Domestic violence

Guidance for nurses
The Royal College of Nursing understands the complex nature of domestic violence and supports the education of nurses and women in the skills needed to prevent and end domestic violence. The RCN believes that there is a need to increase awareness of this problem and to reduce both the physical injuries and psychological distress associated with this crime.

Increasingly, nurses working in all specialities are expected to respond to women who are experiencing domestic violence. Community nurses, midwives, mental health nurses and nurses who work in accident and emergency departments are most likely to care for patients who are experiencing domestic violence. Appropriate interventions from nurses are crucial to the immediate physical and psychological safety of patients. Nurses, midwives and health visitors can significantly contribute to both physical care and psychological healing in patients who look to health care professionals for help.

The RCN advocates that:

- rather than struggling with this issue alone, nurses adopt a co-ordinated team approach, working with their local multi-agency domestic violence forum
- the seriousness of this issue is acknowledged through education and local policies that endorse the protection of women at risk of violence
- nurses in all specialities offer appropriate treatment services to meet the needs of all abused women.

The objectives of this RCN paper are to:

- raise awareness of violence against women in relationships
- provide a guide for the identification and treatment of abused women
- offer a list of resources and contacts to enable nurses to support abused women.

In essence, the RCN seeks to provide guidance and direction for nurses to enable them to respond to patients in ways that are helpful in this difficult area.

Nurses’ own experiences

More and more nurses are themselves subjected to violence in the workplace, from their patients and others in their care\(^1\). Nurses need to understand the complex nature of violence, both from strangers and within families. Almost 93 per cent of nurses, midwives and health visitors are female and may have personal experience of living in violent and abusive families. The RCN aims to support and protect its members from all forms of violence and abuse.

It may be particularly difficult or painful for individual nurses to confront this issue and to support others experiencing violence. Confidential support for RCN members experiencing emotional distress is available through the RCN Counselling Service, while RCN Nurseline provides welfare advice and support. Contact numbers can be found in the organisations offering help section of this publication on page 10.

Each nurse should use their own judgement in how far they feel they can support their patients in this issue and the RCN suggests that nurses endeavour to support women only when they feel ready to do so. Facing the issue professionally may help individuals to deal with personal circumstances. Becoming involved in your local inter-agency domestic violence forum will enable individuals to tackle this issue on both personal and professional levels.
What is domestic violence?

Domestic violence is the actual or threatened physical, sexual, financial or emotional abuse of a person by someone with whom they have, or have had, an intimate, familial or emotional relationship. Domestic violence typically entails repeated abuse intended to instil fear and to control coercively. It is a phenomenon that pervades every aspect of a family’s life and it differs significantly from assault by a stranger(2, 3).

The Scottish Partnership on Domestic Abuse defines it thus:

“Domestic abuse can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviours) sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental/emotional abuse (such as threats, verbal abuse, withholding money and other types of controlling behaviour such as isolation from family or friends). Children are witness to and subjected to much of this abuse; there is a correlation between domestic abuse and the mental, physical and sexual abuse of children,”(43).

Although it is acknowledged that women can be violent towards men, and that violence and abuse occurs in same sex relationships as well as heterosexual ones, and within and across all classes and races, estimates from worldwide research indicate that more than 97 per cent of domestic violence incidents consist of men abusing, intimidating and violating women whom they know intimately and often profess to love (4, 5, 6, 7). There is a growing amount of research evidence identifying an increase in female violence (8). However, in this RCN paper, guidance is focused on supporting women who are experiencing abuse.

In its widest context, domestic violence can refer to any acts of violence that occur within the domestic setting, including child abuse and elder abuse. One study has shown that in 90 per cent of domestic violence cases, children were in the same or adjacent room to the violence (41). National Society for Protection of Children (NSPCC) research into Child Protection Registers shows a correlation between domestic violence and child abuse. They refer to research which revealed that in three out of five cases where children had suffered physical abuse, neglect or emotional abuse, their mothers were also subject to violence by their male partners (42). It is estimated that only 2 per cent of violent attacks on women are reported to the police (22). Parents who were found to engage in ‘ordinary’ partner abuse, involving pushing, shoving and throwing things, were found to be more than doubly at risk of abusing their children. For those engaged in ‘serious abuse’, the risk was higher (8).

