Nurses and violence

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KEY STATEMENT

The Australian College of Nursing (ACN) is committed to ensuring nurses are equipped to safely and compassionately mitigate, manage and prevent domestic and family violence (DFV) in the community as they engage with those affected by violence. This may be when victim-survivors specifically seek support for DFV-related health concerns, or in the course of routine or preventive health care such as cervical or breast screening.

Nursing is a female dominated profession, and as such ACN recognises that nurses may also experience DFV in their own lives. Nurses provide non-judgmental, compassionate care to all, including women and families, and deserve the same kind of respect themselves. ACN encourages nurses who are experiencing DFV to seek support and assistance.

ACN views DFV as unacceptable under any circumstances. Access and equity to support and care for those affected by DFV should be provided as a basic human right.

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 age, gender, race, religion, ethnicity, culture and socioeconomic and demographic groups, but predominantly affects women and children.

Globally, the World Health Organization (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, who may be victims or witness violence against family members. Children witnessing, or being exposed to, DFV are increasingly being recognised as victims of child abuse. DFV is a preventable human rights issue.

Definitions

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' (World Health Organization 2002).

Family violence refers to 'violence between family members, as well as between intimate partners. It involves the same sorts of behaviours as described for domestic violence but includes the broader range of marital and kinship relationships in which violence may occur. For this reason, it is the most widely used term to identify the experiences of Aboriginal and Torres Strait Islander peoples, as it captures the broader issue of violence within extended families, kinship networks and community relationships, as well as intergenerational issues. Family violence is also a relevant term when referring to complex forms of violence where family and in-laws, as well as other family members of the abusive spouse, can both arrange for violent acts to be committed against the victim-survivor or are themselves abusive toward the victim' (Department of Social Services 2019, p. 62)

Domestic violence refers to 'acts of violence that occur between two people who are, or were, in an intimate relationship. It includes physical, sexual, emotional, psychological and financial abuse. While there is no single definition, the central element of domestic violence is behaviour motivated by gendered drivers of violence that can involve controlling a partner through fear, coercion and intimidation — for example by using behaviour that is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal' (Department of Social Services 2019, p. 56). Domestic violence is sometimes called 'intimate partner violence'. To date, data collection within culturally and linguistically diverse (CALD) communities has been poor resulting in incomplete information about DFV within CALD communities (Victorian Family Violence Data Collection Framework 2019). The Royal Commission into Family Violence (2016) states 'the experience of violence and the service response to it can vary markedly for different ethnic and cultural communities.'

The Report identifies issues such as social isolation and cultural attitudes as factors which enable domestic and family violence to be exacerbated and under-reported within CALD communities.

Sexual violence refers to 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim-survivor, in any setting, including but not limited to home and work' (World Health Organization 2002, p. 149).

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 around 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 (World Health Organization 2020). Some groups of women at highest 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 DFV as children (Australian Institute of Health and Welfare 2018).

VAW can have health, social and economic consequences (World Health Organization 2017). Some major health problems from VAW are suicide, injuries, unintended pregnancies which result in various reproductive health 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 (World Health Organization 2021). 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.

Coercive control, sometimes referred to as 'intimate terrorism' is a term used to describe the ongoing, insidious nature of domestic and family violence (DFV), particularly where the abuse is not physical, but pervades the victim-survivor's everyday life (Myhill & Hohl, 2016). Due to the often subtle nature of coercive control, it can be particularly difficult for bystanders to identify warning signs without tailored training (Australian College of Nursing, 2021).

KEY ISSUES

As frontline health professionals, nurses are best placed to recognise and safely intervene in instances of DFV. However, there are several barriers currently limiting the ability for nurses to provide best practice support to those experiencing DFV.

Readiness to help

Literature suggests nurses often have a problem with 'readiness' to mitigate DFV. When patients do disclose, there is evidence 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 children exposed to DFV are recognised in health care settings.

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 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 (International Council of Nurses 2012). All nurses should observe their professional code of conduct and ethics in their practice, which also include readiness to mitigate DFV at all times when engaging with victim-survivors (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 2020) or facilitators to identification (information, screening tools, skills training, support) (Entilli et al. 2017). All these barriers and enablers need to be considered in order to equip nurses to identify and manage patients experiencing DFV (see Table 1).

