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Emergency clinicians' perceived self-efficacy in the care of intoxicated women victims of violence

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ABSTRACT

Background: Previous research has identified perceived self-efficacy to be a vital component of clinicians' positive attitudes towards caring for intoxicated patients and women who have been assaulted. To date, little is known about the perceived self-efficacy and influences among emergency clinicians towards intoxicated women victims of violence.

Method: Using mixed methods, 179 emergency clinicians were surveyed and 22 emergency clinicians were interviewed in South Australia about their education/training, their awareness and use of best practice guidelines and tools, and their perceived self-efficacy toward treating intoxicated women victims of violence.

Findings: There were statistically significant relationships between use of best practice tools (n = 32) and knowledge (χ^2 = 6.52; p = .02) and confidence (χ^2 = 6.52; p = .02) treating women victims of violence. There were also statistically significant relationships between previous alcohol and other drug education/training and knowledge (n = 43), skills and confidence treating both intoxicated patients (χ^2 = 7.85; p = .01) and women victims of violence (χ^2 = 11.63; p < .01). The interviews identified four themes about confidence, knowledge and use of research evidence, education and training, and resources.

Conclusion: Emergency clinicians reported low levels of perceived self-efficacy, and infrequent use of guidelines and tools to support the care of intoxicated women victims of violence. Participants wanted more knowledge and education/training in caring for intoxicated women who have been assaulted, as they felt lacking in these skills.

1. Introduction

Violence against women is widespread in Australia, with a lifetime prevalence of 31% for physical violence and 18% for sexual violence [1]. Alcohol intoxication in either the perpetrator or victim occurs in up to two thirds of all instances of violence against women [2,3]. There is no reliable data on the numbers of women seeking emergency care who are both intoxicated and victims of violence, though research on the prevalence of alcohol among injury presentations in general ranges from 14 to 50% [4,5]. Women who are both alcohol intoxicated and victims of violence are a particularly vulnerable patient population, particularly as intoxicated women who are physically or sexually assaulted are more likely to be blamed and criticised than sober women [6].

After family and friends, health care, particularly emergency care, is the most frequently accessed source of help for women who have been physically or sexually assaulted [3]. Healthcare clinicians are imbued with social authority, respect and trust to give the best medical care while treating all patients with respect and acting in their best interests [7,8]. However, attitudes of emergency clinicians towards intoxicated patients have been widely documented as mostly negative [9] and views about victims of physical or sexual assault range from compassion and empathy to blame and resentment [10,11].

Research in the emergency care setting has identified lack of clinician time and job role as barriers to best practice in care of alcohol intoxicated patients [12,13]. For example, Emergency Department (ED) nurses in one Australian study felt that responding to alcohol was a legitimate part of their role but time pressures reduced opportunities to translate their intentions into practice [14]. Perceived self-efficacy, defined as people's beliefs about their capabilities to produce or achieve certain effects or outcomes [15] has also been identified as a barrier for ED clinicians treating alcohol intoxicated patients [14]. The staff's perceived self-efficacy is vital to a positive therapeutic relationship with such patients [16]. Training and education that specifically focuses on alcohol can improve knowledge, skills and perceived self-efficacy among emergency care staff [17].

Knowledge and skills of emergency care clinicians in responding to women who have been physically or sexually assaulted are reportedly

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inconsistent and deficient [18,19]. Although education and training programs improve emergency clinician knowledge and attitudes, the extent of this change is variable [20]. Previous research has found experience, knowledge and confidence were the keys to clinicians regularly screening for interpersonal violence [19,21].

The aims of this study were to: (i) assess emergency care clinicians' previous education and training about alcohol intoxication, (ii) measure clinicians' current knowledge and confidence in treating intoxicated women victims of violence, and (ii) identify the use and awareness of relevant tools that are validated and widely recognised as best practice (including the Alcohol, Tobacco and Other Drug Clinical Guidelines for Nurses and Midwives [22] and the WHO AUDIT alcohol screening tool [23]) that might affect clinicians' perceived self-efficacy in caring for these patients.

2. Methods

2.1. Study design and participants

This focused-ethnographic research used mixed methods in a sequential design [24]. A cross-sectional survey of emergency care clinicians was conducted prior to qualitative one-on-one interviews by author 1 as part of her PhD studies. This research received approval by the Human Research Ethics Committees of the University of Adelaide and the two participating hospitals.