Large numbers of children live in homes where they witness violence between family members, and violence is not confined to adults – it is a feature of adolescents’ earliest intimate experiences.

Psychiatrists and clinical psychologists are being alerted to the finding that young children are adversely affected by witnessing violence between adults in their homes, and the strongest developmental risk factor for adult partner violence has been found to be childhood conduct problems (19). Children whose mothers are abused are more than twice as likely to be physically abused than children whose mothers are not abused. It is estimated that 70 per cent of men who abuse their partners also physically abuse children in the same home (10, 17(18).

People with disabilities are at the greatest risk of all forms of abuse and violence and are particularly vulnerable to abuse from caregivers, whether in an institutional or non-institutional setting (9).

This RCN paper addresses the issues of male violence and abuse towards women and identifies the phenomenon as: “a systematic, repeated pattern of abusive behaviour with the intention of demonstrating and exercising power and control over the victim.”

The issues of domestic violence are compounded by historical structures in society which condone the view that a man is master of his domain and are illustrated in the workings of many institutions such as the Crown Prosecution Service and, until recently, the police. Since ancient times, the abuse of women by their partners has been sanctioned by society. During the late 1700s, the popular maxim that a husband could beat his wife with a ‘rod not thicker than his thumb’ (the rule of thumb) was thought to have arisen as a result of a court hearing (10) (11).

Domestic violence exists in almost all known societies and has blighted women’s lives throughout the millennia. However such violence has always been resisted, either individually or collectively, in a wide variety of ways (7). Until the end of the 1960s, little public
attention was paid to the issue in the UK. However throughout the 1970s, the refuge movement and other services for women were set up, leading to the national co-ordinating bodies of the Women’s Aid Federations for England, Wales, Scotland and Northern Ireland. These voluntary agencies are partially funded by grants from the Government. Until recently, they were alone in attempting to raise the voices of abused women and children in an empowering way and in developing an analysis of domestic violence based on gendered understandings of the unequal position of women throughout society (7).

The Labour Government, elected in 1997, has made clear its commitment to improving domestic violence services. The *Peace at Home* policy document (Labour Party 1995) (12) suggested the consolidation of inter-agency initiatives and increased funding. Guidelines and support from the Government are to be welcomed by nurses.

**Inter-agency initiatives**

All four countries in the UK support the development of inter-agency domestic violence forums. These groups take the form of forums, bringing together all relevant statutory and voluntary sector agencies. There are at least 200 forums nationally. Domestic violence forums are one of the Government’s principal initiatives in combating domestic violence.

Your local domestic violence forum can be found through at least three routes:

✦ the national Women’s Aid office (in Wales there are three national offices) – telephone numbers are in the reference section on page 10
✦ your local police domestic violence unit, based in your local police station – phone your local police station number, not 999 (in London, these are called community safety units)
✦ your local council – ask for the contact person for the domestic violence forum.

Zero tolerance public awareness campaigns, first used in Scotland, are becoming more visible.

There are three strands to the Government’s policy:

✦ prevention of violence
✦ protection of women from violent men
✦ justice – ensuring that the criminal justice system does deliver justice for victims, by dealing appropriately with the perpetrators of violence against women.

The Department of Health for England (March 2000) (37) and the Scottish Executive (45) have also published good practice guidelines for health care professionals on domestic violence and the RCN supports these initiatives.

The RCN believes that nurses have a significant role to play in supporting these policies and in providing a service to women and children which meets their physical, psychological and safety needs in an empowering, helpful and supportive way.

**Is there a problem?**

The largest increase in recorded violent crimes has been in domestic violence, with 3.4 times more domestic violence crimes reported in 1995 than in 1981 (13). The British Crime Survey estimated that each year there are in excess of 835,999 cases of domestic violence in England and Wales (13). In Northern Ireland last year, the Women’s Aid help line dealt with 17,832 calls and the police were called to 14,889 domestic incidents.

In Scotland, where zero tolerance and other awareness campaigns have been promoted, they have found a more than five-fold increase in calls to their help lines each decade – with 2,000 women using the help lines in the year 1978/79, rising to 14,000 in 1988/89 and more than 55,000 calls received in the year 1998/99.

