A Clinical Guideline for Identifying Intimate Partner Abuse in Women’s Health Services in Hong Kong

by

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A dissertation submitted in partial fulfillment of the requirements for the Degree of Master of Nursing at the University of Hong Kong

August 2012
Declaration

I declare that the dissertation represents my own work, except where due acknowledgement is made, and that it has not been previously included in a thesis, dissertation or report submitted to this University or to any other institution for a degree, diploma or other qualifications.

Signed……………………………………………

Woo Sin Ping
Acknowledgements

I am heartily thankful to my dissertation supervisor, Professor Agnes Tiwari. This dissertation would not have been possible without her guidance, encouragement and excellent mentoring. Professor Tiwari has given me great support throughout my study.

I am grateful to my colleagues of the Department of Health. I would like to extend my thanks to Senior Nursing Officers, Ms Elaine Cheung and Ms Marianna Yip, Nursing Officers, Ms Lo Wai Ling and Ms Leung Suet Wai. I would like to offer my special thanks to Jessica Cheng for her company and support. I will always remember the days we studied together with happiness.

Last but not the least, I would like to thank the two most important persons to me. Thank you to my mother Lo Lau Ying who is the nurturer and the role model to me. Thank you to my husband Choi Ming Wah who loves me and supports me in every single moment during my study. I would like to share the honour with them.
Abstract of dissertation entitled

“A Clinical Guideline for Identifying Intimate Partner Abuse in Women’s Health Services in Hong Kong”

Submitted by

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for the Degree of Master of Nursing
at The University of Hong Kong
in August 2012

Intimate partner abuse (IPA) is a global health problem affecting millions of women. It is linked with a wide range of negative health sequela including injuries, gastrointestinal disorders, chronic pain, depression, gynecological disorders, unwanted pregnancy, and sexually transmitted diseases (CDC, 2011). In Hong Kong and other Chinese societies, incidence of IPA is likely to be under-reported. This phenomenon is presumably due to the cultural norm in which shameful family issues tend not to be disclosed to members outside the family. However, in light of its related negative health consequences, early identification of IPA is important. In Hong Kong where majority of women attend primary health care settings for routine check-up, identification of IPA in this setting is feasible. The Abuse Assessment Screen (AAS), a well-established screening tool for IPA, suits this purpose. Previous studies in Hong Kong have shown that the Chinese version of AAS has satisfactory validity and high
sensitivity for detecting IPA (Tiwari, Fong, Leung, Parker, & Ho, 2007). Therefore, this proposed guideline chose to use the Chinese version of AAS for IPA detection in women’s health services, with the purpose of minimizing under-reporting of IPA in Hong Kong.

The objectives of this study are (1) to conduct a systematic literature review on the IPA identification in health care settings; (2) to synthesize the outcomes from the identified literature for the translation of evidence-based practice; (3) to develop a clinical guideline for identifying IPA in women’s health services; (4) to assess the potential of implementing the proposed guideline; (5) to develop an implementation plan; and (6) to develop an evaluation plan for the proposed guideline.

A systematic literature search was performed for identifying relevant studies. Three electronic databases including PubMed, Ovid MEDLINE (OvidSP), and CINAHL Plus (EBSCOhost) were used. In total, six papers were yielded based on the inclusion criteria. Scottish Intercollegiate Guideline Network (SIGN) 2011 grading system was used to evaluate the level of evidence. The potential of implementing the proposed guideline was assessed based on the transferability of the findings, feasibility, and the cost-to-benefit ratio. An evidence-based guideline was developed
based on the analysed research findings. Finally, an implementation plan and an evaluation plan for the proposed guideline were designed.

An evidence-based guideline for identifying IPA in women’s health services was developed in this translational research. It assists nurses, particularly in the women’s health services, to identify women survivors of IPA.
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<td>ED</td>
<td>Emergency Department</td>
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<td>IFSC</td>
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<td>IPA</td>
<td>Intimate Partner Abuse</td>
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<td>RCT</td>
<td>Randomized Controlled Trial</td>
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Chapter 1: Introduction

Intimate partner abuse (IPA) is a global problem affecting women, irrespective of their socioeconomic status, cultural background, and races. IPA refers as the abusive behaviour within an intimate relationship. It comprises of behaviour including physical abuse, psychological coercion, and sexual assault from the perpetrator against the victim. Intimate partner violence (IPV) refers to any behaviours within an intimate partner relationship that causes physical, psychological and sexual harm (WHO, 2006). Indeed, IPA comprises a broad range of abusive behaviours involving in a current or former intimate relationship. Understanding IPA is important for healthcare professional, particularly those who work in the field of primary health care. This is because a good understanding of IPA helps to make early identification of IPA and in turn leads to early referral and provision of community resources. In addition, many professional organizations advocate routine screening for IPA by nurses. These organizations include the American Nurses Association, the Emergency Nurses’ Association, and the Association for Women’s Health, Obstetrical, and Neonatal Nursing.

Women’s health services in Hong Kong are mainly provided in the primary health care settings. These service providers are responsible for providing general health assessments and disease screenings such as cervical cancer and breast cancer
screening for women. However, the existing practice of IPA identification in women’s health services is very brief. There is not even a specific question enquiring for any history of IPA. Given the negative health consequences linking to IPA, health care professionals, in particular those who work in women’s health services, should help to identify the female victims of IPA by using an evidenced-based guideline and also try to offer help.

**Background**

In Hong Kong, women’s health services are mainly provided by the primary health sectors from the government departments, hospitals and non-governmental organizations. Therefore primary health settings can provide applicable environments for holistic health assessments. For example, women health centers provide healthy life-style education, counseling, basic physical examination, cervical screening and appropriate investigations like mammogram (Department of Health, 2009).

**Prevalence of IPA**

The problem of IPA occurs in many countries. A population-based survey of 48 countries from the World Health Organization (WHO) in 2002 showed 10% to 69% of women experienced physical intimate partner violence in their lives (WHO, 2002). In Chinese societies, several studies have shown that the prevalence of spousal violent victimization ranged from 1.8% to 43% (Hicks & Li, 2003; Leung, Ng, Leung, & Ho,
2003; Xu et al., 2005). In Hong Kong, a household survey showed that the prevalence of 12-month-prior physical violence was 4.5% (Chan, 2005). Another territory-wide survey of Hong Kong pregnant women found that 9% of local pregnant women experienced IPA in 12 months prior to the study (Chan et al., 2010). In 2010, the Social Welfare Department of Hong Kong reported 3613 new battered spouse cases in which 83.6% of the victims were women (SWD, 2010).

Health consequences of IPA

Compared to men, women are far more likely to be attacked by someone within an intimate relationship (WHO, 2002). IPA has been linked to many negative health outcomes including injuries, gastrointestinal disorders, chronic pain, depression, gynecological disorders, unwanted pregnancy, and sexually transmitted diseases (CDC, 2011). WHO summarised 35 health consequences which have been associated with IPA and they were categorised into four types (WHO, 2002). They are physical, sexual and reproductive, psychological and behavioral, and fatal health consequences (Appendix A). IPA not only can jeopardise women’s health directly, it can also increase their engagement in risky behaviour such as the use of tobacco and alcohol for coping the trauma (Humphreys & Campbell, 2011; WHO, 2002).

Significance

Identification of IPA in women’s health services is significant for several reasons.
First of all, as IPA is in general regarded as shameful family issue in Chinese societies and Chinese societies tend not to disclose this shameful issue to members outside the family, incidence of IPA in Hong Kong is likely to be under-reported. However, the characteristic of the victims of IPA in local studies were low educational level, low socioeconomic status, with relationship conflicts and history of substance abuse (Chan, 2005; Chan, Brownridge, Tiwari, Fong, & Leung, 2008; Chan, Chui, & Chiu, 2005; Tiwari et al., 2010). Those characteristics matched the findings of studies in other countries that poverty, relationship conflicts and heavy drinking were associated with risk of IPV (Jewkes, 2002; WHO, 2002). Therefore, those women come to contact the public health system when they seek cheaper health services like family planning, gynecological check-up or other routine check-up. This is the first reason makes the women’s health services an advantage to identify IPA survivors. Second, early identification can provide timely support, early referral and protection to victims of IPA. This can also provide them knowledge about their rights and safety issues in order to protect themselves as well as their children. Lastly, training of IPA identification has practical implication in nursing care. As a result, health care professionals can be more sensitive to the potential cases of IPA and make appropriate response to the survivors of IPA.

