LA TROBE UNIVERSITY

Judith Lumley Centre

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

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Supported by the Victorian Government
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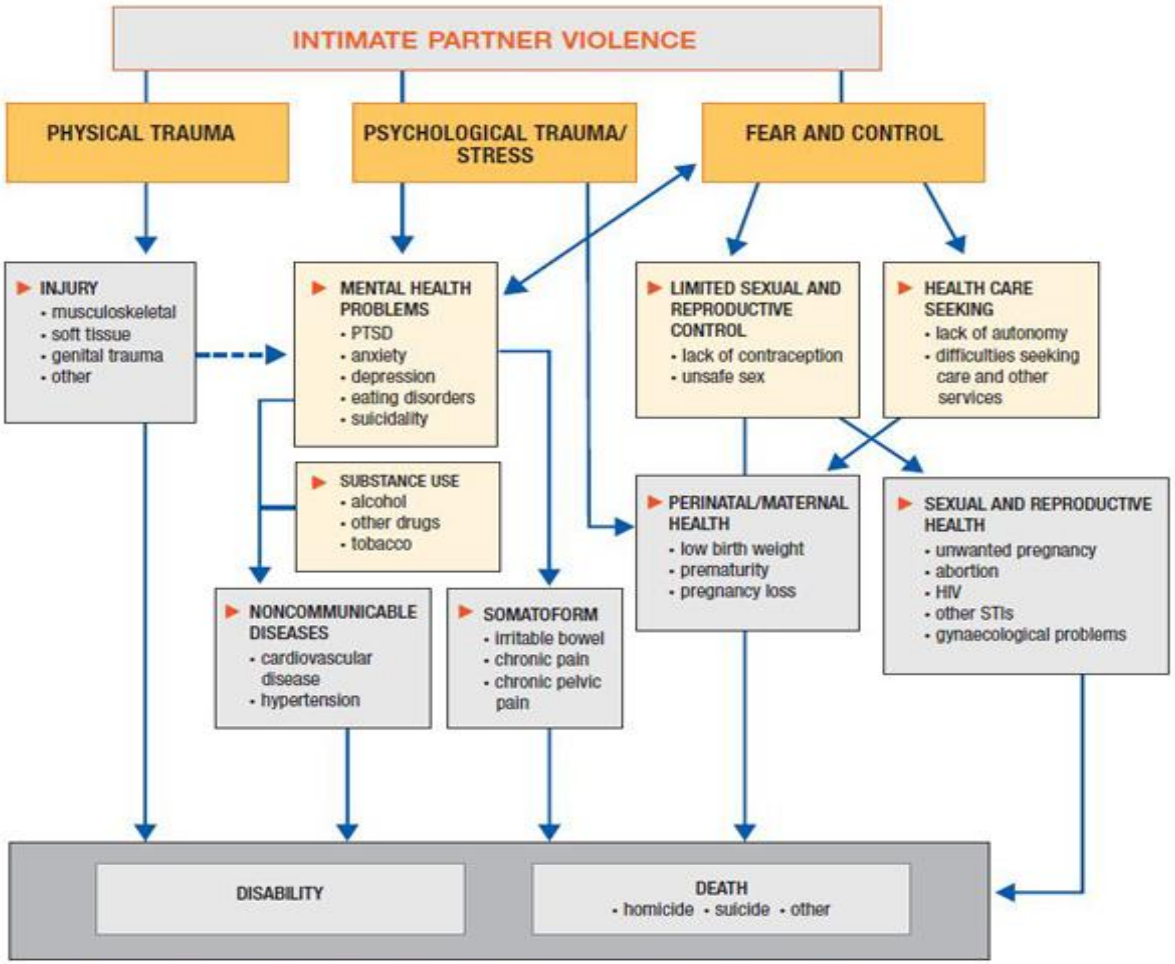
How does partner violence affect women's health? *(WHO 2013)*

Figure 1. Pathways and health effects on intimate partner violence



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 (DEECD, 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

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MOVE aims

That more MCH nurses in the MOVE than comparison arm:

