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The knowledge, attitudes and preparedness of Australian paramedics to manage intimate partner violence patients – a pilot study

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Research

The knowledge, attitudes and preparedness of Australian paramedics to manage intimate partner violence patients – a pilot study

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Abstract

Introduction
Australian ambulance services are currently attempting to improve their capacity to respond to intimate partner violence (IPV) patients, which is a significant contributing factor to the morbidity and mortality of women. Leading health organisations have called for increased training for frontline health care workers, however there is a paucity of literature on the current preparedness of Australian paramedics. A description of the preparedness of Australian paramedics to manage IPV patients has the potential to inform curricula and practice development.

Methods
We surveyed a cohort of qualified Australian paramedics using the modified Physician Readiness to Manage Intimate Partner Violence Survey.

Results
We received 28 completed surveys (16.5% response rate), that revealed most respondents (89.3%) believed they had encountered IPV patients while working as a paramedic, yet only one participant reported comprehensive education or training on the management of such patients. Participants reported low knowledge and preparedness to manage IPV patients. Participant attitudes were poor for self-efficacy, confidence and preparation, and generally neutral for items regarding attitudes toward women and IPV patients.

Conclusions
This study adds to mounting evidence that paramedics frequently encounter IPV patients, have insufficient education and training, and are not prepared to manage such patients. While the results of this study should be interpreted with caution due to a low response rate and small sample, it appears that Australian paramedics would benefit from targeted educational packages that provide the necessary knowledge to recognise and refer patients, modify inappropriate or insufficient attitudes, and prepare paramedics to effectively manage IPV patients.

Keywords:
paramedic education; family violence; research

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Introduction

Australian ambulance services have an integral role to play in preventing and reducing violence towards women, with a key focus on the recognition and referral of intimate partner violence (IPV) patients to care and support (1). Intimate partner violence refers to abuse transpiring between people who are, or were formerly, in an intimate relationship and can take the form of economic, psychological or emotional abuse, controlling behaviours, as well as physical or sexual violence (2). While IPV occurs in all population subgroups, the vast majority of the most damaging violence is perpetrated by men and borne by women (3).

Recent Australian figures show that 17% of women aged more than 18 years had experienced physical or sexual violence and 25% emotional abuse from a current or previous partner since the age of 15 (4). In contrast, only 5% of males aged more than 18 years had experienced physical or sexual violence and 14% emotional abuse from a current or previous partner since the age of 15 (4). Women experiencing IPV report poorer overall health and have greater risk of developing mental health conditions (5,6). On average, more than one Australian woman is killed each week by a current or previous intimate partner (7), and the effects on children can be severe and long lasting (6). Due to the significant impact and high prevalence of IPV, the Australian government developed a National Plan to Reduce Violence against Women and their Children (8) and, more recently, the Royal Commission into Family Violence recommended increased education and training for frontline health care workers (9).

No Australian ambulance service has published comprehensive data on how often they attend IPV patients. However, self-reporting measures demonstrate paramedics believe they frequently respond to IPV patients (10,11). Paramedics are often the first to attend IPV incidents involving emergency services (12) and their interactions with IPV patients have the potential to impact patient engagement with the health care sector and the efficacy of future care (13). Early recognition of abuse through screening has been a key element of improving the health care response to IPV (14), however screening is often not performed effectively due to barriers such as lack of knowledge and training, confidence and preparedness (13). Qualitative research shows that women are accepting of screening by health care professionals as long as it is performed in a non-judgemental and empathetic manner, and the practitioner is confident, skilled and knowledgeable (13). Therefore the knowledge, attitudes and preparedness of practitioners can have a pivotal role in the overall success of their response to IPV.

Most new paramedics employed by one of the eight ambulance services operating in Australia are now required to complete a certified undergraduate degree, however the standard curricula does not currently include mandatory education on IPV. Qualified paramedics report very low rates of IPV education and training and little is known about their current knowledge and attitudes (10,15,16). The need for IPV education within the health care sector has been well established (17), however before such education can take place there is a need to examine the current knowledge, attitudes and preparedness (KAP) to manage IPV patients of Australian paramedics. Such data could assist in the identification of practice gaps that educational packages could address.

