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« Etude de l'extension du recueil européen ISS sur les accidents aux violences envers les adolescents et les femmes »

Proposition for enhanced Violence Module for IDB-AI coding V2.0

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*Le projet n° **JAI/DAP/2004-2/001/WY** « Etude de l'extension du recueil européen ISS sur les accidents aux violences envers les adolescents et les femmes » prend place dans le Programme DAPHNE II – Année 2004, programme européen visant à combattre la violence envers les enfants, les adolescents et les femmes.*

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Proposition for enhanced Violence Module for IDB-AI coding V2.0

1. Context

There were two results of the project :

- a final report, in continuation of the intermediate report published earlier, explaining in detail the methodology, work and recommendations, notably the presentation of different strategies for gathering of medical data on violence;
- a proposition for extensions and enhancements to the existing *Violence Module* coding (version 1.1 - June 2005) for IDB-AI (version 2.0).

This document consists of a brief methodological proposition for a new *Violence Module* for IDB-AI V2.0 and a short description of the consequences to the hospital team of the introduction of these kinds of changes.

2. The new *Violence Module* for the IDB-AI coding V2.0

The new *Violence Module* coding for IDB-AI coding V2.0 is composed of the following :

- a guiding principle
- the specific methodological conditions that are essential for data gathering related to violence.
- an ethical commitment
- the proposition of data elements complementary to those in *Violence Module* IDB-AI V1.1
- a description, in the conclusions, of the consequences of the introduction of a data collection system such as this for the whole of the hospital team.

2.1. Guiding principle :

- The violence module of the Injury Database (IDB) enables systematic medical data collection that may provide valid information about different issues related to hospital and other medical care contacts due to intentional injuries. However, contrary to data collection about non-intentional injuries, a number of difficulties exist in obtaining comprehensive data about the circumstances and context of violence.

- The extension of the data collection for IDB on violence cannot be regarded as a simple administrative and technical extension of the existing system for unintentional injury events (everyday accidents and road accidents). This implies changes in the working practices of the data gathering team, notably a strong ethical commitment and modifications to the existing processes for data collection in this new domain. New and specific methodological conditions are essential for the success of the project.

- Some objections against systematic and comprehensive violence data collection in emergency departments have been demonstrated in a previous EU-project (2000CVG3-321), and these experiences are included in the present recommendations.

2.2. Required specific methodological conditions :

- In this short chapter, we want to summarize the important points for carrying out, in suitable surroundings, the collection of data related to assault, within the current IDB collection framework. These points are developed more completely in the final version of the study.

- The following diagram highlights the principle differences in the steps of the collection of data according to the type of trauma and presents the recommended medical and psychosocial care to be (the points specific to assaults are in bold) :

Comparison of different steps of data collection depending on the type of trauma :

Unintentional Injuries

Reception — Medical treatment

Data collection

Assault: **a strong ethical commitment**

Training

Detection/Exposure — Medical treatment — **Specific actions** — **Risk assessment** — **Debriefing**

Specialised reception — Data collection + **Complementary variables** — **Provision of information** — **Specific aftercare**

The principal differences are explained point by point :

2.2.1. Training : The training of the team in the problems of assault is an important prerequisite for effective data collection on violence in the hospital environment. It is also essential that the people counselling victims of violence are able to recognise the signs, conduct interviews, collect information and, to listen, give information and help them, where help is needed, respecting their confidentiality and security. Without this training the data collection process could be compromised (resulting in systematic under estimation of the prevalence of violence) and even dangerous, both for the victims and the hospital team. A list of the principle points that this training must include is provided in the body of the report.

- It is evident that the development of an adequate competence in medical staffs regarding the reception, counselling and treatment of victims of violence very much depends on their knowledge about the different issues of violence and sequels of violence. However, there is no urge for revealing violence during emergency department contacts if access to shelter, legal, social and medical counseling is not feasible. As part of an establishment of systematic medical data collection about intentional injuries, it is therefore fundamental to provide a multidisciplinary approach in the medical care and to ensure protection of victims against further violence inter alia by setting up shelters and other social services.

2.2.2. Detection and exposure of violence : The application of the *Violence Module* of IDB depends upon the definition of a given injury as intentional and caused by another person. It is the experience from previous systematic medical data gathering in different emergency department settings that the intent of an injury only rarely is revealed initially.

