RESEARCH REPORT | JULY 2022

Family violence against Australian nurses, midwives and carers.

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ANMF Australian Nursing & Midwifery Federation VICTORIAN BRANCH

THE UNIVERSITY OF MELBOURNE

Health, Wellbeing & Relationship Project

Dedication

This report is dedicated to the nurses, midwives and carers who have been working tirelessly to hold up the sky during the COVID-19 pandemic. We are all in this together.

Acknowledgement of Country

We acknowledge that much of this study took place on the traditional lands of the Wurundjeri People of the Kulin Nation. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging and acknowledge the ongoing harm of transgenerational trauma and racism.

Acknowledgement of Survivors

We acknowledge the survivors of family violence who read this work and who contributed to it. We hope it is sensitive to your experience. We acknowledge the multifaceted harms of all forms of family violence and recognise the individual stories of hope and strength that form the basis of this research.

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Author acknowledgments

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Acronyms & abbreviations

ABS	Australian Bureau of Statistics
ANMF (Vic Branch)	Australian Nursing and Midwifery Federation (Victorian Branch)
CAS	Composite Abuse Scale
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
F	Female
FV	Family violence
IPV	Intimate partner violence
M	Male
MRS	Men's Referral Service
Mths	Months
NMHPV	Nursing Midwifery Health Program Victoria
PSS	Personal Safety Survey
PTSD	Posttraumatic Stress Disorder
SA	Sexual assault
SHRFV	Strengthening Hospital Responses to Family Violence

Definition of terms

Family violence

Family violence (FV) refers to behaviour by an intimate or non-intimate family member of a physically, sexually, emotionally or economically abusive, threatening or coercive nature, that may cause a feeling of fear.[1, 2] FV includes abusive behaviour between parents in the home where a child lives. In Victoria, Australia, FV has long been the preferred term by Aboriginal and Torres Strait Islander peoples and is employed throughout both the practitioner, policy and research spheres.[3, 4] When FV is used within this report it refers to a spectrum of violent and abusive acts that might be perpetrated by an intimate or non-intimate family member, including exposure during childhood.

Intimate partner violence

Intimate partner violence (IPV) is defined as physically, sexually or psychologically abusive, controlling and harmful behaviours perpetrated by an intimate partner.[5] When the term IPV is used within this report, it specifically refers to violence by a co-habiting or non-co-habiting intimate partner (i.e. boyfriend, husband, etc) within an established relationship (i.e. six or more months duration). IPV is used when reporting findings from the Composite Abuse Scale (CAS).[6] Research shows that while both men and women can act abusively towards their partner, IPV is most likely to be perpetrated by a man against his female partner or ex-partner, and survivor women are more likely than survivor men to describe acts of IPV against them as inducing "terror".[7, 8, 9]

Sexual assault

Sexual assault describes acts of a violent sexual nature carried out without consent and with force, intimidation or coercion, including rape, attempted rape and other forced sexual activity by an intimate partner, acquaintance or stranger.[10] Sexual assault does not include unwanted sexual touching (i.e. sexual harassment). Within this report, 'sexual assault' is used to refer to non-partner sexual violence as well as items in the CAS[6] that reference rape and attempted rape by an intimate partner.

Reproductive coercion

Reproductive coercion indicates behaviour that interferes with the independent decision-making of a woman in relation to her reproductive health.[11] In this report, reproductive coercion is used to refer to the use of force or attempted force of a woman to become pregnant when she does not want to be (including by tampering with birth control), or to end a pregnancy against her wishes.

Technology-facilitated abuse

Technology-facilitated abuse refers to abusive behaviour facilitated via a technological device (i.e. mobile phone, computer) by a person with whom there has been a casual or serious intimate relationship.[12] Within this report, technology-facilitated abuse refers to the behaviours of monitoring a person's whereabouts using tracking software or distributing or threatening to distribute nude images or video without permission.

Child abuse

Child abuse refers to a range of behaviours that are often encompassed by the term FV, including living in a home where there is parental violence growing up (which we refer to as 'exposure to FV').[10] This project included questions about child abuse based on the Australian Bureau of Statistics Personal Safety Survey (ABS PSS) which refers to behaviour of a physical or sexual nature occurring before the age of 15 years causing physical or sexual harm, perpetrated by somebody over the age of 18 years, from within or outside the family.[13]

Survivor

The term survivor denotes people with lived experience of intimate partner and familial abuse and violence.[14] This term was chosen for use throughout this report because it recognises the strength and resilience of people who have experienced FV and continue to survive. Within this report, 'survivor' refers to an ANMF (Vic Branch) female or male member who has experienced one or more forms of FV.

Member

When the word member is used, it indicates a person with Industry Union membership to the ANMF (Vic Branch), usually a Victorian nurse, midwife or carer.

First line support

First-line support is the recommended initial support for FV survivors in response to someone's practical, emotional, physical, safety and support needs. The World Health Organisation (2014) first-line support model is Listen, Inquire about needs, Validate experience, Enhance safety and offer ongoing Support (LIVES).[88]

How to read the results

The results for women and men are presented separately in this report because men comprised less than a tenth of all project participants and because the gendered nature of DFV in the community suggests the possibility of a different pattern of abuse for men.[15] Where there were not enough male respondents for analysis or the data was not statistically significant, only women respondents' data is presented.

The prevalence of IPV reported by men respondents in our study was disproportionately high compared with national Australian community prevalence rates.[15] There are several factors associated with this finding to keep in mind when reading this report. First, a much higher proportion of men in our study were in a same sex relationship (13.1%, while a further 27.3% did not disclose the sex of their partner) compared to the general community in the ABS PSS (<1.5%).[15] Second, the prevalence of child abuse was higher for men (50.8%) than women (44.0%) and child abuse was associated with higher odds of reporting adult IPV, indicating a life course effect. Third, the margin of error across all the men's data was 4% and there was a relative standard error of up to 12% for men's IPV data, necessitating a greater degree of caution when interpreting this data (for more information, see Appendix A). Fourth, the only two other international studies of men nurses' experiences of IPV in the last 12-months also found that men nurses reported a higher prevalence of IPV than women. This did not reflect community prevalence in the countries where that research was conducted.[23, 43]

A note about age ranges used across the report:

IPV (victimisation and perpetration), technology-facilitated abuse and reproductive coercion was measured since the age of sixteen years, while non-partner adult sexual assault was defined as occurring since fifteen years and childhood abuse before fifteen years. These differences in age reflect the definitions used in each validated measure.[6, 12, 13]

Finally, the survey completed by nurses for this project was conducted in the few months before the COVID-19 pandemic began.

Project summary

Project findings in brief

- → Family violence (FV), including child abuse & intimate partner violence (IPV), was common among both women & men survey respondents. Half of women IPV survivors had been poly-victimised, having also experienced adult sexual assault and/or child abuse.
- → On every measure of health & wellbeing, women and men respondents who had experienced IPV reported worse health and at least twice the number of health professional visits compared to their colleagues without a history of IPV.
- → IPV had impacts for survivor respondents at work, including by intruding into the workplace.
- → Respondents who had experienced FV thought that the ANMF had a role in strengthening FV advocacy & support.

Key recommendations for ANMF (Vic branch) & healthcare workplaces

Raise awareness that FV affects women and men in nursing, midwifery and caring roles with an information campaign that includes survivor stories.

Adopt a trauma and violence-informed approach to guide leadership, education and advocacy on the topic of FV against nurses, midwives and carers, harnessing specialist
FV and health professional expertise.

Develop an online portal with easily accessible FV information for survivors and perpetrators (administered by the ANMF [Vic Branch]).

Collaborate with experienced others to establish an education campaign about responding to FV disclosures by colleagues and ensure that relevant ANMF (Vic Branch) staff receive training in first-line FV support.

Promote first-line training among managers, senior nurses and others where ANMF (Vic Branch) members are employed and advocate that all University nursing and midwifery courses include FV education.

Advocate to change a culture in healthcare workplaces of inflexibility where people fear negative repercussions if they take leave to which they are entitled as survivors.

Understand that workplace safety is an extra issue for FV survivor staff; occupational abuse and aggression can both compound and trigger FV trauma.

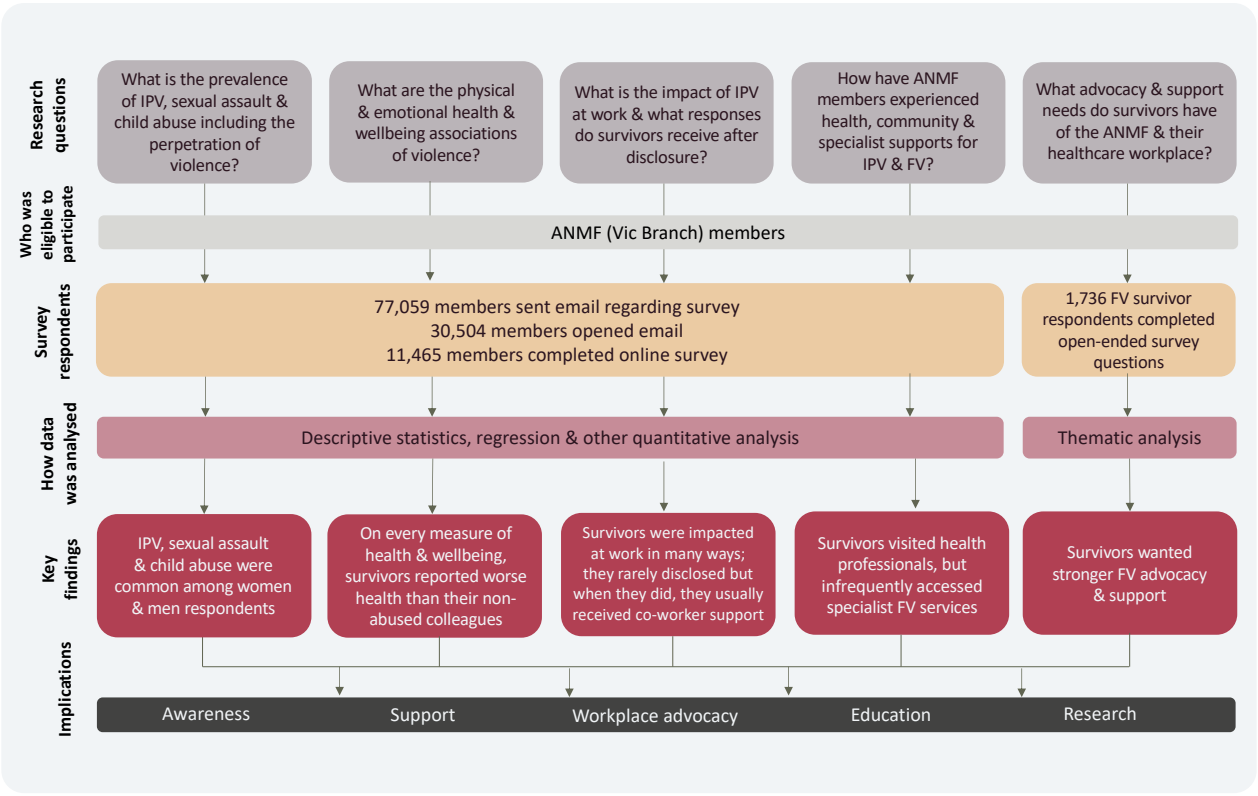
Project background: Family violence against nurses, midwives & carers

Family violence (FV) is a devastating health and social problem in Australia and internationally. It is linked with health issues as varied as depression, anxiety, pregnancy complications and substance use.[15, 16] Survivors of FV access health services more frequently than other people, and nurses, midwives and carers are frontline responders to patient survivors presenting for healthcare.[17] Recent Australian research suggests that health professionals may be at increased risk of FV in their personal lives compared to the broader community, however, more evidence is needed.[18] The report of this research documents the largest FV survey of health professionals in the world.

Project aim

To investigate the prevalence of different forms of FV among nurse, midwife and carer members of the ANMF (Vic Branch), associated health and workplace impacts, service use and support needs (Figure 1).

Figure 1. ***Health, Wellbeing & Relationships Project*** **overview**



Method

An online survey was completed by 10,629 women and 772 men who were ANMF (Vic Branch) members, representing a response rate of 14.9% of everyone sent a project email and 37.6% of those who opened the email. The survey covered six topics (Figure 2), with the largest being violence and abuse. All participants were given information about FV support.

Figure 2. Survey topics

KEY FINDING 1

Adult 12-month & lifetime family violence was common among women & men respondents.

- In the last 12-months, around 1 in 5 women and men had experienced violence by an intimate partner, with more women (7.3%) than men (5.5%) having felt afraid of their partner.
- Across the adult lifetime, 45.1% of women and 35.0% of men had been in a violent relationship.
- Non-partner adult sexual assault had been perpetrated against 18.6% of women and 7.1% of men.
- During childhood, sexual abuse was more widespread against women as girls (14.1%) compared to men as boys (11.4%), while more men as boys (39.2%) had experienced physical abuse compared to women as girls (28.7%).
- Overall, exposure to physical/sexual abuse or exposure to IPV as a child was reported by 50.8% of men and 44.0% of women.
- Half of IPV survivor women had been poly-victimised by also having experienced non-partner sexual assault or child abuse.
- Since the age of sixteen, 11.7% of men and 1.7% of women had behaved in a way that had made a partner or ex-partner feel afraid of them. In the last 12-months, 8.0% of men and 6.0% of women told us they had used controlling, threatening or physically/sexually violent behaviour against their partner.

KEY FINDING 2

Survivor respondents' reported worse health & more visits to a health professional than their colleagues without IPV.

- The odds of suffering poor physical or psychological health, engaging in hazardous drinking, experiencing financial stress and/or reduced social connection were 2-3 times greater for IPV survivor women and men respondents compared to respondents without a history of IPV.
- Survivor women and men respondents were twice as likely to have attended a health professional at least once during the last 12-months compared to their colleagues without a history of IPV.
- Only one in four survivor women had accessed a specialist FV support service during the last 12-months.

KEY FINDING 3

IPV had impacts for survivor respondents at work.

- 1 in 4 survivor respondents (women and men) said their partner had attended work to harass them during the last 12-months.
- One in three women and one in four men had ever spoken about IPV to someone at work.
- For a quarter of these women, their privacy had not been protected and one in ten had received a negative response from their manager.
- During the last year, 31.6% of 12-month survivor women and 30.3% of men had taken leave from work due to their partner's behaviour. Rarely was FV Leave accessed; only 2.1% of survivor women and no survivor men had taken FV Leave. Alternatively, personal/sick had been sought, followed by unpaid and annual leave.

KEY FINDING 4

Survivor respondents thought that the ANMF had a role in strengthening FV advocacy & support.

Survivor member respondents wanted the ANMF (Vic Branch) to:

- Raise awareness that FV happens to ANMF (Vic Branch) members (not just their healthcare patients);
- Act to reduce FV stigma in healthcare workplaces and the broader community;
- Ensure safer & more flexible healthcare workplaces, where FV survivors feel comfortable to access leave to which they are entitled;
- Deliver quick information about accessible & affordable counselling, advocacy, resources & other FV support for survivors.

Implications

This research indicates the importance of greater awareness about the prevalence and impact of FV against nurses, midwives and carers as a specific group of individuals at the frontline of responding to the health and safety of survivor patients presenting for healthcare. The Project findings have implications for FV survivors, health professional practitioners, the ANMF (Vic Branch), healthcare workplaces, educators and researchers.

Listening to the voices of FV survivor respondents, this report recommends greater awareness, targeted support, workplace advocacy, education and research. This could strengthen FV-specific safety and recovery-focused support and resources for survivor nurses, midwives and carers.

Forward

The Victorian Branch of the ANMF represents more than 95,000 nurses, midwives and personal care workers, almost 90 per cent are women.

Our members are the backbone of the health and aged care sectors. They are the carers of the sick and the elderly; they care for women during pregnancy and as they give birth; they provide care and support to families as they raise children.

In community surveys, nurses and midwives are always among the most trusted and respected professionals. But as this report shows, our members' status as healthcare workers does not protect them from the family violence that is unacceptably common in Australia, particularly against women. On the contrary, this study makes clear that nurses, midwives and carers are more likely to experience intimate partner violence than the general population.

We knew from the researchers' smaller survey of women healthcare workers at a major metropolitan Melbourne hospital that our members are over-represented in family violence statistics. Wanting to know more in an effort to ensure the best advocacy and support for our members, ANMF (Vic Branch) approached Dr Elizabeth McLindon to expand on her research.

I would like to thank every one of the 11,465 ANMF members who filled out the University of Melbourne survey, especially the survivors of family violence for whom providing this information would have taken courage. Your contribution has created the largest collection of data globally about the experience of intimate partner violence by nurses, midwives and personal care workers.

This research shows that when nurses and midwives provide care for those who are experiencing family violence, there is a significant chance it will be against the backdrop of their own experiences of violence from an intimate partner.

ANMF cares about the impact of violence and aggression directed to our members in their working lives. We also care about the violence and aggression our members have and are experiencing in their personal lives. As this research shows, there is no separation; our members' work and personal lives are intertwined.

