Perinatal Partnership Program of Eastern and Southeastern Ontario

Woman Abuse in the Perinatal Period
Guidelines for Care Providers

A Collaborative Project

ACKNOWLEDGEMENTS

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Introduction/Background

In January 2002, the Public Health Branch of the Ontario Ministry of Health and Long-Term Care (MOHLTC) made Early Child Development funding available to public health units in order to provide supportive programming to children 0 – 6 years of age, their parents and caregivers. This funding was directed towards a number of new initiatives including those that would address issues related to healthy pregnancy, child development and family abuse prevention.

In addition, all provincial Sexual Assault Care and Treatment Centres received funding from the Ministry of Health to expand sexual assault programs to include services for victims of domestic violence. This completed the commitment announced by the Ontario Women's Directorate in 1997, under their Preventing Violence Against Women initiative.

The Perinatal Advisory Committee of the Perinatal Partnership Program of Eastern and Southeastern Ontario (PPPESO) recommended that a regional view of the issue of violence in pregnancy would be helpful in light of the above funding. As a result, an interdisciplinary, multisectoral committee was struck and the following key activities were identified:

- to develop a standard of practice to screen, identify and refer women experiencing abuse in the perinatal period
- to facilitate intersectoral information sharing and collaboration in the availability and provision of services to anglophone and francophone women experiencing abuse in the perinatal period by:
    - assessing the scope of violence in pregnancy
    - developing an inventory of current initiatives in the region
    - identifying gaps in services
- to identify and assess the learning needs of health care professionals and community service providers, and
- to develop/provide learning resources to and/or inservice education to health care professionals and community service providers.

As care providers, professionals in health and social service sectors are uniquely positioned to identify and to respond to women who have experienced abuse, especially abuse in the perinatal period. It has been suggested that the quality of medical care that an abused woman receives is a predictor of whether she will follow through with referrals to legal, social and health care agencies (Health Canada, 1999). Pregnancy may motivate some woman to seek help – if not for themselves, for the safety of the baby. In fact, pregnancy may be the only time when women who are being abused interface with a number of health care providers and is, therefore, an important time for identification and intervention.

Definition

Woman abuse involves the intent to intimidate a woman, either by actual or by threat of physical, sexual, financial or emotional abuse, by someone with whom she has an intimate, family or romantic relationship. An intimate partner includes: husband, common-law partner, boyfriend, or same sex partner, as well as ex-husband, ex-partner, or ex-boyfriend (Best Practice Guidelines, Ontario Hospital Association, 1999). Woman abuse uses isolation and male privilege to gain power and control over a woman. Woman abuse is a social, health, economic and legal issue. Woman abuse during pregnancy has been well documented as a major health concern to both mother and her unborn baby. It is also known as: spousal abuse, partner abuse, domestic violence, family violence and intimate partner violence.

Did you know ... that the cost of violence against women in Canada is more than 4 billion dollars annually and that the health related costs are estimated to be 1.5 billion dollars a year?

Health Canada, 1999b

Prevalence

Violence affects all women regardless of culture, class, ethnicity, ability, occupation or sexual orientation. The Canadian Violence Against Women Survey found that **51%** of women over the age of sixteen had experienced at least one incident of physical or sexual assault and approximately **25%** of women had been abused by their intimate partners (Intimate Partner Violence (IPV) Guideline, British Columbia Reproductive Care Program (BCRCP), 2003). Reported figures will not necessarily reflect the true prevalence as many incidents go unreported. Fifty-six percent of abused women were 18-34 years old, making woman abuse very much a problem of the 'childbearing years'.

Prevalence During Pregnancy

Pregnancy is a time of change in a relationship. It is also a time when the incidence and nature of violence may also change. MacFarlane (1993) found in about **40%** of the cases, the abuse began during pregnancy. Twenty one percent of the women in Canada who reported being abused by an intimate partner said that they were abused ***during*** pregnancy (IPV Guideline, BCRCP, 2003). If a woman is abused prior to and during a pregnancy, the abuse is likely to continue after the pregnancy. In fact, **95%** of women who were abused in the first trimester of pregnancy were also abused in the 3-month period after delivery (Health Canada, 1999b).

Did you know ... pregnant women have a higher risk of experiencing violence during pregnancy than they do of experiencing problems such as pre-eclampsia, placenta previa or gestational diabetes – health concerns for which they are routinely screened?

Health Canada, 1999b

Dynamics of Abuse

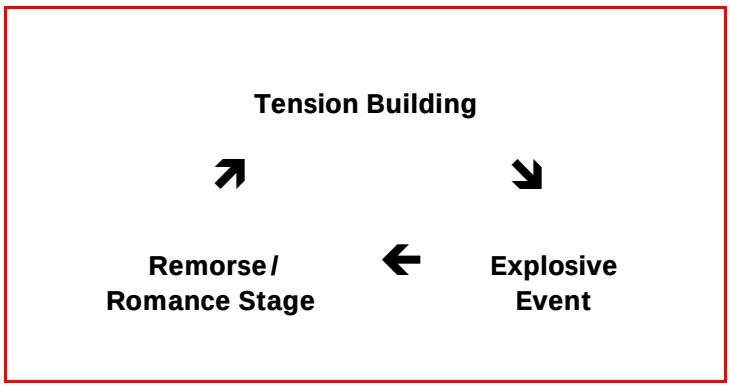
Abuse is related to the misuse of power and control. Abuse has serious consequences for women, their children, their families, their communities and their abusers. Abuse occurs in many different forms including: verbal, mental (psychological), emotional, sexual, physical, cultural, spiritual, financial, ritual and social (Appendix A). While physical violence may be one way that a woman is controlled, women describe an entire pattern of abuse that makes them feel inferior, lessens their decision-making power in the relationship and isolates them from friends and family. Isolation can increase a woman's vulnerability and risk of harm.

Abuse is a systematic pattern of behaviour. Most often, abusers have learned this behaviour through personal experience or by watching others in their family. Unfortunately, abusers have also learned that abusive behaviour is an effective way of establishing or gaining control over another individual. Abuse is rarely present at the start of a relationship. The pattern of abuse usually starts with minor incidents that are not generally thought to be abusive, but become part of a pattern that escalates over time. For example, many women describe their partners initially discouraging them from seeing their

friends and family. Over time, women become more isolated and are more vulnerable to their partner's control.

