

Intimate partner violence and the role of community nurses

Bradbury-Jones, Caroline; Clark, Maria

DOI:
[10.7748/phc.2016.e1184](https://doi.org/10.7748/phc.2016.e1184)

Document Version
Peer reviewed version

Citation for published version (Harvard):
Bradbury-Jones, C & Clark, M 2016, 'Intimate partner violence and the role of community nurses', *Primary Health Care*, vol. 26, no. 9, pp. 42-47. <https://doi.org/10.7748/phc.2016.e1184>

[Link to publication on Research at Birmingham portal](#)

Publisher Rights Statement:
Checked for eligibility: 14/12/2016.
Please note this is not the version of record.
[10.7748/phc.2016.e1184](https://doi.org/10.7748/phc.2016.e1184)

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

Primary Health Care

CPD Professional development

Intimate partner violence and the role of community nurses

Bradbury-Jones C, Clark M (2016) Intimate partner violence and the role of community nurses

Date of submission: 1 July 2016; date of acceptance: 6 September 2016

Caroline Bradbury-Jones

Reader in nursing

University of Birmingham

College of Medical and Dental Sciences

c.bradbury-jones@bham.ac.uk

Maria Clark

Lecturer

University of Birmingham

College of Medicine and Dental Sciences

ClarkMT@adf.bham.ac.uk

Abstract

Intimate partner violence is a common problem that is known to have serious and long-term impacts on health across a lifetime. While community nurses are ideally placed to deal with intimate partner violence, some may be unsure of what to do. They may fear getting things wrong or making the situation worse. Additionally, intimate partner violence is often difficult to identify because it tends to be a hidden issue. This article aims to increase community nurses' confidence in dealing with intimate partner violence. It describes the different forms of intimate partner violence and the associated risks and consequences. The community nurse's role in recognising and responding to intimate partner violence is discussed and we provide practical guidance on how to deal with the issue confidently to preserve patient safety.

Keywords

abuse, community nurse, domestic violence, intimate partner violence, recognition, referral, response, safety

Aims and intended learning outcomes

This article aims to inform the reader about intimate partner violence with particular emphasis on how community nurses can best recognise and respond to the issue. After reading this article and completing the time out activities you should be able to:

- Describe what intimate partner violence is and identify the different forms.
- List the risk factors associated with intimate partner violence.
- Discuss the consequences of intimate partner violence.
- Describe the community nurse's role in recognising and responding to intimate partner violence.
- Deal confidently with intimate partner violence.

Introduction

Intimate Partner Violence (IPV) consists of partner abuse, family abuse, sexual assault and stalking, and can be understood as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty (World Health Organization (WHO) (2013)). There tends to be a number of different terms used (such as domestic violence and/or domestic abuse), which can be a little confusing. In this article we use the WHO (2012) definition that 'IPV refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship'.

Table 1 shows the different forms of IPV (adapted slightly from WHO 2012).

Box 1: Forms of IPV

Physical violence (slapping, hitting, kicking and beating).

Sexual violence (forced sexual intercourse and other forms of sexual coercion).

Emotional/psychological abuse (insults, belittling, humiliation, intimidation, threats of harm, threats to take away children).

Controlling behaviours (isolating a person from family and friends, monitoring their movements, restricting access to money, employment, education or medical care).

Nurses in all settings are ideally placed to assess for IPV and to respond appropriately if a patient discloses. There is evidence, however that they are not always confident in dealing with the issue (Taylor et al 2013). Here the focus is on nurses working in primary and community care settings such as district nurses, practice nurses and adult/children's community nurses. The aim is to assist them to address IPV confidently and safely.

A great deal of IPV is difficult to detect - particularly emotional and coercive forms - and even women who experience it do not always identify their experiences as abusive (Bradbury-Jones et al 2014). This is because they are likely to be rooted in a relationship where subtle yet serious forms of behaviours perpetrated against them become the norm within their lives. Farmer and Callan (2012) suggest that: 'Couple relationships characterised by the coercive control of one partner by the other can lead to the shrinking of victims' worlds, the crushing of their potential and a depth of trauma that can make it almost impossible even to care for their children. Even when a woman escapes from such a situation she will often need significant support to manage the emotional aftermath - and avoid becoming entangled in repetitive abusive relationships again.'

