

## EM ADVANCES

# Caring for victims of intimate partner violence: a survey of Canadian emergency departments

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**ABSTRACT**

**Objective:** We sought to determine the proportion of Canadian emergency departments (EDs) that have intimate partner violence (IPV) universal screening programs and intervention policies and procedures. Of the EDs with programs, we determined what proportion had made changes in their practices during the past 10 years and since the 2003 Canadian Task Force on Preventive Health Care recommendations.

**Methods:** Using the same sampling methods as a 1994 study, we mailed questionnaires to nurse managers of a stratified, random sample of 250 out of 638 (39%) Canadian EDs and followed up with a series of telephone calls.

**Results:** Of the 250 EDs initially contacted, 6 were excluded before the surveys were mailed. The response rate was 78.3% (191/244). Sixty-one (31.9%) of the studied EDs reported the existence of IPV policies and procedures. In this group, 26 (42.6%) applied universal screening and 13 (21.3%) implemented their screening policies after the 2003 national recommendations were published. When these results were compared with those of the 1994 study, there was no difference in the proportion of EDs with IPV policies and procedures or in the proportion of EDs that applied universal screening.

**Conclusion:** Despite increased research into IPV there was no significant change between 1994 and 2004 in the existence of IPV policies or universal screening in Canadian EDs. Policies and procedures that address appropriate responses to patients exposed to IPV should be a priority, with most emphasis directed toward developing effective interventions to which women can be referred.

**Keywords:** intimate partner violence, domestic violence, screening, emergency department, emergency medicine, policies

**RÉSUMÉ**

**Objectif :** Nous avons cherché à savoir quel pourcentage de services d'urgence au Canada est doté de programmes de dépistage systématique de violence conjugale ainsi que de politiques et procédures d'intervention. Parmi les services d'urgence ayant de tels programmes, nous avons déterminé quel pourcentage avait modifié sa pratique au cours des 10 dernières années et depuis la publication, en 2003, des recommandations du Groupe d'étude canadien sur les soins de santé préventifs.

**Méthodes :** Nous avons utilisé la même méthode d'échantillonnage que celle de notre étude de 1994 : nous avons envoyé par voie postale un questionnaire à des gestionnaires en soins infirmiers

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d'un échantillon randomisé et stratifié de 250 des 638 (39 %) services d'urgence au Canada et avons fait des suivis téléphoniques.

**Résultats :** Parmi les 250 services d'urgence contactés au départ, six ont été exclus avant que les sondages ne soient mis à la poste. Le taux de réponse était de 78,3 % (191/244). Soixante et une (31,9 %) des urgences sondées ont signalé l'existence de politiques et de procédures concernant la violence conjugale. De ce groupe, 26 (42,6 %) avaient recours au dépistage systématique et 13 (21,3 %) ont mis en application leur politique de dépistage après la publication des recommandations nationales en 2003. La comparaison de ces résultats avec ceux obtenus en 1994 révèle qu'il n'y a pas de différence en ce qui a trait au pourcentage de services d'urgence dotés de politiques et de procédures relatives à violence conjugale ou de services d'urgence qui réalise le dépistage systématique.

**Conclusion :** Malgré le nombre accru d'études sur la violence conjugale, il n'existe pas de changement significatif entre les résultats de 1994 et ceux de 2004 concernant l'existence de politiques en matière de violence conjugale et le dépistage systématique dans les urgences du Canada. Il faudrait accorder la priorité à la mise en place de politiques et de procédures qui prévoient des interventions appropriées à l'égard des patientes exposées à la violence conjugale, et mettre l'accent sur l'élaboration de ressources efficaces auxquelles les femmes peuvent avoir recours.

## Introduction

Intimate partner violence (IPV) is a significant public health issue that primarily affects women.<sup>1-3</sup> The proportion of women who attend emergency departments (EDs) in North America and are victims of IPV is estimated to be at least 11%, depending on a number of factors, including the definition of IPV used, the time reference, how questions are administered and the population studied.<sup>1,4-10</sup> Despite this, resources for those identified as victims are limited. Some provinces include the exposure of children to IPV within child welfare mandatory reporting laws, but there is no separate mandatory reporting in Canada for IPV victims over 18 years of age.

