Review Article

Toward the Establishment of a Forensic Nursing Specialty in Brazil: An Integrative Literature Review

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ABSTRACT

Background: Over the past two decades, Brazil has made progress in bringing political and community attention to issues related to violence. The recognition of links between violence and health has intensified calls to accelerate the development of a forensic nursing specialty in Brazil.

Aim: The aim of this study was to systematically examine and synthesize the literature on the development of the forensic nursing specialty around the globe and to extract important lessons for the establishment of a forensic nursing specialty in Brazil.

Method: An integrative review was conducted according to the method described by Whittmore and Knafl (2005). Electronic searches of the following databases were conducted between December 2012 and March 2013: CINAHL Plus with Full Text, Criminal Justice, Index to Legal periodicals, MEDLINE, Soc Index with Full Text, Social Work Abstracts, SCOPUS, and PsycINFO. The search terms used were: [(TI nurs* or SU nurs*) and [TI (forensic* or penal or prison*) or SU (forensic* or penal or prison*)] and (sexual assault nurse examiner*). Preestablished inclusion/exclusion criteria were used to select published articles for review.

Results: Twenty-three articles met inclusion criteria and were included in the full review. Important lessons for Brazil are discussed in terms of education and curricular issues and forensic psychiatric nursing.

Conclusions: In Brazil, there is a window of opportunity to contribute the theoretical foundations of forensic nursing science and to advance nursing specialty practice in the areas of Sexual Assault Nurse Examiners and forensic psychiatric nurses.

KEY WORDS:

Brazil; forensic nursing; forensic nursing specialty; integrative review

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Violence is a growing concern in all societies, and because of its direct consequence for health, it is a topic of concern for nurses. In a major report on violence, the World Health Organization (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) cites the rising number of violence-related injuries around the globe, particularly those involving women and children. The report declared violence to be a major public health problem and encouraged its members to develop policies, programs, and health and social services to prevent violence and mitigate its effects.

This call to action is especially relevant in Brazil where violence and injuries are a leading cause of morbidity and mortality. In 2007, 47,707 homicides and 38,419 motor vehicle crashes in Brazil accounted for over two thirds (67%) of all deaths from external causes (Reichenheim et al., 2011). Interpersonal violence is another concern after a survey of 6,760 Brazilian women reported experiences of psychological aggression (78.3%), "minor" physical abuse (21.5%),

and severe physical abuse (12.9%; Reichenheim et al., 2006). This and other studies identify regional, sociocultural, and economic disparities in risk factors for domestic violence such as gender inequality, harsh physical punishment in childhood (Bordin, Paula, do Nascimento, & Duarte, 2006), low socioeconomic status (Reichenheim et al., 2006), and lack of social support (Reichenheim, Patricio, & Moraes, 2008). According to Reichenheim et al., young, Black, and poor men are more likely to be involved in community violence (as both perpetrators and victims), whereas poor Black women are the main victims of domestic violence.

Over the past 2 decades, Brazil has made considerable progress in bringing political and community attention to issues related to violence in general and more particularly to violence against women. In 1994, the Brazilian government signed the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Organization of American States, 1994), enacted a number of important laws, and established the Special Secretariat for Women's Policy aimed at reducing gender violence. Nurses have been instrumental in developing targeted interventions and services such as women's shelters and groups for perpetrators being established throughout Brazil. The recognition that intimate partner violence is a problem in Brazil has motivated proposals for broad and multisector action, with nurses and other health professionals increasingly coordinating these initiatives. This has intensified calls to accelerate the development of a forensic nursing speciality in Brazil.

In 2011, the Brazilian Nursing Federal Council/*Conselho Brasileiro de Enfermagem* identified forensic nursing as a nursing subspecialty (Brazil Federal Council of Nursing, 2011). Although Brazilian nurses had long been working with victims and perpetrators of violence, this declaration formalized the important role that nurses play in mediating the effects of violence on health. As in other jurisdictions, the specialty of forensic nursing in Brazil is still in its infancy, and its inclusion in undergraduate and graduate nursing curricula is limited to a few lectures and scientific events in academic spaces (Silva & Silva, 2009).

With the aim of advancing forensic nursing in Brazil, this integrative review asks what lessons Brazilian nurses can learn from the experiences of other countries in developing a forensic nursing specialty. We begin with an overview of Brazil's history and recent health reforms; we then offer an integrative review of the literature describing the evolution of the specialty and highlighting key themes; and finally, we discuss these lessons in the Brazilian context.

Brazil's History

To understand the current state of forensic nursing and its relevance in Brazil, it is essential to consider a little of the history that led to Brazil's healthcare reforms over the past four decades. Brazil's health system reform is unique because it occurred in tandem with the country's democratization and was fueled by the efforts of health professionals and individuals involved in civil action.

Brazil is a country distinguished by its size and diversity. With an area of 8.5 million km², it occupies almost half of the South American continent (Instituto Brasileiro de Geografia e Estatística, 2010). A 2010 census estimated the country's population to be over 200 million, making it the fifth most populated country in the world (Central Intelligence Agency, 2013). Brazil's social and cultural diversity reflects the history and politics of its discovery and settlement. Its multiethnic population is composed of indigenous peoples of Tupi and Guarani language stock; the Portuguese; Africans brought to Brazil as slaves to work on coffee plantations; and immigrants from various European, Middle Eastern, Japanese, and other Asian countries (globalEDGE & Michigan State University, 2013). Each of Brazil's five regions (north, northeast, center west, southeast, and south) has its own unique geographic, demographic, socioeconomic, and cultural characteristics and health concerns. The southeast region occupies a relatively small portion (11%) of Brazil's land mass, but it is home to almost half of the total population (43%) and is responsible for more than half (56%) of the gross domestic product (Paim, Travassos, Almeida, Bahia, & Macinko, 2011). In contrast, the north region contains most of the Amazon rainforest, is sparsely populated (3.9 persons per km²), and is the country's second poorest region (Central Intelligence Agency, 2013). These regional and economic disparities mean that a small fraction of the population benefit from Brazil's wealth (Messias, 2003). Health inequities and high rates of violence and crime exist in cities and favelas (slums), where houses are poorly built and usually deficient in sanitary resources (Ferreira, Aurélio Buarque de Holanda, 2001).