The cycle of violence also follows a distinct sequence and pattern of behaviour (see below).

Cycle of Violence



Adapted from: A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy, Health Canada, 1999.

The remorse and regret shown by the abuser is one reason women remain in abusive relationships. There are many other reasons including:

- fear that she will not be believed
- feeling that the abuse is her fault
- isolation from her support system and community resources by her abusive partner
- fear that she will have to leave a familiar setting/community to escape/evade the abuse(r)
  → **a particular concern for woman in small and / or rural communities**
- lack of educational qualifications and/or employment skills
- lack of an alternative source of income to support herself and/or her children
- fear of being stalked or killed by her abusive partner
  → **this is particularly relevant when women leave abusive relationships**
- fear that abuser may kill himself if she leaves
- belief that abuse is normal (based on previous experience)
- pressure by family or community to stay with the abuser
- religious doctrine or faith that prevents her from leaving
- reluctance to deny her children their father
- lack of power and control in her life
- refugee or immigrant status and fear of deportation
- inability to speak English or French
- fear that children will be taken away by child welfare authorities and that custody may be awarded to abusive partner, and finally
- love for the abusive partner and the hope that he will change

Adapted from: A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy, Health Canada, 1999.

Women have the right to make choices about disclosing the abuse as well as how and when to accept help. Their decisions must be respected. These women are the experts in determining their level of risk and safety. Healthcare providers need to acknowledge personal feelings about dealing with women who choose not to leave an abusive relationship.

Did you know ... there is a heightened risk of violence by intimate partners after women leave those partners/relationships?

Dynamics of Abuse during Pregnancy

Often, violence escalates during pregnancy and women experience more severe or specifically targeted forms of violence when they are pregnant. Young pregnant women are at even higher risk of violence (Health Canada, 1999b). Specific examples are presented in the table below.

Table 1: Dynamics of Abuse during Pregnancy

Before Pregnancy	*The abuser may:* sexually assault the woman refuse to engage in sex with the woman refuse to or force the use of contraception refuse to protect against sexually transmitted diseases or HIV/AIDS
Once Pregnant	*The abuser may:* force the woman to have an abortion injure with intent of causing a miscarriage force the continuation of an unwanted pregnancy
During Pregnancy	*The abuser may:* start, continue or change the pattern of abuse control/limit/delay access to prenatal care use pregnancy as weapon for emotional abuse (i.e. claim she is unattractive, deny paternity, refuse support) deny access to financial resources (food/supplies) threaten to leave her report her as an unfit mother force her to work
During Labour/Birth	*The abuser may:* control decision-making re: use of pain medication/interventions make negative comments about the baby's gender
After Birth	*The abuser may:* increase abuse deny access to baby demand sex soon after childbirth

Adapted from: A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy, Health Canada, 1999.

Health Impact of Woman Abuse

Intimate partner violence is the most common cause of injury to women - occurring more often than automobile accidents, muggings and sexual assaults by strangers combined (IPV Guideline, BCRCP, 2003). Research has demonstrated that the impact of violence through a woman's life is cumulative, impacts health generally, with specific impact during the perinatal and postnatal periods. Finally, there are threats to maternal and/or fetal health, risk of maternal and/or fetal death from trauma, and complications of pregnancy and childbirth (Table 2).

Table 2: Health Impacts Of Woman Abuse

General	Reproductive	Fetal/Newborn
• physical trauma and injuries • neurologic symptoms • stress/anxiety disorders • somatic disorders • depression • substance abuse • sleeping disorders • eating disorders • chronic pain • chest pain/hypertension • worsening of chronic medical conditions • suicidal ideation • homicide	• sexually transmitted diseases (STDs) • unprotected sexual intercourse • unwanted sexual contact • unwanted pregnancies • lack of control over reproductive decision-making • spontaneous abortions • inadequate prenatal care • complications during delivery • infertility secondary to STDs • psychological reaction(s) to past abuse during labour and delivery	• placental abruption • preterm labour and/or delivery • fetal death • fetal injury (fractures/hemorrhage) • issues around bonding/attachment • poor fetal growth related to poor maternal nutrition • neonatal infection secondary to STDs • neonatal death • decrease in breastfeeding initiation and duration

Adapted from: A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy, Health Canada, 1999 and IPV Guideline, BCRCP, 2003.

The health impact of woman abuse is multifaceted – as demonstrated in the table above. Not only is there physical injury but there may be long lasting psychological effects as well. For example, women who are abused experience high levels of stress and anxiety, often over a long period of time. Stress is known to cause or to exacerbate many other health conditions including cardiovascular conditions, reproductive disorders and some autoimmune diseases (Middlesex-London Health Unit Final Report, 2000).

Women abused by an intimate partner may face **barriers to care**. For instance, the partner may minimize the woman's health concerns thus influencing the woman's decision to seek medical advice and/or intervention. In more dire circumstances, the partner may directly prevent the woman from obtaining health care or may interfere with the delivery of appropriate services when she does access care.

Further, as a result of abuse, the woman may have learned to ignore or diminish her needs and may delay or not seek healthcare. If a woman does seek care, she may access walk-in clinics or the emergency department instead of visiting her primary care provider. Care is fragmented and the issue of abuse may not come to light – which may have been the woman's intent. Women are concerned that revealing the abuse may:

- increase the violence in their relationship and/or
- initiate police and/or child protection involvement (i.e. apprehension of dependent children).

A final barrier to care may lie with health care providers and their discomfort and reluctance to ask about woman abuse. Research shows that women want to be asked about abuse. Research also shows that women have to be asked at least 6-8 times before they will disclose abuse – this reiterates the need for routine and repeated screening. A woman will be abused at least 28 times before a report to the police is made (Jaffe & Burris, 1981).

