Early Days
- Awareness
  - William Appleton 1980
  - Stark, Flitcraft & Frazier 1981
  - General Surgeon’s Report 1986
- Beginning to measure
  - Battering accounts for 1 out of 4 visits by women to emergency services (McLeer & Anwar 1989)
  - Undefined emergency surgical service
  - Chart audits
  - Multiple visits by single patients over years
- Abuse generally undetected (undocumented)

STATUS QUO…
- Crisis intervention by community groups (eg., Women’s Refuge) and govt agencies (eg., Child Youth & Family, Police)
- In Health – invisible - respond only to most severe cases
- ‘Not seeing’ (Denise Wilson)
- Judgemental care (Jackie Campbell)
- ‘They chose to medicalize her chief complaint’ (Carole Warshaw 1989)

Disembodied, ‘ahistorical’ history
- MD Note: Pt 25 y/o BF c/o swelling and pain on the mouth after was hit by a fist about 5 hours ago. No LOC, no visual symptoms, no vomiting, no nausea.
- Physical Exam: Afebrile, hydrated, conscious, oriented X 3. HEENT: has swelling in the upper lip and loose teeth. No evidence of fx.
- XRAY: no fx.
- Discharge DX: Blunt Trauma Face
- Disposition: Ice packs, oral surgery clinic appt, motrin

ED IPV Prevalence
(Abbott et al, JAMA 1995)
1993: 3 EDs and 2 Walk-In Clinics; Denver; n=648
- 54% lifetime prevalence
- 28% abuse by current partner
- 12% visits attributed to partner assault, threat, or intimidation
Search for Risk Factors
- Unable to identify abused women by (Abbott et al.):
  - pattern of injuries
  - cc/dx
  - race/income
- ROUTINE SCREENING

‘Screening’ goals
- Identify cases early
- Provide effective intervention strategies to reduce morbidity and mortality

Accuracy of IPV 3-item Screen
n=322; Feldhaus et al, JAMA 1997
- 30% screen positive
  - Past year physical abuse
  - Current or past partner ‘making you feel unsafe’
- 27% CTS positive
- 71% sensitivity; 84% specificity

Consistency Across Regions
Behavioral Risks Among Patients in the ED (Lowenstein et al., 1999)
- IPV (1 year period prevalence of physical)
  - Akron, Ohio 13%
  - Boston, MA 17%
  - Denver, CO 17%

Screening Reliability
Test-Retest Reliability of Injury Risk Factors (Koziol-McLain et al, 2000)
- One-year period prevalence of intimate partner physical violence
  - Kappa = .79

Screen Predictive Validity
Risk for Short-term (3 mo) Violence (Koziol-McLain et al, 2001; replicated by Houry et al in ED)

<table>
<thead>
<tr>
<th>SCREEN (407)</th>
<th>NEG (n=372)</th>
<th>POS (n=32)</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Aggression</td>
<td>16%</td>
<td>56%</td>
<td>3.6</td>
</tr>
<tr>
<td>Physical Violence</td>
<td>2%</td>
<td>28%</td>
<td>11.7</td>
</tr>
<tr>
<td>Severe Violence</td>
<td>0.3%</td>
<td>13%</td>
<td>46.6</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>9%</td>
<td>22%</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Intimate Partner Violence (IPV) Among Women Seeking Care in an Auckland Emergency Care Department

- Jane Koziol-McLain, Julie Gardiner, Pam Batty, Elaine Fyfe, Lynne Giddings, Maria Rameka, Dale Te Iwamate
- ITRU with Middlemore ECC & Raukura Hauora O Tainui.
- Funded by AUT & NZ MOH

Kaupapa (philosophy)
- Time: Allowing women to speak
- Whakawhanaungatanga: Connectedness
- Forging a path for when the research ends

Screening & Brief Intervention
Empowering – NOT ‘fixing’
- Focus on positive coping strategies and women’s strengths
- Goal is living violence-free (not necessarily leaving)
- Achieving goal is a process, rather than an event
- Principles of empowerment:
  - mutuality and reciprocity,
  - sharing information,
  - giving choices,
  - brainstorming solutions, and
  - making sense of it.

