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Knowledge, Attitude, Preparedness and Behavior of Nurses Towards Intimate Partner Violence in Mental Health Settings

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Abstract

Various studies have explored healthcare professionals' knowledge, attitudes and preparedness towards intimate partner violence (IPV). However, there is a dearth of research, which focuses on nurses working in mental health settings. This study explored the knowledge and preparedness of nurses working in mental health settings to identify and manage IPV. The hypothesis developed for this study was: nurses have negative perceptions towards the management of IPV; and demographic characteristics influence the nurses' perceptions towards IPV. A cross-sectional quantitative survey design was used. One hundred and nine nurses working within the acute in-patient and community mental health setting completed the Physicians Readiness to Manage Intimate Partner Violence Survey (PREMIS). The results of the study show that the participants lack competence in identifying potential victimized individuals and may not feel adequately prepared and knowledgeable to address IPV in their practice. However, they are willing to manage IPV and have identified the need of more competence in the area. These findings are similar to literature which involved populations other than nurses who work in mental health settings. Nurses in mental health settings need training on how to identify and manage IPV cases. Mixed methods research in this area is also recommended.

Keywords: intimate partner violence, nurses, mental health, domestic violence

1. Introduction

The World Health Organization (2013) refers to intimate partner violence (IPV) as "behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors". As cited in Sackett and Saunders (1999), victims claim that the psychological impact of abuse is harder to withstand than the physical aggression itself. Its aftermath is commonly associated with a lack of self-esteem, fear, feelings of self-doubt, confusion, isolation and a deep feeling of self-worthlessness. The severity of such symptoms depends on the severity of the trauma involved, which may consequently cause further feelings of numbness or dissociative responses (Becker, Stuewig, & McCloskey, 2010). The negative psychological effects resulting from the intimidation, control and criticism of the abusive partner, enhances the risk for the victim to develop mental health problems (Dillon, Hussain, Loxton & Rahman, 2013).

The purpose of the current study was to explore the perceptions of nurses working in the Maltese mental health care system, as well as to evaluate their knowledge and attitudes towards IPV.

The Crime, Safety and Victims' Rights survey by the European Union Agency (2021) for fundamental rights reports that in Malta, only 10% of the participants are willing to help a victim of intimate partner violence. A local report by the National Statistics Office (Malta) (2019) showed a constant increase of individuals making use of domestic violence services. For the year 2019, this office reported that 2,565 individuals have sought such services, 80.2% of whom were female. This data highlights that most cases are flagged either by the police or by the domestic violence unit services. Since healthcare professionals also commonly encounter IPV cases, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) urged for the involvement of healthcare professionals to identify IPV through their practice. Although nurses working within the mental health setting may play a key role in supporting victims of IPV, research clearly documents that health care professionals lack knowledge, preparation and competence to address this issue (Tjaden & Thoannes, 2002; Taft & Hegarty, 2010; Howard et al., 2010; Falb et al., 2014).

When addressing staff knowledge and preparedness with regards to IPV, a number of variables need to be considered, as identified by literature on the topic. These variables, which are the ones that have been explored in

this study, include: perceived preparedness and knowledge, actual knowledge, staff preparation, legal requirements, workplace issues, alcohol/drugs, victim understanding and practice issues (Nyame et al., 2013).

Several studies have been dedicated to exploring each of these variables. For example, a body of literature addresses the perceptions surrounding the way health care was being delivered, through the experiences of both professionals and victims of IPV (Rees et al., 2014; Pratt-Eriksson et al., 2014; Bradbury-Jones et al., 2016; Saletti-Cuesta et al., 2018). In this type of research, focus was directed towards perceptions, based on the rationale that the participants, which included professionals and victims, could provide important first-hand information on the consideration for IPV cases in healthcare.

These studies on healthcare professionals' perceptions (including nurses) on IPV, show that there are many perceived challenges related to this area. Some of these were highlighted in the research findings by Baig, Ryan, and Rodriguez (2012). In their study, participants who emerged from various professions including nursing, identified barriers such as responsibility, time, additional resources, privacy, legalities, education and relationships. Notably, nurses felt that IPV was not their responsibility but fell within the remit of their medical colleagues. They also believed that they did not have enough knowledge in this area and so were unsure about what signs to look out for, questions to ask to patients and how to offer support. Additionally, lack of time to address IPV was also perceived as a major issue.

Furthermore, other researchers evaluated actual knowledge. Trevillion et al. (2014) stated that research suggests that domestic violence is highly experienced by mental health service users. Yet, mental health service providers may not be applying screening measures and managing this issue consistently and adequately. A qualitative meta-synthesis by Trevillion et al. (2014) was used to explore health care professionals' knowledge, as perceived by the users. The findings suggested that mental health professionals failed to identify and acknowledge abuse, lacked a psychosocial approach when dealing with such cases, endangered victims through referrals for marital therapy or disclosure of violence in front of perpetrators; and lacked a needed liaison with domestic violence services. Similar findings were presented by Hultmann et al. (2014), who reported that the professionals in their study were reluctant to ask the necessary questions within the Partner Violence Screening (PVS) questionnaire. This was mostly linked to the fear that the questions may trigger further violence and harm the patient. At times, IPV screening was also reported to become a non-urgent priority due to the need to attend to other issues, especially in complex cases.

Other studies on the topic merged a number of variables in an attempt to explore IPV in a comprehensive manner. In this view, they looked at professionals' perceived knowledge, attitudes, beliefs and behaviours (Roelens et al., 2006; Papadakaki et al., 2012; Ramsay et al., 2012; Atinuke et al., 2015; Roush & Kurth, 2016). The research findings arising from this area of study consistently show that many professionals lack the knowledge and preparedness to identify cases of IPV and manage them appropriately. Interestingly, nurses seem to be less confident than other professionals such as doctors, in relation to IPV (Ramsay et al., 2012). Many of these studies included demographic characteristics such as age, professional qualification and years of practice to determine differences in responses upon these variables.

