Sustaining improved family violence practice among Maternal and Child Health nurse teams: MOVE: RCT and two-year follow-up

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How does partner violence affect women’s health? (WHO 2013)

Figure 1. Pathways and health effects on intimate partner violence

- **INTIMATE PARTNER VIOLENCE**
  - **PHYSICAL TRAUMA**
    - Injury
      - Musculoskeletal
      - Soft tissue
      - Genital trauma
      - Other
  - **PSYCHOLOGICAL TRAUMA/STRESS**
    - Mental health problems
      - PTSD
      - Anxiety
      - Depression
      - Eating disorders
      - Suicidality
    - Substance use
      - Alcohol
      - Other drugs
      - Tobacco
  - **FEAR AND CONTROL**
    - Limited sexual and reproductive control
      - Lack of contraception
      - Unsafe sex
    - Health care seeking
      - Lack of autonomy
      - Difficulties seeking care and other services
    - Perinatal/maternal health
      - Low birth weight
      - Prematurity
      - Pregnancy loss
    - Sexual and reproductive health
      - Unwanted pregnancy
      - Abortion
      - HIV
      - Other STIs
      - Gynaecological problems

- **NONCOMMUNICABLE DISEASES**
  - Cardiovascular disease
  - Hypertension
- **SOMATOFORM**
  - Irritable bowel
  - Chronic pain
  - Chronic pelvic pain

- **DISABILITY**
- **DEATH**
  - Homicide
  - Suicide
  - Other

There are multiple pathways through which intimate partner violence can lead to adverse health outcomes. This figure highlights three key mechanisms and pathways that can explain many of these outcomes. Mental health problems and substance use might result directly from any of the three mechanisms, which might, in turn, increase health risks. However, mental health problems and substance use are not necessarily a precondition for subsequent health effects, and will not always lie in the pathway to adverse health.
Rationale

Domestic violence

17% Australian women experience some form of partner violence in lifetime (ABS, 2013)

Risk increased in child bearing years (ABS, 2013)

Screening

Screening controversial - no evidence of effectiveness to improve women’s health but some support for targeted screening, for example with pregnant women (Taft et al., 2013; WHO, 2013)

Screening rates low ~15-30% (Stayton & Duncan, 2005)

No evidence for sustainability of health provider screening behaviours (Taft et al., 2013)

Implementation theory can facilitate sustainability of complex interventions such as screening (May & Finch, 2009)
Context

Victorian Maternal & Child Health service

- Universal and community based
- See 99.8% of new mothers/infants (DEEC, 2011)
- 2009 given new framework for overall practice
- Mandatory DV screening at 4 weeks after birth introduced
- CRAF - not screening training
- Previous trial nurses spoke of their barriers to identifying women
MOVE aims

That more MCH nurses in the MOVE than comparison arm:

**Primary**
- Screen for domestic violence
- Have mothers *disclose/discuss* violence (safety plans)
- Refer abused mothers to appropriate support agencies

**Secondary**
- Feel safer in the domestic violence work that they undertake
- Cause **no harm** through screening
- Abused women report *more satisfaction* with care
- To measure domestic violence prevalence among postpartum mothers
The MOVE design

Normalization process theory
(May et al 2007)
http://www.normalizationprocess.org/

Systematic review

Nurse and stake-holder
Feedback:
Interim/Impact

Multi-method
RCT evaluation

*Government data retrieval
*Women’s outcomes survey (10,000 women)

Consensus model for DV screening and referral care

Intervention Nurse consultant input (PAR)

Normalization process theory theory
(May et al 2007)
http://www.normalizationprocess.org/

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*Women’s outcomes survey (10,000 women)
What is Normalisation Process Theory?  
(May, 2009)

Four main constructs / principles

• Coherence (understanding the work)
• Cognitive participation (joining in)
• Collective action (working together)
• Reflexive monitoring (monitoring progress and quality)
The MOVE domestic violence intervention

What

- Screen @ 4 weeks (mandatory screen)
- Screen also @ 3 or 4 months (MOVE)

Who

- Nurse mentors, MCH team leaders, universal nurses and domestic violence liaison workers

How

- Clinical pathway and guidelines
- Maternal health and wellbeing checklist

Why

- Team discussions, quality assurance and data monitoring
MOVE clinical resources (Maternal wellbeing checklist and clinical pathway and practice guideline) removed from this presentation due to copyright.