Family violence is a health issue. Nurses, midwives and carers who had experienced intimate partner violence were two to three times more likely to experience poor physical or psychological health, engage in hazardous drinking, experience financial stress or reduced social connection.

I wish to thank the many people involved in this research project. From the University of Melbourne Dr Elizabeth McLindon, Prof Kelsey Hegarty and Assoc Prof Kristin Diemer for their commitment and passion; they are inspiring women. Also, to Glenn Taylor, CEO of the NMHPV, past and present members of our Branch Council who gave their time to assist in an advisory capacity, President Maree Burgess, Vice President Andrew Morgan, Lara Jeffrey and Carol Munro.

ANMF (Vic Branch) promises our members their contribution to this important research will not be in vain. This research has provided us with rich information about what it is that our members need from us as their union. We will work with family violence, well- being and other experts, to implement additional support measures that will have practical application for members who have experienced, or are experiencing, family violence, and advocate in the workplace to prevent family violence being perpetrated. This research study is the beginning.

Lisa Fitzpatrick
ANMF (Victorian Branch) Secretary
June 2022

PART A:

Introduction

This section of the report provides an overview of family violence and outlines the contribution to new knowledge made by this research.

Overview

Family violence (FV), including intimate partner violence (IPV), child abuse and sexual assault, are significant health and social issues leading to multiple impacts for survivors.[19] The title of this report, "You can't swim well if there is a weight dragging you down", is a quote from a survivor respondent hinting at the burden and harm of FV.

Australia's IPV prevalence is towards the lower end of the global estimate spectrum of 4% to 75%.[16] One in six adult women and one in sixteen men have experienced physical or sexual violence by a current or former partner in Australia, while emotional partner abuse affects a quarter of women and one in six men.[20] In community surveys of 12-month IPV, 2.3% of Australian women and 1.1% of men tell us physical or sexual partner violence was perpetrated against them, while 4.8% of women and 4.2% of men report emotional partner abuse.[20] Many children are exposed to violence against a parent, causing them psychological and physical harm and increasing the likelihood of abuse in their future intimate relationships.[15, 20]

FV hurts. Violence by a partner or other family member is linked with health issues as varied as depression, anxiety, self-harm, pregnancy complications and substance use.[16, 21, 22] Consequently, FV survivors access health services more frequently than other people.[17]

Recent research with nurses in Australia[18] and the United Kingdom[23] suggests that the prevalence of FV against nurses, midwives and carers (hereafter referred to as 'nurses'), may be higher than the general population. The impact of FV may be particularly influential for nurses given their job as first responders to survivors who present for healthcare. Further, nurses' work can be dangerous; they encounter a higher volume of occupational abuse and aggression from patients and visitors compared to employees in many other industries.[24, 25]

The Australian Nursing and Midwifery Federation (ANMF) (Vic Branch) have a long record of supporting nurses, midwives and carers. In 2016, the Victorian State Government provided up to 20 days of FV leave in a twelve month period to public sector employees including nurses and midwives. The ANMF (Vic Branch) have recognised the importance of understanding more about how FV affects their members and it was within that context that this research was commissioned.

This is a report of the prevalence of various forms of FV against nurses (including IPV perpetration), associated physical, emotional and social health impacts, attendance at health and community services, the response by employers when a workplace disclosure has been made, other employment impacts, as well as advocacy and support needs of this group of survivors.

Research contribution of the project & report outline

This report makes three distinct contributions to the field of understanding and supporting nursing and other health professional survivors of FV.

Firstly, it is the largest investigation of the prevalence of various forms of FV against health professional women and men in the world. Secondly, the study includes rigorous analysis of the health, employment impacts and service utilisation for this specific group of survivors. Thirdly, the report results in informed recommendations for ANMF (Vic Branch) advocacy to more effectively support nurses who, in turn, care for the sick and injured in our community. This study continues the long tradition of breaking the silence about FV in order to better understand, support and care for all survivors.

Part B of this report gives a brief overview of the existing research about FV against nurses, highlighting literature set in the healthcare workplace. In Part C, the cross-sectional survey is detailed, as are the ethical issues and limitations of the project. Part D provides a description of those who took part in this study before their research findings are presented. Part E discusses the findings and summarises the conclusions, while Part F presents recommendations for ANMF (Vic Branch) advocacy.

PART B:

What we know about family violence against nurses

This section of the report delves into existing research about FV against nurses and FV in the workplace. After gaps in the evidence-base have been detailed, the purpose of the current study to address those gaps is presented.

The prevalence of FV against nurses

Nurses, midwives and carers' work in health services ideally positions them to respond to the health sequelae of FV with which patients present.[26] Nursing is highly gendered work, mostly undertaken by women, in an environment where occupational abuse from patients is widespread.[25, 27] For some decades now, Australian and international health systems have understandably been focused on strengthening health professionals' capacity to provide the best care to survivor patients.[26, 28] However, an international body of research has been building to bring the clinician as the survivor into the frame.[23, 29-31] Most of the research about survivor health professionals has been with nurses, finding that FV prevalence is either lower [31-34] or similar to the national population among whom clinician respodents live.[29, 34-39] However, a smaller number of studies have found a higher prevalence of FV against health professional respondents compared to the general population.[18, 23, 40-43] Only two (small sample) studies have asked healthcare worker men (most of whom were nurses) about 12-month IPV, and both found a higher proportion of men compared to women reported exposure, including to physical IPV.[23, 43]

Trauma across the life course and choice of profession

Early life experiences may influence later career choices. Some literature has found an overrepresentation of people who work in mental health, social work, counselling and similar therapeutic fields ('*helping professionals*'), who have experienced childhood adversity and trauma.[44, 45] Explanatory theories for this '*wounded healer*' finding include the idea that people who enter these types of helping professions may have enhanced empathy developed through personal experience.[46] Further, helping professionals may be motivated to transform their adverse experience in order to help others - to be the person they needed.[47, 48] It could also be the case that helping professionals participating in research are more willing or able than others to identify themselves as survivors of trauma because of self-reflective training, supervision and clinical experience with patients.[45, 49] In short, helping professionals may have experienced a greater degree of adversity and hardship than others that is linked to their choice of career, or they may just be better able to identify as trauma survivors compared to others. This helping professional literature is relevant as a useful lens through which to understand the prevalence of trauma and adversity in the lives of people working in similar helping fields, including healthcare.

FV is an occupational issue

FV can impact upon the workplace in direct and indirect ways - survivors may be harassed at work, kept from attending work or suffer lost productivity, absenteeism and job insecurity.[50, 51] However, work can be a crucial component to escaping FV and being able to recover from its traumatic effects.[52] Employment affords financial resources, is a place away from the person at home using violence and can connect survivors with colleagues and others who can provide assistance.[53] It is within this context that workplaces are seen as ideal sites of FV awareness raising and intervention.[51] Not only is workplace action on FV critical to the mitigation of the many costs for both the survivor employee and their employer, FV is an employment equity issue.[51] Workplaces that lack flexibility, understanding and resources unfairly disadvantage FV survivors.[51]

Survivors face many barriers to disclosing FV in their workplace: feelings of shame, embarrassment and the fear of implicit or explicit negative repercussions if they speak up.[54, 55] It is possible that nurses, midwives and carers' may confront additional barriers to seeking support or talking about FV in their healthcare workplace because their role positions them as experts in caring for survivor patients. To better understand and support nurses, some important research questions remain.

Limitations of previous research

Previous research with nurses and other health professionals has not been without limitation, including a lack of rigor in the measurement of IPV and FV,[31, 32, 40] studies with small sample sizes,[35] and low or unpublished response rates.[23] All of these research issues make it difficult to generalise existing survivor health professional research to others working in healthcare. Further, several data gaps affect what is known about FV more broadly: there has been a lack of research about: poly-victimisation, the overlap between victims and perpetrators, survivor men, FV Leave, and how survivors access services.[15, 56, 57]

Not only is workplace action on FV critical to the mitigation of the many costs for both the survivor employee and their employer, FV is an employment equity issue.[51]

Purpose of the current study

The current study sought to address the gaps in the literature as well as extend our previous 2018 work about the prevalence of IPV and FV among a group of 471 health professional women (45.0% response rate) at one Australian hospital.[18] This previous study found that IPV had been experienced by 11.5% of nurses, doctors and allied health professionals during the previous 12-months, 29.7% since the age of 16 years. This findings indicated higher IPV prevalence than the community.[18] Across the life course, 45.2% of health professionals had been affected by IPV, FV or both.[18] In response to this research, the ANMF (Vic Branch) were interested to know if it reflected the broader prevalence of IPV and FV against nurses midwives and carers. Other research questions remained unanswered, including the experience of men and the needs of the nursing survivor workforce that were not being met. It was the ANMF (Vic Branch)'s investment in this research that led to the present study of survivor nurses and ultimately, the answers to those questions. This follows an admirable tradition of Unions leading participation in 'FV and the workplace' research.[50, 54, 55] In the next part of the report, the method designed to find answers to our research questions is detailed.

PART C:

Methodology

This section of the report outlines the methods used to answer the research questions. The survey method, respondent recruitment and ethical considerations are canvassed here. Analysis procedures are described, and a reflection of the project strengths and limitations provided.

Study aims & research questions

The aim of the *Health, Wellbeing & Relationships Project* was to quantify the problem of FV against nurses, midwives and carers on a large scale; to investigate impacts upon the workplace and associations with health and wellbeing, and, to understand what more effective, and targeted advocacy and support would look like for this group of survivors.

Study aims & research questions answered

01

What is the prevalence of intimate partner violence, sexual assault and child abuse, including the perpetration of violence among ANMF (Vic Branch) members?

02

What are the physical and emotional health and wellbeing associations of violence?

03

How have members experienced health, community and specialist supports for IPV and FV?

04

What is the impact of IPV at work and what responses do survivors receive after disclosure at work?

05

What advocacy and support needs do survivors have of the ANMF (Vic Branch) and their healthcare workplace?

Online survey

An online cross-sectional seven-part survey was developed for the whole population of ANMF (Vic Branch) members. Member nurses, midwives and carers work in a range of health settings across the southern Australian state of Victoria. Cross-sectional surveys are an effective method for measuring prevalence and associations, especially for sensitive and stigmatised research topics.[58] The primary focus of the survey was FV, including IPV, followed by health, wellbeing and workplace impacts. The number of survey items each respondent was presented with varied depending on answers they provided. For example, items about IPV impacts on the workplace were only presented to respondents who indicated that they had experienced IPV. Expert advisors, including nurses with lived experience, were critical to refining the survey. The survey was created and delivered online via Qualtrics.[59] A range of standardised measures were incorporated (Table 1). Produced in English, the survey was piloted with 35 people which led to modifications of wording and refined survey pathways.

Table 1. Measures included in the survey

Topic	Measure
Demographics	ABS PSS (12 items) [13]
Physical & emotional health	SF-12 (12 items) [61]
Depression	PHQ-4 (2 items) [62]
Anxiety	PHQ-4 (2 items) [62]
Posttraumatic Stress	Short Screening Scale for DSM-IV Posttraumatic Stress Disorder (7 items) [60]
Alcohol consumption	FAST (4 items) [63]
12-month & adult lifetime IPV	CAS (36 items) [6]
12-month & adult lifetime IPV perpetration	Bespoke (5 items)
Physical & sexual child abuse	ABS PSS (4 items) [13]
Exposure to IPV as a child	WAV Project (1 item) [18]
Non-partner sexual assault	ABS PSS (5 items) [13]
Technology-facilitated abuse	TAR Scale (adapted) (2 items) [12]
Reproductive coercion	Bespoke (2 items)
Workplace impacts of IPV	DV and the Canadian Workplace Survey (11 items) [64]
Health professional attendance & specialist service use	Bespoke (20 items)
Resilience	CD-RISC2 (2 items) [65]
Advocacy & support	Bespoke (5 open-ended questions)

Recruitment

The confidential and voluntary survey was conducted between 30 August 2019 and 7 February 2020. Information about the project was included in ANMF (Vic Branch) newsletters prior to survey commencement to both prime members and advise them of the sensitive research subject so that they could make an informed decision about if, when and where it would be physically and emotionally safe for them to participate. The ANMF (Vic Branch) Secretary sent an invitation email with a survey link to all members. A reminder text message was sent at two time points during data collection.

Participant safety & wellbeing

Throughout the project, the wellbeing of respondents was our main priority. The first page of the online survey contained information about the survey and a link to further plain language information on a Project webpage. At two points throughout the survey, FV specific and general support service phone numbers were displayed.

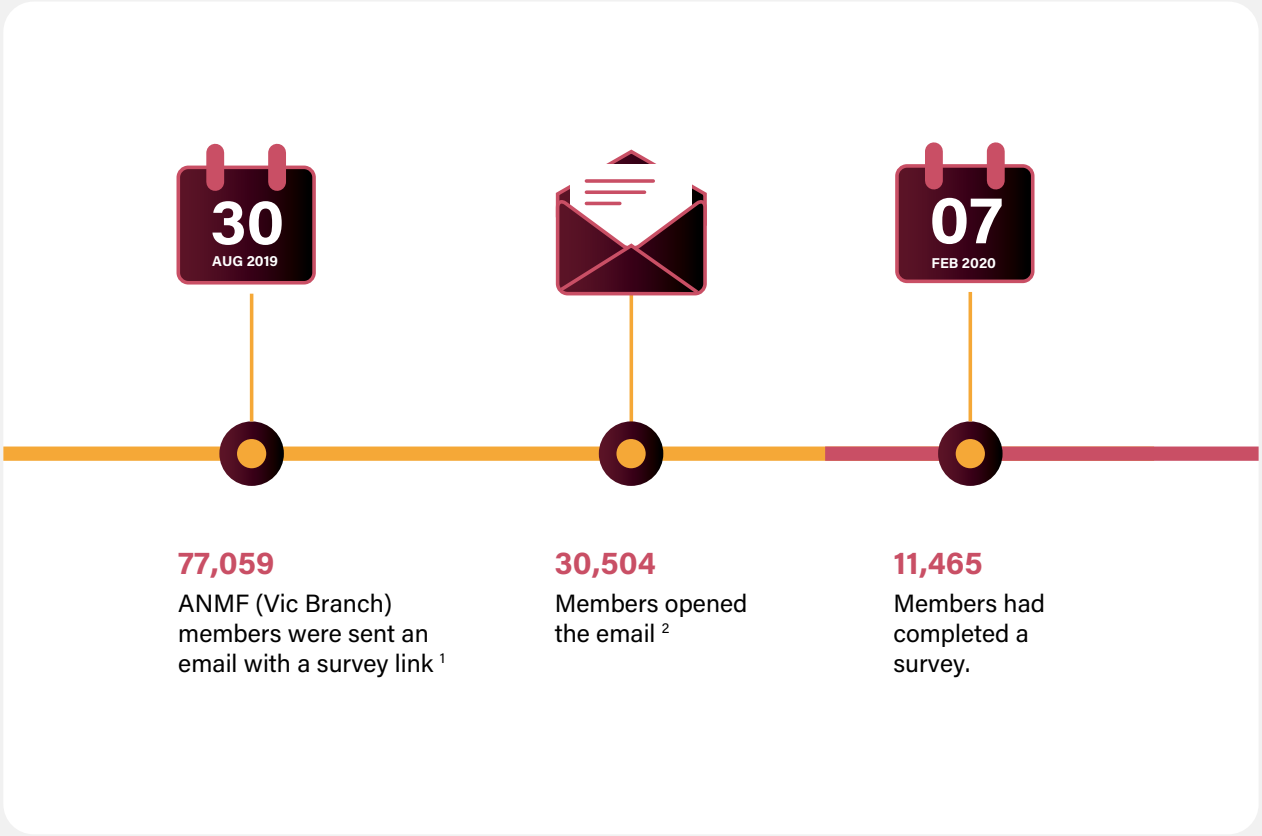
After the FV questions in the survey, a 1-minute mediation exercise, mindfulness resource and grounding practice was presented in the event that disturbing trauma memories or feelings had been triggered for a respondent. A 'Quick Exit' button was located on each page of the survey. The ANMF (Vic Branch) Secretary and the project team sent an email to all Victorian hospital Chief Nurses advising them of the survey and providing information about how to sensitively respond to disclosures, should the need arise. Respondents were encouraged to direct any questions or concerns about the survey to a project phone held by the lead researcher. No calls were made to the project phone for information or support during, or in the months following, recruitment.

Ethics approval was granted by the University of Melbourne Ethics Committee (Ethics ID: 1953826). Respondent consent was implied through survey submission.

Survey response rate

An email with the survey link was sent to all seventy seven thousand and fifty nine ANMF (Vic Branch) members, of whom 30,504 members opened the email and 11,465 members completed a survey. Based on everyone who was sent an email, the response rate was 14.9%; of those who opened the email, the response rate was 37.6% (Figure 3).