There seems to be a lack of research on clinicians' and service users' barriers and ease to enquire and disclose IPV in a mental health setting. A cross-sectional study was conducted with service users who were in contact with statutory or voluntary community mental health teams (n=18) and community mental health professionals who worked within these teams (n=20) (Rose et al., 2011). The mental health professionals reported many barriers that prevented facilitation of enquiry of IPV, such as competing demands, time constraints and the presence of the partner during consultations, a lack of competence and training as well as unclear boundaries in terms of their professional role. The findings indicate that workplace and practice issues are variables that need further exploration within the remit of IPV.

The study that is being presented in this paper attempted to address the variables that have been described, by exploring the perceptions of nurses working in mental health care as well as evaluating actual responses with regards to the knowledge, preparation and management of IPV by Maltese nurses working in the acute and community mental health settings. Furthermore, this study examined the influence of demographic variables on the perceived skills of the studied population. The hypothesis set for the study was based upon the literature that has been described, namely that: nurses have negative perceptions towards the management of IPV; and demographic characteristics influence the nurses' perceptions towards IPV. The rationale to focus this study on nurses in the Maltese context is based on the knowledge that in this country, nurses are situated in a unique position to assess for a history of intimate partner violence in patients seeking care and can therefore provide immediate support. This is brought about by the fact that in Malta, nurses are often the first point of contact in healthcare systems. Furthermore, nurses have prolonged contact time with patients in many of the local areas.

The following research questions were posed to guide the study:

- Are nurses working in the mental health settings knowledgeable towards IPV?
- Are nurses working in the mental health settings prepared to address IPV?

The Theory of Self-Efficacy (Bandura, 1977) was used for the conduction of this study, as the current author was interested to understand how knowledge and preparation influence nurses' competence and confidence to address IPV. Self-efficacy not only relates to a person's perception upon their ability to achieve goals, but also evaluates the possibility to bring about changed behaviours (Bandura, 1984). For this reason, the current researcher identified this theory with the aim to examine the relatedness between nurses' perceived abilities to manage IPV in accordance with their knowledge and preparation.

2. Method

2.1 Research Design

A descriptive quantitative approach, namely a cross sectional survey design was adopted. The variables examined included the perceptions of nurses, which related to knowledge and preparedness towards the management of IPV.

2.2 Setting and Sample

This study was conducted within the acute in-patient and community services of the Maltese state mental health services. Eligibility criteria included nurses who are registered with the Maltese Council for Nurses and Midwives and are currently working in the acute in-patient or community field within the Maltese state Mental Health Services. A total of 160 participants were eligible to participate in the study, of which 115 worked within an in-patient acute setting and 45 worked in the community. Recruitment was carried out through an intermediary to safeguard anonymity and confidentiality. Each eligible participant was given a questionnaire, together with an information letter explaining the conditions of the study. Participation was strictly on a voluntarily basis. This study surveyed all nurses working within the Maltese acute in-patient and community mental health services and so it was a total population survey. This accounts for 160 nurses, out of which 109 (68%) participated in this study. A sample of 109 participants recruited from a population of 160 nurses working in the Maltese acute in-patient or community mental health field guarantees a maximum margin of error of 5.32% with a 95% CI, making the sample representative of nurses working within the acute in-patient or community mental health services in Malta.

2.3 Measures

A survey technique was utilized through the distribution of The Physicians' Readiness to Manage IPV Survey (PREMIS). The PREMIS is a 77 item self-report scale, which includes a respondent profile and 4 domains. The respondent profile distribution of the participants is outlined in Table 1 below.

Table 1. Respondent profile distribution

Demographic Data	**N (%)**
Age	
20-25	20 (18.3%)
26-30	15 (13.8%)
31-35	16 (14.7%)
36-40	6 (5.5%)
41-45	16 (14.7%)
46-50	11 (10.1%)
51-55	11 (10.1%)
56-60	14 (12.8%)
Gender	
Male	32 (29.4 %)
Female	77 (70.6 %)
Qualification	
Staff Nurse	57 (52.3%)
Psychiatric Nurse	31 (28.4 %)
Ward Manager	21 (19.3%)
Years in Mental Health Services	
0-5	40 (36.7%)
6-10	27 (24.8%)

11-15	13 (11.9%)
16-20	9 (8.3%)
21-25	10 (9.2%)
26-30	10 (9.2%)
Area of Practice	
Acute *In-patient mental health setting*	71 (65.1%)
Community mental health setting	38 (34.9%)
Average number of patients seen per week	
Not seeing any patients	2 (1.8%)
Less than 20	30 (27.5%)
20-39 patients	52 (47.7%)
40-59 patients	12 (11.0%)
60 or more patients	13 (11.9%)
Including yourself, how many practitioners at your work site have participated in an IPV training course?	
A few	6 (5.5%)
Some	7 (6.4%)
Most	6 (5.5%)
All	5 (4.6%)
Don't know	85 (78%)

In order to complete the PREMIS, participants are required to either mark the answer that best describes their opinion in relation to multiple choice questions or else rate their response on a 7-point Likert Scale, ranging from a score of 1 (representing strongly disagree) up to a score of 7 (representing strongly agree). The first of the four domains is the "Background scale" which includes two subscales namely "Perceived Preparedness" and "Perceived knowledge" – these measure the participants' perceived knowledge and perceived preparedness to manage IPV. The "Actual Knowledge" scale assesses the competence in identifying potential victims, whilst the "Opinions" Scale consists of eight subscales that measure the respondent's opinions towards "Staff Preparedness", "Legal Requirements", "Workplace Issues", "Self efficacy", "Alcohol/drugs", "Victim Understanding", "Victim Autonomy" and "Staff Constraints". The last scale of the PREMIS names "Practical Issues" and deals with assessing the clinicians' interventions within the last six months, personal experiences related to enquiry, disclosures and familiarity with IPV policies. Further information about the main domains and subscales is presented in Table 2.