Please contact Professor Angela Taft regarding access

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Self-completion preferred by women and nurses
Screening and referral outcome data

MCH routine govt data

- Screening numbers, safety plans and referrals
- Data for all consults 2010-2011 (n=125,155)

MOVE checklists

- Collected from all MCH centres (n=4143)

2621 surveys returned (25%)

- Women report on screenings, referrals and satisfaction with care
Partner violence prevalence in last twelve months

<table>
<thead>
<tr>
<th>Composite Abuse Scale</th>
<th>n= 2621</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥7 (confirmed)</td>
<td>6.8%</td>
</tr>
<tr>
<td>Ever afraid of partner</td>
<td>9.5%</td>
</tr>
<tr>
<td>Abused when pregnant</td>
<td>2.8%</td>
</tr>
<tr>
<td>Abused by previous partner</td>
<td>10.3%</td>
</tr>
</tbody>
</table>
## Screening rates from government data by arm

<table>
<thead>
<tr>
<th></th>
<th>Women screened at 4 weeks</th>
<th>Women screened at 4 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOVE teams</td>
<td>37.1%</td>
<td>36.5%</td>
</tr>
<tr>
<td>Comparison teams</td>
<td>42.7%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>
Screening rates from government data and checklists by arm

<table>
<thead>
<tr>
<th></th>
<th>Women screened with checklists at 4 months</th>
<th>Women screened with checklists at 3 months (not reported in gov. data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOVE teams</td>
<td>53.9% (One MOVE team only)</td>
<td>Range of screening rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(61.9%; 89.0%; 60.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average = 70.5 %</td>
</tr>
<tr>
<td>Comparison teams</td>
<td>23.5%</td>
<td></td>
</tr>
</tbody>
</table>

MOVE: Improving maternal & child health care for vulnerable mothers
## Safety planning and referrals

<table>
<thead>
<tr>
<th></th>
<th>Safety plans</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOVE teams</td>
<td>*4.2%</td>
<td>0.62%</td>
</tr>
<tr>
<td>22,888 clients</td>
<td>(962)</td>
<td>(143)</td>
</tr>
<tr>
<td>Comparison teams</td>
<td>1.4%</td>
<td>0.71%</td>
</tr>
<tr>
<td>28,215 clients</td>
<td>(402)</td>
<td>(201)</td>
</tr>
</tbody>
</table>
Are abused women more satisfied with nursing care?

*Q: The MCH nurse listened to me regarding my needs and medical concerns n=170 abused women*

<table>
<thead>
<tr>
<th></th>
<th>MOVE (%)</th>
<th>Comparison (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not well</td>
<td>8.9% (7)</td>
<td>18.7% (17)</td>
</tr>
<tr>
<td>Very well or somewhat well</td>
<td>*91.1% (72)</td>
<td>81.3% (74)</td>
</tr>
<tr>
<td>Total</td>
<td>n=79</td>
<td>n=91</td>
</tr>
</tbody>
</table>

* No harm from screening
Conclusions from MOVE

• Routine screening rates remain low
• Greater effectiveness with focussed women’s consultation and self-completed screening
• We can increase the rate of identification, disclosure and safety planning but.....is it sustainable??
MOVE 2 - Two year follow up study of MOVE

Are MCH nurses continuing to use the MOVE model and screen/support women experiencing partner abuse, two years on from MOVE?

Made MOVE materials available to comparison teams

Data collection

• Routine screening, safety planning and referral data from LGAs
• Online MCH nurse survey
• 14 stakeholder interviews
Routine data on screening

<table>
<thead>
<tr>
<th>Screen at 4 weeks</th>
<th>Intervention group</th>
<th></th>
<th></th>
<th>Comparison group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no. consults</td>
<td>no. Screened</td>
<td>% screened</td>
<td>no. consults</td>
<td>no. Screened</td>
<td>% screened</td>
</tr>
<tr>
<td>2010-2011</td>
<td>6593</td>
<td>2447</td>
<td>37.1</td>
<td>7979</td>
<td>3408</td>
<td>42.7</td>
</tr>
<tr>
<td>2011-2012</td>
<td>6751</td>
<td>2907</td>
<td>43.1</td>
<td>8334</td>
<td>4243</td>
<td>50.9</td>
</tr>
<tr>
<td>2012-2013</td>
<td>6766</td>
<td>3424</td>
<td>50.6</td>
<td>8643</td>
<td>4866</td>
<td>56.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screen at 4 months</th>
<th>Intervention group</th>
<th></th>
<th></th>
<th>Comparison group</th>
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<td>no. Screened</td>
<td>% screened</td>
<td>no. consults</td>
<td>no. Screened</td>
<td>% screened</td>
</tr>
<tr>
<td>2010-2011</td>
<td>6381</td>
<td>2330</td>
<td>36.5</td>
<td>7638</td>
<td>1792</td>
<td>23.5</td>
</tr>
<tr>
<td>2011-2012</td>
<td>6358</td>
<td>1712</td>
<td>26.9</td>
<td>7753</td>
<td>2404</td>
<td>31.0</td>
</tr>
<tr>
<td>2012-2013</td>
<td>6546</td>
<td>1869</td>
<td>29.0</td>
<td>8589</td>
<td>3080</td>
<td>35.9</td>
</tr>
</tbody>
</table>
# Safety planning and referrals - MOVE 2