Figure 3. Survey timeline



Study strengths & limitations

This study is the most comprehensive investigation of the prevalence of IPV and other forms of interpersonal violence against nurses, midwives and carers to date. Strengths of the study include the large sample size and the use of well-validated survey measures.[6, 12, 13, 60-63, 65] While the response rates of 14.9% and 37.6% respectively are not optimal, given the sensitive nature of the study, the time it took to complete and the heavy work/life demands of respondents, it may be unsurprising. The response rate is also comparable or higher than similar studies.[23, 38, 66]

It is important to note that respondents may have differed from non-respondents in meaningful ways. Non-response bias, social desirability and self-reporting are all issues that can contribute to the under or over-reporting of violence in research.[67] While the sensitive nature of the survey may have been a barrier for some, and over-reporting is generally thought to be rare in FV research, survivors of violence may have been more interested and willing to take part in this study than other people, affecting our conclusions.[68, 69] A measure of IPV was used – CAS[6] – that has been validated with many populations, across multiple language groups, over several decades, but not with men.

For more information about the margin of error across all of the data and the relative stand error of the IPV prevalence data, see Appendix A.

Data analysis

Frequencies and percentages were used to understand and describe the respondents, FV prevalence, and health issues, employment characteristics and service utilisation. Odds ratios, 95% confidence intervals and *P*-values were performed to assess the likely size of associations between FV variables, health variables, and others. Quantitative data was imported, cleaned and coded using SPSS (version 25)[72] and analysed with STATA (version 15).[73]

Qualitative open-ended data varied in length from a short sentence to several paragraphs.

Due to the number of respondents, the amount of qualitative data for analysis was substantial. In this context, the thematic data analysis program NVivo (version 12) was employed to perform auto coding; identifying repeated words or phrases which were then manually coded by the lead researcher to explore concepts, links and meaning.[74] Concepts were then arranged into dominant themes and subthemes.

Having described the project method, the report now moves to the findings.

This study is the most comprehensive investigation of the prevalence of IPV and other forms of interpersonal violence against nurses, midwives and carers to date.

PART D:

Findings

This section of the report outlines key findings from the Health, Wellbeing and Relationships Project, beginning with respondent characteristics and results related to IPV and FV. This is followed by bio-psychosocial health and health professional attendance, impacts of IPV at work, utilisation of specialist IPV and FV services and finished with survivor advocacy and support needs.

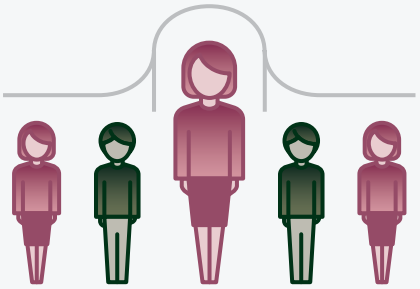
Respondent characteristics

The majority of respondents were women, consistent with the broader ANMF membership (Figure 4), and their response rate was ten percent higher than that of the men who opened a survey email. Respondents represented a slightly higher proportion of women and lower proportion of men compared to the broader ANMF membership. Three quarters were born in Australia (Figure 5) and nearly nine out of ten spoke English as their first language. The average respondent was aged between 45-49 years (Figures 6, 7) and most had children living with them (Figure 8). The majority of women worked part time - a higher proportion than their male colleagues (Figures 9). Appendix B presents complete demographic information of respondents compared to the broader population of the ANMF (Vic Branch).

Figure 4. Gender of respondents (*n*=11,465)

Non-binary *n*=13; Preferred not to say *n*=51

Figure 6. Average age of respondents (*n*=11,321)



45 - 49yrs

Figure 5. Respondents born in Australia compared to overseas (n=8,831)

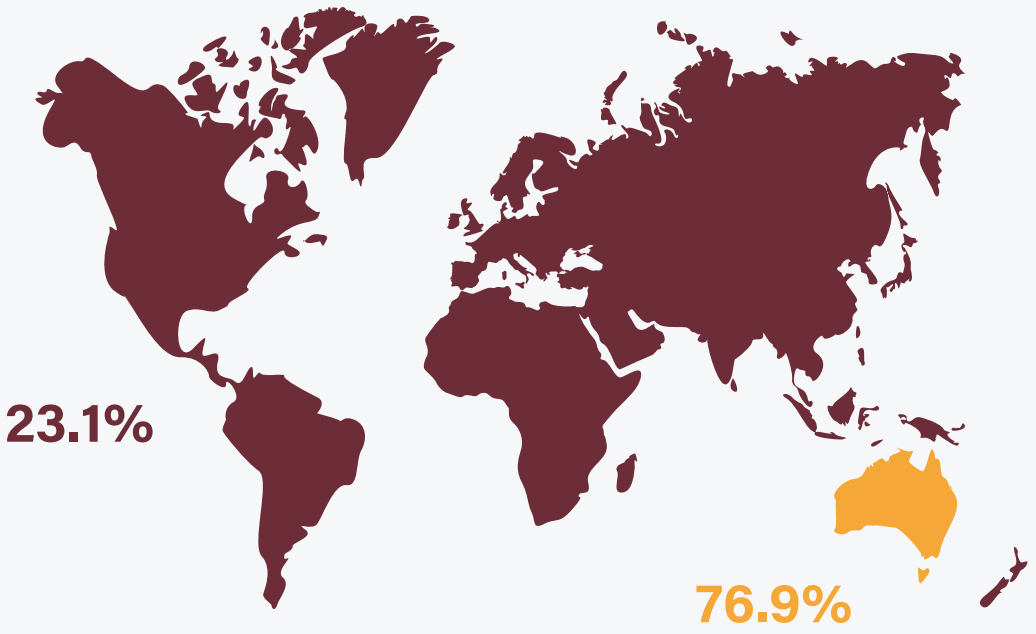


Figure 7. Age of all respondents (years) (*n*=11,321)

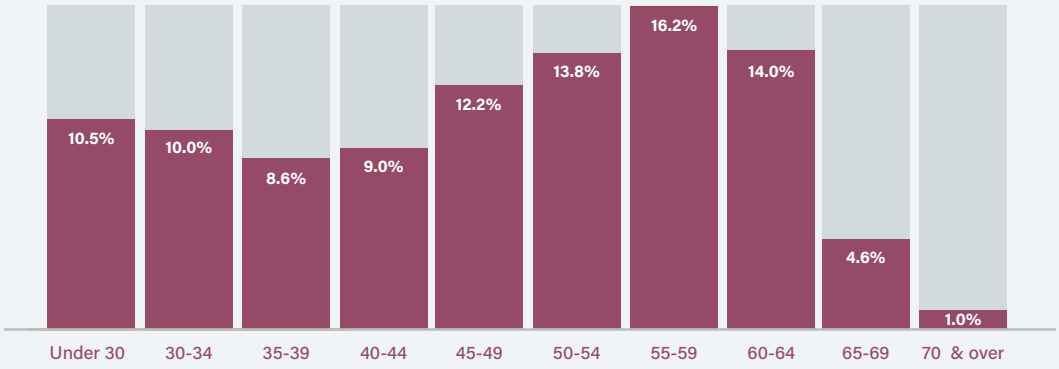


Figure 8. Respondents with children at home

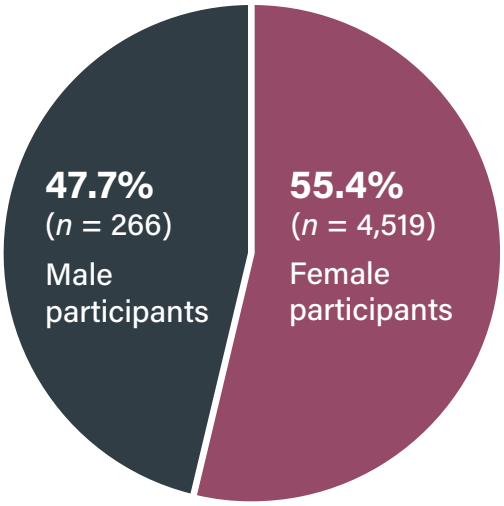
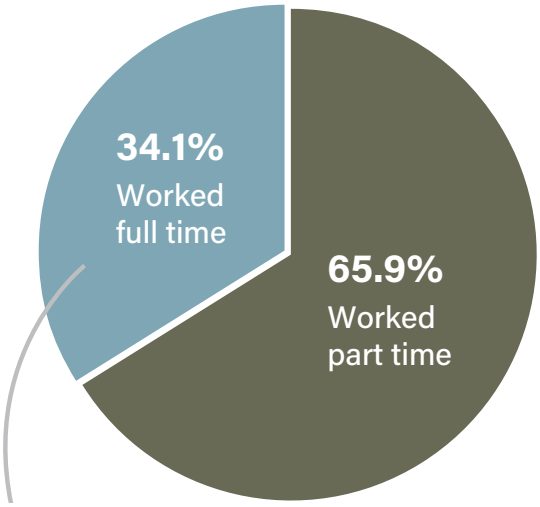
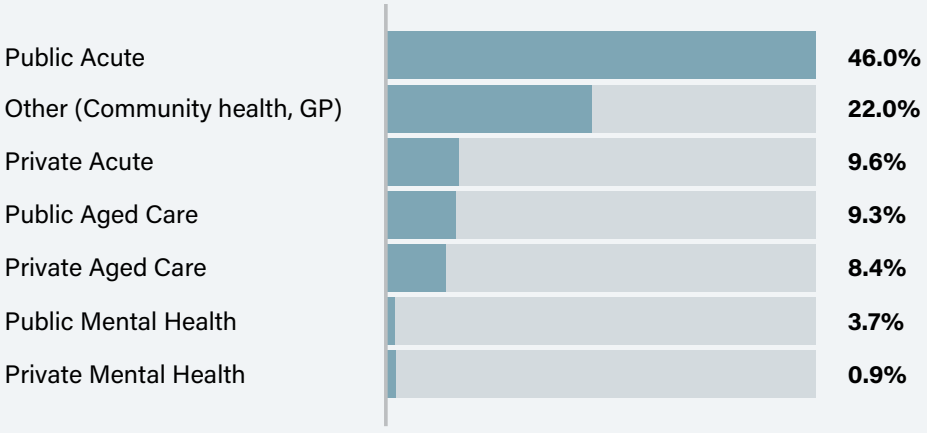


Figure 9. Part time compared to full time respondents (*n*=8,596)



32.7% of women respondents | 55.3% of men respondents

Figure 10. Respondents' sector of work (*n*=8,584)



KEY FINDING 1

Adult 12-month & lifetime family violence was common among women & men respondents.

1.1 Intimate partner violence

Overall, nearly half of women respondents and a third of men had experienced violence or abuse from a partner since the age of sixteen (Figure 11). Almost double the proportion of women (32.2%, 2,894) than men (17.2%, 105) had ever felt afraid of a partner or ex-partner. During the last 12-months, just over one in five respondent women and men had experienced, or were still experiencing, IPV (Figures 12, 13, 14). More women (7.3%, 526) than men (5.5%, 30), had felt afraid of their partner in the last year, and the overall incidents of abuse were higher for women.

Across the study, the majority of respondents were in a relationship with an opposite-sex partner, while 13.1% of men and 2.5% of women had a same-sex partner. Among IPV survivor respondents however, 13.6% of survivor men and 2.1% of survivor women had a same-sex partner, while a much higher proportion (27.3% of men, 22.9% of women) chose not to disclose the sex of their partner.

While reading the results, please remember that some of the male data cell counts are small and should be interpreted with caution.

Figure 11. Prevalence of IPV as an adult (since 16 years)

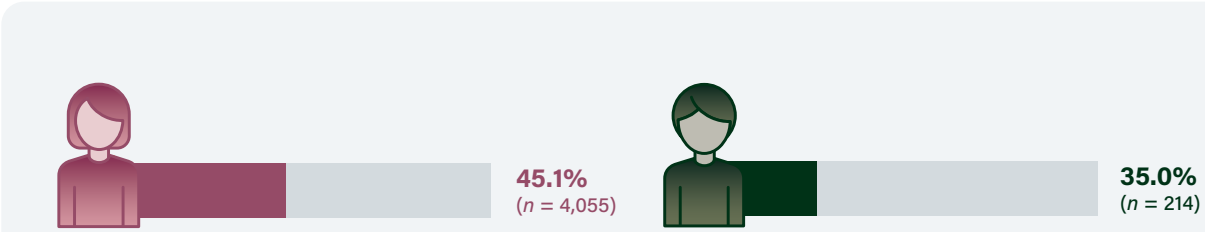
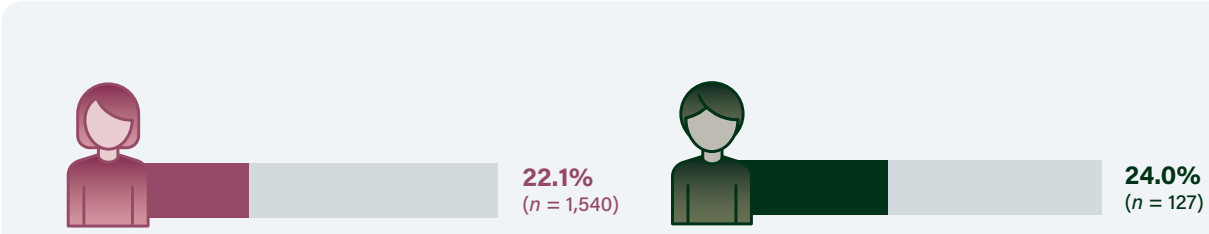


Figure 12. Prevalence of IPV during the last 12-months



Women experienced greater frequency of abusive acts against them and a higher proportion had felt afraid of their partner compared to survivor men in the last 12mths.

A larger proportion of men (13.1%) than women (2.5%) reported having a same-sex partner & a quarter of all respondents did not disclose the sex of their partner.

Figure 13. Type of IPV experienced by women during the last 12-months (Proportion of 12mth survivors)

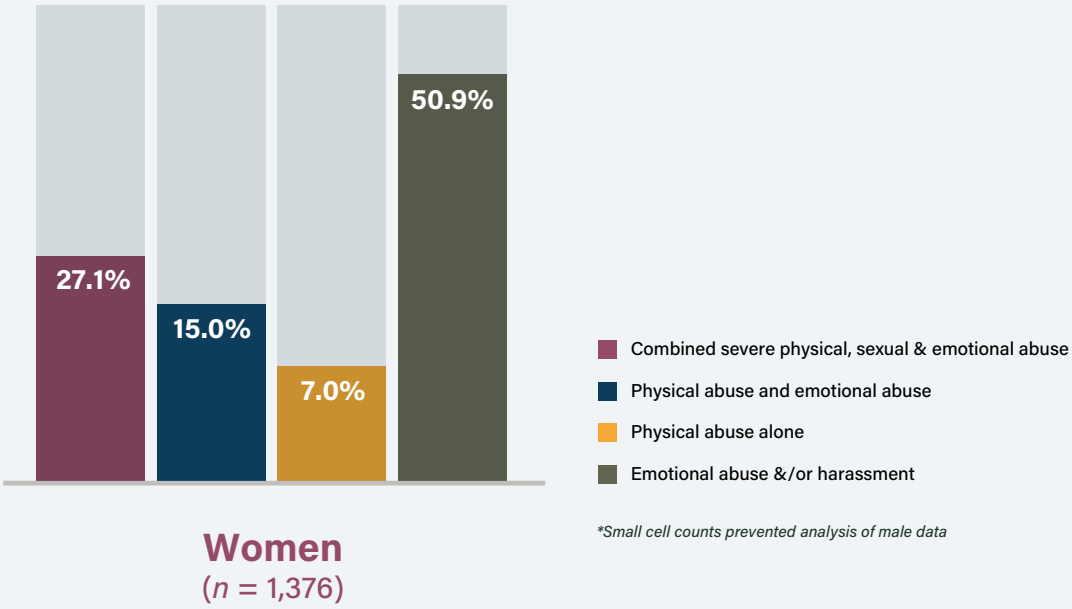
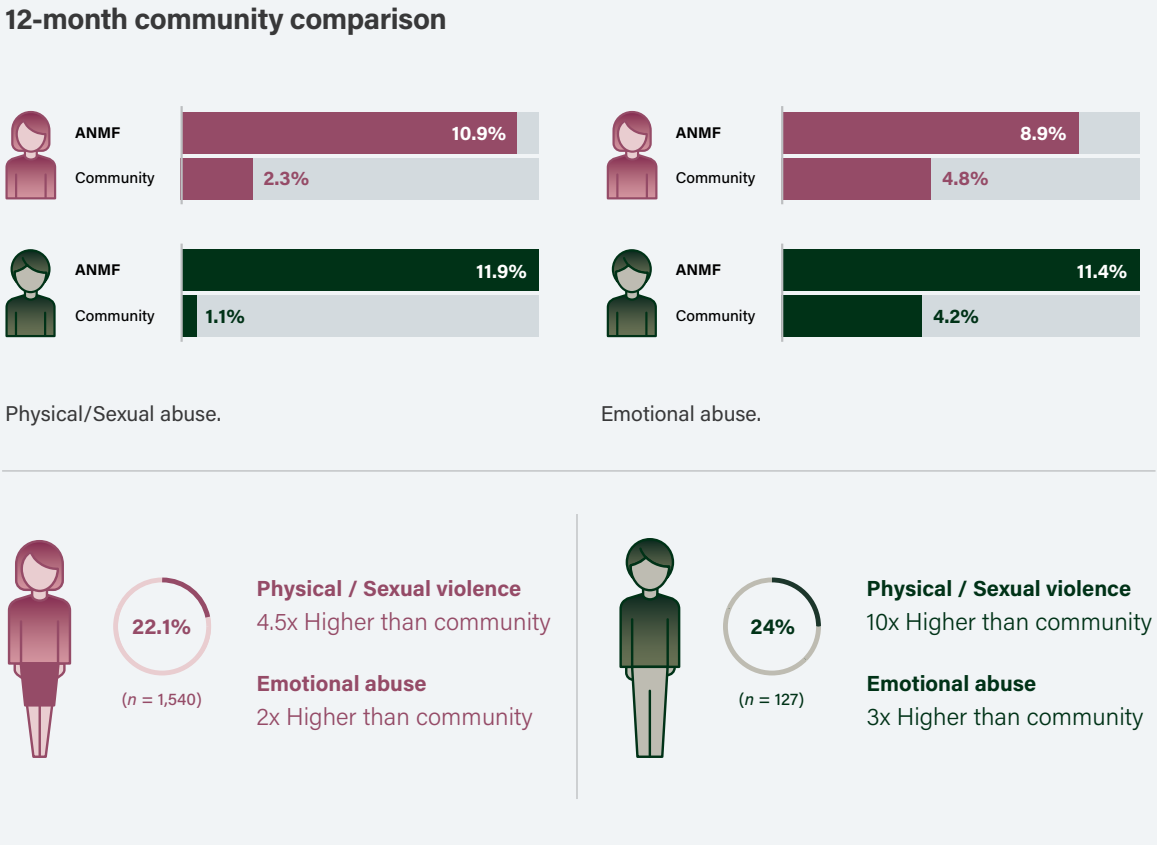


