

A Tool for Measuring Physician Readiness to Manage Intimate Partner Violence

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Background: Intimate partner (domestic) violence (IPV) is a common problem in medical practice that is associated with adverse health outcomes. There are widespread calls to improve IPV education for physicians, but there are few valid, reliable, easily available, and comprehensive measures of physician IPV knowledge, attitudes, and practices that can be used to assess training effectiveness.

Methods: In 2002, expert consensus and previous surveys were used to develop a new survey-based IPV self-assessment tool that included more information on current IPV knowledge and practices than previous tools. The draft tool was evaluated using standard psychometric techniques in a group of 166 physicians in 2002, revised, and then retested in a second group of 67 physicians on three occasions in 2003 and 2004. Analyses were conducted in 2005.

Results: The draft IPV survey tool demonstrated good internal consistency reliability, with Cronbach's $\alpha \geq 0.65$ for ten final scales. The developed scales were closely correlated with theoretical constructs and predictive of self-reported behaviors. On repeat testing, a revised version of the tool was found to have good stability of psychometric properties in a different physician population (Cronbach's $\alpha \geq 0.65$, and internal correlations as predicted), good correlation with measured office IPV practices, and stable results in this population over 12 months.

Conclusions: The final version of this instrument, named the PREMIS (Physician Readiness to Manage Intimate Partner Violence Survey) tool, is a 15-minute survey that is a comprehensive and reliable measure of physician preparedness to manage IPV patients. This tool is publicly available and can be used to measure the effectiveness of IPV educational programs.
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Background

Intimate partner (domestic) violence, IPV, is a common problem in medical practice that is associated with a number of adverse health outcomes.¹⁻⁵ Many believe that these poor outcomes could be improved with better physician education,⁶⁻⁹ but, despite ongoing educational efforts, field studies continue to show that physicians rarely screen for IPV, are not aware of community resources, and are not confident in their abilities to manage IPV patients.¹⁰⁻¹² Importantly, recent medical school graduates report more

emphasis on IPV in medical school, but no improvement in their sense of IPV-related competence.¹³

One factor that may be limiting the success of IPV education programs, as well as a better understanding of physician educational needs, is a lack of convenient and well-defined educational outcome measures. Some researchers have used locally developed survey tools combined with measures of actual change in clinical practices to assess the effectiveness of their IPV education programs.¹⁴⁻¹⁷ This approach provides depth and credibility, but, since the survey tools are usually not further defined or psychometrically tested, and since the clinical data are derived from costly chart reviews or patient interviews, these outcome measures are not well suited for widespread use.

Others have used standardized self-administered survey tools to measure changes in knowledge, attitudes, beliefs, and self-reported behaviors (KABB) following IPV education. This approach is more adaptable to large-scale implementation, but requires that such tools be readily available and tested in multiple settings (i.e., generalizable). Two survey instruments in particular

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have been used to assess physician IPV KABB in multiple settings. One of these tools, developed by LMS at the Centers for Disease Control and Prevention (CDC), is a 13-scale tool that was used to measure the effectiveness of an IPV education program at the University of California-Los Angeles School of Medicine¹⁸ and two community settings.^{19,20} Although this tool has been described on several occasions, the development and underlying psychometric properties of the tool have not been reported in the literature. A separate six-scale IPV KABB tool was developed and tested by Maiuro et al.²¹ This tool was used by Thompson et al.²² to evaluate a live IPV training workshop, and modified by Harris et al.²³ to evaluate an online IPV continuing medical education (CME) program.

These standardized IPV survey tools have features that could be improved. Both tools gather information on provider self-assessed knowledge, attitudes, and beliefs, but neither assesses actual knowledge using current literature as a standard. Likewise, neither tool collects much information on self-reported behaviors (practice issues). For example, the tool developed by Maiuro et al.²¹ asks only about the frequency of IPV inquiry, while the Short tool asks only whether the user asks all new patients about abuse. Finally, neither tool has been shown to provide reliable results in the same population of health professionals over time. The aim of this project was to develop an easily administered, survey-based tool that would provide comprehensive and reliable measures of physician readiness to manage IPV. IPV toolkit elements are available online at www.ajpm-online.net.

Methods

Item Development

Existing IPV physician survey tools were reviewed and initial survey items were adapted from previous work, particularly items from scales developed for the CDC (LMS) and the Massachusetts Medical Society (EA). To establish content validity, the proposed survey items were reviewed by an outside group of IPV educators (see acknowledgments). These reviewers were charged with selecting existing items or developing new ones that reflected key theoretical constructs and measured important IPV educational outcomes, as described in the literature.^{24,25}

Study Populations

The characteristics of the survey tool were evaluated in two different physician populations. Initial psychometric studies were undertaken in a group of 166 practicing physician subscribers to a commercial CME website (the development group). All physician subscribers to the CME website (1100 total physician subscribers in November 2002) were offered a modest honorarium of \$30 of "store credit" at the website, which could only be used toward the purchase of CME programs, for completing the online survey. No CME credit was offered for completing the survey. The website subscriber

base has been used previously to evaluate the effectiveness of online CME programs and been found to be representative of U.S. physicians in general.²⁶

A revised, paper-based version of the survey tool was also tested on three separate occasions in a group of 67 practicing primary care physicians in Phoenix and Kansas City (the evaluation group). These physicians practiced in smaller (fewer than eight physicians) community-based practices, and were participants in a study of online IPV education²⁷ who did not receive specific IPV education during this period. Study physicians were recruited by various approaches from the population of all primary care physicians in Phoenix and Kansas City (approximately 6000 total). Physicians in this study were offered \$25 cash for completing the survey. Although the primary focus of this work was to develop a reliable and comprehensive measure of physicians' self-reported KABB, all offices that participated in the CME study were also visited to compare overall office IPV practices with individual physician self-reported practices. Office practices were assessed using standardized techniques as described elsewhere.²⁷

Psychometric Studies

Final data analyses were completed in 2005. Maximum likelihood factor analysis with an oblique rotation was used to extract key survey factors and verify how well survey items fit the constructs that they were designed to measure.^{28,29} (Factor analysis is a data-reduction technique that transforms data into linear combinations of items. Maximum likelihood analysis is an iterative process to derive parameter estimates that best fit the proposed model. Oblique rotation allows the factors to be correlated, and creates the most simple structure possible among the items.) These methods were selected to obtain a chi-square estimate of fit and to allow the maximum amount of discrimination between factor loadings to be displayed. Cronbach's alpha coefficient was used to determine internal consistency reliability within identified scales.

The construct validity of identified scales was tested by examining the relationship between empirically derived scales and objective values assigned to items, based on the expert panel's original theoretical constructs, using the Rand coefficient.³⁰ The Rand coefficient compares items grouped according to two different clustering solutions and ranges between 0 and 1, with higher values indicating higher levels of agreement between the two solutions. Additionally, correlations among survey items that should be related, such as opinions about the adequacy of previous training and opinions about perceived levels of preparation, were determined. Multiple regression analysis was used to test the internal predictive validity of key survey items.

External Reliability and Validity Studies

Multiple analysis of variance (MANOVA) was used to compare survey item results between two groups of physicians and within the same group of physicians over time. Correlation coefficients were used to measure the relationship between physician self-reported behaviors on the survey and actual office practices as measured during a site visit.

Results

Item Development

The draft instrument developed in conjunction with the expert reviewers contained an 11-question respondent profile (used for tracking and group demographics) and 90 proposed survey questions, some of which had multiple components. Survey questions were grouped into four major sections: (1) background (four items/scales dealing with type of previous IPV training, amount in hours of previous IPV training, perceived [felt] IPV knowledge, and perceived [felt] IPV preparation); (2) actual knowledge (a scale containing 19 multiple choice, matching, and true/false questions); (3) IPV opinions (54 individual questions concerning attitudes and beliefs, scored on a seven-point Likert-type scale from strongly disagree to strongly agree; some opinion items were intentionally worded negatively and were reversed scored); and (4) practice issues (a 13-item scale dealing with self-reported behaviors, such as individual and office IPV practices and policies).

Initial Psychometric Study

The prototype survey instrument was completed online in November 2002 by 166 physicians. Most (76%) of the sample were male and their mean age was 50.4 years (standard deviation [SD]=11.8). Respondents were entirely from the United States. The most common medical specialties were family medicine (22.8%), internal medicine (19.8%), and obstetrics and gynecology (7.8%), although 38 specialties were represented. Respondents had practiced a mean of 20.03 (SD=12.53) years. Approximately 17% did not see patients, but over half saw >60 patients per week. Of the 80% of physicians who provided information on their previous IPV training, 13.5% ($n=18$) had received no previous training, 35.3% had received ≤ 2 hours, 71% had received ≤ 6 hours of training, and 4.8% had received ≥ 25 hours of training.

Instrument Testing and Refinement

Respondents in the initial study group were asked about type, amount, and perceived effectiveness of previous IPV training in the background section of the instrument. The type of previous training was a descriptive item and was not included in the psychometric analyses, nor is it part of the final tool. The amount of previous IPV training was an estimate of total number of hours. The perceived preparation scale included 11 items asking respondents how prepared that they felt they were to work with IPV victims. Scores and responses ranged from 1 (not prepared) to 7 (well prepared), with a mean score of 4.14 (SD=1.49) across all 11 items. Internal consistency of this scale was high ($\alpha=0.959$). The perceived knowledge scale contained

16 items asking how much respondents felt that they knew about IPV. Scores and responses on these questions ranged from 1 (nothing) to 5 (very much), with a mean score of 3.00 (SD=0.82). Internal consistency among items on this scale was also high ($\alpha=0.963$).

The actual knowledge scale was based on findings from the IPV literature, and included 8 multiple choice items and 11 true/false items. Measurement of internal consistency for this criterion-referenced section of the instrument was not appropriate.³¹ A total score of correct items was used to represent actual IPV knowledge.

