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Nursing Best Practice Guideline

Shaping the future of Nursing

Woman Abuse: Screening, Identification and Initial Response

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

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NURSING BEST PRACTICE GUIDELINES PROGRAM

Greetings from Doris Grinspun
Executive Director
Registered Nurses' Association of Ontario

It is with great excitement that the Registered Nurses' Association of Ontario (RNAO) disseminates this nursing best practice guideline to you. Evidence-based practice supports the excellence in service that nurses are committed to deliver in our day-to-day practice.

We offer our endless thanks to the many institutions and individuals that are making RNAO's vision for Nursing Best Practice Guidelines (NBPGs) a reality. The Government of Ontario recognized RNAO's ability to lead this program and is providing multi-year funding. Tazim Virani, NBPG program director, with her fearless determination and skills, is moving the program forward faster and stronger than ever imagined. The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the creation and evaluation of each guideline. Employers have responded enthusiastically to the request for proposals (RFP), and are opening their organizations to pilot test the NBPGs.

Now comes the true test in this phenomenal journey: Will nurses utilize the guidelines in their day-to-day practice?

Successful uptake of these NBPGs requires a concerted effort of four groups: nurses themselves, other healthcare colleagues, nurse educators in academic and practice settings, and employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students need healthy and supportive work environments to help bring these guidelines to life.

We ask that you share this NBPG, and others, with members of the interdisciplinary team. There is much to learn from one another. Together, we can ensure that Ontarians receive the best possible care every time they come in contact with us. Let's make them the real winners of this important effort!

RNAO will continue to work hard at developing and evaluating future guidelines. We wish you the best for a successful implementation!

Doris Grinspun, RN, MSN, PhD(cand), OOnt

Executive Director
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How to Use this Document

This nursing best practice guideline is a comprehensive document providing resources necessary for the support of evidence-based nursing practice. The document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. Guidelines should not be applied in a "cookbook" fashion but used as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

Nurses, other health care professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessment and documentation tools, etc. It is recommended that the nursing best practice guidelines be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. However, it is highly recommended that practice settings/environments adapt these guidelines in formats that would be user-friendly for daily use. This guideline has some suggested formats for such local adaptation and tailoring.

Organizations wishing to use the guideline may decide to do so in a number of ways:

- Assess current nursing and health care practices using the recommendations in the guideline.
- Identify recommendations that will address identified needs or gaps in current services.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story. Implementation resources will be made available through the RNAO website to assist individuals and organizations to implement best practice guidelines.

Woman Abuse: Screening, Identification and Initial Response

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Declarations of interest and confidentiality were made by all members of the guideline development panel. Further details are available from the Registered Nurses' Association of Ontario.

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Woman Abuse: Screening, Identification and Initial Response

Disclaimer

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Summary of Recommendations

	RECOMMENDATION	*LEVEL OF EVIDENCE
Practice Recommendations	**1.0** Nurses implement routine universal screening for woman abuse in all health care settings.	IIb
	2.0 Routine universal screening be implemented for all females 12 years of age and older.	IV
	3.0 Nurses develop skills to foster an environment that facilitates disclosure. This necessitates that nurses know: ■ how to ask the question; and ■ how to respond.	IV
	4.0 Nurses develop screening strategies and initial responses that respond to the needs of all women taking into account differences based on race, ethnicity, class, religious/spiritual beliefs, age, ability or sexual orientation.	III
	5.0 Nurses use reflective practice to examine how their own beliefs, values, and experiences influence the practice of screening.	IIa
	6.0 Nurses know what to document when screening for and responding to abuse.	IV
	7.0 Nurses know their legal obligations when a disclosure of abuse is made.	IV
Education Recommendations	**8.0** Mandatory educational programs in the workplace be designed to: ■ increase nurses' knowledge and skills; and ■ foster awareness and sensitivity about woman abuse.	Ib
	9.0 All nursing curricula incorporate content on woman abuse in a systematic manner.	III
Organization & Policy Recommendations	**10.0** Health care organizations develop policies and procedures that support effective routine universal screening for and initial response to woman abuse.	IV
	11.0 Health care organizations work with the community at a systems level to improve collaboration and integration of services between sectors.	Ib
	12.0 Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: ■ An assessment of organizational readiness and barriers to education. ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. ■ Dedication of a qualified individual to provide the support needed for the education and implementation process. ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices. ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines* based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline *Woman Abuse: Screening, Identification and Initial Response.*	IV

* For interpretation of evidence see p. 10

Interpretation of Evidence

Levels of Evidence

The following framework depicts the levels of evidence that have been used to classify the research that has been used in the development of this guideline.

Ia	Evidence obtained from meta-analysis or systematic review of randomized controlled trials.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

The underlying assumption implicit in this schema is that the randomized controlled trial (RCT) is the 'gold standard' against which all other forms of evidence are evaluated and compared. While this assumption may have a great deal of utility in the biomedical sciences, its relevance to the health and human sciences is less clear. In nursing, where multiple ways of knowing are not only valued, but desired, a hierarchical chart that ascribes a lower place to qualitative research is problematic. More importantly, the chart does not reflect the nature of nursing knowledge, particularly as it exists in the area of violence against women. Understanding health and human experiences requires a knowledge base that extends beyond the establishment of cause and effect relationships, the collection of quantitative data, and the conduct of intervention studies. While all of these are valued, they do not represent the sum total of desired or existing nursing knowledge. Rather, consideration must be given to the nuances and particularities of everyday lived realities. Such knowledge embraces the broader social and political contexts that shape health experiences in general, and those related to violence in particular. To date, much of the knowledge related to violence against women has been generated utilizing various research methodologies, including qualitative (stories) and quantitative (numbers) methods. Consistent with the panel's value of the importance of both stories and numbers, multiple sources of knowledge have been used to inform the development of this best practice guideline. The *Levels of Evidence* framework has been used within the context of these remarks.

Responsibility for Development

The Registered Nurses' Association of Ontario (RNAO), with funding from the Government of Ontario, has embarked on a multi-year program of nursing best practice guideline development, pilot implementation, evaluation and dissemination. This guideline fits within the priority areas of mental health, gerontology, home health care, primary health care and emergency care. This guideline was developed by a multidisciplinary panel convened by the RNAO, conducting its work independent of any bias or influence from the Government of Ontario.

Purpose & Scope

Best practice guidelines (BPG) are systematically developed statements to assist practitioners' and clients' decisions about appropriate health care (Field & Lohr, 1990).

The overall purpose of this guideline is to facilitate routine universal screening for woman abuse by nurses in all practice settings. The intended outcome is increased opportunity for disclosure, which will promote health, well-being, and safety for women. Using evidence-based approaches and recommendations, this guideline offers nurses a repertoire of strategies that can be adapted to various practice environments.

The scope of this guideline is on screening women for intimate partner abuse. The guideline includes all women in intimate relationships, 12 years of age or older and identifies:

- Who should do the screening;
- What should be included in screening; and
- How and under what circumstances screening should occur.

While it is recognized that men may also be victims of intimate partner abuse, the incidence, nature and impact of that abuse is more severe for women.

Although this guideline has been developed primarily for Registered Nurses (RNs) and Registered Practical Nurses (RPNs), it may also be used by other health care practitioners. As well, the recommendations included in this guideline are consistent with current legislation such as the Child and Family Services Act (Ontario), the Criminal Code of Canada and the Regulated Health Professions Act (RHPA) (Ontario). While the guideline may be used outside of Ontario, prior consultation with relevant provincial legislation is encouraged.

This guideline focuses on: *Practice Recommendations* for assisting practitioner and client decisions; *Education Recommendations* for supporting the skills required for nurses; and *Organization and Policy Recommendations* addressing the importance of a supportive practice environment as an enabling factor for providing high quality nursing care, which includes ongoing evaluation of guideline implementation. These are presented following a description of relevant terms and concepts and a discussion of the rationale for the development of the best practice guideline.

It is acknowledged that individual competence in screening varies between nurses and across categories of nursing professionals (RPNs and RNs) and is based on knowledge, skills, attitudes, critical analysis and decision-making skills, which are enhanced over time by experience and education. Individual nurses will perform screening for woman abuse following appropriate education and experience. It is expected that nurses will seek appropriate consultation when client care requirements exceed the nurse's ability to act independently. Effective health care depends on a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and clients, ever mindful of the personal preferences and unique needs of each individual client.

Development Process

In January of 2004, a multidisciplinary panel of health care professionals with expertise in woman abuse from institutional, community and educational settings was convened under the auspices of the RNAO. The panel established the scope of the guideline through a process of discussion and consensus. It was decided to focus on screening, identification and initial response for women experiencing abuse.

Twenty-four published guidelines related to Woman Abuse/Domestic Violence were identified through a systematic search, the details of which are described in *Appendix A*. These guidelines were reviewed according to a set of inclusion criteria, which resulted in the elimination of 10 guidelines. The inclusion criteria were:

- Guideline was in English;
- Guideline was dated no earlier than 1999;
- Guideline was strictly about the topic area;
- Guideline was evidence-based;
- Guideline was available and accessible for retrieval;
- Guideline was developed for populations similar to Canada.

The resulting fourteen guidelines were critically appraised with the intent of identifying existing guidelines that were current, developed with rigour, evidenced-based and which addressed the scope identified by the development panel for the best practice guideline. A quality appraisal was conducted on these 14 clinical practice guidelines using the *Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument* (AGREE Collaboration, 2001). This process yielded a decision to work primarily with five existing guidelines. These were:

1. Department of Health (DH) (2000). *Domestic violence: A resource manual for health care professionals.* Available: http://www.dh.gov.uk/assetRoot/04/06/53/79/04065379.pdf

2. Education Centre Against Violence (ECAV) (2001). *Routine screening for domestic violence in NSW health: An implementation package.* Parramatta: Author.

3. Family Violence Prevention Fund (FVPF) (2004). *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings.* Available: http://endabuse.org/programs/healthcare/files/Consensus.pdf

4. Health Canada. (1999a). *A handbook dealing with woman abuse and the Canadian criminal justice system: Guidelines for physicians.* Available: http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/physician_e.pdf

5. Middlesex-London Health Unit (MLHU) (2000). *Task force on the health effects of woman abuse – Final report.* London, Ontario: Author.

The development panel divided into subgroups to engage in specific activities using the short-listed guidelines, other literature and additional resources for the purpose of drafting recommendations for nursing interventions. This process yielded a draft set of recommendations. The panel members as a whole reviewed the recommendations, discussed gaps and available evidence and came to consensus on a draft guideline.

