

INTERNATIONAL NURSES' DAY 2001

**Nurses, Always There for You:
United Against Violence**

Anti-Violence Tool Kit



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Anti-Violence Tool Kit
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Nurses, Always There for You: United Against Violence

“Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect.”

ICN Code of Ethics for Nurses, 2000

Dear Colleagues,

Violence is a major public health problem that is overtaking infectious diseases as the main cause of morbidity and premature mortality worldwide. Violence also represents a serious threat to individual human rights, as it undermines health, the right to life and the right to be treated with respect. From the home, to the workplace, to the streets, violence is a public health threat that must be rooted out.

Each year, more than 2 million people die as the result of injuries due to violence. Many more survive their injuries but remain permanently disabled. Among persons 15 to 44 years of age, interpersonal violence is the third leading cause of death. In addition to injuries and death, violence can result in a wide variety of other health problems. These include profound mental health consequences, sexually transmitted diseases, unwanted pregnancies, and behaviour problems such as eating and sleeping disorders.

For nurses violence is an all too familiar syndrome – in both our professional and personal lives. Professionally, nurses deal with the terrible outcomes of violence in caring for victims on the job. Nurses are threatened with violence themselves in the workplace. In fact nurses are three times more likely to experience violence than other professionals. And because most violence is perpetrated against women, as a female dominated profession, individual nurses are frequently victims of violence in their personal life.

ICN is pleased to announce a new partnership with the World Health Organisation, the International Labour Organization and Public Services International, to roll out a broad based anti-violence campaign. The top target of this campaign is the elimination of violence from the health sector workplace. Following an up-to-date and comprehensive analysis of the problem, the campaign aims to develop an inventory of best practices from different countries, and to produce guidelines and training materials for the education of policy-makers, employers, workers and the public.

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This year's IND theme and actions are an important part of this worldwide anti-violence campaign. Our IND kit is intended to provide tools and information to assist and encourage national nurses' associations to mount zero-tolerance, anti-violence campaigns in their workplaces, communities, countries and regions. The kit provides fact sheets addressing different aspects of violence, offering comprehensive information on which to base a public anti-violence campaign. You will also find an information rich and graphically powerful poster, which we hope you will post in public areas throughout your community. Action ideas, facts and figures, and sample media materials complete the tool kit for this important initiative.

We are certain that your association will develop further ideas and materials and we ask that you share them with us. Communicating your best practices and successful strategies will contribute greatly to the worldwide effort to eliminate violence. Nurses, as those health care professionals closest to people in all settings of society, can have a powerful effect in reducing violence and promoting a culture of non-violence.

Sincerely,

Kirsten Stallknecht
President

Judith A Oulton
Chief Executive Officer

NURSES ALWAYS THERE FOR YOU: UNITED AGAINST VIOLENCE

Introduction

The 2001 International Nurses' Day kit aims to provide comprehensive information, concrete suggestions for action, and public relations tools to assist nurses and other health care providers to inform and engage the community in reducing violence.

The main information document is organised into four chapters, each addressing a different aspect of the syndrome of societal violence:

- **Chapter One: Violence: A Preventable Disease** This provides an overview of violence, definition, cost and risk factors and puts forward a strategy of a public health approach to the prevention of violence.
- **Chapter Two: Domestic Violence** In reviewing the specific issue of domestic violence, this chapter reviews the spectrum of domestic violence, its often predictable cycle, the health consequences and puts forward possible interventions for nurses and health care providers.
- **Chapter Three: Violence in Health Care Settings** Incidence of violence in health care settings is unacceptably high. This chapter outlines the various expressions of violence in these settings, identifies risk factors and offers advice for prevention and control of violence.
- **Chapter Four: Preventing Violence** See here for how nurses and other health care providers can take concrete steps to prevent violence and promote a culture of non-violence.

Other tools provided here include:

IND activities: an extensive list of possible initiatives and activities that individual nurses and national nurses' associations can undertake in the fight against violence.

Template for a community resource handout: a document suggesting the sorts of resources and contacts you can bring together in an easily produced document to be distributed to the public.

Template media materials: a sample press release and fact sheet on violence provide examples of how you can reach out to the media in order to raise public awareness and develop community solidarity against violence.

ICN Guidelines on Coping with Violence in the Workplace

ICN Position Statement on Violence

Introduction

Violence - being destructive towards another person - is a major public health and human rights concern. It is a leading cause of morbidity and premature mortality worldwide that has increased dramatically in recent decades. Apart from civil conflict and war, violence can be interpersonal, self-directed, physical, sexual and mental, including acts of exclusion. This global epidemic has been neglected, and the social response has more often been reactive rather than preventive.

Violence is a serious problem requiring coordinated action by multiple sectors. Too often violence is seen as a matter for the police and justice system, to the exclusion of the health professionals. However, it must be recognised that violence is a preventable disease, and of great concern to nurses and other health professionals. A recent study at a Geneva hospital pointed out that often the problem of violence is seriously underestimated by health professionals. The health care system and health care providers have particular contribution to offer in tackling violence in all its forms and settings. From the home to the work place and the streets, violence is a public health threat that must be rooted out.