Data from the 54 items in the opinions section of the tool showed that 13 items from earlier survey tools, which primarily represented the physician's role in IPV (e.g., Healthcare providers should not be responsible for identifying cases of IPV; Nothing I do would help prevent future incidents of violence to a victim of IPV), were very skewed, demonstrating a ceiling effect in which where almost all respondents had high scores in the appropriate direction. These items were, therefore, eliminated from the tool.

Initial factor analysis of the remaining 41 opinion items revealed a good-fit ten-factor solution ($\chi^2=629.323$, $df=585$, $p=0.100$). Only factor loadings over 0.2 were displayed. Consequently, over one quarter of the items loaded on a single factor. Where items loaded on two or more factors, the highest loading was used for scale assignment. In most cases, this loading was considerably higher than loadings on other factors (e.g., 0.656 vs 0.258). One factor contained only one item that did not load higher on another factor. Therefore, the reliability of the opinion scales identified in the remaining nine factors was tested.

Using the alpha coefficient to determine the internal consistency reliability within each identified opinion scale, several items were found that could be dropped without losing critical information, and two scales demonstrated insufficient cohesion. After dropping the items that either did not contribute to the scale or were redundant, 36 items remained in the opinions section. Eighteen of these 36 items were from the CDC instrument, 9 were re-worded from the CDC instrument, and 9 were new. Six good-fit scales with 31 items were identified in this section ($\alpha \geq 0.65$), with an additional two scales that were kept for future testing. These eight opinion scales, a sample of contributing items, and their alpha coefficients are displayed in Table 1.

Construct Validity

One measure of construct validity is the extent to which survey items and scales are consistent with their original theoretical constructs. The Rand coefficient for the relationship between the eight empirically derived opinion scales and the objective values assigned to items according to the original theoretical constructs

Table 1. Final opinion survey scales

Scale	Alpha	Total items	Sample item
(1) Preparation	0.85	5	I do not have sufficient training to assist individuals in addressing situations of IPV. (Reverse scored)
(2) Legal requirements	0.82	4	I am aware of legal requirements in this state regarding reporting of suspected cases of: (a) IPV; (b) child abuse; (c) elder abuse.
(3) Workplace issues	0.79	6	There is adequate private space for me to provide care for victims of IPV.
(4) Self-efficacy	0.69	6	I am able to gather the necessary information to identify IPV as the underlying cause of patient illness (e.g., depression, migraines).
(5) Alcohol/drugs	0.70	3	Alcohol abuse is a leading cause of IPV. (Reverse scored)
(6) Victim understanding	0.69	7	Screening for IPV is likely to offend those who are screened. (Reverse scored)
Opinion scales not used in final version			
(7) Constraints	0.47	2	Healthcare providers do not have the time to assist patients in addressing IPV. (Reverse scored)
(8) Victim autonomy	0.37	3	Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.

IPV, interpersonal violence.

developed by the expert panel was 0.89, indicating a high degree of association between the original theoretical constructs and the empirical scales derived with the factor analysis.

Another measure of construct validity is the correlation between instrument scales, which, while measuring different aspects of a physician's preparedness to manage IPV, should move in the same direction. As expected, the perceived knowledge score was significantly correlated with the amount of previous training ($R=0.337$, $p=0.000$) and perceived preparation ($R=0.789$, $p=0.000$). Actual knowledge was also correlated with perceived knowledge ($R=0.201$, $p=0.012$), but, interestingly, not with the amount of previous training or with perceived preparation. Correlations between the three Background item/scales, the actual knowledge scale, and all eight opinion scales are shown in Table 2. As seen in Table 2, five of the six reliable opinion scales and one of the test opinion scales were significantly correlated with perceived preparation, and

perceived knowledge. All opinion scales except those dealing with legal requirements, the relationship between IPV and alcohol/drug use, and victim autonomy were significantly correlated with amount of previous training. All scales except those dealing with preparation, legal requirements, and constraints were significantly correlated with actual knowledge. Several of the reliable opinion scales were also correlated with each other, as shown in Table 3.

A third measure of construct validity is the extent to which self-assessed knowledge, attitudes, and beliefs predict self-reported behaviors. Unlike other standardized IPV surveys, the practice issues section of this survey tool included a diverse list of 13 items related to the physician's actual practice, such as situations in which the physician screens for IPV, actions taken when IPV is identified, the presence and use of IPV resource materials in the practice, and familiarity with workplace policies and community resources. The score for the practice issues scale was based on the sum of appropri-

Table 2. Correlations between opinion, background, and actual knowledge scales, psychometric study

Opinion scales	Background item/scales			
	Amount of prior training	Perceived preparation	Perceived knowledge	Actual knowledge
Preparation	0.319**	0.456**	0.492**	0.151
Legal requirements	0.160	0.535**	0.661**	0.105
Workplace issues	0.398**	0.625**	0.641**	0.175*
Self-efficacy	0.314**	0.623**	0.670**	0.181*
Alcohol/drugs	0.155	0.067	0.117	0.165*
Victim understanding	0.237**	0.236**	0.360**	0.199*
Constraints ^a	0.262**	0.379**	0.407**	0.054
Victim autonomy ^a	0.061	-0.051	-0.030	0.213**

^aTest scales; not used in final version.

* $p<0.05$; ** $p<0.01$ (all two-tailed, all bolded).

Table 3. Correlations among opinion scales, psychometric study

Opinion scale	Preparation	Legal requirements	Workplace issues	Self-efficacy	Alcohol/drugs	Victim understanding	Constraints
Preparation	1						
Legal requirements	0.405**	1					
Workplace issues	0.412**	0.536**	1				
Self-efficacy	0.491**	0.498**	0.576**	1			
Alcohol/drugs	0.063	0.173*	0.081	0.053	1		
Victim understanding	0.204**	0.311**	0.234**	0.361**	0.058	1	
Constraints ^a	0.352**	0.433**	0.431**	0.397**	0.032	0.317**	1
Victim autonomy ^a	0.084	0.086	0.014	0.062	0.212**	0.111	0.080

^aNot used in final version.

* $p < 0.05$; ** $p < 0.01$ (all two-tailed, all bolded).

ate responses to questions in this section. The analysis showed significant correlations between scores on practice issues, all background scales, actual knowledge, and scores on six of eight opinion scales. The only predictor scales not significantly correlated with practice issues were alcohol/drugs and victim autonomy from the opinions section.

Multiple regression analysis of scores on the practice issues scale with all other scale scores entered as independent variables showed a significant relationship between these variables taken together and practice issues ($F=5.76$, $p=0.000$), which explained the variation in practice issues scores fairly well ($R=0.621$, adjusted $R^2=0.319$). A subsequent stepwise multiple regression analysis demonstrated that three of these variables—amount of previous training, and the workplace issues and self-efficacy opinion scales—best predicted variation in practice issues in the initial psychometric group (adjusted $R^2=0.345$).

External Reliability Studies

Following initial psychometric evaluation, the revised survey tool contained 72 items, which included two test opinion scales. A paper version of this tool was then evaluated in a group of 67 community-based physicians on three separate occasions, approximately 6 months apart, from September 2003 to October 2004. This evaluation group differed from the original development group of physicians in several ways. A smaller percentage of this group was male (55% vs 76%). The mean age was lower at 45.1 years ($SD=10.17$) compared to 50.4. All physicians were in community-based practice in Phoenix or Kansas City. Most (82.1%) practiced family medicine, pediatrics, or obstetrics/gynecology. Respondents had practiced a mean of 16.64 ($SD=9.917$) years versus 20.03. Over 85% saw >60 patients per week. Almost one third (31.3%) had had no previous IPV training.

The MANOVA analyses demonstrated several significant differences between the scores obtained on the survey tool from this second group of physicians and scores obtained from the original development group.

The evaluation (second) group scored significantly lower in perceived preparation than the original group ($F=14.9$, $p=0.000$) and significantly lower on one of the eight opinion scales (legal issues: $F=39.0$, $p=0.000$). On the other hand, the evaluation group scored significantly higher in actual knowledge ($F=81.5$, $p=0.000$) and on IPV practice issues ($F=10.1$, $p=0.000$). There were no significant differences in previous training, perceived knowledge, or the other seven opinion scales.

Despite the differences in survey results, the psychometric properties of the tool were consistent (reliable) between the two groups of physicians. Internal consistency reliability, as measured by the alpha statistics, was comparable on all scales (complete data available on request). For example, the perceived preparation scale was found to have an alpha of 0.902 in the evaluation group versus 0.959 in the original development group. These results also held for all eight opinion scales, although three items were removed from the self-efficacy scale to preserve an alpha of ≥ 0.65 . When the original psychometric data were re-tested with these three items removed, the internal consistency reliability for the self-efficacy scale held fairly well at 0.63. The two opinion scales that were less internally consistent in the original group, constraints and victim autonomy, were also less consistent in this group, with alpha statistics of 0.57 and 0.46, respectively.

The between-scale correlations that were identified in the original group were generally present in the evaluation group (complete data available on request). As with the original group, the perceived knowledge score was significantly correlated with hours of previous training ($R=0.85$, $p=0.019$) and the perceived preparation score ($R=0.815$, $p=0.000$). As in the earlier group, IPV knowledge was not correlated with the amount of previous training or with perceived preparation. In contrast to the earlier group, actual knowledge was not correlated with perceived knowledge either.

