

Nurses and violence

Reviewed December 2022

KEY STATEMENT

The Australian College of Nursing (ACN) believes that as the largest health care workforce, every nurse, wherever they practice, has a role to play in the safe and appropriate identification, assessment and ongoing support of people experiencing domestic and family violence (DFV). Nurses at every level, including student nurses, need to be equipped with the necessary resources, knowledge, and skills to support victim-survivors of DFV. According to the World Health Organization (WHO), any DFV nursing activity (routine or specialised) must be trauma-informed and based on the empowerment, safety, and ongoing care of the victim-survivor (2013a, 2013b).

BACKGROUND

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.

DFV is a preventable human rights issue. Globally, the WHO estimates 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 (World Health Organization 2021a; 2013b). 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 (Orr, Fisher, Glauert, Preen & O'Donnell 2020). Children exposed to DFV, either directly or indirectly, are increasingly recognised as victims of child abuse.

To help nurses in the prevention, early identification and support of those impacted by DFV, a health system's approach is required. This includes ongoing DFV nurse education and skill development, clinical practice guidelines/protocols, capacity building, management and leadership support, and referral options (García-Moreno, Hegarty, d'Oliveira, Koziol-MacLain, Colombini & Feder 2015).

DEFINITIONS

According to the National Plan to End Violence Against Women and Children 2022-2032 (National Plan), **intimate partner violence** or **domestic violence** 'refers to any behaviour within an intimate relationship (including current or past marriages, domestic partnerships or dates) that causes physical, sexual or psychological harm' (Commonwealth of Australia 2022).

Family violence 'is a broader term than domestic violence, as it refers not only to violence between intimate partners but also to violence perpetrated by parents (and guardians) against children, between other family members and in family-like settings. This includes for example elder abuse, violence perpetrated by children or young people against parents, guardians or siblings, and violence perpetrated by other family members such as parents-in-law. Family violence is also the term Aboriginal and Torres Strait Islander peoples prefer because of the ways violence occurs across extended family networks' (Commonwealth of Australia 2022).

Often a significant part of the victim-survivors experience of violence, **coercive control**:

'describes someone's use of a pattern of abusive behaviours against another person over time, with the effect of establishing and maintaining power and dominance over them. Abusive behaviours that perpetrators can use as part of their pattern of abuse include physical abuse (including sexual abuse), monitoring a victim-survivor's actions, restricting a victim-survivors freedom or independence, social abuse, using threats and intimidation, emotional or psychological abuse (including spiritual and religious abuse), financial abuse, sexual coercion, reproductive coercion, lateral violence, systems abuse, technology-facilitated abuse and animal abuse' (Commonwealth of Australia 2022).

Throughout this position statement, the term DFV is an inclusive phrase that encompasses all aspects of intimate partner, domestic and family violence that nurses may encounter, and victim-survivors experience. As highlighted in the National Plan (2022), while men can be victim-survivors of DFV, the vast majority of victim-survivors are women and children, and the vast majority of perpetrators are men.

KEY ISSUES

ACN recognises that DFV is a health issue and advocates for robust policies to be developed and implemented to ensure all nurses have the confidence, knowledge, and skills to identify and support victim-survivors of DFV. Ensuring healthcare providers understand the nature and impact of DFV will improve attitudes and foundational knowledge to empower an improved response to DFV (Kalra, Hooker, Reisenhofer, Di Tanna & García-Moreno, 2021; McLindon, Fiolet, & Hegarty, 2021). At a minimum, nurse training must include an understanding of how to safely implement first-line support, as recommended best practice by the WHO (2014).

The WHO 'LIVES' approach includes five simple steps to protect victim-survivors.

L-Listen closely, with empathy, and without judging.

I-Inquire about needs and concerns (emotional, physical, social).

V-Validate experiences and show you understand and believe them.

E-Enhance safety and discuss a plan to protect themselves and any children from harm.

S-Support the victim-survivor by helping them connect to information, services and social support.

READINESS TO HELP

Studies demonstrate a readiness to address DFV is also influenced by having a personal commitment to mitigating violence. This commitment could arise through having a personal experience of DFV in their home life or family or through adopting a feminist or human-rights-informed view of DFV (Entilli & Cipolletta 2017). Further, a commitment can arise through a strong belief that person-centred care must be considered paramount. It is a professional mandate for nurses to care for the well-being of patients. The Code of Conduct of Nurses in Australia requires nurses to provide safe, person-centred, evidence-based practice for the health and well-being 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 states nurses have a responsibility to take appropriate actions to safeguard individuals, families, communities and populations when their health is endangered by another person (International Council of Nurses 2021). All nurses should observe their professional code of conduct and ethics in their practice, which also includes a readiness to always mitigate DFV when engaging with victim-survivors (Ali & McGarry 2018).

MANDATORY REPORTING OF DFV

DFV is considered a form of child abuse due to potential long-term damage to children's health and development. The mandatory reporting of children experiencing DFV is required in some Australian states and territories, but not all. If any child is in imminent danger, mandatory reporting laws for child abuse apply. Refer to the Australian Institute of Family Studies resource which provides specific details on each state and territory's mandatory reporting requirements regarding children and DFV (Australian Institute of Family Studies 2020).

The National Principles for Child Safe Organisations suggest risk management strategies focus on preventing, identifying, and mitigating risks to children and young people. However, these risk management strategies have implications for reporting DFV in the absence of mandatory reporting obligations (Australian Human Rights Commission 2018). Legislation and regulations that allow information sharing between authorised family violence and children's services organisations exist in Victoria and some other Australian states and territories to identify DFV risks and promote children's safety and well-being (Victorian Government 2021).