**Affirming the Needs**
The usual practice in WHS

The women’s health services generally include assessing the health history, conducting general physical examination and laboratory investigations such as pap smear and blood tests (Department of Health, 2011; The Family Planning Association of Hong Kong, 2011; Tung Wah Group of Hospitals, 2011). In normal circumstances, nurses are responsible for taking the health history. It typically includes demographic data, vital signs, present problem or complaints and also past health history. However, the health history taking is very brief and does not have a standard assessment of IPA. Even in the situation where the clients reported complaints of chronic pain syndrome, a health problem that is related to IPA, assessment of IPA is still not conducted. Sympathetically, most of the women’s health services in Hong Kong only aims at detecting breast or cervical cancer (The Family Planning Association of Hong Kong, 2011; Tung Wah Group of Hospitals, 2011). Although psycho-social problem is assessed when necessary (Department of Health, 2011), evidenced-based assessment tool for IPA is still not included in existing practice. IPA detection is still an underdeveloped area in holistic women’s health services.

Evidence-based assessment tool for Chinese women

There are several well-established IPV screening tools, such as the Woman Abuse Screening Tool (WAST), the Partner Violence Screen (PVS), the Abuse
Assessment Screen (AAS) and the Hurt, Insult, Threaten, and Scream (HITS) (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Based on the Rabin et al’s review, the sensitivity for IPA detection of AAS, HITS, WAST, and PVS was 93%-94%, 30%-100%, 47%, and 35%-71%, respectively. For IPA identification, an instrument with high sensitivity is needed in order to avoid under-detection of abusive cases. Likewise, cultural consideration is also an important issue for IPA identification as tolerance and acceptance of the level of violence varies across cultures (Humphreys & Campbell, 2011). Previously, Tiwari and colleagues has developed a Chinese version of AAS in Hong Kong and, based on their study, they demonstrated the scale has a satisfactory validity in identifying IPV cases (Tiwari, Fong, Leung, Parker, & Ho, 2007). So, AAS seems to be a good choice for an evidenced-based tool for clinical guideline.

Objectives of the Study

This study aims to find out whether there are any differences for IPA detection when AAS is used, compared to the usual care in women's health services. This research question guides the critical appraisal, translation, application and implementation parts of the clinical guideline in this translational research. The objectives of this study are as follow:

1. To conduct a systematic literature review on the IPA identification in health
2. To synthesize the outcomes from the identified literature for translation to the evidence-based practice

Chapter 2: Critical Appraisal

Literature Search

Clinical question

In order to facilitate the literature searching for evidence of IPA identification, a question has been constructed:

What effects will it have if nurses initiate the identification of IPA in women’s health services comparing to the usual care?

Search strategies

To identify literature about the identification of women survivors of IPA, a systemic search was undertaken for relevant articles via computerized databases. Three computerized databases were used including PubMed, Ovid MEDLINE (OvidSP), and CINAHL Plus (EBSCOhost).

Keywords

Keywords relating to IPA (intimate partner violence, partner abuse, battered women) and identification (identification, screening) were selected for the searching processes. Additional relevant papers were identified from the reference list from the
yielded articles.

**The inclusion criteria**

1. Randomized controlled trial (RCT) and Quasi-experimental design of IPA screening or identification were included.

2. Only primary studies were selected. The most updated papers were selected if those papers were based on the same studies.

3. Studied Subjects of the studies must be adult female.

4. Articles are written in language of English or Chinese.

**Result**

A total 3317 articles were yielded on 30th August 2011. In PubMed database, 1877 articles were searched and 10 articles were selected. In MEDLINE (OvidSP), 499 articles were searched and 7 articles were selected. In CINAHL Plus (EBSCOhost), 941 articles were searched and only 1 article was selected.

After titles screening and elimination of the repeated articles, 10 papers were selected. After reading the abstracts of the identified papers, 7 papers were yielded according to the inclusion criteria. Among the yielded studies, two papers were based on the same RCT study (Calderon, Gilbert, Jackson, Kohn, & Gerbert, 2008; Humphreys, Tsoh, Kohn, & Gerbert, 2011). Therefore, only the paper of Humphreys et al. (2011) was chosen because it was more updated. As a result, 5 RCTs (Ahmad et
al., 2009; Humphreys, et al., 2011; Koziol-McLain et al., 2010; MacMillan et al., 2009; Rhodes et al., 2006) and 1 Quasi-experimental designed paper (Trautman, McCarthy, Miller, Campbell, & Kelen, 2007) were selected.

**Quality Appraisal Strategies**

Data of the six identified studies were extracted into the table of evidence form. Scottish Intercollegiate Guidelines Network (SIGN) 2011 checklist was used for rating the level of evidence. The table of grading system of SIGN is shown in Appendix B. The tables of evidence for the five RCTs are shown in Appendix C to G. They all addressed appropriate and clearly focused questions. The Quasi-experiment of Trautman et al’s study (Trautman, et al., 2007)  (Appendix H) is an appropriate controlled trial with a clear focused question.

Four of the five RCTs used computer-generated randomized list for assigning study groups (Ahmad, et al., 2009; Humphreys, et al., 2011; Koziol-McLain, et al., 2010; MacMillan, et al., 2009; Rhodes, et al., 2006). MacMillan et al.’s study (2009) used random number table to determine the order of randomization by day or shift. Due to the nature of the screening intervention, participants and investigators were very difficult to be blinded. Participants could know which group they were assigned easily. Assessors could also know whether clients were screened or not screened. Only Ahmad et al.’s study (2009) was able to keep both physicians and clients blind for the
primary purpose of the study.

**High level of evidence**

According to SIGN (2011), studies with high level of evidence should fulfil all or almost all of the criteria. The risk of bias in the high qualified RCTs is low. Therefore, the symbol “+++” is given to the study which is rated to be high level of evidence.

Among the six identified studies, only one study (Ahmad, et al., 2009) in Appendix E was rated with high level of evidence. This study almost met all of the criteria in the RCT checklist of SIGN. The code of “+++” represents all or most of the criteria have been fulfilled (Scottish Intercollegiate Guidelines Network, 2011). Ahmad et al.’s study was conducted at a family practice clinic which was highly relevant to the setting of my topic. The sample size was 314 with low dropout rate (6.7%). Before the recruitment, an off-site biostatistician prepared a computer-generated randomization assignment to avoid bias. The patient assignments were sealed in opaque envelopes and were opened by recruiters after the patients’ written consents were obtained. Therefore, bias was minimized by the randomization and blinding skills. The relevant outcomes were measured by the Abuse Assessment Screen (AAS) and the Partner Violence Screen (PAS). The data of intervention group and control group were compared by using chi-square test and t tests. Ahmad et al.’s study showed that computer-based IPV assessment raised the IPVC discussion rate
with RR=1.4 and the doubled the IPVC detection rate when compared to the standard medical care.

**Medium level of evidence**

Two studies were rated as medium level of evidence and the code “+” is given. They were all RCTs (Humphreys, et al., 2011; Koziol-McLain, et al., 2010) which fulfilled most of the criteria in the SIGN checklist. Moreover, those criteria that have not been fulfilled or not adequately described are considered unlikely to have altering effect on the conclusions (Scottish Intercollegiate Guidelines Network, 2011).

Humphreys, et al. (2011) used computers to assign participants into the intervention or control group randomly. Randomization sequence for group assignment in Koziol-McLain et al.’s study (2010) was also generated by computers. Among the two studies, the dropout rate of Koziol-McLain et al. (2010) was low (13.8% of total participants). The dropout rate of Humphreys et al.’s study (2011) was medium with (26% of total participants).

In addition, these studies used reliable and valid measurement tools like the Abuse Assessment Tool (AAS) and the Partner Violence Screen (PAS) (Humphreys & Campbell, 2011; Rabin, et al., 2009). Chi-square tests and t-tests were used in the data analysis of Humphreys et al.’s study (2011). Another study used statistical software SPSS for reliable data analysis (Koziol-McLain, et al., 2010).
Low level of evidence

Two RCTs only fulfilled some criteria of the SIGN checklist and their conclusions were likely or very likely to be altered by the unfulfilled criteria. Therefore, Rhodes et al.’s study (2006) and MacMillan et al.’s study (2009) were given the code of “−” (Scottish Intercollegiate Guidelines Network, 2011).

In the RCT of Rhodes et al. (2006), a large proportion of eligible patients refused to join the study. Although randomization method was well organized, the high refusal rate was likely to alter their results. MacMillan et al. (2009) study used random table to determine the shift or day for intervention or control. However, the quality of study was rated as low due to the high dropout rate (42% of total participants). A high dropout rate may affect the outcomes of IPV recurrence and quality of life. Therefore, these two RCTs were rated with low level of evidence.