This draft was submitted to a set of 69 external stakeholders for review and feedback. An acknowledgement of these reviewers is provided at the front of this document. Stakeholders represented various health care disciplines, clients and families, as well as professional associations. External stakeholders were provided with specific questions for comment, as well as the opportunity to give overall feedback and general impressions. Forty-five stakeholders returned comments and suggestions to the development panel representing a 65% response rate. For each of the recommendations, the percentage of "agreement with the recommendation" was calculated. Of the 45 respondents, there was 90-100% agreement depending on the specific recommendation. The final results of the stakeholder feedback were compiled and reviewed by the development panel. Discussion and consensus resulted in revisions to the draft document prior to publication.

Definition of Terms

General Definitions

Clinical Practice Guidelines or Best Practice Guidelines: Systematically developed statements to assist practitioner and client decisions about appropriate health care for specific clinical (practice) circumstances (Field & Lohr, 1990).

Consensus: A process for making decisions, not a scientific method for creating new knowledge. At its best, consensus development merely makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al., 1999).

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Organization & Policy Recommendations: Statements of conditions required for a practice setting that enable the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Practice Recommendations: Statements of best practice directed at the practice of health care professionals that are evidence-based.

Guideline-Specific Definitions

Woman Abuse: There are many definitions of woman abuse in intimate partner relationships that have been put forward. For the purposes of this guideline a broad definition, that incorporates a clear and comprehensive understanding of woman abuse while simultaneously capturing the dynamics of intimate partner violence, has been used. The following definition was developed by Reynolds and Schweitzer (1998) for The London Abused Women's Centre:

[Woman abuse is] the intentional and systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a woman through the inducement of fear and/or dependency. The tactics include, but are not limited to, emotional, financial, physical, and sexual abuse, as well as, intimidation, isolation, threats, using the children and using social status and privilege. …Woman abuse includes the sum of all past acts of violence and the promise of future violence that achieves enhanced power and control for the perpetrator over the partner. …Abusive behaviour does not result from individual, personal or moral deficits, diseases, diminished intellect, addiction, mental illness, poverty, the other person's behaviour, or external events. (p. 3.)

This definition extends aspects of the definition from the United Nations Declaration on the Elimination of Violence Against Women (1993).

For a visual depiction of the power and control dynamics, see *Appendix B.*

Screening: The development panel determined by consensus that in the case of screening for woman abuse, screening means imbedding questions about abuse in a health history or incorporating validated screening instruments into the history/assessment process.

Universal screening refers to the characteristics of the group to be screened and occurs when nurses ask every woman over a specified age about her experience of abuse.

Routine screening refers to the frequency with which screening is carried out. Routine screening is performed on a regular basis regardless of whether or not signs of abuse are present.

Indicator-based screening refers to screening whereby nurses observe one or more indicators that suggest a woman may have been abused and subsequently question her about the indicator(s).

The most comprehensive approach is one that combines routine and universal screening. This approach is recommended throughout this best practice guideline.

Initial Response: A series of responses by nurses to a disclosure of abuse. These responses are:

- Acknowledging the abuse;
- Validating the woman's experience;
- Assessing immediate safety;
- Exploring options;
- Referring to violence against women services at the woman's request; and
- Documenting the interaction.

Background Context

Rationale for a Best Practice Guideline on Screening for Woman Abuse

Significance of the Problem

Estimates regarding woman abuse are varied, and depend, in part, on the definitions used, the questions that are asked, and the format used to ask the questions (e.g., questionnaire, survey, etc.). Other factors that contribute to inconsistencies in prevalence rates include socio-demographic characteristics of the sample, the nature and context of the abuse, and whether it is past or current (Cohen & Maclean, 2003). Similarly, the presence or absence of a socio-political context that allows and encourages women to name the violence in their lives influences reporting rates.

The World Health Organization Declaration (2002b) states "violence is a leading worldwide public health problem" (p. 2). Malecha (2003) goes on to say "intimate partner violence is one of the most common forms of violence against women" (p. 315). Between "17-30% of all women treated in hospital emergency departments are victims of domestic violence" (Waller, Hohenhaus, Shah, & Stern, 1996, p. 755), and that "worldwide, 10-50% of women report having been hit or physically assaulted by an intimate partner" (Taket et al., 2003, p. 673).

While early advocates suggested that approximately one in ten women experience violence by their intimate partners each year, subsequent Canadian surveys revealed that the actual figures are, in fact, much higher than these early estimates. The 1993 *Violence Against Women Survey* (Statistics Canada, 1994) reported that of the 12,300 women surveyed, 25% of women 16 years of age and older reported they had been abused by an intimate partner and 10% had been assaulted at least once during the previous 12 months. According to the 1999 *General Social Survey* (Statistics Canada, 2000), 8% of women and 7% of men had experienced violence by an intimate partner at some time during the five years prior to the survey. While these latter figures would seem to suggest a decrease in violence against women, it is particularly noteworthy that in this survey, women reported more serious forms of violence, with more serious consequences, than did men (Pottie Bunge & Locke, 2000). As well, many of those who might be considered most vulnerable were excluded from the survey, namely those from the Yukon, Northwest Territories, Nunavut, those without telephones, and homeless persons (Cohen & Maclean, 2003).

Feldhaus et al. (1997) assert that threats, intimidation and battering escalate over time and that "unrelenting battering of women leads to homicides" (p. 1357). Abuse knows no boundaries; no cultural group, ethnic background, lifestyle, educational or socio-economic background is spared. However, it is important to be mindful that "harm comes to the most vulnerable" (Graham, 2000, p. 33) including, but not limited to, lesbian women, lone mothers, women with mental health issues, women with disabilities, and elderly women (Butterworth 2004; Eckert, Sugar, & Fine, 2002; Graham, 2000; Larkin, Hyman, Mathias, D'Amico, & MacLeod,1999; McClennen, Summers, & Daley, 2002; McFarlane et al., 2001).

In this guideline, the development panel recommends that screening be conducted with all women, ages 12 and older. Current statistics regarding the prevalence of dating violence support the screening of young women. According to the results of a Canadian survey, 8% of female respondents reported that, during high school, their partners had threatened to use physical force if they did not engage in sexual activities; 14% reported that they were forced to engage in sex acts; 50% reported that they had been hurt emotionally; and 9% said that their dating partners had physically hurt them (DeKeseredy & Schwartz, 1998). Although some researchers have suggested that rates of dating violence, victimization, and perpetration are comparable among young men and young women, it is generally agreed that these findings may be attributed to methodological limitations with attention to the number of violent acts, rather than on the context and consequences of the violence. As is the case among older women, violence against younger women typically has more lasting and serious consequences than those experienced by men.

The significance of the problem is further highlighted in the following reports: *Family Violence in Canada: A Statistical Profile* (Statistics Canada, 2004) and the *General Social Survey* (Statistics Canada, 2000). According to Statistics Canada (2004) an analysis of data provided by 94 reporting police agencies across Canada showed that women continue to far outnumber men as victims of assault by a spouse or partner. Females were the victims in 85% of reported cases of spousal violence and half of all family homicides involved spouses with 62% of female homicides committed by male spouses, either current or estranged. This figure is three times the number of men killed by their spouses.

The *General Social Survey* (Statistics Canada, 2000) also validated this information by showing that when compared to males, females were:

- seven times more likely to be sexually assaulted (20% vs. 3%);
- three times more likely to report physical injury (40% vs. 13%) and five times more likely to require medical attention as a result of a violent incident;
- more likely to fear for their lives (38% vs. 7%); and
- more likely to be killed by someone with whom they had an intimate relationship (52% vs. 8%).

Estimates of woman abuse in Ontario are equally compelling. Findings from *The Women's Safety Project* (Randall & Haskell, 1995) revealed that, depending on the particular type of violence measured, between 27% and 51% of women endured one or more physically or sexually abusive incidents.

Sudbury Regional Hospital in Ontario conducted a prospective cohort study that interviewed a random sample of women age 16 years and older in the emergency department (ED) to determine the incidence and prevalence of abuse. Of the 983 women surveyed, 51% disclosed experiencing violence at the hands of an intimate partner in their lifetime and 26% of these disclosed violence within the last year (Cox et al., 2004).

Cornwall Community Hospital in Ontario currently implements screening in their emergency room (ER) and is in the process of expanding the program hospital wide. The program involves mandatory training of ER staff and screening is implemented by RN's with all persons 16 years of age and older. Program evaluation determined rates of disclosure of abuse to be 4.8% with 611 clients disclosing abuse. Despite the low disclosure rate of this new program, community collaboration and requests for information by clients and staff are some of the additional outcomes that have been realized. Clearly the problem remains an important public health concern.

Consequences of Woman Abuse

Health Consequences

The physical and emotional health consequences of violence against women are profound and enduring. Even for women who are able to leave abusive relationships, the consequences often persist long after the violence has ended, and in some cases continue throughout the woman's lifetime (Felitti et al., 1998). In general, research findings suggest that the more prolonged and severe the abuse, the greater its impact on a woman's physical and mental health (Leserman et al., 1996). Further, there is evidence that the impact of different types of abuse and of multiple episodes of abuse is cumulative over time (Malecha, 2003). Women who have experienced violence suffer a multitude of adverse physical and psychological health outcomes. Abused women have more physical symptoms, are more frequent users of health care services, are more likely to suffer chronic pain, have increased rates of depression, anxiety, low self-esteem and attempted suicide and experience abuse during pregnancy and have increased pregnancy-related complications (Malecha, 2003). Women who experience abuse are also more likely to report their physical and mental health as fair to poor (Coker, Bethea, Smith, Fadden, & Brandt, 2002). While no research has been conducted to establish causal relationships between violence and health consequences, the associations are strong and convincing. A full discussion of the health responses to violence is beyond the scope of this guideline. However, a summary of the most salient outcomes can be found in Table 1.

TABLE 1: Health Consequences of Woman Abuse

Physical		
Abdominal/thoracic injuries	Bruises and welts	Chronic pain syndrome
Disability	Fibromyalgia	Gastrointestinal disorders
Irritable bowel syndrome	Lacerations and abrasions	Ocular damage
Reduced physical functioning		
Sexual and Reproductive		
Gynecological disorders	Infertility	Pelvic inflammatory disease
Sexual dysfunction	Unsafe abortion	Pregnancy complications
Unwanted pregnancy	Sexually transmitted infections, including HIV/AIDS	
Psychological and Behavioural		
Alcohol and drug abuse	Depression and anxiety	Smoking
Eating and sleep disorders	Feelings of shame and guilt	Poor self-esteem
Phobias and panic disorders	Physical inactivity	Psychosomatic disorders
Post-traumatic stress disorder	Suicidal behaviour and self harm	
Unsafe sexual behaviour	Substance abuse	
Fatal Health Consequences		
AIDS-related mortality	Maternal mortality	Homicide and suicide

Adapted from: World Health Organization (2002a). *World report on violence and health.* Geneva: Author.