Abuse and the Legal System

Domestic violence is a crime. Physical and sexual abuse, as well as threats to harm, are regarded as **criminal offences** in a variety of sections of the Criminal Code of Canada. Violations of the Criminal Code may result in an indictable offence or summary conviction offence.
Specific charges that may be laid in a case of woman abuse include:

- assault
- aggravated assault
- sexual assault
- sexual assault causing bodily harm
- threatening to cause death or bodily harm
- intimidation
- attempted murder
- criminal harassment
- assault causing bodily harm
- aggravated sexual assault
- uttering threats
- sexual assault with a weapon
- forcible confinement
- murder

In addition, the accused may be charged with violation of a court order or breach of an order, bail or probation condition. Appendix B provides examples of abusive behaviours and their designation within the Criminal Code of Canada.

> To **charge** someone with an offence the police need only reasonable and probable grounds.
> To **convict** the accused, the prosecution must prove the charges beyond a reasonable doubt.
> Health Canada, 1999a

When a woman discloses abuse and charges are laid, she may have to interact with many different facets of the Canadian justice system including: criminal and civil law, family court and the child protection system. The journey through the legal system is complex and the woman should be advised to seek assistance especially if she is planning to leave the relationship. It is important to inform the woman, that once abuse has been reported to the authorities, it is the police (not the woman) that lay the charge(s) against the alleged perpetrator. The process is then beyond the woman's control – a precarious situation for a woman who may already feel powerless and without control in her life. Crown Attorney offices have the mandate to prosecute all cases of woman abuse vigorously and consistently. Only the Crown can withdraw charges once they are laid (Health Canada, 1999a).

> **Remember** ... in Ontario, healthcare providers are mandated to report incidents of domestic violence to Family and Children's Services when there is the threat of abuse or neglect to children under the age of 16. It also may be appropriate for healthcare providers to make a referral to Family and Children's Services during the prenatal period when there is concern about domestic violence.
>
> In most cases, efforts should be made to advise the woman of your mandate to report concern for her children's well-being and safety. Offer her the opportunity to be involved in this process in order to maintain a trusting therapeutic relationship.

Role of Health Care Providers

Pregnancy is both a time of high risk and unique opportunity to identify, assess and assist women who experience woman abuse. Education of health care providers about woman abuse is one of the first steps in the development of an integrated response (Guest 2000). Another important step is the creation of practice environments where disclosure is possible (Society of Obstetricians and Gynecologists of Canada, 1996). The availability of patient education materials and information about specific resources in waiting rooms, examination rooms and washrooms demonstrates health care providers' awareness and sensitivity to the issue of woman abuse. The process of responding to woman abuse in the perinatal period also includes:

- creation of a practice environment that encourages the identification of abuse
- awareness of the signs of abuse
- identification of cases of abuse through routine, universal and comprehensive screening
- individual and institutional preparedness to deal with disclosure of abuse including:
    - appropriate treatment
    - knowledge and identification of key individuals within the institution with expertise and understanding of the dynamics of abuse
- development of policies/protocols and other written resources
- mechanisms to support and refer women
- staff education and support
- establishment/knowledge of intersectoral linkages to provide continuity and ongoing care and support (Guest, 2000).

Screening

"With so many women experiencing abuse during pregnancy, screening for abuse during pregnancy must be **a routine part of prenatal care**." (Health Canada, 1999b, p. 22) Woman abuse should be a topic included on standard forms – a subject that health care providers will address just as they would inquire about medical conditions and lifestyle factors. When the probe/question is visible it serves as a reminder to the health care provider and lends credibility to the issue. In addition, the question may need to be asked more than once before a disclosure is made, therefore, periodic questioning and a systematic approach to woman abuse is needed. Health care providers, health care facilities and community service agencies may adopt a specific screening tool and/or may develop their own policies and/or clinical pathways around screening and treatment after disclosure (Dienemann, Campbell, Wiedehorn, Laughon & Jordan, 2003). Examples of screening tools are presented as Appendices C – F. Guidelines for a sample policy are found in Appendix G.

Wathen and MacMillan (2002) state "(t)here is insufficient evidence to recommend for or against routine universal screening for violence against either pregnant or nonpregnant women …; however, clinicians should be alert to signs and symptoms of potential abuse and may wish to ask about exposure to abuse during diagnostic evaluation of these patients" (p. 582). Principles of routine, universal and comprehensive screening (RUCS) have been endorsed by a number of groups throughout Ontario resulting in the development of the RUCS protocol (see Appendix H for RUCS algorithm).

- **Routine** screening means that questions about abuse are raised on a regular basis whenever women come into contact with any healthcare provider, whether or not indicators of abuse are identified.
- **Universal** screening means that every woman is asked about her current or past experience with abuse. Universal screening is paramount as it lends voice and visibility to the issue.
- **Comprehensive** screening means that women are asked whether they have experienced (as children, adolescents or adults) or are currently experiencing any form of physical, sexual, and/or psychological abuse. (Middlesex-London Health Unit, 2002)

When screening for abuse, healthcare providers must be sensitive to the situation in which the woman may find herself. Some guidelines for screening include:

DO …

- believe the woman's account of the abuse
- let her know abuse is a crime
- let her know that the abuse is not her fault
- let her know that help is available
- help her to identify options
- use non-gender specific language (i.e. partner, significant other)
- listen and validate
- show concern and respect for the woman
- respect confidentiality
- make the woman aware that if there is any threat of abuse or neglect to children under the age of 16, as a professional, you are obligated to report
- respect the woman's life choices and recognize that the process of dealing with abuse must be done at her pace, directed by her decisions
- offer in-house and community resources
- document disclosures accurately and comprehensively
- acknowledge your own attitude toward woman abuse

DO NOT …

- ignore the disclosure
- blame or shame the person
- minimize or maximize the experience
- screen individuals in the presence of others
- use family members to interpret when the woman does not speak the language of the interview
- sacrifice safety and confidentiality in the name of family-centred care
- assume that you know what is best or what will keep the woman safe after disclosure
- judge the woman's past, present or future choices
- use language that may be perceived as equivocal (vague) in a court of law

Until screening for woman abuse truly becomes routine, it may be difficult for healthcare providers to ask the question. Prefacing the question with the phrase **'because violence against women is so common, I ask all of my patients/clients the following question …**' (AAP & ACOG, 2002, p. 87) will reassure women that they are not being singled out by this inquiry.