The last identified study has a well-organized Quasi-experimental design. Trautman et al.’s study (2007) did not fulfill most of the criteria in the SIGN controlled trial checklist because of no randomization and blinding. Although the risk of bias was high, the research question was focused and the intervention was well designed and was clearly investigated. This study was the only study did not have any outside funding or support. Maybe lack of funding was the reason of using a Quasi-experimental design.
The above three studies used reliable and valid IPV screening tools like AAS, PVS and the Women Abuse Screening Tools (Humphreys & Campbell, 2011; Rabin, et al., 2009). They all used statistical software for data analyses including MLwiN, STATA and Statistical Analysis Software (SAS) (MacMillan, et al., 2009; Rhodes, et al., 2006; Trautman, et al., 2007).

**Summary and Synthesis**

The six identified studies were published between 2007 and 2011. Five of them were randomized controlled trials (Ahmad, et al., 2009; Humphreys, et al., 2011; Koziol-McLain, et al., 2010; MacMillan, et al., 2009; Rhodes, et al., 2006) and one was a quasi-experimental study (Trautman, et al., 2007). The sample size of the studies ranged from 50 to 2165, with majority of them having a sample size of 500 (Ahmad, et al., 2009; Koziol-McLain, et al., 2010; MacMillan, et al., 2009).

**Health care setting**

Only two out of the six studies took place in primary health care settings. Humphreys et al.’s study (2011) was conducted in five prenatal clinics in primary health care setting. Ahmed et al.’s study (2009) was conducted in family practice clinic, which is very similar to my proposed setting. The other four studies were carried out in emergency departments (ED) and the participants were women who seek medical care in ED (Koziol-McLain, et al., 2010; MacMillan, et al., 2009;
Rhodes, et al., 2006; Trautman, et al., 2007). MacMillan et al.’s study (2009) was the only one which carried out in multiple health care settings, including the primary care setting, acute care setting, and the specialty setting. However, the comparability of findings from the different settings was poorly addressed in their report.

**Subject characteristics**

There were limitations to the participants’ characteristics in the ED studies as the clients in these studies were excluded if they were found to be critically ill or have impaired mental status. Life-saving should be in a higher priority than screening, therefore the critically ill patients were excluded. Non-English speaking clients were excluded in three of the six studies (Koziol-McLain, et al., 2010; MacMillan, et al., 2009; Rhodes, et al., 2006) because they were unable to communicate with English speaking person individually. And there was difficulty in follow up the ED clients for recurrence of IPV as the nature of the care provided by ED is urgent or emergent only. Therefore, the percentage of loss of follow up in MacMillan et al.’s study (2009) was high. There were less exclusion criteria in studies which were conducted in primary health care setting (Ahmad, et al., 2009; Humphreys, et al., 2011).

**Outcome measures**

Three of the six studies showed that screening intervention increased the IPA or IPV detection rate and the referral rate (Ahmad, et al., 2009; Rhodes, et al., 2006;
Trautman, et al., 2007). These studies also showed that the discussion of IPV between service provider and patient increased by the screening intervention (Humphreys, et al., 2011; Rhodes, et al., 2006). Only two studies investigated the effects of screening on IPV recurrence. Koziol-McLain et al. (2010) found no significant decrease of IPV re-exposure by the screening. MacMillan et al. (2009) also found that IPV re-exposure was not significantly reduced. However, the high percentage of loss of follow up in these studies might affect the result of IPV recurrence data (MacMillan, et al., 2009). Among all the identified studies, only MacMillan et al.’s study (2009) assessed the quality of life of the participants. It found that no significant difference in the quality of life at the phase of the 18 months follow-up.

**Feasibility of computer screening**

Based on the findings of the identified studies, computer-based approach of IPA screening was acceptable for the participants and was effective to increase the IPV detection rate in Canada and the US (Ahmad, et al., 2009; Rhodes, et al., 2006; Trautman, et al., 2007). So, based on the same logic, computer-based approach with touch screen programme in IPV screening might also be acceptable to women in Hong Kong. Moreover, computer-based approach would be more time saving and environmental friendly for IPV screening.

**Potential harms**
Safety is of the most concern for IPA identification. Humphreys et al. (2011) reported 90.9% of the participants in their study rated IPV discussion as helpful or very helpful. Also, in another two IPV screening studies (Koziol-McLain, et al., 2010; MacMillan, et al., 2009), harm or adverse effects were not found to link with the screening intervention. Therefore, the studies concluded that screening or enquiring for IPV in health care settings was safe.

**Recommendations**

According to the identified studies (Ahmad, et al., 2009; Humphreys, et al., 2011; Trautman, et al., 2007), identification of IPA can increase the detection rate and the discussion between health care providers and clients. The identification intervention was not found to cause harmful effect on clients (Koziol-McLain, et al., 2010; MacMillan, et al., 2009). Also, referral, safety plan, and provision of useful resources can be provided to the identified survivors during the identification process of IPA (Rhodes, et al., 2006; Trautman, et al., 2007).

Some well-developed IPV screening tools such as WAST, AAS and PVS are reliable to use. In addition, as understanding of IPV may be influenced by the culture within the society (Humphreys & Campbell, 2011), cultural-specific consideration is needed when conducting the nursing assessment. The Chinese version of AAS has been tested in Chinese societies and was found to have good accuracy and utility for
identifying IPV (Tiwari, et al., 2007). Therefore, the Chinese version of AAS is recommended to use as a screening tool or a basic component for IPA identification.

Education and training of IPA screening for health care professionals are suggested to be provided in order to have a better support for the survivors of IPA (Humphreys, et al., 2011; Rhodes, et al., 2006). Computer-based approach can be considered for screening of IPA. It may be a cost-effective way for IPA detection in the busy healthcare setting. However, the effort and the support of face-to-face screening should not be underrated (Trautman, et al., 2007). It is because the provision of IPV services cannot be replaced by computer. In conclusion, computer-based approach screening is feasible if resources and technological support is adequately provided.

Chapter 3: Translation and Application

After the critical appraisal of the six identified studies in the previous chapter, supportive evidence IPA identification in urban health care settings is found. In this chapter, an evidenced-based practice guideline for IPA identification in Women’s Health Services is developed. It is worthy to implement IPA identification in women’s health care services. It is because IPA identification can increase the detection rate and service provider-patient discussion of IPA (Ahmad et al., 2009; Humphreys, Tsoh, Kohn, & Gerbert, 2011; Rhodes et al., 2006; Trautman, McCarthy, Miller, Campbell,
& Kelen, 2007). The potential of implementation is discussed based on the transferability of the findings from the literature, feasibility, and the cost to benefit ratio.

Implementation Potential

Target audience and setting

The proposed innovation targets women who are under 65 years old and attend Women’s Health Services (WHS). Registered nurses who work in women health centers (WHC) are the users of the proposed guideline.

Philosophy of care

According to the aim of WHS under the Department of Health, “the comprehensive women health programme aims to empower women to make life choices that are conducive to their health and seek appropriate health care or social services when necessary” (Department of Health, 2011b). The proposed innovation is based on the same philosophy of care for the existing women health services. The Family Health Service (FHS) in the Department of Health of the Government of the Hong Kong Special Administrative Region is the main service provider of women’s health services. After understanding the vision and the missions of the family health service, I believe that the WHC are favorable for utilizing the research findings. The missions of WHC under FHS are stated as follow: 1) to empower clients to improve
their health through providing evidence-based, quality assured service in partnership with other providers; 2) to continually upgrade our service through fostering innovation, flexibility and use of technology; 3) to enhance organization and staff competence through training and continual professional development; 4) to provide cost-effective service to meet the changing needs of our clients. The above four missions aim to make FHS to play a leadership role in promoting child and women health in Hong Kong (Department of Health, 2011a). WHC and MCHC play important roles in primary health care. They stress the evidence-based practices and welcome the use of updated technology. The proposed innovation is able to match the philosophy of care of FHS under Department of Health.

**Transferability of the Findings**

In the previous chapter, six identified studies were published from 2006 to 2011. Those studies showed the recent findings which are relevant to the intimate partner violence in urban clinical settings. The proposed innovation is derived from the evidence generated from those studies, which is related to IPA identification in female population.

**Setting**

The identified studies were carried out in clinical settings, either in community health centers or in hospitals in urban districts. WHC and MCHC have similar setting
to that in the identified studies which were also took place in the urban areas in the US, New Zealand and Canada (Appendix I). Geographically, the proposed innovation matches with the best evidence literature.

**Characteristics of target population**

For the proposed innovation, the target population is Chinese women who live in Hong Kong. Although the target population in the identified studies was women in Western countries, findings in their studies may seem applicable for women in Asian countries. Moreover, Hong Kong plays a leading role in the international financial centers and is often described as a place where the Eastern culture meets the Western culture. In addition, the medical system in Hong Kong was adopted from Britain. And the medical practice in Hong Kong is still mainly in the Western medical style. Therefore, the transferability of findings from western studies to the proposed innovation seems culturally applicable.