Economic Consequences

The economic costs related to violence against women are staggering and place a tremendous burden on society, both with respect to lost productivity and increased demands on health and social services. In a report published by Health Canada (2002) it was estimated that the measurable health-related costs of violence against women in Canada exceed $1.5 billion a year. These costs include short-term medical and dental treatment for injuries, long-term physical and psychological care, lost time at work, and use of transition homes and crisis centres. This figure is consistent with an earlier report prepared by the Centre for Research on Violence Against Women and Children that estimated the health costs of woman abuse at $1.54 billion per year (Day, 1995).

Although abuse does not explicitly prevent women from being employed, there is some evidence that women who have experienced violence have diminished earnings and greater difficulty maintaining steady employment. Research in the United States has demonstrated that women with a history of abuse have more frequent periods of unemployment, lower personal incomes, greater job turnover, more physical and mental health problems that affect job performance, and were more likely to receive public assistance as compared to women who had not experienced abuse (Lloyd & Taluc, 1999).

In addition to the direct economic costs associated with woman abuse, indirect costs include the increased utilization of health care services in the immediate and long-term aftermath of abuse. Women who have experienced physical or sexual assault, either during childhood or adulthood, have a greater number of surgeries, visits to health providers, hospital stays, and mental health consultations than those who have not been similarly victimized (Leserman et al., 1996).

Impact on Children

Determining how many children are witnesses to the abuse of their mothers is a complex and controversial undertaking for a variety of conceptual and procedural reasons. While an in-depth discussion of these reasons is beyond the scope of this guideline, most significant is that there are no national prevalence studies in either Canada or the United States that directly measure the number of children who are exposed to violence in their homes. In a recent national survey of child development, parents were asked how often their children, ages 2 to 11 years, observed violence perpetrated in the home by older siblings and parents. Parents reported that 8.6% or approximately 330,000 children witnessed some form of violence in the home (Human Resources Development Canada, 1996). Rodgers (1994) reported that Canadian children were present during almost 40% of wife assault cases; that women feared for their lives in approximately 52% of these cases; and that 61% of the attacks witnessed by children had resulted in serious injury to the women.

The research on child witnesses to the abuse of their mothers offers convincing evidence that many, though not all, of these children are at risk for many of the same physical, emotional and behavioural problems as those who experience violence directly (Berman, Hardesty, & Humphreys, 2003; Graham-Berman & Edleson, 2001; Jaffe, Wolfe, & Wilson, 1990). While it is important to note that not all children suffer long-term adverse effects, and that many exhibit a range of strengths and appear remarkably resilient, the range of potential negative responses is summarized in Table 2. As adults, children who come from violent homes often experience violence in future relationships (Graham-Berman & Edleson, 2001).

TABLE 2: Health Consequences of Woman Abuse on Children

Physical Effects	Psychological and Behavioural Effects
Allergies	Depression and anxiety
Respiratory tract infections	Worry and frustration
Somatic complaints (e.g., headaches)	Low self-esteem
Gastrointestinal disorders (e.g., nausea, diarrhea)	Stress-related disorders
Sleep difficulties (e.g., nightmares, bedwetting)	Hyperactivity
Speech, hearing, and visual problems	Post-traumatic stress disorder
	Low social competence
	Increased aggression with adults and other children
	Attachment problems
	Difficulties in school performance
	Substance abuse
	Suicidal behaviour and self harm
	Conflicts with the law

Source: Berman, H., Hardesty, J., & Humphreys, J. (2003). Children of abused women. In J. Humphreys & J. C. Campbell (Eds.), *Family violence and nursing practice* (pp. 150-187). Philadelphia: Lippincott.

Why Nurses Should Screen for Abuse

Nurses are well-positioned to screen for woman abuse because they are accessible, enjoy a high degree of public trust, and work in a variety of settings. Nurses interact with women during times of stress and illness, as well as during developmental transitions such as adolescence, pregnancy, and parenthood. Nurses utilize a holistic health promotion framework, incorporating strategies of empowerment and advocacy (Ross, 2002). This approach is especially important when intervening with abused women. Supporting the abused woman's choice is critical so as not to replicate a relationship of coercion and control.

Nurses are frequently the first member of the health care team to interface with women experiencing abuse

(Malecha, 2003), and as such must have the knowledge and skills necessary to screen and respond appropriately and effectively (Davidson et al., 2001; Malecha, 2003).

The role of the nurse is to:

- Ask the question;
- Acknowledge the abuse;
- Validate the woman's experience;
- Assess immediate safety;
- Explore options;
- Refer to violence against women services at the woman's request; and
- Document the interaction.

Nurses may hesitate to screen for a variety of reasons, however, it is important to remember that nurses are part of an integrated community response. The nurse is not solely responsible for the development of a comprehensive plan of action. While nursing knowledge and skill are applied to the identification and initial response, there are specially trained individuals/women's advocates in most communities and health care settings that can be readily accessed by the nurse or the woman. Identifying the abuse and linking the woman to specialized services, if that is her choice, is the central process to follow.

Why Routine Universal Screening

The development panel acknowledges the lack of consensus concerning universal versus indicator-based screening for woman abuse by health care providers. Guidelines from Canada (MLHU, 2000; Perinatal Partnership Program of Eastern and Southeastern Ontario (PPPESO), 2004), New Zealand (Ministry of Health, 2002), and the United States (U.S.) (Family Violence Prevention Fund (FVPF), 2004) were reviewed for this best practice guideline. All endorse universal screening in some or all practice settings. In contrast, systematic evidence reviews for the Canadian Task Force on Preventive Health Care (Wathen & MacMillan, 2003) and the U.S. Preventive Services Task Force (Nelson, Nygren & McInerney, 2004) both concluded that there is not enough evidence to recommend for or against universal screening. In addition to these documents, the panel also considered qualitative and quantitative studies, program evaluations, anecdotal data, and expert opinion, including that of abused women themselves to ultimately determine the recommendation for routine universal screening.

This conclusion is based on a framework that differs from the systematic evidence reviews (Nelson et al., 2004; Wathen & MacMillan, 2003) in four significant ways: 1) the outcome of screening; 2) the use of validated tools; 3) the reliance on randomized control trials; and 4) the potential for harm. Each is briefly discussed.

First, in terms of outcome, both the Canadian Task Force and the U.S. Task Force use "reduction in violence" as their outcome measure. The panel embraces a harm reduction approach (Prochaska, DiClemente, & Norcross, 1992). Recommendations consistent with this approach have been put forth and widely accepted for numerous other social problems that have health implications. Examples include assessment of tobacco and alcohol use and pregnancy counselling (FVPF, 2004; Nelson et al., 2004). The goal is to help women move from a stage of *precontemplation* ("I don't have a problem"), to *contemplation* ("Maybe I do, maybe I don't"), or *preparation* ("Yes, I do, what can I do about it?") (Prochaska et al., 1992). Seen in this light, screening creates opportunities for women to disclose and discuss violence in their lives.

Second, both systematic reviews examined standardized tools for accuracy in detecting abuse. While individual nurses or institutions may decide to use a standardized tool, some of which are included in this document, the panel places high value on the nursing history/assessment interview, the demeanor and skill of the nurse, and the normalization of "asking the question". As well, the panel recognizes and supports a woman's right to choose whether or not to disclose abuse. The failure to disclose is not viewed as a failure in the screening process. Even when a woman does not disclose, the act of screening signals the nurse's willingness to assist in a safe and confidential manner. This process fosters a trusting relationship and increases the possibility of a disclosure in the future.

Third, as noted above, the panel based its recommendations on multiple sources of knowledge. The lack of randomized control trials (RCTs) is not viewed as a limitation in the literature on screening. The panel's views regarding the hierarchy of evidence are described earlier in this document (please see *Interpretation of Evidence*, p. 10).

Lastly, the development panel considered the benefits of routine universal screening in relation to any possible harm. Some of the many benefits are:

- Increasing opportunities for women to disclose abuse;
- Increasing opportunities for nurses to identify women who have been abused;
- Linking health consequences to abuse, thereby positioning violence as a legitimate health concern;
- Identifying the health impacts of abuse and providing early intervention;
- Avoiding stigmatization by asking all women about abuse;
- Reducing the sense of isolation abused women experience;
- Affording opportunities to assist children of abused women;
- Giving a strong message that abuse is wrong;
- Informing women about violence against women services and other options that are available; and
- Fostering healthy communities.

In recommending routine universal screening, the panel considered these benefits in relation to any possible harm associated with screening. Based on current knowledge, our conclusion is consistent with that of the Family Violence Prevention Fund's Research Committee (2004) that stated, with respect to screening, "we know of no research to suggest that assessment and/or interventions in health care settings are harmful to patients" (p. 5). Further, failure to implement routine, universal screening could result in more dire health outcomes for abused women, including femicide (Coker et al., 2002; Sharps et al., 2001).

The panel also discussed changing the word, "screening", to "behavioural assessment" in order to differentiate our framework from a more traditional medical model as reflected in the Canadian and the U.S. Task Force reports. In the end, the term "screening" was retained as it is most commonly used and understood at this time.

In conclusion, based on current knowledge and practice in its entirety, panel members assert that routine universal screening, *in conjunction with* comprehensive staff education and ongoing agency and managerial support, constitutes best practice at this time. As with any best practice guideline, these recommendations will be reviewed and revised as new evidence becomes available.

Practice Recommendations

Recommendation 1.0

Nurses implement routine universal screening for woman abuse in all health care settings.

Level IIb

Discussion of Evidence

Woman abuse, as previously discussed, is a significant health problem with serious health consequences. The health care system plays an important role in identifying and preventing public health problems. Routine universal screening, with a focus on early identification of women experiencing abuse, whether or not symptoms are immediately apparent, is a primary starting point for this improved approach to health care practice for woman abuse (Asher, Crespo, & Sugg, 2001; DH, 2000; FVPF, 2004; MLHU, 2000; Poirier, 1997; PPPESO, 2004; Punukollu, 2003). Routine universal screening, as opposed to indicator-based screening, increases opportunities for both identification and effective interventions, validates woman abuse as a central and legitimate health care issue and enables providers to assist both victims and their children (FVPF, 2004, PPPESO, 2004). Screening has been demonstrated to be most effective when conducted in a face-to-face format rather than using self-administered questionnaires (McFarlane et al., 2001). Therefore, routine universal screening should be standard practice as a component of a complete nursing health history.