The aim of this study was to explore the KAP of a cohort of Australian paramedics. Results will comprise the first attempt to collect and report on such data in a paramedic cohort, and have the potential to inform future educational and curricula needs for paramedics in Australia.

Methods

Study design

We utilised a survey design. Data collection took place between September and December 2015 at an Australian university offering a Bachelor conversion degree for qualified paramedics. Recruitment was performed by emailing all currently enrolled students with an invitation to participate and by placing a link to the survey on their main online bulletin board. The survey was delivered online, and was accessible from any device that could access the internet (eg. smart phone, laptop, tablet, personal computer). Participation was voluntary.

Participants

Participants were taken from a convenience sample of currently practising paramedics enrolled in a Bachelor degree conversion course. Participants were from Victoria, New South Wales, Queensland and the Northern Territory.

Instrumentation

The Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) (18) was developed to measure the KAP to manage IPV patients in United States (US) physician populations and has since been adapted for use with allied health care students and practitioners (19). The Modified PREMIS has been used with US allied health care populations including medical, dental, nursing and social work students (19-21). Only one study has reported on the psychometric properties of the modified PREMIS, finding the instrument demonstrated high internal consistency within some IPV constructs (Cronbach's alpha >0.7) but low with others (Cronbach's alpha <0.5); and that its construct validity was shown to be varied with a high significant correlation between perceived and actual knowledge (r=0.859) but no significant correlation between actual knowledge and perceived knowledge (r=0.064) or preparation (r=0.058) (19).

The Modified PREMIS survey is among the most comprehensive measure of KAP available for allied health care populations, however it does not measure overall clinical readiness and lacks any skills based assessment, which are acknowledged limitations. While the psychometric properties of the Modified PREMIS have never been measured with Australian allied health care cohorts, previous validation with an allied health cohort in the US (19) provides evidence for its preliminary suitability in this instance.

The Modified PREMIS (18) was utilised in this study after making slight modifications to the items by altering the wording of 'health care practitioner' to 'paramedic'. This study focused on IPV and therefore four questions on family violence (specific to child abuse and elder abuse) were removed.

The Modified PREMIS is a five-part, 85-item survey. The scale measures background demographics, and contains three sub-scales measuring perceived knowledge, actual knowledge and perceived preparation to manage IPV patients, as well as six attitude sub-scales named victim/autonomy, preparation, alcohol/drugs, victim understanding, legal requirements and self-efficacy. Only five of the sub-scales were used in this study as the four omitted questions resulted in the 'legal requirements' scale having only one item. We also included a separate section at the end of the instrument that measured personal IPV experience.

The same scoring method as described in the original PREMIS (18) was used, with changes to reflect omitted questions. In addition, as per Connor et al (21) a dichotomous variable named 'lifetime experience of IPV' was created which categorised participants into those who have experienced IPV personally or witnessed it in their family, and those who had not.

Data analysis
To conduct analysis SPSS version 18 was used. Participant descriptive statistics were generated and high and low percentage correct answers were examined on each item to identify any questions that were frequently answered incorrectly. Other studies using the Modified PREMIS have reported mean scores for scales, however as our data were non-normally distributed based on Shapiro-Wilk's test ($p<0.05$), medians were calculated for each sub-scale.

Ethics

Ethics approval was granted by a Human Ethics Board, Monash University Human Research Ethics Committee.

Results

In total 28 surveys were returned form participants (16.4% response rate). While most surveys were returned complete and all surveys were used in the study, some contained random missing data (22) where the participant had not answered one or more items. Where missing data impacted statistical analysis we noted the adjusted sample size.

