Original Article

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A Practical Guide to Prevention for Forensic Nursing

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ABSTRACT

Interpersonal violence (IPV) is a pervasive issue across the United States, affecting one in five women and costing the nation up to $750 billion per year in additional healthcare spending. Prevention of IPV by forensic nurses may be an underrecognized and underutilized activity as forensic nursing emphasizes collection of evidence and provision of acute care to victims of violence. The "Upstream Adage" parable has been used to identify activities that can be applied to the care of victims. Forensic nurses can expand their practice activities into an "upstream" focus by targeting communities and individuals at different levels of risk and participating in key interventions before violence occurs. The role for forensic nurses to inform, participate, and implement primary, secondary, and tertiary prevention activities can have positive influences on the problem of IPV that extends well beyond the provision of direct care.

KEY WORDS:

Communities; forensic nursing; interpersonal violence; prevention

A man and woman walking along the river see someone struggling in the water. They rescue the drowning victim and successfully resuscitate him just as they notice two more victims in the water calling for help. They call for help and continue to work on saving the victims. Over time, as more victims continue to be found in the river, the response to drowning victims is improved. Funding is made available to develop a diverse array of new programs to combat this health issue including educating the community, teaching people to swim, improving rescue programs, educating more rescuers, rehabilitating the victims, and increasing services available to the victims. The response has been relatively easy, since the river is next to a large urban area (Downstream City), and there are many resources and people available. However, upstream is primarily rural with a few scattered towns and villages. One day, a rescuer says "What is going on upstream? Why do we have so many victims?" The other rescuers tell him to focus on doing his job rescuing victims and if people upstream need help they will say so. But, the rescuer decides to go upstream to find out what is going on. He finds a bridge with holes through which people fall, no signs warning people of the waterfall, no protective fencing at the riverside and waterfall, and a lack of funding for both bridge repair and community swimming lessons. In addition, some people upriver routinely push others into the water. When this curious rescuer shares his observation with the larger downstream community, he finds a lack of empathy for the residents of the upstream region and outright disbelief that people push others into the water. Nothing is done to develop programs to meet the needs of the rural upstream communities.

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Known as the "Upstream Adage" (Bekemeier, 2008; Butterfield, 2002; Cohen & Chehimi, 2007; Ferguson & Speck, 2010; Kagan, 2011), the opening story is a revision of a popular public health parable that has often been used to promote understanding of the need

for prevention since the late 1970s. Upstream strategies have been those identified as primary prevention activities, meant to impact events before they occur, whereas downstream strategies include those interventions that are reactive to events after their occurrence (Bekemeier, 2008; Butterfield, 2002; Candib, 2000). As forensic nursing is a practice that emphasizes collection of evidence and provision of acute care to victims of violence (a downstream strategy), prevention activities may be underrecognized and underutilized. Because of their focus on acute situations, it may be difficult for forensic nurses to recognize the myriad of ways in which prevention and public or community health activities can be applied to focus on upstream strategies.

To date, the criminal justice system on its own has proven inadequate at preventing interpersonal violence (IPV). Public health professionals have, with limited success, attempted to step in to improve societal IPV outcomes and integrate interdisciplinary approaches with criminology (Akers & Lanier, 2009; Rivara, 2001; Todres, 2010). As a critical and evolving component within the public health system, one of the goals of the forensic nurse should be to prevent and reduce the maltreatment of women and children, specifically, and of human violence in society at large (Glittenberg, Lynch, & Sievers, 2007).

The purpose of this article is to define and clarify the language of IPV prevention, provide examples of successful intervention strategies, and encourage the inclusion of prevention principles and activities into forensic nursing practice.