Healthcare in Brazil

In 1988, Brazil adopted a new constitution, which declared health a right of every citizen and a duty of the state (Paim et al., 2011). Two years later, the Sistema Único de Saúde (SUS) or Unified Health System was established to uphold the principles of universal access, integrality, equity, and social control. Today, the Brazilian healthcare system is composed of three subsystems: the public system (SUS or Unified Health System), which is coordinated by the federal government and administered through overlapping municipal, state, and federal authorities; the private sector, which is financed through private and public resources; and private health insurance (Brazilworks, 2012).

The Review

Aim

The aims of this review were to systematically examine and synthesize the published literature on the development of the

forensic nursing specialty around the globe and to extract important lessons for the establishment of a forensic nursing specialty in Brazil (Broome, 1993; Whittemore & Knafl, 2005). The intent is to offer practical guidance to Brazilian nurses who are working to expand and develop forensic nursing as a specialty in Brazil.

Sample and Inclusion/Exclusion Criteria

We worked with a health sciences librarian to identify search terms and databases that would best address our research question. Throughout the various stages of the review (see Figure 1), articles were retained for full review if they met the following inclusion criteria: (1) the primary focus of the article was the establishment, evaluation, or existence of the forensic nursing specialty; the implementation of courses or programs intended to support the establishment of a forensic nursing specialty; and/or the benefits of establishing a forensic nursing specialty to society and nursing; (2) published in a peer-reviewed journal; and (3) reported original research, meta-syntheses of original research, and/or literature reviews. Dissertations, theses, guidelines, editorials, and news articles were excluded from the review.

Databases Searched

Electronic searches of the following databases were conducted between December 2012 and March 2013: CINAHL Plus with Full Text, Criminal Justice, Index to Legal periodicals, MEDLINE, Soc Index with Full Text, Social Work Abstracts, SCOPUS, and PsycINFO. The search terms used were: [(TI nurs* or SU nurs*) and [TI (forensic* or penal or prison*) or SU (forensic* or penal or prison*)] and (sexual assault nurse examiner*). In addition, all searches were systematically limited to peer-reviewed articles published in English, Portuguese, and Spanish between 1998 and 2013.

Search Outcome

The initial database search retrieved 2,170 articles, and one (1) additional article was identified through a hand search of reference lists. These articles were exported to RefWorks, and the duplicates were removed. The first

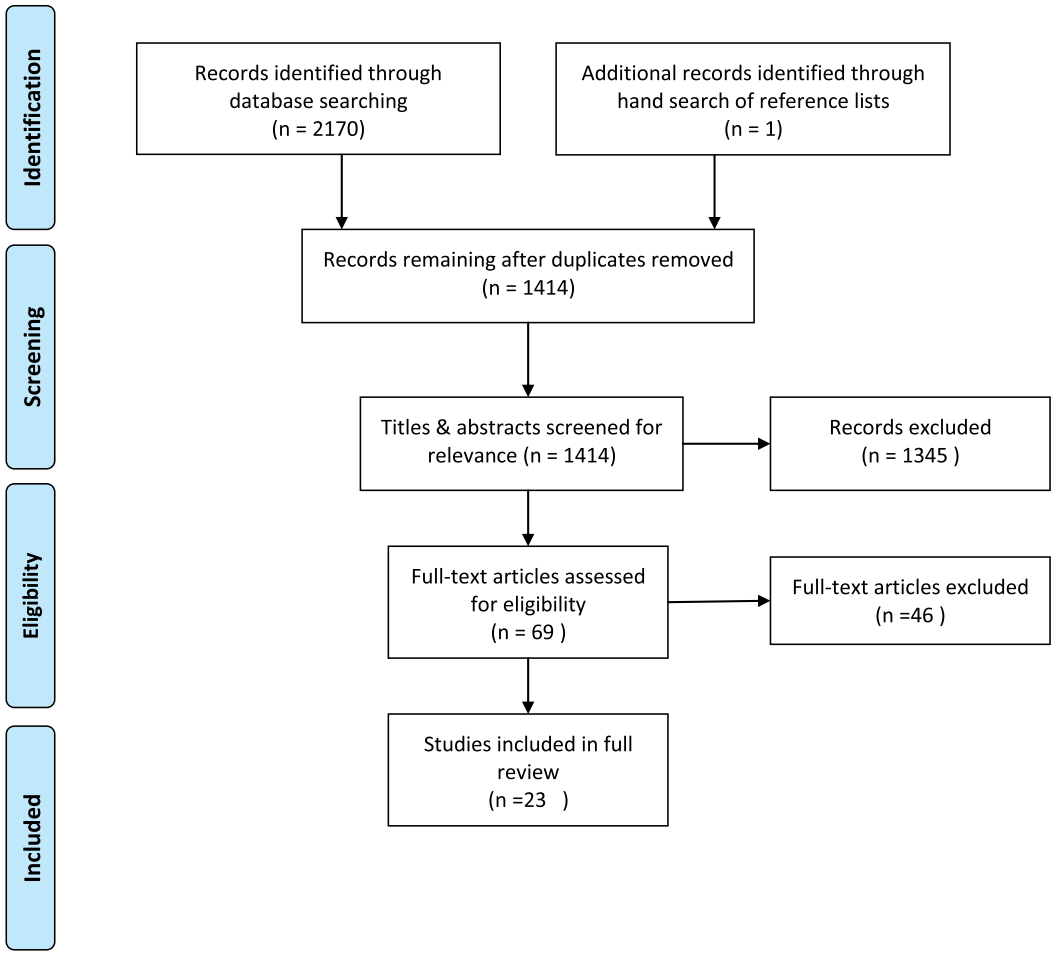

FIGURE 1. Article review flow diagram. Adapted from Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009. Used with permission.

author (R. B.) reviewed the titles and abstracts of the remaining 1,414 articles to ensure that they met the inclusion criteria; of this group 1,345 articles did not meet the inclusion criteria and were excluded. Full text of the remaining 69 articles were then retrieved and reviewed for eligibility. Twenty-three (23) articles were included in the full review. Figure 1 summarizes the review process using the PRISMA flow diagram (adapted from Moher et al., 2009).