Some ways to pose the question are:

1. Within the past year or since you have been pregnant, have you been threatened or actually hit, slapped, kicked or otherwise physically hurt by anyone?
2. Have you ever been forced to have sexual intercourse when you did not wish to participate? Have you been forced to do something you didn't want to do?
3. The injuries you have suggest to me that someone hit you. Is that possible?
4. It seems that the injuries you have could have been caused by someone hurting or abusing you. Did someone hurt you?
5. From my experience as a health worker, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?
6. We know that abuse is so prevalent and pervasive, that we routinely ask all women if they are experiencing any abuse or violence at home.
7. I've noticed that there seems to be some tension between you and your partner. How is that relationship? What happens when you and your partner disagree?
8. Are you afraid of your partner?

9. Does your partner hurt your feelings? Put you down? Criticize your family/friends? Call you names?
10. Are you afraid to take your baby home?

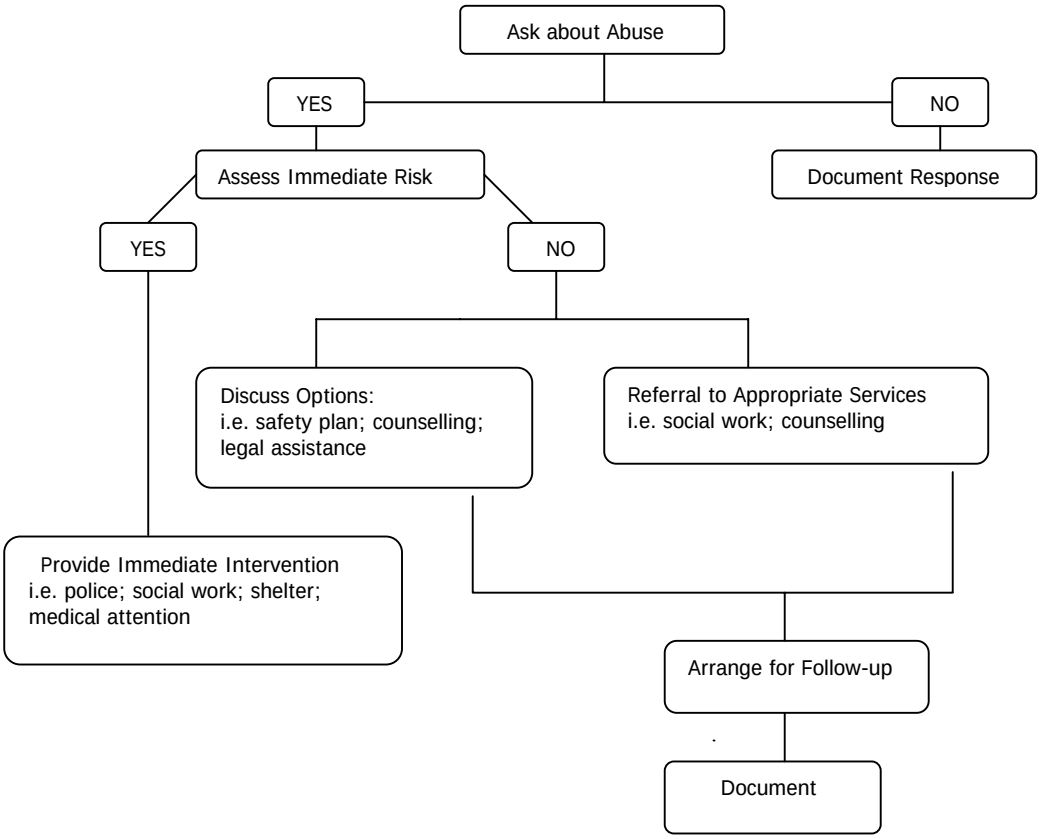
In addition, healthcare providers should recognize that their approach might influence a woman's response to questions about abuse. Questions should be asked in a compassionate and non-judgmental way, in a safe environment. If a woman does disclose about abuse, the woman's immediate and future safety must be assessed and addressed. The role of health care providers is summarized in Table 3.

Table 3: Role of Health Care Providers

Ask about Abuse - introduce it as a routine question
Assess Immediate Risk by Asking Questions about: - presence of children in the home (if there is any risk to the children a report to Children's Aid Society or the local Family and Children's Services must be made) - type of abuse - mental health of the abuser (a history of depression or attempted suicide places the woman at increased risk) - presence/availability of weapons - recent escalation(s) in abuse
Assist the Woman to Develop a Safety Plan including: - disclosure to family/friends/neighbours - contacting local police department (with woman's consent) - arranging for emergency accommodation - accessing legal counsel - gathering documents, clothing, money - providing materials and information about community support/resources ****Women are at higher risk of violence (death) when they leave an abusive relationship****
Make Referrals to Available Resources - medical treatment (emergency department, primary care provider) & follow-up - police and/or legal counsel - social work - Assaulted Women's Helpline - Sexual Assault/Domestic Violence Care and Treatment Centres - social services – financial aid, housing - counselling - community agencies (Children's Aid Society) - women's shelters
Follow-Up - assess need for ongoing support and intervention - assist in co-ordination of integrated service delivery

Adapted from: Best Practice Guidelines for Health Care Providers Working with Women Who Have Been Abused, OHA, 1997.

Sample Algorithm for Health Care Providers



In some cases, both the woman and her abuser may have the same physician. This situation is not a conflict of interest. However, if the physician feels that he/she is unable to provide unbiased care to both individuals, referral of one or both individuals is appropriate. Principles of confidentiality, quality medical care and safety remain paramount for both clients. Information garnered from one individual must not be shared with the partner without explicit permission. In addition, information received from the woman is only documented on her chart and vice versa (Ferris, Norton, Dunn, Gort & Degani, 1997).

Documentation

When a woman discloses about abuse, documentation is of utmost importance. Medical documentation may play a role in proving or disproving criminal intent (Health Canada, 1999a).
Documentation of the incident should incorporate:

- the medical history
- the chief complaint (in the woman's words)
- a description of the event as it relates to pattern of injury
- a detailed description of the injuries (use anatomical diagram or body map)
- photos (may be helpful but can only be taken with the woman's consent)
- specimens, laboratory and/or other diagnostic test findings and diagnosis
- a record of the medical treatment

Adapted from: A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians, Health Canada, 1999.

