Teaching Violence in Health Education: A Workshop Evaluation

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Abstract

Background:
Family violence – including child abuse, partner violence, elder abuse and sexual assault - is a public health and human rights priority. Despite this, health professional education addressing violence has largely been neglected.
Intervention:
We conducted a two-day nurse educator workshop to provide information and resources to support integration of violence teaching and learning into nursing programs. Research Methods: The 21 New Zealand Schools of Nursing (17 which offer an undergraduate degree) were invited to participate in the workshop and in a pre- (2003) and post-workshop (2005) violence curriculum survey. Nineteen (90%) and 20 (95%) schools completed pre- and post-workshop surveys respectively.
Results:
Undergraduate family violence instruction increased an average of four hours, from 8 hours pre-workshop to 12 hours post-workshop. At least half (53%) of the schools post-workshop reported faculty development activities, curricular evaluation (53%) and improvements (68%).
Conclusion:
Nurse educator workshops can be a catalyst for improving the integration of violence teaching and learning in nursing curricula.

Keywords: Education, Nursing; Curriculum; Family Violence

Introduction

The "how" of delivering nursing education has undergone important changes in recent decades. Despite the orientation moving from tasks to reflection, there remains a constant weighing up of what gets included in the time-limited curricula. It is in this context that family violence – including child abuse, partner violence, elder abuse and sexual assault - is demanding to be included. Its place in nursing curricula is based on two arguments. The first is that family violence is a preventable, public health problem. Research consistently documents that family violence affects a significant proportion of the population. For example, approximately one in three women in developed countries experience partner abuse (Cohen, Forte, Du Mont, Hyman, & Romans, 2005; Fanslow & Robinson, 2004; Plichta & Falik, 2001). Unequivocal evidence documents adverse short- and long-term health as well as economic consequences of family violence (Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009; Campbell, 2002; Centers for Disease Control and Prevention, 2008; Dolezal, McCollum, & Callahan, 2009; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Felitti et al., 1998; Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009). And nurses, as the largest group of health care workers, have an important role in the health systems' prevention and response to family violence (Humphreys & Campbell, 2004; Woodtli, 2000). The second argument is based on the assumption that freedom from violence is a human right (Draucker, 2002; Ellsberg, 2006; World Health Organisation, 2006). This conveys a moral responsibility for nurses' involvement in responding to family violence (Wilson, 2000). This article addresses the experience of a New Zealand Nurse Educators in the Tertiary Sector (NETS) working group who convened and evaluated a two-day nurse educator workshop to support the integration of violence teaching and learning into nursing programs.

Health Professional Family Violence Education

Most health systems now have policies for addressing family violence and expect a level of competence among all health professionals. The New Zealand *Family Violence Intervention Guidelines* state, "Health professionals need to become competent in abuse intervention. This includes knowing how to ask questions to identify the presence of abuse, and having the procedures in place to support brief intervention and appropriate referral of identified victims" (Fanslow, 2002, p. 10). But how can these competencies be effectively integrated into nursing education?

Recommendations for improved violence health professional education have been discussed for more than a decade with little effect. The Institute of Medicine (Cohn, Salmon, & Stobo, 2002) calls it "a case of chronic neglect," with minimal research supporting the content, instructional methodologies or outcomes of family violence health professional education. Nursing programs contain variable amounts and types of information, such as "reading only" assignments, and variable provision for related clinical experiences (Woodtli, 2000). Like medical programs, nursing programs may include some violence related content, but the instruction is generally ad hoc, being minimal, barely visible and poorly integrated through the curricula (Cohn et al., 2002; Davila, 2005; Gagan, 2003; Hoff & Ross, 1995; McBride, 1992; McGibbon & McPherson, 2006; Ross, Hoff, & Coutu-Wakulczyk, 1998; Woodtli & Breslin, 1996). Where the content is located is also an issue. McGibbon and McPherson (2006) and Davila (2005) note that violence related content in nursing education is often included in the context of mental health. This suggests that family violence is predominately a mental health issue. Gagan (2003) notes, "placement of content reflects faculty's value of the content and sends a message to students about relevancy" (p. 48). The standard to strive for is violence teaching and learning integrated in a purposeful way throughout the curricula (Cohn et al., 2002).