Screening is particularly important as the proportion of women seeking medical assistance as a result of abuse is estimated to be between 8% and 39%. These estimates are a compilation of abuse-related visits to both emergency rooms and family practice settings. Inspite of the prevalence of abuse and the high rates of visits for medical care, detection rates by medical practitioners are low (Health Canada, 1999b).

The following criteria are used to determine when screening is useful:

- The condition must have a significant effect on the quantity and quality of life;
- Acceptable methods of treatment must be available;
- The condition must have an asymptomatic period during which detection and treatment significantly reduce morbidity and mortality;
- Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear; and
- Tests that are acceptable to patients must be available, at a reasonable cost, to detect the condition in the asymptomatic period (Poirier, 1997).

It is evident that screening for woman abuse fits these criteria.

Specific to screening for woman abuse, the following conditions also need to be considered:

- Screening questions are incorporated into routine health history/intake process;
- Nurses consider the immediate safety of the women;
- Screening occurs when the woman's condition is stable;
- Questions are asked face-to-face and where privacy can be assured;
- Women should be screened alone and never in the presence of their partner, other family members, or children over the age of 3 years; and
- In cases where language is a barrier, only trained cultural interpreters are used (ECAV, 2001; MLHU, 2000).

Abused women may not recognize their partner's behaviour as abusive particularly in the instance of unwanted sexual behaviour. Screening tools use specific terminology that describe the actions of abusers rather than using general terminology like "abuse". Therefore, screening questions need to be clear and examples of abusive behaviour may be needed to help the client understand what constitutes abusive behaviour. There are validated tools that can be used in screening (e.g., the Abuse Assessment Screen (AAS), the Abuse Assessment Screen – Disability (AAS-D), and the Woman Abuse Screening Tool (WAST)), or nurses can develop their own style keeping in mind these principles. See *Appendix C* for examples of the aforementioned screening tools.

As many women do not disclose abuse the first time they are asked, nor do they recognize violence as a health issue, screening for woman abuse should occur not only on the initial health history **but also each time the health history is updated**.

Women presenting with any health issue may be victims of abuse. Jones and Bonner (2002) screened 159 women in an antenatal clinic and had a 10.7% disclosure rate. Leserman et al. (1996) screened 239 women with gastrointestinal disorders in primary care settings and found 66.5% had experienced some form of sexual and/or physical abuse. Kimberg (2001) reported the findings of a survey sponsored by the National Institute for Justice and the Centers for Disease Control and Prevention that revealed a community prevalence rate for intimate partner violence of 24.8%. These findings highlight the importance of screening women for abuse in all health care settings, regardless of the presenting health issue. It also sends a message that nurses' concerns for women go beyond their immediate medical needs.

Recommendation 2.0

Routine universal screening be implemented for all females 12 years of age and older.

Level IV

Discussion of Evidence

The panel reached consensus on the age of 12 for the implementation of routine universal screening, recognizing that this adds to the complexity of implementing this recommendation. Twelve-year olds are involved in relationships, and the Criminal Code of Canada (2003) recognizes that young women between the ages of 12 and 16 are able to consent to sexual activity. Young women are at high risk for abuse in intimate relationships. A study by Wiemann et al. (2000) examined prevalence rates for physical assault by intimate partners among 724 pregnant adolescents 12-18 years of age. Of the women interviewed, 29% had experienced some form of physical violence in the previous 12 months and almost 12% reported being physically assaulted by the fathers of their babies. Therefore, screening for violence at an early age provides an opportunity for early intervention in order to reduce violence in young women's lives, increase awareness about the dynamics of abusive relationships and foster healthy relationships between young women and their dating partners. Young girls are at the beginning of their dating experience and often do not understand the relationship dynamic of control. For example, a study of adolescent girls found that violence was misunderstood as being about anger (71%), confusion (40%) and love (27%) (Hyman,1999). Additionally, *Toward a Healthy Future: Second Report on the Health of Canadians* (Health Canada, 1999c) found that girls were the victims of reported assaults by family members more than boys; victims were female in 80% of sexual assaults and in over 50% of physical assaults. Furthermore, girls were more likely to be sexually assaulted between 12-15 years of age.

The legal implications for screening young women are addressed in *Recommendation 7.0*.

Recommendation 3.0

Nurses develop skills to foster an environment that facilitates disclosure. This necessitates that nurses know:

- **how to ask the question; and**
- **how to respond.** *Level IV*

Discussion of Evidence

The nurse's initial response to a woman experiencing abuse is of great importance. Due to the complexity of the issue, even when directly asked, abused women may not disclose their experiences for many months, or in some cases, years. Guilt, shame, embarrassment, fear of not being believed, fear of being blamed for what has happened, and fear of escalation of violence often prevent women from openly discussing abuse (DH, 2000). Furthermore, this may be the first time the woman has been screened for abuse by a nurse and she may not feel safe to disclose any information (Malecha, 2003). It is therefore necessary to adapt the environment to facilitate disclosure.

In order to facilitate a disclosure the nurse needs to create an environment of openness, safety and trust. It is paramount for each nurse to develop an approach that feels appropriate and comfortable in order to encourage clients to be "frank and open in their response" (MLHU, 2000, p. 33). Maintaining a supportive and non-judgmental approach is essential.

A supportive and non-judgmental approach to screening can be fostered by an environment that openly displays materials that inform women of the staff's willingness to discuss abuse. Strategies include:

- Practitioners having information (posters and educational materials) about violence available and on display;
- Displaying information in both public and private areas of the office environment (i.e., in the washroom where women can read it without being seen); and
- Staff wearing buttons that indicate that they are willing to talk about violence (Stevens, 2003).

Bolin & Elliot (1996) found physicians who wore buttons with an anti-abuse message had more conversations about domestic violence than those who did not wear buttons.

When developing an appropriate response to a woman disclosing abuse, it is important for nurses to maintain a flexible screening protocol. Developing a personal style that appropriately fits the context of the particular encounter is imperative. The process will likely vary, depending upon:

- The health care setting;
- The relationship of the professional to the woman;
- The presenting problem;
- The client's history; and
- The role of the nurse in meeting the client's health needs.

Nurses are members of a multi-disciplinary team and screening responsibilities of team members may differ among practice settings. While one nurse may screen the woman initially, it is the responsibility of all nurses to ensure that the screening steps are followed to ensure optimum care and safety for women.

Asking the Question

Asking the question creates an environment for discussion about violence and allows women to disclose their personal experiences if they so choose. How the question is asked is equally important. Institutions can choose validated tools *(Appendix C)*, or individual practitioners can develop their own style of questioning as part of a health history, provided the following points are included:

- Explain that all women are being asked about abuse because violence is so prevalent in society and there are significant health consequences to abuse (MLHU, 2000);
- Tailor your approach to the woman;
- Inform women that they can expect to be screened each time a health history is taken; and
- Send a clear message that violence is unacceptable.

For specific examples of framing introductory questions see *Appendix D*.

Responding when she says "YES"

To respond appropriately:

- Believe the woman;
- Name the abuse (identify what she is experiencing *is* abuse);
- Assess immediate health needs; if a recent sexual assault has occurred, refer for sexual assault care;
- Assess immediate safety and complete a safety check;
- Explore her immediate concerns/needs and determine a plan of action;
- With the woman's consent, refer to appropriate resources, including multi-disciplinary health team, community specialists, counsellors, support groups, shelters, and justice/advocacy services; and
- Have a contact list of violence against women services available (MLHU, 2000).

If she says "YES", ask:

1. **Are you safe now?**
2. **Would you like to talk about it?**
3. **When did this happen?**
4. **Have you talked to anyone else about this?**
5. **How are you coping?**
6. **What do you need right now?**

Adapted from: Kearsey, K. (2002). Listening for silent screams. *Registered Nurse,* 14 (4), 12-17.

For detailed information and other resources see the following appendices:

- Appendix C *(Assessment Tools for the Nurse)*
- Appendix D *(Framing Introductory Questions)*
- Appendix E *(Clinical Pathways)*
- Appendix F *(Mnemonic Tool ABCD-ER)*
- Appendix G *(Barriers to Screening and Disclosure)*
- Appendix H *(Safety Planning)*
- Appendix I *(Community Resources)*

Nurses should be aware that safety is never guaranteed nor can the most detailed safety plan ensure that the violence will end. The woman experiencing violence is ultimately the only one who can reliably predict the risks she faces and the likelihood for further violence (DH, 2000). Therefore, the "best safety plan is the woman's own plan, one that she views as achievable in her circumstances and one she has a personal commitment to follow" (MLHU, 2000, p. 41).

Responding when she says "NO" and you suspect "YES":

For the woman's safety:

- Discuss what you have observed and explain why you continue to be concerned about her health and safety;
- Offer educational information about the health effects and prevalence of abuse;
- Highlight referral services; and
- Document her responses (MLHU, 2000).

These considerations illustrate nurses' commitment to respect a woman's choice to disclose and give women the power and control over their own situation.

Responding when she says "NO":

In the event that there is no disclosure:

- Share general information/provide education about woman abuse; and
- Document the woman's response (MLHU, 2000).

Recommendation 4.0

Nurses develop screening strategies and initial responses that respond to the needs of all women taking into account differences based on race, ethnicity, class, religious/spiritual beliefs, age, ability or sexual orientation. *Level III*

Discussion of Evidence

Nurses must be cognizant of the cultural diversity of the populations with whom they work. Cultural diversity in this instance is used broadly and may be derived from one's race, ethnicity, class, religious/spiritual beliefs, age, ability or sexual orientation. The College of Nurses of Ontario (CNO) (2003) describes culture as "the learned values, beliefs, norms and way of life that influence an individual's thinking, decisions and actions in certain ways"(p. 3). "Client-centred care requires that nurses recognize the client's culture, the nurse's culture and how both affect the nurse-client relationship" (CNO, 2003, p. 3). Everyone has their own perception of the health care system and past experiences could impact on a woman's willingness to seek help.

Culturally diverse women may be reluctant to answer questions about and/or disclose abuse due to the following factors:

- Isolation from one's community of support;
- General mistrust due to racism, sexism and classism;
- Religious factors;
- Language/communication barriers; and
- Lack of culturally sensitive services (Geffner et al., 2001; Maher, Zillmer, Hadley, & Leudtke, 2002; Melnick et al., 2002).