Participants were 35.7% female (n=10) with a median age of 40 years (IQR = 34-46), which is comparable to a previously reported median age for Australian paramedics (23). Among the sample, 75.0% (n=21) worked as 'advanced life support' paramedics and 82.1% (n=23) worked in a state ambulance service. Of the participants 67.9% (n=19) reported having no previous IPV training, with most of those that reported training stating they had attended a lecture or watched a video. Almost all of the respondents reported encountering IPV at work (n=25, 89.3%) and only 17.8% (n=5) were aware if their employer had a policy on domestic violence. See Table 1 for the full demographic profile.

Knowledge, preparation and opinions
Actual knowledge was scored based on 18 items with a possible score range of 0-38. The median score for our sample was 25 (IQR = 21-28), which equates to 65.8% (IQR = 55.3–73.7%) correct answers.

Perceived knowledge was scored on a 7-point Likert scale (1 = 'nothing' to 7 = 'very much'). The median score was 2.79 (IQR = 2.43-3.86), meaning they felt they knew between 'very little' (2) and 'a little' (3) about IPV.

Perceived preparation was scored on a 7-point Likert scale (1 = 'not prepared' to 7 = 'quite well prepared'). The median score was 2.79 (IQR = 2.43-3.86), meaning they felt between 'minimally' (2) and 'slightly' (3) prepared.

Attitudes were scored on a 7-point Likert scale (1 = 'strongly disagree' to 7 = 'strongly agree'). Fifteen items were reverse coded, after which the preferred score for each item was 7. Median scores for each item ranged between 3 and 7. Median scores for the five opinion sub-scales ranged between 3 and 4 (see Appendix 4). Participants reported low self-efficacy, confidence and preparedness to manage IPV patients. Attitudes towards women and patients were generally neutral, meaning participants neither agreed nor disagreed with attitudinal items. Notably some participants expressed some negative attitudes towards women and patients. See Appendices 1-4 for individual item results.

Previous training
Of the respondents, 67.9% (n=19) reported no previous training, while 28.6% (n=6) reported watching a video or attending a lecture, and only one respondent reported having attended skills based training.

Personal experience
Of the respondents who replied to the question, 29.4% (n=5) of males and 60.0% (n=6) of females reported personally experiencing IPV against themselves. Additionally, 53.6% (n=15) of respondents reported witnessing IPV in their family.

Table 1.Survey respondent demographics

		Total	
		n	%
Total records		**28**	**100%**
Gender	Male	17	60.7%
	Female	10	35.7%
	Missing	1	3.6%
Age (years)	20-29	3	10.7%
	30-39	8	28.6%
	40-49	9	32.1%
	50-59	3	10.7%
	Missing	5	17.9%
Paramedic level	Basic life support	7	25.0%
	Advanced life support	21	75.0%
	Missing	-	0.0%
Where do you work?	State ambulance service	23	82.1%
	Private ambulance service	2	7.1%
	Military	6	21.4%
	Private company	4	14.3%
	Missing	-	0.0%
Work location	VIC	2	7.1%
	NSW	11	39.3%
	QLD	7	25.0%
	NT	5	17.9%
	Missing	3	10.7%
Previous training	None	19	67.9%
	Video	6	21.4%
	Lecture	2	7.1%
	Skills training	1	3.6%
	In-depth	-	0.0%
	Other	-	0.0%
	Missing	-	0.0%
Personal IPV experience	Yes	10	35.7%
	No	15	53.6%
	Missing	3	10.7%
Lifetime IPV experience	Yes	15	53.6%
	No	9	32.1%
	Missing	4	14.3%

Note: 'Where do you work?' question allowed multiple responses
Note: 'Lifetime IPV experience' refers to participants who have experienced IPV personally or witnessed it in their family

Frequency of encountering IPV
Of the respondents 89.3% (n=25) believed they had encountered an IPV patient while at work. Estimates of the number of IPV patients encountered ranged between two and 1000, with just over 57.1% (n=16) of the respondents reporting 2–12 cases, 25.0% (n=7) reporting 75–300, and 7.1% (n=2) reporting 1000 cases. Notably, 10.7% (n=3) reported that they did not believe they had attended an IPV patient, all of whom had served between 6-10 years as a paramedic.

