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ORIGINAL ARTICLE

Preparedness of Australian and British nurses and midwives about domestic violence and abuse

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Abstract

Background: Domestic violence and abuse (DVA) is a major health problem that affects individuals across the world. Nurses, midwives and healthcare providers need to be confident and competent in identifying and responding to DVA.

Aims: To measure current levels of knowledge, opinions and preparedness towards DVA and how it is managed by registered nurses and midwives residing in Australia and the UK.

Methods: A cross-sectional study design was used. Data were collected using the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) measuring the perceived preparation and knowledge, actual knowledge, opinions and practice issues. Australian data were collected in 2018 and UK data were collected in 2017–2018. Descriptive and inferential statistics were used to analyse the data and differences in knowledge and attitudes of British and Australian nurses.

Findings: Nurses and midwives (n = 368; 130 from Australia; 238 from the UK) responded to the survey. Minimal previous DVA training was reported by the participants. Participants had minimal knowledge about DVA, though had a positive attitude towards engaging with women experiencing DVA.

Discussion: Most participants felt unprepared to ask relevant questions about DVA and had inadequate knowledge about available resources. Australian participants scored better than British participants; however, the mean difference in all aspects remained statistically insignificant.

Conclusion: Australian and British nurses and midwives have a positive attitude towards women experiencing DVA; however, the knowledge and skills to support women experiencing DVA are limited.

Implications for nursing policy: Nursing institutions should develop strategic policies regarding mandatory preparation and training of nurses for domestic violence assessment and management.

KEYWORDS
Domestic abuse, domestic violence, intimate partner violence, midwives, nurses, preparation

INTRODUCTION

Domestic violence and abuse (DVA), including intimate partner violence (IPV), is a global health issue estimated to affect approximately one third of women worldwide (World Health Organization [WHO], 2013a). DVA is defined as: 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16

or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse includes, but is not limited to psychological, physical, sexual, financial or emotional abuse' (UK Home Office, 2018). This definition also covers acts of 'honour'-based violence, female genital mutilation (FGM) and forced marriage. The term 'DVA' encompasses a range of abuse and violence occurring within a domestic context and presents in the form of child abuse, elder abuse and IPV. The most common forms of DVA include physical, sexual and psychological abuse (WHO, 2002); however, it can also manifest as financial or material abuse, social abuse and/or coercive control, and individuals may be exposed to one or more forms of abuse at any one time (Devries et al., 2013; WHO, 2013a).

Although any individual can experience DVA, women are more likely to experience violence perpetrated by men, with the perpetrator often being someone familiar to the victim (WHO, 2013a). Women subjected to DVA are at a heightened risk of experiencing physical and psychological trauma and injury, which can result in detrimental health outcomes including death (WHO, 2013a). Individuals who experience DVA are more likely to seek support from healthcare professionals, often as the first point of contact, including nurses (WHO, 2013b), putting them at the forefront of assessment, care and prevention. Despite this, healthcare professionals are often ill-equipped to confront and manage issues arising from DVA due to various reasons, including a lack of skills and education that enables the provision of appropriate, safe therapeutic care and management (Ahmad et al., 2017; Kalra et al., 2017).

Literature associated with DVA has identified that lack of time, continuity of care and perceived norms and taboos can hinder the assessment and identification of women at risk of experiencing violence (Mauri et al., 2015) despite nurses and midwives recognizing their professional responsibilities in addressing DVA (Hooker et al., 2015; Mauri et al., 2015). Training and education can increase routine screening practices for abuse among healthcare professionals which, in turn, can promote safety and well-being among women who experience violence (Baird et al., 2015, 2018; Bradbury-Jones et al., 2017). However, the inconsistencies in training and education for healthcare professionals across the globe (WHO, 2013b) lead to sporadic screening, assessment, referral and care and thus more cases of women experiencing DVA without professional healthcare assistance (Bellia et al., 2020).

Though previous literature has indicated that nurses and midwives may not feel confident in screening and providing appropriate care to DVA victims and survivors, partially attributed to a lack of knowledge and education (Ahmad et al., 2017; Alshammari et al., 2018; Crombie et al., 2016), it is currently unclear as to what skills, knowledge and level of education are required (Kalra et al., 2017). Additionally, although research has suggested training may improve screening practices and understanding of DVA, due to the nature of inconsistent guidelines and programme evaluations, it is difficult to know whether such programmes meet the professionals' needs. The current research focused on nurses and midwives within the context of DVA, has also concentrated on, for example, local and national contexts and generally nurses and midwives (albeit rightly so) independent with some exceptions (e.g., Baird et al, 2018). To move forward, it is not only essential to identify training and education needs, but to determine attitudes, current level of skills, knowledge and associated management among both registered nurses and midwives. This is particularly important in the current context where nurses, midwives, other healthcare professionals as well as a general population move within and between countries. The aim of this study, therefore, was to explore knowledge, attitudes and preparedness towards DVA, and how it is managed by registered nurses and midwives practising in Australia and the UK.