The paper-based survey was administered in two Adelaide metropolitan hospital emergency departments (EDs) where all clinical staff were informed about the survey via email and given a copy, and in six sessions of the Emergency Mental Health Alcohol and Drug (EMHAD) program [25] where all attendees were informed about the survey in person and given a copy. There were 106 respondents to the ED survey, with 64 (response rate 25.6%) from Hospital 1 and 42 (response rate 16.8%) from Hospital 2. There were also 76 respondents in total across six training sessions of the EMHAD program (response rate 65.5%). An extensive search of the existing literature failed to uncover a relevant survey instrument, so an exploratory survey was designed. In addition to a range of demographic variables, *de novo* questions were included to ascertain clinician awareness and use of evidence-based guidelines and tools, perceived self-efficacy and previous education and training. The survey was piloted by two ED nurses from Hospital 1 for timing, comprehension and content. The surveys were administered between January 2012 and April 2013.

Semi-structured interviews of an average of 45 min were conducted with 22 emergency care clinicians using snowball sampling from a range of emergency care services and roles over a seven month period between October 2012 and May 2013. Open questions were used to encourage participants to describe their perceptions and experiences, and follow up questions were used to further explore issues raised or to clarify responses.

2.2. Data analysis

All survey responses were coded and entered into SPSS (version 21.0) for analysis. To determine if either the use of best practice guidelines and tools or previous education and training had an impact on measures of perceived self-efficacy, each question was converted to a dichotomous variable by merging 'strongly agree' and 'agree' together, and 'neutral', 'disagree' and 'strongly disagree' together. Chi square analyses were used to explore the relationship between these two variables and the statements regarding perceived self-efficacy. Details about each interview and about the participant were recorded with full consent, before pseudonyms were assigned and the data was transcribed verbatim, coded manually and analysed by author 1 following an inductive thematic analysis framework [26].

Table 1
Demographic variables of respondents.

Variable	Category	N	%
Gender	Female	148	82.7
	Male	29	16.2
	Missing	2	1.1
Age group	< 30	61	34.1
	30–39	46	25.7
	40–49	47	26.3
	50+	23	12.8
	Missing	2	1.1
Education	Year 10	1	0.6
	Year 12	2	1.1
	Certificate	3	1.7
	Diploma	29	16.2
	Bachelor degree	83	46.4
	Postgraduate qualifications	59	33.0
	Missing	2	1.1
Clinical area	Emergency nursing	122	68.2
	Emergency medicine	11	6.1
	Mental health	4	2.2
	Triage	1	0.6
	Ambulance	4	2.2
	Other	37	20.7
Experience	< 12 months	39	21.8
	1–5 years	56	31.3
	5–10 years	48	26.8
	10 + years	36	20.1
Role	Enrolled nurse	26	14.5
	Registered nurse	126	70.4
	Nurse practitioner	2	1.1
	Medical officer	10	5.6
	Specialist	2	1.1
	Paramedic	1	0.6
	Other	11	6.1
	Missing	1	0.6

3. Findings

3.1. Survey

The majority of respondents were women (n = 148, 82.7%) and working in emergency nursing (n = 122, 68.2%) (Table 1). The largest proportion of respondents per age group were under 30 (n = 61, 34.1%). The majority of respondents had either a bachelor degree (n = 83, 46.4%) or postgraduate qualifications (n = 59, 33.0%). There was an even distribution of years of experience and nurses comprised over 85% of all respondents (Table 1).

The majority of respondents had not undertaken any education or training specifically regarding alcohol and other drugs (AOD) (n = 133, 74.3%) (Table 2). The 43 respondents (24.0%) who had completed AOD education or training reported receiving it through the EMHAD program (n = 13, 7.3%), in-service/hospital training (n = 8, 4.5%), general university studies (n = 6, 3.4%), specialised university studies

Table 2
Previous education and training, and use of best practice guidelines and tools.

Question	Yes N (%)	No N (%)	Missing N (%)
Undertaken AOD specific education/training	43 (24.0)	133 (74.3)	3 (1.7)
Conducted an AOD assessment	87 (48.6)	89 (49.7)	3 (1.7)
Heard of Guidelines	88 (49.2)	91 (50.8)	0
Aware department has a copy of the Guidelines	30 (16.8)	148 (82.6)	1 (0.6)
Use the Guidelines	29 (16.2)	83 (46.4)	67 (37.4)
Heard of AUDIT	38 (21.2)	139 (77.7)	2 (1.1)
Used AUDIT	10 (5.6)	162 (90.5)	7 (3.9)