As well as being taught in an ad hoc fashion, violence content is often not formally identified within the curriculum, systematically evaluated, or theoretically linked. Ross et al (1998) expressed concern that the majority of Canadian nursing schools did not use critical frameworks addressing power and gender issues in their teaching. Several authors have described experiential learning in the form of student workshops that attend to personal values, attitudes and beliefs about violence as well as content, skill and interdisciplinary competency (Davila, 2005; Hayward & Weber, 2003; McGibbon & McPherson, 2006; Wielichowski, Knuteson, Ambuel, & Lahti, 1999). Pedagogical models and issues for addressing family violence teaching and learning are available (Davila, 2005; Gagan, 2003; Hill, 2005), though further development is needed.

Evidence exists to support family violence education positively affecting nurses responses to violence issues (Woodtli, 2000), but there remains questions about the current quantity, quality and integration of violence teaching and learning in schools of nursing. The preparation of nurse educators is an important prerequisite. Yet nurse educator preparation varies, with many expected to teach with minimal experience in the area of family violence (Tufts, Clements, & Karlowicz, 2009). This indicates an important professional development need and provides the opportunity to consider methods for improving violence teaching and learning in schools of nursing. To address this, a working group in New Zealand set out to develop a national nurse educator workshop addressing family violence nursing curriculum strategies.

The Workshop

A nurse educator workshop and accompanying evaluation was organized by a Nurse Educators in the Tertiary Sector (NETS) working group and funded by the New Zealand Ministry of Health. The aim was to influence curricula toward ensuring nurses entering the workforce have the necessary knowledge and skills to address family violence issues in a safe and caring manner. The working group appreciated the variation in curricular models among the schools - and favouring an integrated model of family violence teaching and learning - decided not to develop a standardized training package. The workshop instead focused on sharing of experiences, resources and teaching and learning strategies that each school could then tailor to their educational program needs. Family violence core competencies (Cohn et al., 2002; Humphreys & Campbell, 2004) were explicitly linked to the Nursing Council of New Zealand Competencies for Entry to the Register of Comprehensive Nurse (1999) and to the Ministry of Health guidelines (Fanslow, 2002).

A letter to the Heads of School (Deans) of the 21 New Zealand tertiary nursing education facilities introduced the workshop and accompanying evaluation project. Schools were invited to send two representatives to the workshop. Of the 21 schools, 17 offered a baccalaureate (three-year) nursing program graduating approximately one thousand students annually (Nursing Council, 2001). Faculty member interest in violence education, participation in curriculum development, and completion of the pre-workshop curriculum survey were suggested criteria for attendance.

The two-day workshop was held in May 2004. A working group member with expert facilitation skills (LG) convened the workshop. The workshop attended to learner safety, adult learning principles, and modelled best practice family violence teaching. These included promoting a safe classroom (e.g., transparent agenda, ground rules, referral information), providing a pre-training activity (i.e., survey of current practice), addressing values and beliefs (e.g., opening activity about “difference”), providing interagency education (e.g., panel of community representatives), and gathering learner feedback (i.e., workshop evaluation form). Baseline data indentifying the extent and placement of family violence learning experiences across schools of nursing in the year prior to the workshop (pre-workshop survey, see below) were presented. The program outline is provided in Table 1. The workshop ended with a focus on setting up support networks and individual commitments to increase the visibility of family violence within each school’s curriculum. Participants also agreed on a timeline for the post-workshop curriculum survey. Resource packages that included curriculum documents (e.g., principles, core competencies, staging of curriculum), learning activities, an annotated bibliography, and two videos and a CD were distributed to each school.

Forty nurse educators from 20 schools attended the workshop, some had minimal family violence knowledge, while others had expert knowledge and had been including family violence content in their teaching for a number of years. A few schools sent interdisciplinary team members (such as social workers) who participated in nursing violence teaching and learning. Workshop evaluation forms supported the workshop as being beneficial, particularly with respect to networking, modelling mixed teaching and learning methods, and the provision of resources. Participants also identified additional information needs including about elder abuse, abuse and persons with a disability, and student perspectives.

Methods

A pre- and post-test survey design was used to measure the effectiveness of the two-day nurse educator workshop in increasing violence teaching and learning in New Zealand schools of nursing. The study replicated the methods and instrumentation used by Woodtli and Breslin (2002) to identify "the extent, placement, and learning experiences related to content on abuse and violence against women, children and elders in nursing curricula in baccalaureate nursing programs in the United States" (p. 341). The survey was administered on two occasions referent to the academic year (January – November) before (2003) and after (2005) the workshop. The research protocol was approved by the Auckland University of Technology Ethics Committee and individual Schools of Nursing provided written consent.