METHODS

This study used a cross-sectional design and was approved by the University of Sheffield Research Ethics Committee (reference number 00740; September 2018). Data were collected in 2018 in Australia and 2017–2018 in the UK. Data were collected via Survey Monkey and completion of the survey was considered implied consent. No identifiable information was collected from any participant to ensure anonymity. No incentives for participation were offered. The STROBE guidelines were used for reporting (Supplementary File S1).

Sample

To meet the inclusion criteria, participants were required to be registered practitioners (nurses and midwives) with the relevant authorities in each country: The Australian Health Practitioner Regulation Agency for Australian participants and the Nursing and Midwifery Council for UK participants. Recruitment of participants was facilitated through several professional nursing and midwifery associations and research networks, in both countries, who agreed to advertise and circulate the survey via a live link inclusive of a participant information sheet to their members.

Instrument

We used the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) tool. The tool was initially developed and validated in the United States (Short et al., 2006a, 2006b) and comprises five sections including participant profile, background (including perceived preparedness and knowledge), actual knowledge, opinions and practice issues. The tool contains 67 questions and takes 15–30 min to complete (Short, 2006a, 2006b). This tool was adapted to use within the nursing and midwifery context in the UK and Australia by deleting items not relevant to the context and making minor changes in technical terms. After making the changes, the tool was piloted on a small number of participants ($n = 15$), and further changes to the information sheets

were made. The revised tool still contained the same number of sections and 65 Likert scale statements. As the original tool was developed for physicians, minor adjustments to the language were required to ensure nurses and midwives were addressed in the questions/statements.

Reliability and validity

The psychometric testing of the tool has demonstrated good internal consistency reliability, with Cronbach's alpha of 0.65 (Short, 2006a, 2006b).

Data management and analysis

The response variables exploring the perceived preparedness of nurses to support those experiencing DVA and perceived knowledge about DVA and opinions about DVA were measured on a 7-point Likert scale, where 1 referred to 'strongly disagree' and 7 referred to 'strongly agree'. Actual knowledge was measured with multiple choice and true/false type questions. As mentioned earlier, participants completed the questionnaire via Survey Monkey. Following completion of data collection, data were downloaded from Survey Monkey to Microsoft Excel and then transferred to the Statistical Package for Social Sciences (SPSS) version 25 for further descriptive and inferential analysis.

A total of 457 questionnaires were completed; however, only 368 questionnaires with complete information were analysed. This suggests a completion rate of 81%. In this paper, continuous variables are presented as mean ± SD and categorical variables are presented as percentages or proportions. Comparison between groups (for example, nurses vs midwives; UK vs Australian sample) were completed using *t*-test for continuous variables and chi-square for categorical variables with a 0.05 level of significance. Appropriate assumptions for tests were checked before conducting the test.

RESULTS

Out of 368, 65% ($n = 238$) of the participants were working in the UK and the remaining were working in Australia. Twelve percent of participants ($n = 56$) identified themselves as dual registrants, i.e., as a registered nurse as well as a midwife. As expected, most nurses were female in both countries. The age of participants ranged from 21 to 71 years with a mean of 44.1 years (SD 11.4). 67% of participants had between 6 and 35 years of work experience. Table 1 provides a detailed description of the characteristics of the participants.

Previous DVA training

Participants from both countries reported to have minimal previous training about DVA. The median response of 2 and 5 h (0–100 h) was reported by nurses from the UK and Australia, respectively. Most reported attending a lecture or skill-based training workshop (Table 1).