Table 2. Definition of scales/subscales of the PREMIS

Scale	Definition
Background	
Perceived Preparedness	Identifies the participants' adequacy to respond to IPV
Perceived Knowledge	Refers to the sample's familiarity with the subject, roles and resources
Actual Knowledge	
Actual Knowledge	The participants' competence in identifying potential victimized patients
Opinions	
Staff Preparedness	Professionals' actual skills to discuss IPV with potential victims
Legal Requirements	The legal issues associated with cases of IPV
Workplace Issues	Support received through organizational development of policies and available resources to manage such cases
Self efficacy	Clinician's comfort to manage and address IPV issues
Alcohol / drugs	Professional's knowledge upon the relationship of substances and IPV
Victim Understanding	Participants' beliefs that the victims are capable to leave abusive relationships if they want to, at any time
Victim Autonomy	Professionals' ability to acknowledge and respect the patients' rights to make own decisions
Staff Constraints	Potential situations which may limit staff to encourage disclosure and management of IPV at the place of work
Practical issues	
Practical Issues	Participants' adequacy to enquire, assess and manage cases of IPV

The PREMIS has undergone extensive testing in multiple settings and has shown to have good internal consistency and reliability, with Cronbach's alpha ≥0.65 for ten scales. Additionally, the scales in the tool were closely correlated with theoretical constructs and predictive of self-reported behaviors. A revised version of the tool demonstrated good stability of psychometric properties in a different physician population, good correlation with measured office IPV practices, and stable results in this population over one year (Short, Alpert, Harris & Surprenant, 2006).

The scale was used in its original language, that is, English. English is a second language in Malta and nursing training is also provided in English. Since the PREMIS has already been previously used in research on the nursing population (Alhalal, 2020), it was not changed in any way for use in the current study to retain the validity and reliability of the instrument.

2.4 Ethical Considerations

Permission to carry out this study was sought and granted by the Faculty of Health Sciences, University of Malta's Research Ethics Committee (FREC) [1173: 21032019] together with the necessary approvals from the Director of the Maltese Mental Health Services. Permission to use the PREMIS (Short et al., 2006) was also granted by the authors of the tool. An intermediary distributed and collected the questionnaires to ensure confidentiality and avoid direct contact of the researchers with the participants, thus reducing bias. Participation was strictly voluntarily and completion and returning of the questionnaire implied the participants' consent.

2.5 Data Analysis

Data was analyzed using SPSS version 26®. The Respondent profile included age, gender, year of graduation, years of practice in mental health, area of practice, qualifications, average number of patients seen per week and identification of any previous participation in IPV training from any staff. Scores relevant to each of the five domains were obtained following computation of the specific items as per the PREMIS scoring guide provided by Short et al. (2006). Descriptive statistics, including the mean and median scores together with the interquartile ranges for each scale/subscale, were computed. Test for normality was carried out using the Kolmogorov-Smirnov and the Shapiro-Wilks tests. A Kruskal-Wallis test was conducted with non-parametric testing, which involved analysis of more than two comparative groups, while a Mann-Whitney U test was used for comparing between two groups. Independent sample testing was used in parametric analysis with a sample of two comparative groups, while an ANOVA was used with a sample of more than two comparative groups. Significant relationships between the sample group analysed through the ANOVA tests were consequently computed using the Post hoc Tukey test. Additionally, a 2- independent sample test was carried out to analyse results in-between groups when significant results for the non-parametric testing were identified.

3. Results

The results for each domain were reported following computations of survey items, as instructed on the actual PREMIS. The scores for the 'background', 'actual knowledge', 'opinions' and 'practice issues', including their sub-scales are presented in Table 3. The "theoretical" score (first column in Table 3) describes the possible total minimum and maximum scores that can be obtained by the participants – these were derived from the computation of specific items pertaining to each subscale, as per the instructions accompanying the tool. The "observed" score (second column in Table 3) refers to the actual total minimum and maximum scores obtained by the computation of the participants' actual responses. The mean and SD in the third and fourth column refer to the "observed" responses.

Table 3. Scores for the scales/subscales of the PREMIS

Scale	Theoretical Minimum / Maximum	Observed Minimum / Maximum	Mean	SD
Background				
Perceived Preparedness	12 - 84	12 - 72	2.81	1.26
Perceived Knowledge	16 - 112	16 - 107	2.66	1.22
Actual Knowledge				
Actual Knowledge	0 - 38	7 - 30	17.50	5.58
Opinions				
Staff Preparedness	5 - 35	6 - 35	4.52	1.30
Legal Requirements	4 - 28	4 - 28	3.90	1.45
Workplace Issues	6 - 42	6 - 40	3.88	1.08

Self efficacy	3 - 21	3 - 21	3.66	1.15
Alcohol / drugs	3 - 21	6 - 21	4.77	1.22
Victim Understanding	6 - 42	10 - 33	3.82	0.80
Victim Autonomy	3 - 21	3 - 21	4.38	1.03
Staff Constraints	2 - 14	2 - 10	2.76	1.16
Practical issues				
Practical Issues	3 - 72	4 - 66	30.96	13.84