Sample and Procedure

Potential participants included all 21 tertiary education-based Schools of Nursing in New Zealand. The workshop planners sent an information letter and informed consent form to Heads of School and recommended they delegate completion of the survey to the school's workshop attendees as a means of raising awareness of the issue pre-workshop and improving data accuracy. Pre-workshop surveys were subsequently e-mailed to designated school representatives in February 2004 for reporting of the 2003 curriculum. As was requested by workshop participants and allowing time for curricular change, post-workshop surveys were e-mailed in November 2005 for reporting of the 2005 curriculum. Survey data were entered in SPSS using a coding system to maintain institution anonymity, yet allow matching of pre- and post-workshop data. Paired t-test analysed change in violence course content hours pre- and post- workshop, limited to schools that offer a Baccalaureate nursing degree. Chi-square analysed change in the frequency of curriculum activities pre- and post-workshop. Open-ended question responses were analysed using descriptive content analysis.

Survey Instrument

The Woodtli and Breslin (2002) survey was adapted for this study with permission. The survey instrument, *Evaluation of Family Violence Curriculum in Aoteoroa New Zealand Schools of Nursing*, included four parts with a mixture of closed- and open-ended items. Part 1 included five items about curriculum development such as "Have you undertaken a systematic evaluation of the curriculum for family violence issues in the past year?" and "Do you have a process in place to assist students in addressing personal violence issues?" Part 2 included nine items about course content such as "Do you provide clinical experience as part of your family violence curriculum?" and "Please indicate the number of content hours (instructional time) provided for each year of your curriculum for each family violence issue?" Content related to child abuse, partner violence, elder abuse and sexual assault was assessed. Following Woodtli and Breslin's methods, suicide, self-harm, and horizontal violence teaching hours were assessed to serve as comparison content areas. Part 3 included three items related to adequacy of the family violence teaching and general recommendations. Part 4 asked about school characteristics. The post-workshop survey included four additional items "Do you assess students related to family violence competencies?", "Some believe introducing family violence curriculum results in harm for students. Has this been your School's experience in the past year?", "What challenges have you encountered in providing family violence curriculum and how have you dealt with them?" and whether there were any perceived rewards related to providing violence education.

Findings

Among the 21 eligible schools, 19 (90%) completed the pre-workshop survey and 20 (95%) completed the post-workshop survey. The schools had a mixture of undergraduate and postgraduate programs. Sixteen and 17 participating schools provided an undergraduate program pre- and post-workshop respectively (see Table 2).

Curriculum development

The majority of violence curriculum development indicators increased following the workshop (see Figure 1). Statistically significant increases occurred for curriculum evaluation (16% to 53%), faculty development activities (21% to 53%), and having a process to assist students addressing personal violence issues (72% to 94%). However, less than half of the schools reported explicit family violence competencies (22%) or student assessment (42%) post-workshop. Of schools reporting competencies, they were often broad and non-specific. Of schools reporting student assessments, these occurred in written assignments, exams and clinical practice assessments.

The proportion of schools judging family violence teaching and learning as "adequate" increased from 11% (2 schools) pre-workshop to 50% (9 schools) post-workshop (p=.014). Barriers to violence teaching and learning pre-workshop included an "already full" curriculum, lack of time, and violence not perceived as a priority in their schools. Curriculum changes reported post-workshop included specifying (and increasing) learning outcomes related to family violence, increasing teaching time, integration of family violence through the three years, changing teaching processes, and involving community experts. Several comments noted that while curriculum improvements had been achieved, more work was needed. Recommendations to support violence curriculum improvements pre- and post-workshop were similar and included a desire for faculty development, curriculum planning, networking and additional teaching resources.