The evaluation group scored significantly higher than the development group on the practice issues

Table 4. Mean scale scores for evaluation study group over time, multiple analysis of variance

Scale	Baseline mean (SD)	12-month follow-up mean (SD)	Mean difference	F	<i>p</i>
Background					
Perceived preparation	3.670 (1.05)	3.761 (1.18)	0.091	0.012	0.914
Perceived knowledge	3.553 (0.97)	3.636 (1.08)	0.083	0.001	0.976
Actual knowledge					
Actual knowledge	26.000 (5.18)	26.600 (5.46)	0.600	2.217	0.146
Opinions					
Preparation	4.200 (1.11)	4.126 (1.05)	-0.074	0.001	0.976
Legal requirements	3.923 (1.15)	3.831 (0.99)	-0.110	0.005	0.942
Workplace issues	4.180 (1.05)	4.237 (1.07)	0.057	0.001	0.973
Self-efficacy	3.675 (1.26)	3.867 (1.18)	0.192	1.223	0.276
Alcohol/drugs	4.462 (0.61)	4.308 (0.60)	-0.153	3.333	0.077
Victim understanding	5.060 (0.78)	4.954 (0.80)	-0.106	0.246	0.623
Victim autonomy ^a	4.325 (0.83)	4.292 (0.83)	0.033	0.445	0.509
Constraints ^a	4.654 (1.26)	4.588 (1.26)	0.066	0.000	1.000
Practice issues					
Practice issues	12.349 (7.44)	14.400 (8.36)	2.051	3.805	0.059

^aNot used in final version.

section of the survey (see above), but the internal correlations with other predictor scales were similar. At the 0.05 level of significance, 7 of the 12 predictor variables were significantly correlated with the practice issues items, and, at the 0.1 level, the results were identical to those found in the original psychometric group. As with the original data, multiple regression analysis with all predictor variables entered into the model demonstrated a significant relationship of these variables taken together with the practice issues section ($F=5.281$, $p=0.000$), which explained the variation in this section fairly well ($R=0.741$, adjusted $R^2=0.445$).

The consistency of the survey scores over time in the same physicians was examined via MANOVA analysis. These data, shown in Table 4, indicate that survey scores were quite consistent over the 12-month period of the study, in the absence of outside IPV education or other interventions.

External (Clinical) Validity Study

Five items from the practice issues section of the instrument regarding physical evidence were similar to items obtained from site visits to evaluation physicians' offices. These items were subjected to a correlation analysis, and significant relationships were found for each element pair. These findings suggest that overall office practices in a stable environment reflected individual physician self-reported data, thus providing an extra level of external validation to this section of the survey instrument. Question wording and results are displayed in Table 5.

Discussion

This IPV survey has been named the PREMIS (Physician Readiness to Manage Intimate Partner Violence Survey) tool. In its final form (minus the constraints

and victim autonomy scales), it comprises 67 individual items and requires approximately 15 minutes to complete. The PREMIS tool has a high level of consistency with constructs that theoretically contribute to effective healthcare provider response to victims of IPV and a high level of consistency with earlier instruments. PREMIS is more current and more comprehensive than previous standardized IPV assessment tools. In addition to having been tested in multiple settings, the tool has been shown reliable and valid. Other work demonstrates that PREMIS is sensitive to change and capable of discriminating trained from nontrained physicians.²⁷ The tool, code book, and scoring methodology are freely available for use by IPV educators and program developers (a copy of the PREMIS tool and supporting information are available online at ajpm-online.net).

This instrument has potential usefulness in a number of different ways: (1) as a pre-test and needs assessment to measure physician knowledge, attitudes, beliefs, behaviors, and skills that may need to be addressed during training or other on-site intervention; (2) as a training adjunct to orient physicians to the topic and expose them to the complexity of IPV issues; (3) as a post-test to determine changes in physician KABB over time or as the result of training; and (4) as a comparative instrument to assess differences in KABB between physicians who have received training and those who have not.

Current limitations of this tool include a lack of psychometric data from nonphysician healthcare providers and a lack of correlation with individual IPV practices. While the tool could be used to assess the readiness of medical students or nurses (for instance) to manage IPV, it would be reasonable to also evaluate the tool's psychometric properties in these populations. Also, as with any self-report instrument, this survey tool does not assess actual behaviors, although the data show a good correlation between certain elements of

Table 5. Correlations between individual physician self-reported practices and overall office practices measured by site visit

Survey item	Office visit item	Correlation	<i>p</i>
Is there a protocol for dealing with adult IPV at your clinic/practice?	Does the office have a written policy or protocol addressing the screening, documentation, and referral of IPV victims?	0.270	0.029*
Is a camera available at your work site for photographing IPV victims' injuries?	Is a camera with adequate film available to photograph patient injuries?	0.534	0.000**
Are IPV patient education or resource materials (posters, brochures, etc.) available at your practice site?	Does the reviewer see public IPV information posters in the practice? Does the reviewer see IPV brochures or other patient education materials (not posters) available for patient access? ^a	0.433	0.001**
I screen all new female patients.	Do any physicians or other practitioners in this practice routinely screen all adult female patients for IPV?	0.424	0.001**
Do you feel you have adequate adult IPV referral resources for patients at your work site?	Does the practice routinely refer IPV victims to hospital social workers, public agencies, or similar assessment services?	0.262	0.041*
Do you feel you have adequate knowledge of referral resources for patients in the community (including shelters or support groups) for adult IPV victims? ^a	Does the practice routinely refer IPV victims directly to IPV service providers such as DV shelters or local DV advocacy coalitions? Have representatives of local IPV service providers (e.g., shelters) ever visited the practice for training or consultation? Does the reviewer see any evidence of contact with local IPV service providers? If yes, does the reviewer see any evidence of ongoing referrals to local IPV service providers? ^a		

^aSum of items.

p*<0.05; *p*<0.01 (all bolded).

DV, domestic violence; IPV, interpersonal violence.

the PREMIS tool and office practices measured in stable settings. Future studies should investigate not only the relationships between the KABB items on the tool and actual physician behaviors, but also the relationship among KABB items, physician behaviors, and patient outcomes.

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PREMIS Tool-Kit Instructions

The PREMIS tool-kit consists of the Physician Readiness to Manage Intimate Partner Violence instrument, codebook, and SPSS syntax and scoring information document. The instrument may be used for determining training needs as well as evaluating training programs. Needs assessment data may be used as the baseline for training evaluations, and follow-up data may be collected immediately and/or some time after the training program has occurred. Although the instrument has been psychometrically tested among physicians only, it may also be useful for other health care providers as well.

The PREMIS instrument consists of five sections: Respondent Profile, Background, Intimate Partner Violence (IPV) Knowledge, Opinions, and Practice Issues. The Respondent Profile may be altered to suit specific circumstances; however, revising other sections would compromise the reliability and validity of the tool.

The codebook and SPSS syntax and scoring documents have been provided to assist in creating the final variables to be examined or compared in additional analyses. Within each of the four latter sections of the PREMIS instrument, several items have been combined to create scales (some items need scoring or reversing prior to scale creation). The Background Section contains the two composite items, Perceived Preparation and Perceived Knowledge. In the Knowledge Section, correct items are scored and a composite created. Eight scales are derived from the Opinion Section. Finally, the Practice Issues Section contains several items that may be considered separately or as a composite item.

If the data are coded according to the codebook provided, the SPSS syntax may be used intact to achieve the variables analyzed in the published article.

Lynn M. Short, PhD, MPH

PHYSICIAN READINESS TO MANAGE INTIMATE PARTNER VIOLENCE

Background

1. Estimated total number of hours of previous IPV training: _____

2. Please circle the number which best describes how prepared you feel to perform the following:
(1 = Not prepared; 2 = Minimally; 3 = Slightly; 4 = Moderately; 5 = Fairly well; 6 = Well; 7 = Quite well prepared)

	Not Prepared				Quite Well Prepared		
	1	2	3	4	5	6	7
a. Ask appropriate questions about IPV	1	2	3	4	5	6	7
b. Appropriately respond to disclosures of abuse	1	2	3	4	5	6	7
c. Identify IPV indicators based on patient history and physical examination	1	2	3	4	5	6	7
d. Assess an IPV victim's readiness to change	1	2	3	4	5	6	7
e. Help an IPV victim assess his/her danger of lethality	1	2	3	4	5	6	7
f. Conduct a safety assessment for the victim's children	1	2	3	4	5	6	7
g. Help an IPV victim create a safety plan	1	2	3	4	5	6	7
h. Document IPV history and physical examination findings in patient's chart	1	2	3	4	5	6	7
i. Make appropriate referrals for IPV	1	2	3	4	5	6	7
j. Fulfill state reporting requirements for:							
- IPV	1	2	3	4	5	6	7
- Child abuse	1	2	3	4	5	6	7
- Elder abuse	1	2	3	4	5	6	7

3. How much do you feel you now know about:
(1 = Nothing; 2 = Very Little; 3 = A little; 4 = A moderate amount; 5 = A fair amount; 6 = Quite a bit; 7 = Very Much)

	Nothing				Very Much		
	1	2	3	4	5	6	7
a. Your legal reporting requirements for:							
- IPV	1	2	3	4	5	6	7
- Child abuse	1	2	3	4	5	6	7
- Elder abuse	1	2	3	4	5	6	7
b. Signs or symptoms of IPV	1	2	3	4	5	6	7
c. How to document IPV in patient's chart	1	2	3	4	5	6	7
d. Referral sources for IPV victims	1	2	3	4	5	6	7
e. Perpetrators of IPV	1	2	3	4	5	6	7
f. Relationship between IPV and pregnancy	1	2	3	4	5	6	7
g. Recognizing the childhood effects of witnessing IPV	1	2	3	4	5	6	7
h. What questions to ask to identify IPV	1	2	3	4	5	6	7
i. Why a victim might not disclose IPV	1	2	3	4	5	6	7
j. Your role in detecting IPV	1	2	3	4	5	6	7
k. What to say and not say in IPV situations with a patient	1	2	3	4	5	6	7
l. Determining danger for a patient experiencing IPV	1	2	3	4	5	6	7
m. Developing a safety plan with an IPV victim	1	2	3	4	5	6	7
n. The stages an IPV victim experiences in understanding and changing his/her situation	1	2	3	4	5	6	7

IPV Knowledge. Check one answer per item, unless noted otherwise.