Findings

The articles in this review were published in eight (8) different countries: Australia, Canada, England, Finland, Germany, Sweden, Turkey, and the United States. Nine (9) articles address issues associated with forensic nursing education and curricular issues, nine (9) focus on some aspect of the Sexual Assault Nurse Examiner (SANE) role (see Figure 2), and four (4) relate to various aspects of forensic psychiatric nursing practice (Altman, Tetzlaff, Mulrow, Gøtzsche, Ioannidis, & Moher, 2009).

Forensic Nursing Education and Curricular Issues

Although nurses have long worked in forensic settings in forensic nursing roles, specialized forensic education was not available until the 1980s, and there was little-to-no forensic content in general nursing curricula (Kent-Wilkinson, 2009a). As elsewhere, nurses in Turkey were working in settings that required knowledge and skill in the forensic sciences (e.g., emergency departments, trauma, drug treatment facilities, forensic psychiatry, etc.), yet they had no formal education in the area (Gökdoğan & Erkol, 2005). This situation sparked calls in the literature for the inclusion of forensic nursing content in undergraduate nursing education programs to ensure high-quality nursing care (Gökdoğan & Erkol, 2005) and also to prepare practitioners who can help break the cycle of violence and improve healthcare delivery for individuals affected by violence (Freedberg, 2008).

Rutty (2006) points out that increasing rates of global violence rationalize the need for forensic nursing content in all nursing programs to enable registered nurses (RNs) to provide holistic and medicolegal care for patients and participate as full members of medicolegal teams. Rutty also calls for the establishment of clearly defined roles for forensic nursing and standards for all facets of forensic nurse specialist practice in the United Kingdom and around the globe.

Radzyminski (2006) from the United States argues that the recommendation of the American Association for the Colleges of Nursing "that master's level graduate programs prepare nurses as generalists" (p. 33) will create a gap in the educational ladder when masters-prepared clinical nurse specialist and nurse practitioner programs are redesigned as doctoral programs (i.e., PhD or DNP programs). Radzyminski contends employing a population health framework as the foundation for generalist curricula for graduate forensic nursing education addresses this gap and will prepare candidates for complex care situations

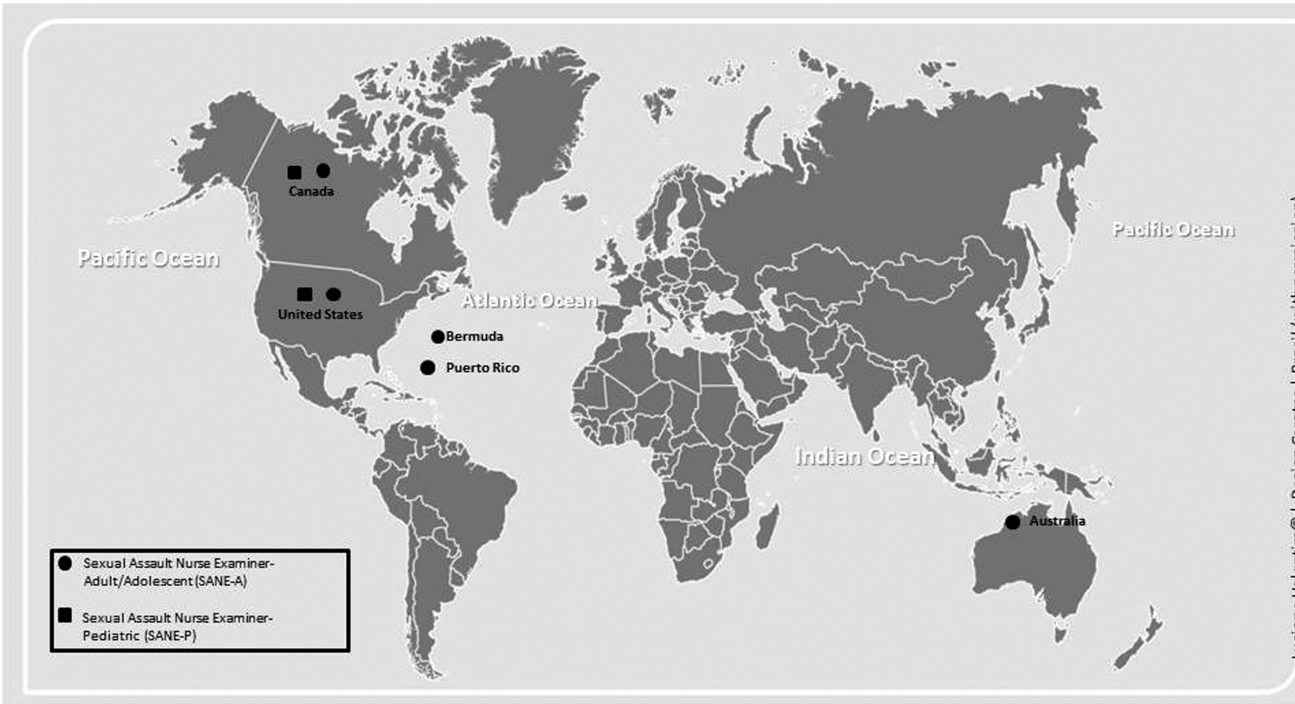

FIGURE 2. Number of IAFN-certified SANEs by country (K. Maguire, personal communication March 21, 2013).

related to particular populations, practice settings, or systems issues. With these competencies, forensic nurses would have requisite skills and knowledge to address complex forensic healthcare issues at all levels of practice.