NHS Choices (2016) provides a detailed list of questions people can ask themselves about their partners' behaviour: Are you ever scared of your partner? Has your partner ever forced you to do something that you really didn't want to do, including sexually? Has your partner ever hurt or threatened you or your children? Has your partner tried to keep you from seeing your friends or family? The questions reflect the different forms of IPV and can be invaluable in helping someone to identify their experiences as IPV. Nurses too might find this a useful point of reference.

Complete time out activity 1.

Time Out 1

Ask some of your colleagues what they think constitutes IPV and compare those accounts with Box 1. Do your colleagues recognise the full range of behaviours that might constitute IPV? You might find it interesting to discuss and reflect on this issue with them.

IPV occurs in all relationship configurations (irrespective of gender or sexuality) and Flinck and Paavilainen (2010) remind us that women do abuse men. However, IPV perpetrated by men against women forms the most violent and the most repeated form. Globally, it is estimated that as many as one third of all women have experienced (or are likely to experience) IPV in their lifetime. In Britain, the Office for National Statistics (ONS 2015) reported that young women were twice as likely as men to have experienced IPV, with 8.5% of women and 4.5% of men having experienced abuse in the last year.

Working with the ONS (2015) figures, out of 1,000 patients seen over one year, statistically 85 women and 45 men will be experiencing IPV. Richardson and colleagues (2002) reported on a survey of women attending general practice, with 160 out of 949 women participants (17%) experiencing physical violence from a partner or former partner in the past year. Lifetime prevalence was even higher, with 41% of women reporting experiences of physical violence. Yet IPV is a hidden problem and most people do not disclose. The reasons for this will be discussed later.

Complete time out activity 2.

Time Out 2

Pause now to reflect on your caseload of patients and to recall situations where you suspected that IPV might be occurring. What in particular alerted you to the situation? Was it what a patient said or behaviour that you observed? Are some forms of IPV more difficult to identify, e.g. controlling behaviour? Make a brief note of your experiences so that you can re-check these as your reading progresses.

IPV associated risks and consequences

While there are a number of well-documented risk factors and associations for IPV, these are complex and often overlapping. Understanding these is important because they can be alerting signs for IPV. Mental health problems and drug and alcohol misuse are closely linked with IPV and their combined relationship is sometimes referred to as the 'toxic trio' (Co-ordinated Action against Domestic Abuse, CAADA 2014). These are neither the cause nor the consequence of IPV per se. Instead they form a matrix of interrelated factors that impact on each other. Pregnancy can be a high risk time for some women who may present in pregnancy with an exacerbation or first instance of IPV (Seng & Taylor 2015). Van Parys et al (2014) reported that one fifth (20.4%) of women in their study experienced some form of IPV in the 12 months before and/or during pregnancy. Pregnancy related IPV has serious consequences for women including maternal depression (Woolhouse et al 2014) and in extreme cases mortality (Campbell et al. 2004). It also has adverse foetal outcomes for example, premature birth, low birth weight and stillbirth (O'Reilly et al 2010).

Disability is a risk factor for IPV among many women. Brownridge (2006) reported that more than half of disabled women have experienced IPV. Disabled women experience the same types of abuse as all women, but some experience the additional harms of abuse that is impairment related. Breckenridge and colleagues (2014) reported that this includes withholding assistive devices or refusing to provide basic care. IPV does not respect age and although adolescence is a risk factor, across the age span older people experience it too (McGarry et al 2011). Overall it is helpful to conceptualise IPV as something that can happen to anyone at any stage of their life.

Complete time out activity 3.

Time Out 3

There are well-known risk factors associated with IPV that occur across the life-course. List as many risks as possible and for each, write a sentence explaining why this is a risk.

Check out your understanding against the risk factors listed by WHO (2012) on page 4
http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

IPV is associated with long-term mental health impacts such as post-traumatic stress, anxiety, addiction and suicide risk (Devries et al 2011). Across the life course there are detrimental effects on psychological and emotional wellbeing for women, children and family relationships resulting in compromised health (Symes et al 2014). Many children live in a home where IPV is an issue and there is indubitable evidence that it does them both short and long-term harm (Humphreys & Bradbury-Jones 2015). They are far more likely than other children to experience a range of health-related problems including post-traumatic stress, depression and behavioural difficulties (Smith et al 2014). Importantly, children who live in households where IPV is a problem are at risk of being abused themselves (Coordinated Action Against Domestic Abuse (CAADA) 2014).