When physical violence occurs, other forms of abusive behaviours are perhaps more common. These may include: threats, intimidation, manipulation or isolation; keeping a woman without money, locked in or deprived of food; or using her children in various ways to frighten her or enforce compliance. It can also include systematic criticism and belittling comments aimed to destroy self-esteem. Domestic violence is rarely found to be a one-off event and attacks tend to become more frequent and increasingly severe over time (14).
These factors make it almost impossible to determine the exact extent of domestic violence. The Home Office (1995) listed the difficulties women have in seeking help:

- it is difficult to report, due to the emotional relationship between the victim and the perpetrator
- a fear of reprisals
- a tendency to minimise rather than exaggerate the violence and hide it from families and friends
- pressure from family/local community to remain in the relationship
- worry about the effect on their children
- financial pressure
- not knowing a safe place to go
- a less than helpful response from those agencies to whom they may have turned for help
- repeated abuse may undermine a woman’s confidence in her ability to take decisions and act.

Women are ashamed and reluctant to report the crime, and until recently the police have not always believed the women or taken their complaints seriously. The criminal justice system has traditionally dealt leniently with perpetrators. For example, the conviction rate for rape has fallen from 32 per cent of cases tried in court in 1977 to 18 per cent in 1987. In 1993, only 10 per cent of rape cases were convicted. A woman who has been raped knows the man who carried out the attack in 83 per cent of cases.

Women often try hard to hide or minimise the violence they have suffered, yet it is clear that they are ready and willing to disclose to nurses if they think they will be believed and supported.

A social services inspectorate report (1995) reported from the British Crime survey (1992) that:

- women experiencing domestic violence are most likely to be aged between 16 and 29 years old
- having children increases the risk of assault
- incidents are particularly likely to occur at the weekend and at night
- victims are unlikely to report the incident to the police – only one in five assaults were reported

In western countries where research attempts to document abuse, the estimated rates are between one in four women in Britain and one in three or two in Canada and the United States. (19)

### Physical violence
- Biting
- Bruising
- Burning
- Choking/strangling
- Hitting
- Kicking
- Knifing
- Murder
- Punching
- Scalding
- Scratching
- Slapping
- Sleep deprivation
- Starving

### Sexual abuse/assault
- Forced sex – anal/vaginal/oral
- Urinating on
- Sexual assault using objects
- Forced tying up
- Enforced prostitution
- Forced to mimic pornography/ take part in pornography

### Psychological abuse
- Criticism
- Verbal abuse
- Isolation from family and friends/work
- Humiliation and degradation
- Extreme jealousy and possessiveness
- Financial deprivation
- Made to think they are going mad
- Threats
- Destroying personal belongings
- Forced to do menial/trivial tasks

Why does it happen?

Explanations for domestic violence have been covered extensively in research and policy literature (21, 22, 23).

The current view, endorsed by the Government and agencies such as the Women’s Aid Federation England (WAFE) (1996) is that:

“We can never be absolutely certain about what causes some men to be violent and not others. However research and experience of working with thousands of women and children in refuges tells us that domestic violence seems to be rooted in men’s domination and control over women, backed up by societal and/or legal support for men’s right to control their wives and children using force if necessary.” (2)

The Edinburgh Zero Tolerance Project (1998) (5) found that one in five young men and one in 10 young women thought violence against women was occasionally acceptable. The report concludes that: “Looking at responses to all the questions about hitting women and forcing them to have sex...we found that one in two young men and one in three young women considered such behaviour acceptable in certain circumstances.”

In earlier and similar research, a random sample of men were given ‘conflict’ scenarios and asked to say whether they would use violence to enforce their wishes in these situations (20). It was found that:

✦ only 37 per cent of the men said that they would never use violence in any of these situations
✦ 17 per cent said that they would in every example
✦ about half said that they would do so in some circumstances
✦ the percentage of men who admitted using violence did not differ appreciably by class.

Children in Britain are socialised into an increasingly violent society, where physical punishments and deliberate humiliation of children are used as parenting strategies for the vast majority of parents in contemporary British society (24). A Department of Health research study found that more than 90 per cent of parents used physical punishments and deliberate humiliation as parenting strategies. Parenting strategies are carried forward into adult life and hence into the workplace. Physical punishment was given by either or both parents, daily or more often, for 7 per cent of children. This included babies of one year and under, who were hit more than once, everyday by one or both parents. For 45 per cent of the sample, physical punishment happened at least once a week.