Emerging results report a mean score of 2.81 for the subscales of 'perceived preparation' (SD=1.26) and a mean score of 2.66 for 'perceived knowledge' (SD=1.22), indicating that the respondents may not feel adequately prepared and knowledgeable to address IPV in their practice. This is further confirmed by the mean score of 17.50 (SD=5.58) on the 'actual knowledge' scale reflecting the lack of competence in identifying potential victimized individuals. Conversely, a mean score of 4.52 (SD=1.26) on the "staff preparation" subscale indicates that staff are willing to manage IPV at work. An average mean score of 3.90 (SD=1.45) was reported for sub-scales 'legal requirements', 'workplace issues' (M=3.88, SD=1.08) and 'self-efficacy' (M=3.66, SD=1.15) on the 'opinion' scale, indicating the need of more competence in such areas. Mean scores of 4.77 (SD=1.22) were reported on the 'alcohol/drugs' subscale whilst a mean score of 3.82 (SD=0.80) and 4.38 (SD=1.03) were reported for the subscales 'victim understanding' and 'victim autonomy' respectively, suggesting that participants are aware of the relatedness between substance use and violence, of the importance to understand the victim's role in abuse; and of considering patient's rights. A mean score of 2.76 (SD=1.16) on the "staff constraint" subscale indicates that the participants have no issues related to staffing levels, time allocation, policies and IPV enquiry. Results also report a lack of practice issues by the participants with a mean score of 30.96 (SD=13.84) on the Practice Issue scale.

Table 4. Background, Actual knowledge and Practical Issue Domain results according to demographic characteristics

Domains	**Background**						**Actual Knowledge**			**Practical issues**		
Subscale	Perceived Preparation			Perceived Knowledge			Actual Knowledge			Practical Issues		
	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.
Age												
20-25	51.50	7.62(7)	0.37	51.95	8.26 (7)	0.31	62.03	15.50(7)	0.03	71.95	17.07(7)	0.02
26-30	37.77			41.57			61.17			45.47		
31-35	58.66			53.19			52.59			46.81		
36-40	58.00			76.75			27.92			29.67		
41-45	64.59			64.31			56.63			57.81		
46-50	58.86			63.23			65.77			72.77		
51-55	63.91			53.95			40.00			43.91		
56-60	52.00			50.21			54.18			52.75		
Year of Graduation	54.17	3.00(3)	0.39	47.98	4.06 (3)	0.26	47.98	8.07(3)	0.05	49.67	6.66(3)	0.08
Before 1989	61.53			66.69			66.69			69.25		
1990-1999	60.35			57.35			57.35			46.22		
2000-2009	49.07			52.26			52.26			57.51		
2010-2019												
Qualification												
EN	30.42	5.97(3)	0.11	29.25	5.36 (3)	0.15	39.17	1.80(3)	0.62	60.17	2.73(3)	0.44
SN or higher	52.23			53.51			55.61			59.30		
RMN	58.48			61.21			59.65			52.52		
Ward managers	63.62			56.81			51.19			46.74		
Years in Mental Health	50.96	15.42(5)	0.01	51.38	12.06	0.03	54,78	12.16(5)	0.03	57.41	3.43(5)	0.63
0-5	62.43			66.76	(5)		57.65			54.41		

6-10	40.88			46.23			54.54			54.62		
11-15	75.72			66.39			67.44			37.28		
16-20	34.60			32.25			33.60			59.90		
21-25	71.20			61.65			59.55			58.50		
26-30												
Number of patients seen per week	59.50	14.21(4)	0.01	37.25	15.57	0.04	73.75	4.49(4)	0.34	84.00	4.24(4)	0.38
	71.70			72.37	(4)		48.50			57.42		
Not seeing patients	49.93			52.20			58.10			51.06		
	54.46			47.42			57.92			65.63		
Less than 20	36.54			35.85			52.04			50.92		
20-39												
40-59												
60 or more												
Nurses attending to any IPV training	90.50	14.12(4)	0.01	85.75	10.06	0.04	69.33	19.60(4)	0.01	74.83	3.59(4)	0.47
	77.71			61.57	(4)		55.43			56.29		
A few	64.75			74.33			33.75			66.17		
Some	57.50			60.80			60.50			50.10		
Most	49.79			50.58			55.13			52.99		
All												
Don't know												
	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.
Gender†												
Male	58.38	1124.000	0.47	54.91	1229.00	0.04	42.58	1145.50	0.56	46.34	955	0.07
Female	53.60	(-0.72)		55.04	(-0.02)		60.16	(-0.58)		58.60	(-1.84)	
Area of practice†	50.77	1048.50	0.06	51.75	1118.00	0.14	55.71	1284.50	0.68	51.24	1082.00	0.09
Acute wards	62.91	(-1.91)		61.08	(-1.47)		53.67	(-0.41)		62.03	(-1.70)	
Community												

† These variables have been analysed using the Mann-Whitney U non-parametric test

Table 5. Opinion Domain result according to demographic characteristics

Domain	**Opinion**																	
Subscale	Legal Requirements			Self efficacy			Alcohol / drugs			Victim Understanding			Victim Autonomy			Staff Constraints		
	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.	Mean Rank	H (df)	Sig.
Age																		
20-25	43.03	15.50	0.03	45.68	18.44(7)	0.01	55.05	7.73	0.36	39.50	10.84(7)	0.15	47.25	14.36	0.05	48.73	7.40(7)	0.39
26-30	41.57	(7)		29.93			52.27	(7)		52.60			51.47	(7)		48.20		
31-35	48.94			57.50			68.47			72.91			62.69			57.50		
36-40	64.58			59.92			39.50			52.25			34.33			52.00		
41-45	56.53			66.03			44.59			60.25			68.34			58.88		
46-50	71.36			72.14			57.18			52.59			74.64			44.00		
51-55	77.73			67.27			49.36			58.86			49.09			57.59		
56-60	56.86			54.50			63.71			53.29			43.89			71.86		
Year of Graduation	65.13	8.07	0.05	57.30	11.08	0.01	56.57	1.11	0.78	57.02	3.89	0.28	47.20	8.92	0.03	66.59	4.15	0.25
Before 1989	66.92	(3)		68.61	(3)		52.25	(3)		51.31	(3)		73.94	(3)		53.75	(3)	
1990-1999	50.33			62.39			59.69			64.15			56.02			52.76		
2000-2009	47.16			42.87			52.24			49.46			50.39			50.52		
2010-2019																		
Qualification																		