Resilience is an important issue and some children positively negotiate the stress and conflict created by exposure to IPV. However, it is important to remember the negative impacts on children in many cases of IPV. Evidence from serious case reviews (an investigation when a child dies or is seriously harmed) tells us that children and families who have suffered long-term injuries or death from IPV are likely to have accessed primary care on more than one occasion, often frequently, and usually involving contact with nursing as well as medical staff (Appleton & Peckover 2015). Missed medical appointment(s) may be a sign that all is not well. Community nurses have a crucial role in spotting this indicator and following up any children exposed to IPV, working to protect those at risk of harm.

Recognising IPV

Complete time out activity 4.

Time Out 4

Most people who experience IPV are likely to try and hide their experiences. Draw two columns on a piece of paper. In the left-hand column write three reasons why this might be the case. Leave the other column blank for time out activity 6.

It is extremely unusual for a patient to disclose abuse un-prompted. Instead they may give a number of cues that indicate a problem. It is increasingly recognised that IPV is likely experienced as a continuum or spectrum of abuse, involving misuse of individual power and control. 'Red flags' indicating coercive control are extremely important (such as a partner always present, humiliation or belittling, or not letting a patient speak for themselves). The more complex feature of abuse is the experience of significant and repeated experience of psychological fear or distress. Controlling or coercive behaviour may be less easy to spot, yet the mental and emotional impact is far reaching. In your own practice you may notice a patient or client being distressed, frightened or making contact with you more often than usual. This might prompt you to intuit that all is not well. Look back to Time Out 2. Did any of the patients you suspected as having IPV experiences exhibit this subtle way of seeking help?

To make the issue of dealing with IPV even more challenging, most patients who experience IPV will deny it if asked and they may often have been asked a number of times before they feel confident enough to disclose. The reasons are complex but IPV is steeped in stigma, personal or family shame/dishonour and fear. In their UK study, Rose et al (2011) reported that fear operates in a number of ways and encompasses fear of social services involvement and the removal of children; fear that they will not be believed; fear that disclosure will result in further violence; fear of disruption to family life; and fear of the consequences for immigration status.

Responding to IPV

Some nurses may feel less confident about raising the issue of psychological violence with patients due to the idea that IPV may be culturally-contingent or acceptable among some populations. Walsh et al (2015) highlighted that wherever 'traditional beliefs' relegate women to unequal roles and access to resources, their independent means to safety is limited. It is vital for nurses to remember that while abuse may be perceived or even defended by victims and perpetrators as a form of cultural violence, it is never acceptable. Nurses may compound a victim's distress through excluding them from the dominant culture of acceptable behaviour; by rejecting or ignoring the signs of help-seeking or by assuming cultural differences exclude them from non-violent social norms. All victims of abuse are likely to deny, minimise or resist describing their experience as abuse, and it is crucial that nurses too do not revert to cultural explanations to justify non-reporting of violent, abusive behaviour. There is no typical type – any patient irrespective of age, gender, sexuality or socioeconomic status may experience IPV (National Institute for Health and Care Excellence (NICE) 2014) or be at risk of IPV in the future.

Many nurses are reluctant to raise the issue with their patients. Fear of causing offence and saying the wrong thing are commonly cited as barriers to discussing the issue (Taylor et al 2013). Many nurses say they need to develop their confidence in engaging women in crucial conversations about their safety (Bradbury-Jones 2015, Bradbury-Jones et al 2016a, Sprinks 2016). Talking openly (but safely) about IPV indicates that it is an issue that can be discussed and part of this is of course adopting a non-judgemental and accepting stance (Richardson et al 2001). As with all nursing care, compassion and empathy go a long way in supporting patients to deal with their IPV experiences. Exploring how to support others who have had traumatic experiences is crucial in promoting recovery and when dealing with IPV, trauma informed health assessment is important. Grafton Integrated Healthcare (2014) suggest six principals of trauma informed care, including creating a culture of comfort; recognising that some practices can be re-traumatising; and thinking about the language we use. For example, in dealing with IPV, asking the question 'what has happened to you?' rather than 'what is wrong with you?' can have significant benefits in promoting a trauma informed approach to care.

Overall, although it can be difficult to raise the issue of IPV with patients, evidence suggests that most women are not offended when asked about it (Koziol-McLain et al 2008; Taylor et al 2013). A rule of thumb is that it is better to raise the issue, than to remain silent. There are however, some important considerations when discussing IPV as indicated in Box 2.