Discussion

This study aimed to explore the KAP to manage IPV patients of a cohort of Australian paramedics. These preliminary results suggest paramedics may lack the necessary KAP to properly manage IPV patients. These findings may indicate that the Australian paramedic curricula is not properly preparing future practitioners to respond appropriately to IPV patients, which could result in missed opportunities to recognise and refer IPV patients to care and support. Key findings and implications will be discussed.

Knowledge, attitudes and preparedness
The median value for the actual knowledge scale (65.8%) should be considered low as most of the items measuring knowledge referred to essential knowledge necessary to recognise and refer IPV patients accurately and appropriately. This result is unsurprising as two-thirds of participants reported no previous education or training with respect to IPV, and those that had received training had only attended a lecture or watched a video, both of which have been shown to be largely ineffective as educational methods due to shortcomings such as the inability to practise skills (24). Results were relatively consistent with similar allied health care populations such as nurses (20), suggesting that this knowledge deficiency is not limited to paramedicine, and were also consistent with Australian paramedic undergraduate students (25), indicating findings may not be limited to practicing paramedics and may stem from a deficiency in the curricula.

The median score for perceived knowledge expressed as a percentage is 39.9%, which is considerably lower than actual knowledge. This would imply that our cohort of paramedics did not feel confident in their knowledge. This may result in paramedics not feeling confident enough to discuss IPV with patients even when they do have reason to suspect it, which has been shown to be a major barrier for health care practitioners to respond to IPV (26). This is further evidenced by the perceived preparation scale which showed that participants felt only 'slightly' prepared to manage IPV patients. It would seem appropriate, therefore, that specific IPV training be implemented which empowers participants to feel confident in their ability to recognise and manage IPV, which has been previously called for by the World Health Organization (27).

With evaluation of item-level responses it is clear that participants would benefit from education surrounding the theoretical background to IPV, identification of IPV, how to question patients, documentation and legal requirements, all of which form part of recommended curricula for frontline health care workers (27,28) and would be necessary to ensure a sensitive and effective response to patients.

Median scores across the five attitude subscales ranged 3.70–4.83. These scores roughly reflected the corresponding mean scores when the PREMIS was initially used with US physicians (18), other allied health care populations (19-21) and Australian paramedic students (29). The uniformity of results in attitude subscales across health care disciplines may be a reflection of general community attitudes, and highlights the difficulties inherent in changing or improving attitudes. One previous review found no reliable evidence to show that the attitudes of health care practitioners in regards to IPV can be changed or improved (24). Therefore this finding should not be construed as a deficiency unique to paramedicine and should be the subject of future research.

Overall, participant attitudes concerning their own self-efficacy and preparation were poor, which might be expected given the lack of comprehensive training and education. Interestingly, qualified paramedics actually scored lower in self-efficacy items than paramedic students given the same instrument (29). This may suggest once paramedics begin to encounter IPV patients their self-efficacy decreases as they feel their training is insufficient. Previous research has shown feeling unprepared and having a lack of resources (such as protocols) can impact on the willingness of practitioners to screen patients (26). Therefore there is a risk that by not properly preparing and providing adequate resources to paramedics they will become reluctant to discuss IPV with patients, and may even begin to intentionally ignore signs and symptoms of IPV to avoid conversations they find difficult or confronting.

Items concerning attitudes towards women and patients were mostly neutral, which may be considered insufficient as both positive attitudes towards women and patient autonomy have been reported as essential to an appropriate approach to patients (13). This is because IPV patients desire to be believed and to be treated in a compassionate and non-judgemental manner (13), and therefore it is important that paramedics have appropriate attitudes. It is unclear due to a lack of research if the absence of positive attitudes will impact on patient approach, however as this has the potential to negatively impact patients and provides opportunities for more research in this area.

Notably some participants held some inappropriate attitudes, such as believing that patients are not able to make appropriate choices about their situation and that patients do not have the right to choose if paramedics intervene. This belief was also found in a population of Australian student paramedics (29). Such attitudes are problematic as they indicate similar beliefs to those that are theorised to lead to the use of violence within relationships, namely believing it is acceptable to use power and control to coerce another person into following a course of action they haven't chosen for themselves (2). There is a potential that any misapplication of power and control arising out of these attitudes will have negative impacts on patient outcomes (13), regardless of whether the paramedic believes that they are acting in the patient's best interests.