Writing from Germany, Lambe and Gage-Lindner (2007) describe collaborative efforts involving German educators and international forensic nursing scholars to revise university-based nursing curricula to include forensic nursing content. These authors suggested that additional support for the continued development of the forensic nursing specialty in Germany might include international "train-the-trainer" and visiting scholar programs through which German nursing instructors can refine their knowledge and skills as they relate to the care of forensic clients.

In the United States, Freedberg (2008) highlights the important role of nurse educators in preventing and reducing the consequences of domestic violence and abuse. Freedberg asserts that integrating forensic nursing concepts and skills into the undergraduate nursing curricula will help prepare practitioners who can help break the cycle of violence and close the gap that exists in healthcare delivery for individuals affected by violence.

In the first of a series of articles, Kent-Wilkinson (2009a) explored forensic nursing education in North America by interviewing educators that had developed some of the first forensic nursing courses and programs in their area. Applying a constructivist approach to her data analysis, Kent-Wilkinson affirmed the definition of forensic nursing as "…a recognized global specialty of nursing, integrating the application of nursing art and science at the clinical/legal interface serving the human health experience as a response to violence in society" (p. 208). Evidence in the data delineated how forensic nursing was different from nursing in general and different from other forensic disciplines in that forensic nurses often care for persons who are victims or perpetrators of crime or both. In their practices, forensic nurses routinely interact with justice system(s), employ knowledge of the law and forensic sciences, and frequently testify in court. Forensic nursing practice also differs from other forensic disciplines in that forensic nurses care for a wide range of clients (i.e., victims and offenders, living and deceased) of all ages, extend care to clients' families and communities, attend to holistic health needs (including medication administration), and theoretically ground their practice in paradigms of care and social justice. When making a case for the need for the development of specialty roles and specific education in forensic nursing, it is important to be aware of how forensic nursing is different and being able to articulate these differences when lobbying for initiation of this specialty.

Kent-Wilkinson's (2009b) study of forensic nursing education in 2008 also revealed that forensic nursing involves distinct knowledge and dual knowledge. She further contends that dual knowledge makes forensic nursing practice unique and requires curricula that integrate both nursing knowledge and knowledge from forensic science and the forensic behavioral sciences along with the legal and scientific processes.

By the mid-1990s, the first forensic nursing education programs were in existence. In her analysis of social factors influencing forensic nursing education, Kent-Wilkinson (2009b) attributed the growth of forensic nursing education programs to the following: (a) the proactive efforts of nurses dedicated to provide better care to victims and offenders; (b) the efforts of local champions who initiated and sustained programs; (c) the support of governments and institutions of higher learning; (d) administrators who understood and supported the role of forensic nurses; (e) flexible curricular structures that allowed for elective options; (f) heightened public awareness of forensics through mass media; and (g) increased market demands and job creation.

Despite these social supports and broader availability of forensic nursing education programs, Kent-Wilkinson's (2011) recent review of the literature shows that role development and education across all forensic nursing subspecialties was uneven. The role of the SANE is well developed as are clinical training certificate programs to prepare nurses with the skills needed to practice in the role. However, there is a lack of forensic nursing education programs available for other major forensic subspecialties such as death investigator, clinical forensic nursing, and forensic psychiatric nursing.

Burgess, Piatelli, and Pasqualone (2011) described collaboration between the Boston College Biology Department and the Connell School of Nursing's graduate forensic nursing program to develop and offer 12 forensic modules in an undergraduate biology laboratory course. We suggest that forensic science courses and laboratories could become foundational courses for the application of forensic science to nursing practice (see Supplement Digital Content 1 for Table 1, http://links.lww.com/JFN/A12).

SANE Roles

Fifteen years ago, Ciancone et al. (2000) surveyed SANE programs in the United States and described their characteristics. Sixty-one of the 92 programs in existence at the time returned the survey (66%), over half of the programs (55%) had been operating for less than 5 years, and just over half (52%) provided the initial sexual assault examination in hospital emergency departments. The median wait time for initial examination and evidence collection was 3 hours (range = 1–8 hours), and follow-up was offered consistently to all clients. Respondents reported similarities in their programs with respect to staffing, training, sexually transmitted infection (STI) and pregnancy prophylaxis, and documentation techniques. There was, however, wide variability in the use of STI cultures, human immunodeficiency virus (HIV) testing, and alcohol and drug screening, and most programs were unable to provide information concerning follow-up and legal outcomes. The

authors concluded that there is not a single, best structure for SANE programs and that future programs need to take into account community needs and resources when developing programs.

In 2006, Logan et al. (2006) reported that there were 549 SANE programs in operation across the United States. The researchers randomly sampled (by state) 231 of these programs with the aims of examining SANE and law enforcement policies and working relationships with community organizations, describing the perceived benefit of SANE programs for sexual assault survivors, and identifying barriers and potential solutions to common program issues. Most programs surveyed provided service 24 hours a day, 7 days per week (82.7%) from hospital emergency or other hospital departments (60.1%); the remaining SANE programs were housed in rape crisis centers (15.2%), free standing clinics (8.2%), and criminal justice system agencies (e.g., police department, prosecutor's office, or victims assistance program; 9.6%). Eighty percent of SANE programs reported having excellent working relationships with their local rape crisis centers. Respondents also endorsed excellent working relationships with law enforcement agencies (53%), domestic violence agencies (63.3%), the prosecutor's office (52.6%), and hospital administrators and hospital staff (51.5%; Logan et al., 2006). The perceived benefits of SANE programs for survivors reflected those in the literature and included client-centered care, high quality of evidence collection, and follow-up referrals to support services. Challenges to the development and maintenance of SANE programs include staffing, funding, and conflicts or lack of communication with various stakeholders (Logan et al., 2006).