1. What is the strongest *single* risk factor for becoming a victim of intimate partner violence?
 - Age (<30yrs)
 - Partner abuses alcohol/drugs
 - Gender – female
 - Family history of abuse
 - Don't know

2. Which *one* of the following is generally true about batterers?
 - They have trouble controlling their anger
 - They use violence as a means of controlling their partners
 - They are violent because they drink or use drugs
 - They pick fights with anyone

3. Which of the following are warning signs that a patient may have been abused by his/her partner?
(Check all that apply)
 - Chronic unexplained pain
 - Anxiety
 - Substance abuse
 - Frequent injuries
 - Depression

4. Which of the following are reasons an IPV victim may not be able to leave a violent relationship?
(Check all that apply)
 - Fear of retribution
 - Financial dependence on the perpetrator
 - Religious beliefs
 - Children's needs
 - Love for one's partner
 - Isolation

5. Which of the following are the most appropriate ways to ask about IPV?
(Check all that apply)
 - "Are you a victim of intimate partner violence?"
 - "Has your partner ever hurt or threatened you?"
 - "Have you ever been afraid of your partner?"
 - "Has your partner ever hit or hurt you?"

6. Which of the following is/are generally true? (Check all that apply)
 - There are common non-injury presentations of abused patients
 - There are behavioral patterns in couples that may indicate IPV
 - Specific areas of the body are most often targeted in IPV cases
 - There are common injury patterns associated with IPV
 - Injuries in different stages of recovery may indicate abuse

7. Please label the following descriptions of the behaviors and feelings of patients with a history of IPV with the appropriate stage of change.

1 = Precontemplation 2 = Contemplation 3 = Preparation
 4 = Action 5 = Maintenance 6 = Termination

- Begins making plans for leaving the abusive partner
- Denies there's a problem
- Begins thinking the abuse is not their own fault
- Continues changing behaviors
- Obtains order(s) for protection

8. Circle **T** for "true", **F** for "false", or **DK** if you "don't know" the answer to the following:

- a. Alcohol consumption is the greatest single predictor of the likelihood of IPV. T F DK
- b. There are good reasons for not leaving an abusive relationship. T F DK
- c. Reasons for concern about IPV should not be included in a patient's chart if s/he does not disclose the violence. T F DK
- d. When asking patients about IPV, physicians should use the words "abused" or "battered." T F DK
- e. Being supportive of a patient's choice to remain in a violent relationship would condone the abuse. T F DK
- f. Victims of IPV are able to make appropriate choices about how to handle their situation. T F DK
- g. Health care providers should not pressure patients to acknowledge that they are living in an abusive relationship. T F DK
- h. Victims of IPV are at greater risk of injury when they leave the relationship. T F DK
- i. Strangulation injuries are rare in cases of IPV. T F DK
- j. Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim. T F DK
- k. Even if the child is not in immediate danger, physicians in all states are mandated to report an instance of a child witnessing IPV to Child Protective Services. T F DK

Opinions

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

<i>Statements</i>	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Agree</i>	<i>Strongly Agree</i>			
1. If an IPV victim does not acknowledge the abuse, there is very little that I can do to help.	1	2	3	4	5	6	7
2. I ask all new patients about abuse in their relationships.	1	2	3	4	5	6	7
3. My workplace encourages me to respond to IPV.	1	2	3	4	5	6	7
4. I can make appropriate referrals to services within the community for IPV victims.	1	2	3	4	5	6	7
5. I am capable of identifying IPV without asking my patient about it.	1	2	3	4	5	6	7
6. I do not have sufficient training to assist individuals in addressing situations of IPV.	1	2	3	4	5	6	7

Statements	Strongly Disagree	Disagree	Agree	Strongly Agree			
7. Patients who abuse alcohol or other drugs are likely to have a history of IPV.	1	2	3	4	5	6	7
8. I feel comfortable discussing IPV with my patients.	1	2	3	4	5	6	7
9. I don't have the necessary skills to discuss abuse with an IPV victim who is:							
a) Female.	1	2	3	4	5	6	7
b) Male.	1	2	3	4	5	6	7
c) From a different cultural/ethnic background.	1	2	3	4	5	6	7
10. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for the violence.	1	2	3	4	5	6	7
11. I am aware of legal requirements in this state regarding reporting of suspected cases of:							
a) IPV.	1	2	3	4	5	6	7
b) Child abuse.	1	2	3	4	5	6	7
c) Elder abuse.	1	2	3	4	5	6	7
12. I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g., depression, migraines).	1	2	3	4	5	6	7
13. If a patient refuses to discuss the abuse, staff can only treat the patient's injuries.	1	2	3	4	5	6	7
14. Victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
15. I comply with the Joint Commission standards that require assessment for IPV.	1	2	3	4	5	6	7
16. Health care providers have a responsibility to ask all patients about IPV.	1	2	3	4	5	6	7
17. My practice setting allows me adequate time to respond to victims of IPV.	1	2	3	4	5	6	7
18. I have contacted services within the community to establish referrals for IPV victims.	1	2	3	4	5	6	7
19. Alcohol abuse is a leading cause of IPV.	1	2	3	4	5	6	7
20. Screening for IPV is likely to offend those who are screened.	1	2	3	4	5	6	7
21. There is adequate private space for me to provide care for victims of IPV.	1	2	3	4	5	6	7
22. I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (e.g., bruises, fractures, etc.).	1	2	3	4	5	6	7
23. Women who choose to step out of traditional roles are a major cause of IPV.	1	2	3	4	5	6	7
24. Health care providers do not have the knowledge to assist patients in addressing IPV.	1	2	3	4	5	6	7
25. I can match therapeutic interventions to an IPV patient's readiness to change.	1	2	3	4	5	6	7
26. Use of alcohol or other drugs is related to IPV victimization.	1	2	3	4	5	6	7
27. I can recognize victims of IPV by the way they behave.	1	2	3	4	5	6	7

Practice Issues

1. How many *new diagnoses* (picked up an acute case, uncovered ongoing abuse, or had a patient disclose a past history) of IPV would you estimate you have made in the last 6 months?

- None
- 1-5
- 6-10
- 11-20
- 21 or more
- N/A – not in clinical practice

2. Check the situations listed below in which you currently screen for IPV: (“screening” means asking about IPV in the absence of specific statements by the patient disclosing IPV; check all that apply)

- Not applicable – I am not in clinical practice
- I do not currently screen
- I screen *all* new patients
- I screen *all* new female patients
- I screen *all* patients with abuse indicators on history or exam
- I screen *all* female patients at the time of their annual exam
- I screen *all* pregnant patients at specific times of their pregnancy
- I screen *all* patients periodically
- I screen *all* female patients periodically
- I screen certain patient categories only (Check below)
 - Teenagers
 - Young adult women (under 30 years old)
 - Elderly women (over 65 years old)
 - Single or divorced women
 - Married women
 - Women with alcohol or other substance abuse
 - Single mothers
 - Black or Hispanic women
 - Immigrant women
 - Lesbian women
 - Homosexual men
 - Depressed/suicidal women
 - Pregnant women
 - Mothers of all my pediatric patients (if applicable)
 - Mothers of pediatric patients who show signs of witnessing IPV
 - Mothers of children with confirmed or suspected child abuse, neglect
 - Other. Please specify: _____

3. How often in the past 6 months have you asked about the possibility of IPV when seeing patients with the following:

	Never	Seldom	Some- times	Nearly always	Always	N/A
a. Injuries	1	2	3	4	5	6
b. Chronic pelvic pain	1	2	3	4	5	6
c. Irritable bowel syndrome	1	2	3	4	5	6
d. Headaches	1	2	3	4	5	6
e. Depression/anxiety	1	2	3	4	5	6
f. Hypertension	1	2	3	4	5	6
g. Eating disorders	1	2	3	4	5	6

4. In the past 6 months, which of the following actions have you taken when you identified IPV? (*Check all that apply*)

- Have not identified IPV in past 6 months
- Provided information (phone numbers, pamphlets, other information) to patient
- Counseled patient about options she/he may have
- Conducted a safety assessment for the victim
- Conducted a safety assessment for victim's children
- Helped patient develop a personal safety plan
- Referred patient to:
 - Individual therapy
 - Couples therapy
 - Child therapy/support group
 - On-site social worker/advocate
 - Battered women's program/shelter
 - Alcohol/substance abuse counseling
 - Local DV/IPV hotline
 - Police, sheriff, or other local law enforcement
 - Housing, educational, job, or financial assistance
 - Other referral (*describe*): _____
 - Other action (*describe*): _____
 - Child Protective Services
 - Legal advocate/victim witness advocate
 - Batterers' treatment program
 - Religious leader/organization
 - Battered women/s support group
 - National DV/IPV hotline
 - Lesbian/Gay/Transgender/Bisexual support group

5. Is there a protocol for dealing with adult IPV at your clinic/practice? (*Check one*)

- Yes, and widely used
- Yes, and used to some extent
- Yes, but not used
- No
- Unsure
- Not applicable to my patient population
- I am not currently in a clinical practice

6. Are you familiar with your institution's policies regarding screening and management of IPV victims?

- Yes No N/A

7. Is a camera available at your work site for photographing IPV victims' injuries?

- Yes - - *Type*: Polaroid or other instant camera, Digital, Other: _____
- No
- Unsure
- Not applicable to my patient population
- I am not currently in a clinical practice

8. Do you practice in a state where it is legally mandated to report IPV cases involving competent (nonvulnerable) adults?