Previous training

The majority of participants (67.9%) had not undergone structured IPV training and only one respondent reported undertaking skills based training, which adds further evidence that paramedics rarely receive comprehensive IPV education (10). This general lack of education found in the paramedic samples studied may indicate deficiencies in the paramedic curricula and there is a need to review the content of paramedic courses to ascertain if alterations are necessary. Adequate training is important as previous research has shown that untrained and unprepared practitioners are less likely to recognise and refer IPV patients to care and support (26), resulting in missed opportunities to connect patients with services that may assist them to reduce future harm.

Frequency of encountering IPV

Despite mounting evidence that paramedics frequently encounter IPV patients (10,11) it is difficult to draw firm conclusions as precise IPV data are not collected by Australian ambulance services. Results from this study confirm those of a previous self-reporting measure delivered to 50 Australian paramedics, where it was found that 90% of paramedics reported encountering at least one case of suspected IPV in the last year, with the average number of cases being 3.66(10). These are significant findings as patients may not always present with obvious or traumatic symptoms (30) and as paramedics generally lack sufficient education they may be unlikely to suspect and ask about IPV in many cases. Hence, such self-reported measures maybe potentially under-reporting the true frequency of paramedics encountering IPV, and increased education could therefore result in much higher rates of reporting. It is believed that reporting of IPV is low due to the high barriers to disclosure which include untrained practitioners not asking patients about IPV, asking inappropriately, or displaying behaviours and attitudes which make patients less likely to disclose (31). Therefore by improving education it may improve accuracy of reporting from paramedics which could improve overall reporting thus creating a more accurate picture of the scale of the issue.

Personal experience of IPV

Of the respondents, 26.7% of men and 55.6% of women reported experiencing IPV to their persons, which is around three times the rate experienced by the general population (4). Our question about personal IPV experience was not directly comparable with Australian population statistics however, as we asked about physical and emotional violence together. Also due to the low response rate it is possible that results are skewed

towards paramedics with a previous history of IPV and may have therefore had a higher interest in responding to the study.

This topic warrants further investigation as it is unclear if personal experience of IPV influences workplace behaviours, such as willingness or reluctance to discuss IPV with patients (26). Additionally, mental health conditions such as depression, anxiety and post-traumatic stress disorder are known to be associated with IPV (32), therefore there is a risk to paramedic wellbeing by exposing those with personal IPV experience to additional vicarious trauma in education and on the job. Thus if ambulance services do adopt IPV protocols it would be important that they provide appropriate educational delivery options, as well as ensuring support services are available to paramedics.

Implications for future practice
Despite the sampling limitations, results from this pilot study indicated Australian paramedics encounter IPV frequently, do not have the necessary KAP to manage IPV patients and, rarely, have adequate training. Further research should be undertaken with larger samples to provide more robust figures.

Structured training should be incorporated into the Australian paramedic curricula that provides paramedics with the required knowledge to recognise and refer IPV patients, improves inappropriate and insufficient attitudes and properly prepares them to manage these patients.

Additionally, should further research confirm that paramedics are personally overrepresented in IPV statistics there is a need to explore potential causative factors as well as ensure paramedic wellbeing before introducing education and clinical guidelines.

Limitations

Our study was significantly limited by the small sample size which may not be representative of the broader paramedic population. Our recruitment method may also have biased results toward participants with an interest in the topic. Furthermore, as our participants were degree conversion students they may differ significantly from paramedics who have completed an undergraduate degree, which is the norm for paramedics in Australia.

Additional limitations include the use of an instrument that has not been validated for use in this population, the limitations of Likert scales (particularly patients being influenced by previous questions and being unwilling to respond to the extremes) and numerous items requiring long-term recall and self-reported answers.