When screening for abuse, it is recommended that nurses use gender-neutral language, as not all women are in heterosexual relationships (McClennen et al., 2002). Women with physical/mental disabilities are at greater risk for all types of abuse as they experience abuse in higher proportions than the general population (DisAbled Women's Network (DAWN), 1996).

Campbell & Campbell (1996) highlighted the importance of screening for woman abuse in the language most appropriate for the woman."If a clinician does not understand the meaning of words used…a breakdown in communication can result. Asking what unfamiliar words mean demonstrates a willingness to learn and appreciate cultural nuances rather than pretending that such differences do not exist or are related to a lack of education" (p. 459).

A study conducted by Iavicoli et al. (2001) found that acceptance of woman abuse varied by ethnic background and that cultural norms may keep women from recognizing abuse. Therefore, nurses need to be aware of ethnocentric biases in nursing practices that may impact on the woman's willingness to disclose abuse. *Appendix G* outlines some barriers to disclosure.

When screening a teen woman, the nurse will need to use different skills and language to promote an environment of comfort and safety. To communicate effectively, it is important to gain an understanding of the young woman's level of understanding of the question(s) being asked. Affirm with the young woman that she has the right to feel safe and confirm that she is not to blame for any incident that she may have experienced. The nurse should also discuss limits of confidentiality with the teen woman. Under certain conditions, nurses may be obligated by law to report abuse. See *Recommendation 7.0* for reporting requirements. Offer reassurance that you will refer the young woman to other community resources in order to provide further support.

The nurse is responsible for developing a communication plan to make the woman an informed partner in the provision of care. *A Guide to Nurses for Providing Culturally Sensitive Care* (CNO, 2003) provides information on communication strategies including working effectively with an interpreter in the event of a language barrier. This practice standard also guides nurses in providing culturally sensitive care through self-reflection, acquiring cultural knowledge, facilitating client choice, and establishing mutual goals.

Recommendation 5.0

Nurses use reflective practice to examine how their own beliefs, values, and experiences influence the practice of screening. *Level IIa*

Discussion of Evidence

Self-reflection assists nurses to identify the values and biases that underscore their approach and interventions. Nurses need to honestly examine their reactions to different situations to discover why they respond in a particular way. In some circumstances, a nurse may seek help from others to assist in reflection (CNO, 2004a). For more information on reflective practice, the College of Nurses of Ontario (2004a) has prepared a fact sheet entitled *Quality Assurance Reflective Practice.*

The Department of Health report (2000) states 25% of women from professional backgrounds have experienced abuse at some time in their lives. Since nursing is largely made up of women, this would suggest a probability that many nurses have experienced or are experiencing violence at the hands of their intimate partners. In a survey of ER nurses, Ellis (1999) found that 57.5% of the respondents had personal experience with woman abuse; 25% reported they experienced the abuse themselves, while 32.5% reported that the abuse was experienced by a parent, friend, spouse or other. As stated in Ross (2002), if trauma from abuse has not been worked through, screening may trigger unanticipated responses by the nurse. As a result, barriers to effective intervention with abused women may surface. Attitudes and beliefs about woman abuse have long been identified as a barrier to effective clinical response (Maiuro et al., 2000).

Kurz (1990) determined staff responses to battered women in the ER demonstrated definite patterns/correlations between characteristics of women experiencing violence and the staff response to these women. The study found that staff were more reluctant to engage with women who presented with "discrediting attributes" such as alcohol use, evasiveness, reluctance to talk to staff or behaviour deemed inappropriate by staff. Additionally, staff felt that although they gave the woman information, they were not sure if the information was acted upon. Larkin et al. (1999) state "male nurses were significantly less likely to identify a woman as positive for partner violence…it may be that either male providers are less comfortable or [abused women] are less willing to confide in male providers, since perpetrators themselves are typically male" (p. 674).

Vicarious trauma (VT) is defined as a change that occurs to the trauma nurse as a result of compassionate care given in response to the client's traumatic experiences (Robinson, Clements, & Land, 2003). VT can impact nurses emotionally, socially, physically, spiritually and professionally. Nurses and organizations must be aware of the development and the effects of VT. Symptoms may be manifested by profound changes in the nurse's sense of meaning, identity, worldview, and beliefs about self and others. Nurses need to recognize the cumulative impact of trauma work. VT is interactive – it ties the nurse's responses to client trauma and is shaped by both characteristics of the situation, as well as the nurse's unique psychological needs and cognitive belief system. Nurses need to become aware of their reactions by gaining insight into their own somatic signals of distress (Robinson et al., 2003) and should develop a support network in which they can safely share their experiences in order to mitigate the effects of VT.

Recommendation 6.0

Nurses know what to document when screening for and responding to abuse. *Level IV*

Discussion of Evidence

Prior to initiating screening the nurse needs to inform the woman of the scope and limits of confidentiality. While nurses ensure privacy and confidentiality of health information that they collect through their practice, it is important to note that confidentiality and disclosure of pertinent personal health information cannot be guaranteed in the following cases:

- When the nurse suspects child abuse/neglect;
- When the nurse learns of possible harm to self (client) or others; and
- When documents are subpoenaed by the courts (Ontario Ministry of Information and Privacy (OMIP), 2004).

Documentation is an integral aspect of safe, effective nursing practice (CNO, 2004c) and must be comprehensive, legible and accurately reflect screening practice (Health Canada, 1999b; 1999c; MLHU, 2000) as it may be used by the justice system as evidence during legal proceedings (Canadian Nurses Protective Society (CNPS), 1996b; Rozovsky & Inions, 2003). The record needs to include:

- A safety check;
- Direct quotations of what the woman describes;
- Direct observations made by the nurse; and
- Referrals discussed and made and/or information given.

As with all nursing documentation, the record should be non-biased, containing direct observations by the nurse. Use of non-biased terms such as "chooses", "declines" or "patient states" are more appropriate than using judgmental terms like "alleges" or "victim" (Health Canada, 1999a; 1999b; MLHU, 2000). An example would be "patient states 'my husband beat me'" (non-judgmental) rather than "victim alleges she was assaulted by partner" (judgmental).

Referral services and secondary intervention would include more detailed documentation such as:

- Relevant health history;
- History of abuse including the first, worst and most recent incident;
- Where and when the abuse took place;
- Name and relationship of abuser;
- Detailed description of injuries and photos (if taken); and
- All health care provided and information and/or referrals to resources provided to the woman (Health Canada, 1999a; MLHU, 2000).

When no disclosure of abuse is made the nurse should document "no disclosure to abuse screening" (Health Canada, 1999a, MHLU, 2000).

Nurses have legal, ethical and professional requirements that guide the management of client records (CN0, 2004b, 2004c; CNPS, 1996a; 1996b; OMIP 2004; Rozovsky & Inions, 2003). Policies and procedures concerning access to the woman's health information need to be developed as part of the screening protocol in all health settings. Women need to be aware, prior to screening, that the interaction will be documented and the documentation will be part of her health record that she can access at a later date should it be required. Disclosure of health information to individuals or agencies outside of the health care team needs the woman's expressed consent, except in cases previously discussed.

Recommendation 7.0

Nurses know their legal obligations when a disclosure of abuse is made. *Level IV*

Discussion of Evidence

There are three main considerations when a disclosure of abuse is made:

- Reporting woman abuse;
- Young women and disclosures of abuse; and
- Children who witness woman abuse.

All nurses have learned that respecting client confidentiality is a critical aspect of the nurse-client relationship. It is important for nurses to realize when there are ethical, professional and legal exceptions to client confidentiality (CNPS, 1996a). Nurses need to be aware of their professional Code of Ethics (Canadian Nurses Association (CNA), 2002), practice standards related to confidentiality and health information (CNO, 2004b) and the policies related to confidentiality specific to their workplace. The new Ontario legislation on the protection of health information also has implications for nurses. Within the new Personal Health Information Protection Act (OMIP, 2004), there are guidelines related to documentation and disclosure of personal health information as discussed in *Recommendation 6.0*.

Reporting Woman Abuse

There is no mandatory obligation to report woman abuse to the police. It is the woman's right to choose if she wishes to have police involvement and she must consent to this involvement prior to the nurse initiating such action. Nurses must respect the woman's decision and advocate for her right to choose (Health Canada, 1999b).

Young Women and Disclosures of Abuse

Since this best practice guideline recommends screening for woman abuse for women ages 12 and over, disclosure of abuse by a teen woman may necessitate the involvement of the Children's Aid Society (CAS). The following information is a general guide to practice in this area.

According to the Criminal Code of Canada (Department of Justice, 2003) young women over the age of 12 are able to consent to sexual activity in the following circumstances:

- When she is between the ages of 12-14 and the age difference between the two persons is not more than 2 years; and
- When the young person is age 14 or older and the other person is not in a position of trust or authority.

While teen sexuality may pose a challenge for the individual nurse, it is not necessarily a reportable event as illustrated in the above circumstances. The factors that define a report to CAS are:

- When the young woman is under 16 years of age and the alleged abuser is a person in a care-giving role; or
- When the young woman is under 16 years of age and the alleged abuser is in a role of authority or trust.

Assaults by a boyfriend are reportable only if these conditions apply or if the teen's parent(s)/caregiver(s) know of the abuse and do nothing to provide appropriate supervision to protect the young woman from harm.

There is no age of consent for treatment or for collecting information to establish a health record, so young women are entitled to make their own health decisions (OMIP, 2004; Rozovsky & Inions, 2003;), provided the health care professional feels they understand the circumstances and can make an informed choice. Once the capable young woman has made a treatment decision, parent(s)/caregiver(s), or CAS can not have assess to the health record without her consent (OMIP, 2004). In the case of a conflict, the capable young woman's decision always takes precedence. As this is recent legislation that will impact nursing practice, it is advised that nurses consult with their nurse-manager and/or their agency's privacy officer.

Children who Witness Woman Abuse

As noted in the background section, child witnesses to woman abuse may experience immediate and long term adverse effects (Berman et al., 2003; Graham-Berman & Edleson, 2001; Jaffe et al., 1990). According to the Child and Family Services Act (Ministry of Children and Youth Services, 2003), this situation may be reportable to the Children's Aid Society as it can represent a condition of harm for the child. Nurses are advised to consult their local CAS to discuss individual situations. Further, all health care organizations need to have a protocol in place with their local Children's Aid Society.