Course Content

Among schools with a baccalaureate program, mean hours of violence instruction increased 50% from 8 hours pre-workshop to 12 hours post-workshop (see Table 3). This compared to a 38% increase (from 7.4 to 10.2 hours) for the comparison teaching and learning topics including suicide, self-harm and horizontal violence. Instruction increased for child abuse (2.8 to 4.7 hours), partner violence (2.1 to 3.6 hours), and elder abuse (2.2 to 2.8 hours). While these increases are important, they did not reach statistical significance. Sexual assault instruction hours and all violence category reading hours remained stable pre- and post-workshop. Mean hours of violence reading decreased less than one percent, compared to a decrease of 46% for comparison reading for suicide, self-harm and horizontal violence. Violence instruction was distributed across the three years of the curriculum with the majority (48%) in year 2. Schools reported family violence content was included in family or community health nursing (child abuse and neglect, partner abuse), clinical praxis (partner abuse), gerontological health (elder abuse), mental health (partner abuse, sexual assault) and sexual health (sexual assault).

Six (32%) schools provided violence related clinical experience pre-workshop compared to eight (44%) schools post-workshop (p=.32). However, the clinical experience was typically optional (in five of the six pre-workshop and six of the eight post-workshop). Placements were offered in women's refuge (shelter), a child abuse centre and rape crisis centre. Elder abuse service agencies were not mentioned in the range of possible clinical experiences. Rather than offering students placements in the community, some schools reported they

invited representatives from service agencies as guest speakers to avoid placing additional burden on services already considered under pressure.

Curriculum Innovations

Seven (35%) schools reported implementing violence teaching and learning activities following the workshop, compared to 4 (23%) in the year before the workshop (p=.51). Activities implemented after the workshop included case studies and role plays; using a variety of multimedia resources such as on-line interactive session, narratives and video-clips; and government and community service agency speakers. Curricular innovations included making violence content more transparent, providing on-going education for curriculum planners and taking a 3-year developmental approach to violence-related competencies.

Post-Workshop Teaching and Learning Experiences

A challenge to integrating violence post-workshop included perceived resistance by faculties, signalled by a lack of viewing family violence as a priority and lack of support for lecturers teaching family violence content: "Support of colleagues in the teaching of these issues was lacking." Another challenge was poor student attendance for family violence sessions, though faculty were unsure whether it related to the topic or being "a Friday afternoon session".

Participants also identified the need for lecturer skills in creating a safe classroom environment and in facilitating discussion when students disclosed abuse or when judgmental attitudes dominated the discussion. One nurse educator reported, "Some students state there is no need to read stories of children abused in New Zealand and that lecturers are scaremongering. This is disappointing." The skill in teaching was evident in many of the participant responses such as in the following comment,

> *Having a counsellor for students to debrief with on site has been a strategy that has worked well. Judgmental views towards both victims and perpetrators are usually different after being informed. Students are asked for their comments in regards to these views and a healthy debate usually occurs and the results are usually positive.*

Other comments included, "Generally, students are overwhelmingly interested and wanting to learn, this is affirming" and "Receiving requests for additional sessions to help their ability to identify, support and refer in transition for their RN role".

Participants were well aware of the need to consider student well-being when introducing family violence content; 85% shared strategies to minimize student harm. The two (10%) schools responding that violence teaching and learning has caused harm followed with comments describing strategies to minimise harm such as, "Students that are harmed normally are or have been in abusive relationship and have been offered counselling and are able to debrief with a lecturer promptly." Another participant commented, "Some students arrive at class prepared to participate but find that they cannot cope as discussion can trigger suppressed emotions." The importance of addressing personal issues was also raised, "It is challenging for some and raises issues some would rather ignore but it is essential students deal with their own feelings and responses if they are to be effective nurses." Rather than harm, some indicated benefit for students,

> *On the contrary, it appears that students who have experienced, or who are experiencing FV are appreciative and supportive of the issues being raised or addressed, some students also see this as an opportunity to share their story and*

know that they will be respected and supported, interestingly, this does not appear to be a need for referral, but a chance to share.

Discussion

Introducing new content into nursing curriculum will always be fraught with difficulty. This is certainly the case for family violence, where the content is sensitive and controversial, as well as unknown to a majority of nurse educators (Gagan, 2003; Simmonds, Foster, & Zurek, 2009). We found that a two-day nurse educator workshop - focusing on sharing of experiences, resources and teaching strategies and setting up networks for ongoing support - was successful in increasing family violence curriculum across New Zealand schools of nursing. Prior to the workshop, 11% of schools reported family violence was adequately addressed in their curriculum, increasing to 50% following the workshop. The mean number of family violence instructional hours increased from 8 to 12 hours, with increases across child abuse and neglect, partner violence, and elder abuse. Teaching and learning methods reported by participants post-workshop included the use of multimedia resources (eg videos, news reports, on-line programs), case studies, role play and guest speakers. Alongside curricular development, schools reported increased family violence faculty development activities.