An example of tailoring a SANE program to a community's needs and resources was evident in Dandino-Abbott's (1999) article describing the establishment and 1-year outcomes of the Lucas County Sexual Assault Response Team. This initiative was a unique intersectoral collaboration involving the prosecutor's office, sheriff's department, police department, two competing acute care facilities in the Toledo area, and the Toledo YWCA Rape Crisis Center. After one year of operation, there were clear improvements in the care provided to victims of sexual assault including shorter time-to-care, decreased length of hospital stay, improved documentation quality, and better coordination of interagency services. Dandino-Abbott underscored the vital importance of specialized training for SANEs, multidisciplinary involvement, and intersectoral communication and collaboration to build and maintain a high-quality Sexual Assault Response Team. The longer the Team and their respective agencies worked together, the greater the improvements in care to victims of sexual assault.

In the province of Ontario, Canada, Stermac and Stirpe (2002) examined hospital records of 515 women to compare services provided by SANEs with that of physicians. Women seen by SANEs and physicians were similar in demographic characteristics as seen in their reported use of alcohol and drugs before the sexual assault, the type of coercion they experienced during the assault, and the incidence of vaginal and anal rape perpetrated against them. The major difference between care provided by SANEs and physicians was that physicians treated women with more physical trauma as per the program's protocol. Consistent with existing literature at the time, the average assessment time was slightly shorter for women seen by SANEs than for those seen by physicians (3.25 vs. 4 hours), and physicians had more interruptions (25.1%) than did SANEs (20.0%). On the basis of these findings, Stermac and Stirpe support the SANE model as an effective approach for providing high-quality and effective care to victims of sexual assault victims.

The importance of intersectoral and multidisciplinary collaboration along with effective communication among stakeholders is noted by several authors as being critical to the development and maintenance of successful SANE programs (e.g., Houmes et al., 2003; Logan et al., 2006). Hutson (2002) contends that

> [t]hrough a multidisciplinary approach, including SANEs, physicians, police, and prosecutors, nurses can combine their expertise to improve not only the medical care of the victims but also the safety of the community in which they live and practice their professions. (p. 87)

Two articles in the review focused on the role of the SANE with children and adolescents. Bechtel et al. (2008) conducted a retrospective chart review to determine whether the use of SANEs in one pediatric emergency department improved the care of children and adolescents who had been sexually assaulted. The authors conducted a chart review of a sample of persons who attended a Connecticut pediatric emergency department between December 2004 and December 2006 for documentation of a genitourinary (GU) examination and the presence of injury, evaluation and prophylactic treatment for STIs and pregnancy, assessment by a unit social worker, and referral for follow-up by community-based sexual assault crisis services. Of the 114 children and adolescents whose charts were included in the review, almost two thirds (n = 60) were seen by a SANE. Those seen by SANEs had more complete examinations that included GU examination (71% vs. 41%) and GU injury documentation (21% vs. 0%). SANEs also had higher rates of screening for STIs, pregnancy prophylaxis, and referrals to mental health services and the Rape Crisis Centre (98% vs. 30%). There were no statistically significant between-provider differences in referrals to a social worker. Bechtel and colleagues concluded that not all SANEs documented performance of a GU examination, STI testing, and/or STI and HIV prophylaxis. This led them to recommend that SANE services require ongoing monitoring and quality assurance checks to

ensure thorough health assessment of children and teens who have been sexually assaulted.

In 2012, Marchetti, Fantasia, and Molchan employed focus groups to describe the attitudes of SANE-As (SANE-A meaning adults/adolescents) regarding the possibility of cross-training to care for patients aged <12 years (Marchetti et al., 2012). Most participants supported the notion of cross-training, although a few opposed the proposal citing the emotional toll of working with children who have been sexually assaulted and the need for adequate education, training, and support. The authors suggest that their findings can inform the acute care and evidence collection practices used in the care for pediatric patients who have been sexually assaulted.

Finally, Campbell and her colleagues (2005) reported the results of their national study of SANE programs to describe nurses' most recent expert testimony experiences to identify whether qualities of individual nurses or of the programs in which they work were associated with difficulties giving expert testimony. Forty-three percent of the SANEs had no difficulty during their most recent expert testimony. Logistic regression revealed that younger nurses, SANEs with more experience, and SANEs in administrative roles encountered fewer problems giving testimony. Level of education was not associated with difficulty in giving testimony; however, forensic training, working in an established SANE program, and good relationships with prosecutors were also associated with fewer problems during expert testimony (see Supplemental Digital Content 2 for Table 2, http://links.lww.com/JFN/A13).

Forensic Psychiatric Nursing

In Australia, Martin et al. (2007) examined the adequacy of the Graduate Nurse Program (GNP) at the Thomas Embling Hospital of the Victorian Institute of Mental Health (trading as Forensicare). The GNP, established in 1994, employed preceptorship, in-house lectures, competency examinations, and placement evaluations to prepare students for psychiatric nursing practice. Participants reported that the environment was safe and supportive, and graduates felt confident and prepared as psychiatric nurses. Although limitations of undertaking a GNP in a forensic setting were identified, the participants from the past program who had gone on to work in other services did not believe that their nursing careers had been disadvantaged. The authors concluded that, although a forensic setting is a suitable context for a GNP, graduates also require a foundation year of psychiatric nursing theory.

Also in Australia, Cashin et al. (2010) used ethnographic methods to explore the experience of providing nursing care in a forensic setting, where the routines, regimes, and regulations of the custodial environment dominate. Through participant observation, semistructured interviews, and artifacts, the authors sought to understand "cultural migration" (changes in nursing culture over time) in a forensic hospital. An earlier study at the same hospital described nurses as "entrapped in and disempowered by routines and battles with custodial staff leaving the nurse–patient relationship as non-therapeutic" (p. 44). The current study revealed a shift in the way that nurses described their practice and articulated the desire to increase therapeutic engagement with patients, although there was a lack of clarity concerning how nurses could enact therapy in the forensic environment.