TABLE 1 Descriptive statistics ($N = 368$)

	Australia *n* (%)	UK *n* (%)	Total
Profession			
Nurses	91 (70.0)	230 (96.6)	321
Nurse midwife	39 (30.0)	8 (3.4)	47
< 25	9 (6.9)	14 (5.9)	23
25–45	39 (30.0)	111 (46.6)	150
> 45	82 (63.1)	113 (47.5)	195
Male	12 (9.2)	18 (7.6)	30
Female	118 (90.8)	220 (92.4)	338
Years of experience			
1–5	19 (14.6)	30 (12.6)	49
6–15	24 (18.5)	76 (31.9)	100
16–25	27 (20.8)	53 (22.3)	80
26–35	36 (27.7)	21.0)	86
> 35	24 (18.5)	29 (12.2)	53
Hours of training in DV			
No training	41 (31.5)	62 (26.1)	103
< 24 hours	74 (56.9)	156 (65.5)	230
More than 24 h	15 (11.5)	20 (8.4)	35

Perceived preparation to manage DVA

As mentioned previously, participants were asked to rate their level of preparation with regard to managing various aspects of DVA on a scale of 1–7. Most rated themselves as slightly to moderately prepared as shown in Figure 1. Most participants felt more prepared to follow national guidelines (mean 5; SD 1.8), identify signs and symptoms of DVA (mean 4.8; SD 1.6) and appropriately respond to disclosure of DVA (mean 4.7; SD 1.8). However, most participants felt less prepared to assess the readiness for change (mean 3.9; SD 1.8), conduct a safety assessment (3.6; SD2) and create safety plans (mean 3.5; SD2) for affected women. Figure 1 presents the differences in mean scores (SD) between Australian and UK participants.

Perceived knowledge of DVA

Participants rated their perceived knowledge of DVA on a scale of 1–7 with most feeling that they have little to moderate knowledge with regard to items: why women do not disclose (mean 4.91; SD 1.9), sign and symptoms of DVA (mean 4.76; SD 1.6) and national guidance on child protection issues (mean 4.6; SD 1.8). Participants rated themselves relatively low on knowledge about the perpetrators

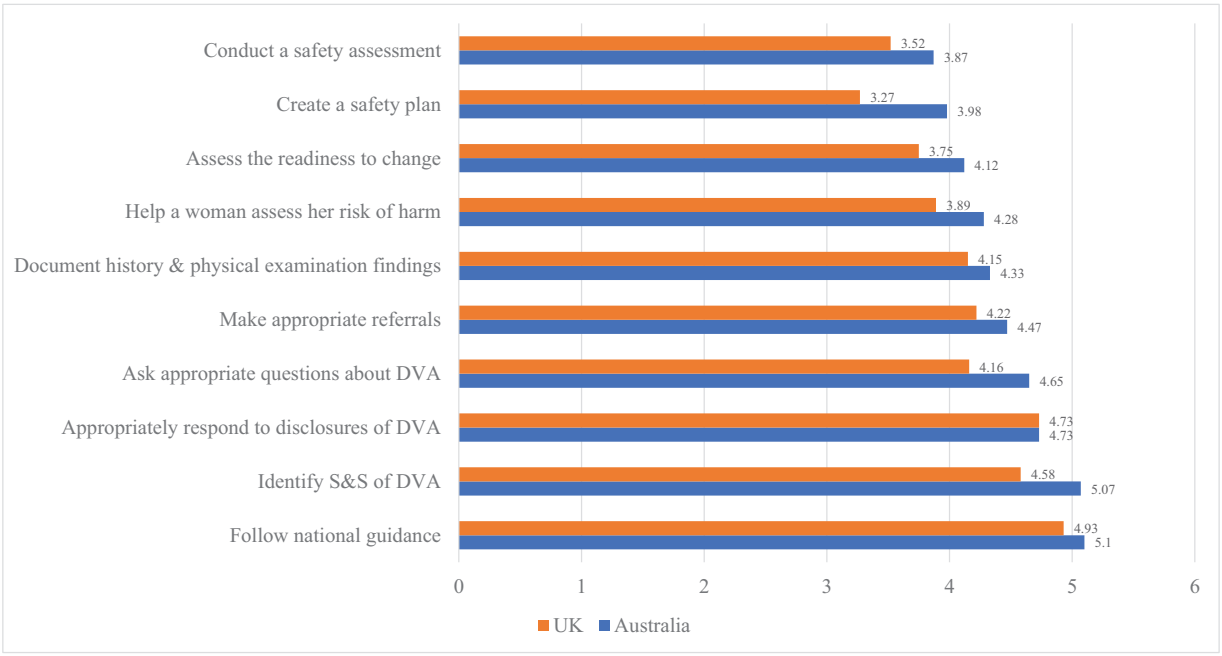

FIGURE 1 **Perceived Preparedness with regards to DVA among nurses from UK and Australia.** (1 = Not prepared; 2 = Minimally; 3 = Slightly, 4 = Moderately; 5 = Fairly well; 6 = Well; 7 = Quite well prepared)