<table>
<thead>
<tr>
<th></th>
<th>MOVE year (T0) n =22,888 clients</th>
<th>Two years post MOVE (T2) n =24,656 clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safety plans</td>
<td>Referrals</td>
</tr>
<tr>
<td>MOVE teams</td>
<td>4.2 % (962)</td>
<td>0.6 % (143)</td>
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<tr>
<td>Comparison teams</td>
<td>1.4 % (402)</td>
<td>0.7 % (201)</td>
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</table>
Online survey results

• The MOVE 2 MCH nurse anonymous online survey similar to baseline MOVE surveys (NPT framework)
• Permits cross survey comparisons of implementation factors over time
• Survey questions included nurse attitudes and beliefs, support and safety, skills and knowledge, service system, organisational context, resources and referrals
• MOVE 2 survey response rate 77% (n=123/160)
Coherence: what is the work?

<table>
<thead>
<tr>
<th>Survey question</th>
<th>MOVE 2 (T0)</th>
<th>MOVE 1 (T0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I feel uncomfortable when I have to ask all women about FV’</td>
<td>*36 (66%)</td>
<td>24 (46%)</td>
</tr>
<tr>
<td>(Disagree or strongly disagree) (n=107/111)</td>
<td>32 (64%)</td>
<td>29 (48%)</td>
</tr>
</tbody>
</table>
Do people join in the work?

<table>
<thead>
<tr>
<th>Do people join in the work?</th>
<th>MOVE year (T0)</th>
<th>MOVE 2 (T2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey question</td>
<td>MOVE</td>
<td>Comparison</td>
</tr>
<tr>
<td>‘In the past 6 months I have experienced barriers to asking about FV at 4 weeks’ (Yes) (n=106/110)</td>
<td>48 (89%)</td>
<td>40 (77%)</td>
</tr>
<tr>
<td>‘I have used the following resources in talking with women about FV’ (Yes)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>• MOVE MWB checklist (n=92)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MOVE clinical practice guidelines (n=85)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MOVE clinical pathway (n=83)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Collective action: How do people do the work?**

<table>
<thead>
<tr>
<th>Survey question</th>
<th>MOVE year (T0)</th>
<th>MOVE</th>
<th>Comparison</th>
<th>MOVE</th>
<th>Comparison</th>
</tr>
</thead>
</table>
| ‘I feel that our work practices mean I feel safe when visiting women at home’  
(Agree or strongly agree)  
(n=109/113) | *46 (82%) | 33 (62%) | 35 (66%) | 31 (52%) |
| ‘I understand why women don’t leave partners who are abusing them’  
(Agree or strongly agree)  
(n=107/113) | 50 (91%) | 50 (96%) | 46 (85%) | 46 (78%) |
| ‘I feel supported by my team leader in doing this work’  
(Agree or strongly agree)  
(n=106/107) | 35 (65%) | 38 (73%) | 26 (53%) | *42 (72%) |
Reflexive monitoring: do people monitor the work?

<table>
<thead>
<tr>
<th>Survey question</th>
<th>MOVE year (T0)</th>
<th>MOVE 2 (T2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘We get useful feedback about how well we are doing in our FV work at team meetings’</td>
<td>19 (35%)</td>
<td>10 (21%)</td>
</tr>
<tr>
<td>(Agree or strongly agree) (n=106/104)</td>
<td>11 (21%)</td>
<td>17 (30%)</td>
</tr>
</tbody>
</table>
Barriers to screening and referral

• Heavy workloads
• Lack of privacy
• Limited domestic violence links for referral support
• Lack of monitoring and reflection on domestic violence work
Facilitators to screening and disclosure

- Maternal health and wellbeing checklist and guidelines/pathway
- Increased discussion around domestic violence work
- Domestic violence liaison worker support
Conclusion- MOVE success

Sustainable FV screening and improved care

Theory informed, nurse centred model has led to improved and sustained outcomes in areas such as

- Nurse - client interaction
- Increased and sustained safety planning with women

What's needed to maintain sustainable practice?

- Ongoing organisational support for additional maternal health visit at 3 months
- Increased, regular accessible nurse FV training
- Maintaining FV service links and monitoring practice
- Improve quality assurance mechanisms
- Enable more and effective referrals
- Improve quality and range of routine data collection to enable routine monitoring of screening and follow-up
Victorian Royal Commission into Family Violence
Keynote Speakers:

- Dr Claudia Garcia-Moreno, MD, MSc, World Health Organization, Geneva, Switzerland
- Prof Jacquelyn Campbell, PhD, RN, FAAN, Johns Hopkins School of Nursing, Baltimore, USA
- Prof Jane Koziol-McLain, PhD, RN, Auckland University of Technology, Auckland, New Zealand
- Ms Rosie Batty, Family violence campaigner, Australian of the Year 2015

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Publications


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Women’s Health West
Berry Street Domestic Violence services

Funding:

[Logos for Australian Government, VicHealth, and Victoria: The Place To Be]