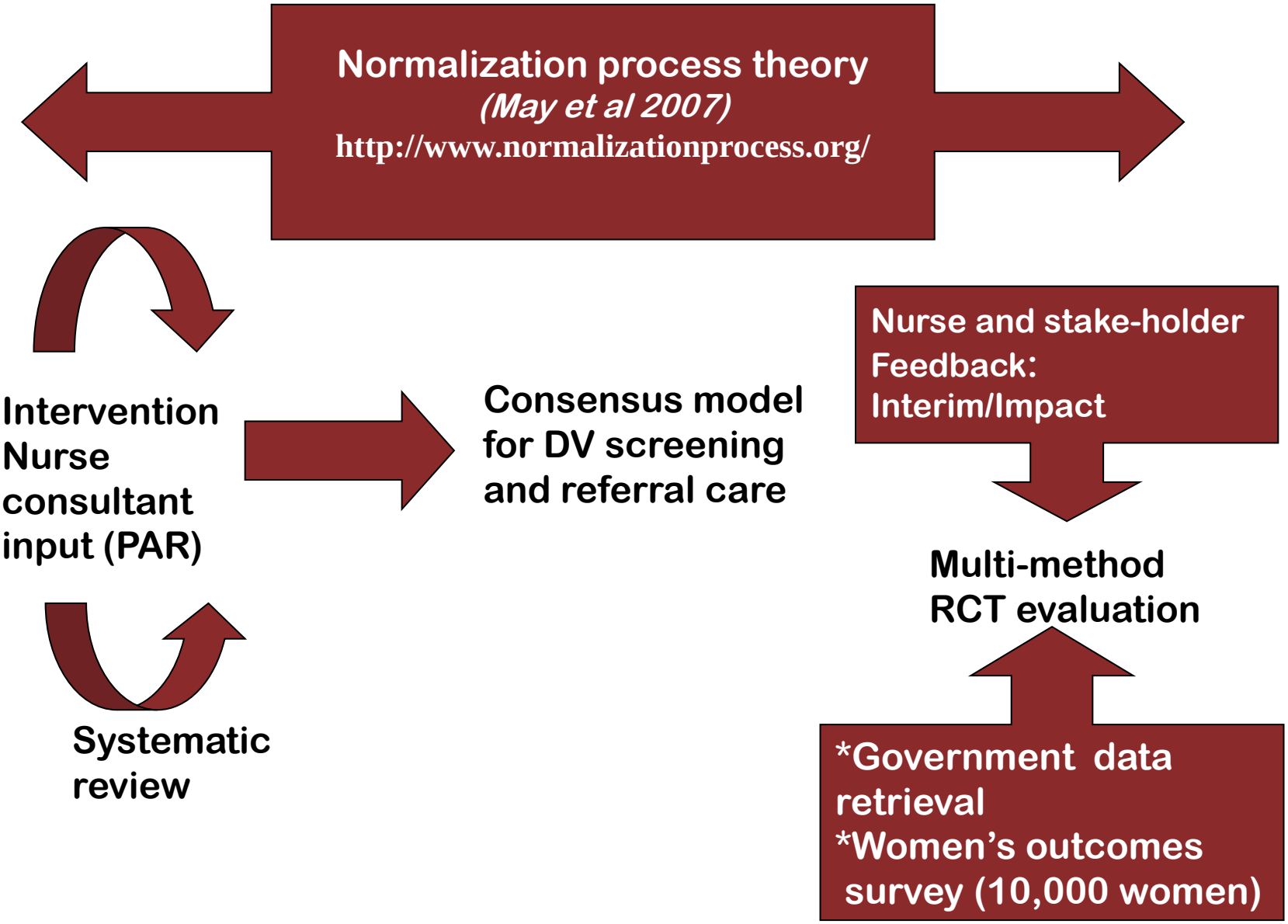
Primary

- 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



What is Normalisation Process Theory?