- Yes
- No
- Unsure
- N/A (Not in practice)

9. For every IPV victim you have identified in the past 6 months, how often have you:	Never	Seldom	Some- times	Nearly always	Always	N/A
a. Documented patient's statements re IPV in chart	1	2	3	4	5	6
b. Used a body map to document patient injuries	1	2	3	4	5	6
c. Photographed victim's injuries to include in chart	1	2	3	4	5	6
d. Notified appropriate authorities when mandated	1	2	3	4	5	6
e. Conducted a safety assessment for victim	1	2	3	4	5	6
f. Conducted a safety assessment for victim's children	1	2	3	4	5	6
g. Helped an IPV victim develop a safety plan	1	2	3	4	5	6
h. Contacted an IPV service provider	1	2	3	4	5	6
i. Offered validating or supportive statements	1	2	3	4	5	6
j. Provided basic information about IPV	1	2	3	4	5	6
k. Provided referral and/or resource information	1	2	3	4	5	6

10. Are IPV patient education or resource materials (posters, brochures, etc.) available at your practice site? (Check one)

- Yes, well-displayed, and accessed by patients
- Yes, well-displayed, but not accessed by patients
- Yes, but not well-displayed
- No
- Unsure
- Not applicable to my patient population
- Am not currently in a clinical practice

11. Do you provide abused patients with IPV patient education or resource materials? (Check one)

- Yes, almost always
- Yes, when it is safe for the patient
- Yes, but only upon patient request
- No, due to inadequate referral resources in the community
- No, because I do not feel these materials are useful in general
- No, other reason (*specify*) _____
- Not applicable to my patient population
- I am not currently in a clinical practice

12. Do you feel you have adequate adult IPV referral resources for patients at your work site (including mental health referral)?

- Yes
- No
- Unsure
- I am not currently in a clinical practice
- Not applicable to my patient population

13. Do you feel you have adequate knowledge of referral resources for patients in the community (including shelters or support groups) for adult IPV victims?

- Yes
- No
- Unsure
- I am not currently in a clinical practice
- Not applicable to my patient population

Thank you for completing this survey.

Section II: Background

1. **PrevTrn** How much previous training about intimate partner violence (IPV/DV) issues have you had? (Please check all that apply.) **Code each response as a separate 0/1 item**

- PrvTrn01 [] None
- PrvTrn02 [] Read my institution’s protocol
- PrvTrn03 [] Watched a video
- PrvTrn04 [] Attended a lecture or talk
- PrvTrn05 [] Attended a skills-based training or workshop
- PrvTrn06 [] Medical/nursing/other school—classroom training
- PrvTrn07 [] Medical/nursing/other school—clinical setting
- PrvTrn08 [] Residency/fellowship/other post grad training
- PrvTrn09 [] CME program
- PrvTrn10 [] Other in-depth training (more than 4 hours)
- PrvTrn11 [] Other (specify) PrvTrnOt: _____

2. **HrsPrTrn** Estimated total number of hours of previous IPV training: _____

3. **Prep** (Code these PrepA, PrepB..., PrepJ1, PrepJ2, PrepJ3) Please circle the number which best describes how prepared you feel to perform the following:

(1 = Not prepared; 2 = Minimally prepared; 3 = Slightly prepared; 4 = Moderately prepared; 5 = Fairly well prepared; 6 = Well prepared; 7 = Quite well prepared)

	<i>Not Prepared</i>			<i>Quite Well Prepared</i>				
a. Ask appropriate questions about IPV	1	2	3	4	5	6	7	
b. Appropriately respond to disclosures of abuse	1	2	3	4	5	6	7	
c. Identify IPV indicators based on patient history, and physical examination		1	2	3	4	5	6	7
d. Assess an IPV victim’s readiness to change	1	2	3	4	5	6	7	
e. Help an IPV victim assess his/her danger of lethality	1	2	3	4	5	6	7	
f. Conduct a safety assessment for the victim’s children	1	2	3	4	5	6	7	
g. Help an IPV victim create a safety plan	1	2	3	4	5	6	7	
h. Document IPV history and physical examination findings in patient’s chart	1	2	3	4	5	6	7	
i. Make appropriate referrals for IPV	1	2	3	4	5	6	7	
j. Fulfill state reporting requirements for:								
- IPV	1	2	3	4	5	6	7	
- Elder abuse	1	2	3	4	5	6	7	
- Child abuse	1	2	3	4	5	6	7	

4. **FItKn** (Code FItKnA1, FeltKnIA2,... FeltKnN) How much do you feel you now know about: (1 = Nothing; 2 = Very Little; 3 = A little; 4 = A moderate amount; 5 = A fair amount; 6 = Quite a bit; 7 = Very Much)

	<i>Nothing</i>			<i>Very Much</i>				
a. Your legal reporting requirements for:								
- IPV	1	2	3	4	5	6	7	
- Child abuse	1	2	3	4	5	6	7	
- Elder abuse	1	2	3	4	5	6	7	
b. Signs or symptoms of IPV	1	2	3	4	5	6	7	
c. How to document IPV in patient’s chart	1	2	3	4	5	6	7	
d. Referral sources for IPV victims	1	2	3	4	5	6	7	
e. Perpetrators of IPV	1	2	3	4	5	6	7	
f. Relationship between IPV and pregnancy	1	2	3	4	5	6	7	
g. Recognizing the childhood effects of witnessing IPV	1	2	3	4	5	6	7	
h. What questions to ask to identify IPV	1	2	3	4	5	6	7	
i. Why a victim might not disclose IPV	1	2	3	4	5	6	7	
j. Your role in detecting IPV		1	2	3	4	5	6	7
k. What to say and not say in IPV situations with a patient	1	2	3	4	5	6	7	
l. Determining danger for a patient experiencing IPV	1	2	3	4	5	6	7	
m. Developing a safety plan with an IPV victim	1	2	3	4	5	6	7	
n. The stages an IPV victim experiences in understanding								

and changing his/her situation

1 2 3 4 5 6 7

Section III: IPV Knowledge. Check one answer per item, unless noted otherwise.

1. **KnRisk** What is the strongest *single* risk factor for becoming a victim of intimate partner violence?

- [1] Age (<30yrs)
- [2] Partner abuses alcohol/drugs
- [3] Gender – female
- [4] Family history of abuse
- [9] Don't know

2. **KnBatr** Which *one* of the following is generally true about batterers?

- [1] They have trouble controlling their anger
- [2] They use violence as a means of controlling their partners
- [3] They are violent because they drink or use drugs
- [4] They pick fights with anyone

3. Which of the following are warning signs that a patient may have been abused by his/her partner?
(check all that apply) **Code each response as a separate 0/1 item**

- KnWrng1** [] Chronic unexplained pain
- KnWrng2** [] Anxiety
- KnWrng3** [] Substance abuse
- KnWrng4** [] Frequent injuries
- KnWrng5** [] Depression

4. Which of the following are reasons an IPV victim may not be able to leave a violent relationship?
(check all that apply) **Code each response as a separate 0/1 item**

- KnCntLv1** [] Fear of retribution
- KnCntLv2** [] Financial dependence on the perpetrator
- KnCntLv3** [] Religious beliefs
- KnCntLv4** [] Children's needs
- KnCntLv5** [] Love for one's partner
- KnCntLv6** [] Isolation

5. Which of the following are the most appropriate ways to ask about IPV?
(check all that apply) **Code each response as a separate 0/1 item**

- KnAsk1** [] "Are you a victim of intimate partner violence?"
- KnAsk2** [] "Has your partner ever hurt or threatened you?"
- KnAsk3** [] "Have you ever been afraid of your partner?"
- KnAsk4** [] "Has your partner ever hit or hurt you?"

6. Which of the following is/are generally true? (check all that apply) **Code each response as a separate 0/1 item**

- KnInj1** [] There are common, non-injury presentations of abused patients
- KnInj2** [] There are behavioral patterns in couples that may indicate IPV
- KnInj3** [] Specific areas of the body are most often targeted in IPV cases
- KnInj4** [] There are common injury patterns associated with IPV
- KnInj5** [] Injuries in different stages of recovery may indicate abuse

7. Please label the following descriptions of the behaviors and feelings of patients with a history of IPV with the appropriate stage of change.

- 1 = Pre-contemplation 2 = Contemplation 3 = Preparation
 4 = Action 5 = Maintenance 6 = Termination

- KnSOCA [] Begins making plans for leaving the abusive partner
 KnSOCB [] Denies there's a problem
 KnSOCC [] Begins thinking the abuse is not their own fault
 KnSOCD [] Continues changing behaviors
 KnSOCE [] Obtains order(s) for protection

8. Circle **T** for "true", **F** for "false", or **DK** if you "don't know" the answer to the following: **Code T=1; F=2; DK=9**

Kn8a – Kn8k

- a. Alcohol consumption is the greatest single predictor of the likelihood of IPV. T F DK
 b. There are no good reasons for not leaving an abusive relationship T F DK
 c. Reasons for concern about IPV should not be included in a patient's chart if s/he does not disclose the violence. T F DK
 d. When asking patients about IPV, physicians should use the words "abused" or "battered." T F DK
 e. Being supportive of a patient's choice to remain in a violent relationship would condone the abuse. T F DK
 f. Victims of IPV are able to make appropriate choices about how to handle their situation. T F DK
 g. Health care providers should not pressure patients to acknowledge that they are living in an abusive relationship. T F DK
 h. Victims of IPV are at greater risk of injury when they leave the relationship. T F DK
 i. Strangulation injuries are rare in cases of IPV. T F DK
 j. Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim T F DK
 k. Even if the child is not in immediate danger, physicians in all states are mandated to report an instance of a child witnessing IPV to Child Protective Services T F DK

Section IV: Opinions

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

O1 – O32

Statements	Strongly Disagree	Disagree	Agree	Strongly Agree			
1. If an IPV victim does not acknowledge the abuse, there is very little that I can do to help.	1	2	3	4	5	6	7
2. I ask all new patients about abuse in their relationships.	1	2	3	4	5	6	7
3. My workplace encourages me to respond to IPV.	1	2	3	4	5	6	7
4. I can make appropriate referrals to services within the community for IPV victims.	1	2	3	4	5	6	7
5. I am capable of identifying IPV without asking my patient about it.	1	2	3	4	5	6	7
6. I do not have sufficient training to assist individuals in addressing situations of IPV.	1	2	3	4	5	6	7
7. Patients who abuse alcohol or other drugs are likely to have a history of IPV.	1	2	3	4	5	6	7
8. Victims of abuse have the right to make their own decisions about whether hospital staff should intervene.	1	2	3	4	5	6	7