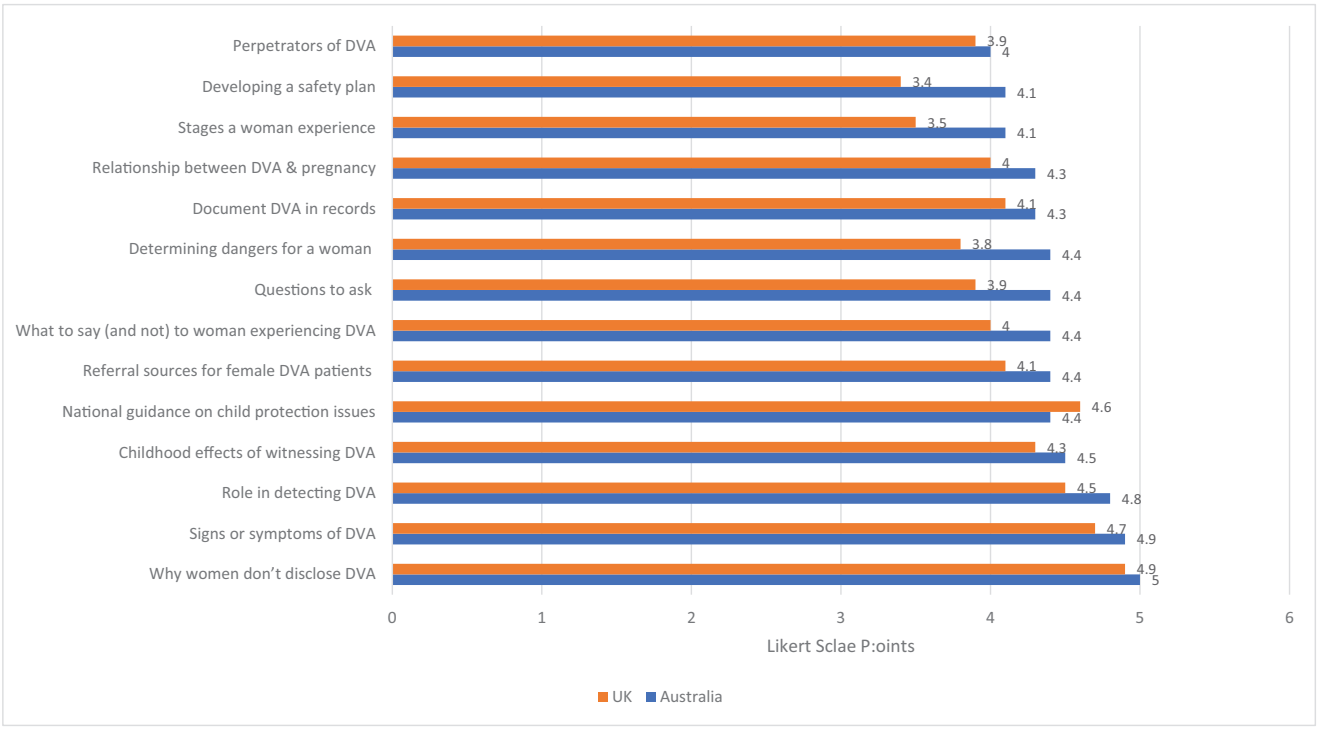

FIGURE 2 **Perceived knowledge about DVA among nurses from UK and Australia.** (1 = nothing; 2 = very little; 3 = a little; 4 = a moderate amount; 5 = a fair amount; 6 = quite a bit; 7 = very much

(mean 3.9; SD 1.801), stages women experience (mean 3.7; SD 2) and developing a safety plan (mean 3.6; SD 2). Figure 2 reports the mean scores (SD) between the two countries.

Actual knowledge about DVA

Most participants, from both countries, demonstrated a good understanding of the medical conditions associated with

DVA. The common indicators of the DVA and the reasons why women may struggle to leave an abusive relationship (Supplementary File S2). However, less than a quarter (11%) thought it was appropriate to ask directly if the partner had ever hit or hurt the woman, and only 30% knew that women have reasons for not leaving.