Interpersonal Violence Defined

Although much of the violence literature uses the acronym IPV for intimate partner violence, IPV also represents interpersonal violence, which is a more encompassing term for the overarching issues of violence that impact society across the lifespan. IPV as used in this paper is defined as the insidious and sometimes deadly violence that occurs between individuals or small groups and includes child maltreatment, youth violence, intimate partner violence, sexual violence, and elder abuse (Butchart, Phinney, Check, & Villaveces, 2004, p. vii). Some researchers have focused specifically on violence against women; in that context, IPV may be defined as any act of gender-based violence, which may "cause or have potential to cause harm…rooted in sexual inequality…[and] represents a serious violation of women's human rights" (Watts & Zimmerman, 2002, p. 1232). In a position statement on violence as a public health issue, the International Association of Forensic Nurses (IAFN) states that "violence is an international public health issue that destroys the quality of life in communities and societies worldwide" (IAFN, 2009b). The various definitions make it clear that IPV encompasses many types of violence, including, according to the World Health Organization, collective violence among and between societies (Krug, Dahlberg, Mercy, Ziwi, & Lozano, 2002).

IPV is a pervasive issue across the United States, impacting individuals residing in rural and urban settings in every state. Black and colleagues (2011) conducted the National Intimate Partner and Sexual Violence Survey and found that one in five women and 1 in 71 men have been sexually assaulted in their lifetimes, that half of female victims of rape were raped by an intimate partner and nearly half of all men and women in the United States have been a victim of psychological abuse by an intimate partner. Clearly, the problem of IPV goes far beyond highly publicized incidents such as the recent massacre of children and educators in Newtown, CT, or the escape of three women who had been brutalized as the sex slaves of an Ohio man.

In addition to damaging the lives of affected individuals and the communities in which they reside, IPV has a serious negative economic impact on society. Specifically, victims of abuse use two to two and a half times the healthcare resources as the average person, adding up to $750 billion per year to national healthcare spending. This represents 17%–37% of annual national healthcare expenditures (Dolezal, McCollum, & Callahan, 2009). In an environment of increasingly scarce healthcare resources, the prospect of reducing those expenditures should be sufficient to motivate policymakers to invest in IPV prevention.

It is clear that prevention interventions save money. For example, the Prevention Institute and the California Endowment with the Urban Institute (2007) reported that, when all cost savings, including direct medical costs, decreased long-term disability, and reduced work and school absenteeism, are combined, the California Tobacco Control Program has saved $3 billion over 8 years and motorcycle helmet laws have saved $48 million over 5 years. The authors noted that breastfeeding education and outreach together have saved $3.2 billion per year. Although it is clear that IPV is a significant and costly health issue in both human suffering and economic cost, it may be unclear how prevention can be incorporated into the practice of forensic nursing.

While forensic nursing has traditionally been defined as the healthcare response to (criminal and interpersonal) violence, there also exists "a professional and ethical responsibility to serve, advocate for and empower patients, families and their communities" (IAFN, 2009a, p. 1). Forensic nurses can work to improve crime victims' health outcomes through their interactions within the legal arena, systems of care, and community agencies as well as with individuals. Crime victims and perpetrators must be identified, further injury or death must be prevented, and potential for abuse must be detected (IAFN, 2009a). When

viewed within this context, the forensic nurse can play a pivotal role in the practice of IPV prevention. Nurses in general and forensic nurses in particular strive to improve the lives of clients. Clearly, violence of any kind does not make things better. Hence, there is a role for forensic nurses in IPV prevention.

Public Health Prevention

In most areas of care and prevention, there are established "best practices"; it is essential that there is a consensus or a "universal understanding" of what those best practices should be. This is no different when seeking to understand different levels of violence prevention activities. Troy and Clements (2007) noted that, once a universal understanding of possibilities is established, effectiveness and utilization should be tested by the forensic nursing and research communities to establish which strategies work best and how they should be deployed.

In reviewing successful public health prevention interventions, clean water, sewage treatment, and vaccinations come to mind. Those were relatively simple solutions (primary prevention solutions) to very concrete problems. However, since those early days, public health has continually evolved in concert with medical advancements. During World War II and the war in Vietnam, improvements in medical and surgical care became the focus. That was followed by a focus on occupational and transportation hazards (Rivara, 2001). Although the resultant prevention strategies were more complex than those used for clean water, human behavioral factors were not yet part of the equation. However, as the public health focus turned to the prevention of injury, the need to attend to human behaviors became apparent. Smoking cessation, helmet use, and seatbelt laws are just a few of the areas in which the public health community has had a positive impact on human behavior (Dahlberg & Mercy, 2009). Therefore, it is clear that a public health focus can have a significant and positive impact on many societal problems whose solutions require behavioral change.