Remember ... do not document a disclosure of abuse in any record that the woman may take home with her (i.e. the prenatal record). **Ensure** that this information is documented elsewhere.

Remember ... if the healthcare record is subpoenaed, the defense has access to all the information contained within it. **Do not** document any non-medical information that may jeopardize the woman's safety (eg. her whereabouts if she leaves the relationship).

Prevention

Prevention of woman abuse is an onerous task. Healthcare providers can take a proactive role in prevention and early screening. Prevention of woman abuse requires an increased awareness and understanding of the dynamics of abuse. An important part of prevention entails empowering women. Health care and service providers can address prevention strategies directly with clients, as well as, within their own organization and community. Levels of prevention are outlined below.

Table 4: Prevention of Abuse

Primary	Secondary	Tertiary
• acceptance of a philosophy of zero tolerance for violence • violence free workplace • education re: non-violent child-rearing practices • lobby against violence in media • education re: the inter-generational aspects of abuse • intervention with children of abused woman	• early identification and intervention to precursors of abusive situations • advocating for necessary services • routine screening and assessment • provision of educational materials • assist in co-ordination of services and agencies in community • facilitate interdisciplinary approach(es) to care	• working with families that have experienced violence • safety planning • referrals/information re: legal assistance employment housing childcare health services social support counselling

Adapted from: IPV Guideline, BCRCP, 2003.

Summary

Asking women about abuse gives a strong message that:

- there are serious health effects of woman abuse
- health care providers recognize that woman abuse is a serious societal issue, as well as a crime and
- health care providers are prepared to help.

Awareness of woman abuse, its prevalence, unique dynamics and consequences for women is paramount if health care providers and community service agencies are to respond in such a way as to safeguard women and their dependent children from physical injury, psychological distress and further incidents of abuse. Routine screening, early identification and intervention, appropriate referrals and treatment offer strategies to address woman abuse in the perinatal period. By responding appropriately to disclosures of woman abuse, health care providers are in a position to enable women to reduce risk to themselves and their children.

Finally ... remember, health care providers are not **exclusively** responsible for finding solutions to woman abuse, but instead, should see themselves as part of a **community response system.**

Metro Woman Abuse Council, 1997, p. 15.

Recommendations

In order to provide optimal care to women in the perinatal period, the following recommendations are made.

1. Routine, universal and comprehensive screening for woman abuse become the standard of care throughout the region.

2. Each woman is asked about the presence of violence in her life, especially during the perinatal period. Questions should be raised in a variety of ways and a variety of settings, including emergency departments, primary care settings (physicians, midwives, nurse practitioners), walk-in clinics, prenatal classes, obstetrical units, post-partum units and/or neonatal intensive care units.

3. The safety of the woman and any dependent children be assessed whether or not disclosure has been made.

4. All healthcare providers recognize when health and safety are at risk and assist in safety planning particularly if/when a woman is planning to leave the relationship.

5. Healthcare facilities and community service agencies have policies in place to respond to disclosures of abuse (i.e. appropriate referrals for treatment, support and follow-up, resources available in their community, obligations around reporting to authorities and documentation requirements).

6. Healthcare providers are aware of their obligation to report any and all cases of alleged or suspected child abuse or neglect to a child and family service authority.

7. Education about woman abuse, especially violence in the perinatal period, be addressed in a number of forums including (but not limited to): prenatal classes, nursing and medical curricula, professional organizations, individual healthcare agencies/facilities, community service agencies, primary care providers and secondary school curricula.

8. Healthcare providers are aware of the issue of woman abuse, especially its impact during the perinatal period. This committee agrees to facilitate/provide educational sessions about screening for abuse, dynamics of abuse and safety planning - both formally and informally.

9. While recognizing the constraints of the healthcare system, healthcare providers carefully consider whether they can competently care for the woman, the abuser and other family members in their practice. Diligent efforts should be made to refer one client to another provider.

Services and Resources

Services	
Police, Fire or Ambulance 911	Crisis Intervention Centre 1-888-757-7766
Services for Abused Women 613-745-4818 Services pour femmes battues 613-745-3665	S.O.S Femmes 1-800-387-8603
Resources	
Ontario Network of Sexual Assault/Domestic Violence Care and Treatment Centres www.satconario.com	Guide to Services for Assaulted Women in Ontario (2nd ed.) Community Information Toronto, 1999. www.communityinfotoronto.org
Assaulted Women's Helpline 1-866-863-0511 or 1-866-863-7868 (TTY) www.awhl.org (provides service as well)	Education Wife Assault 427 Bloor Street West - Box 7 Toronto, ON M5S 1X7 416-968-3422 or 416-968-7335 (TTY) www.womanabuseprevention.com
The National Clearinghouse on Family Violence 7th Floor, Jeanne Mance Building Tunney's Pasture Ottawa, ON K1A 1B4 1-800-267-1291 or 613-957-7285 http://www.hc-sc.gc.ca/nc-cn	Metropolitan Action Committee on Violence against Women and Children 158 Spadina Road Toronto, ON M5R 2T8 416-392-3135 | 1-877-558-5570 www.metrac.org
Best Start: Maternal, Newborn and Early Child Development Resource Centre 1900-180 Dundas St. West Toronto, ON M5G 1 z8 1-800-397-9567 or 1-416-408-2249 www.beststart.org	Ontario Women's Health Network – A Directory of Health Services in Eastern Ontario (Stormont, Dundas, Glengarry & Prescott-Russell). 2000. and In Our Hands – A Guide to Women's Health and Community Services (Eastern Ontario). 2001 1-877-860-4545 http://www.owhn.on.ca
Ontario Women's Justice Network www.owjn.org	Services for Assaulted Women – Reference Manual for Service Providers of Assaulted Women (Ottawa, Carleton, Stormont, Dundas, Glengarry, Prescott-Russell & Renfrew). 1997 613-725-3601

For information about resources and initiatives in your area, contact the Helpline at your local Public Health Unit or the Assaulted Women's Helpline.