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<i>Statements</i>	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Agree</i>	<i>Strongly Agree</i>			
9. I feel comfortable discussing IPV with my patients.	1	2	3	4	5	6	7
10. I don't have the necessary skills to discuss abuse with an IPV victim who is:							
a) Female	1	2	3	4	5	6	7
b) Male	1	2	3	4	5	6	7
c) from a different cultural/ethnic background	1	2	3	4	5	6	7
11. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.	1	2	3	4	5	6	7
12. I am aware of legal requirements in this state regarding reporting of suspected cases of:							
a) IPV	1	2	3	4	5	6	7
b) child abuse	1	2	3	4	5	6	7
c) elder abuse	1	2	3	4	5	6	7
13. Health care providers do not have the time to assist patients in addressing IPV.	1	2	3	4	5	6	7
14. I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g., depression, migraines).	1	2	3	4	5	6	7
15. If a patient refuses to discuss the abuse, staff can only treat the patient's injuries.	1	2	3	4	5	6	7
16. Victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
17. I comply with the Joint Commission standards that require assessment for IPV.	1	2	3	4	5	6	7
18. Health care providers have a responsibility to ask all patients about IPV.	1	2	3	4	5	6	7
19. My practice setting allows me adequate time to respond to victims of IPV.	1	2	3	4	5	6	7
20. I have contacted services within the community to establish referrals for IPV victims.	1	2	3	4	5	6	7
21. Alcohol abuse is a leading cause of IPV.	1	2	3	4	5	6	7
22. Victims of abuse often have valid reasons for remaining in the abusive relationship.	1	2	3	4	5	6	7
23. I am too busy to participate on a multidisciplinary team that manages IPV cases.	1	2	3	4	5	6	7
24. Screening for IPV is likely to offend those who are screened.	1	2	3	4	5	6	7
25. There is adequate private space for me to provide care for victims of IPV.	1	2	3	4	5	6	7
26. I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (e.g., bruises, fractures, etc.).	1	2	3	4	5	6	7
27. Women who choose to step out of traditional roles are a major cause of IPV.	1	2	3	4	5	6	7
28. Health care providers do not have the knowledge to assist patients in addressing IPV.	1	2	3	4	5	6	7
29. I can match therapeutic interventions to an IPV patient's readiness to change.	1	2	3	4	5	6	7
30. I understand why IPV victims do not always comply with staff recommendations.	1	2	3	4	5	6	7
31. Use of alcohol or other drugs is related to IPV victimization.	1	2	3	4	5	6	7
32. I can recognize victims of IPV by the way they behave.	1	2	3	4	5	6	7

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Section V: Practice Issues

1. **NewDiag** How many *new diagnoses* (picked up an acute case, uncovered ongoing abuse, or had a patient disclose a past history) of intimate partner violence (IPV) would you estimate you have made in the last 6 months?

- [0] None
- [1] 1-5
- [2] 6-10
- [3] 11-20
- [4] 21 or more
- [9] N/A – not in clinical practice

2. Check the situations listed below in which you currently screen for IPV: (*check all that apply*)

Code each response as a separate 0/1 item

- CurScr9 Not applicable – I am not in clinical practice
- CurScr0 I do not currently screen
- CurScr1 I screen all new patients
- CurScr2 I screen all new female patients
- CurScr3 I screen all patients with abuse indicators on history or exam
- CurScr4 I screen all female patients at the time of their annual exam
- CurScr5 I screen all pregnant patients at specific times of their pregnancy
- CurScr6 I screen all patients periodically
- CurScr7 I screen all female patients periodically
- CurScr8 I screen certain patient categories only (check below)
 - CurScr8a Teenagers
 - CurScr8b Young adult women (under 30 years old)
 - CurScr8c Elderly women (over 65 years old)
 - CurScr8d Single or divorced women
 - CurScr8e Married women
 - CurScr8f Women with alcohol or other substance abuse
 - CurScr8g Single mothers
 - CurScr8h Black or Hispanic women
 - CurScr8i Immigrant women
 - CurScr8j Lesbian women
 - CurScr8k Homosexual men
 - CurScr8l Depressed/suicidal women
 - CurScr8m Pregnant women
 - CurScr8n Mothers of all my pediatric patients (if applicable)
 - CurScr8o Mothers of pediatric patients who show signs of witnessing IPV
 - CurScr8p Mothers of children with confirmed or suspected child abuse, neglect
 - CurScr8q Other. Please specify:
 - CurScrOt _____

3. How often in the past six months have you asked about the possibility of IPV when seeing patients with the following:

	Never	Seldom	Some-time	Nearly always	Always	N/A
--	-------	--------	-----------	---------------	--------	-----

QinSita – QinSitg

a. Injuries	1	2	3	4	5	6
b. Chronic pelvic pain	1	2	3	4	5	6
c. Irritable bowel syndrome	1	2	3	4	5	6
d. Headaches	1	2	3	4	5	6
e. Depression/Anxiety	1	2	3	4	5	6
f. Hypertension	1	2	3	4	5	6
g. Eating disorders	1	2	3	4	5	6

4. In the past 6 months, which of the following actions have you taken when you identified IPV? (check all that apply) **Code each response as a separate 0/1 item**

- IDAAct0 [] Have not identified IPV in past 6 months
- IDAAct1 [] Provided information (phone numbers, pamphlets, other information) to patient
- IDAAct2 [] Counseled patient about options she / he may have
- IDAAct3 [] Conducted a safety assessment for the victim
- IDAAct4 [] Conducted a safety assessment for victim's children
- IDAAct5 [] Helped patient develop a personal safety plan
- IDAAct6 [] Referred patient to:
 - IDAAct6a [] Individual therapy
 - IDAAct6b [] Child Protective Services
 - IDAAct6c [] Couples therapy
 - IDAAct6d [] Legal advocate/victim witness advocate
 - IDAAct6e [] Child therapy/support group
 - IDAAct6f [] Batterers' treatment program
 - IDAAct6g [] On-site social worker/advocate
 - IDAAct6h [] Religious leader/organization
 - IDAAct6i [] Battered women's program/shelter
 - IDAAct6j [] Battered women/s support group
 - IDAAct6k [] Alcohol/substance abuse counseling
 - IDAAct6l [] National DV/IPV Hotline
 - IDAAct6m [] Local DV/IPV hotline
 - IDAAct6n [] Lesbian/Gay/Transvestite/Bisexual support

group

- IDAAct6o [] Police, sheriff, or other local law enforcement
- IDAAct6p [] Housing, educational, job or financial assistance
- IDAAct6q [] Other referral (describe): IDAct6qD: _____
- IDAAct6r [] Other action (describe): IDAct6rD: _____

5. Protocol Is there a protocol for dealing with adult IPV at your clinic/practice? (check one)

- Protocol**
- [3] Yes, and widely used
- [2] Yes, and used to some extent
- [1] Yes, but not used
- [0] No
- [7] Unsure
- [8] Not applicable to my patient population
- [9] I am not currently in a clinical practice

6. Policies Are you familiar with your institution's policies regarding screening & management of IPV victims?

Policies

- [1] Yes [0] No [9] N/A

7. Camera Is a camera available at your work site for photographing IPV victims' injuries?

Camera

- [1] Yes -- Type: **CamPolar** [0/1] Polaroid or other instant camera, **CamDigit** [0/1] Digital, **CamOth** [0/1] Other: **CamOthSp** _____
- [0] No
- [7] Unsure
- [8] Not applicable to my patient population
- [9] I am not currently in a clinical practice

8. Do you practice in a state where it is legally mandated to report IPV cases involving competent (non-vulnerable) adults? **LegReprt**

- [1] Yes
- [0] No
- [7] Unsure
- [9] N/A (Not in practice)

9. For every IPV victim you have identified in the past 6 months, how often have you:

IDAct2a – IDAct2k

	<i>Never</i>	<i>Seldom</i>	<i>Some- times</i>	<i>Nearly always</i>	<i>Always</i>	<i>N/A</i>
a. Documented patient's statements re. IPV in chart	1	2	3	4	5	6
b. Used a body-map to document patient injuries	1	2	3	4	5	6
c. Photographed victim's injuries to include in chart	1	2	3	4	5	6
d. Notified appropriate authorities when mandated	1	2	3	4	5	6
e. Conducted a safety assessment for victim	1	2	3	4	5	6
f. Conducted a safety assessment for victim's children	1	2	3	4	5	6
g. Helped an IPV victim develop a safety plan	1	2	3	4	5	6
h. Contacted an IPV service provider	1	2	3	4	5	6
i. Offered validating or supportive statements	1	2	3	4	5	6
j. Provided basic information about IPV	1	2	3	4	5	6
k. Provided referral and/or resource information	1	2	3	4	5	6

10. **MatAvail** Are IPV patient education or resource materials (posters, brochures, etc.) available at your practice site? (*check one*)

- [3] Yes, well displayed, and accessed by patients
- [2] Yes, well displayed, but not accessed by patients
- [1] Yes, but not well displayed
- [0] No
- [7] Unsure
- [8] Not applicable to my patient population
- [9] Am not currently in a clinical practice

11. **MatGive** Do you provide abused patients with IPV patient education or resource materials? (*check one*)

- [5] Yes, almost always
- [4] Yes, when it is safe for the patient
- [3] Yes, but only upon patient request
- [2] No, due to inadequate referral resources in the community
- [1] No, because I do not feel these materials are useful in general
- [0] No, other reason (*specify*) MatGivOt_____
- [8] Not applicable to my patient population
- [9] I am not currently in a clinical practice

12. **RefOnSit** Do you feel you have adequate adult IPV referral resources for patients **at your work site** (including mental health referral)?

- [1] Yes
- [2] No
- [7] Unsure
- [8] I am not currently in a clinical practice
- [9] Not applicable to my patient population

13. **RefComm** Do you feel you have adequate knowledge of referral resources for patients **in the community** (including shelters or support groups) for adult IPV victims?