Most of the identified studies targeted on women who aged 18 years old or above (Appendix I). Only Koziol-McLain et al.’s (2010) study recruited younger women (women who aged 16 years old and above). The mean age of the women in those identified studies ranged from 33 to 44 years old. The middle-age group is the main target population of the existing WHS in WHC and MCHC. Therefore, the age of the target population of the proposed innovation is similar to those in the identified
Benefiting to sufficient clients

All WHS clients can benefit from the proposed innovation. There were over 35000 attendances to the women health service in 2010 (Census and Statistics Department, 2011). The implementation of IPA identification will help to identify IPA survivors. Proper referral and introduction of community resources can be timely provided to the IPA survivors. They will have more chances to seek help and enhance their safety. Also, all the WHS clients will be able to know more about IPA. The increase of service provider-client discussion can arouse awareness of IPA in community.

Time frame of the innovation

The proposed innovation will be implemented over a two year period. In the first year of implementation, every client will participate in the proposed innovation. And then, each identified IPA survivor will have a six to nine month phone- or interview-follow-up. The evaluation of the first year cases will be completed during the second year of implementation. There will be at least three months for preparing the evaluation report.

After evaluating the above criteria of transferability, the research findings can fit into the proposed innovation.
Feasibility

There are several facilitating factors related to the proposed innovation which can make the screening become even more feasible. WHC and MCHC nurses are primary health care professionals so that they prefer prevention or detection of health problems in early stage. They are experts in disease prevention, case identification and health promotion. Nurses always have the autonomy of carrying out innovation when there is supportive evidence. Nurses also have the freedom to make feedbacks and comments for the innovation. For example, WHS nurses have been using New Zealand cardiovascular guideline to do a systemic screening programme for cardiovascular risk since 2010. Healthy lifestyle talk, Cholesterol controlling workshop and referrals are given to clients based on the guideline. To facilitate the use of proposed guideline, briefing session and training workshop for the proposed innovation will be provided to the WHS nurses.

The implementation of innovation will not interfere inordinately with the current staff functions. Computer programme or self-administrated questionnaire is recommended to be completed by clients before the interview. Therefore, the innovation is unlikely to disturb the existing operation. Moreover, nurses are able to assess the safety of IPA survivors and to respond appropriately to the disclosure of clients’ IPA history. These skills and knowledge facilitate the existing programme to
be more holistic and well-rounded.

The objectives of the proposed innovation are compatible with the vision and the mission of the Family Health Service of the Department of Health. Therefore, the administrators are likely to approve the evidence-based innovation. WHS medical officers and in-charge nursing officers will welcome the innovation because they concern the women’s physical and psychological health. As other MCHC staffs may concern the problem of witnessing violence in childhood, they would support the innovation too. The atmosphere of WHC and MCHC is favorable for the utilization of research findings such as breast feeding, growth and nutrition and cervical screening.

Generally, nurses may think that IPA is a sensitive issue and may afraid of offending the clients. Some nurses may not feel comfortable to ask or do not know how to assess IPA. Some people may feel powerless to change the problem because the choice of staying or leaving the perpetrator is still the clients’ own choice. The above obstacles are related to a lack of professional preparation in IPA management. In the training sessions, graduates of family violence course and social workers will be invited to share their knowledge and experiences. Moreover, trainings on result interpretation of assessment tool and skill of performing danger assessment will also be provided. The briefing sessions can be held in Saturday in which nurses and other medical staffs do not need to be released in official hours. The training workshop can
be held in Saturday afternoons for WHS nurses. Therefore, it does not affect the manpower required for the daily practices. Application of Continuing Nursing Education (CNE) point for the IPA management education is one way to increase the motivation of attendance.

The innovation may increase the workload of information technology team as modification of the existing computer programme in WHS is needed. The existing WHS computer system is not compactable for screening programme and record management. Automated computerized system is the latest trend of medical record management. Therefore, new version of software and hardware should be considered in the proposed innovation. Electronic record system is widely used in child health monitoring and cervical screening programme. Therefore, it seems reasonable to ask for more support from the technology team.

Regarding to the time constraints, the AAS is chosen for the proposed innovation (Appendix J). Generally, it only takes three to five minute for a woman to complete AAS. The Chinese version of AAS has been validated for the use with Chinese women (Tiwari, Fong, Leung, Parker, & Ho, 2007). Standard referral letter is also available from the Social Welfare Department (Appendix K). The availability of existing resources increases the feasibility of the proposed innovation. In conclusion, the feasibility of the proposed innovation is high.
Cost-benefit Ratio of the Innovation

Potential risks

The recent studies showed IPA identification is no harm to clients (Koziol-McLain et al., 2010; MacMillan et al., 2009). However, IPA identification is absent in the current practice in WHS. Regarding the adverse health consequence of IPA which are discussed in previous chapter, there are potential risks of no IPA identification due to following reasons: 1) IPA survivors cannot be identified if they are not willing to disclose their IPA history; 2) Community resources for the IPA survivors cannot be fully utilized as the needs of IPA services maybe underestimated; 3) there is no window to break the cycle of violence before the survivors get hurt and attend the emergency medical services; 4) some IPA survivors are not aware that they are suffering. For example, some sexually abused women may perceive that the acceptance of sexually abuse is one of “wife’s duties”. On the other hand, there is possibility that nurses may feel sad after listening to the IPA survivor’s story. Therefore, the demand of staff counseling service may be increased.

Potential benefits

On the other hand, there are potential benefits for both the WHS clients and the service providers. All Clients have a chance to know more about IPA through the discussion between the service provider and the clients (Calderon, Gilbert, Jackson,
Kohn, & Gerbert, 2008). Since useful information can be provided to the Identified
IPA survivors through the innovation, they can have a more informed choice for
whether seeking help or not from the health care professionals and the social workers.
Proper referral can be given when necessary. IPA survivors will know more about the
issue of their safety through the danger assessment. Therefore, further violence or
abuse can be reduced or stopped after the intervention of IPA services provided by the
social workers or other relevant organizations.

In service providers’ perspective, staff can gain more knowledge about IPA and
learn the handling skills. Communication barriers with IPA survivors and
misconception can be eliminated by the professional trainings of IPA management.
The use of evidence-based assessment tool and danger assessment can be applied to
other services such as antenatal, postnatal and child health monitoring. The proposed
innovation can add value to the existing service. Eventually, IPA survivors can make
their decisions that are conducive to their health and seek appropriate health care and
social services. As a result, the proposed innovation fulfills the objectives of a
comprehensive women health’s service.

**Short-term costs**

Financial support from the headquarters is very important. As WHC and MCHC
have already had parts of the necessary hardware such as private interview room and
computers for the proposed innovation, the short-term cost associated with the proposed innovation is mainly on renewing computer programme and training of nursing staff. Laptops with touch screen for computer-assisted screening can be considered if a larger amount of budget is secured. Computer screening was acceptable for clients in the four identified studies reviewed in chapter two (Ahmad, et al., 2009; Humphreys, et al., 2011; Rhodes, et al., 2006; Trautman, et al., 2007).

**Long-term costs**

There are potential costs for the maintenance of the computer programme, the security software charge, the useful information cards and the proposed innovation may increase the workload of the staff due to the follow-up for the identified cases. In addition, the psychological, medical care or social service expenses may be increased due to the increase of the identified IPA cases.

After comparing the benefits and the risks of the proposed innovation, IPA identification is worth to be implemented in health care settings.

**Evidence-based Practice Guideline**

Transferability, feasibility and the cost-benefit ratio of the proposed innovation are discussed in the above sections. The conclusion is clear that the proposed innovation is transferable, feasible and affordable in WHC and MCHC. An evidence-based practice guideline will be developed based on the analysed research
findings. The recommendations will be explained and justified systemically in the following section.

**Name of proposed innovation**

Clinical Guideline for Identifying Intimate Partner Abuse in Women’s Health Services

**Purpose**

To assist nurses of women’s health services to identify women survivors of intimate partner abuse

**Objectives**

1. To increase nurses’ knowledge of the practice of IPA identification.
2. To increase the detection rate of IPA.
3. To monitor the recurrence rate of the identified IPA cases.

**Target population**

Women who are under 65 years old and attend women’s health services are the target population.

**Recommendations of the Clinical Guideline**

Recommendations of the clinical guideline are based on the findings from the six identified papers: “Increasing discussion of intimate partner violence in prenatal care using video doctor plus cueing: a randomized, controlled trial” (Humphreys, et al.,

The evidence from the identified studies along with their level of evidence is provided to support the statement.

**Recommendation 1**

The Abuse Assessment Screen (AAS) should be used. (Grade A)

AAS is validated in Humphreys, et al. (year)(1+) and Ahmad, et al. (2009) (1++) studies. Also, the Chinese version of AAS is available and validated for use in the local setting (Tiwari, et al., 2007). Since the average time for completing AAS is short (e.g. three to five minutes), this screening tool is suitable for the busy practicing
centers.