Figure 14. 12-month IPV among women (*n*=7,847) and men (*n*=570) respondents compared to the Australian population



1.2. Sexual assault, technology-facilitated abuse and reproductive coercion

Figure 15 indicates that nearly one in five women and less than one in ten men had experienced sexual assault as an adult perpetrated by someone who was not their partner. Sexual assault was distinctly gendered, with all women and three quarters of men offended against by male perpetrators. An equal proportion of men and women had experienced a partner or ex-partner using technology to monitor them or threaten to, or actually, distribute nude images/video without their permission (Figure 16). Figure 17 displays the proportion of women who had experienced a partner or ex-partner's use of force to end a pregnancy or to become pregnant against their wishes.

Figure 15. Non-partner sexual assault (since 15 years)

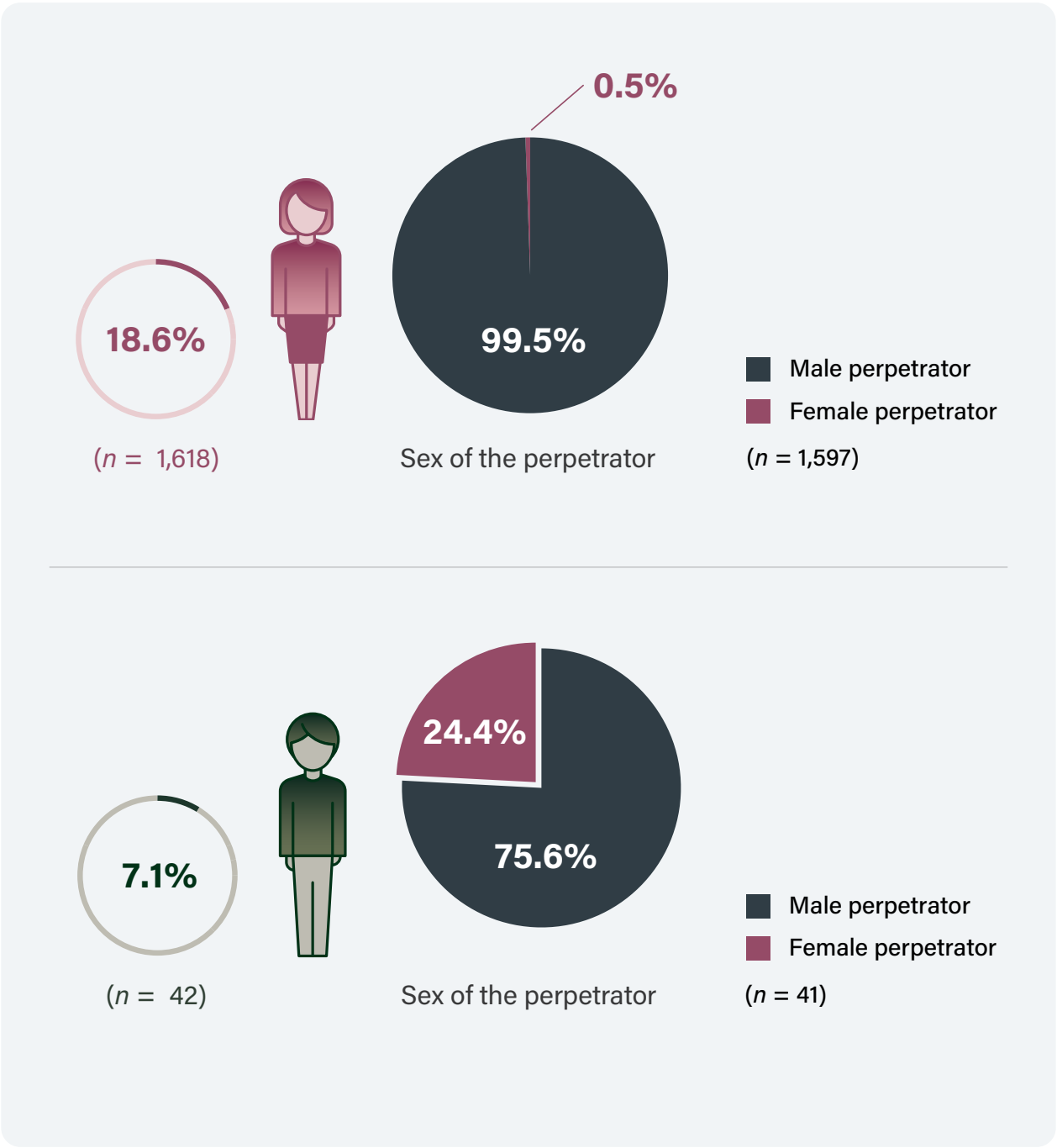
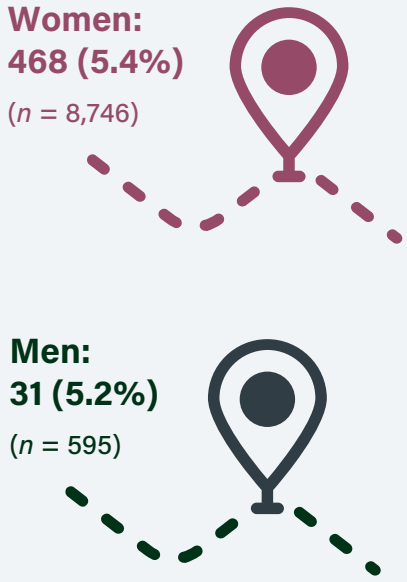
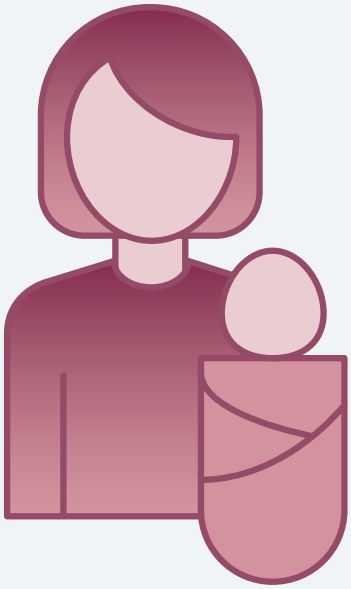


Figure 16. Technology-facilitated partner abuse (since 16 years)



Partner or ex-partner used tracking software to monitor or distribute nude images without permission.

Figure 17. Reproductive coercion against women (since 16 years)



Women:
496 (5.7%)

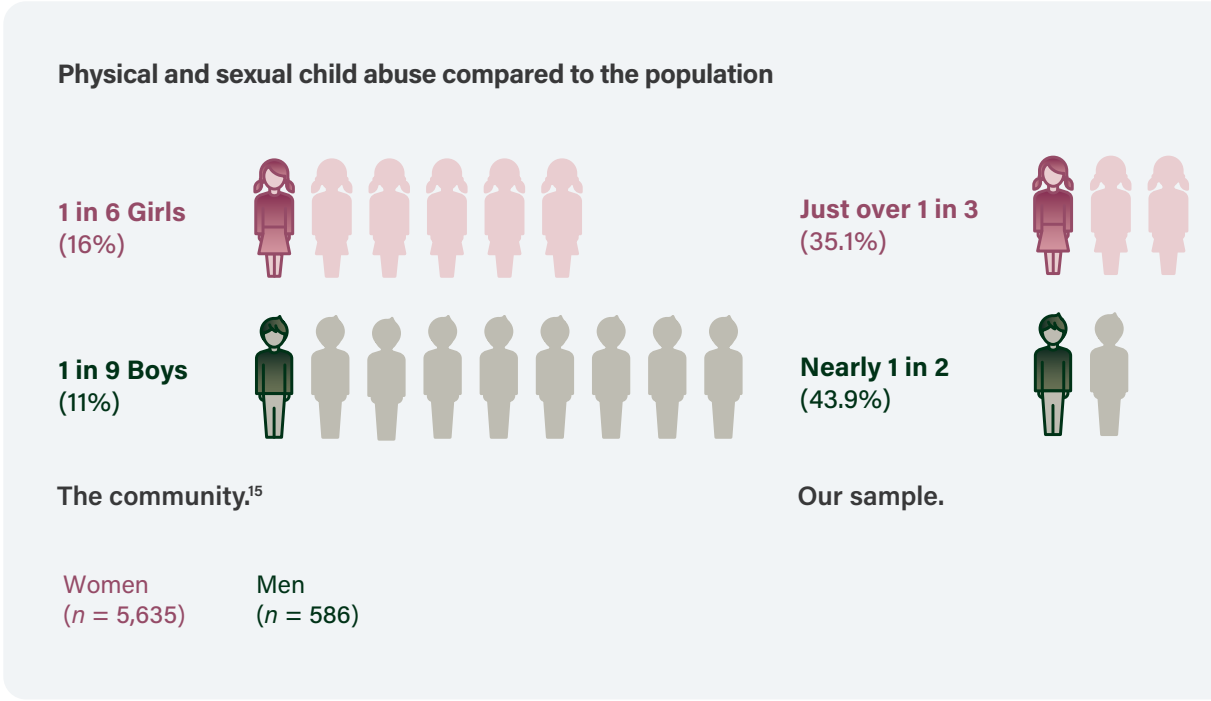
(*n* = 8,788)
(Women-only question)

1.3 Child abuse

A high proportion of men and women respondents had experienced physical and/or sexual abuse before the age of fifteen by somebody aged over 18 years (Figures 18, 19). Physical abuse was more common among men as boys, while sexual abuse was more common among women as girls. Nearly half of women (44.0%, 3797) and half of men (50.8%, 298) reported one, two or three types of abuse in childhood. Sexual or physical abuse in childhood (perpetrated by anyone) had been experienced by nearly half of men and more than a third of women. Around one in four of all respondents had been exposed to IPV in their home when they were growing up.

Figure 18. Abuse during childhood: Physical, sexual or exposure to FV

Figure 19. Child abuse prevalence compared to the Australian population

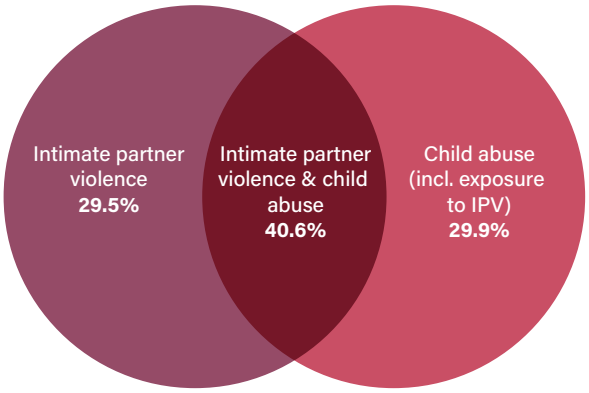


1.4 Poly-victimisation

Half of the women who participated in this study had been poly-victimised, and had a co-occurring history of either non-partner sexual assault and/or child abuse across the life course. For more than one in ten survivor women, their history of abuse included all three trauma types: victimisation in childhood, partner violence in adulthood and adult sexual assault by somebody else.

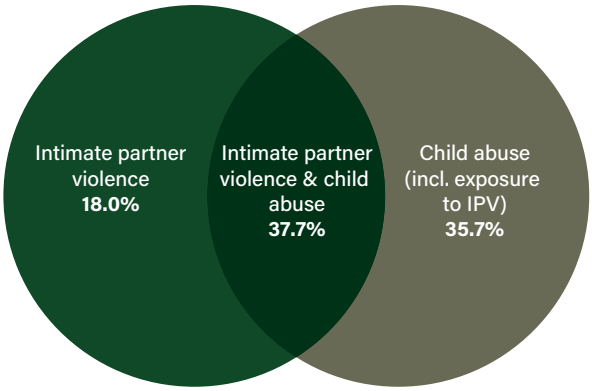
For both men and women in our study, child abuse was associated with adult IPV. The odds that a respondent had experienced IPV in adulthood were nearly three times higher for men survivors of child abuse (physical, sexual or IPV exposure) compared to other respondent men; and two and a half times higher for women IPV survivors compared to other respondent women (Figures 20, 21). This finding indicates that child abuse may influence future abuse experiences.

Figure 20. Overlap in women's experiences of intimate partner violence and child abuse



Women (*n*=5,189)

Figure 21. Overlap in men's experiences of intimate partner violence and child abuse



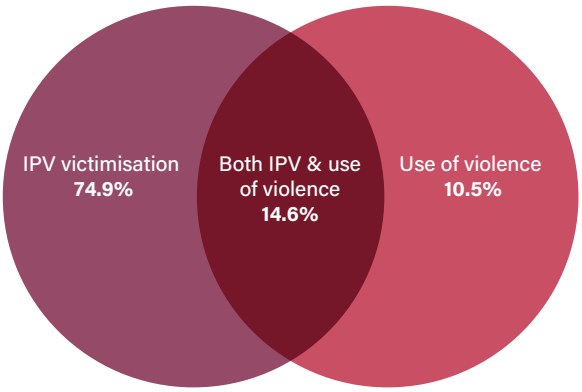
Men (*n*=345)

1.5 Abuse complexity

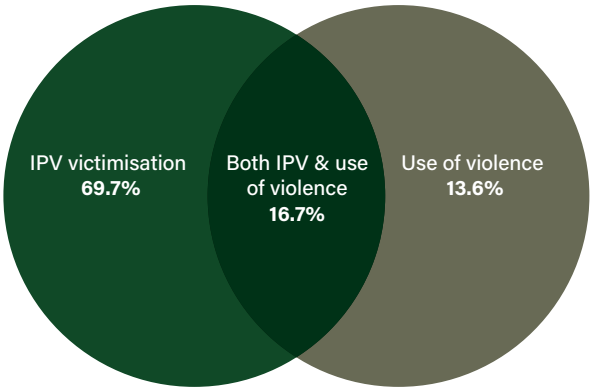
Of all respondents, 17.6% (99) of men and 16.0% (1,346) of women had used controlling, threatening or physically/sexually violent behaviour against a partner or ex-partner since the age of sixteen. Across the adult lifetime, 11.7% (64) of men and 1.7% (142) of women had made their partner feel afraid of them. In the last 12-months, 8.0% (40) of men and 6.0% (403) of women has used controlling, threatening or physically/sexually abusive behavior against their partner. Of all respondents who acknowledged they had made a partner feel afraid of them during the previous 12-months, 9 out of 10 were men (6.0%, 29).

Some of the respondents who had perpetrated abusive behaviour in their intimate relationships had also been the victim of IPV (Figure 22). Since they were aged sixteen years, a quarter of all respondents said they had both used violence against a partner and been the victim of violence from a partner. More than double the proportion of men compared to women had used abusive behaviour against a partner in the absence of violence being directed at them (Figure 23). Further, among the men and women respondents who disclosed having both used violence and been the victim of it, the type of abuse they had survived was different: men were more likely to have experienced emotional abuse and/or harassment, while for women, the abuse was more likely to be physical or sexual.