- Very often violence, for example domestic abuse, is hidden and not immediately admitted to be the cause of trauma by the victims. Detection of assault here is not the result of an "objective" scientific analysis (e.g. a bacteriological analysis) it consists of providing the victim with the support and confidence to **voluntarily admit** that the injuries are the result of violence.

- Therefore it is important that the personnel are aware and trained in the detection and exposure of the assault. Certain behaviours, symptoms and circumstances of presentation for treatment can raise suspicion and lead to questioning the patient about the cause of the injuries. Part of the contents of the SIVIC website (created as part of the DAPHNE project) has been included in the body of the report, providing the tools for detection of violence for medical personnel. It is not sufficient to make a diagnosis and ask closed questions (which require yes/no answers) but to understand how to create hypotheses, offering the potential victim the support and an opportunity for admission and follow up of the information.

➔ Finally the response to the question to the intentionality of trauma in IDB V1.1 (Intent = 3 – Assault or 4 – Other Violence) is very significant because it is the result of the complex process of detection and exposure.

2.2.3. Specific conditions for interview : There are at least two specific conditions required for collection of information about violence: knowledgeable, qualified, personnel and the availability of an isolated room which permits a secure free exchange between the victim, who may be alone, and the data gatherers. Therefore, we state the following ethical commitment: "The material and human resources must be sufficient and adapted to the needs of this kind of interview. It must be ensured that these resources are present before initiating an interview."

2.2.4. Recording of specific data : This section covers the variables complementary to the previous version of the coding manual for IDB V1.1.

- A list of variable to collect, including for example socio-demographic data elements that were not included in the IDB coding manual (level of education, employment status), is included in the final report. There is a distinction between two data collections :
- that is based upon a limited number of selected emergency departments, and which may include comprehensive information about intentional injuries/violence;
- and a systematic medical data collection of hospital contacts, including all emergency department contacts, in a given region or country.

- Since 1995, in Denmark data about all hospital contacts are recorded in the National Patient Register by a set of codes that equals the IDB coding manual, excluding data about perpetrators

however. In the following we draw upon the experiences from both comprehensive medical data collection and from the Danish National Patient Register.

- Concerning minimum medical data collection in medical units, the following point proposes the two most important complementary variables to add to the four existing variables in v1.1 of the IDB coding manual as the basis for v2.0 of the module, The difficulties associated with the addition of extra data elements are noted, but these two variables are indispensable to improve the prevention of injuries, and it is therefore recommended to include them to achieve better information about different issues of violence, notable partner violence. *These data elements are not integral to the necessary changes to the IDB coding*. Taking into account the guiding principle (section 2.1) and the essential training of personnel are much more important in this regard.

- We have already pointed to the difficulties in obtaining reliable data about intentional injuries if certain measures are not adopted regarding the reception of patients in emergency settings. Moreover, many studies show that the manner in which questions related to domestic violence are formulated is extremely important. The interview process and the way the questions are posed greatly influence the results of the interview most importantly the prevalence recorded. This point is also developed in the final report. It is important to note that to approach the interview with questions that are too broad and direct (e.g. “Are you the victim of domestic violence?”) is not the correct way. The questions must avoid using explicit terms with strong connotations like “rape”, “domestic violence”, “battered woman”, etc. Since the late 1990’s a number of medical associations have published guidelines for questionning patients that may have been victims of violence. These guidelines should be adapted in pre- and postgraduate medical training.

- It is recommended using indirect questions (e.g. “What happens when your partner is angry?”) and suggesting a series of actions (e.g. “Have you been slapped, punched?” etc.) and to refer to the general occurrence of domestic violence than initially to pose direct questions. The personnel must be asked to formulate indirect questions, even if they will result in coding as per the manual for the IDB. However, more direct questioning about violence may be part of an acknowledgment of violence as a public health issue that should not be regarded as a personal and hidden problem. During recent years, concerns about violence against women have changed the public attitude towards this problem and it may be time for more open discussions also in medical units.