More than 20 per cent of parents used implements to hit their children and 35 per cent of the children in the study had experienced a punishment which was rated as ‘severe’ - defined as ‘those that were intended to, had the potential to, or actually did cause physical or psychological injury or harm to the child’ (25).

This report highlighted the significance of children’s early experiences to their developing attitudes to violence. They recommend that, to make an impact on violence prevention, we have to promote positive parenting, which does not transmit the message that violence is an acceptable way of sorting out problems or conflicts.

Teasing, joking, and bullying are also commonplace in our culture and are frequently used as parenting strategies. The RCN has developed policies to tackle these behaviours when they occur in the workplace (26).

Previous explanations of domestic violence have focused on identifying some pathology or weakness in the woman. Most of them have taken a victim-blaming stance, whereby women are seen as inviting violence in various ways, like ‘nagging’, or enjoying or being addicted to violence, or putting up with it, because it is their culture (21). Psychological labels have evolved, for example the Battered Woman Syndrome (BWS) (27), describing women with psychological, emotional and behavioural deficits arising from chronic and persistent violence. This syndrome has been recognised recently in British courts.

The theories about why men are violent towards women and children, and not for example violent towards other men, traditionally view these men as ‘sick’ or psychologically deranged (21, 28). In the medical or psychological literature, they are viewed as mad or sad, rather than bad. Theories range from sinful, poor impulse control, paroxysmal rage attacks and transgenerational transmission to drink and drugs. Researchers have looked for organic or biochemical abnormalities, dietary deficiencies and psychological functioning in individual men, but no consistent patterns have been found (28).

Woman abuse is too prevalent to be the deviance of a few; it is far more likely to exist on a continuum within the psychology and actions of all men (29).
The effects of domestic violence on health

Domestic violence is a health problem for women, and not just because of the injuries they receive. It leads to acute and chronic physical injury, miscarriage, and loss of hearing or vision, physical disfigurement, and often depression, alcoholism and sometimes suicide.(29)

Children are affected too, and many women and children develop post-traumatic stress disorder, and experience years of distress. In industrialised countries rape and domestic violence take about five healthy years of life away from women aged between 15 and 44.

In the USA it has been estimated that domestic violence is the largest cause of female injury, with a larger number of injuries than from car accidents, muggings and stranger rapes combined(29,30). Of the women attending accident and emergency departments in the USA, almost 35 per cent are there because of domestic violence, although only about 5 per cent are identified as such.(31,32). In London, it is estimated that 100,000 women a year seek medical treatment as a result of domestic violence(36). The costs of providing treatment for injuries and psychological harm were estimated as £189 million in Greater London alone(36).

Pregnancy is often a time when abuse begins or intensifies(19,33,34). It has been found that one in seven women experiencing violence were institutionalised in psychiatric wards or received psychiatric referrals, yet no evidence of domestic violence was recorded in their referral notes(17). One in four incidents of domestic abuse result in substantial physical injuries, on average each survivor reported having suffered more than four serious injuries – for example knocked unconscious, broken nose, jaw or cheekbone, fractured arm leg or rib. Women in violent relationships also frequently experience depression and somatic complaints such as migraine and non-specific pains in the stomach and joints. Women living in violent relationships have significantly poorer health than women who do not live in such relationships. The psychological impact of domestic violence can be more debilitating than physical injuries."(35)

Women look to the health services for the health problems that are a consequence of domestic violence. Nurses are in a position to respond to women, in supportive, appropriate and empowering ways.

What can nurses do?

The RCN recommends that every nurse adopt an empowering and supportive approach to all female patients using a structured framework.

There are two main issues to be considered:
✦ How can you ensure that the service you offer is appropriate and helpful to women who may be reluctant to disclose abuse?
✦ What should you do if a woman discloses to you that she has been abused?

Sensitive and appropriate treatment services

The most effective approaches are collaborative ones. As a team or a unit, contact your local domestic violence forum and:
✦ become informed – find out about initiatives in your area, identify your forum co-ordinator and your named nurse for child protection
✦ work with your local domestic violence forum and play a significant role in creating policy, so that women are listened to, believed and offered supportive and appropriate care
✦ engage support for staff training and a co-ordinated team approach.