Violence takes many forms that can range from child abuse and neglect, to bullying at school or in the workplace, violence against women, sexual assault, rape, elder abuse or homicide. The impact of physical violence, verbal abuse and sexual harassment is of great concern in view of its prevalence and extremely negative consequences including physical injury or death, depression, overwhelming fear, physical disorders (e.g. migraine, vomiting), absenteeism, stunted growth and sexual disturbances.

A WHO Task Force on Violence and Health 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, mal-development or deprivation*"¹.

Magnitude of the Problem

Each year, more than 2 million people die as the result of injuries due to violence. Many more survive their injuries but remain permanently disabled, both physically and emotionally. There is evidence that the incidence of injuries is growing and that the health disabilities associated with them are becoming more serious for the individuals concerned, and for society at large. It is estimated that injury and violence contribute 14.5% of the burden of disease in the developed world and 15.2% in the developing world. In many countries violence is endemic and the leading cause of death among males 15-34 year age group.

Violence has traditionally been seen as the domain of law enforcement. Societal responses have primarily been of a punitive or containment nature, though in many societies violence is effectively condoned, particularly violence against women. The role of the health sector has tended to be limited to one of treatment and disability prevention, and damage control. The health sector has played little role in violence prevention, and even less to comprehensive response to creating safe and non-violent environments.

Risk factors for violence

Understanding of risk factors is important in reducing the magnitude of violence. There is increasing evidence that violence is associated with urbanisation, family fragmentation, poverty, deprivation and social stress. Poverty is frequently directly or indirectly an underlying factor in violence. The inequities that poor people suffer, feelings of disempowerment, fear, insecurity and frustration are contributing factors to violence.²

The growing use of illicit drugs in most countries seems to be related to increase in violence. Alcohol abuse is also commonly associated with violent behaviour such as domestic violence. A significantly higher percentage of partner abuse incidents are linked to alcohol abuse³. Often media glamorisation of violence such as in films, music and magazines, is thought to contribute to violence. Societal tolerance or even acceptance of abuse and violence to settle disputes is a contributing factor. Interpersonal relationships that involve adverse social and economic hardships can lead to experience of greater rate of violence. Some of the main risk factors for violence include:

- Increased use of illicit drugs and alcohol
- Easy availability of guns and weapons of violence
- Gender inequalities and son preference
- Cultural values that glamorise violence and masculinity
- Unemployment, poverty and homelessness
- Violent programmes shown on television and movies
- Situations of armed conflict

Some Facts

Worldwide the greatest majority of victims of violence are women.

- ❖ At least one in five of the world's female population has been physically or sexually abused by a man or men at some time in their life.
- ❖ In the USA 28% of women reported at least one episode of violence from partner.
- ❖ In the developing countries one third to over one half of women report being beaten by their partner.
- ❖ In the Caribbean one in three women has been sexually abused as a child.
- ❖ 45% of women in India reported at least a single incident of violence in their lifetime
- ❖ In Philippines 47.2 % of women reported at least one incident of spousal violence in their lifetime.
- ❖ In Kenya 42% of women reported being beaten by partner.
- ❖ In Nicaragua 52% of women reported abuse by partner.

**Source: UNICEF 2000, Domestic Violence Against Women.
Innocenti Research Centre, Florence: Italy.**

Because violence is a many-faceted problem, no one professional group can effectively manage it. Combating violence requires the skills and expertise of various professionals and the support of the entire community. A multidisciplinary team should include representatives from the health sector, education, social and legal services, law enforcement, employers organisations, trade unions, NGOs and community leaders, to ensure a comprehensive approach to prevention, intervention and treatment.

The social and economic cost of violence

Violence is a major social and financial burden to the individual, the family and the community. Calculating the cost of violence is an effective way to alert policy makers to the seriousness of the problem and the importance of prevention. The cost of violence goes beyond financial loss to include loss of human potential and capacity to be productive member of society.

The emotional and mental health impact of violence includes loss of self-esteem, increased anxiety and stress, dysfunctional family life, compromised child development leading to weakened adults and the perpetuation of abuse from generation to generation.

The 'hidden' costs are also alarming. These include poor school performance due to violence, legal costs, years of life lost because of premature death, disability and long-term care.

Socio-economic cost of violence

Direct costs: value of goods and services used in treating or preventing violence	<ul style="list-style-type: none"> ▪ Health care ▪ Police ▪ Criminal justice ▪ Housing ▪ Social services
Non-monetary costs: pain and suffering	<ul style="list-style-type: none"> ▪ Increased morbidity ▪ Increased mortality ▪ Abuse of alcohol and drugs ▪ Depressive disorders
Economic effects: labour market, productivity impacts	<ul style="list-style-type: none"> ▪ Decreased labour market participation ▪ Reduced productivity ▪ Lower earnings ▪ Increased absenteeism
Social effects: impact on relations, quality of life	<ul style="list-style-type: none"> ▪ Transmission of violence to other generations ▪ Reduced quality of life ▪ Loss of self-esteem ▪ Increased stress and anxiety

Source: Adapted from Buvinic M., Morrison A.R. Shifter M. (1999), Too Close to Home: Domestic Violence in the Americas. Washington D.C. Inter-American Development Bank.

Public health approach to prevention of violence

Violence, like many other health problems, can often be prevented if approached strategically. A concerted and multi-sectoral public health approach is needed to combat it. The primary goal of a public health approach is to prevent violence, by combining defensive activities and interventions designed to promote early identification and care of victims of violence and non-recurrence of abuse. Steps in a public health approach to prevention of violence include:

1. Collect data and define the cause and the problem.
2. Identify vulnerable groups and prevention measures for each stage of their lifecycle.
3. Develop and pilot interventions to promote protective conditions and minimise vulnerability in different settings.
4. Implement interventions based on pilot results and measure outcome.