Box 2: Important considerations when asking about IPV

Think about whether it is appropriate and safe to ask (is the person alone? Is the environment private? Does the context lend itself to disclosure?)

Never ask in the presence of a family member, friend, or child who is old enough to understand.

Show willingness to listen and respond.

Use an appropriate professional interpreter if needed, but never a family member.

Complete time out activity 5.

Time Out 5

Think about your caseload and the patients you wrote about in Time Out 2. Are there any of these patients or the places in which they were seen where discussing IPV would be appropriate and safe? Are there any places where you would NOT discuss IPV? Give reasons for your answers.

When faced with disclosure or if concerned about the safety of a patient it is important to know how to respond. Neglecting to report concerns may in fact violate a professional standard of care, or criminal law (Nursing & Midwifery Council 2015). Action can take a number of forms, and it is important not to feel isolated in the decision-making process. It may be helpful to share your concerns and planned actions with a colleague. Many nurses working in other settings will have some point of specialist referral and/or advice within their organisation, for example a domestic violence specialist nurse or midwife. Accessing such expertise can be reassuring and helpful to nurses when dealing with suspected or disclosed IPV. It is important to follow organisational guidelines and to inform an appropriate person within your organisation. This may be a line manager or a lead nurse for domestic violence. Whatever the decision, it is absolutely crucial that accurate, contemporaneous records are made. These may be required to inform future decision making and in some cases, records can be subpoenaed. Precision and detail are therefore crucial.

Some community nurses reading this article will be working with general practices in the Identification and Referral to Improve Safety (IRIS) programme (www.irisdomesticviolence.org.uk/iris/). This is a general practice-based training support and referral programme with enhanced referral to specialist services. Nurses working in these practices should benefit from the programme's abuse aware culture and the availability of clear referral routes to a specialist advocate

Being mindful that disclosure of IPV is a high risk point for women and children's safety is important. Immediate action to preserve the safety of women and children is crucial (Nursing & Midwifery Council (NMC) 2015). Where children are present within an IPV situation their safety and protection needs to be a priority. A child protection concern should be raised and in the UK the Multi-Agency Safeguarding Hub (MASH) is an important point of referral:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf. Awareness of local IPV referral pathways is important and community nurses might also find it helpful to equip themselves with the free 24-hour National Domestic Violence Helpline (0808 2000 247).

Finally, it is helpful to accept that women may not always leave an abusive relationship. In this case, action may seem more like non-action. However, disclosure does not equate to exiting an abusive relationship. Reasons why women stay are complex and for many women remaining in a relationship is the only option – at least for the time being (Bradbury-Jones et al 2016a). Long-term safety planning may require small scale interventions over a longer period of time. There are practical barriers to immediate safety, as well as a need to identify secure opportunities for longer term planning. Working in partnership with other agencies is crucial, but this may be a step down the line from initial disclosure. Social services, police, housing and acute services may be involved, as well as independent sector agencies providing crucial care and support. Follow-up care will need to be undertaken, to ensure patients and

their families remain engaged with services offering support. It may be the nurse who undertakes this follow up, or another appropriate person or service.

Complete time out activity 6.

Time out 6

In time out activity 4 you made a list of reasons why people who experience IPV often try to conceal it. In the right-hand column now write down some ways that you believe community nurses might help to address each reason.

Next steps

IPV has a significant impact on those who experience it and the health effects are sometimes compounded by an inappropriate or poor professional response. Community nurses spend a great amount of time with women, children and families in primary care. Community nurses are increasingly called upon to reduce the medical burden of care. Scott (2016) and Wynton (2016) have observed the challenges for practice nurses faced by dwindling resources and increasing demands. In the UK, a forthcoming strategy to recruit more practice nurses may help in the longer term. More immediately, making every contact count in community and primary care is crucial in dealing with IPV (Feder et al 2011). Also, training and education about IPV is essential; primary care professionals who engage in regular training are more likely to be effective in identifying and responding to abuse, and to feel confident in raising the issue of psychological abuse (Turner et al 2015).