Women experiencing domestic violence repeatedly mention that they would be willing and relieved to disclose the violence that is happening to them if they believed that the nurse, midwife or health visitor was empathetic and would be emotionally supportive. Psychological healing can begin with a believing and non-judgmental attitude.(16). Demonstrating respect for the woman and validating her experience following disclosure can begin the process of recovery.

Nurses can offer help to women by providing a high quality care service but also, in their roles in commissioning health care services, they can ensure that resources are available for domestic violence issues.
Nurses can provide help in the following five areas:

✦ Identification
✦ Assessment
✦ Documenting and reporting
✦ Safety planning
✦ Referral.

Identification

A structured and co-ordinated approach to identifying individuals is important. Local domestic violence forums can co-ordinate policy development and local decisions can be taken on which approach to screening is adopted.

There are some areas of health care where routine screening of all patients may be appropriate, such as midwifery, accident and emergency, mental health services, community nursing and health visiting. Other areas may wish to adopt an approach where not every patient is screened, but all staff are aware that domestic violence may be a factor.

Appropriate questions for women will need to be determined locally, to reflect regional cultural needs, and be developed within a multi-agency forum. The British Medical Association\(^{(39)}\) has suggested the following:

✦ Do you ever feel afraid of your partner?
✦ Has your partner or ex-partner ever physically hurt or threatened you?
✦ Has your partner ever threatened or abused your children?

Guidelines for use in obstetrics and gynaecology and in accident and emergency, developed by Camden Multi-Agency Domestic Violence Forum\(^{(40)}\), adopt the following approach:

“We are sorry if you have been asked these questions before. According to recent research, one in four women face violence in their home during their lifetime, so we are now routinely asking every woman about domestic violence.”

If a decision is made against routine enquiry of all patients, it is especially important that health staff have an awareness of the indicators of domestic violence. The following circumstances have been identified as likely indicators that should arouse suspicion and are based on guidelines for good practice\(^{(37)}\):

✦ Does the woman make frequent appointments for vague complaints or symptoms?
✦ Are appointments often missed?
✦ Are there injuries that seem inconsistent with the explanations of accidental causation (such as falls or walking into doors etc) and are these injuries to the face, head and neck, chest, breast and abdomen?
✦ Is there evidence of multiple injuries at different stages of healing?
✦ Does the woman try to minimise the extent of her injuries?
✦ Does the woman appear frightened, excessively anxious or distressed?
✦ Does a partner or other family member always accompany the woman when she attends a consultation?
✦ Does the partner appear aggressive and overly dominant? And is the patient passive and afraid?

All screening techniques need to be handled with care and staff should be properly trained in the use of enquiry tools. Ways of improving services to patients are a continuing aspect of nursing care.

Assessment

Assess the patient physically and psychologically for signs and symptoms of abuse. Work with the patient, adopting a believing and accepting approach. Attempt to raise her self-esteem by believing her and acknowledging that it was not her fault. Listening, believing and supporting can enhance psychological healing.

The following are signs and symptoms of abuse:

Physical signs and symptoms

● Head, neck and facial injuries
● Pain or tenderness
● Bruises of various ages
● Delay in coming for treatment
● Pelvic pain or tenderness
● Back pain or tenderness
● Chest pain or tenderness
● Dizziness
● Numbness
● Tingling of extremities
● Injuries to arms or fingers.

**Emotional signs and symptoms**
● Depression
● Anxiety
● Suicidal gestures
● Substance abuse
● Sleep disturbance
● Withdrawal from touch
● Avoidance of eye contact
● Low self-esteem
● Unkempt appearance
● Hostility.

**Common injuries**
✦ Bilateral, multiple bruises or lacerations in various stages of healing
✦ Patterned injuries (injuries that show the imprint of the object used to strike the patient)
✦ Injuries to the arms, especially along the ulnar side of the arm
✦ Injuries to the genitals or breasts
✦ Injuries to the abdomen during pregnancy, vaginal bleeding
✦ Periorbital haematoma
✦ Nasal fracture
✦ Perforated tympanic membrane
✦ Fractured mandible
✦ Burns from cigarettes, appliances, friction, arson
✦ Strangulation marks
✦ Occult presentations – in which abuse may be masked by other problems such as drug overdoses, self-harm and other psychiatric presentations.