Attitudes about DVA

Understanding women's experiences

Participants showed some understanding of women's situations within the context of abuse. Most participants felt that nurses have a responsibility to ask all patients about DVA (4.4; SD1.9). Most participants did not think that women staying in abusive relationships should accept responsibility for their situation or they could leave the abusive relationship if they wanted to (mean 1.62; SD 1.3). Most participants also disagreed that there was little they could do if the woman did not acknowledge the abuse (mean 2.9; SD 1.6) (Supplementary File S3).

Role of alcohol

Most participants agreed that use of alcohol or other drugs is related to DVA (mean 4.7; SD 1.5) and alcohol abuse is a leading cause of DVA (mean 4.4; SD 1.6). However, participants were less likely to agree with the statement suggesting that female patients who abuse alcohol/other drugs are likely to have a history of DVA (mean 3.8; SD 1.5).

Preparedness

Most participants somewhat agreed to statements related to being aware of national legal reporting requirements, having necessary skills to discuss DVA with male, female patients and those from a different culture/ ethnicity (mean score; 4.1 to 4.4); however, mean score for statements about having sufficient training (mean 3.9; SD 2) and knowledge (mean 3.65; SD 1.9) to assist victims in addressing DVA remained relatively low.

Self-efficacy

The mean score of the statements about nurses' comfort in discussing DVA with patients was 4.5 (SD 1.8). The mean scores for all other statements with regard to the ability to gather information about DVA when a patient presented with a condition like depression or migraine (mean 3.6; SD 1.6), ability to identify DVA without asking questions (3.3; SD 1.6), asking every new female patient about DVA (mean 3.1; SD 2.2) and the possibility of identifying DVA by the way women behave (mean 3.2; SD 1.5) remained lower than 3.7 indicating a disagreement (Supplementary File S3).

Workplace issues

Most participants felt that they can make appropriate DVA referrals (mean 4.8; SD 1.9), their organizations encourage them to respond to DVA (mean 4.7; SD 1.9) and they have contacted services to refer women (mean 3.7; SD 2.5). Most also agreed that they can gather the necessary information to identify DVA (mean 3.8; D 1.7) and that there is adequate space in the setting to support women (mean 3.9; SD 2). However, participants from both countries disagreed that their setting allows them adequate time to respond to women experiencing DVA (mean 3.4; SD 2).

The action taken when DVA was identified

As indicated in Supplementary File S4, in the last 6 months of completing the questionnaire, between 10% and 27% of participants reported providing information, education or counselling to women; however, safety planning occurred much less frequently. The most common sources of referrals included child protection team/social services (17.1%), individual counselling (15.5%), domestic violence advocate/social worker (14.7%), police (13.6%) or domestic violence service/refuge (11.2%). Most participants remained unsure about the existence of a protocol and only 16% of participants felt that it is widely used in their setting. Twenty-five percent (25%) of the respondents stated not having DVA patient education material (for example, posters and brochures) available within the workplace, and only 5% of the participants mentioned always providing patient education or resource materials, though nearly 17% mentioned providing material on request. Similarly, only 11.7% of the participants mentioned having adequate DVA referral resources for women at their worksite and only 11% mentioned having adequate knowledge of referral resources in the community.

Inferential analysis

There was no statistically significant difference in the mean knowledge score of nurses in the UK (57.20 ± 22.97) and Australia (63.03 ± 23.14) [t (347) = 1.830, p = 0.06]. Similarly, no differences were observed among the mean preparedness scores of UK (4.12 ± 1.60) and Australian (4.46 ± 1.60) [t (366) = 1.957, p = 0.05] nurses. However, significant differences were observed between the mean attitude scores of UK (98.01 ± 16.91) and Australian (102.77 ± 15.96) nurses ± 23.14) [t (284) = 2.311, p = 0.02].

Positive correlations were found among demographic variables and mean preparedness, knowledge and attitudes. Age was positively associated with preparedness (r = 0.22, $p < 0.01$), knowledge ($r = 0.21$, $p < 0.01$) and attitudes ($r = 0.13$, p = 0.03). The mean clinical experience was also positively associated with preparedness ($r = 0.10$, $p = 0.048$) and knowledge (r = 0.11, p = 0.045), although there was no correlation with attitudes (r = 0 .09, p = 0.117). The hours of domestic

violence training were positively associated with the preparedness ($r = 0.24$, $p < 0.01$) and knowledge ($r = 0.24$, $p < 0.01$). However, there was no association between the hours of training and attitudes ($r = -0.18$, $p = 0.787$).

