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Nursing Network On Violence Against Women: Providing Health Care in Shelters
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Women and children in shelters experience the health problems of women and children everywhere, plus additional problems endemic to group living and battering relationships. Since the shelter movement began, a variety of methods of addressing shelter health care needs have evolved. Most have depended on the ingenuity of shelter boards, directors, workers, and volunteer nurses from the community. The purpose of this Nursing Network Column is to briefly outline some of the most common health problems encountered in shelters, make suggestions for ways to address these problems, and describe some of the programs which have been used by shelters and nurses across the country. We participated in and/or originated some of these approaches ourselves (Campbell and Humphreys, 1984), and read about others. For the most part, however, we heard about these plans from individual nurses and shelter workers across the country. This article is designed to be useful to both shelters and nurses—shelters which are looking for ways to better address the health care needs of residents, and nurses who would like to be involved with services for battered women.

Health Care Needs

When women and their children are first admitted to shelters, there is a need to assess them for injury from beating, check for communicable diseases and make sure that ongoing health problems can be properly dealt with in the shelter. During the stay at the shelter, outbreaks of communicable diseases can occur and various injuries can happen, especially among the children. The shelter stay can also be an opportunity to promote health, address ongoing health concerns, and establish a better plan for obtaining health care after the shelter residency.

Injuries From Battering

As shelters have found through experience, it is best to be safe and refer any woman at all seriously injured from a beating to an emergency room or clinic for examination. Serious internal or head injuries can appear relatively innocuous. Thus, any woman coming for intake who has visible signs of beating on the head, who complains of having been kicked or punched in the ribs or stomach, or who lost consciousness even momentarily during the beating, should be examined by a health professional. Even if the woman has been to an emergency room before shelter admission, these kinds of injuries may have been overlooked, especially if she was bleeding profusely or had a visible facial injury (Sheridan, Bel- nap, Engel, Katz, and Kelleher, 1985). One way to protect against this possibility is to make sure that she had a complete physical at the emergency room. Another helpful possibility is to have a network of nurses “on call” who can be contacted by telephone for assistance if the intake worker is unsure of the best direction to take.

It is sometimes difficult to get the battered woman to an emergency room, especially if she has arrived during the night. On the other hand, the immediate documentation of injuries by a health professional can be extremely important evidence for future legal action. The ideal scenario is to have a nurse practitioner or clinical nurse specialist (nurses prepared at the masters level and/or certified to perform physical examinations and offer certain interventions independently) or a nurse skilled in physical assessment present at the shelter to do intake examinations and health histories of the women and their children. We do not know of any shelter which has this kind of service on a 24-hour basis, but a few shelters do have a nurse on

staff part-time or full-time. Several shelters

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have teams of volunteer nurses who rotate weekly visits (e.g., Hollencamp & Attala, 1986), or have contracts with public health departments for regular visits, and/or have arrangements with schools of nursing so that student nurses are present at regular times for assessment.

Alternative Strategies to Provide Health Assessment

Some shelters have contracts with health care clinics to provide physicals for residents. However, safety can become an issue each time women have to leave the shelter. There are already so many things that the women must do away from the shelter, that health care provided there is a real advantage. With a good communication system with the regular shelter staff nurses can initiate an excellent follow-up system, and staff can ask the important questions about day-to- day management in person. Shelter health care is always best if there is a collaborative effort between nurses and shelter staff.

Other issues at intake are proper precautions for children with communicable diseases and medications or other treatment for chronic conditions which may have been left at home or may run out during the shelter stay. Again, it is ideal to have a nurse do a thorough assessment and handle these problems within the first 24 hours of arrival. A relatively simple procedure like removing stitches would require a trip to a clinic without a nurse on site. If this is not possible, protocols can be written by nurses or physicians for shelter workers to refer to. This system can also work for the common emergencies and mini-epidemics (e.g., flu, infant diarrhea) which arise in any communal living situation. It is helpful if local health care professionals prepare such protocols with shelter staff and help to update them periodically. In that way the protocols can reflect the cultural groups served, physical arrangements and health care system of the particular shelter and community. Local public health departments can be called to help with this as part of their regular community responsibilities. One innovative health department has even included the local shelter in a grant to provide health care to the homeless.