While there was an increase in the number of schools evaluating and making changes to their curriculum, they continue to identify a need to improve family violence priority and integration through the curriculum. There was limited improvement in integrating core family violence competencies and assessment points in nursing curricula. The integration of family violence in clinical experiences was limited. While students in some programs could select a short clinical option in women's refuge for example, assessment (and intervention) of clients for family violence has not yet been integrated into clinical teaching. We also noted little change in sexual assault instruction and a decrease post-workshop in elder abuse reading, with no elder abuse agencies listed for potential clinical placements. In retrospect, few sexual assault and elder abuse readings were referenced in the workshop and the Ministry had not yet published their Elder Abuse Guidelines (Glasgow & Fanslow, 2006).

In measuring and reporting violence instructional and reading hours in schools of nursing, one must consider several questions. First, how many curricular hours are enough? The post-workshop level of family violence education reported for New Zealand nursing students compares favourably to US (Woodtli & Breslin, 2002) and Canadian (Ross et al., 1998) studies with the exception of sexual assault. Mean instructional hours reported by Ross et al for child abuse, partner violence, elder abuse and sexual assault were 4.0, 3.6, 2.7 and 3.4 respectively. New Zealand child abuse instruction was somewhat higher (4.7 hours), yet sexual assault instruction was lower (1.2 hours). Woodtli and Breslin reported the proportion of schools with less than 2 hours of instructions for child abuse, partner violence, elder abuse and sexual assault as 18%, 30%, 46% and 46% respectively. New Zealand again compares favourably (6%, 25%, 12.5% and 69% respectively) with the exception of sexual assault. Indeed, 38% (n=6) of New Zealand schools reported no teaching and learning addressing sexual assault, indentifying an important gap in the preparation of New Zealand nurses.

Secondly, while the amount of teaching hours is important, what about quality? Participants acknowledged that the majority of nurse educators had family violence educational needs themselves. It is possible that when educators lack confidence to facilitate discussion they

may avoid family violence in their teaching, or perhaps emphasize factual learning rather than process learning. And along with teacher preparation, which teaching methods best achieve student learning to provide sensitive, effective family violence care? While we can apply educational research regarding effective teaching methods, which pedagogies are most likely to promote competent, reflective practitioners prepared to address the issue of family violence sensitively? In answering "how much is enough" and "what is quality violence teaching and learning" we must be clear on graduate learning outcomes. Research demonstrates health professional education results in learner change in attitudes and knowledge (Cohn et al., 2002), but the effect on clinical outcomes remains untested.

Clinical Integration

Several schools in this study reported that students "may possibly" gain experience in addressing family violence in their usual clinical placements. The authors' experience would indicate this has been the exception rather than the rule. While guidelines exist, New Zealand district health boards are still in the process of developing systems to support assessment and intervention. A recent New Zealand evaluation of acute care hospitals found that among those reviewing charts for partner violence screening, six (22%) reported screening 25% or more of eligible women (Koziol-McLain, Garrett, & Gear, 2009). This brings to light the relatively measured translation of health care policy (Fanslow, 2002) into clinical practice. Schools would be advised to work closely with local district health board Family Violence (including Child Protection) Coordinators. Indeed, a wider consideration of interagency efforts to eliminate violence are needed (Ellsberg, 2006). Schools must be sensitive to sending out nursing students sensitized to family violence, only to be faced by practicing nurses who respond, "family violence screening, oh we don't do that here."

Sustainability

This study documented an increase in violence teaching and learning in the academic year following a two-day workshop, but are the improvements sustainable? Our goal was to support participants serving as change agents in integrating family violence curriculum in their respective schools. Yet in the year following the workshop, some of the workshop attendees had already left their academic setting. Some of the participant recommendations provide a glimpse of what would be needed to support sustainability. These include a national (linked to international) web-based resource for information sharing; ongoing training for all nurse educators, particularly for those involved in clinical teaching to ensure quality role modelling; resource a working group that could support and monitor progress and provide technical support. Technical support could attend to updating and further developing problem-based learning cases, and model student learning outcomes and accompanying assessments, including development and support for Objective Structured Clinical Examination (OSCE).