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Appendices

Appendix A

Types of Abuse

Type of Abuse	Selected Examples
Verbal	yelling, insults, name calling, ridiculing, threats
Mental (psychological)	using tactics to convince the woman that she is crazy or stupid, brainwashing, manipulation, withholding affection
Emotional	using guilt and other strategies to make the woman think she's a bad mother/partner/person, ignoring or neglecting her, using jealousy to control her
Sexual	preventing choice about sex, birth control or STD protection, any unwanted sexual contact, degrading the woman's body
Physical	hitting, choking, kicking, punching, throwing things, use of weapons, shoving, pushing, threats of violence
Cultural	belittling the woman's culture, racial insults
Spiritual	belittling the woman's religion, keeping her from practicing her faith, mocking her beliefs
Financial	controlling decisions about finances, not allowing the woman access to money, stealing her belongings/money, refusing to pay bills, not allowing her to work or go to school
Ritual/Ritualized	Satanic or so-called Christian cults, patterned abuse
Social	isolating the woman from friends or family, controlling her whereabouts and who she can associate with, intercepting her mail, denying her privacy

Adapted from: Lanark County Coalition against Violence, 2003 & IPV Guideline, BCRCP. 2003.

Appendix B

Types of Abuse Considered Crimes in Canada

Type of Abuse	Criminal Offence	Not an Offence
Physical	hitting, pinching, slapping, pushing, punching, kicking, burning, choking, biting, shooting, stabbing, cutting, forcible confinement	
Sexual	sexual touching, or sexual activity that is unwanted and not consented to	
Emotional/ Psychological	making threats to harm a person or a third party, damaging property, repeatedly following or communicating, watching or behaving in a threatening manner (stalking or criminal harassment)	humiliating, insulting, ignoring, screaming, calling someone names, telling someone what they are or are not allowed to do, where they can go, and who their friends can be
Financial		refusing to let someone have any money, refusing to allow someone to get a job

Adapted from: Abuse is wrong in any language. Ottawa, Ontario. Department of Justice Canada and the Attorney General of Canada, 1995. Report No. HV 6626.23C3A38. In 'A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians. Health Canada, 1999.

Appendix C

Routine Universal Comprehensive Screening (RUCS) Protocol

1. YES NO

☐ ☐ Experienced abuse in last 12 months? ☐ sexual ☐ physical ☐ emotional ☐ financial

☐ ☐ Experiencing abuse now? ☐ sexual ☐ physical ☐ emotional ☐ financial

☐ ☐ Experienced abuse in the past? ☐ sexual ☐ physical ☐ emotional ☐ financial

☐ Answers **NO, but indicators present** (go to #3)

☐ ☐ Do you still have contact with abuser? _____

☐ ☐ Do you feel safe now? _____

☐ ☐ Children under 16 at risk? _____

2. **If client answers YES to any of the above,** complete the following:

Done
☐ Document health assessment, if necessary
☐ Give referral card
☐ Provide transportation
☐ Discuss situation
☐ Provide counselling
☐ Intervention offered & declined

Referrals Made During Visit
☐ Abused Women's Helpline
☐ Short-term care/housing/shelter
☐ Emergency sexual assault care
☐ Police
☐ Children's Aid Society
☐ Sexual Assault/Domestic Treatment Centre

_____
_____
_____
_____
_____
_____

3. **If the client report NO abuse, but <u>indicators are present</u>,** continue with following interventions:

Done
☐ Discuss specific indicators that cause you to suspect abuse
☐ Provide general information about woman abuse and negative health effects
☐ Document responses and any suspect indicators (see over)

_____
_____
_____
_____
____

Signature & Title: _____ Date: _____

RUCS Health Assessment

(Describe frequency and severity of present and past abuse, using direct quotes from the client. Describe mechanism, location, and extent of injury and/or other symptoms and/or other conditions. Remember to emphasize first, worst and most recent incidents for both present and past abuse).

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Source: London-Middlesex Health Unit, 2002

Appendix D

Antenatal Psychosocial Health Assessment Tool

Problems in the following antenatal psychosocial areas have been shown to be associated with unfavourable postpartum outcomes (see below). This guide should be used as the topics for discussion to plan for supports or services to meet these needs.

The contents of this form may be sensitive. Careful consideration should be given before sharing this information with other caregivers.

LEGEND

CA – child abuse	LBW – low birth weight
CD – couple dysfunction	PI – physical illness
PD – postpartum depression	WA – woman abuse

Bold type indicates good evidence of association
Regular type indicates fair evidence of association

ANTENATAL FACTORS

Family Factors

Social Support (**CA**, **WA**, PD)

- How does your partner/family feel about your pregnancy?
- What support do you get from your family/friends/partner?
- Who will be helping you when you go home with your baby?
- What friends/family do you have in town?

Recent Stressful Life Events (**CA**, **WA**, **PD**, PI)

- What life changes have you experienced this year?
- What changes are you planning during this pregnancy?

Couple's Relationship (**CD**, **PD**, WA, CA)

- How will your partner be involved in looking after your baby?
- How do you share tasks at home? How do you feel about this?
- What do you think your relationship will be like after the baby?
- Do you have any concerns about your relationship?

Socioeconomic Status (LBW)

- Employment/occupational history (both partners)
- Do you have financial worries?

Maternal Factors

Prenatal Care (late onset) (**WA**)

- First prenatal visit in third trimester? (check records)

Prenatal Education (refusal or quit) (**CA)**

- Are you planning to take prenatal classes?

Feelings toward pregnancy after 20 weeks (**CA**, **WA**)

- How did you feel when you found out you were pregnant?
- How do you feel about it now?

Relationship with parents (**CA**)

As a child did you feel loved by your parents?
How did you get along with your parents?
In what ways will you parent like your parents did?
What would you like to do differently?

Self Esteem (**CA**, WA)

What concerns do you have about becoming/being a mother?

History of Psychiatric or Emotional Problems (**CA**, **WA**, PD)

Have you ever had emotional problems?
Have you ever seen a psychiatrist or therapist?

Depression in this Pregnancy (**PD**)

How has your mood been during this pregnancy?

Substance Abuse

Smoking (**LBW**)

Do you smoke?
How many cigarettes do you smoke each day?
Would you like help in trying to quit smoking?