The public health approach is similar to the nursing process. It begins by defining the problem and progresses to identify risks and prevention factors, developing and evaluating interventions, and finally implementing interventions.

Though these steps are presented in series, they are likely to occur almost simultaneously. For example, information collected to define the problem may also be useful in evaluating outcomes. Similarly, information gained in programme implementation and evaluation may be used to develop new and innovative interventions.

Define Defining the problem includes delineating mortality, morbidity, and risk taking behaviours. This step includes obtaining information on the demographic characteristics of the person involved, place and time of the incident, the circumstances under which it occurred, the victim/perpetrator relationship and the severity and cost of the injuries. In other words the first step looks at who, when, where, what and how of the violent incident.

Identify The second step involves identifying risk and protective factors for violent or accident-leading behaviour and the associated injuries. While the first step examines who, when, where, what and how, the second step looks at "why" the violence took place.

Develop The third step aims at developing interventions based upon information obtained from the previous steps and testing these or other interventions. An important component of the evaluation step is to examine the impact of the interventions on health outcomes and to document the processes that contribute to the success or failure of an intervention.

Implement In the final or implementation stage interventions that have been proven or are highly likely to be effective are applied to resolve the problem. It is important to collect data to evaluate the programme's effectiveness. It is equally important to determine the cost-effectiveness of interventions.

A public health approach to this preventable disease will provide sound framework for combating violence in all settings.

Definition

Domestic or family violence describes destructive behaviours perpetrated by partners and former partners, family members, household members and other close personal relationships. It can range from physical abuse to sexual assault or rape, and psychological abuse including intimidation, harassment, damage to property, threats to kill or to harm, restraints of normal activities or freedom and denial of access to resources.^{4,5}

More often than men, women are targets of violence. They are subjected to domestic violence* that can be manifested through physical and verbal abuse, sexual harassment**, and bullying***. Certain culturally condoned traditional practices, such as female genital mutilation and female infanticide, are also considered violent acts against women. In some cultures “honour killings” of female relatives is perpetrated and even tolerated.

The United Nations Declaration on the Elimination of Violence against Women defines violence as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats such as acts, coercion, or arbitrary deprivation of liberty, whether occurring in private or public life”.⁶

Societal tolerance of such abuses has been a contributing factor to the existence of such behaviours. In many societies, wife abuse is perceived as acceptable behaviour and justified as a normal and routine part of married life. The absence of credible support systems for women victims helps perpetuate an escalation of violence.

Although reliable data on the prevalence of violence against women by their partners are scarce, especially in developing countries, a growing body of research confirms its pervasiveness. For example, 40 population-based quantitative studies, conducted in 24 countries on four continents, revealed that between 20% and 50% of the women interviewed reported that they had suffered physical violence from their male partners. In addition, surveys also indicate that at least one in five women suffer rape or attempted rape in their lifetimes.

*Domestic violence is a pattern of behaviours that may start with palpable tension and intimidation in the relationship and progresses to physical assault with injury to the woman (or man) and sometimes the children. It is a pattern of meaningful, purposeful, coercive behaviour directed at achieving control over the victim.

**Sexual harassment: any unwanted, unreciprocated and unwelcome behaviour of a sexual nature that is offensive to the person involved, and causes that person to be threatened, humiliated or embarrassed.

***Bullying is offensive behaviour through vindictive, cruel, malicious or humiliating attempts to undermine an individual or groups of employees.

Violence against women throughout the life cycle

<i>Phase</i>	<i>Type of violence</i>
Pre-birth	Sex-selective abortion; effects of battering during pregnancy on birth outcomes
Infancy	Female infanticide; physical, sexual and psychological abuse
Girlhood	Child marriage; female genital mutilation; physical, sexual and psychological abuse; incest; child prostitution and pornography
Adolescence and adulthood	Dating and courtship violence (e.g. acid throwing and date rape); economically coerced sex (e.g. school girls having sex with "sugar daddies" in return for school fees); incest; sexual abuse in the workplace; rape; sexual harassment; forced prostitution and pornography; trafficking in women; partner violence; marital rape; dowry abuse and murders; partner homicide; psychological abuse; abuse of women with disabilities; forced pregnancy
Elderly	Forced "suicide" or homicide of widows for economic reasons; sexual, physical and psychological abuse

Child Abuse

Child abuse is a major unrecognised problem, impairing the health and welfare of children and adolescents. Consequences are often immediate, impinging on the formative years, and long lasting, following victims throughout their lives.

Hundreds of millions of the world's children face violence, including the threat of death, each day in their social, educational, economic and family situations. It happens quite openly in many societies. Children are exploited by industries looking for cheap labour, they are sexually exploited, used as cannon fodder in wars and as a source of human organs. They are chained up, pushed out of society and schools and deprived of even the most basic health care, despite a host of national and international laws in their favour. They survive as best they can, but it is not surprising that they often go on to treat others as they have been treated themselves⁷.