Screen and Brief Intervention
- Trained nurse research assistants
- Women entered during randomly selected shifts
- Exclude impaired/non-English speaking women
- Only enter once

Healthcare Setting Surveillance: Auckland

<table>
<thead>
<tr>
<th></th>
<th>LIFE TIME</th>
<th>SCREEN POSITIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care (n=174)</td>
<td>44.3% (36.9%, 51.7%)</td>
<td>21.3% (15.2%, 27.4%)</td>
</tr>
</tbody>
</table>

But how did it go?
- Did women mind being asked?
- Was it helpful?
Evaluating Screening: Women’s Perceptions (Giddings et al)

- Reminded of past abuse and determined “it won’t happen again”
- “It made me feel finally released... of that burden and pain”
- “It helped me understand about abuse and things”
- Decided to talk with friend who was in an abusive relationship
- A few women talked with their children about past abuse, often for the first time.
- One woman said her children responded, “Oh mum. Why didn’t you tell us before?”

Themes

1. “The painful memories came back”
   - “Anything can trigger it [the fear]”
2. “It’s long overdue”
   - “Pleased to be involved”
3. “You need to tell the women”
   - “you [health professionals] do it; you’re the first to see it.”

Screening literature: evidence insufficient

- Ramsey et al., British Medical Journal, 2002
- MacMillan & Wathen, Canadian Task Force on Preventive Health Care, JAMA 2003

BUT...

- No study demonstrates screening as harmful
- No study demonstrates it is not effective
- Do not include qualitative studies
- Ethically difficult to justify a control group
- 2 ED screening and intervention studies - neither collected individual-level longitudinal interview data

What we know...

- Women don’t mind being asked.
- Abused women can be accurately and safely identified in the health care setting
- Brief screens have acceptable sensitivity, specificity and predictive value (Houry et al 2004; Koziol-McLain et al, 1999)
- 10-wk program for women leaving battered women’s shelters/refuges (Sullivan & Bytee, 1999)
- ↓ physical violence & depression & ↑ QOL & social support
- Prenatal clinic intervention (Parker et al., 1999)
- ↓ physical violence & ↓ threat of violence
- General practice (McFarlane et al 2006)
- Simple assessment = case management

Collecting Partner Violence Intervention Effectiveness Evidence

Three Innovative Clinical Trials

- Canada
  - Marilyn Merritt-Gray, RN, MN
- Australia
  - Kelsey Hegarty, MBBS, FRACGP, DIPRACOG, PhD
- New Zealand
  - Jane Koziol-McLain PhD, RN
**WISE STUDY**  
women in safe environments

Jane Koziol-McLain; Ian Hassall (IPP); Janet Fanslow (U of A)  
Raukura Hauora O Tainui (South Auckland); South Auckland Family Violence Prevention Network (SAFVPN); Northland Health (Whangarei)  
New Zealand Health Research Council

**AIM**  
Test healthcare Site Based Partner Violence Screening and Intervention Efficacy

**Period**  
- October 2005 – September 2008

**SITES**  
- South Auckland  
  - Raukura Hauora O Tainui primary care clinics  
  - Whangarei  
  - Northland Health Emergency Department

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**OBJECTIVES**

- **Phase One**
  - Convene community participatory action research groups to specify a trial protocol

- **Phase Two**
  - Enrol 400 (in each of two sites) ≥ 16 y/o women in a clinical RCT.  
  - Collect follow-up measures at 3 months.