DISCUSSION

This is the first large-scale and cross-sectional study that explored the knowledge, attitudes and preparedness of UK and Australian registered nurses and midwives in relation to DVA. Findings indicated that although participants felt they had knowledge about DVA, there was discordance between perceived and actual knowledge. This may be explained by the fact that participants from both countries indicated receiving minimal training and education about DVA. These findings are not surprising considering previous research has identified that undergraduate nursing and midwifery curricula lack DVA educational content, meaning many newly qualified nurses and midwives are ill-equipped to support women who experience DVA (Hutchinson et al., 2020).

Lack of training not only affects a practitioner's confidence and ability to assess situations where DVA is taking place but, more significantly, can also jeopardize the life or safety of the victim (Ali et al., 2022). It should also be noted that having sound knowledge of DVA may also not help nursing and midwifery students to appropriately recognize and respond to DVA situations (Bradbury-Jones & Broadhurst, 2015). Lack of education and training among nurses and midwives is particularly concerning (Ali et al., 2022) considering international and national guidelines that place the nursing and midwifery profession at the forefront of the provision of care for those who experience abuse (Doran et al., 2019; Lovi et al., 2018; WHO, 2013b). Congruent with international and national expectations was the acknowledgement by the participants, in this study, of their professional role in screening for DVA. This was despite practice constrained by the limitations associated with, for example, lack of education, limited resources and demands on time. Lack of knowledge and resources associated with DVA combined with the limited implementation of DVA interventions such as safety planning, as found in this study, can result in missed care opportunities for women.

DVA against women is complex and multifaceted, often resulting in trauma, and evidenced by the multiple and intersecting physical, psychological, and psychosocial impacts experienced by those exposed to abuse. Considering the skill required in the provision of such care, it is not surprising that less than a third of participants in this study indicated they had provided care or taken action to support women who may have been experiencing DVA. To provide therapeutic care to those exposed to DVA, a multifaceted and holistic trauma-informed care approach is needed (Stokes et al., 2017) and nurses and midwives need to be provided with educational and training opportunities to develop this skill. Aligned with the findings of this study, research has identified that healthcare professionals are often ill-equipped, and lack support and training in providing care for individuals exposed to DVA. Additionally, a lack of resources and interagency referral can act as barriers to providing holistic care to women (Bellia et al., 2020; Vijayalakshmi et al., 2020).

Generally, both nurses and midwives require greater knowledge and education, and the ability to apply this knowledge to assist those experiencing DVA. This education should integrate trauma-informed care in recognition of the severe and lasting impacts of DVA. Consistency in the approach to equipped nurses and midwives with the ability to provide care for DVA victims can assist with meeting the expectations of national and international guidelines of both professions in helping reduce the increasing burden of DVA on individuals, communities and society.

Limitations

The number of Australian participants was much lower than UK participants and some Australian participants did not provide any demographic information, which may have helped us analyse the data further. The tool while theoretically should only take 15–30 min, can be perceived very long and may have affected completion of the questionnaire. Another limitation is that the tool and our study only asked about DVA against women and not men. There is greater recognition now that men also experience DVA, further research needs to be conducted to explore nurses and midwives' ability to support anyone experiencing DVA regardless of their gender or identity.

Implications for nursing policy

Nursing institutions should develop strategic policies regarding mandatory preparation and training of nurses for domestic violence assessment and management. It is necessary to develop policies to increase awareness, knowledge and preparation of the nurses, midwives and other healthcare professionals in their response to ensure the appropriate identification and management of DVA.

CONCLUSION

DVA is a sensitive and complex issue, and how it is taught at a pre-qualifying level can have implications on the practitioner's preparedness to deal with DVA and to provide appropriate and sensitive care. Use of various educational strategies that include addressing attitudes and commonly held beliefs may help to engender a better understanding of the phenomenon and as a result may help prepare nurses and midwives. Further research should explore the quality and quantity of education provided to pre-registration nursing and midwifery and allied healthcare students. There is also a need to explore the abilities of nurses, midwives and allied healthcare professionals to support victims of DVA from diverse cultures.

AUTHOR CONTRIBUTIONS

Study design: PA, JM, EL; data collection: PA, RA, JM; data analysis: PA, RA, AY, RW; study supervision: PA, JM, EL; manuscript writing: PA, JM, RA, EL, AY, RW; critical revisions for important intellectual content: PA, JM, RW, EL.

CONFLICTS OF INTEREST

No conflict of interest has been declared by the authors.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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