

***“Evaluation of a Hospital-based Training Program on Intimate Partner Abuse”***

***co-funded by***

***Sunnybrook and Women's College Health Sciences Centre***

***and***

***The Canadian Nurses' Foundation***

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**I. Introduction**

The purpose of this report is to provide our funding partner, The Canadian Nurses' Foundation, through the Nursing Care Partnership, a final report on the, *Evaluation of a Hospital-based Training Program on Intimate Partner Abuse*.

Increasingly, male violence against women is recognized as a major public health concern and a violation of human rights (World Health Organization, 2002). Two of the most common forms of violence against women are intimate partner violence, or IPV (also known as domestic violence, woman abuse or wife assault), and coerced sex, whether it takes place in childhood, adolescence, or adulthood (WHO 2002; Population Health Report XXVII (4)1999).

The formal health care system is often the first and only outside contact for women and children who are experiencing violence. Health care professionals thus have a limited but critical role to play in recognizing, responding appropriately, treating and referring victims of IPV (Greaves et al., 1995). An improved role for health care professionals would be to detect abuse before a patient presents in crisis (Alpert, Sege & Bradshaw, 1997). Although controversial as to whether or not screening improves women's overall health, (MacMillan & Wathen 2003; Ramsay et al. 2002; United States Preventive Services Task Force 1996) advocates argue that early detection of IPV by health care professionals provides an opportunity for women to receive support, discuss their options, develop strategies to improve personal and family safety and receive referrals for counselling, shelters or other resources.

It has, however, been notoriously difficult to ensure health professionals, especially physicians, develop the necessary knowledge and skills to competently assess or screen for past or current experiences of abuse (e.g. Cole, 1999). While numerous education and training programs for health care professionals have been developed, few have been evaluated. We do not know, for example, the minimum amount of time required for an education program to have lasting impact, we do not know the most effective means of delivering training on IPV, nor whether or not new attitudes and knowledge are maintained post training.

The focus of our research project was the development, implementation and evaluation of an education and training program on IPV for health care professionals at a large urban hospital in Toronto, Canada.

## II. Method

Both quantitative and qualitative data were collected. A pre-test post-test method was used to determine changes in knowledge, skills, attitudes and practice that resulted from the training initiative. Qualitative data were collected through interviews with eleven participants.

The survey was adapted from the DV Health Care Provider Survey developed by Maiuro et al (2000) and consists of six subscales: Perceived Self Efficacy, System Support, Blame Victim, Fear of Offending/Professional Role Resistance, Victim/Provider Safety, and Frequency of DV Inquiry. Minor modifications were made to reduce the number of questions that dealt with confronting batterers as this was not covered in the training.

Eight program areas, representing key entry points into the hospital system and a diversity of professional experience, were selected for the training program: the emergency department, operating room, labour and delivery suite, postpartum floor, pre-operation/day surgery, post-surgery, first year residents, and the family practice clinic.

Informed consent was obtained from one hundred and eleven health care professionals who completed the pre-test and participated in the training program. Post-tests were administered a minimum of three and a maximum of six months after training. Fifty-five participants completed post-tests.

Participants at both pre-test and post-test were preponderantly female (95.5% and 94.5%), ranged in age from 23 to 61 years, and were primarily nurses (80% and 78%).

## III Results

All professions were equally likely to have participated at pre-test and post-test  $\chi^2 (2, N = 163) = .16, ns$ . Similarly, participation from different program remained stable from pre-test to post-test  $\chi^2 (7, N = 166) = 7.62, ns$ .

The only subscale that was significant at the post-test was Perceived Self-efficacy. No other subscale scores were significant at the post-test. See Table 2

Table 1 Pre-test Post-test Subscales

		<b>Pre-test</b>	<b>Post-test</b>	
		M (SD)	M (SD)	<i>t</i>
Perceived Self-Efficacy	PSE	3.11 (.79)	3.53 (.77)	3.25**
System Support	SS	3.36 (.70)	3.51 (.90)	-1.16
Blame Victim	BV	1.78 (.66)	1.69 (.67)	.81
Professional Role Resistance	PRR	2.29 (.81)	2.16 (.78)	.99
Victim/Provider Safety	VPS	3.32 (.57)	3.40 (.66)	-.78
Frequency of DV Inquiry	FI	7.48 (4.79)	8.07 (5.78)	-.70

\*\* $p < .01$

Perceived self-efficacy was related to greater belief in system support, lower professional role resistance, and higher safety concerns. It was not, however related to more frequent asking about DV.

One item probed the frequency of inquiry by asking participants to agree or disagree with the statement “I don’t have time to ask about DV.” Although the differences were not significant, they were surprising. At pre-test, 67% reported that they *agreed* or *strongly agreed* with this statement while 16.5% *disagreed* or *strongly disagreed*. At post-test, 74.6% reported that they *agreed* or *strongly agreed* with this statement while 12.8% *disagreed* or *strongly disagreed*. Correlations between this statement, age, and the frequency of DV inquiry subscale were examined. The only significant relationship was for age and this statement at the pre-test with younger health care providers more strongly endorsing this item at the pre-test than older health care providers.

#### **IV Discussion**

We found a one hour training on IPV was sufficient to increase personal self-efficacy amongst participants. Feelings of inadequacy and powerlessness have been identified as significant “affective barriers” to screening. (Davis & Harsh 2001) Thus, improving self-efficacy may be considered essential in reducing barriers to screening. One hour of training was not, however, sufficient to change practice behaviours as measured by increased screening for IPV. Although not captured in our data, one nurse manager did make a point of telling us that the numbers of referrals for patients who disclosed IPV had increased on her unit post-training. Also not captured in our study was the report that in the weeks after training one frontline nurse approached her manager and asked for help regarding her own abusive intimate relationship.

Others have also found it easier to change attitudes and increase knowledge about IPV than to influence practice (Schoening et al 2004; Roberts et al 1997; Saunders et al 2005; Hinderliter, Doughty, Delaney, Pitula, & Campbell 2003). However, Saunders and colleagues found that while their brief training did not impact screening rates, trained workers were more likely to discuss women’s fears and safety concerns and were perceived by clients as significantly more helpful and comfortable in talking about the abuse (Saunders, et al). Such findings and our own data leads to questions about the ability of assessment tools (such as the one utilized in our pre and post-tests) to accurately measure practice behaviours in an area of practice as complex as IPV.

#### **V Dissemination**

One manuscript was submitted and is currently in revision. In addition, the project findings have been presented in part or in whole at the following conferences:

McMahon E, Mason R, Gold K, McGillicuddy P, Norris P. Practice Based Research Symposium at Sunnybrook and Women’s College Health Sciences Centre. Toronto, ON., June 23, 2005

Mason R, McMahon E, Gold K, McGillicuddy P, Norris P. Evaluation of a hospital-based training program on domestic violence. 2004 National Conference on Health and Domestic Violence: Health Consequences Over the Lifespan. Boston, MA., Oct. 22-23, 2004.

McMahon E. & Mason R. “We know we should do something but what exactly?” Nurses’ knowledge of domestic violence. Thirteenth International Nursing Conference of the Nursing Network on Violence Against Women International. Boston, MA., Oct. 23-25, 2004.

McMahon E. & Mason R. Nurses’ knowledge of domestic violence: Does education change practice? Annual Nurse Practitioner Conference: Creating a Vision for the Future. Toronto, ON., Nov. 12–13, 2004.

Mason R. & Du Mont J. Evaluating hospital-based responses to intimate partner violence: Uncovering the knowledge to practice gap. Global Forum on Health, Forum 8. Mexico City, Mexico, Nov. 17-20, 2004.