Parenthood shows high levels of depression, high levels of marital dissatisfaction, a spike in domestic violence and significant issues related to identity for women when they become mothers today. Among the conclusions of a significant eight nation study, both qualitative and quantitative, carried out by the European Commission[17] is the proposition:

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[14] Halford, W. Kim, 2000, Australian couples in millennium three, prepared for the Department of Family and Community Services, National Families Strategy

[15] Schmied, V., 2011, idib.

[16] See: http://www.rcfv.com.au/

[17] Lewis, Suzan and Janet Smithson (ed). 2006. *Gender, Parenthood and the Changing European Workplace: Young adults negotiating work-family boundaries TRANSITIONS.* European Commission: Brussels.

> A frequently recurring theme across the countries is the ways in which gender shapes parenthood and makes motherhood different from fatherhood both in everyday family life and in workplaces. The transition to parenthood appears to be a critical 'tipping point' on the road to gender equity.[18]

This study has been followed by an extensive five year study[19] that is looking at how parenting roles are constructed by professionals, welfare states, and popular media, and will assess how cultural and institutional norms and images are perceived and realized by expecting and new parents.

The issues go deeper than access to financial resources or family support, though these are necessarily important. Men and women respond differently to the birth for reasons of life experience and expectations but also the fact that pregnancy and birth is often a profound and life changing experience. This is something that is not adequately responded to by the health services that have historically been concerned with infant health and wellbeing.

The birth of a child is 'a critical life stage' that is often experienced as overwhelming.[20] The research on the TtoP shows that attempts by many couples to achieve a form of gender equal or egalitarian families after the birth of an infant are being stifled by a 'logic of gendered choice'.[21] Tensions between gender equity and the requirement to care are most often played out through the maternal sense of self. There was a decline in the postnatal health and well-being for approximately one-third of the women interviewed for my research[22], a figure consistent with findings from research on the TtoP.[23] Accordingly the first years of parenthood were found to be associated with maternal stress, depression, marital dissatisfaction and issues related to identity. Links between stress, depression and unfulfilled expectations regarding roles and responsibilities were recognized by **Glade, Bean and Vira**[24] in their review of fifty-nine studies on Family Therapy and the TtoP. **Nystrom and Ohrling's**[25] analysis of thirty-three studies by nurses argued that there was an association between maternal self-efficacy, depression and social/marital supports, while **Cowan and Cowan**[26] found links between a failed expectation of gender equity and depression. **Golberg and Perry-Jenkins**[27] linked this outcome to an incongruence between the expectations and

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[18] Lewis and Smithson, 2006. idib.

[19] Grunow, Daniela, *Transition to parenthood: International and national studies of norms and gender division of work at the life course transition to parenthood* (see: http://cordis.europa.eu/project/rcn/96665_en.html)

[20] Perren, Sonja, Agnes Wyl, Dieter Burgin, Heidi Simoni, and Kai Klitzing. 2005. Intergenerational Transmission of Marital Quality Across the Transition to Parenthood. *Family Process* 44 (4):441-459; Perren, Sonja, Agnes Von Wyl, Dieter Burgin, Heidi Simoni, and Kai Von Klitzing. 2005. Depressive symptoms and psychosocial stress across the transition to parenthood: Associations with parental psychopathology and child difficulty. *Journal of Psychosomatic Obstetrics and Gynecology* 26 (3):173-183; Glade, Aaron, Roy Bean, and Rohini Vira. 2005. A prime time for Marital/Relational Intervention: A review of the transition to parenthood literature with treatment recommendations. *The American Journal of Family Therapy* 33:319-336; Golberg, A.E., and M. Perry-Jenkins. 2004. Division of labor and working-class women's well-being across the Transition to Parenthood. *Journal of Family Psychology* 18 (1):225-236; Nystrom, K, and K Ohrling. 2004. Parenthood experiences during the child's first year: literature review. *Journal of Advanced Nursing* 46 (3):319-330.

[21] Singley, S G, and K Hynes. 2005. Transitions to parenthood - Work-family policies, gender, and the couple context. *Gender & Society* 19 (3):376-397.