**Recommendation 2**

Professional education for intimate partner abuse management should be provided for nurses. (Grade A)

Koziol-McLain, et al. (2010) (1+) emphasized the needs of appropriate training for staff. Training programs should be provided to nurses emphasizing on the importance of privacy, confidentiality, and communication skills in handling sensitive issue (Ahmad, et al., 2009) (1++). Standardized training for the skills in responding to IPA survivors is needed due to ethical and safety consideration. The training should also include an overview of IPA, appropriate response to IPA disclosure, safety assessment and community resources information (MacMillan, et al., 2009) (1-).

**Recommendation 3**

A single private room should be used for completing the AAS and the interview. (Grade B)

Private area should be provided to clients for completing the AAS screening tool (Trautman, et al., 2007) (1-). Although other studies did not mention about the privacy measure in detail, privacy and confidentiality are essential in such sensitive topic. Due to a concern of the safety of the clients, individual interview in a private room is recommended in order to avoid the presence of the perpetrator.
Recommendation 4

Computer-based questionnaire displaying on computers with touch screen is recommended. (Grade A)

Computer-based screening is an effective, time-saving method for identifying IPA in busy medicine practice and seems to be acceptable by clients. (Ahmad, et al., 2009) (1++). In Trautman, et al.’s study (2007) (1-), they found that that clients were able and ready to answer questions about their health using a computer screening tool. They also found that computerized screening for intimate partner violence significantly increased the detection rate compared to the usual care. Rhodes, et al.’s study (2006) (1-) also found that women are willing to disclose domestic violence risks during a computer screening. They also showed that computer screening increased the rate of domestic violence communication between health care provider and patient in an urban setting. In conclusion, computer-based approach is feasible in urban health care settings such as WHC and MCHC in Hong Kong.

Recommendation 5

Nurses should perform danger assessment to client with positive results in AAS. (Grade A)

Assessment of patient’s safety was provided for the identified cases in Ahmad’s study (Ahmad, et al., 2009) (1++) and in Rhodes et al.’s study (Rhodes, et al., 2006)
Safety assessment for the identified cases plays an important role in IPA identification. Presumably, willingness to seek help and resources may be increased by the result of safety assessment.

**Recommendation 6**

Referral should be made available for the identified cases. (Grade A)

Most of the identified studies emphasized on the importance of a proper referral for IPA survivors (Ahmad, et al., 2009; Koziol-McLain, et al., 2010; MacMillan, et al., 2009; Rhodes, et al., 2006; Trautman, et al., 2007) (1++ to 1-). Referral to social workers of Integrated Family Services Centers (IFSC) should be made according to the address of the clients. Standard referral letter can be faxed to IFSC to ensure the safety and the confidentiality of the IPA survivors.

**Recommendation 7**

Helpful information card or leaflet should be provided. (Grade B)

Information about the local community resources were provided in MacMillan et al’s study. (MacMillan, et al., 2009) (1-). Small information cards are suitable for distribution and are convenient for carrying. Therefore, useful information for IPA survivors should be printed on and distributed on a small information card. A family support service information card is available for distribution (Appendix M).

**Recommendation 8**
Nurses should follow up the identified cases for at least six- to twelve-months.

(Grade A)

Follow up action can help to monitor the recurrence of IPA and evaluate the effectiveness of the proposed innovation. However, in Koziol-McLain, et al.’s screening study (2010), a three-month follow up was not found to cause a significant reduction of IPA re-exposure by screening intervention (Koziol-McLain, et al., 2010) (1+). But in another study which IPA survivors were monitored for at least six month, observed re-exposure of IPA in screened group was lesser than those in the non-screened group (MacMillan, et al., 2009) (1-). Since WHS is an annual base health care service provided by FHS, follow up action such as revisit interview or phone-interview can be conducted for IPA survivors for six- to twelve-months.

Chapter 4: Implementation Plan

After assessing the transferability of evidence, feasibility and cost-benefit of the proposed innovation in the previous chapter, the next chapter is to develop the implementation plan. The implementation plan comprised of three parts, which are the communication plan, the pilot testing, and the evaluation. First, the two main components of the communication plan are discussed. They are the stakeholder identification and the communication processes. Secondly, a well-designed pilot study is depicted with the aim of improving the proposed innovation in the clinical
environment. Finally, the effectiveness of the proposed innovation will be determined in the evaluation plan.

**Communication Plan**

**Identification of relevant stakeholders**

There are two kinds of stakeholders in the proposed innovation: service providers and service recipients. Service providers include the administrators, nursing staff, medical officers, information technology supporting team and social workers. And the service recipients consist of clients who attend the WHS in WHC and MCHC.

Women who attend to WHS in the selected centers are the stakeholders of service recipients. The Chinese version of AAS is the tool for intimate partner abuse (IPA) identification. The participation of clients in completing the AAS is important either in paper-based questionnaire or computerized questionnaire using screen touch system.

The relevant stakeholders of service provision are administrators, nursing officers, medical officers, nurses, information technology supporting team and social workers of the IFSC. Their functions and their influences on the proposed innovation will be illustrated in the following sessions.

The main administrators of WHS are the senior nursing officers and medical officers of Family Health Service who work in the headquarters of the Department of
Health. The proposed innovation cannot proceed without their approval. Support from the administrators can help to secure resources and manpower for the proposed innovation. Previous studies found that computer-based approach have led to significant higher detection rates compared to usual care (Rhodes et al., 2006; Trautman, McCarthy, Miller, Campbell, & Kelen, 2007). Therefore, computer-based questionnaire is more preferable than the paper-based questionnaire. The advocator should try the best to persuade them to use computer-based approach screening.

Nursing officer is the person in-charge in a WHC or MCHC. The support and the active participation of nursing officers will facilitate the implementation of the proposed innovation. Nursing officer acts as a bridge of communication between the administrators and the clinic staff. Moreover, she is responsible for the utilization of the resources and manpower in a clinical setting. It is not unusual that some staff will support an innovation and someone will not. Therefore, the nursing officer is at an irreplaceable position in this proposed innovation.

Nurses in WHS are also the main service providers in daily practices. They often have very good rapport with clients. They are responsible for the detailed personal history taking and to provide individual counseling based on client’s needs. The workload of nurses may become heavier should the proposed innovation have implemented. This is because of the danger assessment and individual counseling
given to the IPA survivors. Therefore, nurses should be included in the communication plan.

Medical officers in the WHC and MCHC are responsible for physical examination and referral. They are advocators of evidence-based practice. Medical officers of the WHS concern about the physical and psychological health of women in Hong Kong. They may perhaps aware of the problem of IPA in Hong Kong but they may not be familiar with the identification tool of IPA. This is a good opportunity to introduce them the evidence based screening tool. According to the common practice in the clinical setting in Hong Kong, medical officers have the authority to make referral for clients. The implementation process should become smoother with the support of the medical officers.

If the proposed innovation uses the approach of computer-based screening, the IT supporting unit should be included in the communication plan. Modification of database and the exploration of the use of computer-based AAS screening should be discussed with IT supporting team. A feasibility testing should be carried out before the pilot test.

According to the recommendation, appropriate referral to IFSC should be provided to IPA survivors. This action will affect the workload of social workers. All WHS clients will complete the AAS either through the computer-based or paper-based
questionnaire as routine practice according to the proposed innovation. Immediate referral to IFSC will be provided for clients’ safety. The IFSC social workers are experts in managing IPA cases. They have sufficient resources and follow-up procedures for IPA survivors. As a result, the quality of life can be improved and the recurrence of IPA can be reduced. Therefore, a good relation between WHS and IFSC can ensure a good quality of service.

**Communication process**

The existing practice of women’s health assessment only provides a brief psycho-social assessment. There is no an evidence-based screening tool or even a standard question concerning IPA. Moreover, there is no professional training for the management of IPA. An evidence-based guideline can increase the confidence of the frontline staff in managing IPA cases. The communication plan will elicit the benefits of the proposed innovation compared to the brief psycho-social assessment.

At the beginning, I will discuss the drawbacks of the existing practice for IPA identification with the nursing staff. A peer group of nurses who express their concerns about the problem of IPA will be formed. Then, a systematic search of relevant literature will be carried out using electronic databases. The findings based on the literature search will be shared in the peer review meeting. Existing evidence has shown that IPA identification is harmless to clients. AAS is simple and safe to be
used in clinical setting. Computerized questionnaire is also feasible and environmental
friendly.