2.2.5. Specific treatment actions : A number of specific treatments have been identified where the medical team must notify the data collectors : in the case of physical violence, create a medical certificate (e.g. certificate describing cuts and other injuries), in cases of sexual assault, use an anatomical diagram to identify lesions, possibly using photography, etc.

2.2.6. Risk assessment : This assessment must allow the team to evaluate the risk to the victim of returning to their usual surroundings. If the victim does not feel comfortable returning to these surroundings or there is an increase in the frequency and seriousness of injuries suffered up to a risk of murder, it is imperative to take immediate and final measures, with the victim’s consent. It is also important, if necessary, to assess the risk to children staying in the house and alert the relevant social services. Information about legal aid, provision of shelter services and other social services should be included in the instructions for medical staffs at all emergency departments and other medical care units.

2.2.7. Information to provide : The team that is responsible for a victim of assault must be able to provide information concerning the victims’ rights, and relevant support structures, or to direct them immediately to someone else within the hospital that can provide this. This information includes : police contacts, social workers, charities offering support, legal advice, etc. This could take the form of relevant documents and lists contacts made available to the victims. This point, like

the preceding point, shows that the entire hospital team is involved in the creation of a support structure that is strong, high quality and committed: the data gathering, medical and administrative teams must all work together to ensure a high quality service.

2.2.8. Specific follow-Up : As well as after care for the victim, debriefings must regularly be planned for the interview team to act as forum to discuss techniques and to manage the stress and other problems experienced as a result of contact with the victims.

2.2.9. Ethical commitment : As has it has been explained before, collection of this kind of information calls for a strong, detailed, ethical commitment for the entire team at the interview centre. This commitment is described in the following point.

2.3. The Ethical commitment :

The ethical commitment of the hospital personnel must include at a minimum the following ten points.

The ethical commitment for interviews related to domestic violence :

Ethic 1. The security of the victims and the data gatherers is essential and must guide all decisions about the interview methods (e.g. a private room must be used for the collection of information)

Ethic 2. It is essential that protection of confidentiality is assured, for the interview and also during the after care of the victim and with any use of the data collected.

Ethic 3. All member of the team must be selected using strict criteria (receptiveness, ability to listen, empathy, etc.) and receive specialised training (minimum one day). Particular attention must be given to respect for, and listening to, the victim.

Ethic 4. The interview methodology must include the provision of basic information on the rights of the victim and ability to respond to requests for help. The interviewers must be able to provide this information and advice themselves.

Ethic 5. The victim must be advised about the confidentiality procedures created for the interview and the usage of data.

Ethic 6. Debriefings must be organised to share experiences amongst the team members.

Ethic 7. The methodology used (e.g. the formulation of questions) must be based on the latest knowledge in the field.

Ethic 8. The groups responsible for the project and researchers have a moral obligation to ensure that their results are correctly interpreted and are used to promote the prevention of abuse.

Ethic 9. The interview and therefore the disclosure of injuries in a hospital accident and emergency department does not only imply the provision of the most appropriate medical care (naturally this dimension still exists), but also implies the capacity of a team to manage "emergency situations", which most often demand specialised knowledge and experience not contained within the purely medical team (ability to listen, sensitivity to the problem, specific actions and responses, provision of relevant information, risk assessment, etc.). The entire hospital team must put in place a global strategy for handling this type of traumatism within the hospital including relevant services, a strategy for security and strong collaboration between medical staff, social services, support networks, etc.

Ethic 10. The material and human resources must be sufficient and adapted to the needs of this kind of data gathering. It must be ensured that these resources are present before initiating this kind of process.

➔ **Several of these points are only briefly mentioned in the introduction of the existing *Violence Module* coding manual of IDB-AI V1.1:** "To enhance the quality and quantity of data about violence related injuries, data collectors must link to other sources such as law enforcement agencies, victims' crisis centres, and shelters. Secondly, extreme care, sensitivity, and confidentiality must be exercised in extracting information from patients who have already undergone trauma from a violent event. Therefore, persons who gather and document injury information must be highly sensitised and well-trained. Moreover, services should be made available to the victim to immediately alleviate some of the trauma - both mental and physical - of the injury event." **These sentences are manifestly insufficient to describe the specificity of data gathering related to assault and the risks involved.**

2.4. The variables of the *Violence Module* :

- The new version of the data dictionary for IDB-AI is mostly based on the international CICET (Classification internationale des causes externes des traumatismes), ICECI (International Classification of External Causes of Injury) in English, developed under the guidance of the World Heath Organisation (WHO). This is true for the four variables contained in the *Violence Module* for IDB-AI v1.1. The ICECI complements Chapter XX, "External causes of morbidity and death", in CIM-10. This is therefore a good point for continuity and of the influence of data dictionary.