Child abuse prevention is an issue in which health and related professionals need to take on the full responsibility of their role in identifying and treating victims and preventing its occurrence. Policy makers should be involved at an early stage to ensure commitment. Efforts to prevent child abuse must be developed in partnership between governments, civil society, non-governmental organizations, international organizations, universities, community groups, and scientists. The prevention of child abuse should be integrated into existing efforts to prevent and combat other forms of violence, including domestic violence against women.

The United Nations Convention on the Rights of the Child must form the basis for actions against child abuse. The Convention sets out the rights of children and is the most widely ratified of all United Nations conventions.⁸

Domestic violence goes largely unreported or underreported due to cultural acceptance of abuse, fear of retaliation, shame and stigma, and lack of safe shelters for victims of violence and their families.⁹

The Cycle of Violence

Domestic violence involves repeated and increasingly severe assault. Victims often include children. Even when children are not directly victims of violence, witnessing violence in the home can adversely affect their emotional development and mental health. Domestic violence frequently follows a three phase cycle that include the following:

- ❖ **Tension building phase:** This phase involves abusive incidents such as slapping or verbal abuse. The victim tends to deny that abuse is happening and attempts to control the situation. The victim may even feel responsible for the behaviour of the abuser and self-blame for causing the violent behaviour. Both partners try to maintain equilibrium, with the victim behaving according to the preferences of the abuser. Tension builds during this stage until they can no longer maintain equilibrium.
- ❖ **Tension releasing phase:** The tension accumulated during the first phase is released and a serious violent incidence occurs, resulting in injuries. Victims usually do not seek help or legal assistance during this stage and do not cooperate with efforts to help them for fear of revenge or because of a sense of loyalty to the abuser.
- ❖ **Apologetic, regretful, repentant phase:** The apologetic phase is characterised by displays of abuser remorse, kindness and seeming loving behaviour to the victim. The perpetrator of the violence typically apologises for the violence, gives the victim gifts and promises never to be violent again. The victim believes the abuser's promises and finds it difficult to leave when the abuser is behaving well. Once this phase ends the cycle repeats itself with tension building again. Tragically many women feel trapped and may not leave until the situation worsens and then it is too late.¹⁰

Other Vulnerable Groups

The subject of societal violence is, sadly, too broad to cover all aspects in this document. However, attention should be brought to violence perpetrated on other vulnerable groups in society.

Children can be victims of violence outside the home as well as within the family. Trafficking in young girls, forced prostitution and severe forms of child labour are other forms of violence. In the military sector, an estimated 250'000 children under 18 years of age - some as young as seven - are currently serving in government armed forces or armed opposition groups as soldiers, spies, messengers, and porters. Often,

the most dangerous missions are delegated to child soldiers, e.g. advance troops in mined areas.¹¹

Recently, special attention has highlighted the plight of women in times of social disorder. Women are being used as a tool of war as victims of organized rape in armed conflict situations or sexual violence in refugee camps.

Racist attacks and attacks motivated by homophobic sentiments are increasing and repugnant expressions of societal violence.

Health consequences of violence

Domestic violence has very serious negative consequences for the health of the victim and nurses need to understand its implications and how to care for those affected. Nurses and other health care professionals are often the main point of contact with other services to which victims may need referrals. Violence increases risk for poor health, causes unnecessary suffering, and can cause other health problems such as:

- Lacerations, fractures and injury to internal organs
- Unwanted pregnancy
- HIV/AIDS and other sexually transmitted infections
- Chronic pain
- Depression, fear and anxiety
- Low self-esteem and eating problems
- Post-traumatic stress disorder
- Fatal outcomes such as suicide, homicide and maternal death

The victims of domestic violence often live in shame and embarrassment by what is happening to them and may not know where to seek help. They are also fearful of taking any action that might make the situation worse. As shown in the table below, some myths perpetuate domestic violence.

Some myths in domestic violence

Myth: A man's home is his castle; women are subservient to men. This myth treats a woman as second class and denies the existence of domestic violence.

Myth: The victim provoked and deserved the violence. This is an example of victim blaming at its worst, justifies violence and sets the abuser free.

Myth: Family matters are private and men should control and discipline women and children. This myth does not separate discipline from violence and perpetrates the man's right to control family members, including use of violence.

Myth: The abuser who asks for forgiveness must be excused. This myth allows the abuser to suffer no consequences for violent behaviour and assumes the behaviour will stop.

Myth: Some form of violence and force must be tolerated and accepted. This myth encourages the community to ignore violence.

Myth: Violence is a problem of poor and uneducated people. This myth discounts the prevalence of violence in all socio-economic levels.

Together these myths combine to create a culture that accepts and tolerates violence against women and ignores action against its perpetrators. The aim should be to destroy the myths and break the silence against domestic violence.

Adapted from: Valente, S.M.(2000), Evaluating and managing intimate partner violence.

The Nurse Practitioner, 25(5)

Barriers to care and treatment

Victims of violence and health care providers often face barriers in obtaining and providing treatment. Victims may deny violence because of shame and embarrassment, fear of reprisals by perpetrator, economic dependence on the partner or perpetrator, and fear of abandonment. Nurses and other health care providers may lack assessment skills in domestic violence and may fail to ask about violence for fear of raising a private and domestic matter and because they lack adequate referral facilities.