Limitations

This study evaluated curricular changes across schools of nursing in New Zealand following a two-day nurse educator workshop. As such, it tested a single intervention among a small number of schools with no comparison schools. Therefore, statistical and historical bias are important study limitations. While the number of schools was small, resulting in inadequate statistical power to detect change, a 95% response rate supports the study being representative of New Zealand schools of nursing. In addition, there is the potential for measurement error. The reliability of curricular surveys is likely to be affected by the availability of curricular details and attention to information gathering. The survey completers, as workshop participants, had a vested interest in the survey, but may have had

limited time and curricular knowledge. Additionally, their interest might have increased post-workshop resulting in closer scrutiny discovering previously missed curricular elements or acknowledging content was not in fact being offered. However, it is a possibility that the pre-workshop (and post-workshop) surveys themselves served an educational (awareness raising) purpose. Finally, this study measured curricular changes, the outcomes of student learning and client support are endpoints that remain untested.

Conclusions

A national New Zealand nurse educator workshop provided a forum for discussion and resource sharing that supported the integration of family violence in New Zealand schools of nursing. While the workshop was useful, additional work is needed to direct schools of nursing in evidence-based methods to ensure graduate nurses are prepared to support individuals, families and communities suffering from violence in a caring and sensitive manner. Nurses have the opportunity to place violence teaching and learning in their curriculum, joining with the health care community, government and community agencies in declaring, as a current New Zealand campaign argues, family violence - "It's not OK".

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Table 1. Selected Workshop Content

Session	Description/Method	Purpose/Rationale
A Nurse's Story of Abuse	Nurse's narrative account of abuse by her husband including response of children, family and health care providers	• Reinforce *awareness* of family violence (partner abuse and child abuse & neglect) as a health issue • Increase *sensitivity* to family violence experience through narrative • Increase *sensitivity* to our personal abuse histories
Traumatised Teachers & Learners	Sharing of experiences and strategies for safely addressing family violence in curriculum	• Acknowledge teachers and learners as at risk for family violence across the life span • Create *safety* for teaching and learning
Is it realistic to expect nurses to screen for family violence	Panel debate for and against partner abuse screening in the health care system (and including in curriculum)	• Addresses *barriers* to responding to family violence in health care
Family Violence Competencies	Presented by national Nursing Council representative	• Identify nurse *competencies* • Link competencies to nursing regulatory body
Introduction to curriculum development	Presentation of a proposed model for family violence curriculum following the model for cultural safety education in New Zealand (awareness; sensitivity; safety)	• *Integrate* family violence content across curriculum
Reducing Family Violence in Aotearoa NZ: Tensions & Challenges	Panel presentation including representatives from women's refuge (shelter), stopping violence program, and children's commissioner	• *Interdisciplinary/intersectoral* teaching and practice
Innovations & resource sharing	Exemplar teaching and learning exercises presented	• Provide *resources*
Action curriculum change	Group activity setting action plan for change post-workshop	• Support sustainable *change*
Postgraduate issues	Master's and doctoral curriculum and thesis/dissertation supervision discussed	• Support development of *nurse leaders* in reducing family violence (in practice, education, research and policy)

Table 2. School Characteristics

	Pre-Workshop (n=19)		Post-Workshop (n=20)	
	Frequency	%	Frequency	%
Programs offered				
UG and PG	13	68.4	13	65.0
UG only	3	15.8	4	20.0
PG only	3	15.8	3	15.0
Educational Facility				
University	5	26.3	6	30.0
Polytechnic	14	73.7	14	70.0
UG Program Student Enrolment				
≤100	0	0	2	11.8
101-200	6	37.5	3	17.6
201-300	4	25.0	7	41.2
301-400	3	18.8	0	0
401-500	2	12.5	4	23.5
500+	1	6.3	1	5.9
Faculty FTE				
Mean ± SD	25.4 ± 14.5		20.9 ± 12.6	
Range	8 – 58		6 - 47	
(missing)	(5)		(1)	