Table 1.
Barriers and enablers to disclosure and identification of DFV.

Barriers to patients' disclosing	**shame, being judged or not believed, and confidentiality concerns**
Barriers for health practitioners' identification	**insufficient time or skills, feeling overwhelmed by the emotional nature of the work or their own DFV experience**
Facilitators to identification	**information, screening tools, skills training, support**

Not routine procedure

Asking about DFV should be part of a normal assessment process for nurses and other health professionals, particularly where nurses recognise signs a patient may be experiencing abuse and violence. Currently, health care workers can use risk assessment and screening tools such as the 'HITS' tool (hurt, insult, threaten, scream) (Sherin et al. 1998) and 'HARK' (humiliation, afraid, rape, kick) (Sohal, Eldridge & Feder 2007). While tools such as HITS and HARK provide relatively effective screening for signs of physical violence (Iverson et al. 2013), they may not adequately equip nurses and other health care professionals to recognise the warning signs of non-violent forms of DFV, such as coercive control (Australian College of Nursing 2021).

Victim-survivors of 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. Physical indicators can include 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 the health problems it causes. 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 (Carlsson et al. 2018). It should be short and easy and the time and place for initiating this conversation must be carefully considered. It should be noted that CALD women may be accompanied by their abuser, acting as interpreter and effectively preventing report of the abuse. In these cases, finding a reason to send the suspected abuser on a task while talking with the woman can be an effective way to create trust (Hegarty et al. 2020). Insisting on a few days stay in hospital might allow the woman to consider her next steps within a safe environment (Dawson et al. 2019).

Lack of education and training

A lack of education and training on DFV are common barriers nurses experience in implementing DFV screening. Literature suggests the intimate nature of DFV screening is unique and may require highly interactive training throughout pre-licensure education and work orientation (Wyatt, McClelland & Spangaro, 2019, State of Victoria, 2016). Training should assist nurses to provide non-judgmental support to women experiencing DFV whether women acknowledge the abusive relationship or not (Francis, Loxton & James 2017; Di Giacomo et al. 2017). Specialised training might be required as there is a need for interpersonal, trusting, and relationship skills between nurses and patients to successfully screen for DFV (Baird et al. 2018). Training should provide adequate information and guidance for nurses on what to do and who they can refer DFV cases to. For example, providing a hotline number to report DFV cases (Australian Federal Police, 2020), toolkits and/ or applications for organisations and workers in various sectors on how to deal with DFV cases (1800RESPECT National Sexual Assault, Domestic Family Violence Counselling Service, 2020) and referral to other DFV support services. Training should be ongoing (NSW Parliament 2021)

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/ resources, environments, data systems for feedback and a supportive culture (Rollè et al. 2018).
2. Lead advocacy efforts to ensure nurses 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. Through the Nurses and Violence Taskforce, join leading advocacy groups in promoting a nationally consistent definition of DFV that acknowledges the insidious, devastating impact of DFV, even where no signs of physical violence are present such as coercive control.
4. 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 and screening tools across all health care settings. 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.
5. Advocate for change and support work that will improve the capacity of the primary health care system to respond to DFV, increasing access to counselling, and exploring options to improve data collection about DFV in general practice and primary health care settings.

For government to:

1. 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.
2. Invest in a national digital platform that reliably reports on specific population groups, identifies key drivers of DFV, such as mental health and drug and alcohol abuse.
3. Develop a standardised dataset that enables incidents to be captured across different datasets and to assess the impact and outcomes for victim-survivors.
4. Provide long-term funding for research into DFV prevention, detection, and management especially within the most vulnerable communities, working with affected communities.
5. Consider a Medicare item for DFV counselling in recognition of its importance for a victim-survivor's recovery.
   a. Short term: Australian Government to consider 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.
   b. Long term: consideration to be given to establishing a Medicare item number or a similar mechanism that will allow medical practitioners to record a DFV-related consultation or procedure and so more accurately ascertain the public cost of DFV.

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