**Documenting and reporting**
A full and accurate record of the patient’s condition may prove extremely helpful to the woman. For example, if she decided at some future time to take legal action against the abuser, evidence related to her assault must be collected, labelled and handled.

Unlike child abuse, the reporting of abuse of adults is not mandatory. To protect the patient’s rights to confidentially and safety, reporting violence against an adult to the police or other agencies is generally done only with the patient’s knowledge and permission. It is essential to obtain the woman’s consent. It is acceptable to discuss the issues with your manager, to seek support and guidance.

In some units photographing the injury is required. One nurse-led, innovative project has been developed in Lancashire, which ensures that the patient receives an appropriate, sensitive and accurate response from nurses. Patients with injuries are screened for domestic violence and a photographic record made which can be used as evidence if the patient wishes to pursue this in the future.

If you believe that children are in danger, child protection procedures will need to be followed, including contacting the named child protection nurse in your area. In addition, women may want to refer themselves to other agencies and the nurse is in a position to enable this contact to take place.

**Safety planning**
Once any response to the patient’s immediate needs has been made, it is important to make an assessment of safety. Conducting a safety assessment with the woman may help them to think through their situation and make decisions about what they need to do.

Every nurse should determine whether the patient is afraid to go home, if necessary referring the patient to Women’s Aid where experienced help is available.

A full safety assessment should address:
✦ the history of abuse of the woman and her children, considering any escalation in frequency, intensity or severity
✦ whether the abuser is: making verbal threats? Physically violent? Frightening/disturbing/threatening friends and neighbours? Threatening to harm or abduct the children? Actually harming the children? Frequently intoxicated (drugs/alcohol) and more violent in this state?
✦ the woman’s current fear of the situation and her beliefs about her immediate danger
- self-harm or suicide threats/attempt by the abused person
- attempts to get help – from police, courts or refuges during the past 12 months
- the availability of emotional support and practical support from friends and family.

If the patient may be returning to a living situation that may expose her to abuse in the future, recommend that she prepare a safety bag to keep hidden in a secure place, such as a friend’s house. It should contain cash for phone calls or taxis and important telephone numbers. Documents such as passports, visas and birth certificates for herself and her children, legal papers, marriage licence, bank books and insurance papers should also be taken or photocopied.

The most dangerous time for a woman and children is when she is planning to leave her abuser, as her partner may escalate the intensity of the violence as he becomes aware of his impending loss of control. Telling her to leave without adequate preparation is dangerous.

**Referral advice**

Prepare a short list of local resources to be given to patients to include: support groups for battered women, financial aid, victims’ services, legal aid, local refuges, counselling services, crisis lines and the local authority emergency housing service. Your local refuge or Women’s Aid will be the most experienced in supporting women during a crisis and are competent in advocacy and support work. Women's Aid exists in all four countries in Britain and will support women experiencing violence and abuse. Many forums produce local leaflets with lists of relevant agencies where women can seek help, enabling them to begin to take control of their situation.

**Disclosure – what to do when a patient discloses abuse**

Women who believe they are being taken seriously and treated with respect are likely to disclose their problems to you. Good practice guidelines to manage a disclosure indicate that you need to ensure:

- privacy
- confidentiality
- a non-judgmental, believing and empowering response
- that enough time is given to allow the woman to come to conclusions in her own way – this is one of the most supportive things you can do
- you ask gently, using open-ended, non-threatening questions
- that you validate her when she does tell you of the abuse. An expression of disbelief could dissuade her from telling you any more, so acknowledge how hard it has been to tell a stranger
- she is reassured – tell her how common you know domestic violence to be and assure her she is not to blame
- you get all the details that your job requires, explaining that not telling as much as she can may mean the difference between re-housing or not, or an effective prosecution. Explain the extent and limits of your confidentiality.
- she is not pressurised into doing something or agreeing to action that she is uncomfortable with, as only she will know the length to which her abuser will go to hurt, punish, control or find her
- her confidence is built by acknowledging what she has tried to do already.