(May, 2009)

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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

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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

a.taft@Latrobe.edu.au

Self-completion
preferred by
women and nurses

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Screening and referral outcome data

MCH routine govt data

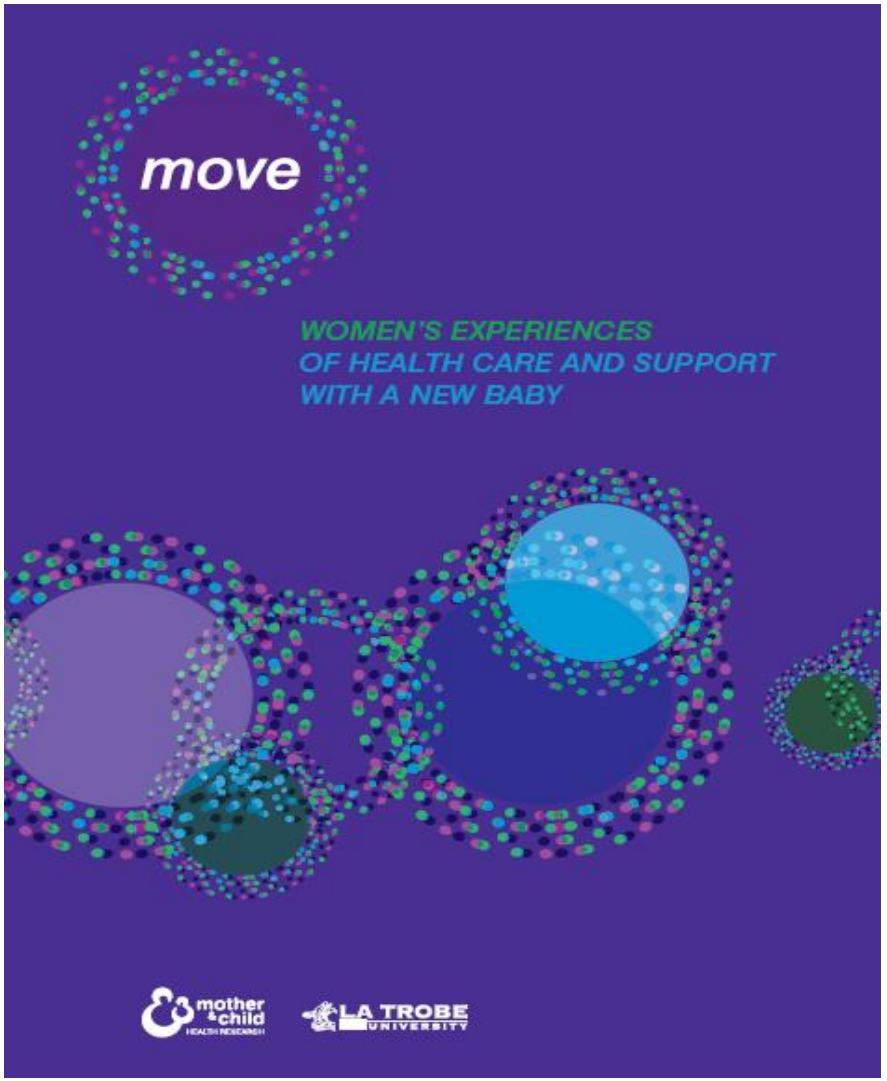
- Screening numbers, safety plans and referrals
- Data for all consults 2010-2011 (n=125,155)

MOVE checklists

- Collected from all MCH centres (n=4143)

2621surveys returned (25%)

- Women report on screenings, referrals and satisfaction with care



Partner violence prevalence in last twelve months

Composite Abuse Scale	n= 2621
≥7 (confirmed)	**6.8%**
Ever afraid of partner	9.5%
Abused when pregnant	2.8%
Abused by previous partner	10.3%

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Screening rates from government data by arm

	Women screened at 4 weeks	Women screened at 4 months
MOVE teams	**37.1%**	**36.5%**
Comparison teams	**42.7%**	**23.5%**

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Screening rates from government data and checklists by arm

	Women screened with checklists at 4 months	Women screened with checklists at 3 months (not reported in gov. data)
MOVE teams	**53.9%** (One MOVE team only)	Range of screening rates (61.9%; 89.0%; 60.5%) **Average = 70.5 %**
Comparison teams	**23.5%**	

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Safety planning and referrals

	Safety plans	Referrals
MOVE teams **22,888 clients**	***4.2%** **(962)**	**0.62%** **(143)**
Comparison teams **28,215 clients**	**1.4%** **(402)**	**0.71%** **(201)**

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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

	MOVE (%,n)	Comparison (%,n)
Not well	**8.9% (7)**	18.7% (17)
Very well or somewhat well	***91.1% (72)**	81.3% (74)
Total	n=79	n=91

* No harm from screening

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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??