Conclusions

Despite study limitations our results add further evidence that paramedics frequently encounter IPV patients, rarely receive adequate training, and do not appear to have adequate knowledge, attitudes and preparedness to manage IPV patients. There is a clear need to conduct further research in this population to confirm that any identified educational deficiencies are addressed and that paramedics are able to provide an appropriate response to IPV patients. By improving education paramedics may be more likely to recognise and respond appropriately to IPV patients, which may improve health care outcomes. Improved education and training in IPV would most likely be of significant benefit to patients and paramedics, and this should be undertaken as a priority for the profession.

Conflict of interest

The authors declare no competing interests. Each author of this paper has completed the ICMJE conflict of interest statement. Brett Williams is an Associate Editor of the Australasian Journal of Paramedicine.

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Appendix 1. Percentage correct for actual knowledge items

Question	% correct	% incorrect
What is the strongest single risk factor for becoming a victim of intimate partner violence?	21.4%	78.6%
Which one of the following is generally true about batterers/perpetrators?	75.0%	25.0%
Which of the following are warning signs that a patient may have been abused by his/her partner?		
Chronic unexplained pain	60.7%	39.3%
Anxiety	78.6%	21.4%
Substance abuse	64.3%	35.7%
Frequent injuries	82.1%	17.9%
Depression	78.6%	21.4%
Which of the following are reasons an IPV victim may not be able to leave a violent relationship?		
Fear of retribution	82.1%	17.9%
Financial dependence on the perpetrator	85.7%	14.3%
Religious beliefs	67.9%	32.1%
Children's needs	85.7%	14.3%
Love for one's partner	67.9%	32.1%
Isolation	78.6%	21.4%
Which of the following are the most appropriate ways to ask about IPV?		
'Are you a victim of intimate partner violence?'	89.3%	10.7%
'Has your partner ever hurt or threatened you?'	75.0%	25.0%
'Have you ever been afraid of your partner?'	7.1%	92.9%
'Has your partner ever hit or hurt you?'	39.3%	60.7%
Which of the following is/are generally true?		
There are common, non-injury presentations of abused patients	53.6%	46.4%
There are behavioural patterns in couples that may indicate IPV	64.3%	35.7%
Specific areas of the body are most often targeted in IPV cases	60.7%	39.3%
There are common injury patterns associated with IPV	57.1%	42.9%
Injuries in different stages of recovery may indicate abuse	78.6%	21.4%
Label the following descriptions of the behaviours and feelings of patients with a history of IPV with the appropriate stage of change:		
Begins making plans for leaving the abusive partner	53.6%	46.4%
Denies there's a problem	82.1%	17.9%
Begins thinking the abuse is not their own fault	78.6%	21.4%
Continues changing behaviours	28.6%	71.4%
Obtains order(s) for protection	50.0%	50.0%
Alcohol consumption is the greatest single predictor of the likelihood of IPV	35.7%	64.3%
There are no good reasons for not leaving an abusive relationship	42.9%	57.1%
Reasons for concern about IPV should not be included in a patient's patient care record if s/he does not disclose the violence	71.4%	28.6%
When asking patients about IPV, paramedics should use the words 'abused' or 'battered'	60.7%	39.3%
Being supportive of a patient's choice to remain in a violent relationship would condone the abuse	57.1%	42.9%
Victims of IPV are able to make appropriate choices about how to handle their situation	28.6%	71.4%
Health care providers should not pressure patients to acknowledge that they are living in an abusive relationship	46.4%	53.6%
Victims of IPV are at greater risk of injury when they leave the relationship	25.0%	75.0%
Strangulation injuries are rare in cases of IPV	25.0%	75.0%
Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim	71.4%	28.6%
Even if the child is not in immediate danger, paramedics in Victoria are mandated to report an instance of a child witnessing IPV	0.0%	100.0%