Figure 22. Overlap in women's and men's experience of IPV as a victim and/or perpetrator during the last 12-months

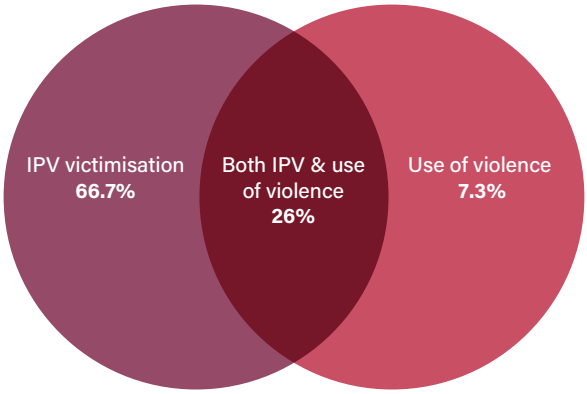


Women (*n*=1,589)

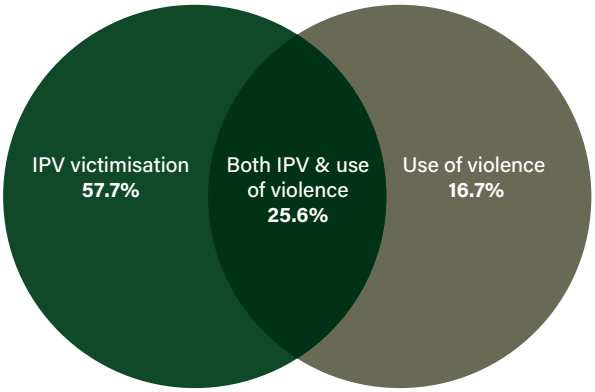


Men (*n*=132)

Figure 23. Overlap in women's and men's experience of lifetime IPV as a victim and/or perpetrator (since 16 years)



Women (*n*=4,041)



Men (*n*=234)

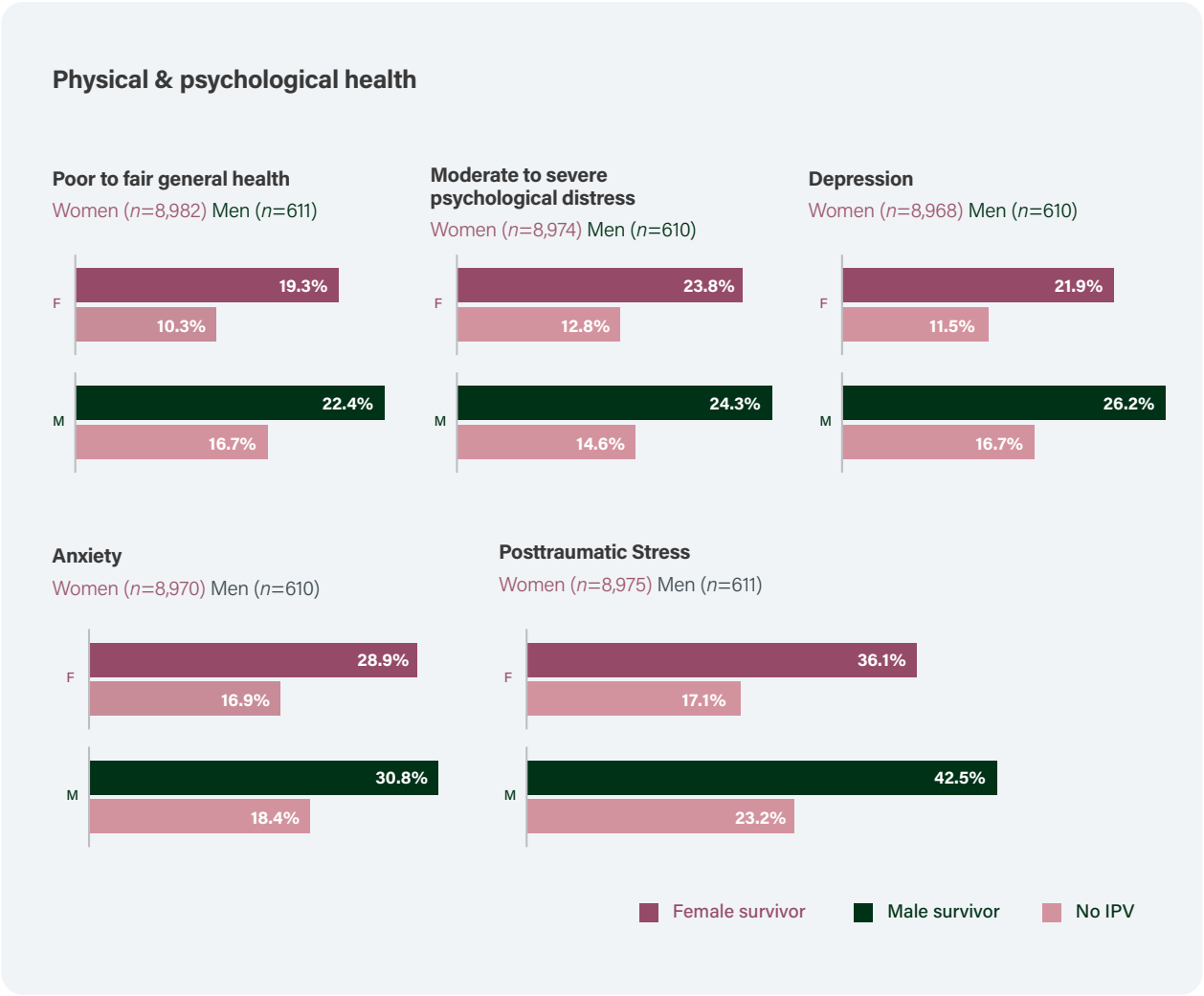
KEY FINDING 2

Survivor respondents' reported worse health & more visits to a health professional than their colleagues without IPV.

Survivors of IPV had increased odds of reporting poor health that were up to three times that of respondents who had not experienced IPV (Figures 24, 25). Further, the health disadvantage was more pronounced for survivor respondents whose IPV had occurred in the last 12-months.

Irrespective of IPV exposure, however, many ANMF respondents identified problems with their health and wellbeing. In fact, between one in ten and a third of respondents who had not experienced IPV, reported health issues.

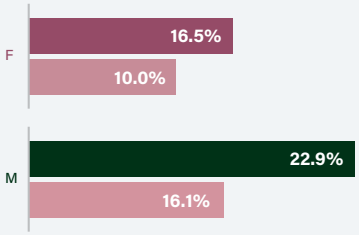
Figure 24. Differences on measures of health & wellbeing among IPV respondents with and without IPV



Social health

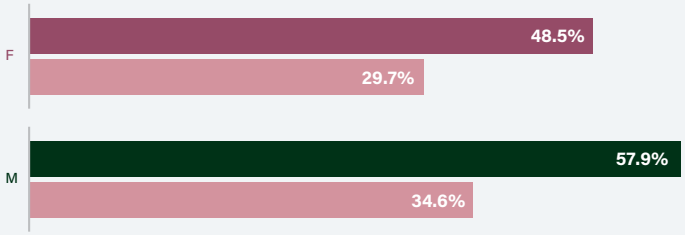
Hazardous drinking

Women (*n*=8,989) Men (*n*=611)



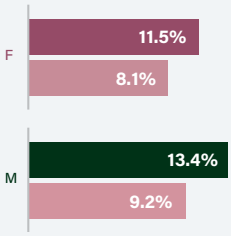
Financial stress

Women (*n*=7,695) Men (*n*=524)



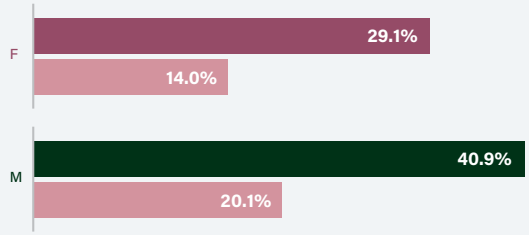
Diminished resilience

Women (*n*=7,897) Men (*n*=534)



Unable to access support from friends/family

Women (*n*=7,897) Men (*n*=534)



Female survivor Male survivor No IPV

ANMF survivor respondents indicated strong resiliency (coping strategies used in the aftermath of trauma) compared to trauma survivors working in other fields reported in other studies.[65, 80]

I like to help people and sometimes this makes me realise I am lucky despite all my stress, there are others out there far less fortunate... I had a time when I needed time out of giving but I did not last long in another profession. Even though I was climbing the ladder fast and got constantly promoted it did not give me the satisfaction I get from this job. Interacting with people in special ways and helping them through their journey..."

38-year-old survivor woman working in public acute

I have learnt from the negative experiences I had when I was younger in an abusive relationship, over the years recognising they were not my problems. I have done a lot of self-reflection and analysis to discover what drives me to be the best person I can be. Helping others in my role as a health care professional gives me strength... Seeing those less fortunate and embracing the positive attitude of those who have so little on the surface builds my resilience."

57-year-old survivor woman working in public aged care

"Knowing that I am stronger because of my experiences and I am able to use this to help others who may have had similar experiences and are not coping as well."

55-year old survivor woman working in public aged care

"I love the work I do as a nurse. People come from all works of life with different experiences and I feel my personal life experiences with domestic violence have made me a better nurse who can connect with people...to comfort patients and provide care on a more personal level. My experiences ensure that I can empathise with real people."

50-year-old survivor woman working in private acute

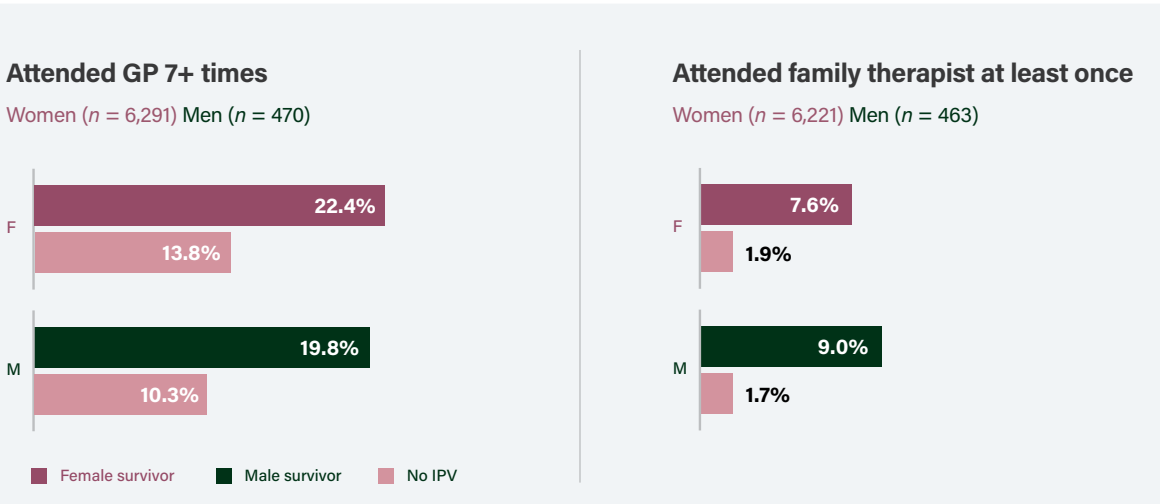
Figure 25. Survivor women and men's increased odds of reporting bio-psychosocial health issues compared to their non-abused colleagues (*n*=8,968)

All respondents were asked how frequently they had visited a range of different health professionals during the 12-months preceding the survey (Figure 26). 12-month survivor respondents were twice as likely to have attended a health professional at least once compared to other respondents (OR 1.9, 95% CI 1.7 to 2.1).

"...I'm worried about basic physical and social function at this stage. As far hope goes, it's all I have. I hope to get well enough to return to the job I love. I know my patients miss me a great deal."

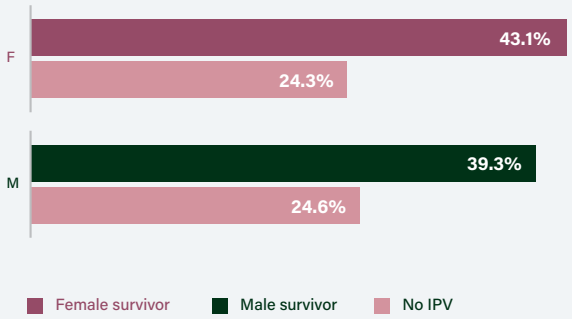
42 year-old survivor man working in public acute

Figure 26. Health professional attendance during the last 12-months: Comparison between 12-month IPV survivor women and men compared to respondents who had not experienced IPV



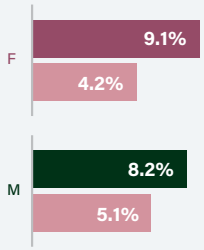
Attended psychologist/counsellor at least once

Women (*n* = 6,316) Men (*n* = 470)



Attended psychiatrist at least once

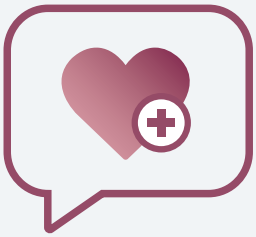
Women (*n* = 6,195) Men (*n* = 462)



> **"I have been a consumer and know what it's like to be in a mental health service. I want to use my experience to assist others in any way possible."**
>
> 35 year-old survivor man working in public mental health

When women IPV survivors were asked if they had spoken to a health professional about their relationship issues in the last 12-months, those that had named a family therapist (76.1%, 121) or psychologist (71.0%, 760) most frequently.

Only one in four IPV survivor women with recent IPV experience had accessed a specialist service (e.g. IPV, legal, counselling) during the 12-months before the survey (Figure 27). Of the 127 men who had experienced IPV in the last year, five (4.5%) had contacted a specialist service.

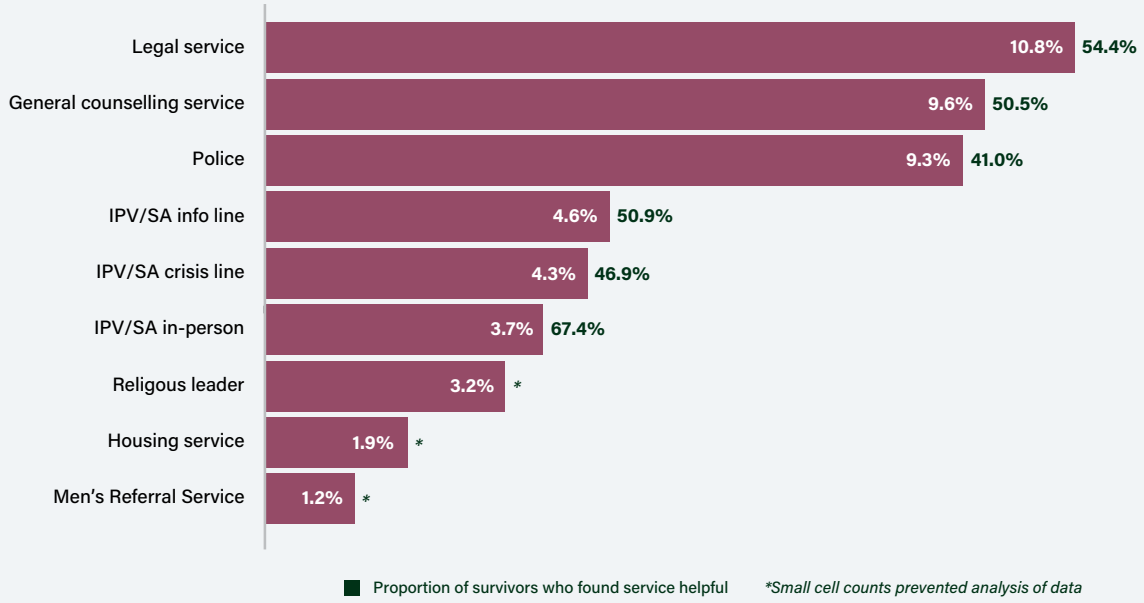


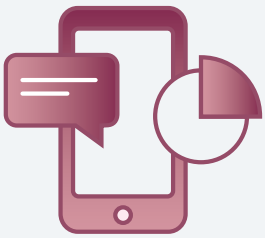
Survivor women who had seen one or more health professionals in the last 12mths were less likely than non-survivor women to find that health professional helpful in meeting their needs, with survivor women rating the health professional as helpful or very helpful an average of 51.7% of the time, compared to an average of 63.1% of the time for women without IPV.

Figure 27. 12-month IPV survivor women's contact with a IPV/FV specialist service during the last year (*n*=1,324)

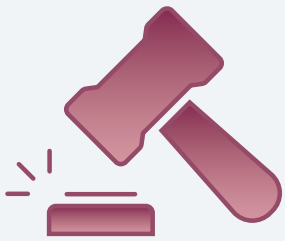
12mth survivor women's contact with specialist services

Of all specialist services, survivor women rated the in-person family violence or sexual assault service as most helpful in meeting their needs.





A quarter of 12mth survivor women (24.4%) and men (25.0%) had accessed at least one specialist service (IPV, legal, counselling) in the last 12mths.