With the support of nursing colleagues, the next step in the communication
process is to gain approval from the nursing officer in-charge. The leading role of
nursing officer is significant to any innovation. The concern of nursing officer is about
the improvement of the quality of the services and the client’s outcome. She
welcomes suggestions about the improvement of the service with supporting evidence.
Therefore, the detail of literature findings, transferability, feasibility, cost-benefit ratio
and evaluation plan should be prepared. Nursing officer will be invited to the working
group too. With the support of nursing officers, the next step is to persuade the
medical officers to implement the proposed innovation. In the usual practice of WHS,
medical officers often agree to implement innovations that can improve the quality of
services and innovations that bring benefit to clients.

The finally step of the communication process is to convince the administrators
in the headquarters of WHS. The proposed innovation is in line with the philosophy of
Women Health Services of the Department of Health. Senior medical and nursing
officers may agree with this evidence-based practice. Nowadays, the use of computer
is gradually integrated into the daily clinical practice of Family Health Service such as
the immunization record and the antenatal checkup. Therefore a well-prepared
proposal with transferability of evidence, feasibility and evaluation plan should be provided. IT supporting unit should be contacted if the administrators agree for the use of computer-based screening approach. This is because the development of the electronic version of AAS takes time. Likewise, the IT supporting unit has to modify the WHS database if the administrators do not agree on the use of computer-based screening approach for IPA identification. With the approval of implementation, communication with the external parties such as the IFSC can be proceeded. To understand the operation of IFSC, communications with the representatives of the IFSC social workers will be crucial. A good relationship with IFSC can improve the referral system for the identified IPA cases. In addition, follow-up for the referred IPA cases will be easier to conduct with the good cooperation with IFSC. IFSC concerns the psycho-social problem of family unit. Their social workers are experts in handling family violence cases. WHS concerns the quality of health and the physical health problems of the IPA cases. Therefore, IFSC is likely to cooperate with health care professionals for the care of the IPA survivors.

After having a good communication with different stakeholders of the service providers, posters and display boards with information of IPA for WHS clients should be considered. An introduction of the IPA identification process and relevant information should be posted on the display boards in the waiting hall. A short video
showing the IPA identification process can be shown to clients sitting in the waiting hall after watching the healthy life style video. As a result, the WHS clients will not be surprised of the IPA screening by AAS and they will feel more comfortable to accept the proposed innovation.

Training for the potential users of the proposed guideline will be divided into two parts: the briefing session and the training workshop. The contents of the training will be designed by the working group. A briefing session will be provided to all WHS staffs including medical officers and nursing staff. The health consequences of IPA and the need of IPA identification in Hong Kong should be stressed in the briefing session. The administration of AAS and referral management should be delivered to the audiences along with concise notes. Then, a workshop will be given to the nursing officers-in-charge and the nurses in WHS as they are the key users of the proposed guideline. In order to have better understanding of the AAS, the details of the AAS items should be included. The privacy and confidentiality of the clients should be emphasized. The information about IPA such as the danger assessment, the brief IPA counseling and the skills of using helpful materials should be included too. A guideline handbook will be given to each attendance. The handbook will have a flow chart of the care for the IPA survivors. It will also contain the recommended verbatim for the use of the danger assessment and counseling. The comprehensive workshop
will consist of a role play session, video and handbook in order to facilitate the implementation. Feedbacks of the workshop from the participants will be collected for potential improvement.

**Pilot Study Plan**

A pilot test should be carried out in clinical setting before the full implementation. By solving the unexpected difficulties emerged during the pilot test, it may help to ensure the success of the full implementation of the proposed innovation. There are three objectives of the pilot study:

1. To assess the acceptability of the proposed innovation for WHS clients;
2. To assess the acceptability of the proposed innovation for WHS nurses;
3. To explore any difficulties in providing referral and counseling.

**Time frame**

A pilot test will be carried out in one selected MCHC where the proposer of the innovation works. The center has about 130 WHS cases per month. The expected number of identified IPA cases will be 20. In Hong Kong, the prevalence of physical violence in past 12 months was 4.5% (Chan, 2005). In order to recruit the expected sample size from the center, the estimated time for the pilot test will be three months. The preparation for the proposed innovation includes working group formation and training. Two months should be sufficient for the preparatory work. Modification of
the existing computer system of WHS such as the addition of IPV screening items will take about two months to complete. Revision of the guideline and evaluation of the pilot test will take about one month to complete. In total, the estimated timeframe for the pilot test and the preparatory work will take six months.

**Training**

Briefing session for all WHS nurses and medical officers will be arranged. A half-day briefing session will include information such as the IPA problem in Hong Kong, usage of clinical guidelines, the AAS screening tool, interpretation of screening results and the referral management. A more comprehensive training workshop will be arranged for the nurse-in-charge of WHC and MCHC first. Then each of WHS nurses should attend the workshop before the implementation of the innovation. A whole day workshop will include information such as the international and local problem of IPA, selection of identifying tool, usage of AAS, details of the clinical guideline, the danger assessment and the counseling skills. The workshop will include role play and the demonstration of danger assessment, counseling skills and technique of providing helpful materials. In order to facilitate the communication between WHS and IFSC, site visits will be arranged for nurses and social workers.

In addition, the content and literature notes of training workshop will be posted on the departmental intranet. The new comers of WHS can study the contents of the
training workshops by themselves. Moreover, the staffs from other services within the Department of Health can also access to the content if they are interested. The update version of the guideline or the latest news about IPA can be posted on the website via departmental portal.

**Evaluation of Pilot**

**Recipient’s acceptability of the proposed innovation**

According the objectives, the client’s acceptability of proposed innovation will be assessed. Each WHS client will be invited to complete a self-administrated questionnaire. The survey will include three questions as follow:

1. **Do you feel comfortable to answer the AAS questionnaire?**
2. **Do you think the IPA identification by nurses is helpful?**
3. **Do you think the IPA identification can arouse the awareness of IPA in the community?**

The answers will be rated on a 5-point Likert scale ranging from “Strongly Agree”, “Agree”, “Neutral”, “Disagree” and “Strongly Disagree”.

**Nurse’s acceptability of the proposed innovation**

There are twelve registered nurses and one medical officer providing WHS in the center. A quick individual interview will be performed after the pilot test. The acceptability of nurses towards the innovation will be assessed during the interview.
The proposer will also ask about the difficulties of carrying out the proposed innovation and recommendations. The opinions and recommendations from the interviewees will be discussed in the working group meeting. The working group will make modifications for the innovation according to the opinions and recommendations obtained.

Chapter 5: Evaluation Plan

Identifying Outcomes

In the evaluation plan, there are two patient outcomes and one healthcare provider outcome. The identified outcomes will be the indicators of the effectiveness of the proposed innovation. Moreover, appropriate analysis methods will be adopted for different outcomes.

Client outcome

The purpose of the proposed innovation is to help nurses of the WHS to identify women survivors of IPA. Therefore, the rate of successful IPA identification based on the AAS is the primary outcome. The effectiveness of the proposed innovation is mainly based on the rate of successful IPA detection. This is a significant term to determine the success of proposed innovation. In addition, the secondary client outcome is the rate of IPA recurrence of the identified survivors in six months after. The identification of IPA in primary health setting is worth to promote if there is a
significant drop of the recurrence rate.

**Healthcare provider outcome**

The knowledge of IPA identification and management of healthcare providers affect nurses’ confidence in handling IPA case. The barriers of asking about IPA, such as discomfort and fear of offending, can be eliminated by professional education. Therefore, an increase of IPA knowledge can help to improve the nursing competence in using AAS.

**Determining the nature and number of clients to be involved**

The Family Health Service of the Department of Health provides women health services to women who aged at 64 years old or below (Department of Health, 2009). All female clients who are in a current or recent intimate relationship within the past twelve months will be included in the evaluation plan. However, there are two exclusion criteria for the clients:

1. Women who cannot be alone in the interview;
2. Women who cannot read and understand English or Chinese.

The sample size is calculated by a free online sample size calculator (Raosoft, 2004). The margins of error and confidence level are set to be 5% and 95% respectively. The calculated sample size is 380 intimate partner abused survivors.

**When and how often to take measurement**
The primary outcome of the proposed innovation is the rate of IPA identification using AAS. The number of the identified IPA survivors can be retrieved from the monthly statistic data of the WHC and MCHC. The accumulated data will be gathered and summed up twelve months after the full implementation.

Another patient outcome is the recurrence rate of IPA in six months after. This outcome will be measured at the entry time and six months after the first identification. Phone follow-up will be performed by the WHS nurses in-charge since the sixth month till the eighteenth month after commencement of proposed innovation.

The healthcare provider outcome is the WHS nurses’ knowledge about IPA. Pretest and posttest will be held before and after the training workshop. Every WHS nurses who attend the workshop will be asked to complete the pretest and the posttest questionnaire.