Health departments or individual nurses can also be helpful in setting up shelter practices which will help stop the spread of communicable diseases. Rather than public health inspection being a dreaded ordeal, it can become a learning experience for both sides if the health department is contacted ahead of time for a discussion of what problems the shelter is having and what information would be helpful. Careful attention to food preparation, diaper changes, and nutritional needs can help decrease the chances of infections. Paper plates and plastic utensils can become a way to prevent disease if the shelter is not equipped (e.g., with restaurant washing equipment) to adequately cleanse dishes and silverware for a transient population. At the same time that some precautions are vital, communicable diseases among shelter children sometimes cause overreactions. A nurse can help explain that conditions like viral conjunctivitis (“pink eye”), although infectious, do not necessarily require isolation of a child.

Particular Health Problems of Battered Women

It has been documented that battered women experience more physical symptoms than other groups of women (Campbell, 1987). These have sometimes been characterized as “psychosomatic symptoms,” implying that they are a sign of emotional problems. However, such

physical symptoms can be the result of old and new injuries from battering. They are also frequently physical manifestations of stress, the stress of battering and/or the stress of leaving a spouse and most of one's belongings to come to an unknown place. In addition, there may be other health problems which are causing the symptoms. A thorough health assessment may be extremely important in sorting out what is happening to the battered woman. She may have neglected her own health because she was too embarrassed to seek out the health care system or was prevented from doing so by her spouse.

Battering during pregnancy is also a frequent occurrence (Helton, 1986). The pregnant woman in the shelter is at risk for pregnancy complications, including premature labor and miscarriage, resulting from the battering. She will also commonly experience a strong desire to reconcile with her spouse so that the baby will know its father. It is useful to have an organization providing prenatal classes connected with the shelter, so that women can attend classes while in residence even if it is only on a one-time basis. Nurses can also provide individual information and instruction.

Finally, sexual abuse has been documented as occurring in approximately 40 percent of all cases of battering (Campbell, 1987; Finkelhor & Yllo, 1980; Russell, 1982; Shields & Hanneke, 1983). This is a subject which battered women are not likely to bring up unless asked about it directly. Yet it is an issue with serious emotional and health implications of its own. If nurses are providing regular health assessments at the shelter, sexual abuse should be part of the history. The question, "has your husband (partner) ever forced you into sex you did not wish to participate in?" (Russell, 1982) has been used successfully to elicit the information. If the woman replies affirmatively, she can be asked to describe what happened. The advantage of having a nurse inquire into this area is that the nurse can then

perform a physical examination to determine if there has been vaginal or anal trauma. In addition, a nurse can talk to the woman in depth about sex-related fears and any secondary physical symptoms as a result of the sexual abuse. If nursing care is not available at the shelter, shelter workers can fulfil at least the verbal parts of this process.

Health Promotion

The shelter can also be used to provide information, referral, and group interventions to enhance the health of the residents. There are a number of health related topics which can be taught, including stress management techniques, advantages and disadvantages of various birth control methods, common child health problems, and the like. However, the topics and scheduling of such classes or groups needs to be arranged according to the priorities and desires of the current shelter residents. Some well-meaning programs of this sort planned far in advance have turned out to be frustrating experiences for the women, staff, and nurses involved. It is useful if the nurse can be flexible in carrying out the program, perhaps arranging a general "health" session and providing the information asked for by the particular women at the session.

An important area of nursing care in shelters is providing information and referrals about the health care needs of the woman's children. Because this has been (and may continue to be) a family in turmoil, immunizations, well child examinations, and the like may have been neglected. The mothers usually want very much to have their children's health taken care of but they also require nonjudgmental providers. They may have previously been distrustful of the health care system or unable to obtain adequate care for their children or themselves. If they are going to a new living situation, they may no longer be near enough to or eligible for health care

services from their former provider. If nurses in the shelter can make the mother a partner in providing health care to her children and give her credit for her parenting, she may be willing to follow through on a referral after she leaves the shelter. A "nurse-to-nurse" referral system is extremely helpful in establishing a health care habit after the shelter experience. If nurses are not made an ongoing part of the shelter, the local public health nurses or visiting nurses can also be a source of such help.