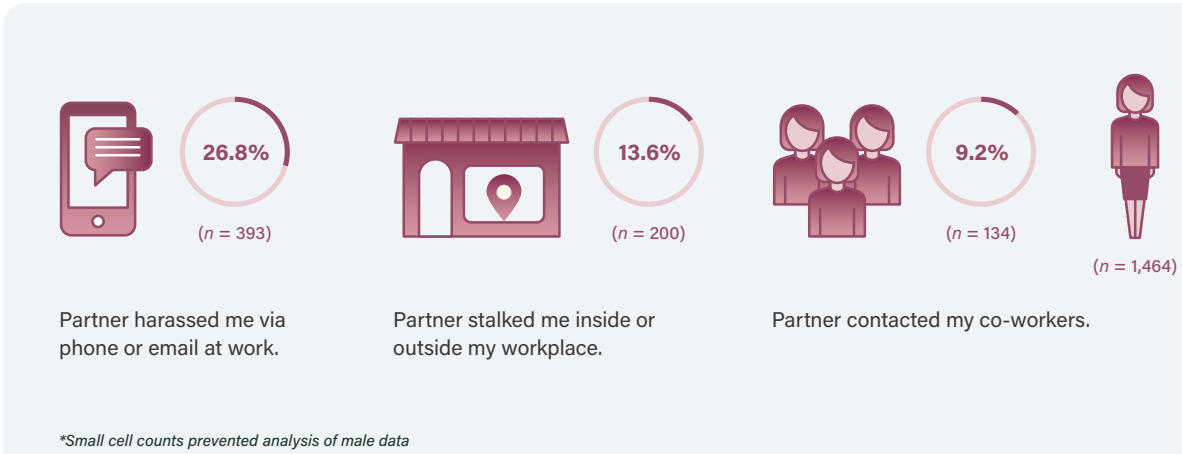
The service with the highest attendance rate in the last 12mths was a legal service, followed by a general phone or in-person counselling service.

KEY FINDING 3

IPV had impacts for survivor respondents at work.

Survivor women respondents whose IPV had occurred in the last 12-months shared experiences of IPV intruding onto their workplace, including being harassed and stalked at work (Figure 28). For one in ten lifetime survivor women and one in five men, their abusive partner had worked at their same workplace (Figure 29).

Figure 28. Ways that IPV had intruded onto the workplaces of 12-month survivor women

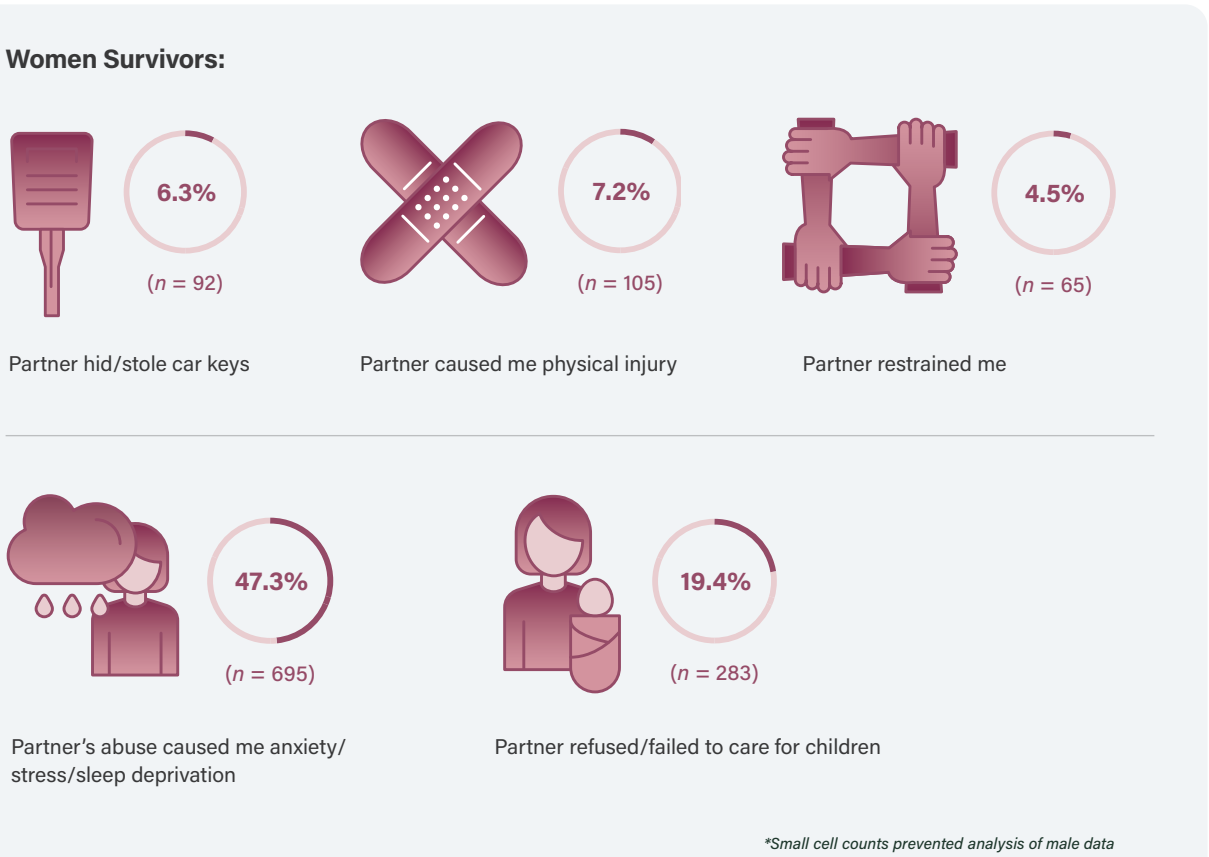


**Small cell counts prevented analysis of male data*

Figure 29. Adult lifetime IPV survivors whose abusive partner worked at the same workplace

The impact of FV on the workplace was most pronounced when IPV had occurred during the last 12-months, including by stopping survivor respondents from getting to work (Figure 30).

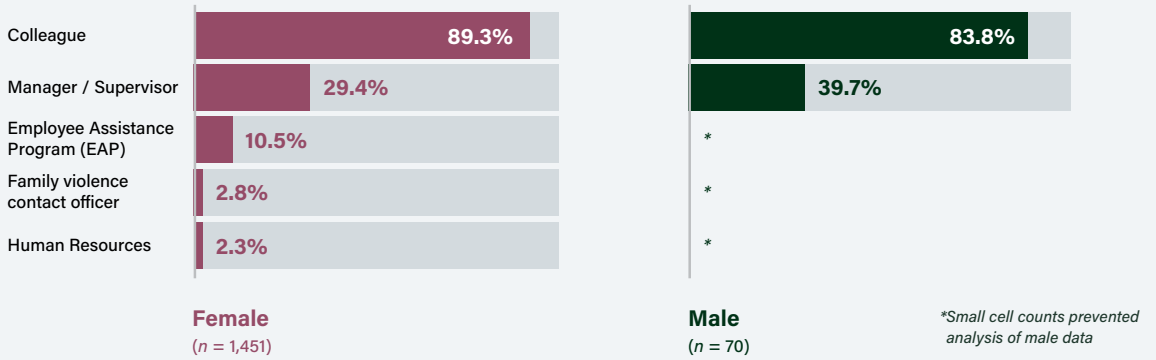
Figure 30. Different ways that 12-month survivor women were prevented from getting to work



Only a third of survivor women and a fifth of men had ever spoken to someone at work about violence in their relationship, and by far the most common person with whom they had that discussion was a colleague (Figures 31, 32). Following disclosure at work, a range of supports were received: for women, support of a co-worker (i.e. listening ear, practical support), was most frequently cited, while for men, it was the Employee Assistance Program (Figure 33). A third of 12-month survivor women and men said they had taken leave from work because of their partner's behaviour during the previous 12-months (Figure 34). Rarely though, was FV Leave taken - only 2.1% (31) of women who had been a violent relationship in the past year and no survivor men had accessed FV Leave. Personal or unpaid leave were the two most commonly accessed categories of leave taken by survivor respondents (Figure 35) (see Appendix C for further leave information).

Figure 31. Adult lifetime survivor women and men who had ever spoken about IPV to someone at work

Figure 32. Person at work to whom survivors spoke about IPV



> **"...I received a kind ear. A hug. I felt heard...They fielded calls for me to ensure my ex didn't get through, and understood that I was the only one who would take time off for sick kids etc. ... Some days I'm a mess, and I don't feel like facing the world, other days my workplace is my only haven."**
>
> 49-year-old survivor woman working in private acute

> **"I was too ashamed to discuss it with my employer or work colleagues, as I did not want them to see me as different or vulnerable in the work place."**
>
> 61-year-old survivor woman working in private acute

> **"Once I let them in, my colleagues were very supportive. I work with & care for women, & I think I have a wealth of experience to share."**
>
> 56-year-old survivor woman working in public acute

Figure 33. Types of support survivor women and men received following IPV disclosure at work

There were gendered differences in workplace support received after talking to someone at work

Support offered by a co-worker/colleague (eg. Listening ear, practical support etc).

Received by 569 (51.0%) of all the women who had discussed IPV with someone at work.

Main type of support received by **survivor women** after they spoke to someone at work.

Employee Assistance Program support.

Received by 29 (49.1%) of all the men who had discussed IPV with someone at work.

Main type of support received by **survivor men** after they spoke to someone at work.

Different types of workplace support received

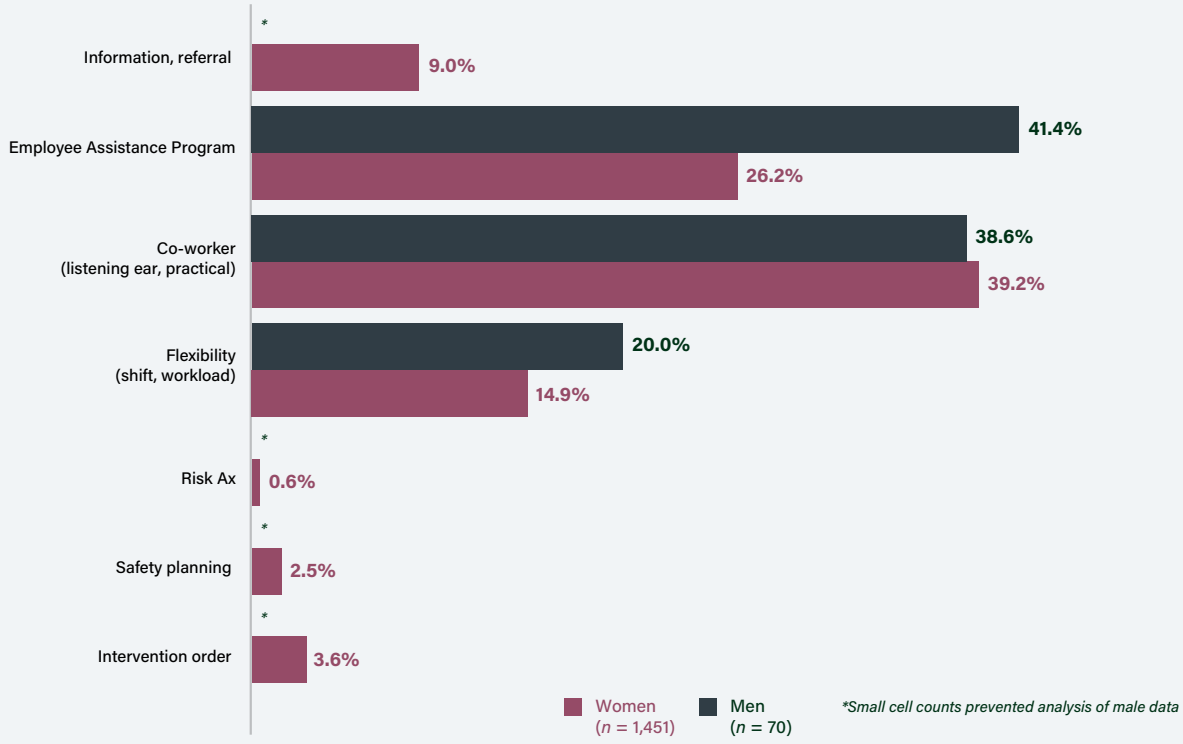


Figure 34. 12-month & adult lifetime IPV survivors who took leave from work during the last year because of their partner's behaviour

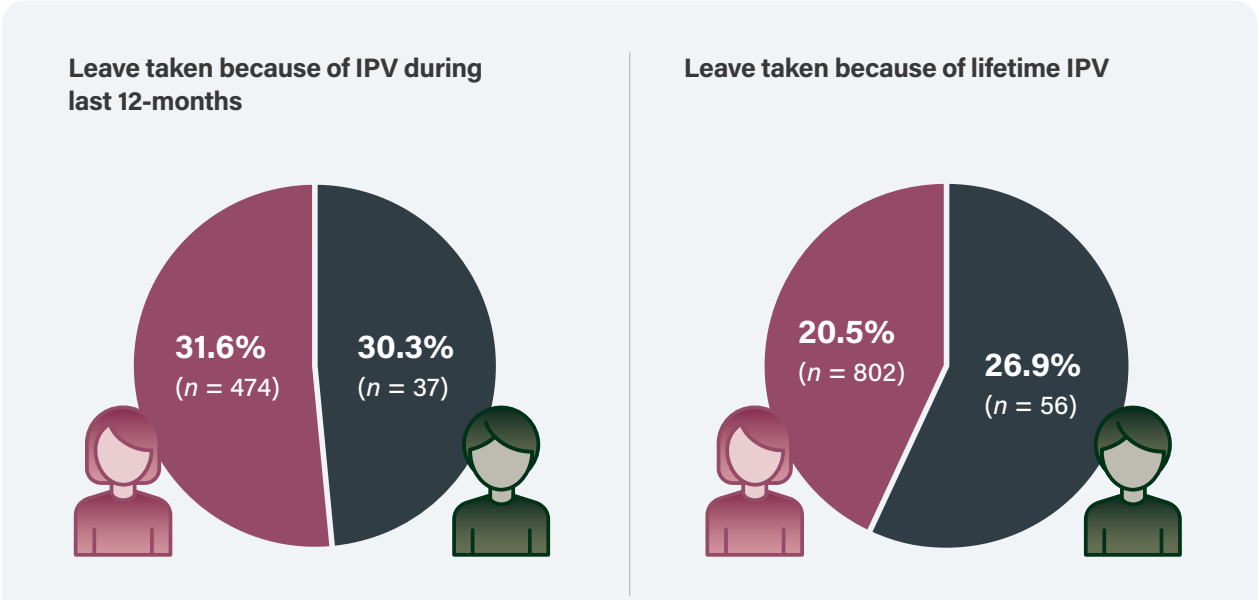


Figure 35. Type of leave that IPV survivors had taken during the last 12-months

The most common type of leave was personal leave. Taken by:

18.6% of survivor women (*n* = 286)

20.5% of survivor men (*n* = 26)

Followed by unpaid leave. Taken by:

7.3% of survivor women (*n* = 113)

7.3% of survivor men (*n* = 8)

However, the leave type attracting the highest median number of days was long service leave:
Median days: 20 | Min: 0 | Max: 130

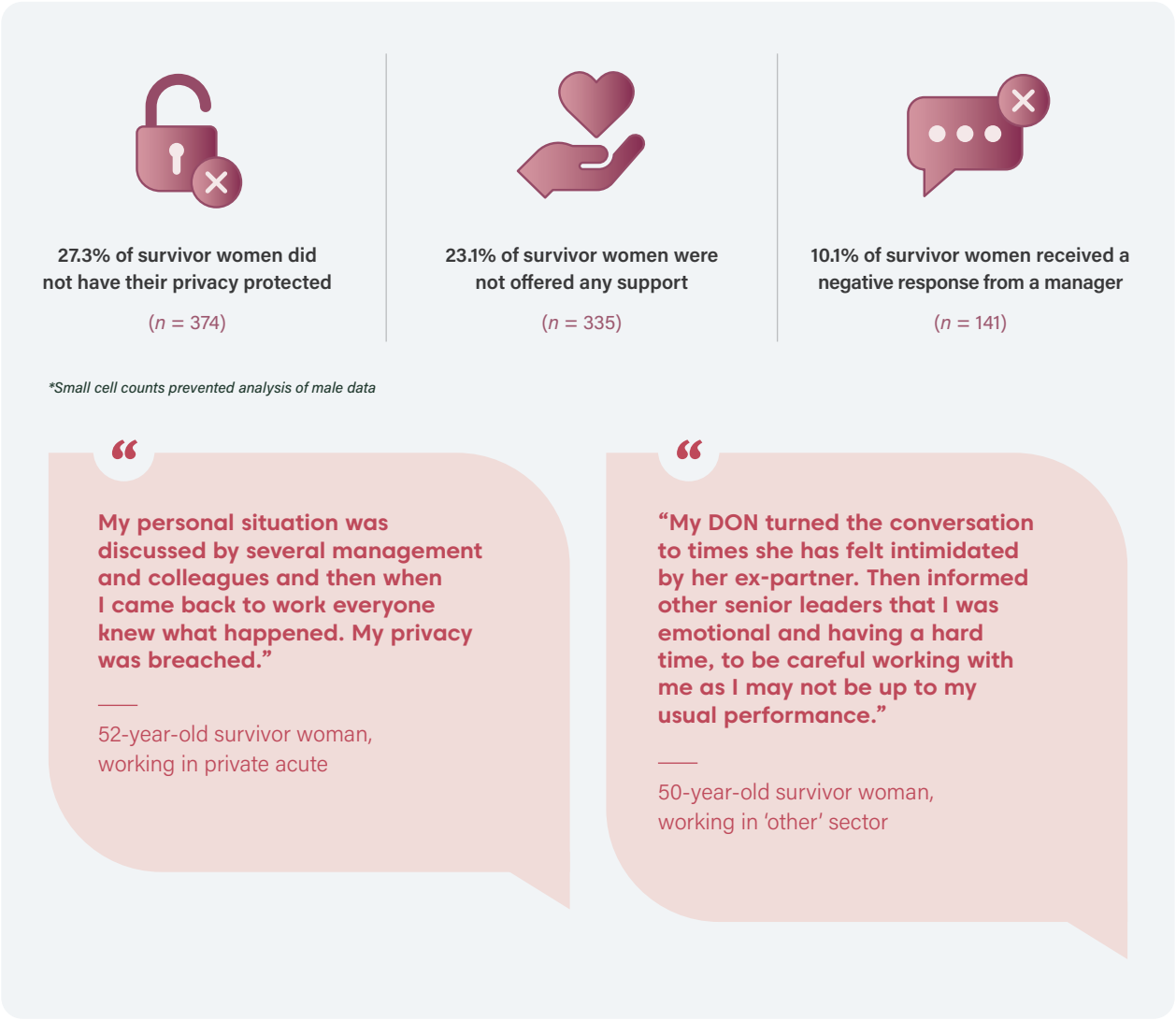
Followed by annual leave:
Median days: 10 | Min: 0 | Max: 80

Women (*n* = 1,540)

Men (*n* = 127)

Unfortunately, sometimes survivors found that their privacy had not been protected or support was not offered (Figure 36).