- [1] Yes
- [0] No
- [7] Unsure
- [8] I am not currently in a clinical practice
- [9] Not applicable to my patient population

Thank you for completing this survey.

SPSS Syntax and Scoring Information for PREMIS Tool

Section II Background:

/* Create scores for Perceived Preparation and Perceived Knowledge:

```
COMPUTE Prep =  
MEAN(prepa,prepb,prepc,prepd,prepe,prepf,prepg,preph,prepi,prepj1,prepj2,prepj3) .  
EXECUTE .  
COMPUTE FltKn = MEAN(  
fltka1,fltka2,fltka3,fltka4,fltka5,fltka6,fltka7,fltka8,fltka9,fltka10,fltka11,fltka12,fltka13,fltka14,fltka15,fltka16,fltka17,fltka18,fltka19,fltka20,fltka21,fltka22,fltka23,fltka24,fltka25,fltka26,fltka27,fltka28,fltka29,fltka30,fltka31,fltka32,fltka33,fltka34,fltka35,fltka36,fltka37,fltka38,fltka39,fltka40,fltka41,fltka42,fltka43,fltka44,fltka45,fltka46,fltka47,fltka48,fltka49,fltka50,fltka51,fltka52,fltka53,fltka54,fltka55,fltka56,fltka57,fltka58,fltka59,fltka60,fltka61,fltka62,fltka63,fltka64,fltka65,fltka66,fltka67,fltka68,fltka69,fltka70,fltka71,fltka72,fltka73,fltka74,fltka75,fltka76,fltka77,fltka78,fltka79,fltka80,fltka81,fltka82,fltka83,fltka84,fltka85,fltka86,fltka87,fltka88,fltka89,fltka90,fltka91,fltka92,fltka93,fltka94,fltka95,fltka96,fltka97,fltka98,fltka99,fltka100,fltka101,fltka102,fltka103,fltka104,fltka105,fltka106,fltka107,fltka108,fltka109,fltka110,fltka111,fltka112,fltka113,fltka114,fltka115,fltka116,fltka117,fltka118,fltka119,fltka120,fltka121,fltka122,fltka123,fltka124,fltka125,fltka126,fltka127,fltka128,fltka129,fltka130,fltka131,fltka132,fltka133,fltka134,fltka135,fltka136,fltka137,fltka138,fltka139,fltka140,fltka141,fltka142,fltka143,fltka144,fltka145,fltka146,fltka147,fltka148,fltka149,fltka150,fltka151,fltka152,fltka153,fltka154,fltka155,fltka156,fltka157,fltka158,fltka159,fltka160,fltka161,fltka162,fltka163,fltka164,fltka165,fltka166,fltka167,fltka168,fltka169,fltka170,fltka171,fltka172,fltka173,fltka174,fltka175,fltka176,fltka177,fltka178,fltka179,fltka180,fltka181,fltka182,fltka183,fltka184,fltka185,fltka186,fltka187,fltka188,fltka189,fltka190,fltka191,fltka192,fltka193,fltka194,fltka195,fltka196,fltka197,fltka198,fltka199,fltka200,fltka201,fltka202,fltka203,fltka204,fltka205,fltka206,fltka207,fltka208,fltka209,fltka210,fltka211,fltka212,fltka213,fltka214,fltka215,fltka216,fltka217,fltka218,fltka219,fltka220,fltka221,fltka222,fltka223,fltka224,fltka225,fltka226,fltka227,fltka228,fltka229,fltka230,fltka231,fltka232,fltka233,fltka234,fltka235,fltka236,fltka237,fltka238,fltka239,fltka240,fltka241,fltka242,fltka243,fltka244,fltka245,fltka246,fltka247,fltka248,fltka249,fltka250,fltka251,fltka252,fltka253,fltka254,fltka255,fltka256,fltka257,fltka258,fltka259,fltka260,fltka261,fltka262,fltka263,fltka264,fltka265,fltka266,fltka267,fltka268,fltka269,fltka270,fltka271,fltka272,fltka273,fltka274,fltka275,fltka276,fltka277,fltka278,fltka279,fltka280,fltka281,fltka282,fltka283,fltka284,fltka285,fltka286,fltka287,fltka288,fltka289,fltka290,fltka291,fltka292,fltka293,fltka294,fltka295,fltka296,fltka297,fltka298,fltka299,fltka300,fltka301,fltka302,fltka303,fltka304,fltka305,fltka306,fltka307,fltka308,fltka309,fltka310,fltka311,fltka312,fltka313,fltka314,fltka315,fltka316,fltka317,fltka318,fltka319,fltka320,fltka321,fltka322,fltka323,fltka324,fltka325,fltka326,fltka327,fltka328,fltka329,fltka330,fltka331,fltka332,fltka333,fltka334,fltka335,fltka336,fltka337,fltka338,fltka339,fltka340,fltka341,fltka342,fltka343,fltka344,fltka345,fltka346,fltka347,fltka348,fltka349,fltka350,fltka351,fltka352,fltka353,fltka354,fltka355,fltka356,fltka357,fltka358,fltka359,fltka360,fltka361,fltka362,fltka363,fltka364,fltka365,fltka366,fltka367,fltka368,fltka369,fltka370,fltka371,fltka372,fltka373,fltka374,fltka375,fltka376,fltka377,fltka378,fltka379,fltka380,fltka381,fltka382,fltka383,fltka384,fltka385,fltka386,fltka387,fltka388,fltka389,fltka390,fltka391,fltka392,fltka393,fltka394,fltka395,fltka396,fltka397,fltka398,fltka399,fltka400,fltka401,fltka402,fltka403,fltka404,fltka405,fltka406,fltka407,fltka408,fltka409,fltka410,fltka411,fltka412,fltka413,fltka414,fltka415,fltka416,fltka417,fltka418,fltka419,fltka420,fltka421,fltka422,fltka423,fltka424,fltka425,fltka426,fltka427,fltka428,fltka429,fltka430,fltka431,fltka432,fltka433,fltka434,fltka435,fltka436,fltka437,fltka438,fltka439,fltka440,fltka441,fltka442,fltka443,fltka444,fltka445,fltka446,fltka447,fltka448,fltka449,fltka450,fltka451,fltka452,fltka453,fltka454,fltka455,fltka456,fltka457,fltka458,fltka459,fltka460,fltka461,fltka462,fltka463,fltka464,fltka465,fltka466,fltka467,fltka468,fltka469,fltka470,fltka471,fltka472,fltka473,fltka474,fltka475,fltka476,fltka477,fltka478,fltka479,fltka480,fltka481,fltka482,fltka483,fltka484,fltka485,fltka486,fltka487,fltka488,fltka489,fltka490,fltka491,fltka492,fltka493,fltka494,fltka495,fltka496,fltka497,fltka498,fltka499,fltka500,fltka501,fltka502,fltka503,fltka504,fltka505,fltka506,fltka507,fltka508,fltka509,fltka510,fltka511,fltka512,fltka513,fltka514,fltka515,fltka516,fltka517,fltka518,fltka519,fltka520,fltka521,fltka522,fltka523,fltka524,fltka525,fltka526,fltka527,fltka528,fltka529,fltka530,fltka531,fltka532,fltka533,fltka534,fltka535,fltka536,fltka537,fltka538,fltka539,fltka540,fltka541,fltka542,fltka543,fltka544,fltka545,fltka546,fltka547,fltka548,fltka549,fltka550,fltka551,fltka552,fltka553,fltka554,fltka555,fltka556,fltka557,fltka558,fltka559,fltka560,fltka561,fltka562,fltka563,fltka564,fltka565,fltka566,fltka567,fltka568,fltka569,fltka570,fltka571,fltka572,fltka573,fltka574,fltka575,fltka576,fltka577,fltka578,fltka579,fltka580,fltka581,fltka582,fltka583,fltka584,fltka585,fltka586,fltka587,fltka588,fltka589,fltka590,fltka591,fltka592,fltka593,fltka594,fltka595,fltka596,fltka597,fltka598,fltka599,fltka600,fltka601,fltka602,fltka603,fltka604,fltka605,fltka606,fltka607,fltka608,fltka609,fltka610,fltka611,fltka612,fltka613,fltka614,fltka615,fltka616,fltka617,fltka618,fltka619,fltka620,fltka621,fltka622,fltka623,fltka624,fltka625,fltka626,fltka627,fltka628,fltka629,fltka630,fltka631,fltka632,fltka633,fltka634,fltka635,fltka636,fltka637,fltka638,fltka639,fltka640,fltka641,fltka642,fltka643,fltka644,fltka645,fltka646,fltka647,fltka648,fltka649,fltka650,fltka651,fltka652,fltka653,fltka654,fltka655,fltka656,fltka657,fltka658,fltka659,fltka660,fltka661,fltka662,fltka663,fltka664,fltka665,fltka666,fltka667,fltka668,fltka669,fltka670,fltka671,fltka672,fltka673,fltka674,fltka675,fltka676,fltka677,fltka678,fltka679,fltka680,fltka681,fltka682,fltka683,fltka684,fltka685,fltka686,fltka687,fltka688,fltka689,fltka690,fltka691,fltka692,fltka693,fltka694,fltka695,fltka696,fltka697,fltka698,fltka699,fltka700,fltka701,fltka702,fltka703,fltka704,fltka705,fltka706,fltka707,fltka708,fltka709,fltka710,fltka711,fltka712,fltka713,fltka714,fltka715,fltka716,fltka717,fltka718,fltka719,fltka720,fltka721,fltka722,fltka723,fltka724,fltka725,fltka726,fltka727,fltka728,fltka729,fltka730,fltka731,fltka732,fltka733,fltka734,fltka735,fltka736,fltka737,fltka738,fltka739,fltka740,fltka741,fltka742,fltka743,fltka744,fltka745,fltka746,fltka747,fltka748,fltka749,fltka750,fltka751,fltka752,fltka753,fltka754,fltka755,fltka756,fltka757,fltka758,fltka759,fltka760,fltka761,fltka762,fltka763,fltka764,fltka765,fltka766,fltka767,fltka768,fltka769,fltka770,fltka771,fltka772,fltka773,fltka774,fltka775,fltka776,fltka777,fltka778,fltka779,fltka780,fltka781,fltka782,fltka783,fltka784,fltka785,fltka786,fltka787,fltka788,fltka789,fltka790,fltka791,fltka792,fltka793,fltka794,fltka795,fltka796,fltka797,fltka798,fltka799,fltka800,fltka801,fltka802,fltka803,fltka804,fltka805,fltka806,fltka807,fltka808,fltka809,fltka810,fltka811,fltka812,fltka813,fltka814,fltka815,fltka816,fltka817,fltka818,fltka819,fltka820,fltka821,fltka822,fltka823,fltka824,fltka825,fltka826,fltka827,fltka828,fltka829,fltka830,fltka831,fltka832,fltka833,fltka834,fltka835,fltka836,fltka837,fltka838,fltka839,fltka840,fltka841,fltka842,fltka843,fltka844,fltka845,fltka846,fltka847,fltka848,fltka849,fltka850,fltka851,fltka852,fltka853,fltka854,fltka855,fltka856,fltka857,fltka858,fltka859,fltka860,fltka861,fltka862,fltka863,fltka864,fltka865,fltka866,fltka867,fltka868,fltka869,fltka870,fltka871,fltka872,fltka873,fltka874,fltka875,fltka876,fltka877,fltka878,fltka879,fltka880,fltka881,fltka882,fltka883,fltka884,fltka885,fltka886,fltka887,fltka888,fltka889,fltka890,fltka891,fltka892,fltka893,fltka894,fltka895,fltka896,fltka897,fltka898,fltka899,fltka900,fltka901,fltka902,fltka903,fltka904,fltka905,fltka906,fltka907,fltka908,fltka909,fltka910,fltka911,fltka912,fltka913,fltka914,fltka915,fltka916,fltka917,fltka918,fltka919,fltka920,fltka921,fltka922,fltka923,fltka924,fltka925,fltka926,fltka927,fltka928,fltka929,fltka930,fltka931,fltka932,fltka933,fltka934,fltka935,fltka936,fltka937,fltka938,fltka939,fltka940,fltka941,fltka942,fltka943,fltka944,fltka945,fltka946,fltka947,fltka948,fltka949,fltka950,fltka951,fltka952,fltka953,fltka954,fltka955,fltka956,fltka957,fltka958,fltka959,fltka960,fltka961,fltka962,fltka963,fltka964,fltka965,fltka966,fltka967,fltka968,fltka969,fltka970,fltka971,fltka972,fltka973,fltka974,fltka975,fltka976,fltka977,fltka978,fltka979,fltka980,fltka981,fltka982,fltka983,fltka984,fltka985,fltka986,fltka987,fltka988,fltka989,fltka990,fltka991,fltka992,fltka993,fltka994,fltka995,fltka996,fltka997,fltka998,fltka999,fltka1000) .  
EXECUTE .
```