Education Recommendations

Recommendation 8.0

Mandatory educational programs in the workplace be designed to:

- **increase nurses' knowledge and skills; and**
- **foster awareness and sensitivity about woman abuse.** *Level Ib*

Discussion of Evidence

Education is the foundation of the success of all activities in the screening for woman abuse. Guidelines are more likely to be effective if they take into account local circumstances and are supported by an ongoing educational program about woman abuse (DH, 2000). Such programs need to be current, relevant and easily translated into practice. Health professionals also need assistance in developing the interviewing techniques that will enhance their comfort level with respect to asking intimate and emotionally sensitive questions about abuse (MLHU, 2000).

Regardless of where they work, nurses in both acute care and community settings are likely to encounter women who have experienced violence. It is therefore essential that nurses have the knowledge and skills to screen and respond appropriately and effectively (Davidson et al., 2001; Malecha, 2003).

Education of health care providers can increase the number of women who are screened for abuse (Garcia & Parsons, 2002; Goff, Byrd, Shelton, & Parcel, 2001; Ramsay, Richardson, Carter, Davidson, & Feder, 2002). According to Goff et al. (2001) there was a "significant relationship between education about [woman] abuse and an individual's level of preparedness, beliefs about how and when to screen, and outcome expectations associated with domestic violence" (p. 49-50).

Through education, nurses and nurse educators can be catalysts for improving nursing care of women in abusive relationships (Fishwick, 1998). Education programs need to include an advocacy component. In a randomized controlled trial with a two-year follow up, Sullivan and Bybee (as cited in Punukollu, 2003) found that "advocacy services led to greater effectiveness in obtaining resources, a decrease in physical violence…and an improved quality of life and social support at 10 weeks post shelter" (p. 4). As such, nurses need to advocate on behalf of abused women to improve access to services.

All educational programs should include:

- Definition of woman abuse;
- Prevalence data;
- Dynamics of abuse;
- Health consequences;
- Role of the nurse;
- Barriers to screening *(Appendix G)*;
- Community resource awareness *(Appendix I)*;
- Consequences of the woman's disclosure; and
- Confidentiality and legal implications (*Recommendation 7.0*).

Appendices J and *K* contain several resources to aid educators in developing educational programs.

Effective education programs will utilize a variety of approaches. Drawing on the experiences of the diverse cultures and ethnic groups that nurses represent, health providers can be assisted to understand the cultural health needs of clients (Campbell & Campbell, 1996). A prerequisite to educating nurses is for the educators themselves to gain awareness of, and sensitivity to, the issue of woman abuse. Such awareness can be gained through a variety of techniques including:

- "Train the Trainer" programs;
- Role play;
- Workshops;
- Educational videos and other media presentations *(Appendix J)*;
- Preceptorship and mentorship programs;
- Written materials, ongoing awareness and reflective practice; and
- Guest speakers such as women's advocates.

It is important to include in the design of educational programs the identification of an individual or group of individuals to champion the program. This group will assume responsibility for maintaining and revising program content to reflect current and new knowledge and understanding. This group can also be responsible for the orientation of new staff and the development of ongoing educational programs with respect to screening for woman abuse.

Recommendation 9.0

All nursing curricula incorporate content on woman abuse in a systematic manner. *Level III*

Discussion of Evidence

According to Ross (2002), it is necessary to inform policy makers, educators and researchers about gaps in educational services related to violence and areas of needed research in order that future nurses can be educated about abuse. Women abuse content must be taught in both a theoretical and contextual manner in order "to place violence within the context of social acts that have far-reaching effects on personal and public health, for which perpetrators are considered to be morally accountable" (Ross 2002, p. 8). Hoff and Ross (as cited in Ross, 2002), reported the results of a survey of Ontario Schools of Nursing that identified the curriculum development needs of faculty. All of the schools reported that they included content on violence issues in their curriculum, if only in readings. Three quarters reported that planned clinical instruction was "incidentally rather than systemically included as part of the curriculum" (Ross 2002, p. 18).

Ellis (1999) states that education on abuse and supporting resources are essential components of nursing school curricula. "Virtually all the literature about screening for the health effects of woman abuse stresses the need to provide adequate education to health care professionals about the nature, prevalence, dynamics, health effects and…interventions…at the undergraduate, graduate, postgraduate and continuing education levels" (MLHU, 2000, p. 47). According to Mezey (2001) "greater awareness of the issue and understanding of the problems facing victims of domestic violence can be achieved through incorporating the subject into…post graduate educational programs" (p. 546). Curricula should allow students to gain factual information and clinical experience about domestic violence. "Nursing education must use a two-pronged approach to educate faculty…and prepare students through curricula integration, clinical experience and other means" (Hinderliter et al., 2003, p. 452). Davidson et al. (2001) report that groups who had participated in training programs achieved statistically significant improvements in knowledge, attitudes and skills. Thus, the development panel recommends that content be included in all aspects of the curriculum and implemented in a systematic manner.

Organization & Policy Recommendations

Recommendation 10.0

Health care organizations develop policies and procedures that support effective routine universal screening for and initial response to woman abuse. *Level IV*

Discussion of Evidence

In order for routine universal screening to be effective, organizations need to develop policies that support nursing practice while considering client needs and outcomes (PPPESO, 2004). These policies will reflect the unique setting where the screening is to take place. It is recommended that these policies include "who is (or is not) to be screened, when screening will be undertaken, by whom, how the screening is incorporated into workplace practices and changes to workplace practices which could facilitate routine universal screening" (ECAV, 2001, p. 3). The creation of policy and procedures should address the following:

- Mandatory routine universal screening practice (Campbell & Furniss , 2003; Koziol-McLain & Campbell, 2001);
- Initial and continuing education for nurses (ECAV, 2001; MLHU, 2000; Metro Woman Abuse Council (MWAC), 2003);
- Development of screening protocols (Kimberg, 2001);
- Routine documentation practice (ECAV, 2001; MLHU, 2000; MWAC, 2003);
- Promotion of safety for women and their children (MLHU, 2000; MWAC, 2003);
- Confidentiality (DH, 2000);
- Structure designed to ensure privacy and supportive environment (DH, 2000; Kimberg, 2001);
- Linkages with relevant community agencies (DH, 2000; MLHU, 2000; MWAC, 2003); and
- Supportive counselling for staff – such as through Employee Assistance Programs to address the issue of vicarious trauma (ECAV, 2001).

Examples of policies can be found in *Appendix L.*

Recommendation 11.0

Health care organizations work with the community at a systems level to improve collaboration and integration of services between sectors. *Level Ib*

Discussion of Evidence

With the intent of providing optimal health care, screening interventions proposed to identify abused women must be informed by the experiences of these women as they access health services. Studies exploring abused women's perspectives of barriers to leaving abusive relationships repeatedly report organizational barriers, specifically the lack of co-ordination among all service providers as a hindrance to accessing services (Gerbert et al., 1996; Lutenbacher, Cohen, & Mitzel, 2003). Screening programs within health care settings have the potential to increase case findings of women who are abused (Mueller & Thomas, 2001) and have demonstrated greater success when implemented in collaboration with other sectors (McCaw, Berman, Syme, & Hunkeler, 2001). Not only were screening rates improved, but women participating in these programs reported an increase in their satisfaction with the health care organization's response to partner violence as well as increased self-referral to services. All sectors such as violence against women, health, justice and social services should work together to identify system barriers and improve co-ordination of services for abused women, thereby enhancing the health care response to woman abuse.

Recommendation 12.0

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- **An assessment of organizational readiness and barriers to education.**
- **Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.**
- **Dedication of a qualified individual to provide the support needed for the education and implementation process.**
- **Ongoing opportunities for discussion and education to reinforce the importance of best practices.**
- **Opportunities for reflection on personal and organizational experience in implementing guidelines.**

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines* based on available evidence, theoretical perspectives and consensus. The *Toolkit* is recommended for guiding the implementation of the RNAO guideline *Woman Abuse: Screening, Identification and Initial Response.* *Level IV*

Discussion of Evidence

Graham et al. (2002) indicate that in order for guidelines to be implemented successfully, a critical step must be the formal adoption of the guidelines by the organization. One way this can be accomplished is by incorporating recommendations into policies and procedures around routine universal screening for woman abuse. This key step helps to provide direction regarding the expectation of the organization and facilitates integration of the guideline into such systems as the quality management process.

Initiatives such as the implementation of best practice guidelines require strong leadership from nurses who are able to transform the evidence-based recommendations into useful tools that will assist in directing practice. It is suggested that the RNAO *Toolkit* (2002) be considered to assist organizations develop the leadership required for successful implementation. Refer to *Appendix M* for a description of the RNAO *Toolkit: Implementation of Clinical Practice Guidelines.*

Research Gaps & Future Implications

The panel, in reviewing the evidence for the development of this guideline, has identified several gaps in the research literature related to screening for and initial response to woman abuse. Consistent with our belief in the importance of different types of knowledge, a need for research that includes a variety of approaches including quantitative and qualitative methods has been identified. Further, the panel believes research will have the largest impact when conducted by research teams comprised of community and academic partners. In considering the research gaps, the following research priorities were identified to benefit client outcomes:

Screening approaches (different approaches):

- What is the most effective way to screen for and respond to abuse for diverse populations including:
  - same sex partners
  - seniors/elders
  - teen women (12-16)
  - women with disabilities (physical and mental)
  - immigrants/newcomers
  - ethnically diverse
  - aboriginals
  - women in rural/isolated communities?
- What methods of screening are most effective:
  - interviews
  - standardized tools
  - self administered questionnaires?
- What is the impact of repeated screening on women?

Education:

- What strategies need to be in place to sustain screening practices in organizational settings once initial education is complete?
- What strategies are most effective in educating nursing students to ensure they incorporate screening into their practice?

Outcomes of Screening:

- What are the long and short-term outcomes of screening for and responding to abuse on the:
  - woman
  - nurse
  - health care system
  - community agency
  - broader community?

Impact on Children:

- What is the impact on children when women disclose abuse in the context of screening?

Evaluation/Monitoring of Guideline

Organizations implementing the recommendations in this nursing best practice guideline are encouraged to consider how the implementation and its impact will be monitored and evaluated. The following table, based on a framework outlined in the RNAO *Toolkit: Implementation of Clinical Practice Guidelines (2002)* illustrates some indicators for monitoring and evaluation.