The shift toward examining violence as a public health issue began in the 1980s (Ferguson & Speck, 2010), when it was recognized that homicide and suicide occurred more often among specific populations. Although violence differs from other public health issues, many types of violence are linked and share common risk factors, including poverty, family history, substance abuse, and other behavioral patterns (Krug et al., 2002). Traditionally, societal solutions for IPV as well as other behaviorally related public health problems such as substance abuse have rested in the hands of the criminal justice system, albeit with little or no success (Dahlberg & Mercy, 2009). Basile and Smith (2011) noted that, given the "sheer magnitude of the problem" (p. 412), IPV is particularly well suited for a public health response. They also pointed out that most of the consequences of IPV are health related, asserting that public health problems are preventable and more emphasis should be placed on reducing factors that put people at risk while increasing factors that protect people from the problem.

While the medical prevention model focuses on the patient as an individual, the public health prevention model looks at the population as a whole. Differences in prevention models and levels of prevention are illustrated in Table 1. Both the medical and public health models include primary, secondary, and tertiary prevention levels, with the public health model expanding those levels to reflect the population paradigm. Returning to the upstream adage, prevention can be seen as those activities that occur before acts of violence to prevent the violence from ever happening through impact on changes to root causes of the violence (Bekemeier, 2008; Butterfield, 2002; Kagan, 2011).

The goal of primary IPV prevention is to stop victimization and perpetration (i.e., the IPV act) before it occurs (Centers for Disease Control [CDC], 2004). Primary prevention typically focuses on knowledge, attitudes, and behaviors (consider the success of seatbelt use today), which influences individuals, relationships, and communities. Primary prevention often utilizes the impact of social learning to promote change. All levels of prevention should include awareness of issues of gender inequalities and impact of sociocultural norms, presented with sensitivity and respect (Amar, Bess, & Stockbridge, 2010; Basile & Smith, 2011).

Forensic nursing has traditionally focused on secondary IPV prevention, which seeks to prevent further injury/violence after an event has occurred (Butchart et al., 2004). This focus includes the acute support and care of victims and promoting criminal justice resolution. Finally, tertiary prevention interventions focus on eliminating the long-term harm, and like secondary interventions, they occur after the violent act (CDC, 2004) and include rehabilitation of the individual who has experienced IPV as well as policy and legislation development, public education, and prevention program development and evaluation (Table 1).

Public health prevention brings a unique perspective to the fight against IPV as it is an interdisciplinary and science-based process, which incorporates innovative activities, emphasizes collective action and cooperative efforts, and aims to include multidisciplinary and comprehensive responses to issues affecting overall health of populations (Basile & Smith, 2011; Buzawa & Buzawa, 2012; Krug et al., 2002). Krug et al. have stated that "by definition, public health is not about individual patients. Its focus is on dealing with diseases and with conditions and problems affecting health, and it aims to provide the maximum benefit for the largest

TABLE 1. Models and Levels of Prevention

Levels of prevention	Medical model	Public health model	Injury and violence prevention model
Primary prevention	Keep individuals from becoming sick or injured For example, hand washing education	Keep populations from becoming sick or injured For example, vaccination for influenza	Prevent victimization and/or perpetration before it occurs to keep populations from becoming injured For example, school parenting programs
Secondary prevention	Treat individual illnesses/injuries through medication, medical management, or surgery For example, acute treatment	Treatment of population illnesses or injuries For Example, case-finding activities such as mammography screening	Care/treatment of individuals who are victims of violence For example, sexual assault examinations conducted during acute phase via multidisciplinary teams
Tertiary prevention	Rehabilitating individuals after illness/injury For example, rehabilitation services after traumatic injuries	Developing policy and legislative changes to promote primary and secondary prevention activities For example, funding for breast and cervical cancer screening for populations at higher risk	Rehabilitation of individuals after victimization or perpetration as well as policy/legislative changes in the promotion of primary and secondary prevention activities for the population For example, stiffer penalties For example, increased funding for mental health services after sexual assault

Note. Centers for Disease Control & Prevention, 2004; Chamberlain, 2006.

number of people" (p. 3). Furthermore, they conclude that it is accepted within the public health field that small investments to combat health issues can have "large and long-lasting benefits" (Krug et al., 2002, p. 243).