Figure 36. Negative outcomes after disclosing IPV to someone at work (since 16 years)



KEY FINDING 4

Survivor respondents thought that the ANMF had a role in strengthening FV advocacy & support.

One thousand, seven hundred and thirty-six survivor members responded to the open-ended survey question: "*How can the ANMF improve advocacy and support for members who are experiencing family violence?*". These survivor respondents made hundreds of suggestions, and thematic analysis of their textual data identified two dominant themes:

01 *Advocate* and 02 *Support*

Both themes contained distinct subthemes: *Raise FV awareness; Reduce stigma; Make workplaces safer from occupational abuse, Ensure flexible workplaces where people feel they can take leave* (advocate)*; Accessible counselling/advocacy; Information exchange,* and *FV case management* (support)*.*

Advocate

In this theme, survivor respondents reflected that they wanted **awareness raised** about the prevalence and impact of FV against nurses, not just their patients. For example, these survivor nurses said:

"Family violence is often something we are very ashamed of. I was too ashamed to discuss it with my employer or work colleagues, as I did not want them to see me as different or vulnerable in the work place... Maybe publishing the stories of members who have survived abuse, if they are willing to share them, may assist others to leave and get out of their damaging relationships. You can't swim well, if there is a weight dragging you down."

—— 63 year-old survivor woman, working in private acute

"Keep talking about it! Knowing we are not alone or stupid for expecting more kindness/ respect/understanding makes things easier."

—— 62 year-old survivor woman, working in public acute

Some survivor respondents commented that they wanted to read the stories of other survivor nurses, to not to feel so alone. This normalising of shared experience was suggested as a way of **breaking down the stigma** that many survivor respondents identified feeling:

"Advocate for all nurses to have a solid understanding of the lived experience of family violence - not just the focus on identifying and responding with clients but to understand that this is the experience of so many of their colleagues and indeed themselves and their own families. This could help shift profession-wide and community-wide attitudes about violence against women."

—— 57 year-old survivor woman, working in 'other' sector

Survivor respondents spoke about how unsafe workplace environments could trigger traumatic impacts and reminders. As these survivor respondents said:

"...I have had bruises on my arms from residents & an ignorant blind sided approach to this problem by management. Are we workers supposed to just put up with this abuse by residents? It triggers my anxiety all the time & I avoid those violent residents as much as possible because...it reminds me of my abusive ex partner. I don't go to work to get abused...Management are doing nothing about the abuse us staff experience. It makes me want to find another job sometimes."

—— 41 year-old woman, working in private aged care

"I don't think I am the only nurse who has a history of family violence and now does not cope when confronted with violence in the workplace. There has to be some sort of recognition ... that past experiences outside of work will impact on capacity to cope at work."

—— 40 year-old woman, working in public acute

Many survivors highlighted **flexibility** as a key to more responsive workplaces where staff could attend appointments to do with FV without having to provide identifying information or exhausting their leave allocation:

"Advocate for more flexible work environment, especially with shift work, to fit around childcare, family commitments, counselling, police interviews & legal proceedings. Rather than having to use up valuable and limited leave entitlements."

—— 52 year-old survivor woman, working in public acute

Some survivors spoke about feeling uncomfortable to disclose FV in the workplace, whilst positively acknowledging the industry attainment of FV Leave:

"Allow staff who have issues and request flexible work arrangements (FWA) to be heard. My workplace promotes FWA however to get this, I had to jump hoops and caused me a lot of anxiety. My physical and mental health suffered going through the process and the intimate information requested by my manager was daunting."

—— 58 year-old survivor woman, working in public acute

"Staff feel threatened, harassed and intimidated when managers have discussions with staff around their personal leave rates...Their priority appears to be dollars and reducing the amount of sick leave taken, despite it being an agreement entitlement."

—— 55 year-old survivor woman, working in public acute

Commonly, survivors identified barriers to accessing personal or FV Leave. The principle barrier being a workplace culture or management that caused staff to worry about implicit or explicit negative repercussions if they accessed leave to which they were entitled:

"Ensure appropriate leave can be taken as bosses don't like people to take it."

—— 64 year-old survivor woman, working in 'other' sector

Support

Within this theme, survivor respondents spoke about wanting more FV-specific information, advocacy, and support, **"Be an access point for support services that doesn't require disclosure in the workplace"** (53 year-old survivor woman, working in 'other' sector). Many survivors spoke about the **lack of affordable and accessible counselling** to assist in their recovery from violence whilst juggling their clinical roles:

"Offer free relationship counselling. I don't access it myself as I'm a single mum who earns too much for a health care card but doesn't have enough to be accessing weekly psychology sessions from reputable professionals of my choice. It's not something for my budget, but if it was offered free through work I would probably attend."

—— 41-year-old survivor woman, working in public acute

Some survivors had experienced the Employee Assistance Program as limited, and some suggested strengthening the FV expertise of the Nursing and Midwifery Health Program Victoria (NMHPV). Different models of support and advocacy were proposed, the most dominant of which was FV **counselling and advocacy**.

"Give nurses more than the 10 psychologist sessions a year with the mental health care plan."

—— 25-year-old survivor woman, working in private mental health

"When I was seeking counselling there was a very long wait list to see a psychologist. I think that better access to counselling (or more psychologists) would improve outcomes."

—— 28 year-old survivor woman, working in public acute

Many survivor respondents suggested that a central online or phone **information point** (a portal) for survivor nurses could help them access information about a range of FV services and resources, **"Have a portal that gives all the links and apps for personal safety and support services."** (59 year-old survivor woman, working in public acute). These survivors did not think their Union should necessarily be providing direct support services, rather, they believed there was a role for the Union in coordinating an **information exchange** specific to Victorian nurses:

"Education and information through existing ANMF channels. I think the nursing and midwifery health program is likely good, and that service was recommended to me this past year...due to significant workplace and personal relationship stress that almost got me dismissed from work. However, I feel as though the service is more for people with drug/alcohol problems, which I do not have."

—— 50 year-old survivor woman, working in public aged care

The final model of support that survivor respondents championed was **FV case management**. The survivors whose voices informed this theme were suggesting the need for more support than an information portal but not the direct provision of crisis or clinical counselling services:

"Have confidential case workers assigned to at risk people and people asking for help."

—— 51 year-old survivor woman, working in public acute

Many survivors spoke of financial, housing, legal, parenting and other hardships associated with FV; identifying the need for an accessible and informed advocate/case manager to provide information and referral to a range of community-based specialist services:

"[Survivors need] Financial support, whether an interest free loan or charity... I recently found myself in in an AirBNB with the clothes on my back. I went to Kmart and bought deodorant, chap stick, undies, PJs, phone charger. Contribute to a portion of the cost of an AirBNB, petrol, new phone/SIM."

—— 30 year-old survivor woman, working in 'other' sector

"What I have learnt about family violence is...Resources are stretched to the limit and really are only available to victims of physical abuse who are at risk of death. I found myself homeless with 2 dependents working 7 days to make ends meet. I needed a team that could help me navigate the legal complexities. I needed a case worker that I could check in with. My income was too high to qualify for legal aid but not high enough to afford a lawyer... [I need] someone who understands the system and can guide and direct. It's a nasty maze out there and people like me navigate it blindly."

—— 54 year-old survivor woman, working in public acute

Survivor respondents revealed that more needs to be done for them to feel free from stigma, able to access leave without worrying about negative repercussions and have the information they need to access the advocacy and support they need. The results of this project are now concluded. The next part of this report presents a discussion of the faindings within the context of the broader literature about FV and health professionals.

PART E:

Discussion of findings

In this part of the report, the project's five key findings are synthesised in the context of broader research about FV and health professionals.

This study represents an important and unique contribution to the FV research field, finding that: abuse across the life course was common and overlapping for survivor nurse respondents, impacted negatively upon bio-psychosocial health, resulted in higher attendance to health services and professionals, caused problems at work, and left survivor nurses with a range of advocacy and support needs.

KEY FINDING 1

Adult 12-month & lifetime family violence was common among women & men respondents

Nursing and IPV

Compared to the community, IPV during the last 12-months and across the adult lifetime appeared to be much more prevalent in the lives of respondent women and men ANMF members.[15, 20, 79] This finding, along with the poly-victimised nature of the abuse many women had experienced, was notable, supporting the link between personal trauma and choosing nursing as a profession.[75] The overrepresentation of IPV among ANMF member respondents confirms and extends our findings from a smaller previous study about women health professionals.[18]

FV against men in nursing

This study provides new insight into the prevalence of IPV against men nurses, midwives and carers, with the prevalence of IPV reported in this study much higher than community prevalence rates for men.[13] These findings would appear to validate two previous studies that reported a higher proportion of healthcare worker men who had been exposed to IPV in the last 12-months, compared to their women colleagues.[23, 43]

It is possible that the men who participated in this study and who have made a career in nursing more generally, are not completely representative of men in broader Australian society. For example, in Australian population surveys, men with same-sex partners make up less than 1% of the population, but among the respondents to this survey, 13.1% of men reported a same-sex partner and another 27.3% did not tell us the sex of their partner.[13] While male nurses, midwives and carers are not a homogenous group, they have chosen to undertake difficult, often sensitive work in an essential, though arguably under-recognised or paid, female-dominated profession.[76] Male nurses may not conform to traditionally narrow concepts of masculinity, if 'being a man' means toughness, dominance and aggression, as, in some segments of our community, it does.[7] Further, the higher proportion of men than women who chose to miss the survey questions about IPV (Appendix A), gives rise to the possibility that self-selection bias may have played a bigger role for respondent men than women in our sample.[77] The survivor men who did complete the IPV questions may have done so, at least in part, because the survey gave them a voice they may not always feel they have.[57]

Life course influences on FV

Child abuse (physical/sexual) had affected nearly half of respondent men as boys and more than a third of respondent women as girls. Like the prevalence of IPV, child abuse was substantially higher in this study compared to that documented in the general community, despite asking the questions in the same way.[13] A potential violence life course effect was observed: self-identification of child abuse was associated with higher odds of reporting adult IPV, especially for male respondents. This is consistent with evidence about the cumulative risk of adult partner violence for people exposed to abuse during childhood.[15] The possibility of a life course effect could add to our understanding about why the prevalence of adult IPV among all respondents, but especially men, was so high.

The heavy child abuse load among this sample of health professionals may indicate that, as suggested by the '*wounded healer*' literature, childhood adversity could be consciously or unconsciously related to increased motivation or capacity to care for others in a profession like nursing.[45]

KEY FINDING 2

Survivor respondents reported worse health & more visits to a health professional than their colleagues without IPV.

Health impacts of IPV

The odds of reporting poor physical and/or psychological health were two to three times greater for IPV survivor respondents compared to their colleagues who had not experienced IPV. This finding is consistent with a wealth of research about the health impacts of IPV in the general population and speaks to its tremendous harm.[16, 21] Charged with the healthcare and rehabilitation of patients, survivor nurses carry a substantial health burden themselves.

Consistent with previous literature, 12-month survivor women respondents were twice as likely to have attended a health service or professional at least once in the past year compared to non-abused respondents.[15, 78] While the survey did not ask about the reason for the healthcare presentation, only about half the time survivor respondents rated the healthcare professional as helpful, and unless the health professional was a counsellor, survivor respondents were unlikely to have discussed relationship issues with them.

Specialist service use for survivors

Only a quarter of women and men survivor respondents who had been exposed to violence in the previous 12-months had attended a specialist FV, IPV or sexual assault service during that time. This finding is consistent with community data suggesting that people do not often seek advice or support (even informal) after incidents or FV, IPV or sexual assault.[79]

Health and wellbeing of nurses without IPV

In general, the bio-psychosocial health and wellbeing of nurses who had not experienced IPV across our sample also raised concerns: between one in ten and one in four women and men respondents without a history of IPV reported impaired physical health and/or psychological distress, including PTSD. Male respondents who had not experienced IPV reported worse health and wellbeing compared with their female colleagues without IPV, and up to 35% were experiencing financial stress and one in five could not access support from friends or family. This is consistent with other research about nurses' health and underscores the potential benefit of targeted support and advocacy.[23]

Resilience of nurses

Despite the health issues reported by respondents, both survivors and those without a history of IPV demonstrated strong personal resilience in response to adversity. Using a measure of psychological resilience to adapt and recover from hardship, compared to several other studies with non-nursing trauma sufferers, the survivor nurses in this sample indicated greater resiliency, consistent with a non-traumatised population.[65, 80] Previous work on vicarious resiliency has highlighted the positive change and strengthened capacity to cope that has been observed among helping professionals - including those who have experienced trauma - and underscores the psychological resources of ANMF (Vic Branch) members.[81]

KEY FINDING 3

IPV had impacts for survivor respondents at work.

Impacts of IPV at work

Survivor respondents in this study echoed the experience of concerning workplace impacts of IPV raised in other research, including having been harassed while at work and prevented from attending work.[54, 55, 82, 83] Consistent with previous research, when survivor respondents did talk about IPV at work, this was overwhelmingly likely to be to a colleague, rather than a manager.[50, 55] However, some differences with previous workplace literature are worth noting: the proportion of survivor women in our study who had disclosed IPV to someone at work was around 10% lower compared to respondents in the important workplace studies of McFerran (2011), MacGregor et al. (2016) and Rayner-Thomas (2016).[50, 54, 55] This might indicate that nurses (perhaps because they care for *others*) confront additional barriers to talking about IPV - and potentially accessing assistance at work - compared to employees in other professions. This may be especially true for survivor men, who were even less likely than women in our study to have discussed IPV to someone at work.

FV Leave

The present study provides new information about the accessibility of FV Leave. Of the third of 12-month survivor respondents who had taken leave from work due to their partner's behaviour in the previous year, most had accessed non-FV Leave, (i.e., personal, unpaid or annual leave). Despite FV Leave having been hard fought for by Australian Unions in recent years, this study heard from many survivors who felt unable to access FV Leave, or other forms of leave, without negative repercussion. This is consistent with other research[55] and suggests that adding leave to industry awards is only one part of the puzzle; more needs to be done to encourage a workplace culture in which staff are aware of FV leave and not worried about confidentiality breeches or other negative consequences.

Cumulative abuse experiences

The present study corroborates findings from our earlier work that survivor nurses can find the workplace to be a trauma-triggering environment when threatened with aggression from patients or visitors; a big issue in Australian healthcare services.[84, 85] Irrespective of IPV exposure, nurses are a group at significant risk of vicarious or secondary trauma because their work involves listening to the stories of survivor patients.[86] When nurses are then exposed to direct aggression against them at work, this can act as a second layer to the cumulative abuse load. If nurses have lived experience of child abuse, FV, IPV and/or sexual assault, like half or more of the survivor respondents in this study, then the potential for traumatic memories and impacts to be triggered represents a third layer to the cumulative abuse load, making work and recovery more difficult.