A study conducted in Finland by Tenkanen et al. (2011) assessed the acquisition and mastery of core competencies and performance of core interventions among RNs and practical mental nurses. The authors found statistically significant between-group differences ($p \leq 0.05$) with respect to pharmacotherapy, knowledge of forensic psychiatry and violent behavior, therapeutic responses to violent individuals, emotion management, and responsiveness to individual patient needs. The authors concluded that RNs, as opposed to practical mental nurses, are better prepared to provide care in forensic psychiatric nursing settings and recommend that all nurses working in forensic settings require ongoing education in forensic psychiatry and in forensic psychiatric nursing.

Rask and Brunt (2006) studied Swedish patients' and nurses' perceptions of the frequency and importance of their verbal and social interactions on a forensic psychiatric nursing unit. Seventy-three patients and 87 nursing staff completed surveys for the study; 78% of the nursing staff were licensed mental nurses, and 13% were RNs with postgraduate training in psychiatry. The patients perceived "supportive/encouraging interactions" and "reality orientation interactions" to be the most frequent and supportive/encouraging interactions and "social skills training" to be the most important interactions. In contrast, nurses perceived the supportive/encouraging interactions and the "practical skills training" as the most frequent and the supportive/encouraging interactions, "interpretative interactions," and practical skills training as the most important interactions. Overall, patients reported that interactions occurred less frequently than what the nurses reported. The authors call for further research to elucidate patient perspective of the daily life on a forensic psychiatric unit and the nature of verbal and social interactions between patients and nurses (see Supplemental Digital Content 3 for Table 3, http://links.lww.com/JFN/A14).

Discussion

Around the world, children, women, and the elderly are among the most frequent victims of interpersonal violence, including sexual violence (Krug et al., 2002). This review showed the effectiveness of SANEs in emergency departments in the immediate care of adult (e.g., Houmes et al., 2003; Stermac & Stirpe, 2002) and child (Bechtel et al.,

2008; Ciancone et al., 2000; Marchetti et al., 2012) victims. With its high rates of sexual assault and interpersonal violence (Reichenheim et al., 2006), Brazil has a need for a category of health professionals that can create and maintain effective linkages between the healthcare and justice systems to meet the physical, psychosocial, and legal needs of victims of violence. Work by Logan and colleagues (2006) indicates that SANEs are ideally suited to fulfill this mandate as they have excellent working relationships with law enforcement and domestic violence agencies, prosecutors, and hospital administrators and other hospital staff. Other benefits of SANEs for victims of violence include client-centered care, high quality of evidence collection, and follow-up referrals to support services. Given its resonance with current directions in Brazilian nursing education (Brazil National Council of Education, 2001), there is a growing interest among Brazilian nurses (Silva & Silva, 2009) and nursing organizations (Brazil Federal Council of Nursing, 2011) in the establishment of SANEs roles, standards of practice, and specialty certification.

The mentally ill are another underserved group whose care needs often intersect with the health and justice systems. In Brazil, mental health policy is legislated by Law Number 10.216 (Government of Brazil, 2001), which ensures that persons experiencing a mental disorder will have access to the highest quality care in the least restrictive therapeutic environment. In most instances, the preference is for community-based mental health services within the context of family-centered care. International experience (e.g., Tenkanen et al., 2011) shows that nurses who work with these individuals require specialized education in forensic psychiatric nursing.

Not surprisingly, the findings of this review echo calls around the world for curricular changes to increase forensic nursing content in undergraduate, graduate, and specialty nursing education (Gökdoğan & Erkol, 2005; Lambe, & Gage-Lindner 2007). Given the longstanding acknowledgment of violence as a healthcare issue (Krug et al., 2002), forensic nurses remain an "…untapped resource in anti-violence strategies and a critical link in the administration of justice" (International Association of Forensic Nursing, 2006). In Brazil, where there is increasing attention to the health and healthcare needs of individuals affected by violence (Reichenheim et al., 2011), there is a window of opportunity to contribute the theoretical foundations of forensic nursing science and to advance nursing specialty practice in the areas of SANEs and forensic psychiatric nurses (Backes, Erdmann, & Buscher, 2010; Dantonio, 2010; Mason, 2002). In Brazil, as well as in countries like England (Rutty, 2006), Germany (Lambe & Gage-Lindner, 2007), and Turkey (Gökdoğan & Erkol, 2005), increasing forensic nursing content in nursing curricula and establishing certification in forensic nursing are the critical first steps to advance and promote forensic nursing as a specialty.

Currently, in Brazil, nursing educators are revisiting curricula, pedagogy, and political projects with the aim of implementing curricula and dynamic teaching strategies to support critical, reflective, and meaningful learning. This is an opportune time to advance forensic nursing education to meet the cultural, socioeconomic, and policy demands of the nation. The development and strengthening of nursing as a profession throughout history have been motivated by social demands to meet the dynamic needs of human beings. This is an evolving process that involves both knowledge development and political mobilization. The time is right for developing forensic nursing science and forensic nurse specialty practice in Brazil as a way to increase nurses' autonomy and improve Brazilian healthcare.

In Brazil, the educational preparation and regulation of nursing practice is governed by laws to ensure that practitioners have the knowledge and skills to provide care in a variety of contexts and in response to new and complex challenges of modern societies, always mindful of the human being (Brazil National Council of Education, 2001; Monteiro, 2009). International experiences highlighted in this study emphasize the potential for forensic nursing to respond to social demands and point the way for policy makers and administrators of Brazil's National Health System (SUS), which is grounded in the ideals of prevention and health promotion. For example, basic health units and family health strategies are scattered throughout the country and, as primary healthcare services, are gateways to the public healthcare system. If employed in these settings, forensic nurses could liaise with local schools to provide education for students; provide community-based services for women, children, and the elderly affected by violence as well as to those living with psychiatric illness; and serve as resources to other professional groups.