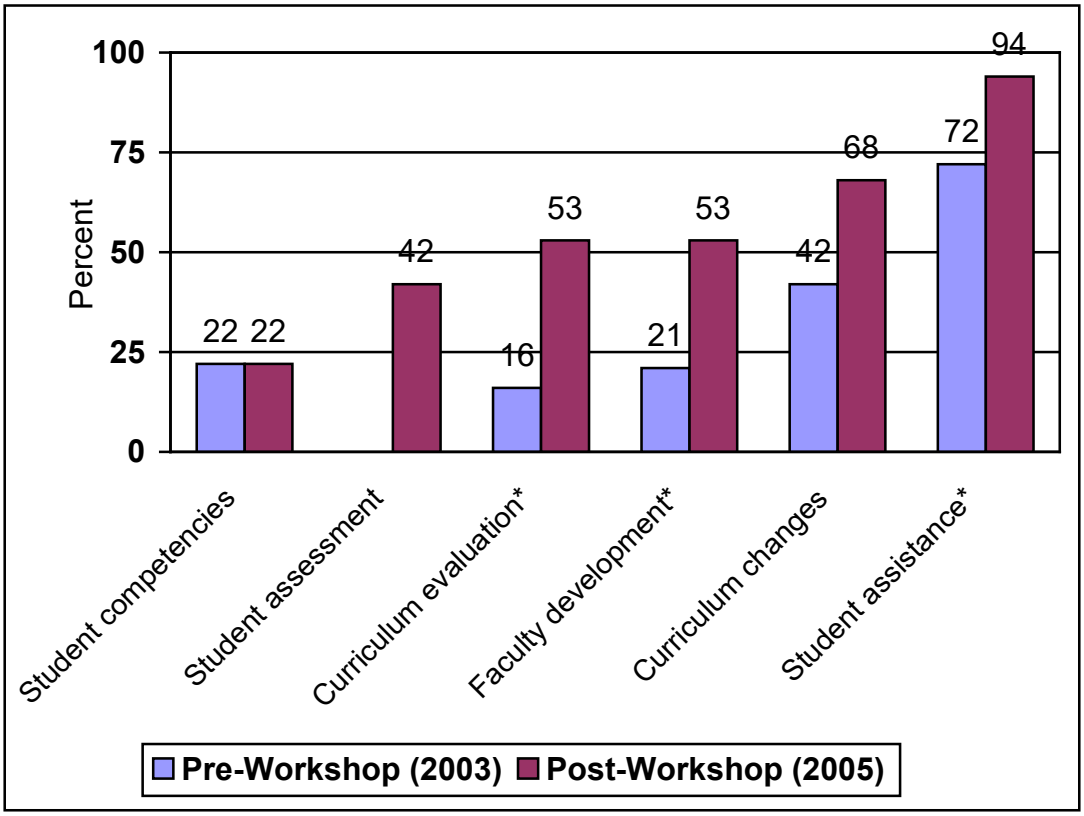
Notes: UG=undergraduate (baccalaureate); PG=postgraduate (master's and doctorate)

Table 3. Undergraduate Nursing Mean Hours of Family Violence Instruction and Reading Pre- and Post-Workshop (N=16)

	Instruction Hours									Reading Hours		
	Year 1		Year 2		Year 3		Total			Total		
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	p	Pre	Post	p
Child Abuse	1.2	0.9	0.8	2.1	0.9	1.7	2.8	**4.7**	.18	2.2	**2.8**	.80
Partner Violence	0.3	0.6	0.9	1.8	0.9	1.2	2.1	**3.6**	.06	1.8	**2.0**	.95
Elder Abuse	0.6	0.8	1.3	1.3	0.3	0.7	2.2	**2.8**	.13	2.7	**1.3**	.32
Sexual Assault	0.1	0.1	0.6	0.7	0.3	0.4	1.1	**1.2**	.88	0.3	**.05**	.50
Family Violence	**2.1**	**2.3**	**3.6**	**5.9**	**2.5**	**4.1**	8.2	**12.3** ↑4.1 (50%)	.08	6.9	**6.6** ↓0.3 (4%)	.64
Comparison (Suicide, Self-Harm & Horizontal Violence)	1.0	0.7	3.3	6.0	3.1	3.5	7.4	10.2 ↑2.8 (38%)	.22	9.8	5.3 ↓4.5 (46%)	.38

Notes: New Zealand undergraduate nursing programs span three curricular years; p-value based on paired t-test for 15 undergraduate programs reporting hours both pre- and post-workshop.

Figure 1. Family Violence Curriculum Activities (N=19)



* p<.05