Using Nursing Students in Shelters

There are several levels of student nurses which can be used to help provide nursing services at the shelter. Associate degree and diploma programs may use the shelter to provide instructor supervised experience in teaching physical examinations and health education. Baccalaureate programs often find the shelters an excellent place to provide community health experiences for students. Some programs have specific courses in family violence with a clinical component which can be provided at shelters (Campbell & Humphreys, 1984). Many baccalaureate programs have such courses for RN students returning to get a BSN degree. These students are already licensed and therefore can practice more independently. One innovative course on family violence is used as a primary clinical course in such an RN continuation program and includes extensive clinical time at a local shelter (P. Alford, University of Detroit, personal communication, December 1986). Not only do these students help provide health care in shelters, but also they learn to be more sensitive to problems of battered women whom they will encounter in other settings after graduation.

Almost all majors in graduate nursing programs can use shelters as a clinical placement. Psychiatric and mental health nursing majors can lead groups (e.g., Campbell, 1986; Janosik & Phipps, 1982), conduct play therapy for children, and carry an individual case load. The shelter also provides excellent learning opportunities for graduate students in primary care and women's health programs. Nursing school faculty often provide services themselves during student vacations or set up a network to fill in, so that services are not interrupted. Since nursing students have a great deal of coursework and supervised practice in interpersonal communication, they require less training than other volunteers by the shelter. Interested shelters can contact local schools of nursing directly or, perhaps more effectively, work through the local "old girls' network" to find nurses who are already advocates of the shelter movement and ask them to recruit nursing resources.

Partnership

Individual nurses have worked with the leaders of the shelter movement since its inception. Nurses have served on shelter and advocacy program advisory boards and boards of directors working hand-in-hand with others interested in providing services to battered women. At least one shelter director is also a nurse (Laura McKenna of La Casa de las Madres, San Francisco, California) The more that nurses are involved in shelters, the more they will become advocates for battered women in other roles that they play both as health care providers and as citizens.

The most useful partnerships are where the nurses providing the health care become as much a part of the regular volunteer and/or staff activities of the shelter as possible. The women and children who use the shelter are also part of this partnership and have the final say when it comes to their own health. We have found that posting a regular time and sign-up

list for nurses visits on a weekly basis generates both self-referral from shelter residents (women and children) and referrals from staff. It is important to maintain records useful for nurses,

women, and staff and to always discuss our ideas about possible interventions with staff as well as individual women and children. This kind of care becomes more of a sharing process than is found in traditional health care—we all learn from each other. It thus becomes empowering to the women and children as well as to the nurses and staff!

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Announcements

Barbara Parker, PhD, RN, of the Nursing Network on Violence Against Women (NNVAW), is collecting copies of health protocols and programs of health care being used in shelters. Please send such material to her at: University of Maryland School of Nursing, B. C. Campus, Catonsville, MD 21228. This information will be made available to nurses and shelters nationwide. What is gathered will be listed in an upcoming Response column. The Network also has a national directory of nurses who are committed to ending violence against women and who can be contacted to help set up health programs in shelters. We are also collecting copies of courses for nurses on battering and violence against women. To add your course to the collection or to obtain copies of other courses or the directory, please write to the NNVAW c/o C. King, Division of Nursing, University of Massachusetts, Amherst, MA 01060.

Safe Home Program

The Safe Home Program (SHP), a new and small service offering short-term emergency shelter to abused and/ or neglected elders or disabled adults, was recently established under the auspices of the Central Vermont Council on Aging. A referral is placed in the home of a private citizen who has been carefully screened and trained. Caregivers provide meals, support, companionship, and physical assistance when needed and are paid by the program. After placement, the program provides follow-up services. SHP offers the participant a secure setting in which to gain greater control of their lives. For more information about SHP, contact: Rebecca Sherlock, Coordinator, Safe Home Program, Central Vermont Council on Aging, 18 South Main St., Barre, VT 05641 (802) 479-0531.