Data Analysis

IPA will be identified by the Chinese Version of AAS. The data collection procedure will be easier if computer based approach is used. The central computer system can be used to generate the data summary based on the request. However, each center should input the results of all completed AAS questionnaires into the database. The key proposer will extract the data monthly and monitor the implementation of the proposed innovation. As all the demographic data and results of laboratory
investigations are input into the centralized WHS database, data of identified IPA survivors can be retrieved with headquarters’ approval. At the end of the proposed innovation, the rate of IPA identification can be found out.

A follow up reminder will be faxed to each center with the case number of the identified IPA survivor six months since the identification. The case number of identified IPA survivors can be extracted out from the WHS database. A designated nurse will perform phone follow-up for each IPA survivors. The result will be faxed back to the innovation proposer for further analysis. One sampled, two-tailed paired t-test for follow-up can be used to test the significance.

Healthcare providers refer to nurses who participate in the women health services. Pretest and posttest with ten multiple choice questions will be designed by the working group. The content of test will be about the care of the IPA survivors and their families. The improvement of the knowledge of IPA of the healthcare provider can be shown by the significant increase of marks. The two sets of data from protest and posttest will be input into the computerized statistical programme SPSS.

**Basis for an Effective Change of Practice**

The proposed innovation is built based on the existing system of Women Health Services provided by the Government. However, a lack of standard screening tool makes the problem of IPA like a taboo in the community health services. The
proposed innovation makes a first step to identify IPA survivors in primary health setting. Apart from the effectiveness of the proposed innovation, it has already aroused the awareness of the healthcare professionals towards IPA. In addition, the ultimate goal of intervention is to stop IPA. Therefore, the statistical significant drop of the rate of IPA recurrence can affirm the value of the proposed innovation.

In a real clinical setting, it is not likely that all identified IPA survivors would accept a referral. Therefore, the success of the proposed innovation will be determined by the rate of IPA identification. The proposed innovation will be considered as effective if the detection rate is higher than a previous local study (Chan, 2005). The success of the proposed innovation is also supported by the training of healthcare professionals. After the training, the WHS nurses can know more about IPA including its adverse health consequences, IPA screening tool, skills of doing the danger assessment and providing helpful information. The awareness of IPA will be embedded into the mind of the healthcare professionals in wherever they work.
## Tables of health consequences of intimate partner violence (WHO, 2002)

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<tr>
<th>Category</th>
<th>Consequences</th>
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<tr>
<td><strong>Physical</strong></td>
<td>Abdominal/thoracic injuries</td>
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<td>Bruises and welts</td>
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<td>Chronic pain syndromes</td>
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<td>Disability</td>
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<td>Fibromyalgia</td>
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<td>Fractures</td>
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<td>Gastrointestinal disorders</td>
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<td>Irritable bowel syndrome</td>
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<td>Lacerations and abrasions</td>
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<td>Ocular damage</td>
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<td>Reduced physical functioning</td>
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<td><strong>Sexual and reproductive</strong></td>
<td>Gynecological disorders</td>
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<td>Infertility</td>
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<td>Pelvic inflammatory disease</td>
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<td>Pregnancy complications/miscarriage</td>
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<td>Sexual dysfunction</td>
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<td>Sexually transmitted diseases, including HIV/AIDS</td>
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<td>Unsafe abortion</td>
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<td>Unwanted pregnancy</td>
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<td><strong>Psychological and behavioral</strong></td>
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<td>Depression and anxiety</td>
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<td>Eating and sleep disorders</td>
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<td>Feelings of shame and guilt</td>
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<td>Phobias and panic disorder</td>
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<td>Physical inactivity</td>
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<td>Poor self-esteem</td>
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<td>Post-traumatic stress disorder</td>
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<td>Psychosomatic disorders</td>
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<td>Smoking</td>
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<td>Suicidal behavior and self-harm</td>
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<tr>
<td></td>
<td>Unsafe sexual behavior</td>
</tr>
<tr>
<td><strong>Fatal health consequences</strong></td>
<td>AIDS-related mortality</td>
</tr>
<tr>
<td></td>
<td>Maternal mortality</td>
</tr>
<tr>
<td></td>
<td>Homicide</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
</tr>
</tbody>
</table>
**Scottish Intercollegiate Guidelines Network (SIGN) Coding System (2004)**

<table>
<thead>
<tr>
<th>Level of evidence</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ++</td>
<td>High quality meta analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1 +</td>
<td>Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias</td>
</tr>
<tr>
<td>1 -</td>
<td>Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias</td>
</tr>
<tr>
<td>2 ++</td>
<td>High quality systematic reviews of case-control or cohort or studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal</td>
</tr>
<tr>
<td>2 +</td>
<td>Well conducted case control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal</td>
</tr>
<tr>
<td>2 -</td>
<td>Case control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies, e.g. case reports, case series</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion</td>
</tr>
</tbody>
</table>
Appendix C

Table of evidence

<table>
<thead>
<tr>
<th>Bibliographic citation</th>
<th>Study type</th>
<th>Evidence level</th>
<th>Subject Characteristic</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Length of follow up</th>
<th>Outcome measures</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humphreys et al., 2011</td>
<td>RCT (n=50)</td>
<td>1+</td>
<td>Pregnant women reported IPV risk</td>
<td>Video Doctor plus Provider Cueing Intervention in prenatal clinics</td>
<td>Usual care (behavioral counseling)</td>
<td>1-month</td>
<td>Provider-patient discussion of IPV</td>
<td>Initial assessment: Intervention group: 81.8% (p&lt;0.001) Control group: 16.7% (p&lt;0.001) 1-month follow up: Intervention group: 70.7% Control group: 23.5% (p&lt;0.001)</td>
</tr>
</tbody>
</table>

- Pregnant women reported IPV risk
- Age ≥ 18 years old
- Gestation ≤ 26 weeks
- Recruited from Jun 2006 to Dec 2007 in 5 prenatal clinics in San Francisco Bay Area
# Appendix D

## Table of evidence

<table>
<thead>
<tr>
<th>Bibliographic citation</th>
<th>Study type</th>
<th>Evidence level</th>
<th>Subject Characteristic</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Length of follow up</th>
<th>Outcome measures</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koziol-McLain et al., 2010</td>
<td>RCT</td>
<td>1+</td>
<td>Women attended ED&lt;br&gt;Age ≥ 16 years old&lt;br&gt;Recruited from Apr 2007 to Dec 2007 in a ED of hospital in a north island of New Zealand</td>
<td>Standardized IPV screen, statements about the unacceptability of violence, risk assessment &amp; referral</td>
<td>Usual care</td>
<td>3 months</td>
<td>Short-term violence re-exposure</td>
<td>Intervention group: 12% (20/167)&lt;br&gt;Control group: 13.6% (24/177)</td>
</tr>
<tr>
<td>Bibliographic citation</td>
<td>Study type</td>
<td>Evidence level</td>
<td>Subject Characteristic</td>
<td>Intervention</td>
<td>Comparison</td>
<td>Length of follow up</td>
<td>Outcome measures</td>
<td>Effect size</td>
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</tr>
<tr>
<td>Ahmed et al., 2009</td>
<td>RCT (n=314)</td>
<td>1 ++</td>
<td>Women in a current or recent relationship</td>
<td>Computer-based multi-risk assessment report attached to the medical chart.</td>
<td>Standard medical care</td>
<td>Nil</td>
<td>IPVC detection</td>
<td>↑ IPVC discussion (RR=1.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age ≥ 18 years old</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑ IPVC detection (RR=2.0)</td>
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<tr>
<td></td>
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<td></td>
<td>Recruited from Mar 2005 to Sep 2005 in a hospital-affiliated, academic family practice clinic in Toronto</td>
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</table>
## Table of evidence

<table>
<thead>
<tr>
<th>Bibliographic citation</th>
<th>Study type</th>
<th>Evidence level</th>
<th>Subject Characteristic</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Length of follow up</th>
<th>Outcome measures</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacMillan et al., 2009</td>
<td>RCT (n=707)</td>
<td>1 –</td>
<td>Adult women had positive results in IPV screening. Aged 18 to 64 years old. Recruited from 7/2005 to 12/2006 at 12 primary care setting, 11 ED and 3 Obst /Gyne clinics</td>
<td>Subsequent discussion and referrals if positive in screening by using Women Abuse Screening Tool (WAST)</td>
<td>Non-screened group with usual care</td>
<td>6, 12 and 18 months</td>
<td>IPV re-exposure Quality of life Potential harm of screening</td>
<td>Observed recurrence of IPV: Screened vs non-screened: 46% vs 53% (modeled OR= 0.82) No sig. difference in quality of life No harms of screening</td>
</tr>
<tr>
<td>Bibliographic citation</td>
<td>Study type</td>
<td>Evidenc e level</td>
<td>Subject Characteristic</td>
<td>Intervention</td>
<td>Comparison</td>
<td>Length of follow up</td>
<td>Outcome measures</td>
<td>Effect size</td>
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<tr>
<td>Rhodes et al., 2006</td>
<td>RCT (n=2165)</td>
<td>1–</td>
<td>Women aged 18 to 55 years and triaged as medically non-emergent Recruited from 6/2001 to 12/2002 in two emergency departments in USA</td>
<td>Self-administered computer-based health risk assessment</td>
<td>Usual care</td>
<td>Nil</td>
<td>Rate of DV discussion, disclosure and receipt of services (e.g. safety assessment and referral)</td>
<td>Intervention group: DV discussion: 56% DV disclosure: 14% DV services: 57% Control group: DV discussion: 45% DV disclosure: 8% DV services: 43%</td>
</tr>
</tbody>
</table>
## Table of evidence