[22] Garvan, J. 2010. *Maternal ambivalence in contemporary Australia: navigating equity and care,* ANU, PhD thesis see: www.maternalhealthandwellbeing.com

[23] McHale, J P, C Kazali, T Rotman, J Talbot, M Carleton, and R Lieberson. 2004. The transition to coparenthood: parents' prebirth expectations and early coparental adjustment at 3 months postpartum. *Development and Psychopathology* 16:711-733.

[24] Glade, Bean and Vira, 2005, idib.

[25] Nystrom & Ohrling, 2004, idib.

[26] Cowan & Cowan, 1998, idib.

[27] Golberg & Perry-Jenkins, 2004, idib.

the experience, and an ambivalence between a right to express discontent and the status quo. The researchers often went on to reflect on a need to review expectations and/or strengthen the couple relationship by way of overcoming these shortfalls, individual rather than structural change.

This period has been said to be followed by a trend towards 'traditional' gender roles whereas there is evidence to suggest that the use of traditional as an analytic category is in question. The basis for this characterization has been that men often work longer hours and the vast majority of women take on a greater load of the household and childcare duties, even if they too are working full time.[28] This assertion is descriptive rather than analytical. There is a vast array of literature to show that women are doing more housework than men, even if they have children and are working full time, but this is generally followed by evidence of raised levels of stress and/or depression; an unfulfilled expectation that they would have shared both the care and the housework.

A distinction between childcare and housework is useful in this case. The quantity of housework expands during this period, with many of the tasks related to the care of the infant/child. The negotiation of this work coupled with the prime responsibility for care contributes to maternal stress. The women interviewed for my doctoral thesis[29] were not taking time out from the workforce to attend to the housework and conform to traditional roles, but because they are concerned with the health and well-being of their infants. There has often been a reliance on 'traditional' to hold together an array of characteristics that have been associated with gendered roles, whereas in this period of change it is critical to promote strong working relationships within families.

3. Associated Research

Here below I have highlighted key points from associated documents. You will see that much of the research is Australian and where it is not I have indicated how the findings may be useful in the Australian context.

A paper by **Marion Tower et al.** (2012)[30] found that the experience of women who seek help from health and welfare professionals in response to domestic violence tends to be negative. The authors argue that there is a disconnect between women's experience of violence and how nurses construct their needs and deliver care. Particularly in light of earlier evidence of a lack of disclosure this paper provides for a way of engaging with mother's stories and thus breaking down these barriers. The authors emphasise the importance of adopting a flexible and open-minded response to women affected by domestic violence.

Leesa Hooker et al. (2012)[31] draw attention to a lack of research on DV screening in the well child setting and the study by **Spangaro** (2010)[32] highlighting the fact that much abuse

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[28] Singley & Hynes, 2005. idib.; McHale, idib.; Cowan & Cowan, idib.; Golberg idib.; Glade idib.; Maher, JaneMaree, and A. Singleton. 2004. The 'New Man' is in the house: Young men, social change and housework. *Journal of Men's Studies* 12 (3):227-240.

[29] Garvan, 2010, idib.

[30] Tower, Marion, Jennifer Rowe and Marianne Wallis, 2012, Reconceptualising health and health care for women affected by domestic violence, *Contemporary Nurse,* 42(2): 216–225

[31] Hooker, Leesa, Bernadette Ward and Glenda Verrinder, 2012, Domestic violence screening in Maternal and Child Health nurses practice: a scoping review, *Contemporary Nurse*, October, 42 (2)

[32] Spangaro, J.M., A.B. Zwi, R.G. Poulos and W.Y.N Man, 2010, Who tells and what happens: disclosure & health service response to screening for intimate partner violence, *Health and Social Care in the Community*, 18 (6)

remains hidden and that efforts are required to make it possible for women to talk about their experience and to seek help.

Rebecca O'Reilly (2007)[33] found a paucity of literature on domestic violence against women throughout the childbearing years but furthermore, she concluded that the incidence is poorly addressed by health care professionals.

Tamara Power et al. (2011)[34] found that many women privilege their mothering role over other areas of their lives, and for ill women, it can be difficult to relinquish what they see as their maternal responsibility. Mothering while ill is difficult and women facing illness may need encouragement to accept help. Nurses are in an excellent position to encourage women to identify and draw upon sources of support.