2.4.1. Description of variables for the Violence Module in the existing IDB-AI V1.1. :

Var1. Victim/Perpetrator relationship

Required field length :
n
Definition :
The relationship of the person committing the violent act to the injured person.
Context :
Intentional injury surveillance systems collect mainly information about injured persons. However, to better understand the type of violence (e.g., family violence vs. violence committed by strangers), it is important to collect information about the person(s) inflicting the injury. Such information will help determine the main types of violence that are prevalent in a society and will help practitioners develop effective prevention strategies.
Guide for use :
Code this data element for all injuries related to assault. Select the code that best describes the relationship of the perpetrator to the victim at the time of the incident. Note that for this surveillance, the use of the words "victim" and "perpetrator" imply no judgement, legal or otherwise. If two or more categories are judged to be equally appropriate, select the one that appears first in the code list. If there are several perpetrators, code information about the perpetrator who contributed most to the injury.
Overview of codes :
1 Spouse or partner
2 Parent
3 Other relative
4 Unrelated care giver
5 Acquaintance or friend
6 Official or legal authority
7 Stranger
8 Other specified relationship
9 Unspecified relationship

Var2. Sex of perpetrator

Required field length :
n
Definition :
The sex of the person who inflicted the injury.
Context :
This data element provides additional information about the person who caused the violent injury.
Guide for use :
Code this data element for all injuries related to assault.
Full list of codes :
1 Male
2 Female
9 Unknown

Var3. Age group of perpetrator

Required field length :
n
Definition :
The age group of the person who inflicted the injury.
Context :
This data element provides additional information about the person who caused the violent injury.
Guide for use :
Code this data element for all injuries related to assault.

Age group of perpetrator :
1 Child (0-14 years old)
2 Adolescent (15-24 years old)
3 Adult (25-64 years old)
4 Elderly (65+ years old)
9 Unknown

Var4. Context of assault

Required field length :
n
Definition :
The circumstances surrounding the violent injury event.
Context :
A large number of injuries occur during assaults. However, little is known about the type of assaults during which injuries occur (e.g., family quarrels, drug-related incidents, gang-related violence, etc.). To better understand violence-related injuries, it is important to collect information about the circumstances in which injury-causing assaults occur. This information can help guide development of prevention strategies.
Guide for use :
Code this data element for all injuries related to assault. Select the code for contextual factor, most recent to the injury event, which describes the reason for the assault. If there are more contextual factors, select the more recent factor.

Overview of codes :

1 Altercation
2 Illegal acquisition or attempted illegal acquisition of money or property
3 Drug-related incident
4 Sexual assault
5 Gang-related incident
6 Other crime
8 Other specified context of assault
9 Unspecified context of assault

- Experiences from previous systematic medical data collection demonstrate that it is very common among medical staff to refrain from obtaining information about victim-perpetrator relationships. These data are not regarded as medical but judicial information that may violate medical secrecy.

- To identify the number and character of hospital contacts due to partner or domestic violence may demand comprehensive information about the perpetrator. It is, however, the Danish experience that data about the place of occurrence, the mechanism of injury and the type and localisation of the injury may identify most incidents of domestic/partner violence without violation of medical secrecy by collecting information about perpetrators.

2.4.2. Suggestions for new coding variables in V2.0 of IDB-AI :

- The first two complementary variables proposed concern all types of assault (an indicator of severity and a free text description), the following two data elements a specific to domestic violence (type of assault, frequency during the last 12 months):

VarComp1. Types of Domestic Abuse (non exclusive - 2 codes)

Required field length :
2 x (nn)
Definition :
Description of types of assault related to domestic abuse.
Context :
The frequency and severity of different types of assault related to domestic abuse is badly understood. To better understand these assaults, and to develop adequate strategies for prevention, it is important to collect the data describing them more precisely. It is possible to select two codes.
Guide for use :
Use this data element for all injuries relating to domestic violence. Choose the most appropriate code(s) concerning the most recent violent episode.