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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

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Routine data on screening

	Intervention group			Comparison group		
	no. consults	no. Screened	% screened	no. consults	no. Screened	% screened
Screen at 4 weeks						
2010-2011	6593	2447	**37.1**	7979	3408	**42.7**
2011-2012	6751	2907	**43.1**	8334	4243	**50.9**
2012-2013	6766	3424	**50.6**	8643	4866	**56.3**
Screen at 4 months						
2010-2011	6381	2330	**36.5**	7638	1792	**23.5**
2011-2012	6358	1712	**26.9**	7753	2404	**31.0**
2012-2013	6546	1869	**29.0**	8589	3080	**35.9**

Safety planning and referrals - MOVE 2

	MOVE year (T0) n =22,888 clients		Two years post MOVE (T2) n =24,656 clients	
	Safety plans	Referrals	Safety plans	Referrals
MOVE teams	**4.2 %** (962)	0.6 % (143)	**5.9 %** **(1452)**	0.9 % (225)
Comparison teams	**1.4 %** (402)	0.7 % (201)	**1.4 %** **(415)**	0.9 % (263)

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?

	MOVE year (T0)		MOVE 2 (T2)	
Survey question	**MOVE**	**Comp**	**MOVE**	**Comp**
'I feel uncomfortable when I have to ask all women about FV' (Disagree or strongly disagree) (n=107/111)	*36 (66%)	24 (46%)	**32 (64%)**	**29 (48%)**

Do people join in the work?

Do people join in the work?	MOVE year (T0)		MOVE 2 (T2)	
Survey question	**MOVE**	**Comparison**	**MOVE**	**Comparison**
'In the past 6 months I have experienced barriers to asking about FV at 4 weeks' (Yes) (n=106/110)	48 (89%)	40(77%)	37(74%)	39(65%)
'I have used the following resources in talking with women about FV' (Yes) • **MOVE MWB checklist** (n=92) • **MOVE clinical practice guidelines** (n=85) • **MOVE clinical pathway** (n=83)	NA	NA	***38 (81%)** ***17 (43%)** ***13 (34%)**	10 (22%) 9 (20%) 5 (11%)

Collective action: How do people do the work?

	MOVE year (T0)		MOVE 2 (T2)	
Survey question	**MOVE**	**Comparison**	**MOVE**	**Comparison**
'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?

	MOVE year (T0)		MOVE 2 (T2)	
Survey question	**MOVE**	**Comparison**	**MOVE**	**Comparison**
'We get useful feedback about how well we are doing in our FV work at team meetings' (Agree or strongly agree)(n=106/104)	19 (35%)	11 (21%)	10 (21%)	17(30%)

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

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Facilitators to screening and disclosure

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

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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