To be effective, health care providers need training in detecting, assessing, treating and preventing violence. Many health care providers believe that domestic violence is not a health issue but a social issue to be addressed outside the healthcare system. Often health workers ignore the problem because they may not know what to do about it, especially if the victim denies violence or provides other explanations for injuries. Health workers may miss the underlying problem of domestic violence and the opportunity to help or prevent further violence.

Interventions

The risk of further reprisals and violence should be assessed and the safety of the victim assured before sending the abused woman home or letting her return to the violent environment. Health care providers can take the following actions:

- ✓ Ensure that the safety of the person and of any children involved is the first priority in deciding any intervention.
- ✓ Treat the victim with respect and dignity; listen with empathy and without being judgmental.
- ✓ Assist people to make informed choices about their lives without making decisions for them.
- ✓ Maintain confidentiality and be aware of the consequences if this is not respected.
- ✓ Identify and work with other people and agencies that can be involved in addressing the issue, such as child and family protection groups, primary health care groups.
- ✓ Lobby for domestic violence to be placed within the government's crime reduction programme with resources allocated for reducing its incidence.
- ✓ Provide information about social support systems and networks including telephone numbers, safe refuge or shelter.
- ✓ Explain the cycle of violence.
- ✓ Empower women; build self-esteem, explain that no one deserves abuse.
- ✓ Highlight the need for keeping identification documents, money, phone numbers, a list of safe houses, shelters and other resources for abused women.
- ✓ Provide advice and referrals to community resources and groups that provide counselling and legal support for abused women.
- ✓ Involve the community in the reporting and rebuking of violent partners.

Ethical dilemmas

Domestic violence has serious health consequences and involves grave violations of human rights. However cultural tolerance and attitude towards domestic violence make it difficult for victims to report abuse and for health care providers to take preventive actions. Health care professionals often face competing responsibility to report the abuse and to protect the victim from harm and to respect the victim's choices and autonomy. Nurses and other health care providers must examine ethical dilemmas related to informed consent, confidentiality and autonomy. They must demonstrate compassion and understanding even when the victim refuses to leave the abusive relationship.

Ethical and safety recommendations for domestic violence research¹²

- ❖ The safety of respondents and the research team is paramount, and should infuse all project decisions
- ❖ Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the under-reporting of abuse
- ❖ Protecting confidentiality is essential to ensure both women's safety and data quality
- ❖ All research team members should be carefully selected and receive specialized training and on-going support
- ❖ The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research
- ❖ Fieldworkers should be trained to refer women requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms
- ❖ Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development
- ❖ Violence questions should be incorporated into surveys designed for other purposes only when ethical and methodological requirements can be met.

CHAPTER three **Violence** **in Health Care Settings**

There are concerns that violence against health care personnel is increasing. More assaults occur in the health care and social services industries than in any other sector. Health care settings cover the broad range of places where care takes place: the home, school, factory, streets, hospitals, clinics and other health facilities. Nurses and other health care providers worldwide work in places where violence is often used as a means of dispute resolution.

Health care settings are areas of high activity and emotion related to health and illness and care seeking. This involves close interaction between health personnel, patients and family members. The prevalence of violence against nursing personnel is of great concern when comparisons are drawn with other professions. A study conducted in 1990 in Pennsylvania (USA), found that 36% of the emergency room nurses responding had been physically assaulted at least once during the previous 12 months, while only 6% of probation and parole officers surveyed had been physically assaulted during the same period.¹³

Whereas previously incidents of violence occurred in specific departments within the hospital -- i.e. emergency rooms and psychiatric wards -- this is no longer the case. "General patient rooms have replaced psychiatric units as the second most frequent area for assaults", recent studies show. This trend towards increasing general violence is found in all health care settings in rural as well as inner city and urban areas.

Among health personnel, nursing staff is most at risk of workplace violence. The most likely victims are the student nurse, the staff nurse and the charge nurse along with ambulance staff.

While physical assault of nursing personnel is almost exclusively perpetrated by patients, there are reported cases of abuse or violence initiated by patients' family members, other health personnel (including nurse colleagues and physicians) and "intruders" (persons having no legitimate reason for approaching nursing personnel). Although it is true that male nurses have been victims of abuse and violence in the workplace, this is a relatively recent phenomenon, less frequent but equally intolerable.

Sexual harassment, a specific form of abuse, is occurring against nurses at an alarming rate. Surveys document this high prevalence: for example, 69% of the nurses interviewed in the United Kingdom, 48% in Ireland and 76% in the United States. In one UK study, of the 114 reporting incidents of sexual harassment, 98 of them were women. It is important that sexual harassment not be seen as isolated occurrences. Experience demonstrates that, in fact, harassment, if not reported, tends to escalate in seriousness over time.

Workplace violence crosses borders, work settings and occupational groups. As shown in the table below, violence takes many forms and varieties of behaviours with homicide as the ultimate form of violence.