EN	44.92	1.80	0.62	51.83	0.58	0.90	57.58	2.50	0.48	49.83	2.75	0.53	38.92	10.55	0.01	82.92	6.78	0.08
SN or higher	52.92	(3)		57.40	(3)		59.70	(3)		56.61	(3)		49.87	(3)		50.61	(3)	
RMN	60.56			52.61			50.56			48.44			69.95			52.61		
Ward managers	54.71			53.60			49.40			62.26			49.98			61.21		
Years in Mental Health	45.04	12.16	0.03	52.34	3.99	0.55	57.26	2.63	0.76	56.61	6.57	0.25	53.15	2.26	0.81	52.61	2.29	0.81
0-5	68.54	(5)		57.26	(5)		54.17	(5)		53.06	(5)		54.91	(5)		50.72	(5)	
6-10	50.00			52.38			63.00			70.08			66.77			60.62		
11-15	62.06			71.22			45.83			49.89			50.50			53.89		
16-20	45.90			45.15			46.10			56.45			54.60			61.65		
21-25	67.55			58.20			54.95			37.35			51.80			63.15		
26-30																		
Number of patients seen per week	35.75																	
Not seeing patients	51.42	4.49	0.34	59.50	15.18	≤0.001	37.75	4.05	0.40	51.75	4.89	0.30	68.00	8.98	0.06	43.25	2.66	0.62
Less than 20	58.93	(4)		70.05	(4)		55.07	(4)		57.82	(4)		51.83	(4)		56.70	(4)	
20-39	42.46			47.07			53.78			50.32			50.82			52.94		
40-59	62.08			38.63			47.50			51.50			53.33			49.42		
60 or more				66.42			69.31			70.96			78.58			66.27		
Nurses attending to any IPV training	86.67	19.60	0.01	67.00	5.11	0.28	46.67	2.57	0.63	62.67	1.88	0.76	71.25	1.88	0.76	53.75	1.88	0.76
A few	83.07	(4)		74.00	(4)		39.71	(4)		37.79	(4)		43.50	(4)		41.71	(4)	
Some	70.25			65.83			54.00			48.67			58.33			64.33		
Most	77.30			57.30			50.90			80.70			80.20			58.50		
All	48.06			51.69			57.16			54.81			53.08			55.32		
Don't know																		
	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.	Mean Rank	U (z)	Sig.
Gender†																		
Male	57.70	1145.50	0.56	57.08	1165.50	0.66	49.06	1042.00	0.20	59.88	1076.00	0.30	50.14	1076.50	0.30	60.31	1062.00	0.25
Female	53.88	(-0.58)		54.14	(-0.45)		57.47	(-1.27)		52.97	(-1.04)		57.02	(-1.04)		52.79	(-1.14)	
Area of practice†	54.09	1284.50	0.68	49.03	925.00	0.01	54.89	1341.50	0.96	54.25	1296.00	0.74	51.17	1077.00	0.08	52.63	1181.00	0.28
Acute wards	56.70	(-0.41)		66.16	(-2.71)		55.20	(-0.48)		56.39	(0.34)		62.16	(-1.75)		59.42	(-1.08)	
Community																		

† These variables have been analysed using the Mann-Whitney U non-parametric test

Table 6. ANOVA results for the subscales Staff Preparedness and Workplace Issues according to demographic characteristics

Domains	**Opinion**									
Subscale	Staff Preparedness					Workplace Issues				
	N	Mean	St Deviation	F	P-value	N	Mean	St Deviation	F	P-value
Age										
20-25	20	4.49	1.48	1.96	0.07	20	3.28	0.84	2.98	0.01
26-30	15	4.99	1.36			15	3.56	0.54		
31-35	16	5.14	1.21			16	3.89	0.95		
36-40	6	4.10	1.47			6	4.06	0.33		
41-45	16	4.61	1.06			16	4.33	1.19		
46-50	11	3.75	1.38			11	4.73	1.27		

51-55	11	3.87	0.92			11	4.09	0.72		
56-60	14	4.59	1.14			14	3.65	1.50		
Gender†										
Male	32	4.40	1.33	0.38	0.54	32	4.10	0.84	3.15	0.08
Female	77	4.58	1.29			77	3.78	1.16		
Year of Graduation										
Before 1989	23	4.26	1.32	2.61	0.06	23	3.77	1.25	4.48	0.01
1990-1999	18	4.03	1.43			18	4.56	1.20		
2000-2009	27	5.02	1.07			27	4.01	1.04		
2010-2019	41	4.56	1.39			41	3.53	0.78		
Qualification										
EN	6	3.43	0.71	2.09	0.11	6	2.89	1.63	3.38	0.02
SN or higher	51	4.75	1.24			51	3.72	0.87		
RMN	31	4.44	1.42			31	4.17	1.22		
Ward managers	21	4.41	1.28			21	4.13	0.97		
Years in Mental Health										
0-5	40	4.40	1.31	2.27	0.05	40	3.66	1.03	4.22	≤0.001
6-10	27	4.47	1.33			27	4.43	0.90		
11-15	13	5.58	0.91			13	3.65	0.91		
16-20	9	4.11	1.33			9	4.31	0.75		
21-25	10	4.56	1.38			10	2.97	1.26		
26-30	10	4.18	1.10			10	4.08	1.21		
Area of practice†										
Acute wards	71	4.79	1.29	0.22	0.64	71	3.61	0.93	1.90	0.17
Community	38	4.03	1.19			38	4.38	1.71		
Number of patients seen per week										
Not seeing patients	2	4.70	0.71	0.95	0.44	2	4.00	0.71	2.64	0.06
Less than 20	30	4.19	1.25			30	4.11	0.77		
20-39	52	4.64	1.32			52	3.68	1.00		
40-59	12	4.95	1.22			12	3.44	1.07		
60 or more	13	4.31	1.48			13	4.54	1.65		
Nurses attending to any IPV training										
A few	6	4.23	0.89	1.74	0.15	6	5.56	0.99	7.49	≤0.001
Some	7	3.49	0.94			7	4.74	1.17		
Most	6	4.63	1.79			6	4.42	1.20		
All	5	3.92	0.91			5	3.83	0.70		
Don't know	85	4.66	1.31			85	3.65	0.95		