The British Medical Association (39) suggests the following action after abuse has been disclosed:

- respect and validation
- response and risk assessment
- record-keeping
- information-giving
- information sharing and confidentiality
- support and follow-up.
Conclusions

Nurses and other health care professionals can and should play a major role in empowering women living with violence, and promote education, social policies and attitudes that proactively prevent violence towards women from known men.

The RCN supports and encourages nurses to promote the health of women and children experiencing domestic violence through multi-agency collaboration. The links between domestic violence and health are clear and nurses are ideally placed to make an impact on the health of women.

Nurses have a major contribution to make as practitioners and providers of appropriate care for women experiencing violence. However many nurses also have a role in planning care and commissioning services, and they will want to ensure that their voice is heard in the new local commissioning structures in community care.

One nurse, midwife or health visitor working alone on this issue may feel very isolated, but by developing local protocols together as a ward team and developing a departmental response you will feel far more powerful. Linking up with your local multi-agency domestic violence forum will be the most effective way to challenge this issue.

Organisations offering help

RCN Counselling Service for members
Tel: 0845 769 7064 (local rate in the UK)

Women’s Aid National Office England
(offers refuge, advocacy, legal advice and emotional support)
P O Box 391
Bristol
BS99 7WS
Tel: 0117 944 4411
Tel: 0845 702 3468 (24-hour help line)

Northern Ireland Women’s Aid Federation
129 University Street Belfast
BT7 1HP
Tel: 028 9024 9041
Tel: 028 9033 1818 (24-hour help line)

Scottish Women’s Aid
Norton Park
57 Albion Road
Edinburgh
EH7 5QY
Tel: 0131 475 2372

Welsh Women’s Aid
38-48 Crwys Road
Cardiff
CF2 4NN
Tel: 02920 390874
Aberystwyth
Tel: 01970 612748
Rhyl
Tel: 01745 334767

Southall Black Sisters
52 Norwood Road
Southall
Middlesex
UB2 4DW
Tel: 020 8571 9595
Refuge
2-8 Maltravers Street
London
WC2R 3EE
Tel: 020 7395 7700 (office)
Tel: 0870 599 5443 (24-hour crisis line)
Refuge for Women with Learning Difficulties
Beverley Lewis House
PO Box 7312
London
E15 4TS
Tel: 020 8522 0675

Advice and legal services
Immigration Advisory Service
Tel: 020 7378 9191
Lesbian and Gay Switchboard
Tel: 020 7837 7324

Rape Crisis
PO Box 69
London
WC1X 9NJ
Tel: 020 7916 5466 (office)
Tel: 020 7837 1600 (help line)

Childline
Freepost 1111
London
N1 0BR
0800 1111 (freephone)

Children’s Legal Centre
University Of Essex
Wivenhoe Park
Colchester
SYCO 43Q
Tel: 01206 873820.

RCN Nurseline
8-10 Crown Hill
Croydon
Surrey
CRO 1RZ
Tel: 020 8681 4030

Intervention Programmes for Male Perpetrators of Violence
Domestic Violence Intervention Project
(court mandated referrals and self-referral)
London
Tel: 020 8563 7983

Women’s support groups
Tel: 020 8748 6512

Domestic Violence Probation Project
(court mandated)
1 Parliament Square
Edinburgh
EH1 1RF
Tel: 0131 469 3408

Everyman Project
(support services for men wishing to stop behaving violently/abusively)
142 Landor Road
London
SW9 9JA
Tel: 020 7737 6747

Preventing Violence In Relationships
(An independent programme for men in Northern Ireland, helping them to address violent or aggressive behaviour.)
Contact Gerry Heery on Tel: 028 9061 2724

Further reading
Training and Education

The RCN supports multi-agency collaboration and suggests that nurses, midwives, and health visitors join local domestic violence forums. Training and courses available include:

✦ Those provided by your local domestic violence forum, via local Women’s Aid group/community safety unit/local council.
✦ National Women’s Aid training courses. See phone numbers on page 10.
✦ Primary contact solutions (PCS) Tel: 020 8488 5491 www.primarycontact.co.uk
✦ Awareness in practice PO box 9825 London W11 1FN Tel: 020 7221 4585

RCN members can order RCN publications through RCN Direct – 0845 772 6100. Have your membership number ready.

References


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