Examples of violent behaviours in the work place

Bullying	Homicide
Mobbing	Rape
Victimising	Wounding
Intimidation	Battering
Threats	Physical attacks
Ostracism	Kicking
Sending offensive messages	Biting
Aggressive posturing	Punching
Rude gestures	Spitting
Interfering with work equipment	Squeezing/pinching
Hostile behaviour	Stalking
	Harassment including sexual, racial

Source: ILO (1998), World Of Work. No. 26. Sept/Oct. 1998

Risk factors

Risk factors for health care and other social service workers include:¹⁴

- Availability of drugs or money in hospitals, clinics and pharmacies making them targets for robbery.
- Unrestricted movement of the public in clinics and hospitals, increasing presence of organised gang groups, drug or alcohol abusers, dissatisfied family members and visitors, long waits in emergency rooms and frustration to obtain care.
- Low staffing levels in hospitals related to health care reform, downsizing, retrenching, etc.
- Isolated work with patients during examinations or treatment.
- Assignments in remote clinics and hospitals or high crime areas such as disadvantaged communities.
- Lack of training of staff in recognising and managing aggressive and violent behaviour.
- Poorly lighted streets or parking areas.
- Dealing with patients, families and visitors who are in stress, pain, grief and frustration with health care services with the nurse as scapegoat.
- Long waiting times in health care facilities.

Nursing is a predominantly female profession and in some countries violence toward women is tolerated. This tolerance can put nurses and other female health care providers at greater risk. There is almost acceptance that violence is part of nursing role and many nurses often feel they are considered 'legitimate targets' and that violence is seen by others in society as just part of the nurse's job.

Attacked by a patient

"I am an RN who has been in nursing for over three years. Last year I was attacked by one of my patients. This changed my life. I began having nightmares, crying spells and feelings of anxiety when caring for alcoholic patients. I decided to take back control of the situation and press charges against the patient. I was discouraged by my peers, the Workers Compensation Board and the local police, all of whom seemed to feel assault was part of my job. The police officer said that as an RN this was part of my job. I was shocked. If I wore a police uniform, there would be a charge - assaulting a police officer. Do laws not apply if you assault a nurse? Do I have fewer rights than any one else? I love my job and would do no other. This does not mean however that I am open for abuse of any kind. I deserve the same kind of respect as any one else."

Kim Lowry, RN. Adapted from: Canadian Nurses, August 2000, Vol.96 No. 7

Consequences of violence against nurses and other health care providers

- Deterioration in the quality of care and low morale
- Abandonment of the profession and reducing expert staff from the profession
- Negative effects on recruitment into the profession
- High stress levels and increase in errors at work
- High turnover of staff
- Increased health costs and lost productivity due to absenteeism

Prevention and control of violence in health care settings

Preventing violence in the work place involves management commitment and employee involvement. Together, employees and employers should initiate a worksite analysis, hazard prevention and control and safety and health training. To ensure an effective violence prevention programme, management and health workers must work together to create an environment of zero-tolerance for violence. Audit teams such as "patient assault team" or "threat assessment team" can assess the risk of abuse in the workplace. Once these are determined preventive measures can be designed.

Preventive measures include:¹⁴

- Install and maintain alarm systems and arrange for reliable response system when an alarm is triggered.
- Respond promptly to complaints of abuse and emergencies.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations.

- Provide client or patient waiting rooms that maximise comfort and minimise distress.
- Provide secure bathrooms for staff separate from patients and visitor facilities.
- Install bright lighting. Replace burned out lights, broken windows and locks.
- Establish liaison with local police and prosecutors and report all incidents of violence.
- Require all health workers to report all assaults or threats to a supervisor. Keep logbooks and reports of incidents.
- Advise and assist staff in requesting police assistance of filing charges against abuser.
- Ensure adequate and properly trained staff for restraining patients. Where possible, use properly trained security officers to deal with aggressive behaviour.
- Take measures to reduce waiting time and frustration in emergency rooms and other places.
- Supervise the movement of violent or psychiatric patients.
- Ensure that staff is not alone in emergency areas or walk-in clinics particularly at night.
- Transfer aggressive patients to acute care units or other restrictive settings.
- Ensure that nurses and other health care workers are not alone when carrying out intimate physical examinations.
- Develop policies and procedures for home health care providers, presence of others in the home, and refusal to provide services in hazardous situation.
- Provide staff with security escorts to parking areas in evening or late hours and in remote health facilities.
- Establish a daily work schedule for field staff to keep a designated contact person informed about whereabouts.

Victims of workplace violence suffer short and long term psychological trauma, fear of returning to work, changes in relationships with co-workers and family, feelings of incompetence, guilt, powerlessness and fear of criticism by supervisors or managers. It is important that assistance, including crisis counselling and stress debriefings, is provided to victims of abuse.

In a 1998 report entitled *Violence at Work*, the International Labour Office says that response to violence should be multi-faceted. It should be:

- **preventive**, looking at the causes behind the violence, not only at its effects;
- **targeted**, because you cannot attack every kind of violence in the same way;
- **multiple**, in the sense that a combination of different types of response are needed;
- **immediate**, a planned response of immediate intervention should be ready ahead of time to contain the effects of violence;
- **participatory**, in that all the people directly and indirectly part of the violence, including family members, top management, colleagues and victims, become involved;
- **a long-term response**, in that a follow up is needed because the consequences of violence are also long-term.

ICN Position

The International Council of Nurses condemns all forms of abuse and violence against nursing personnel, including sexual harassment. Such incidents are considered to be violations of nurses' rights to personal dignity and integrity. Furthermore, violence in the health workplace threatens the delivery of effective patient services. If quality care is to be provided, nursing personnel must be ensured a safe work environment and respectful treatment.

Particular attention has been placed on the elimination of abuse and violence against nursing personnel, as they represent a category of workers considered most at risk. It must be stressed, however, that the International Council of Nurses strongly condemns such acts perpetrated against **any** category of health personnel, employed person or private citizen.