Results also highlight that years working in mental health, average number of patients seen per week and IPV training, influenced the sub-scale for 'perceived preparation'. This was found to be similar for the sub-scale of 'perceived knowledge', except that this was also influenced by gender. However, the domain for 'actual knowledge' was found to be only influenced by the gender variable. The sub-scale for legal requirements relating to the legal procedures relevant to IPV reports was found to be influenced by age, year of graduation, years in mental health and training. Yet, the sub-scale for 'self-efficacy' referring to self-confidence and self-competence to address IPV was found to be influenced by age, year of graduation, number of patients seen per week and area of practice. Age, year of graduation and qualification were found to influence the sub-scale for 'victim autonomy' relating to the safeguarding of victims' rights to make own decisions. The sub-scale for 'staff preparation' relating to the nurses' ability to facilitate disclosure and management of IPV, was found to be only influenced by years in mental health. Meanwhile, the sub-scale for 'workplace issues', which related to the operational procedures relevant to the management of IPV at work, was found to be influenced by age, year of graduation and previous IPV training.

The domain for 'practice issues' relating to the staff's adequacy to enquire and discuss IPV during practice, was found to be influenced by age. The sub-scales for 'alcohol/drugs', 'victim understanding' and 'staff constraints' were not influenced by the socio-demographic characteristics pertaining to this sample which included age, gender, year of graduation, years in mental health, qualification, area of practice, average number of patients seen and nurses attending to any IPV training. Comparison between groups was also analysed and findings recorded a significance between all the eight sub-groups relating to 'age', with older ages showing higher mean ranks and to 'gender', with females showing more significance. RMN's were more significant than EN's, SN's and ward managers when the variable for 'qualifications' was compared. The variable for 'year of graduation' showed a significance between participants who graduated between 1990 and 1999 as compared to those who graduated between 2010 and 2019. 'Years in mental health' showed a significance between the groups 6 to 10, 16 to 20 and 21 to 25. Community nurses reported to be more self-efficient when compared to participants working in the acute mental health setting on the variable for the 'area of practice'. A statistical significance was also found between nurses with a case load of less than 20 patients per week and those with a case load of 60 or more on the 'average number of patients seen per week' variable. 'Nurses attending to any IPV training' showed a significance between those reporting 'a few', 'some' and 'don't know'.

4. Discussion

Scores pertaining to the PREMIS included the domains of 'background', 'actual knowledge', 'opinion' and 'practice issues'. The findings pertaining to each of these four domains shall be discussed, in relation to the hypothesis: nurses have negative perceptions towards the management of IPV and demographic characteristics influence the nurses' perceptions towards IPV.

The 'background' domain includes the sub-scales for 'perceived knowledge' and 'perceived preparation'. The 'perceived knowledge' subscale assessed the nurses alleged knowledge of signs and symptoms of IPV, referral resources, documentation, identification, relatedness of IPV to pregnancy, determination of risks, professional's role in IPV, and understanding about the stages of change. The mean score on the 'perceived knowledge' sub-scale shows that Maltese nurses working in the acute and community mental health settings feel that they lack the adequate knowledge to address IPV. Apart from lack of knowledge to identify and support potential victims, assess risks of violence and address IPV according to the victim's readiness for change; this study reports that the participating nurses also perceived that they lacked the preparation required to manage IPV. This has severe implications to practice as participants feel that they are not well equipped to ask appropriate questions about IPV, provide adequate responses upon disclosure of IPV, assess levels of lethality, refer, support the victim's readiness to change, and identify IPV indicators following patient's history. Research claims the importance of organizational support to encourage enquiry and disclosure of IPV at the workplace (Swailes, Lehman & McCall-Hosenfeld, 2017; Trevillion, Howard, Morgan, Feder, Woodall & Rose, 2012). Hence, one of the reasons for the lack of knowledge evidenced through this study may be the lack of organizational efforts to highlight the importance of IPV identification and management. However, the cultural element may also be in play since locally, the negative psychological impact of IPV has only recently been given the importance it deserves. To this extent, the Maltese Commissioner of Mental Health (2016) has specifically remarked that more governmental efforts are required to acknowledge the importance of mental health professionals in the national approach towards IPV. Notably, in Malta, it seems that nurses are not the only professionals who lack knowledge on how to approach IPV. In fact, in 2016, detailed guidelines for reporting domestic violence were issued for journalists and media content producers (Dimitrijevic & Murphy, 2016).

Research has long focused on providing safety from the negative physical consequences of IPV, highlighting the involvement of primary healthcare (Arias & Pape, 1999; Dillon et al., 1999; Gilchrist, Gilbert & Bowen, 2018). Even though the involvement of nurses working in primary healthcare in the management of IPV has been recognized and training has been provided to such professionals (Gilchrist et al., 2018), local studies still report a lack of knowledge and preparation (Attard Bason, 2017; Vella Ali, 2017). This concurs with the findings reported in this study and highlights that such deficit in knowledge and preparation, is not just exhibited by nurses working in mental health settings. Such findings are also comparable to international studies that included various professionals who also reported such deficits (Forsdike, O'Connor, Castle & Hegarty, 2019; Nyame, Howard, Feder & Trevillion, 2013; Rose, Trevillion, Woodall, Morgan, Feder & Howard, 2011; Ruijne et al., 2019; Trevillion et al., 2012; Trevillion, Hughes, Feder, Borschmann, Oram & Howard, 2014).