Simon Lapierre (2008)[35] argues that limited attention has been paid to the issue of mothering in the context of domestic violence and that the dominant discourse in this area has been characterized by a deficit model. He concluded there is a need for less blame and more support for women with children.

The paper by **Carolyn Frohmader** (2011)[36] draws attention to high levels of domestic violence and sexual assault of women with disabilities. Women and girls with disabilities have considerably fewer pathways to safety, and are less likely to report - yet programs and services either do not exist or are extremely limited.

An online resource on indigenous/Aboriginal experience of domestic violence in Australia, is listed under **Creative Spirits**.[37] This provides an overview of the incidence of violence and emphasises the importance of empowerment, partnership and community involvement with solutions. Another important resource in this regard is the **Australian Indigenous Health Info Net** which provides access to information, resources and more.

Two international studies that may provide useful indicators, the first from Finland and the second from Canada. **Marita Husso et al.** (2012)[38] set out to explore professional processes for making sense of violence intervention. They found a tendency by healthcare professionals to arrive at sense-making practices where it is possible to focus on fixing the injuries and bypassing the issue of violence as the cause of symptoms and injuries. The results indicate that developing successful practices both in identifying survivors of domestic violence and in preventing further victimisation requires a broad understanding of the effects of domestic violence and the challenges for health care professionals in dealing with it. There is a need for new perspectives in creating an adequate response both for victims and for professional that includes strong support at the organisational level.

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[33] O'Reilly, Rebecca, 2007, Domestic violence against women in their childbearing years: A review of the literature, *Contemporary Nurse,* 25: 13–21

[34] Power, Tamara, Debra Jackson, Roslyn Weaver and Bernie Carter, 2011, Social support for mothers in illness: A multifaceted phenomenon, *Contemporary Nurse* 40(1): 27–40

[35] Lapierre, Simon, 2008, Mothering in the context of domestic violence: the pervasiveness of a deficit model of mothering, *Child and Family Social Work,* 13

[36] Frohmader, Carolyn, 2011, Submission to the preparation phase of the UN analytical study on violence against women and girls with disabilities

[37] Creative Spirits, Domestic and Family Violence (online resource) http://www.creativespirits.info/aboriginalculture/people/domestic-and-family-violence#axzz3iaNYhKU2

[38] Husso, Marita, Tuija Virkki, Marianne Notko, 2012, Making sense of domestic violence intervention in professional health care, *Health and Social Care in the Community*, 20 (4)

The second Canadian study by **Joni Leger et al.** (2015)[39] found that programs that delivered social support by peers to postpartum depression to be promising. This approach may also be useful in the support of women who experience family violence. Leger found that interventions should be targeted and take into consideration the age of the mother, any cultural and linguistic differences, the mother's circumstances and her needs. All volunteers should receive training before providing support and be screened for their ability to commit their time. Although the results were mixed, they provide insights into how peer support volunteers can be an innovative part of a team approach to intervention. And following on from peer support programs **Lucy Paton et al.** (2013)[40] found in an Australian study that the success of intensive home visiting programs were dependent on the relationship between home visitor and the mother. The role of a trusting relationship between nurses and participants, that included shared decision making, was central to program engagement. A clear distinction was made by the mothers, in that they were engaging in a relationship, and not a program.

Resources and Links

DV Alert – online info and training

Education Centre Against Violence (NSW)

Domestic Violence – What Can Nurses Do

Family Violence Resources (Victoria)

Family Safety Framework Manual (South Australia)

Gender Equity through Health promotion

Federal Government – clinical practice guidelines DV antenatal

AWAVA

Baby Makes 3, Carrington Health

[39] Leger, Joni and Nicole Letourneau, 2015, New mothers and postpartum depression: a narrative review of peer support intervention studies, *Health and Social Care in the Community*, 23 (4)

[40] Paton, Lucy, Julian Grant and George Tsourtos, 2013, Exploring mothers' perspectives of an intensive home visiting program in Australia: A qualitative study, *Contemporary Nurse,* 43(2): 191-200