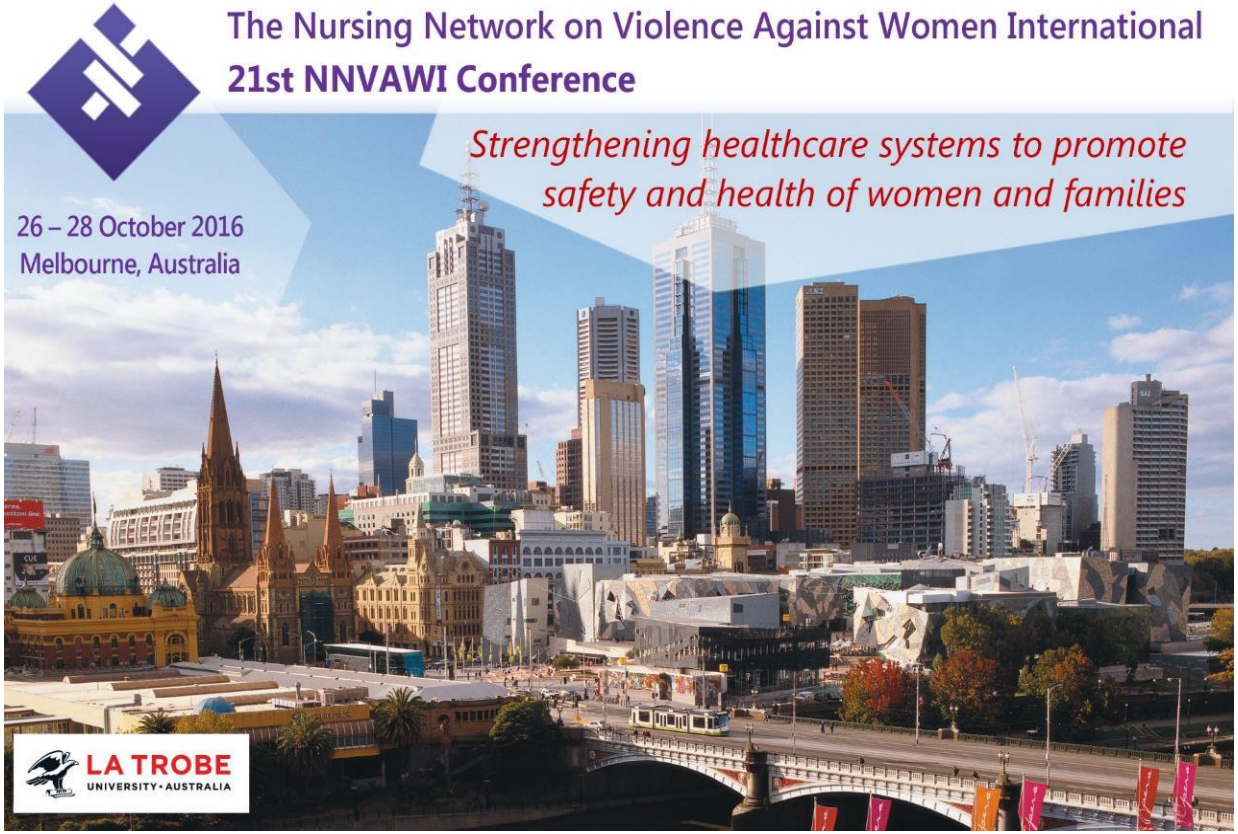
- Nurse - client interaction
- Increased and sustained safety planning with women

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

Family violence and health system response
International nursing conference Melbourne Oct 26-28



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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Find more information at www.latrobe.edu.au/jlc/news-events/NNVAWI-Conference-2016

Publications

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Taft, A. J., Small, R., Humphreys, C., Hegarty, K., Walter, R., Adams, C., & Agius, P. (2012). Enhanced maternal and child health nurse care for women experiencing intimate partner/domestic violence: protocol for MOVE, a cluster randomised trial of screening and referral in primary health care. *BMC Public Health,* 12(1), 811.

Taft , A., Hooker, L., Humphreys, C., Hegarty, K., Walter, R., Adams, C., Agius, P. & Small, R. (2015). Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomised trial. *BMC Medicine, 13*(150). doi:10.1186/s12916-015-0375-7

Publications

Hooker, L., Small, R., Humphreys, C., Hegarty, K., & Taft, A. (2015). Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial. *Implementation Science*, 10(39).

Hooker, L., Small, R., & Taft, A. (2016). Understanding sustained domestic violence identification in maternal and child health nurse care: process evaluation from a 2-year follow-up of the MOVE trial *Journal of Advanced Nursing, 72*(3), 534-544. doi:10.1111/jan.12851

Hooker, L., & Taft, A. (in press). Using theory to implement sustained nurse domestic violence screening and supportive care interventions. *Journal of Research in Nursing*.

Acknowledgements

MOVE Coordinators: Catina Adams, Ruby Walter and Leesa Hooker

MCH Nurse Teams:

Maribyrnong, Melton, Moreland , Hobson's Bay, Brimbank, Darebin, Whittlesea and Yarra

Domestic Violence Services:

Women's Health West

Berry Street Domestic Violence services

Funding:

Australian Government
Australian Research Council

VicHealth

Supported by the Victorian Government
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