! The full text of the ICN Position Statement on Violence is included as a separate document in this toolkit.

! The ICN publication *Guidelines on Coping with Violence in the Workplace*, have been included in this toolkit. These guidelines may also be accessed and downloaded from the ICN Web site at <http://www.icn.ch>.

Prevention of violence in all its forms and in all settings requires concerted initiatives by many sectors and the community. Nurses and other health workers have intimate knowledge of homes and other settings where violence takes place and they must take actions to break the cycle. Health professionals who work in the community may suspect or detect signs of violence during home visits or when the victim seeks health care. Nurses working in hospital emergency rooms or clinics may be the first to come in contact with victims of violence.

Community health nurses and others visiting homes, prisons, and retirement homes may be the first line of contact and the only source of help for victims of abuse. Too often health care workers are victims of violence. Violence is a complex problem that requires multi-sectoral approach.

Routine screening and protocols

Those working to improve the response of the health sector violence, emphasize the importance of universal screening of women and girls and the development of action protocols.

Screening is the practice of routinely asking all clients/patients if they have experienced violence.

Protocols are written plans that define, for a particular setting, the procedures that should be followed to identify and respond appropriately to victims of abuse. Studies show that with proper training and protocols, health care workers can become more sensitive to issues of violence. One example is the emergency department of the Medical College of Pennsylvania, Philadelphia, PA, United States. After introducing training and protocols on violence, the proportion of female trauma patients found to be battered increased fivefold, from 6% to 30%. There are no "profiles" that can reliably predict who is a likely victim of abuse. Instead, some professionals advocate screening of all patients.

An example of a screening question

Because violence is so common, some advocate universal screening of all women who come to the clinic if they have been hit or abused by their partner.

"Sometimes when I see a woman with an injury like yours it is because somebody hit her. Did this happen to you?"

"Sometimes when people come to the clinic with symptoms like yours we find that there may be trouble at home. Has someone been hurting you?"

"You mentioned that your partner drinks alcohol. Does he ever become violent?"

Source: Adapted from World Health Organisation (1997), Violence against women. Fact sheet

Universal screening, however, must be introduced with caution. Careless implementation of screening may lead to client abuses, ranging from victim-blaming, to breaches of confidentiality, to rape.

Counselling, legal assistance and self-help groups provide other kinds of ongoing services that victims need. Shortcomings in support services may make providers feel isolated and helpless because their ability to help their clients is limited. Furthermore, the volume of clients may be so great, and their needs so urgent, that effective care beyond a basic level becomes difficult.

Guidance for health workers

The following is a list of possible recommendations tailored specifically to the challenge of dealing with domestic violence in a clinical setting. Modifications should be explored for other types of abuse and for other settings.

1. Do not be afraid to ask. Contrary to popular belief, most women are willing to disclose abuse when asked in a direct and non-judgmental way, indeed, many are silently hoping someone will ask.
2. Create a supportive non-judgmental environment. Let her tell her story. State clearly that no one deserves to be beaten or raped under any circumstance.
3. Be alert for "red flags". While the best way to uncover domestic violence is to ask directly, several injuries or conditions should raise suspicion for abuse:
 - ❖ chronic, vague complaints that have no obvious physical cause;
 - ❖ injuries that do not match the explanation of how they were sustained;
 - ❖ a partner who is overly attentive, controlling, or unwilling to leave the woman's side;

- ❖ physical injury during pregnancy;
 - ❖ a history of attempted suicide or suicidal thoughts; and
 - ❖ delay between injury and the seeking of treatment.
4. Establish whether the woman feels that either she or her children are in immediate danger. If so, help her consider alternative courses of action. Is there a friend or relative she can call? If there is a woman's shelter or a crisis centre in the area, offer to contact them.
 5. Explain that she has medical and legal rights. The penal codes of most countries criminalize rape and physical assault, even if no specific laws against domestic violence exist. Try to find out what legal protections exist in your locale for victims of abuse and where women and children can turn for help in enforcing their rights.
 6. Be prepared to offer a follow-up appointment.
 7. Consider providing space in the clinic for self-help support groups.
 8. Display posters and leaflets on domestic violence, rape and sexual abuse, where these are available, to raise awareness of the issues and encourage patients to report any abuse they may be experiencing.
 9. When possible, avoid prescribing mood-altering drugs to women who are living with an abusive partner, since these may endanger their ability to predict and react to their partner's attacks.
 10. Develop and maintain contacts with women's groups and other governmental and non-governmental agencies, who offer support to women experiencing violence. Ensure that up to date information on their services is prominently displayed, in the appropriate languages.

It is important to identify and screen for risk factors associated with violent behaviour:

- ✓History of assault or other violent behaviour
- ✓Diagnosis of dementia
- ✓Intoxication from drugs or alcohol
- ✓Characteristics of the environment or the treatment itself

Full information on these risk factors must be disseminated to all persons likely to be involved in incidents of violence and those responsible for staff at risk.

A Case Study of How Nurses Help

The Tulsa Police Department introduced the Sexual Assault Nurse Examiners (SANE) program in 1991 to ensure more timely and accurate collection of forensic evidence for use in prosecuting suspected rapists. In the process, SANE developed a unique, community based team approach that has become a national model for the dignified and compassionate treatment of sexual assault victims.