Appendix 2. Median perceived knowledge scores by item

How much do you think you know about:	Median	25th Percentile	75th Percentile
Your legal reporting requirements for IPV	3	2	4
Signs or symptoms of IPV	4	3	5
How to document IPV on a PCR	3	2	4
Referral sources for IPV victims	3	2	3
Perpetrators of IPV	3	2	4
Relationship between IPV and pregnancy	2	2	3
Recognizing the childhood effects of witnessing IPV	3	2	4
What questions to ask to identify IPV	3	2	4
Why a victim might not disclose IPV	4	3	5
Your role in detecting IPV	4	2	4
What to say and not say in IPV situations with a patient	3	2	4
Determining danger for a patient experiencing IPV	4	3	4
Developing a safety plan with an IPV victim	2	2	3
The stages an IPV victim experiences in understanding and changing their situation	2	2	3
Perceived knowledge scale	2.43	1.93	3.50

Appendix 3. Median perceived preparation scores by item

How prepared do you feel to:	Median	25th Percentile	75th Percentile
Ask appropriate questions about IPV	4	3	5
Appropriately respond to disclosures of abuse	5	3	5
Identify IPV indicators based on patient history, and physical examination	4	3	5
Assess an IPV victim's readiness to change	2	2	4
Help an IPV victim assess his/her danger of lethality	3	2	4
Conduct a safety assessment for the victim's children	4	2	5
Help an IPV victim create a safety plan	2	1	3
Document IPV history and physical examination findings on a PCR	4	2	5
Make appropriate referrals for IPV	3	2	5
Fulfil state reporting requirements for IPV	3	2	4
Perceived preparation scale	3.20	2.45	4.20

Appendix 4. Median attitude scores by item (reverse coded items in grey)

For each of the following statements please respond on the scale between Strongly Disagree (7) and Strongly Agree (1):	Median	25th Percentile	75th Percentile
If an IPV victim does not acknowledge the abuse, there is very little that I can do to help (R)	5	5	5
I would ask all patients about abuse in their relationships	3	2	3
I can make appropriate referrals to services within the community for IPV victims	4	3	5
I am capable of identifying IPV without asking my patient about it (R)	5	4	5
I do not have sufficient training to assist individuals in addressing situations of IPV (R)	3	1	3
Patients who abuse alcohol or other drugs are likely to have a history of IPV	4	3	5
Victims of abuse have the right to make their own decisions about whether paramedics should intervene	5	4	5
I feel comfortable discussing IPV with my patients	5	4	5
I don't have the necessary skills to discuss abuse with an IPV victim who is:			
Female (R)	4	3	5
Male (R)	4	3	6
from a different cultural/ethnic background (R)	4	3	5
If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence (R)	7	5	7
I am aware of legal requirements in Victoria regarding reporting of suspected cases of IPV	4	2	5
Paramedics do not have the time to assist patients in addressing IPV (R)	6	5	7
I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (eg. depression, migraines)	4	3	4
If a patient refuses to discuss the abuse, paramedics can only treat the patient's injuries (R)	4	3	5
Victims of abuse could leave the relationship if they wanted to (R)	5	4	6
Paramedics have a responsibility to ask patients about IPV	5	4	6
Alcohol abuse is a leading cause of IPV (R)	4	3	4
Victims of abuse often have valid reasons for remaining in the abusive relationship	5	4	6
Screening for IPV is likely to offend those who are screened (R)	4	3	5
I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (eg. bruises, fractures, etc.)	4	3	5
Women who choose to step out of traditional roles are a major cause of IPV (R)	6	5	7
Paramedics do not have the knowledge to assist patients in addressing IPV (R)	4	3	5
I can match therapeutic interventions to an IPV patient's readiness to change	3	3	4
I understand why IPV victims do not always comply with paramedic recommendations	5	5	5
Use of alcohol or other drugs is related to IPV victimisation	5	3	5
I can recognise victims of IPV by the way they behave (R)	5	4	5
Victim autonomy scale	4.83	4.17	5.00
Preparation scale	3.70	3.00	4.50
Alcohol/drugs scale	4.17	3.67	4.33
Victim understanding scale	4.83	4.58	5.17
Self-efficacy scale	3.67	3.17	4.00

Note: (R) indicates medians have been reversed due to reverse coded questions