Overview of codes :

11	Slap
12	Punch, kick
13	Strangulation or attempted strangulation
14	Burns
15	Threat or use of a knife or other weapon
16	Threatening to kill or attempted murder
19	Other types of physical violence
21	Sexual assault
22	Attempted rape
23	Rape
24	Gang rape
29	Other types of sexual violence

VarComp2. Frequency of this type of assault in the last 12 months (2 codes)

Required field length :
n
Definition :
The frequency of the most serious type of violent act in the last 12 months.
Context :
It is important to know the frequency of the different types of assault over 12 months to determine the point in the cycle of violence that the victims present themselves.
Guide for use :
This variable should be used for all types of injury related to domestic violence. Select the most appropriate code concerning the frequency of the violent episode selected in the previous data element (2 possible codes).

Overview of codes :

1	1 time
2	2 or 3 times
3	between 4 and 10 times
4	more than 10 times
9	not specified

3. Conclusions

➔ **It is not acceptable to conduct data gathering with the sole intention of collecting data, leading to strongly biased results, without a global strategy for the management of this type of contact throughout the hospital and which could, in fact, place the victim of injuries and collection team in danger.**

➔ As a result of the work on the essential methodological steps to collect information about assaults, the question is raised as to the pertinence of an interview in the hospital accident and emergency department, given the strong constraints and the commitment required from the collection team and the site as a whole. This can be stated as :

If the conditions described previously can be put in place, then the data gathering for the *Violence Module* of IDB is possible and justified. If these conditions cannot be fulfilled, due to lack of time, of means and/or commitment of the team on site, it would be better maybe to not collect the injuries due to assault during the systematic collection of IDB data in the hospital.

- An alternative solution could consist of putting in place a collection of data for a limited period of time (e.g. one year) for certain hospitals (the most committed).

- However, experiences from the systematic collection of medical data for all hospital contacts in Denmark demonstrates that information about intent, place of occurrence and mechanism of injury by IDB coding principles (ICECI) linked to information about type and localisation of injury by ICD10 (WHO's International Classification of Diseases) may identify different type of assaults. Hence, we do not recommend the setting up of systematic medical data collection to provide nationwide information about intentional injuries. However the provision of comprehensive data about specific issues related to partner violence must be based upon the above mentioned principles for reception of victims of violence.

➔ More generally, it should be asked if the specifics of the collection of data related to assault are so important, that it is not enough to add some questions on assault amongst the questions relating to other types of traumatism. The implications are perhaps too important to combine, within a single collection of data, everyday accidents, road accidents and assault. A specific data collection is perhaps a solution.

➔ That is not to say that the exchange of experience between the domains of unintentional injury and intentional injury are not of value. It can be seen in this project, that the collection and therefore "exposure" of assault in hospital accident & emergency department implies not only the delivery of the most appropriate medical care (although this dimension still exists naturally) but also implies the capacity of a whole team deal with "urgent situations", that make the most often demand on the abilities and knowledge outside the purely medical field (capacity to listen, sensitivity to the problem, answer questions, specific actions, provision of good information, risk assessment, etc.).

➔ The "exposure" of violence in the accident and emergency department can be (or should be, if possible) a first step in a process of change for the victim. The first contact should not be botched and reduced to simply filling in a technical questionnaire.

➔ It is obvious that the only data gatherers (for IDB or another system) should not be solely responsible for this process. **It is important to note that the introduction of data collection related to assault has consequences that must be put in place by the whole hospital team, within the hospital, a global strategy for the management of this kind of assault** (by the development of specific services, a security strategy, increased collaboration among the medical team, social services and support networks etc.).

➔ The collection of data relating to assault must not be considered as a simple administrative and technical extension to the domain of unintentional injury. It is a specific field that requires a big investment in terms time, commitment, establishing a specific strategy and the financial means.

➔ The importance and gravity of the subject, its recent emergence in the field of public health and the delay in recording this kind of data in hospitals mean that such an investment is justified and essential. **Consultation with experts in this domain, especially experts from the DAPHNE network, is an essential condition for successful data gathering.**