Given the high incidence of women who are exposed to IPV attending EDs, there is a potential opportunity for health care providers to assist these individuals. Universal screening of women presenting to EDs is viewed by some as one way in which the health care system can serve victims of IPV. ED policies and procedures may also identify services to support such individuals. It is important to distinguish between IPV policies and procedures generally, and the actual implementation of universal screening. Despite a lack of evidence for a positive effect from IPV interventions, it is likely beneficial for health care providers to recognize IPV and respond to it in a way that maximizes benefits and avoids additional harm to the victim.

Universal screening is generally only advocated when an effective intervention exists. This may not be the case for IPV; no Canadian interventions to which women can be referred following IPV screening have been shown effective in reducing violence or improving health outcomes for women.<sup>11,12</sup> Both the 2003 Canadian Task Force on Preventive

Health Care (CTFPHC) and the 2004 United States Preventive Services Task Force (USPSTF) concluded that there is insufficient evidence to recommend for or against routine screening for IPV.<sup>13,14</sup> However, these guidelines also state that health care providers "need to be alert to the signs of abuse." Identification of a woman exposed to IPV can only be effective if there are appropriate resources to address her needs and if it does not place her at increased risk of reprisal from her partner.

Given the dissemination of updated practice guidelines, we sought to determine the proportion of Canadian EDs that have IPV intervention policies and procedures, universal screening programs for victims, and had made changes in these practices during the past 10 years and since the CTFPHC recommendations. A 1994 study found that 39% of the 198 emergency nurse managers who were surveyed reported specific IPV policies and procedures in their ED, and 13% practised universal screening for victims.<sup>15</sup>

## Methods

### Study design

This was a cross-sectional survey of Canadian ED nurse managers that was approved by the joint Hamilton Health Sciences/McMaster University Review Ethics Board. This study employed the same sampling strategy as used by Hotch and colleagues<sup>15</sup> in 1994 to comparatively determine the proportion of hospitals with IPV intervention policies and procedures and the proportion with a universal screening program for victims of IPV.

### Selection of participants

All of the 118 major Canadian teaching hospitals with EDs

and a random selection of nonteaching hospitals with full-service EDs were surveyed. Using a random number generator, we selected 132 of the 638 nonteaching hospitals with EDs listed in the 2004 Canadian Hospital Association Guide to Canadian Health Care Facilities to study. Pediatric hospitals and other specialized facilities were excluded because they were unlikely to have any IPV programs.<sup>15</sup>

### Survey questionnaire

Both English- and French-language versions of the questionnaire were available. Our questions focused on identifying the presence within EDs of current IPV intervention policies and procedures, universal screening programs for victims of IPV, as well as awareness of CTFPHC recommendations, and any IPV intervention policies and procedures implemented after the 2003 publication of the CTFPHC recommendations.

### Study protocol

Between September and December 2004, nurse managers from each of the selected EDs were contacted to determine their willingness to take part in the study. A questionnaire was mailed to each participating site along with a \$2 coffee shop coupon incentive. Unlike the original survey, which used a single mailing for follow-up, we employed up to 2 telephone calls to encourage enrolment.

### Measurements

Information on the following primary outcome variables was captured: the proportion of EDs that have IPV policies and procedures, the proportion of EDs that apply universal screening, the proportion of EDs that are aware of the CTFPHC recommendations and the proportion of EDs that have implemented IPV policies and procedures since 2003.

### Data analysis

Sample size calculations were based on the prior study by Hotch and colleagues.<sup>15</sup> The cumulative survey results are presented using descriptive summary statistics with proportions

and percentages. Comparisons of proportions were carried out using  $\chi^2$  analysis, and a  $p$  value of less than or equal to 0.05 was deemed to be statistically significant. Data were analyzed using SPSS version 11.0 (SPSS Inc.).

## Results

Of the 250 EDs initially contacted, 1 refused participation and 5 were excluded (2 veterans', 1 children's, 2 wrong addresses) prior to surveys being mailed, resulting in a study population of 244 EDs. The response rate was 78.3% (191/244).