Many nurses reading this article will have personal experiences of IPV (Bradbury-Jones et al 2016b). Sprinks (2016) has reported on a recent Nursing Standard survey of 1,455 nurses, midwives healthcare assistants and nursing students in the UK. In the survey 51% of respondents said that a partner or family member had been verbally abusive or used controlling behaviour causing them psychological or emotional stress, 44% experienced physical violence at some point in their lives and 22% reported that they were forced by a partner into sexual activity. These figures indicate the extent of nurses' own IPV experiences. Building capacity for self-care is important (Bradbury Jones et al 2016b). We hope community nurses in such circumstances will be empowered to take action (in whatever form) to protect themselves and any children from further harm in the same caring way as they protect their patients.

Conclusion

Crucial conversations about IPV are integral to healthcare in community contexts (Bradbury-Jones 2015, Bradbury-Jones et al 2016a). Community nurses are well placed to make every contact count for the prevention of IPV but like other nurses, although they may know its prevalence and nature, they may lack confidence in addressing the issue with their patients or their families (Taylor et al 2013, Bradbury-Jones et al 2014). The CPD article has discussed different aspects of IPV and explored the community nurse's role in relation to recognition and response. We have provided information on the different types of IPV and the risk factors associated with them. The insights gleaned from reading this article and doing the time out activities might help increase community nurses' confidence in dealing with this important and complex area of nursing practice. We want to convey a take-home message that dealing with IPV is not so different from dealing with many other sensitive, personal and difficult issues in nursing. Nurses' core values of compassion, empathy and care go a long way in helping them to deal with IPV effectively.

Complete time out activity 7.

Time out 7

You have now read the article and completed the activities. Now write a reflective account on what you have learned and how this might help you in the future. Guidelines to help you write the reflection are on page xxx????.

Accepted version

References

- Appleton J & Peckover S (2015) Child Protection, Public Health and Nursing. Dunedin Academic Press, Edinburgh.
- Bradbury-Jones C & Taylor J (2013) Establishing a domestic abuse care pathway: guidance for practice. *Nursing Standard* 27, 27, 42-47.
- Bradbury-Jones C, Taylor J, Kroll T & Duncan F (2014) Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation. *Journal of Clinical Nursing*, 23, 21-22, 3057-68.
- Bradbury-Jones C (2015) Talking about domestic abuse: Crucial conversations for health visitors. *Community Practitioner*, 88(12), 40-43.
- Bradbury-Jones C, Appleton JV & Watts S (2016a) Recognising and responding to domestic violence and abuse: the role of public health nurses. *Community Practitioner*. 89, 3, 24-8.
- Bradbury-Jones C, Clark MT, Parry J & Taylor J (2016b) Development of a practice framework for improving nurses' responses to Intimate Partner Violence. *Journal of Clinical Nursing*. doi: 10.1111/jocn.13276
- Breckenridge J, Devaney J, Kroll T, Lazenbatt A, Taylor J & Bradbury-Jones C (2014) Access and utilization of maternity care for disabled women who experience domestic abuse: a systematic review. *BMC Pregnancy and Childbirth*, 14, 234.
- Brownridge, DA (2006) Partner Violence against Women with Disabilities: Prevalence, Risk, and Explanations, *Violence Against Women*. 12, 805-822.
- Campbell, J., Garcia-Moreno, C., Sharps, P. (2004) Abuse During Pregnancy in Industrialised and Developing Countries. *Violence Against Women* 10, 7, 770-789
- Co-ordinated Action Against Domestic Abuse (CAADA) (2014) In plain sight: The evidence from children exposed to domestic abuse.
[www.caada.org.uk/sites/default/files/resources/In plain sight the evidence from children exposed to domestic abuse.pdf](http://www.caada.org.uk/sites/default/files/resources/In%20plain%20sight%20the%20evidence%20from%20children%20exposed%20to%20domestic%20abuse.pdf) (Last accessed: September 14 2016)
- Devries K, Watts C, Yoshihama M et al (2011) Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine*. 73, 1, 79-86.
- Farmer E & Callan S (2012) Beyond Violence: Breaking cycles of domestic abuse. Centre for Social Justice. (Last accessed August 4, 2016)
<http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/DA%20Full%20report.pdf>
- Feder G, Davies RA, Baird K et al (2011) Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet*. <http://www.irisdomesticviolence.org.uk/iris/> (Last accessed: September 14, 2016)
- Flinck A & Paavilainen E (2010) Women's Experiences of Their Violent Behavior in an Intimate Partner Relationship. *Qualitative Health Research*. 20, 3, 306-318.
- Grafton Integrated Health Care Network (2014) Six Principles of Trauma Informed Care:
<https://www.grafton.org/six-principles-of-trauma-informed-care/>. Accessed 15.09.16
- Humphreys C & Bradbury-Jones C (2015) Domestic Abuse and Safeguarding Children: Focus, Response and Intervention. *Child Abuse Review*. 24, 4, 231-234.
- Koziol-McLain J, Giddings L, Rameka M et al (2008) Intimate Partner Violence Screening and Brief Intervention: Experiences of Women in Two New Zealand Health Care Settings. *Journal of Midwifery & Women's Health*, 53, 6, 504-510.
- McGarry J, Simpson C & Hinchliff-Smith K (2011) The impact of domestic abuse for older women: a review of the literature. *Health and Social Care in the Community*. 19, 1, 3-14.