The lack of knowledge reported by the participants was again reconfirmed through the mean score reported on the 'actual knowledge' domain. This scale measures the knowledge related to risk factors with becoming a victim, truth about batterers, warning signs of potential abuse, reasons for staying in a violent relationship, appropriate ways to ask about IPV, presentations of IPV; and the actual stages of change. Such findings may be attributed to

the limited forensic content in nursing education, which limits nurses' ability to effectively manage cases of violence at the workplace (Freedberg, 2008). In Malta, IPV-related content in undergraduate nursing courses is also limited, once again reflecting the lack of interest in the subject that can be seen on a wider national level. This may be one of the reasons why nurses lack knowledge to identify IPV. In 2018, a local study attempted to identify and explore the barriers faced by women survivors of IPV when seeking help, as well as those faced by professionals when delivering a service to the survivors. One of the recommendations emerging from this research was the need of specialist training and the provision of more guidance to front liners (Clark et al., 2018). Conversely, the introduction of a Bachelor's Degree in Mental Health Nursing at the University of Malta, which includes a study unit focusing on forensic mental health, might increase the awareness of psychiatric nurses towards the management of IPV.

This study also identifies a lack of competence and confidence to manage IPV based on the mean scores of the subscales within the 'opinion' domain, namely 'legal requirements', 'self-efficacy'. 'alcohol/drugs', 'victim autonomy', 'victim understanding', 'staff constraints', 'staff preparation' and 'workplace issues'. Nurses report difficulties on the 'legal requirements' sub-scale. This may be related to the fact that IPV is unfortunately perceived either as something that should not be publicly scrutinized or else as a way to promote 'discipline' (Erez, 2002; Rees et al., 2014). This means that it can often go underreported due to victim blaming or lack of credibility associated with the complexity of mental health disorders (Rose et al., 2011). The local study by Clark et al. (2018) identified this as one of the main barriers in Malta, describing it as 'justice-system' barrier, thus referring to the difficulties that are faced when approaching the police and courts with IPV occurrence. Notably, in 2018, the 'Gender-Based Violence and Domestic Violence Act' was introduced in the Maltese law to strengthen the legal framework concerning violence against women (Group of Experts on Action against Violence against Women and Domestic Violence, 2019).

It is important to acknowledge the strong medical model of care that is enforced in Malta, placing doctors on top of the professional hierarchy in relation to the care of the client (Hain & Fleck, 2014). This model may limit the nurse's autonomy to address the legal requirements pertaining to IPV; as such issue would fall under the doctor's responsibility and not the nurse's. This in spite of the fact that research denotes the important role of the nurse in IPV cases, in view of their therapeutic engagement and time spent with the patients (Stayton & Duncan, 2005). Participants also reported challenges related to the 'self-efficacy' sub-scale. This subscale is composed of items related to identifying routine enquiry, confidence in discussing IPV, ability to identify abuse, matching of therapeutic interventions according to the victim's readiness for change; and the recognition of IPV victims by the way they behave. This lack of self-efficacy may be due to the lack of autonomy pertaining to nursing practice, as described previously. Research suggests that enquiry for IPV should be a standardized practice, as victimized and non-victimized mental health users specified the importance for such enquiry (Hultmann, Möller, Ormhaug & Broberg, 2014; Rose et al., 2011; Trevillion et al., 2014). Approach to mental health treatment is commonly focused on the alleviation of symptoms of disease and not the identification of possible causative factors (Rose et al., 2011), which consecutively may limit the opportunity for nurses working in the mental health services to improve their confidence to identify IPV; as standardized enquiry is not practiced locally. Furthermore, research suggests that mental health clinicians do not consider identification of IPV within their role, which may explain the lack of enquiry as a standard practice (Trevillion & Howard et al., 2012).

The findings related to the 'workplace issues' sub-scale highlights the lack of hospital policies, guidelines, referral pathways and available resources to manage IPV. These findings corroborate those reported in international studies stating that mental health service users have identified that most often, mental health service providers failed to adequately refer victims to other services (Nyame et al., 2013; Rose et al., 2011; Ruijne et al., 2019; Trevillion et al., 2014). Victims have often claimed feeling endangered through referrals, which potentially induced further coercion (Murray et al., 2016; Rose et al., 2011). These findings uncover the lack of coordination and cooperation between existing services and professionals, suggesting that this may easily hinder the nurses' ability to adequately address IPV at the workplace. In Malta, a range of victim services are offered by both governmental and non-governmental entities. These include pragmatic support such as shelters and help lines and legal assistance (Group of Experts on Action against Violence against Women and Domestic Violence, 2019). Azzopardi, Cassar-Camilleri and Scicluna (2004) reported a high demand for such services. However, it is acknowledged that these services commonly work in silos. This may explain the results of the current study, featuring the referral challenges that were encountered by the participants. To this extent, local studies have affirmed the need of developing new mental health services, specifically designed to promote well-being through screening and prevention of IPV (Azzopardi et al., 2004; Fenech & Zammit, 2009). It is for this purpose that there is a crucial need for skilled

professionals and support groups to overcome the barriers pertaining to the management of IPV (Rose et al., 2011; Trevillion et al., 2012; Trevillion et al., 2014).

Maltese nurses working in the acute in-patient and community settings report no major problems related to the potential barriers to address IPV with regards to staffing levels, privacy and time allocation with patients; measured within the 'staff constraints' subscale. These findings contrast with those reported in international studies, which link the lack of identification and management of IPV to time constraints and priority issues (Hultmann et al., 2014; Nyame et al., 2013; Trevillion et al., 2012). This may suggest that international organizations may exhibit shortage of staff when compared to the Maltese setting.