IPV Prevention for the Forensic Nurse: Implications for Clinical Practice

The most common role played by forensic nurses is "downstream" at the secondary prevention level, in which forensic nurse evaluation activities are carried out within the context of sexual assault programs, death investigation programs, and child advocacy centers. Support and care of victims is essential to aid in treating injuries, minimizing harm, reducing secondary victimization, and promoting criminal justice resolution. "High-quality services can minimize all forms of harm caused to victim….[it is] the consequences of IPV [that] are most likely to affect a victim in the long term" (Butchart et al., 2004, p. 61).

Forensic nurses can expand their secondary prevention activities into an upstream focus by targeting communities and individuals at different levels of risk and offering key points for intervention before violence occurs. Returning to the opening parable, what would upstream (primary) prevention look like? What would it mean to our communities if victims were kept from falling into the river or being pushed in? Ideas for the parable would incorporate some of the following: signage to warn people approaching the river or waterfall (education about the danger), erecting barriers at the point of entry (policy development, which also requires education of the legislators to let them know why they need to spend money to build a barrier), funding for repairs, education for those people who have been pushed in to help keep them from entering the river in the first place, and also, education for those who have fallen in previously to keep them from falling in again. Each of these interventions is limited only by the imagination, resources, and abilities of those individuals advocating, developing, implementing, and evaluating those interventions. It is the modification of risk and protective factors for violence at the community level that is a natural focus for primary prevention by forensic nurses (DeGue et al., 2012).

As the need for "upstream" prevention of IPV at all levels of the population grows, there are additional roles that forensic nurses can play (Chamberlain, 2006; CDC, 2004; IAFN, n.d.; Krug et al., 2002; Rivara, 2001). Butterfield (as cited by Kagan, 2011) urged all nurses to be proactive. She went on to characterize nurses as "complex problems solvers in ambiguous and dynamic

situations" (p. 76). Clearly, this descriptor is apropos to forensic nurses.

In addition to the active involvement of care for victims of IPV, forensic nurses in particular should be involved in an array of tertiary prevention activities including

- participating in the development and evaluation of prevention programs;
- consulting and collaborating with community agencies;
- educating community service agencies, community members, legislators, funders, and policy makers;
- promoting and conducting IPV research;
- developing and promoting policy and legislation;
- promoting evidence-based practice;
- advocating for community level change;
- lobbying for funding and services for victims;
- facilitating access to care; and
- supporting perpetrator response research.

It should be noted that, upon implementation, the outcomes of these activities constitute primary prevention strategies.

Forensic nurses bring an increased level of understanding of the dynamics involved with victimization and perpetration as well as the holistic focus of nursing care to this practice arena. This focus provides the forensic nurse with a unique "opportunity to address community causes and cross cutting risk factors" (Butchart et al., 2004, p. 3) to encourage awareness/knowledge of prevention; stimulate participation in all levels of prevention; and promote knowledge, attitudes, beliefs, behaviors, and environmental changes essential for successful prevention programs. In addition, Butchart et al. noted that, in the prevention of violence, it is essential not only to include care for the victim but also to prevent the "development and perpetration of violent behavior in the first place" (p. 35). Primary prevention for risk of perpetration includes changing adolescent risk behaviors and skill building around issues of pregnancy, parenting, relationship development, and substance abuse (Whitaker, Murphy, Eckhard, Hodges, & Cowart, 2013). Primary prevention activities that forensic nurses are in a key place to promote include education regarding screening for IPV by healthcare providers, promoting bystander intervention for all age groups, and highlighting the importance of intervening with peers who may be at risk for perpetration (Basile & Smith, 2011). DeGue et al. (2012) noted that violence prevention campaigns should review the success of HIV prevention and alcohol prevention programs, which encompass multilevel prevention strategies with the goal to change individual and community attitudes.