NICE (2014) Domestic violence and abuse: how services, social care and the organisations they work with can respond effectively. NICE, London.

NHS Choices (2016) Recognising the signs of domestic violence. Available:
<http://www.nhs.uk/Livewell/abuse/Pages/signs-domestic-violence.aspx>

Nursing and Midwifery Council (NMC) (2015) The Code: Professional standards of practice and behaviour for nurses and midwives. Nursing and Midwifery Council, London, HMSO.

Office of National Statistics (2015) Violent Crime and Sexual Offences - Intimate Personal Violence and Serious Sexual Assault; in Domestic Crime Prevention. Office of National Statistics, HMSO
http://www.ons.gov.uk/ons/dcp171776_394500.pdf

O'Reilly R, Beale B, Gillies D (2010) Screening and Intervention for Domestic Violence During Pregnancy Care: a Systematic Review. *Trauma Violence Abuse*. 11, 190-201.

Richardson J, Feder G, Eldridge S, Chung WS, Coid J & Moorey S (2001) Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice. *British Journal of General Practice*. 51, 468-470

Richardson J, Coid J, Petruckevitch A et al (2002) Identifying domestic violence: cross sectional study in primary care. *BMJ*. 324, 274.

Rose D, Trevillion K, Woodall A et al (2011) Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry*. 198, 3, 189-194.

Scott G (2016) Let's empower practice nurses to improve care. *Nursing Standard*. 30, 34, 3.

Seng J & Taylor J (2015) (eds) *Trauma Informed Care in the Perinatal Period*. Dunedin Academic Press, Edinburgh.

Smith E, Belton E, Barnard M et al (2014) Strengthening the Mother-Child Relationship Following Domestic Abuse: Service Evaluation. *Child Abuse Review*. 24, 261-273.

Sprinks J (2016) Urgent training in domestic abuse is needed to open closed doors. *Nursing Standard*. 30, 41, 12-13.

Symes L, Maddoux J, McFarlane J et al (2014) Physical and sexual intimate partner violence, women's health and children's behavioural functioning: entry analysis of a seven-year prospective study. *Journal of Clinical Nursing*, 23, 19-20, 2909-2918.

Taylor J, Bradbury-Jones C, Kroll T et al (2013) Health professionals' beliefs about domestic abuse and the issue of disclosure: a critical incident technique study. *Health & Social Care in the Community*. 21, 5, 489-499.

Turner W, Broad J, Drinkwater J et al (2015) Interventions to Improve the Response of Professionals to Children Exposed to Domestic Violence and Abuse: A Systematic Review. *Child Abuse Review*. doi: 10.1002/car.2385.

Van Parys A, Deschepper E, Michielsen K et al (2014) Prevalence and evolution of intimate partner violence before and during pregnancy: a cross-sectional study. *BMC Pregnancy and Childbirth*, 14, 294.

Walsh J, Spangaro J & Soldatic K (2015) Global understandings of domestic violence. *Nursing & Health Sciences*, 17, 1, 1-4.

Woolhouse H, Gartland D, Mensah F, Brown S (2014) Maternal depression from early pregnancy to 4 years postpartum in a prospective pregnancy cohort study: implications for primary health care. *BJOG*. doi: 10.1111/1471-0528.12837

World Health Organization (WHO) (2012) Understanding and addressing violence against women. Available:
http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

World Health Organization (WHO) (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization, Geneva.

Wynton L (2016) New strategy planned to boost nurse numbers in general practice. *Nursing Standard*. 30, 34, 7.