VICARIOUS TRAUMA AND SELF-CARE

As a nurse, having a lived experience of DFV is common (Dheensa et al. 2022) and may enhance nurse care for DFV victim-survivors (McLindon, Humphreys, & Hegarty, 2019). However for many, identifying and supporting victims-survivors can be confronting and distressing. This can impact the way healthcare providers respond to their patients and may lead to vicarious trauma (Royal Australian College of General Practitioners 2022). Vicarious trauma is not a sign of weakness, but is defined as a negative transformative experience in the helper. This transformation can occur due to the cost of empathetic engagement and bearing witness when working with victim-survivors with traumatic histories or exposure to traumatic material (Blue Knot Foundation 2021).

Optimising protective factors and mitigating risk factors such as minimising exposure to trauma material can reduce the potential impact of vicarious trauma. Professional boundaries are protective factors that can be challenged in this context and may be optimised through external support services such as clinical supervision (Blue Knot Foundation, 2021). This provides an opportunity for reflective practice on the experience, self-awareness, self-care, identifying the challenges of the therapeutic relationship, and boundary testing. Education can support the nurse in the prevention, early identification and in seeking treatment for vicarious trauma and reducing the impact.

POSITION STATEMENT Nurses and violence

To promote self-care, the **individual nurse and their workplace** can implement several strategies, framed by the RACGP (2022) as personal, professional and organisational awareness, balance and connection (ABC).

For **individuals**, this encompasses:

A – reflecting on your own emotional responses and be aware of signs of distress.

B – establishing professional boundaries and knowing your limits, making healthy lifestyle choices in your personal time.

C – creating workplace connections and knowing what services you can refer patients to, to share the load and foster healthy personal connections outside of the workplace.

Workplaces can also implement the ABC strategy to support the care of nurses who work with victims-survivors of DFV.

A – providing regular continuous professional development such as in-service training specific to DFV and vicarious trauma; providing debrief opportunities and offering information on external support services for staff.

B – ensuring policies are available on teamwork and referral pathways; providing a system to guide staff in managing DFV cases; ensuring the physical security of staff is in place.

C – establishing formal and informal mentoring supervision; encouraging opportunities for staff to connect professionally and socially.

In addition to the above strategies, if nurses are experiencing feelings of distress or overwhelm, talking to close friends, family members or a trusted colleague is a good place to start. Nurses can also access free and confidential counselling through their workplace Employee Assistance Service or Program, 1800 RESPECT, Lifeline (13 11 14) or access mental health supports through their health care provider.

RECOMMENDATIONS

FOR ACN TO:

1. Collaborate with other health organisations to develop policies to support an integrated coordinated care approach for victim-survivors requiring support through leadership, clinical protocols, tools, infrastructure and resources, environments, data systems for feedback and supportive culture (Rollè et al. 2018).
2. In line with the National Plan, lead advocacy efforts, in line with the National Plan, to ensure nurse who are victim-survivors are supported and protected through access to DFV leave, services such as emergency housing, food provisions, childcare and

counselling. Until nurses themselves have accessed adequate support services, they are unlikely to refer patients, even with the best training and risk assessment tools available.

3. Collaborate with existing state-based DFV providers for best practice training of health care workers (Education Centre Against Violence 2021), to develop and implement national, nursing-specific modules. Once established, this training should be mandatory to equip all nurses with the skills to recognise the patterns and warning signs of DFV; follow evidence-based risk assessment and management strategies to safely, compassionately and effectively intervene (Alshammari, McGarry & Higginbottom 2018); establish trust and communication giving the victim-survivor the confidence and resources to leave the relationship; as well as best practice referral pathways for ongoing health and social services. This will protect the victim-survivor and health care workers and prevent further escalation of abuse.
4. Advocate for every nurse to receive clinical supervision, particularly for those working in services most likely to encounter victim-survivors of DFV, such as general practice, emergency and family planning. This clinical supervision should be underpinned by the RACGP ABC strategy.

FOR THE AUSTRALIAN GOVERNMENT TO:

1. Invest in a national, de-identified digital platform that reliably reports on specific population groups, and identifies key drivers of DFV, such as gender inequality and reinforcing factors like alcohol and drug misuse. This standardised dataset would enable incidents to be captured across different datasets and allow a more holistic assessment of the impact and outcomes for victim-survivors.
2. Continue to fund Australia's National Research Organisation (ANROWS) to conduct long-term research into frontline DFV prevention, detection, and management in collaboration with the health care and services sectors, as well as affected communities.
3. Consider establishing a Medicare item number for a family violence wraparound package of care including counselling and therapeutic services distinct from a general practitioner mental health treatment plan. This would be similar to the existing Obstetrics item numbers 16590, 16591, and 16407, but available across all areas of health care and would allow medical and nurse practitioners to record a DFV-related consultation or procedure.
4. Ensure mandatory reporting of children experiencing DFV is uniform across Australia and that the information is transparent and shared across jurisdictions.

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Associate Professor Leesa Hooker MACN – Chair

Dr Catriona Booker FACN

Dr Elizabeth Emmanuel FACN

Sharan Ermel MACN

Dr Renee Fiolet MACN

Associate Professor Rebecca O'Reilly MACN

Dr Jacqui Pich MACN

Victoria Roberts MACN

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Adjunct Professor Kylie Ward FACN – CEO Australian College of Nursing

Ms Linda Davidson FACN – ACN National Director of Professional Practice

Dr Jacqui Hoepner – Manager of Policy and Advocacy

Dr Carolyn Stapleton FACN – ACN Director of Policy and Advocacy

Dr Penelope Wilson – ACN Policy Strategist

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