	Structure	Process	Outcome
Objectives	■ To evaluate the supports available in the organization that allow nurses to screen for woman abuse.	■ To evaluate the changes in practice that lead to improved screening for woman abuse.	■ To evaluate the impact of implementation of the recommendations.
Organization/ Unit	■ Review of best practice guideline: *Woman Abuse: Screening, Identification and Initial Response* by organization to determine policy implications. ■ Design orientation/ professional development sessions. ■ Nurse leader identified to champion implementation process.	■ Develop policy on screening for woman abuse consistent with the guideline. ■ Modify existing policies to be consistent with screening for woman abuse. ■ Select the approach/tools to screen for woman abuse in the setting.	■ ⇧# of protocols with external agencies consistent with the guideline. ■ Staff satisfaction.
Nurse/ Provider	■ % of nurses attending orientation/professional development sessions. ■ Nurse's commitment to screen.	■ Nurses self assessed knowledge of: • dynamics of woman abuse; • conditions for screening; • initial response to disclosure; • referral sources; and • documentation procedures. ■ Nurses' self reports of: • universal screening of women 12 and over; • educating women about why screening is occurring; • support for women's choices; • adequate documentation; and • comfort with screening.	■ Documentation of "asking the question" on health history (chart audit). ■ Nurses modify practice based on policy/procedure and orientation/professional development session.

	Structure	Process	Outcome
Client			■ % of woman screened. ■ Women report: • knowledge of why screening occurred – feeling listened to, respected; and • feeling their choice was supported.
Financial Costs	■ Health care settings fund nurses' participation in orientation/professional development sessions. ■ Adequate financial resources to implement routine universal screening.	■ Cost of educational programs and resource materials.	■ Overall resource utilization.

Implementation Strategies

The Registered Nurses' Association of Ontario and the guideline development panel have compiled a list of implementation strategies to assist health care organizations or health care disciplines that are interested in implementing this guideline. A summary of these strategies follows:

- Have a dedicated person such as an advanced practice nurse or a clinical resource nurse who will provide support, clinical expertise and leadership. The individual should also have good interpersonal, facilitation and project management skills.

- Establish a steering committee comprised of key stakeholders and members committed to leading the initiative. Develop a work plan to track activities, responsibilities and timelines.

- Provide educational sessions and ongoing support for implementation. The education sessions may consist of presentations, facilitator's guide, handouts, and case studies. Binders, posters and pocket cards may be used as ongoing reminders of the training. Plan education sessions that are interactive, include problem solving, address issues of immediate concern and offer opportunities to practice new skills (Davies & Edwards, 2004).

- Provide organizational support such as having the structures in place to facilitate the implementation. For example, utilizing replacement staff so participants will not be distracted by concerns about work; having an organizational philosophy that reflects the value of best practices through policies and procedures; and developing new assessment and documentation tools (Davies & Edwards, 2004).

- Identify and support designated best practice champions on each unit to promote and support implementation. Celebrate milestones and achievements, acknowledging work well done (Davies & Edwards, 2004).

- Organizations implementing this guideline should look at a range of self-learning, group learning, mentorship and reinforcement strategies that will, over time, build the knowledge and confidence of nurses.

- Beyond skilled nurses, the infrastructure required to implement this guideline includes access to specialized resources. Orientation of the staff to the use of specific materials must be provided and regular refresher trainings planned.

- Teamwork, collaborative assessment, treatment and interdisciplinary work is beneficial in implementing guidelines successfully. Referrals should be made, as necessary, to appropriate services or resources within the organization or agency and in the community.

- RNAO's Advanced/Clinical Practice Fellowships (ACPF) Project is another way that registered nurses in Ontario may apply for a fellowship and have an opportunity to work with a mentor who has expertise in screening for and responding to woman abuse. With the ACPF, the nurse fellow will have the opportunity to hone their skills in screening for and responding to woman abuse.

- Identify, develop and support BPG Champions and include people who have expertise in the topic area, facilitation skills, and knowledge of adult education principles in order to support, develop, mentor, and train other nurses within organizations to ensure knowledge transfer.

In addition to the strategies mentioned above, RNAO has developed resources that are available on the website. A *Toolkit* for implementing guidelines can be helpful if used appropriately. A brief description of this *Toolkit* can be found in Appendix M.

A complete version of the document is available at: http://www.rnao.org/bestpractices.

Process for Update/Review of Guideline

The Registered Nurses' Association of Ontario proposes to update this best practice guideline as follows:

1. Each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area every three years following the last set of revisions.
2. During the three-year period between development and revision, RNAO Nursing Best Practice Guidelines program staff will regularly monitor for relevant literature.
3. Based on the results of the monitor, program staff will recommend an earlier revision period. Appropriate consultation with a team of members comprising original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the three-year milestone.
4. Three months prior to the three-year review milestone, the program staff will commence the planning of the review process by:
   a. Inviting specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
   b. Compiling feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
   c. Compiling new clinical practice guidelines in the field, systematic reviews, meta-analysis papers, technical reviews, randomized controlled trial research, and other relevant literature.
   d. Developing a detailed work plan with target dates and deliverables.

The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A: Search Strategy for Existing Evidence

STEP 1 – Database Search

A database search for existing guidelines on Woman Abuse/Domestic Violence was conducted by a university health sciences library. An initial search of the MEDLINE, EMBASE and CINAHL databases for guidelines and articles published from January 1, 1996 to December 31, 2003 was conducted using the following search terms: "domestic violence (physical or sexual abuse of spouse or intimate partner)", "violence against women", "intimate partner violence", "partner abuse", "spouse abuse", "screening", "assessment", "practice guideline(s)", "clinical practice guideline(s)", "standards", "consensus statement(s)", "consensus", "evidence-based guidelines" and "best practice guidelines".

STEP 2 – Structured Web Site Search

One individual searched an established list of 49 web sites for content related to the topic area. This list of sites, reviewed and updated in Fall 2003, was compiled based on existing knowledge of evidence-based practice websites, known guideline developers, and recommendations from the literature. Presence or absence of guidelines was noted for each site searched as well as date searched. The websites at times did not house a guideline but directed to another web site or source for guideline retrieval. Guidelines were either downloaded if full versions were available or were ordered by phone/email.

- Agency for Healthcare Research and Quality: http://www.ahcpr.gov
- Alberta Heritage Foundation for Medical Research – Health Technology Assessment: http://www.ahfmr.ab.ca//hta
- Alberta Medical Association – Clinical Practice Guidelines: http://www.albertadoctors.org
- American College of Chest Physicians: http://www.chestnet.org/education/hsp/guidelines.php
- American Medical Association: http://www.ama-assn.org
- British Medical Journal – Clinical Evidence: http://www.clinicalevidence.com/ceweb/conditions/index.jsp
- Canadian Coordinating Office for Health Technology Assessment: http://www.ccohta.ca
- Canadian Task Force on Preventive Health Care: http://www.ctfphc.org
- Centers for Disease Control and Prevention: http://www.cdc.gov
- Centre for Evidence-Based Mental Health: http://cebmh.com
- Centre for Evidence-Based Pharmacotherapy: http://www.aston.ac.uk/lhs/research/med/EvidenceBP/ebmpacks.jsp
- Centre for Health Evidence: http://www.cche.net/che/home.asp
- Centre for Health Services and Policy Research: http://www.chspr.ubc.ca
- Clinical Resource Efficiency Support Team (CREST): http://www.crestni.org.uk
- CMA Infobase: Clinical Practice Guidelines: http://mdm.ca/cpgsnew/cpgs/index.asp
- Cochrane Database of Systematic Reviews: http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME
- Database of Abstracts of Reviews of Effectiveness: http://www.mrw.interscience.wiley.com/cochrane/cochrane_cldare_articles_fs.html
- Evidence-based On-Call: http://www.eboncall.org
- Government of British Columbia – Ministry of Health Services: http://www.hlth.gov.bc.ca/msp/protoguides/index.html

- Institute for Clinical Systems Improvement: http://www.icsi.org/index.asp
- Institute of Child Health: http://www.ich.ucl.ac.uk/ich
- Joanna Briggs Institute: http://www.joannabriggs.edu.au/about/home.php
- Medic8: http://www.medic8.com/ClinicalGuidelines.htm
- Medscape Women's Health: http://www.medscape.com/womenshealthhome
- Monash University Centre for Clinical Effectiveness: http://www.med.monash.edu.au/healthservices/cce/evidence
- National Guideline Clearinghouse: http://www.guidelines.gov
- National Institute for Clinical Excellence: http://www.nice.org.uk
- National Library of Medicine Health Services/Technology Assessment: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat
- Netting the Evidence: A ScHARR Introduction to Evidence-Based Practice on the Internet: http://www.shef.ac.uk/scharr/ir/netting
- New Zealand Guidelines Group: http://www.nzgg.org.nz
- NHS Centre for Reviews and Dissemination: http://www.york.ac.uk/inst/crd
- NHS Nursing & Midwifery Practice Dev. Unit: http://www.nris.gcal.ac.uk/nmpdu.htm
- NHS R & D Health Technology Assessment Programme: http://www.hta.nhsweb.nhs.uk/ProjectData/index.asp
- PEDro: The Physiotherapy Evidence Database: http://www.pedro.fhs.usyd.edu.au/index.html
- Queen's University at Kingston: http://post.queensu.ca/~bhc/gim/cpgs.html
- Royal College of General Practitioners: http://www.rcgp.org.uk
- Royal College of Nursing: http://www.rcn.org.uk/index.php
- Royal College of Physicians: http://www.rcplondon.ac.uk
- Sarah Cole Hirsh Institute: http://fpb.cwru.edu/HirshInstitute
- Scottish Intercollegiate Guidelines Network: http://www.sign.ac.uk
- Society of Obstetricians and Gynecologists of Canada Clinical Practice Guidelines: http://www.sogc.medical.org/sogcnet/index_e.shtml
- The Canadian Cochrane Network and Centre: http://cochrane.mcmaster.ca
- The Qualitative Report: http://www.nova.edu/ssss/QR
- Trent Research Information Access Gateway: http://www.shef.ac.uk/scharr/triage/TRIAGEindex.htm
- TRIP Database: http://www.tripdatabase.com
- U.S. Preventive Service Task Force: http://www.ahrq.gov/clinic/uspstfix.htm
- University of California, San Francisco: http://medicine.ucsf.edu/resources/guidelines/index.html
- University of Laval – Directory of Clinical Information Websites: http://132.203.128.28/medecine
- University of York – Centre for Evidence-Based Nursing: http://www.york.ac.uk/healthsciences/centres/evidence/cebn.htm

STEP 3 – Search Engine Web Search

A website search for existing guidelines on woman abuse was conducted via the search engine "Google", using the search terms identified above. One individual conducted this search, noting the search term results, the websites reviewed, date and a summary of the findings. The search results were further critiqued by a second individual who identified guidelines and literature not previously retrieved.

STEP 4 – Hand Search/Panel Contributions

Additionally, panel members were already in possession of a few of the identified guidelines. In some instances, a guideline was identified by panel members and not found through the previous search strategies. These were guidelines that were developed by local groups or specific professional associations. Results of this strategy yielded one additional guideline.