Alcohol (**WA**, CA)

How may drinks do you have per week?
Are there times when you drink more than that?
Do you or your partner have a problem with alcohol or drugs?

Family Violence

Women or partner experienced or witnessed abuse (**CA**, WA)

What was your parents' relationship like?
Did you ever see or hear your father scaring or hurting your mother?
Have you ever been severely hit or scared by (either of) your parents?

Current or Past Woman Abuse (**WA**, CA, PD)

How do you and your partner solve arguments?
Have you ever been hit/pushed/slapped by your partner?
Do you ever feel frightened by what your partner says or does?
Does your present partner humiliate you or psychologically abuse you in other ways?
Have you ever been forced to have sex against your will?

Previous Child Abuse by Woman or Partner (**CA**)

Do you have any children who are not living with you? If so, why not?

Child Discipline (**CA**)

How do you think you will discipline your child?
How do you deal with your kids at home when they misbehave?
How did your parents discipline you?

Source: Reid et al., 1998.

Appendix E

Woman Abuse Screening Tool (WAST)

1. In general, how would you describe your relationship?

2. How do you and your partner work out arguments?

3. Do arguments ever result in you feeling down or bad about yourself?

4. Do arguments ever result in hitting, kicking or pushing?

5. Do you ever feel frightened by what your partner says or does?

6. Has your partner ever abused you physically?

7. Has your partner ever abused you emotionally?

Source: Queen's University, Royal College of Physicians and Surgeons of Canada

Appendix F

The "Safe" Tool

Screening does not have to involve a long list of questions that may be inappropriate or difficult to use in some situations. The SAFE tool was designed to be memorized easily and used quickly:

S How would she describe her **spousal** relationship?

A What happens when she and her partner **argue**?

F Do **fights** result in her being hit, shoved or hurt?

E Does she have an **emergency** plan?

Source: Safe Tool, nd.

Appendix G

Policy Guidelines - Sample

Health care providers employed by, and affiliated with _____ have a responsibility to identify, and effectively respond to, women who have been abused, and to prevent future woman abuse, where possible, regardless of the woman's ethnicity, cultural values, race, creed, class, marital status, sexual orientation, physical ability, psychological state, or psychiatric and/or criminal history.

Steps in the process include:

1. Strategies in place to help providers identify when a woman is involved in an abusive situation, to respond effectively to her and to prevent future abuse where possible.

2. Strategies that promote the empowerment of women.
   Woman abuse is:
   an abuse of power,
   against the law, and
   not the fault of the woman.
   Many women are victims of abuse.
   Women who have been abused have options and the right to choose.
   Health care providers are not exclusively responsible for finding solutions to woman abuse, but instead should see themselves as part of a community response system.

3. Ensure no woman is denied access to appropriate health care and social services should she leave, remain in, or return to an abusive situation.

4. Have all services in consultation with those for whom they are planned.

5. Have human resources policies that provide safety and confidentiality mechanisms for providers when, and if, they disclose cases of abuse. Ensure that supportive information and follow-up is made available to these providers.

6. Have a system of accountability for providers within the organization, and for the organization itself, using criteria that are specific, measurable and achievable.

Adapted from: Best Practice Guidelines for Health Care Providers Working with Women Who Have Been Abused, OHA, 1997.

Appendix H

Sample Policy

Board of Health Administration Procedure: Abuse, Woman - Staff Training and Response

The Board of Health:

- promotes the rights of women to live free from abuse;
- is committed to the identification of woman abuse and the development and implementation of practical and program-appropriate strategies for screening, assessment, documentation, safety planning, referral, and prevention of woman abuse;
- works in collaboration with individuals, community groups, government agencies, police, educational institutions, legal and medical professions to build effective partnerships and coalitions of people interested in making Peterborough County and City a safer place for woman; and
- will provide training to employees to the level appropriate for the employee's role in responding to woman abuse.

Definition

Woman abuse as it applies to this policy is the actual, or threat of, physical, sexual, psychological/emotional, or financial abuse to a woman; a threat to a third party such as a child; and/or destruction of property such as a family pet or cherished item.

Objectives

1. To ensure a consistent and effective response to woman abuse.
2. To ensure staff are trained to identify, and respond to, woman abuse appropriately.

Procedure

The content of staff training and the nature of response to woman abuse will vary depending on the characteristics of the staff position. Staff will fall into one of the following three categories.

1. Recognition and Referral

Staff in these positions generally have brief contacts with women in public settings.
This category applies to:

- administrative support staff;
- and program staff assigned to: Food Safety; Local Needs; Rabies Control; Safe Water and Sewage Disposal.

Staff will receive training on forms of abuse, indicators of woman abuse, various impacts of woman abuse, and how to ask about when indicators are present. If an individual discloses abuse the employee will:

- acknowledge any disclosure and reassure the individual that you believe her, and you would like to help;
- check that the individual agrees that this information can be shared with other Health Unit staff who are specially trained to provide assistance and support;
- alert Health Unit staff member trained in woman abuse response;
- if an on-site Health Unit referral is not practical in the short-term ensure that the individual is
- aware of, and has contact numbers for, community services and supports specializing in woman abuse such as legal services, counselling, shelters, and safety networks; and adhere to the Board of Health's policy regarding confidentiality.

2. Screening (Based on Indicators) and Follow-up

Staff in these positions have both brief and longer-term contacts with women in both public and private settings.
This category applies to:

- management staff;
- payroll bookkeeper;
- program staff assigned to: Child Health; Reproductive Health; Nobody's Perfect; Infant and Toddler Development; Healthy Babies, Healthy Children Family Home Visiting; Healthy Lifestyle; Dental; Sexual Health; Genetics; Communicable Diseases; Paediatric Clinic (assessments not involving private consultation with females over 12 years of age) and Keene Health Centre.

Staff will receive training on forms of abuse, impact of abuse, indicators of woman abuse, and how to ask about abuse when indicators are present. If there are indicators of abuse, but no abuse is report the employee will:

- provide additional opportunities for disclosure;
- assure individual of confidentiality; ensure individual is aware of, and has contact numbers for, community services and supports specializing in woman abuse such as legal services, counselling, shelters, and safety networks;
- document interaction or intervention as per program guidelines; and
- adhere to the Board of Health's policy regarding confidentiality.