Troy and Clements (2007) noted that forensic nurses offer education and empowerment to victims and have the potential to apply forensic-nursing-based psychoeducation to program development and involvement in research and prevention activities. Participating in IPV prevention initiatives and advocating for sustainability as well as improving forensic medical services and the criminal justice system are crucial tertiary prevention activities that aid in meeting the medical, psychological, and social needs without prioritizing or diminishing the role of evidence collection (Butchart et al., 2004). In addition, forensic nurses can speak to the need for coordination of care and services, such as through the funding and development of community campaigns to prevent violence or promote bystander intervention.

So, how might the "Upstream Adage" look when it is applied to the issue of IPV?

Meet Amy, a 19 year old woman who grew up in "Small-Village Upstream." She had never been exposed to a river or large populations of people. During her travel to college in "Downstream City," she met Dave. Dave talked her into staying with him at "Riverside Village" where they become intimate. She stayed for a while but soon realized that she was being isolated and controlled as Dave did not allow her to be in contact with friends or family. When she attempted to leave, Dave pushed her into the river where she became another victim requiring rescue in Downstream City. At her evaluation, Amy met a forensic nurse who not only completed the forensic examination that was part of the criminal justice process but also assisted her in getting necessary services as Amy had not been to Downstream City before. The forensic nurse who cared for Amy was able to add Amy's story to her work advocating for funding for community violence prevention education in Small Village and Riverside Village. The forensic nurse is also a part of a speaker's bureau in which she provides education to adolescents and local community agencies on topics of risks of substance abuse, promotion of healthy relationships, parenting education, and bystander training. Their experiences led Amy and the forensic nurse to speak to the legislature and the criminal justice system about the risks of revictimization and the importance of bystander awareness.

There are a number of IPV prevention activities that could be enacted in the scenario just described. It is worth noting that some actions can be categorized at several levels of prevention and among various disciplines (Akers & Lanier, 2009). For example, the arrest and sentencing of Dave within the context of the legal system may constitute a primary prevention activity for Amy in that it prevents additional injury to her. Engaging Dave in an evidence-based offender management program represents tertiary prevention, by reducing the community threat of reoffense in the future. The forensic nurse can be proactive in communities by encouraging evaluation and research regarding perpetration and treatment (DeGue et al., 2012).

Other primary prevention activities could include creating posters regarding violence and shelter availability for posting in local businesses, including the college that

Amy attends; developing bystander awareness education that promotes intervention by her family and friends; and creating a young adult dating violence prevention program in Amy's home and college communities.

The supportive services that Amy received immediately after her care in Downstream City clearly fall into the secondary prevention level, but the encouragement that she received to become an anti-IPV spokesperson in her community may represent both tertiary prevention as part of her recovery from the experience of violence as well as primary prevention, making future potential IPV victims aware of potentials and resources. Finally, forensic nurses may pursue tertiary prevention by participating in research and policy development to identify community education and service needs (Dorfman, Sorenson, & Wallack, n.d.).

The IAFN (2009a) *Forensic Nursing Scope and Standards of Practice* clearly delineates that the role of forensic nurses is that of "caring for victims and perpetrators of intentional and unintentional injury" (p. xi), across the lifespan for the living and the deceased. Forensic nurses already focus on the immediate care needed for victims, typically as part of a multidisciplinary team. In addition to providing all crucially needed crucial services at the secondary prevention level, forensic nurses can have a positive influence on the problem of IPV that extends far beyond the provision of direct service. Advocating for community awareness and prevention programs, lobbying for additional resources, and informing IPV policy development have a greater potential for impacting the problem of IPV and represent an arena in which forensic nurses can have a major impact.

The examples provided in Amy's story are activities that real-time forensic nurses can do on a regular basis in their communities. Forensic nurses can advocate for and use evidence-based strategies in their daily practice and, when working, to develop, manage, and evaluate community programs and lobby for resources needed to improve access to care. Ferguson and Speck (2010) note that promoting active work beyond sexual assault care allows the forensic nurse to be a stakeholder and collaborator with community agencies. Forensic nurses already require specialized education and supervised practice to gain the skills necessary to provide effective care in this "multifaceted and complex practice specialty" (IAFN, 2009a, p. 1). The integration of primary and tertiary prevention into forensic nursing preparation and continuing education will ensure that all forensic nurses have an expanded repertoire of competencies to confidently implement upstream prevention.

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