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**RCT Design**

INDEX VISIT | 3 MONTH FU
---|---
Informed Consent | Usual Care | Outcomes
Screening + Brief Intervention | Outcomes

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**Conceptual Framework**

**INTERVENTION**  
SELF CARE  
↑ Knowledge  
↑ Skill acquisition  

**OUTCOMES**

---

**Antecedent Variables**

<table>
<thead>
<tr>
<th>Individual (W/P)</th>
<th>ED Relationship</th>
<th>Characteristics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics</td>
<td></td>
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</table>

**Interventions to**

- ↑ Self-Care
  - ↑ Skill Acquisition
  - ↑ IPV Knowledge

**Proximal Outcomes**

- ↑ Accessing services
- ↑ Safety actions

**Distal Outcomes**

- ↓ Violent Event Exposure
- ↓ Experience of Battering
While we wait for the evidence...

I do want to make sure that what we are doing about intimate partner abuse is the right thing. Are we really doing what we should do? That's my question, not should we do it at all.

Sugg

- Education a must
- Acknowledgment/support of nurses living with/surviving abuse
- System response needs to be well developed
- Clear guidelines for screening

Working Toward System Change:
Hospital Responsiveness to Family Violence

- How are DHBs performing in terms of institutional family violence prevention?
- Are the family violence intervention guidelines being implemented (eg., mandatory screening, six-step process)?
- Is institutional change being sustained over time?
- What are enablers/barriers to change in the area of domestic violence?

Hospital audits

- Delphi Instrument for Hospital Based Domestic Violence Programs (Agency for Healthcare Research and Quality, 2002)
- Audit acute care hospitals in Aotearoa/NZ
- 27 hospitals participated in 1 or more audits
- Baseline; 12 mo FU; 30 mo FU

Median CAN programme score 12 to 30 MO: ↑8 (16%)

[Graph showing data]

Median PA programme score 12 to 30 MO: ↑21 (75%)

[Graph showing data]

Conclusions from hospital audits

- Some programmes were more successful in their development (achieving system indicators) – those with dedicated FV Coordinators.
- Change takes time
- Auditing is a useful process: serves to promote change
- Need ongoing support for sustainability
The VIP, Violence Intervention Programme supports health sector family violence programmes throughout New Zealand

Hon Pete Hodgson
1/08/2007

Budget 2007 set aside $11.2 million to:
• ensure that victims of violence using health services receive the support they require, and
• ensure that staff are trained and competent to screen health service users who may be victims of child and partner abuse.

Education
• Affirmation of wholistic philosophy of care (te whare tapa wha; bio/psycho/social/spiritual)
• Students want to learn how to screen for IPV
• Don’t be overprotective, over-precious
• Levels across curriculum
  1. Awareness of issues of family violence
  2. Sensitivity about issues of family violence
  3. Safety in practice at a basic level

Sustainable Change
• Educating health professionals is not by itself sufficient to address the problem of IPV
• Providing tools (practice guidelines) and institutional support increases the likelihood of creating sustainable change
• Reform must be institutionalised to sustain IPV innovations and behavioural change

Health Care Culture Change
• Reasons for visit usually hidden from view.
• Change in culture from traditional medical model.
• Even institutional support is not enough
• It’s about changing a practice that is entrenched in our societies’ values to keep violence in the home behind closed doors.

Conclusions
Research is needed to examine IPV screening and interventions using mixed-methods, longitudinal, well-controlled studies that are geographically diverse represent diverse racial and ethnic populations

However, even with research evidence of a positive screening effect, societal, structural and professional issues will continue to play a dominant role in determining health professionals’ engagement in reducing intimate partner violence
Continue to challenge and think beyond individuals and partner violence

- Doing more for children
- Challenging punishment models
- Increasing primary and secondary prevention activities
- Consider lifetime trauma (all traumas)
- Focus on communities
- Focus on causes and strategies to eliminate disparities in access to and utilization of existing resources in racial and ethnically diverse communities
- Work with communities (where the solution lies) in developing culturally relevant programs

www.trauma-research.info
www.ednurse.org