The current study reports that the Maltese nurses working in the acute and community mental health settings demonstrate readiness to address IPV. This readiness is revealed through the mean score reported for the 'victim autonomy', 'victim understanding' and 'staff preparation' sub-scales. 'Hence, the scores in the current study reflect that the development of effective therapeutic relationships is at the core of the work of nurses in the acute and community mental health settings. These findings further corroborate the reported findings on the 'staff constraints' sub-scale, suggesting a rationale for why nurses do not exhibit constraints to provide care towards victims of IPV. Therapeutic relationships are said to be developed through empathy, trust, respect, kindness and honesty (Charrois, 2011) and studies reported that effective therapeutic skills induced a sense of acknowledgement and understanding towards victims (Hultmann et al., 2014; Rose et al., 2011; Trevillion et al., 2012). The strong prosocial and altruistic trait that is found within the Maltese culture (Vella at al., 2019) may be a potential contributor to the scores obtained in the current study, in relation to the nurses' readiness to address IPV.

Maltese nurses working in the acute and community mental health settings also showed increased awareness in the relatedness of alcohol/drugs to IPV. This finding echoes the results obtained by Nyame et al., (2013). One can assume that the high scores relating to the nurses' knowledge towards alcohol/drugs, is gained through actual practice and enhanced through global efforts to acknowledge the damaging consequences induced by substances. The unequivocal association between substance misuse, mental health and IPV has been evidenced through 30 years of research, raising global awareness about the incidence and harm related to alcohol/drug use (Eckhardt, Parrott & Sprunger, 2015). Similarly, local substance misuse prevention efforts are widespread and abundant, possibly equipping professionals such as the ones participating in the current study with the necessary knowledge in relation to the link between drug use and IPV (ESPAD, 2019; Portelli, 2018).

Findings from the fourth domain, namely that termed 'practice issues' indicates that Maltese nurses working in the acute and community mental health settings lack adequate enquiry and identification of IPV in their practice. Such findings corroborate those found in international literature, highlighting that IPV is undetected and underreported (Agar & Read, 2002; Morgan, Zolese, McNulty & Gebhardt, 2010; Swailes et al., 2017; Trevillion et al., 2014). Locally, no recent population-based surveys on the incidence of IPV have been conducted (Group of Experts on Action against Violence against Women and Domestic Violence, 2019). Subsequently, this links to the local lack of data on the topic, which makes it hard to establish accurate comparisons between incidence and actual reporting/detection.

One of the main strengths of the current study is that it is the first one of its kind to explore the perceived knowledge, preparation, confidence and competence of nurses working in a mental health setting, in relation to managing IPV. In this view, the findings add to the understanding of this topic on an international level especially by identifying the specific areas in which nurses in mental health settings mostly lack knowledge and competence.

Although efforts to minimize potential limitations have been taken into consideration, one major concern is attributed to the fact that this study incorporates a quantitative approach. A mixed method design would have been more appropriate to examine this phenomenon in more detail since a deeper understanding of the nurses' perceptions towards IPV could have been obtained through interviews. Another limitation was that the chosen tool was described to be quite difficult to complete, especially, since nurses were not knowledgeable on the topic. This could have influenced the response rate of this study, even though it was high. A number of recommendations emerged from this study. The most evident need is that of training at pre-registration level as well as for registered nurses. The potential contribution of mixed methods research in order to understand the management of IPV in mental health settings also emerged from this study. Finally, the introduction of practice guidelines and policies on the identification and management of IPV for nurses in the mental health setting is an additional important recommendation.

5. Conclusion

The study presented in this paper focused on examining the perceptions of the management of IPV, of Maltese nurses working in the acute and community mental health settings.

For this purpose, the Theory of Self-Efficacy (Bandura, 1977) was used as the theoretical base, as it addresses people's perceived ability to perform upon the actions taken towards a designated task. A quantitative cross-sectional design was implemented and the Physician's Readiness to Manage Intimate Partner Violence Survey (PREMIS) by Short et al. (2006) was utilized. The following research questions were posed to guide the study:

- Are nurses working in the mental health settings knowledgeable towards IPV?
- Are nurses working in the mental health settings prepared to address IPV?

Results showed that nurses working in the acute and community mental health settings showed low scores on their perceived and actual knowledge towards IPV, perceived preparedness, legal implications, workplace and practice issues. High scores were reported on victim understanding, victim autonomy, awareness about the relatedness of IPV to substance abuse and staff preparation to address IPV at work. The 'staff constraints' sub-scale showed an average score suggesting that staff did not perceive staffing levels and time allowance to limit them from managing such cases. This showed that although Maltese nurses working in the acute and mental health settings did not feel knowledgeable and prepared to manage IPV, they reported their readiness to address such issues. Females were found to be more knowledgeable on IPV than males, but no significance was reported through gender upon other domains. Furthermore, the study showed that knowledge, preparedness, confidence and competence to address IPV improved with age and years of experience. Psychiatric nurses were found to empathize more with such patients. A caseload of less than 20 patients per week was found to be significant, indicating that higher scores were achieved with a smaller number of patients seen per week. The present study also concluded that these scores affect practice, indicating that there is a lack of enquiry and screening of IPV at the workplace. However, demographic analysis showed that younger nurses were more motivated to support victimized patients. This study is the first to include nurses working in the mental health settings and is also the first, to utilize the PREMIS on a population of nurses.

Recommendations for education and practice revolve on the need to provide training to healthcare professionals on the theoretical knowledge related to the cycle of abuse and factors which predispose the occurrence of IPV victimization and perpetration. Training on how to screen for, and manage presenting cases of IPV is also crucial. Additionally, there is a need to raise awareness about the negative physical and psychological consequences from IPV to encourage appropriate reporting and screening.

The authors report no conflict of interest.

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