Table 1 provides our primary results along with those of the 1997 study in a comparative manner. Of the 191 survey respondents, 61 (31.9%) reported the existence of IPV policies and procedures. Among the 61 EDs with IPV policies, 26 (42.6%) applied universal screening. When these results were compared with those of the 1994 survey, there was no significant difference between them with respect to the proportion that had IPV policies and procedures ( $p = 0.95$ ) or to the proportion that applied universal screening ( $p = 0.889$ ).

Since the national guidelines were published in 2003, 13 of the 61 EDs (21.3%) revised or implemented new policies and procedures (Table 2). Of the 13 EDs that reported implementing policies and procedures since 2003, the nurse managers of 5 (38.5%) indicated that they were aware of the new CTFPHC guidelines.

## Discussion

Following their study in 1994, Hotch and colleagues<sup>15</sup> concluded that the implementation of IPV policies and procedures in Canadian EDs was infrequent and inadequate. Our study reveals no significant changes in the 10-year period since Hotch and coauthors' study, which may reflect the lack of evidence for screening and for referral to IPV interventions. However, it is noteworthy that only 39.3% (24/61) of EDs with IPV policies and procedures were

**Table 1. Comparison of survey responses: 2004 and 1994**

Survey item	No. (and %) of respondents		$p$ value*
	2004 survey	1994 survey	
Response rate	191/244 (78.3)	198/230 (86.1)	NA
Have IPV policies and procedures	61/191 (31.9)	78/198 (39.4)	0.125
Apply universal screening	26/191 (13.6)	26/198 (13.1)	0.889

IPV = intimate partner violence.  
\* $p$  value from  $\chi^2$  test.

**Table 2. 2004 respondents with intimate partner violence policies and procedures**

Survey item	No. (and %) of responses; $n = 61$
Apply universal screening	26 (42.6)
Aware of CTFPHC recommendations	24 (39.3)
Implemented IPV policies and procedures since 2003*	13 (21.3)

CTFPHC = Canadian Task Force on Preventative Health Care.  
\*Since CTFPHC recommendations.

aware of the CTFPHC recommendations. As was found in the 1994 study, knowledge and action on IPV policies in 2004 was infrequent among the hospitals surveyed.

There is improvement in the quality of scientific research in the IPV field.<sup>16</sup> This includes identification of what patients want and need from health care providers as well as information about what is not effective in reducing IPV. The results of our study suggest that despite the scientific evidence of the past decade, the ED management of IPV has not changed significantly. Although there remains insufficient evidence for or against universal screening, 13.6% of hospitals still engage in this practice. In addition, only 38.5% of nurse managers working in EDs that implemented IPV policies and procedures after the new guidelines were published were aware of the guidelines. The mismatch between guidelines and hospital practice suggests a need to develop national health strategies for bringing researchers, health care providers and policy-makers together to determine approaches for assisting victims of IPV. Moreover, the ways in which national, institution-directed guidelines are disseminated should be examined. Creating and implementing policies and procedures for appropriate responses to ED patients exposed to IPV should be a priority while interventions to which women can be referred are developed and studied.

## Limitations

Although we used the same sampling strategy as Hotch and colleagues used in 1994, we were unable to survey the identical institutions because the list of previously studied hospitals was not available and many hospitals had since changed their status.

Another limitation of both the original study and ours was the inclusion of all teaching hospitals and only a randomly selected number of nonteaching sites. While this sampling method led to an enrolment bias weighted toward teaching sites, it enabled us to directly compare our results with those of Hotch and coauthors.

The most serious limitation of this study, like many surveys, is the potential for nonresponse bias. We attempted to minimize this by following up with repeat telephone calls to increase the response rate.

Finally, we were unable to assess the degree of adherence to IPV policies by the EDs that reported having such policies.

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## Conclusion

Despite increased research into IPV, there was no significant change between 1994 and 2004 in the existence of IPV policies or universal screening in Canadian EDs. Policies and procedures that address appropriate responses to patients exposed to IPV should be a priority, with most emphasis directed toward developing effective interventions to which women can be referred.

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