After a rape, the scene that follows in most urban hospitals -- including those in Tulsa before SANE -- is almost as traumatic as the assault itself. Tulsa police would bring the rape victim to a crowded emergency room where she waited, sometimes eight hours or more, to be examined by physicians who first had to tend to gunshot wounds, heart attacks, and other life-threatening conditions.

As a solution, the Tulsa police department and Call Rape, a local victims' advocacy organization, with a research grant from United Way, came up with the idea of using trained nurses to conduct forensic exams--and to do them away from the emergency rooms in a central, more private setting.

Today, when a rape is reported in Tulsa, a police officer goes to the scene to pick up the victim. At the same time, Call Rape volunteers and a Sane nurse report to a quiet, comfortable suite at the Hillcrest Medical Center. When the victim arrives, she is immediately examined. A Call Rape volunteer remains with her during the exam. Meanwhile, a second volunteer -- often a male -- helps the victim's family deal with the assault's emotional effect on the victim.

Typically SANE nurses handle between 16 and 18 cases per month. Police officials note substantial improvement in the quality of the forensic evidence since the programme began, and a higher rate of convictions due to rape victims' increased willingness to submit to exams.

Innovations in American Government Program 1994 Winner. Sexual Assault Nurse Examiners Program. City of Tulsa Human Services The Tulsa Police

Strategies and interventions

Most health workers may lack training to deal with all aspects of violence. They may also lack time to address the needs of victims of violence. One of their major roles is to identify, provide care and refer victims of violence to appropriate services. Nurses and others can:

- Be a good and non-judgemental listener to victims of violence. Victim blaming will discourage victims of violence from seeking health care in future.
- Be vigilant to signs and symptoms of abuse and do follow-up.
- Where appropriate, routinely ask all clients about their experiences of abuse as part of history taking.
- Provide appropriate care and documentation of abuse including details of the abuser.
- Refer victims to available community resources.
- Maintain privacy and confidentiality of client information and records.

Prevention of violence is an important part of promoting a culture that does not tolerate violence and abuse. Nurses and other health care workers can integrate information, education and communication strategies to promote a culture of non-violence.

The Swedish National Centre for Battered and Raped Women was set up to provide medical and psychosocial support for battered and raped women, initiate research projects within the medical service and provide information and education about violence against women. Some of the strategies employed to achieve these aims were:

- ❑ Medical services are the best placed to take action against domestic violence.
- ❑ Specially trained staff available for examinations and consultations 24 hours a day is a successful strategy.
- ❑ Close cooperation between health workers, the police, the legal system and women's groups is a must. Without it the phenomenon of violence will never be wiped out.
- ❑ National cooperation is essential in a small country like Sweden. The legitimacy and financing of this operation must come from national top levels.
- ❑ Training on violence and abuse against women should be included in medical postgraduate curricula.
- ❑ Research to develop medical models and obtain more knowledge of sexual violence as a phenomenon is needed.
- ❑ Cooperation between sectors needs to be further improved in order to develop a model for the care and attention of women who have experienced abuse.

Risk assessment of violence in the workplace

Assessing the risk of violence and identifying the hazards is an important first step in predicting and preventing violent behaviour. The following steps are useful in risk assessment:¹⁶

- ❖ Evaluate aspects of the job that can be more hazardous such as stressful work environment or extent of contact with the public
- ❖ Identify staff and others who are at higher risk of violence. For example staff working in remote clinics, homes, emergency rooms.
- ❖ Determine adequacy of existing precautions e.g. is security adequate? Are there qualified staff on duty? Are violent incidents reported and acted upon?
- ❖ Record and report findings of risk assessment and ensure appropriate preventive measures are in place.

Once the risk assessment is done strategies can be developed to prevent violence or to provide care and support to victims of violence.

Promoting a culture of non-violence

The overall aim is promoting a culture of non-violence, prevention, protection and early intervention. Violence is a public health issue. Its prevention and the promotion of non-violent communities should be incorporated into health education and activities of the health care workers. Key areas for intervention include:¹⁷

- Advocacy and awareness raising
- Education for building a culture of non-violence
- Training
- Resource mobilisation
- Direct service provision to victims of abuse
- Networking and community mobilisation
- Legal reform and supportive legislation
- Monitoring intervention and measures
- Data collection and analysis
- Early identification of high-risk families, communities, groups and individuals.

CONCLUSION

Violence is a complex issue with varied causes and determinants. Violence in society is an increasing problem of already epidemic proportions. Women are often considered legitimate targets of violence and this attitude must change.

Health care workers, especially nursing personnel, are recognized as being at higher personal risk of abuse and violence in the workplace. Nurses, predominantly women, are victims of the rise in domestic as well as workplace violence. Particular attention has been placed on the elimination of abuse and violence against nursing personnel, as they represent a category of workers considered most vulnerable. It must be stressed that such acts perpetrated against **any** category of health personnel, employed person or private citizen must be strongly condemned.

Nurses are well placed to identify risk of violence in different settings and to take measures to ensure safety and health at home, the community and workplaces. To do this requires close partnerships with various sectors.

For too long violence has been seen as outside the domain of health sector. It is time to recognise that violence is a preventable public health threat that is amenable to public health measures. Nurses, united with other groups and services in society, must be in the forefront to combat violence and create safe living and working environments.

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