Limitations of the Integrative Review

This integrative review was limited to articles written in English, Spanish, or Portuguese and published in a peer-reviewed journal. All articles in the review focused on the establishment, evaluation, or existence of the forensic nursing specialty; the implementation of courses or programs intended to support the establishment of a forensic nursing specialty; and/or the benefits of establishing a forensic nursing specialty to society and nursing. Although the articles focused on the SANE and forensic psychiatric nursing subspecialties, most acknowledged the existence and potential value to society of all forensic nursing subspecialties.

Conclusion

In this article, an integrative review of the establishment and practice of specialty forensic nursing practice around the world is provided. Its aim was to distill lessons for nurses in Brazil who are seeking to advance forensic nursing education and specialty practice. The review supports the ongoing efforts

of Brazilian educators to increase forensic nursing content in undergraduate and graduate nursing programs to prepare graduates who can effectively respond to the needs of Brazilian society, particularly those whose health, psychosocial, and legal needs intersect.

References

Backes, D. S., Erdmann, A. L., & Büscher, A. (2010). O cuidado de enfermagem como prática empreendedora: Oportunidades e possibilidades [Nursing care as entrepreneurial practice: Opportunities and possibilities.]. *Acta Paulista de Enfermagem, 23*(3), 341–347. Retrieved from http://www.scielo.br/pdf/ape/v23n3/v23n3a05.pdf

Bechtel, K., Ryan, E., & Gallagher, D. (2008). Impact of sexual assault nurse examiners on the evaluation of sexual assault in a pediatric emergency department. *Pediatric Emergency Care, 24*(7), 442–447. doi:10.1097/PEC.0b013e31817de11d

Bordin, I. A., Paula, C. S., do Nascimento, R., & Duarte, C. S. (2006). Severe physical punishment and mental health problems in an economically disadvantaged population of children and adolescents. *Revista Brasileira de Psiquiatria, 28*(4), 290–296.

Brazil Federal Council of Nursing. (2011). *Resolution #389, Federal Council Nursing. Official Gazette, 202 (Section 1, pp. 146).* Federal Republic of Brazil. Retrieved from ftp://ftp.saude.sp.gov.br/ftpsessp/bibliote/informe_eletronico/2011/iels.out.11/Iels199/U_RS-COFEN-389_181011.pdf

Brazil National Council of Education. (2001). *Higher education camera. Resolution CNE/CES No. 3. Institutes for Undergraduate National Curriculum Guidelines in Nursing.* Retrieved from http://portal.mec.gov.br/cne/arquivos/pdf/CES03.pdf

Brazilworks. (2012). *Brazil's healthcare system: Towards reform? A BrazilWorks briefing.* Retrieved from http://www.brazil-works.com/wp-content/uploads/2012/09/Brazil-Health-Care-System-Towards-Reform.pdf

Broome, M. E. (1993). Integrative literature reviews for the development of concepts. In Rogers, B. L., Knafl, K. A. (Eds.), *Concept development in nursing* (2nd ed., pp. 231–250). Philadelphia, PA: W.B. Saunders Co.

Burgess, A. W., Piatelli, M. J., & Pasqualone, G. (2011). Criminalistics and the forensic nursing process. *Journal of Forensic Nursing, 7*(2), 97–104. doi:10.1111/j.1939-3938.2011.01105.x

Campbell, R., Townsend, S. M., Long, S. M., Kinnison, K. E., Pulley, E. M., Adames, S. B., & Wasco, S. M. (2005). Organizational characteristics of Sexual Assault Nurse Examiner programs: Results from the national survey project. *Journal of Forensic Nursing, 1*(2), 57–64, 88.

Cashin, A., Newman, C., Eason, M., Thorpe, A., & O'Discoll, C. (2010). An ethnographic study of forensic nursing culture in an Australian prison hospital. *Journal of Psychiatric and Mental Health Nursing, 17*(1), 39–45. doi:10.1111/j.1365-2850.2009.01476.x

Central Intelligence Agency. (2013). The world factbook 2013–14. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/index.html

Dandino-Abbott, D. (1999). Birth of a sexual assault response team: The first year of the Lucas County/ Toledo, Ohio, SART program. *Journal of Emergency Nursing, 25*(4), 333–336.

Dantonio, P. (2010). Histories of nursing: The power and the possibilities. *Nursing Outlook, 58*(4), 207–213. doi:10.1016/j.outlook.2010.04.005

Ferreira, Aurélio Buarque de Holanda. (2001). Miniaurelio century XXI: The mini dictionary of the Portuguese language (4th ed., extended rev.). Rio de Janeiro, Brazil: Nova Fronteira.

Freedberg, P. (2008). Integrating forensic nursing into the undergraduate nursing curriculum: A solution for a disconnect. *Journal of Nursing Education, 47*(5), 201–208.

globalEDGE., & Michigan State University. (2014). *Brazil: History.* Retrieved from http://globaledge.msu.edu/countries/brazil/history

Gökdoğan, M. R., & Bafra, J. (2010). Development of a sexual assault evidence collection kit—The need for standardization in Turkey. *Nurse Education Today, 30*(4), 285–290. doi:10.1016/j.nedt.2009.07.015

Gökdoğan, M. R., & Erkol, Z. (2005). Forensic nursing in Bolu, Turkey: A survey. *Journal of Clinical Forensic Medicine, 12*(1), 14–17.

Government of Brazil. (2001). *Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental (LEI No. 10.216) [Provides for the protection and rights of people with mental disorders and redirects the mental health care model (Law No. 10.216)].* Retrieved from http://legis.senado.gov.br/legislacao/ListaPublicacoes.action?id=232459

Houmes, B. V., Fagan, M. M., & Quintana, N. M. (2003). Establishing a sexual assault nurse examiner (SANE) program in the emergency department. *Journal of Emergency Medicine, 25*(1), 111–121.