If an individual discloses abuse the employee will:

- acknowledge any disclosure and ensure a safe, private environment;
- based on setting, offer referral to Injury Prevention, Family Health program staff or other community support services;
- use the **Woman Abuse Protocol** to gather information and document follow-up;
- provide advice or interventions within scope of practice and position description;
- obtain consent to share information with the woman's health care providers;
- ensure the individual is aware of, and has contact numbers for, community services and supports specializing in woman abuse such as legal services, counselling, shelters, and safety networks; and
- adhere to the Board of Health's policy regarding confidentiality.

3. Screening (Universal, Comprehensive), Assessment, Documentation, Safety Planning, and Referral

This category applies to:

- Nurse Practitioners;
- Public Health Nurses; and
- Registered Nurses who have private consultations with women.

Staff will receive training on forms of abuse, impact of abuse, indicators of woman abuse, and how to ask about abuse through routine, universal screening. If there are indicators of abuse, but no abuse is reported the employee will:

- provide additional opportunities for disclosure;
- assure individual of confidentiality;
- ensure individual is aware of, and has contact numbers for, community services and supports specializing in woman abuse such as legal services, counselling, shelters, and safety networks; document interaction or intervention as per program guidelines; and
- adhere to the Board of Health's policy regarding confidentiality.

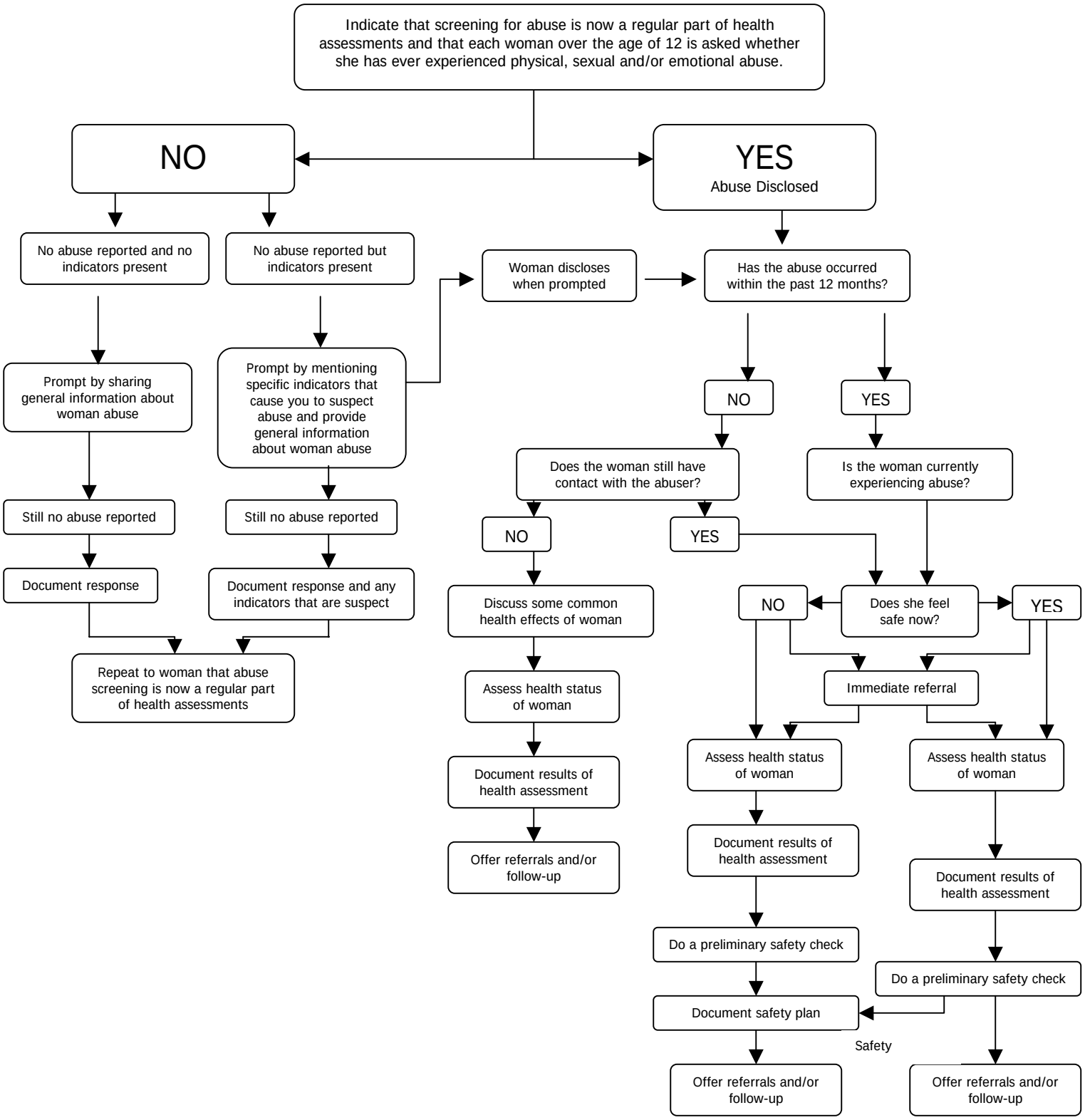
If individual discloses abuse the employee will:

- acknowledge any disclosure, and ensure a safe, private environment;
- use the **Woman Abuse Protocol** to record the woman's experience of abuse, assess safety, develop a safety plan if necessary, and document the results of the assessment;
- provide medical advice or interventions within the scope of practice of the staff member;
- obtain consent to share disclosure information with the woman's health care providers;
- ensure the individual is aware of, and has contact numbers for, community services and supports specializing in woman abuse such as legal services, counselling, shelters, and safety networks; and
- adhere to the Board of Health's policy regarding confidentiality.

Source: Peterborough County-City Health Unit, 2004

Appendix I

Routine Universal Comprehensive Screening (RUCS) Protocol



Source: Task Force on the Health Effects of Woman Abuse
Middlesex-London Health Unit, 2002

NOTES