<table>
<thead>
<tr>
<th>Bibliographic citation</th>
<th>Study type</th>
<th>Evidence level</th>
<th>Subject Characteristic</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Length of follow up</th>
<th>Outcome measures</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trautman et al., 2007</td>
<td>Quasi-experimental design (n=1005)</td>
<td>1-</td>
<td>Women attended in ED for medical treatment Recruited from 4/2003 to 5/2003</td>
<td>Computer-based health survey with IPV questions</td>
<td>Computer-based health survey without IPV questions</td>
<td>Nil</td>
<td>IPV detection rate</td>
<td>Intervention group: IPV detection rate: 19%</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Referral rate to social work</td>
<td>Referral rate: 4%</td>
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<td></td>
<td></td>
<td></td>
<td>Control group: IPV detection rate: 1%</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td>Referral rate: 1%</td>
</tr>
</tbody>
</table>
### Characteristics of Target Audience and Settings

<table>
<thead>
<tr>
<th>Studies</th>
<th>Target Audience</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humphreys, et al., 2011</td>
<td>Pregnant women with IPV ≥ 18 years old ≤ 26 weeks gestation</td>
<td>Prenatal clinics in urban districts of USA</td>
</tr>
<tr>
<td>Koziol-McLain, et al., 2010</td>
<td>Women ≥ 16 years old</td>
<td>Emergency department in urban district of New Zealand</td>
</tr>
<tr>
<td>Ahmed, et al., 2009</td>
<td>Women ≥ 18 years old</td>
<td>Hospital-affiliated family practice clinic in Toronto</td>
</tr>
<tr>
<td>MacMillan, et al., 2009</td>
<td>Women aged 18 to 64 years old</td>
<td>1. Primary care sites (family practices and community health centers)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Acute care sites (emergency departments)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Specialty care sites (obstetrics / gynecology clinics)</td>
</tr>
<tr>
<td>Rhodes, et al., 2006</td>
<td>Women aged 18 to 55 years old</td>
<td>Emergency departments of one urban academic medical center and one suburban community hospital</td>
</tr>
<tr>
<td>Trautman, et al., 2007</td>
<td>Women aged 18 to 87 years old</td>
<td>One academic urban emergency department in USA</td>
</tr>
<tr>
<td>Proposed Innovation</td>
<td>Women aged 18 to 64 years old</td>
<td>1. 3 Women’s Health Centers (WHC) in Hong Kong</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 10 Maternal and Child Health Center (MCHC) have WHS</td>
</tr>
</tbody>
</table>
# Appendix J

## English and Chinese Version of the Abuse Assessment Screen (AAS)

### Abuse Assessment Screen

1) Within the last year, have you been **emotionally** hurt by someone? Examples of emotional hurt:
- yells at you
- is hypercritical towards you
- shames you in front of friends/family/strangers
- ridicules you (e.g. about her appearance or behavior)
- monitors you
- isolates you from friends/family
- threatens to hit you
- threatens to throw something at you
- accuses you (e.g. of doing something wrong)
- destroys something belonging to you

If **yes**, by whom (check all that apply)

- [ ] Husband
- [ ] Ex-husband
- [ ] Cohabiter
- [ ] Boyfriend
- [ ] Other (specify)

2) Within the last year, have you been **physically** hurt by someone? Examples of physical hurt:
- throws something at you
- pushes or shoves you
- slaps you
- grabs you
- drags your hair
- threatens you with a weapon

---

### 虐待評估篩選問卷

1) 在過去一年內，您是否有受到精神傷害？精神傷害的例子：
- 對您吼叫
- 對您吹毛求疵
- 在朋友／家人／陌生人面前羞辱您
- 奚落您（如嘲笑您的外貌或行爲）
- 監視您
- 將您與朋友／家人隔離
- 恐嚇要打您
- 恐嚇要向您扔東西
- 指責您（如做錯某些事情）
- 毁壞屬於您的東西

如是，誰傷害您（請在適用的全部方格內加上剔號）
- [ ] 丈夫
- [ ] 前夫
- [ ] 同居伴侶
- [ ] 男朋友
- [ ] 其他 （ 請 列 明 ）

2) 在過去一年內，您是否有受到身體傷害？身體傷害的例子：
- 向您扔東西
- 推撞您
- 掌摑您
- 恐嚇要打您
- 拉扯您的頭髮
- 以武器恐嚇您
- 打您
• hits you
• beats you up
• kicks you
• chokes you
• burns or scalds you
If yes, by whom (check all that apply)
□ Husband
□ Ex-husband
□ Cohabiter
□ Boyfriend
□ Other (specify) ________________

3) Within the last year, have any one forced you to have sexual activities? Examples of forced sexual activities:
• insists on having sex with you against your wish (he may or may not use force)
• ignores your request to use condom when they have sex
• insists on having oral or anal sex (he may or may not use force)
If yes, by whom (check all that apply)
◆ Husband
□ Ex-husband
□ Cohabiter
□ Boyfriend
□ Other (specify) ________________

4) Are you afraid of your partner or anyone you listed above? ________________

Appendix K

Sample for Reference

File Ref.: Referring Unit
Tel. No.: (Name and Address)

Officer-in-charge
Receiving Unit
(Name and address)

Dear Sir/Madam,

Date

Referral of Spouse / Cohabitant Battering Case

I refer to the telephone discussion between _________________________
and __________________________ of your unit on ________________________.

This is to refer ______________ (Name), Female/Male*, Age _____,
HKIC No. _____________ of _____________________________ (Address) Tel
_________________ to you for follow-up services.

(Please specify any special requirement of the service user on way(s) & time to
contact him/her: ____________________________________________)

The following information is provided for your reference:

(a) The above-named has been known to our unit since ______________.

(b) Family Particulars:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Sex/Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person being referred</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(c) Presenting Problems:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

(d) Services Rendered:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

(e) Remarks: (e.g. other related document(s) if available)

__________________________________________________________________

I shall be grateful for your necessary action. For enquiries, please contact
______________________________, at tel. __________________.

                                 
(                                 )

(Name of Officer-in-charge, referring unit)

* delete whichever is inappropriate
## Grade of Recommendation of Scottish Intercollegiate Guideline Network 2011

<table>
<thead>
<tr>
<th>Grade</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results</td>
</tr>
<tr>
<td>B</td>
<td>A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+</td>
</tr>
<tr>
<td>C</td>
<td>A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++</td>
</tr>
<tr>
<td>D</td>
<td>Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+</td>
</tr>
</tbody>
</table>

**Good Practice Point**

Recommended best practice based on the clinical experience of the guideline development group

http://www.sign.ac.uk/guidelines/fulltext/50/annxeb.html
Family Support Service Information Card

If you need information on family support service, please call:

Integrated Social Service
Social Welfare Department – Family Help-line 2343 2255

Temporary Accommodation Service
Tung Wah – CEASE Crisis Centre 18 281
Christian Family Service Centre – Serene Court 2787 6865
Po Leung Kuk – Sunrise Court 2890 8330
Po Leung Kuk – Wai On Home 2793 0223
Po Leung Kuk – Dawn Court 2243 3210
Harmony House – Refuge Centre for Women 2522 0434
Caritas, Hong Kong – Family Crisis Support Centre 18 288
(for both men and women)

Emotional Support Service
Caritas, Hong Kong – Crisis Hotline 18 288
Caritas, Hong Kong – Extra-marital Affairs Support Service 2537 7247
Hong Kong Council of Social Service – HKCSS Mutual Aid Hotline 1878 668

Legal Aid Service (Enquiry in respect of an injunction order, divorce proceedings and custody of children etc.)
Hong Kong Office 2537 7677
Kowloon Office 2380 0117

Men’s Hotline
Harmony House – Men’s Hotline 2295 1386
Po Leung Kuk – Men’s Hotline 2890 1830

There are brighter days ahead
References


Against Women, 14(11), 1295-1312. doi: 10.1177/1077801208325088


Hicks, M. H., & Li, Z. (2003). Partner violence and major depression in women: a


The Family Planning Association of Hong Kong. (2011). Women's Health Service, 2011, from