Section III - IPV Knowledge:

/* First score Knowledge Items:

```
IF knrisk = 3 Kn1 = 1.  
IF knbatr = 2 Kn2 = 1.  
IF knAsk1 = 0 Kn51 = 1.  
IF knAsk3 = 0 Kn53 = 1.  
IF knsoca = 3 Kn7A = 1.  
IF knsocb = 1 Kn7B = 1.  
IF knsocc = 2 Kn7C = 1.  
IF knsocd = 5 Kn7D = 1.  
IF knsoce = 4 Kn7E = 1.  
EXECUTE.
```

```
IF kn8a = 2 Kn8Ascore = 1.  
IF kn8b = 2 Kn8Bscore = 1.  
IF kn8c = 2 Kn8Cscore = 1.  
IF kn8d = 2 Kn8Dscore = 1.  
IF kn8e = 2 Kn8Escore = 1.  
IF kn8f = 1 Kn8Fscore = 1.  
IF kn8g = 1 Kn8Gscore = 1.  
IF kn8h = 1 Kn8Hscore = 1.  
IF kn8i = 2 Kn8Iscore = 1.  
IF kn8j = 2 Kn8Jscore = 1.  
IF kn8k = 2 Kn8Kscore = 1.  
EXECUTE.
```

/*Note: Now compute Knowledge Score:

```
COMPUTE KNSUM = SUM(Kn1,Kn2,knwrng1,knwrng2,knwrng3,knwrng4,knwrng5,kncntlv1,  
kncntlv2, kncntlv3,kncntlv4,kncntlv5,kncntlv6,knask2,knask4,Kn51,Kn53,kninj1,kninj2,  
kninj3,kninj4,kninj5,Kn7A,Kn7B, Kn7C,Kn7D,Kn7E,Kn8Ascore,Kn8Bscore,Kn8Cscore,  
Kn8Dscore,Kn8Escore,Kn8Fscore,Kn8Gscore,Kn8Hscore,Kn8Iscore,Kn8Jscore,Kn8Kscore) .  
EXECUTE .
```

Section IV - Opinions:

/* Reverse coding for negatively worded Opinion Items:

RECODE

O1 O5 O6 O10a O10b O10c O11 O13 O15 O16 O21 O23 O24 O27 O28 O32

(1=7) (2=6) (3=5) (4=4) (5=3) (6=2) (7=1)

INTO R1 R5 R6 R10a R10b R10c R11 R13 R15 R16 R21 R23 R24 R27 R28 R32 .

/*Create Opinion Scale Scores - Note Scales 7 & 8 did not demonstrate internal consistency reliability and need retesting:

COMPUTE Sc1StaffPrep = MEAN(R6,R10a,R10b,R10c,R28) .

EXECUTE .

COMPUTE Sc2LegReq = MEAN(O12a,O12b,O12c,O17) .

EXECUTE .

COMPUTE Sc3WkPI = MEAN(O3,O4,O19,O20,O25,O26) .

EXECUTE .

COMPUTE Sc4SE = MEAN(O2,O9,O14) .

EXECUTE .

COMPUTE Sc5AIDrg = MEAN(O7,R21,O31) .

EXECUTE .

COMPUTE Sc6VctmUnd = MEAN(R1,R11,R15,R16,O18,R24) .

EXECUTE .

COMPUTE Sc7VictmAut = MEAN(O8,O22,O30) .

EXECUTE .

COMPUTE Sc8StfConstrnts = MEAN(R13,R23) .

EXECUTE .

Section V - Practice Issues:

Note: Recode Practice Issues #1 - NewDiag to eliminate N/A code:

RECODE

NewDiag (9=SYSMIS) .

Note: Create Practice Issues #2 - Currently Screen as a weighted composite variable:

IF curscr9 = 1 CurScreen = . .

IF curscr0 = 1 CurScreen = 0.

IF curscr8 = 1 CurScreen = 1.

IF curscr3 = 1 CurScreen = 2.

IF curscr4 = 1 CurScreen = 2.

IF curscr5 = 1 CurScreen = 2.

IF curscr7 = 1 CurScreen = 3.

IF curscr2 = 1 CurScreen = 4.

IF curscr6 = 1 CurScreen = 4.

IF curscr1 = 1 CurScreen = 5.

EXECUTE.

/*Note: Create Practice Issues #3 - QinSita-g -- questioning in specific situations - mean score across items:

RECODE

qinsita qinsitb qinsitc qinsitd qinsite qinsitf qinsitg (6=SYSMIS) .

EXECUTE .

COMPUTE QinSitMN = MEAN(qinsita,qinsitb,qinsitc,qinsitd,qinsite,qinsitf,qinsitg) .

EXECUTE .

/* Note: Recoding Practice Issues #4 f- Actions when have Identified IPV to create a score for sum of appropriate actions, referrals, and total of actions and referrals:(Note: inappropriate referrals are not discounted, and the referral score is not included in the total Practice Issues score created below.):

IF idact0 = 1 IDActTot = 0.

EXECUTE.

COMPUTE IDActTot = SUM(idact1,idact2,idact3,idact4,idact5,idact6) .

EXECUTE .

COMPUTE IDRefTot =

SUM(idact6a,idact6b,idact6d,idact6e,idact6f,idact6g,idact6h,idact6i,idact6j,idact6k,idact6l,
idact6m,idact6n,idact6o,idact6p,idact6q,idact6r) .

EXECUTE.

COMPUTE IDTotAct = SUM(IDActTot,IDRefTot).

EXECUTE .

/* Note: Recode Practice Issues #5 Protocol, #6 Policies, #7 Camera, #8 LegReprt:

RECODE

Protocol

(7=SYSMIS) (8=SYSMIS) (9=SYSMIS) INTO Protocol2 .

EXECUTE .

RECODE

Policies

(9=SYSMIS) INTO Policies2.

EXECUTE .

RECODE

Camera

(7=SYSMIS) (8=SYSMIS) (9=SYSMIS) INTO Camera2 .

EXECUTE .

RECODE

LegReprt

(7=SYSMIS) (9=SYSMIS) INTO LegReprt2 .

EXECUTE .

/*Note: Recoding Practice Issues #9 - 2nd set of Activities regarding ID of IPV victim:

RECODE

idact2a idact2b idact2c idact2d idact2e idact2f idact2g idact2h idact2i idact2j idact2k
(6=SYSMIS) .

EXECUTE .

COMPUTE IDAct2MN =

MEAN(idact2a,idact2b,idact2c,idact2d,idact2e,idact2f,idact2g,idact2h,idact2i,idact2j,idact2k) .

EXECUTE .

/*Note: Compute Composite Practice Issues Score:

COMPUTE Praclss =

SUM(newdiag,CurScreen,QinSitMN,IDActTot,Protocol2,Policies2,Camera2,LegReprt2,
IDAct2MN,matavail,matgive,refonsit,refcomm) .

EXECUTE.