KEY FINDING 4

Survivor respondents thought that the ANMF had a role in strengthening FV advocacy & support.

Advocacy

Consistent with our previous research and the work of others, survivor respondents wanted increased awareness and advocacy in the healthcare field and broader community that FV affects nurses, midwives and carers.[84, 87] Increased FV awareness in the workplace may be critical to creating a safe, supportive and positive workplace environment for survivors.[87] By sharing stories of lived experience, survivors thought that their feelings of isolation and stigma may be reduced for others.

Support

To manage the impacts of FV as well as the intersecting challenges of being a nurse, survivor respondents proposed different models of enhanced FV-specific advocacy, support and information. Survivors who had found it difficult to afford or access the counselling or advocacy they required, suggested that the ANMF (Vic Branch) provide a direct FV support service. Others proposed that ANMF (Vic Branch) strengthen their role by providing FV-specific information, a sensitive first-line response, workplace advocacy and referral.[88] The study heard from many survivors who wanted their workplace to develop the capacity to more supportively respond to their survivor needs, identifying a role for the ANMF (Vic Branch) in advocating for this.

This concludes discussion of the project findings in the context of the broader literature landscape. The final part of this report presents the recommendations that are indicated by our results and their implications.

PART F:

Recommendations

The extensive data and numerous survivor voices that contributed to this study raise several implications. Arranging these into recommendations is an attempt to translate the knowledge generated by the member respondents into stronger ANMF (Vic Branch) advocacy for survivor nurses, midwives and carers. This report is concluded with recommendations for ANMF (Vic Branch) advocacy categorized under five themes: *awareness, support, workplace advocacy, education, and research.*

Recommendations for ANMF (Vic Branch) advocacy:

Awareness

- → Lead a campaign to break the silence that FV affects women and men nurses, midwives and carers.
- → Share survivor stories. Survivor voices are essential to making organisations responsive to survivors needs. Survivor members have been poly-victimised, experienced stigma, and are unlikely to have disclosed violence in their workplace. These and other survivor members' stories should be shared. Digital stories may be a way of hearing survivor voices without survivors having to retell their story repeatedly.
- → Adopt a trauma and violence approach to inform leadership, education and advocacy on the topic of FV against nurses, midwives and carers.

Support

- → Harness the expertise developed by Strengthening Hospitals Response to Family Violence (SHRFV) to inform how the ANMF (Vic Branch) responds to and supports survivor nurses, midwives and carers.
- → Develop an online portal with easily accessible FV information for nurse/midwife survivors and perpetrators administered by the ANMF. In addition to resources and workplace entitlements, the portal could include content about managing traumatic triggers at work, mitigating the impacts of vicarious trauma and evidence-based self-care.
- → Strengthen the capacity of the expanded Nursing and Midwifery Health Program Victoria (NMHPV) to respond to FV as a specialty issue, including with case management. NMHPV could link with SHRFV and relevant specialist FV services to inform their approach. The finding that many member respondents reported physical and psychological health and social problems (not just FV survivors), is an endorsement for continued investment in the capacity and expertise of NMHPV to respond to FV survivors and those who use violence.
- → Advocate to ensure that Employee Assistance Programs have appropriate FV specialisation and training, are able to perform FV sensitive enquiry at intake and can provide an adequate number of sessions to members.
- → Ensure that members who need financial assistance to access private counselling/ advocacy are able to apply to the ANMF's Florence Nightingale (hardship) fund.

Workplace advocacy

- → Advocate to senior nurse/midwives and Human Resource departments in organisations where members are employed to change a culture of people fearing negative repercussions if they take Family Violence Leave or personal leave to which they are entitled.
- → Create an online function to collate information about responses to FV in the workplace that can be used by the ANMF (Vic Branch) to structurally advocate to government and relevant health and human service policy departments on behalf of a range of survivors.
- → Promote healthcare workplace flexibility. Survivors told us that they often felt like their workplace was inflexible and this made attending appointments and other aspects of moving towards safety and recovery, more difficult.
- → Understand that workplace safety is an extra issue for FV survivor nurses, midwives and carers. In addition to the impacts of stress and fear experienced by all nurses, midwives and carers exposed to occupational abuse and aggression, traumatic FV memories can be triggered for survivors when their workplace is unsafe.

Education

- → Collaborate with experienced others to establish an education campaign about responding to disclosures of FV by colleagues, including definitions of FV and resources. SHRFV has a suite of training resources to assist.
- → Ensure that relevant ANMF (Vic Branch) staff receive training in first line FV support.
- → Promote the need for training in first-line support among colleagues, managers, senior nurse/ midwives, Human Resource and security staff at services where members are employed.
- → Advocate to the Australian Nursing and Midwifery Accreditation Council (ANMAC) for all University nursing and midwifery courses to include FV education, including about FV, IPV and sexual assault prevalence among nurses, midwives and carers.

Better supporting nurses, midwives and carers is not only important for their wellbeing, their families and their workplaces, it may also enhance the healing work that nurses, midwives and carers strive for every day with their patients.

Research

→ To remain responsive to the needs and experiences of ANMF (Vic Branch) members, repeat FV research to monitor changes to IPV prevalence, health issues, workplace impacts and service use. Ensure evaluation is built into any new initiatives, including Union or workplace advocacy and support.

Report Conclusion

We have investigated how family violence, including intimate partner violence, sexual assault and child abuse affects thousands of nurses, midwives and carers, and listened to the voices of survivors. In doing so, project respondents have led us to a richer understanding about the commonality of FV and its multifaceted impacts, illuminating a clearer FV advocacy and education voice for the ANMF (Vic Branch) going forward. Better supporting nurses, midwives and carers is not only important for their wellbeing, their families and their workplaces, it may also enhance the healing work that nurses, midwives and carers strive for every day with their patients.

We end this report by saluting the voice of the survivor respondent below and sincerely thanking all nurses, midwives and carers for their essential work:

"I decided a long time ago that I needed to do a job with purpose. To make an actual difference to someone's life. I love nursing, all aspects: the good bad and sometimes really ugly parts. It's not a glamorous job, it's not a job everyone actively thanks you for all the time but it's the kind of person I want to be. I want to be supportive, empathetic, constantly learning new things to maintain my integrity even in the toughest situation... It's that family that just lost a family member, that patient that never has any family in to visit, that patient that passed away with no one to hold their hand. These need caring people, and I care a lot, I respect myself and my job and I couldn't think of anything I could do that would be more satisfying than this."

— 24 year-old survivor woman working in private acute

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Appendices

Appendix A. More information about error rates and missing IPV data

Proportionally more women than men participated in this study, affecting analysis of the men's data, as well as the error rate. Margins of error are an expression of the amount of random sampling error in the results of a survey; the larger the sample size, the smaller the margin of error.[70] The higher the margin of error, the more caution that should be used interpreting the results of a survey. Across the whole male data set, the margin of error was 4%, while for the female data it was less than 1%. Narrowing in on the IPV data specifically, a higher proportion of men than women chose to miss the survey questions about IPV, leading to a higher relative standard error in the men's IPV data. The relative standard error is an estimate of the likely difference between the sample and the total population, expressed as a percentage.[71] While the relative standard error of the women's IPV prevalence data was 4%, the relative standard error of men's prevalence data ranged between 11% to 12%. The male sample results therefore require a greater degree of interpretive caution.

By the time respondents had reached the end of the IPV items in the survey, they had been presented with more than 65 questions. The proportion of women respondents who missed all 30 IPV items was 11.2% (1,195) of all the women who started the survey, not including a further 21.3% (2,274) who were skipped from these questions because they had not been in a relationship during the relevant timeframe. A higher proportion of male respondents missed all IPV items (16.3%, 146) or were skipped from seeing the questions because they had not been in a relationship (13.2%, 103). It can be surmised that the people missing from the data were likely fatigued by the number of questions and/or affected by their sensitive nature, either because they did not want to be reminded of a past history of trauma or because the questions seemed irrelevant to those without IPV. Prevalence rates in surveys are based on information obtained from a sample of all the people who were approached to participate in the survey (i.e. the total population). The prevalence rates in this report might be meaningfully different from those that would have resulted had all those approached to participate in the survey taken part.[71]

Appendix B. Detailed demographic data

Table 2: Demographic characteristics of survey respondents compared to the broader ANMF population

Characteristic	No. (%) of total respondents	No. (%) of women respondents	No. (%) of men respondents	No. (%) of ANMF member population[a]
Sex	(*n*=11,465)	-	-	(*n*=87,076)
Female	10,629 (92.7)	-	-	79,264 (91.0)
Male	772 (6.7)	-	-	7,790 (8.9)
Non-binary	13 (0.1)	-	-	n.a.
Preferred not to say	51 (0.4)	-	-	n.a.
Age (years)	(*n*=11,321)	(*n*=10,519)	(*n*=760)	
<30	1,189 (10.5)	1,109 (10.5)	75 (9.9)	16,098 (18.5)
30-39	2,113 (18.7)	1,937 (18.4)	167 (22.0)	23,015 (26.4)
40-49	2,401 (21.2)	2,213 (21.0)	173 (22.8)	17,689 (20.3)
50-59	3,399 (30.0)	3,182 (30.2)	209 (27.5)	17,595 (20.2)

Characteristic	No. (%) of total respondents	No. (%) of women respondents	No. (%) of men respondents	No. (%) of ANMF member population[a]
60-69	2,101 (18.6)	1,962 (18.6)	134 (17.6)	10,007 (11.5)
≥70	118 (1.0)	116 (1.1)	2 (0.2)	918 (1.1)
Country of birth	(*n*=8,831)	(*n*=8,227)	(*n*=564)	
Australia	6,795 (76.9)	6,380 (77.5)	384 (68.0)	n.a.
Other	2,036 (23.1)	1,847 (22.5)	180 (31.9)	n.a.
English first language	7,789 (88.5)	7,300 (89.0)	452 (80.6)	n.a.
Aboriginal	83 (0.9)	80 (1.0)	3 (0.5)	n.a.
Torres Strait Islander	13 (0.1)	13 (0.2)	0	n.a.
Both Aboriginal and Torres Strait Islander	11 (0.1)	11 (0.1)	0	n.a.
Intimate relationship status	(*n*=10,195)	(*n*=9,497)	(*n*=649)	n.a.
In a current relationship[†]	7,361 (72.2)	6,827 (71.9)	504 (77.7)	n.a.
Relationship during past 12mths (*n*=9,658)[†]	7,779 (76.3)	7,201 (75.8)	545 (83.9)	n.a.
Ever been in a relationship (*n*=10,195)	9,682 (95.0)	9,021 (95.0)	614 (94.6)	n.a.
Current relationship status				
Living with a partner	2,160 (24.6)	1,958 (23.9)	189 (33.7)	n.a.
In a relationship, but not living with partner	556 (6.3)	514 (6.3)	39 (7.0)	n.a.
Married	4,470 (50.8)	4,182 (51.1)	274 (6.1)	n.a.
Separated	324 (3.7)	306 (3.7)	14 (2.5)	n.a.
Divorced	669 (7.6)	634 (7.7)	32 (5.7)	n.a.
Widowed	214 (2.4)	209 (2.6)	4 (0.7)	n.a.
Not in a relationship/single	1,179 (13.4)	1,093 (13.3)	80 (14.3)	n.a.
Sex of current partner	(*n*=6,776)	(*n*=6,297)	(*n*=452)	
Male	6,209 (91.6)	6,135 (97.4)	59 (13.1)	n.a.
Female	559 (8.2)	158 (2.5)	392 (86.7)	n.a.
Non-binary	8 (0.1)	4 (0.1)	1 (0.2)	n.a.
Family	*n*=8,772	*n*=8,177	*n*=558	
Currently pregnant	-	126 (1.5)	-	n.a.
No children	2,320 (26.4)	2,093 (25.6)	213 (38.2)	n.a.
Children at home	4,799 (54.7)	4,519 (55.3)	266 (47.7)	n.a.
Sector of work	(*n*=8,584)	(*n*=7,995)	(*n*=552)	(*n*=87,076)
Public Acute	3,947 (46.0)	3,678 (46.0)	255 (46.2)	41,280 (47.4)
Private Acute	824 (9.6)	788 (9.9)	32 (5.8)	10,490 (12.0)
Public Mental Health	320 (3.7)	244 (3.1)	73 (13.2)	2,379 (2.7)

Characteristic	No. (%) of total respondents	No. (%) of women respondents	No. (%) of men respondents	No. (%) of ANMF member population[a]
Private Mental Health	81 (0.9)	66 (0.8)	15 (2.7)	528 (0.0)
Public Aged Care	801 (9.3)	747 (9.3)	51 (9.2)	1,686 (1.9)
Private Aged Care	724 (8.4)	672 (8.4)	48 (8.7)	12,371 (14.2)
Other	1,887 (22.0)	1,880 (22.5)	78 (14.1)	18,342 (21.1)
Hours of work per week	(*n*=8,596)	(*n*=8,004)	(*n*=553)	
1-3 days (24 hrs or less)	2,138 (24.9)	2,072 (25.9)	54 (9.8)	28%
>3-4 days (25-34 hrs)	3,526 (41.1)	3,318 (41.4)	193 (34.9)	n.a.
5 days (35-44 hrs)	2,468 (28.7)	2,210 (27.7)	249 (45.0)	n.a.
6 or more days (45 hrs+)	464 (5.4)	404 (5.0)	57 (10.2)	64%

Notes

Denominators vary due to missing responses; base = all survey respondents who responded to the question

n.a. Data not collected by ANMF (Vic Branch)

[a] ANMF (Vic Branch) October 2019 data. Please note, the ANMF (Vic Branch) population to whom survey information was sent in August 2019 was 77,059 members

[†] 513 respondents were omitted as they had never been in a relationship

Appendix C. More information about workplace leave

Table 3. Number (%) of survivor women and men respondents who had taken leave (any) during the past 12-months due to a partner's behaviour

	Women who had experienced IPV in the last 12mths	Men who had experienced IPV in the last 12mths	Women whose IPV occurred longer than 12mths ago	Men whose IPV occurred longer than 12mths ago	Total number of survivors who took leave type
Type of leave (1+ days)	(N=1,540)	(N=127)	(N=1,473)	(N=59)	(N=3,199)
Personal (sick, carer)	286 (18.6)	26 (20.5)	67 (4.5)	5 (8.4)	384 (12.0)
Unpaid	113 (7.3)	8 (6.2)	16 (1.1)	1 (1.7)	138 (4.3)
Annual	92 (6.0)	4 (3.1)	13 (0.9)	1 (1.7)	110 (3.4)
Family violence	31 (2.1)	0	6 (0.4)	0	37 (1.2)
Long service	15 (1.0)	3 (2.3)	1 (0.1)	0	19 (0.6)

Appendix D. Principles of a trauma & violence-informed approach

Table 4. Principles of a trauma & violence-informed approach for Australian healthcare (Adapted from McLindon, 2020, p. 213)[89]

Principles	Description
Understanding	Foster an organisational culture that demonstrates understanding of trauma and violence and the complexity of human responses. Underpin interactions with staff and patients with this understanding. Train all staff on the associations between trauma and health impacts, including vicarious trauma.
Safety	Create an emotionally and physically safe health service in consultation with survivor staff and patients regarding inclusive and safe strategies. Confidentiality, compassion, a non-judgemental attitude, clarity, predictability and choice are central. Work towards minimising distress and maximising autonomy.
Trust & Transparency	Build and maintain relationships of trust among staff and between staff and patients. Understand that these relationships are an important vehicle towards health and recovery. To assist with this goal, organisational operations should be transparent.
Survivor voices	The voices of those with lived experience are integral to an organisation's capacity to be sensitive to the needs and experiences of everyone using the system. Genuinely consulting survivors is critical for building trust, establishing safety, and harnessing resilience and growth.
Collaboration & Connection	Recognise the role everyone has in making a system trauma and violence informed. This includes understanding that recovery and growth can emerge from meaningful sharing of power and decision-making. Collaborate with specialist FV, IPV and sexual assault services, strengthening pathways with those services.
Strengths	Focus on resilience/growth empowerment and hope, building on the strengths of staff and patients, rather than only responding to perceived deficits and problems. Work to meet the specific needs of survivors, recognising that each experience of trauma, and path of recovery after trauma, is unique.
Culture, history & gender sensitivity	Organisations need to offer culturally safe and gender responsive services, learning from the healing tradition of Aboriginal communities. A trauma and violence informed approach is aligned with the shift towards cultural safety – the principles of both put responsibility on systems to make policies and practices responsive and inclusive to optimise support for survivors.

Notes

The principles in this table are informed by the thoughtful work of Browne et al. (2015) [90]; Elliott et al. (2005) [14]; Harms (2015) [91]; Harris and Fallot (2001) [92]; Herman (1992) [93]; Ponic et al. (2016) [94]; Quadara (2015) [95] & Reeves (2015) [96], among others.

Health Wellbeing & Relationship Project

Family violence against Australian nurses, midwives and carers.

Research Report
July 2022