Hutson, L. A. (2002). Development of sexual assault nurse examiner programs. *Nursing Clinics of North America, 37*(1), 79.

Instituto Brasileiro de Geografi a e Estatística. (2010). *2010 Population census.* Retrieved from http://www.ibge.gov.br/english/estatistica/populacao/censo2010/default.shtm

International Association of Forensic Nursing. (2006). *What is forensic nursing?* Elkridge, MD: Author. Retrieved from http://iafn.org/displaycommon.cfm?an=1&subarticlenbr=137

Kent-Wilkinson, A. (2009a). An exploratory study of forensic nursing education in North America: Constructed definitions of forensic nursing. *Journal of Forensic Nursing, 5*(4), 201–211. doi:10.1111/j.1939-3938.2009.01055.x

Kent-Wilkinson, A. (2009b). Forensic nursing education in North America: Social factors influencing educational development. *Journal of Forensic Nursing, 5*(2), 76–88. doi:10.1111/j.1939-3938.2009.01038.x

Kent-Wilkinson, A. (2011). Forensic nursing educational development: An integrated review of the literature. *Journal of Psychiatric and Mental Health Nursing, 18*(3), 236–246. doi:10.1111/j.1365-2850.2010.01667.x/full

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds.). (2002). World report on violence and health. Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf

Lambe, A., & Gage-Lindner, N. (2007). Pushing the limit: Forensic nursing in Germany. *Journal of Forensic Nursing, 3*(3–4), 117.

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P., … Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: Explanation and elaboration. *Journal of Clinical Epidemiology, 62*(10), e1–e34.

Logan, T. K., Cole, J., & Capillo, A. (2006). Program and sexual assault survivor characteristics for one SANE program. *Journal of Forensic Nursing, 2*(2), 66–74.

Marchetti, C. A., Fantasia, H. C., & Molchan, L. (2014). Attitudes of adult/adolescent sexual assault nurse examiners and caring for younger patients. *Journal of Emergency Nursing, 40*(1), 39–45. doi:10.1016/j.jen2012.09.002

Martin, T., Donley, M., Parkes, J., & Wilkins, C. F. (2007). Evaluation of a forensic psychiatric setting to provide a graduate nurse program. *International Journal of Mental Health Nursing, 16*(1), 28–34.

Mason, T. (2002), Forensic psychiatric nursing: A literature review and thematic analysis of role tensions. *Journal of Psychiatric and Mental Health Nursing, 9*(5), 511–520. doi:10.1046/j.1365-2850.2002.00521.x

Messias, E. (2003). Income inequality, illiteracy rate, and life expectancy in Brazil. *American Journal of Public Health, 93*(8), 1294–1296.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLos Med, 6*(7), e1000097. doi:10.1371/journal.pmed.1000097

Monteiro, B. A. (2009). *Guidelines and bases for national education and nursing schools in the 1960s: A historical overview*. MSc Thesis, School of Nursing, University of São Paulo, São Paulo. Retrieved from http://www.teses.usp.usp.br/disponivel/7/7131/tde-20052009-110837/

Organization of American States. (1994). Inter-American Convention on the prevention, punishment and eradication of violence against women (Convention of Belem do Para). Retrieved from http://www.oas.org/juridico/english/treaties/a-61.html

Paim, J., Travassos, C., Almeida, C., Bahia, L., & Macinko, J. (2011). Health in Brazil 1. The Brazilian health system: History, advances, and challenges. Lancet, *377*, 1778–1797. doi:10.1016/S0140-6736(11)60054-8

Radzyminski, S. (2006). Population health as a framework for forensic nursing curriculum. *Journal of Forensic Nursing, 2*(1), 33–41.

Rask, M., & Brunt, D. (2006). Verbal and social interactions in Swedish forensic psychiatric nursing care as perceived by the patients and nurses. *International Journal of Mental Health Nursing, 15*(2), 100–110.

Reichenheim, M. E., de Souza, E. R., Moraes, C. L., de Mello Jorge, M. H., da Silva, C. M., & de Souza Minayo, M. C. (2011). Violence and injuries in Brazil: The effect, progress made, and challenges ahead. *Lancet, 377*(9781), 1962–1975.

Reichenheim, M. E., Moraes, C. L., Szklo, A., Hasselmann, M. H., Ramos de Souza, E., de Azevedo Lozana, J., & Figueiredo, V. (2006). The magnitude of intimate partner violence in Brazil: Portraits from 15 capital cities and the Federal District. *Cadernos de Saúde Pública, 22*(2), 425–437.

Reichenheim, M. E., Patricio, T. F., & Moraes, C. L. (2008). Detecting intimate partner violence during pregnancy: Awareness-raising indicators for use by primary healthcare professionals. *Public Health, 122*(7), 716–724.

Rutty, J. E. (2006). Does England need a new genesis of forensic nursing? Forensic Science, Medicine, and Pathology, *2*(3), 149–156. doi:10.1385/FSMP:2:3:149

Silva, B. S., & Silva, R. C. (2009). Forensic nursing: A specialty to be known. *Cogitare Enferm, 14*(3), 564–583. Retrieved from http://ojs.c3sl.ufpr.br/ojs2/index.php/cogitare/article/view/16191/10709

Stermac, L., & Stirpe, T. (2002). Efficacy of a 2-year-old sexual assault nurse examiner program in a Canadian hospital. *Journal of Emergency Nursing, 28*(1), 18–23.

Tenkanen, H., Tiihonen, J., Repo-Tiihonen, E., & Kinnunen, J. (2011). Interrelationship between core interventions and core competencies of forensic psychiatric nursing in Finland. *Journal of Forensic Nursing, 7*(1), 32–39. doi:10.1111/j.1939-3938.2010.01093.x

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546–553.