STEP 5 – Core Screening Criteria

The above search method revealed twenty-four guidelines, several systematic reviews and numerous articles related to woman abuse.

The final step in determining whether the clinical practice guideline would be critically appraised was to have the development panel screen the guidelines based on the following criteria, which were determined by panel consensus:

- Guideline was in English;
- Guideline was dated no earlier than 1999;
- Guideline was strictly about the topic area;
- Guideline was evidence-based (e.g. contained references, description of evidence, sources of evidence);
- Guideline was available and accessible for retrieval; and
- Guideline was developed for populations similar to Canada.

RESULTS OF THE SEARCH STRATEGY

The results of the search strategy and the decision to critically appraise identified guidelines are itemized below. Fourteen guidelines met the screening criteria and were critically appraised using the *Appraisal of Guidelines for Research and Evaluation (AGREE)* (AGREE Collaboration, 2001) instrument.

TITLE OF THE PRACTICE GUIDELINES CRITICALLY APPRAISED

British Columbia Reproductive Care Program. (2003). Intimate partner violence during the perinatal period. Available: http://www.rcp.gov.bc.ca/Guidelines/Obstetrics/IPV.July.2003.Final.pdf

Department of Health (DH) (2000). Domestic violence: A resource manual for health care professionals. Available: http://www.dh.gov.uk/assetRoot/04/06/53/79/04065379.pdf

Education Centre against Violence (2001). *Routine screening for domestic violence in NSW health: An implementation package.* Parramatta: Author.

Family Violence Prevention Fund. (1999). Preventing domestic violence: Clinical guidelines on routine screening. Available: http://endabuse.org/programs/healthcare/files/screpol.pdf

Family Violence Prevention Fund. (2004). National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. Available: http://endabuse.org/programs/healthcare/files/Consensus.pdf

Health Canada. (1999a). A handbook dealing with woman abuse and the Canadian criminal justice system: Guidelines for physicians. Available: http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/physician_e.pdf

Health Canada. (1999b). A handbook for health and social service professionals responding to abuse during pregnancy. Available: http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/pregnancy_e.pdf

Institute for Clinical Systems Improvement. (2003). Domestic violence. Available: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=170

MacMillan, H. L. & Wathen, C. N. (2001). Prevention and treatment of violence against women: Systematic review and recommendations: Technical report. Available:http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=3657&nbr=2883

Metro Woman Abuse Council. (2003). *Best practice guidelines for health care providers working with women who have been abused* (Rep. No. 401). Ontario Hospital Association.

Middlesex-London Health Unit. (2000). *Task force on the health effects of woman abuse – Final report.* London, Ontario: Author

Ministry of Health. (1998). Family violence: Guidelines for health care sector providers to develop practice protocols. Available: http://www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/a6c310fefbf4127c4c256817006f67ec/$FILE/FamViol.pdf

Ross, M. (2002). Nursing education and violence prevention, detection and intervention. Available: http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/2003nursviolence_e.pdf

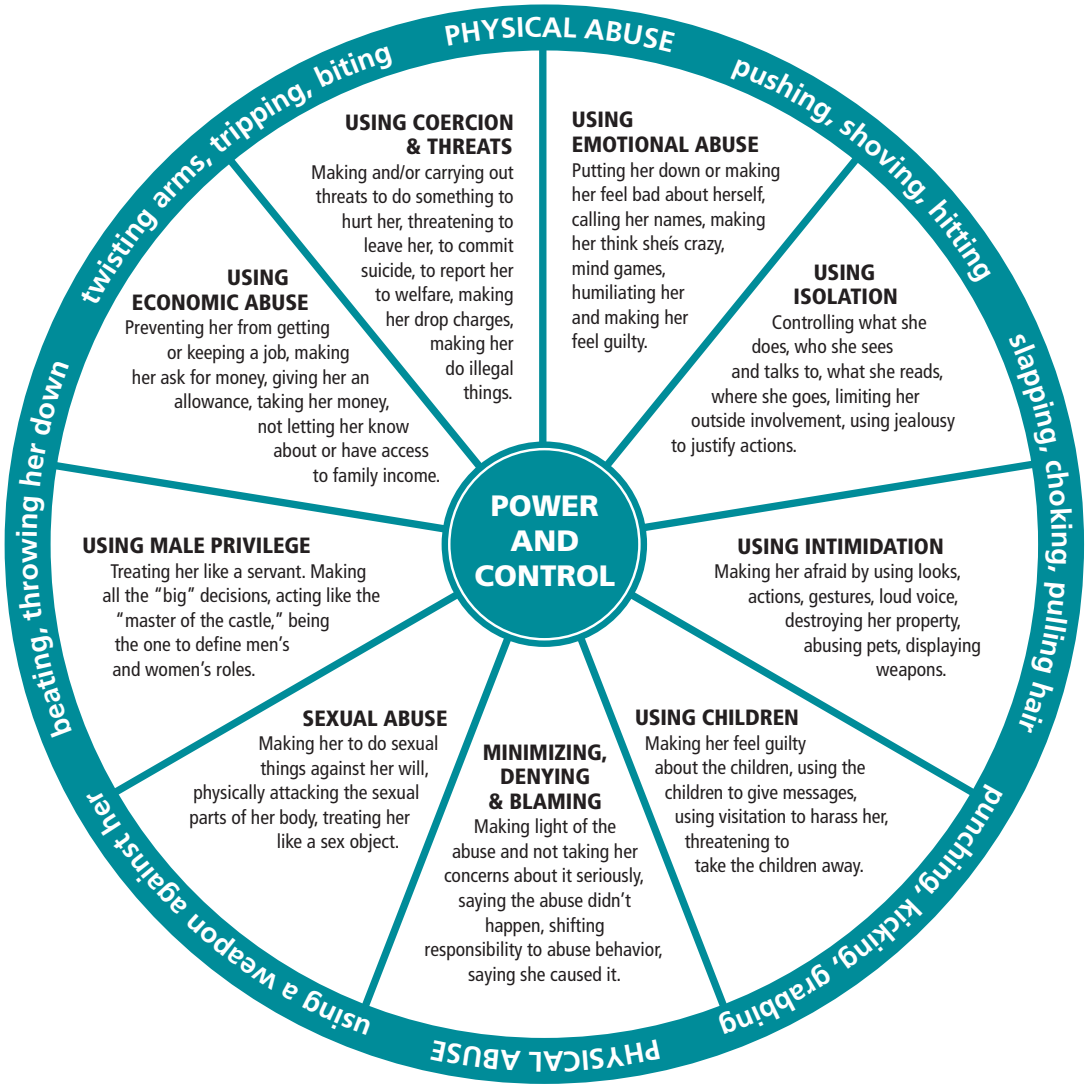
Yick Flanagan, A. (2001). Domestic violence in ethnic minority communities: Guidelines for healthcare providers. *Journal of Professional Nursing, 17*(1), 33-39.

Appendix B: Power and Control Wheel

The Power and Control Wheel, developed by the *Domestic Abuse Intervention Project*, (Duluth, MN) is a visual aide that demonstrates the dynamics of power and control in abusive relationships.

At the centre of the behaviour is the desire of the abuser to maintain power and control over the woman, and the relationship. While each individual abuser will use different patterns of behaviour to maintain power and control, there tends to be many common traits of abusive behaviour. The spokes on the wheel illustrate these common traits and include: emotional abuse; economic abuse; sexual abuse; isolation; intimidation; using gender privilege; threats; and manipulating children or other people.

The outer rim of the wheel depicts the overall threat or actual use of physical violence to coerce compliance, and to keep the abused woman under control.



Source: National Center on Domestic and Sexual Abuse. Domestic Abuse Intervention Project. *Power and Control Wheel.* Reprinted with permission.

Appendix C: Assessment Tools for the Nurse

ABUSE ASSESSMENT SCREEN[1] (AAS)

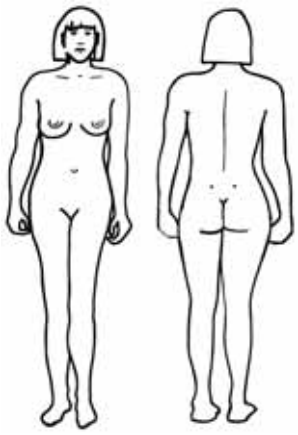
1. **WITHIN THE LAST YEAR,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

   If YES, by whom?_____
   Total number of times_____

2. **SINCE YOU'VE BEEN PREGNANT,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

   If YES, by whom?_____
   Total number of times_____

   MARK THE AREA OF INJURY ON THE BODY MAP.
   SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

   SCORE

   1 = Threats of abuse including use of a weapon _____
   2 = Slapping, pushing; no injuries and/or lasting pain _____
   3 = Punching, kicking, bruises, cuts and/or continuing pain _____
   4 = Beating up, severe contusions, burns, broken bones _____
   5 = Head injury, internal injury, permanent injury _____
   6 = Use of weapon; wound from weapon _____

   If any of the descriptions for the higher number apply, use the higher number.

3. **WITHIN THE LAST YEAR,** has anyone forced you to have sexual activities? YES NO

   If YES, by whom?_____
   Total number of times_____

Developed by the Nursing Research Consortium on Violence and Abuse. Readers are encouraged to reproduce and use this assessment tool.

Source: McFarlane & Parker, (1994). In Fishwick, N. (1998). Assessment of women for partner abuse. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 27*, 661-670. Reproduced with permission.

[1] Note: this tool is validated

ABUSE ASSESSMENT SCREEN – DISABILITY[2] (AAS-D)

The Abuse Assessment Screen – Disability (AAS-D) was developed and tested to address the range of abuse experienced by women with physical disabilities.

1. **Within the last year,** have you been hit, slapped, kicked, pushed, shoved, or otherwise physically hurt by someone? **YES** **NO**
   If YES, who? (Circle all that apply)

   Intimate partner Care provider Health professional Family member Other

   Please describe: _____

2. **Within the last year,** has anyone forced you to have sexual activities? **YES** **NO**
   If YES, who? (Circle all that apply)

   Intimate partner Care provider Health professional Family member Other

   Please describe: _____

3. **Within the last year,** has anyone prevented you from using a wheelchair, cane, respirator, or other assistive devices? **YES** **NO**
   If YES, who? (Circle all that apply)

   Intimate partner Care provider Health professional Family member Other

   Please describe: _____

4. **Within the last year,** has anyone you depend on refused to help you with an important personal need, such as taking your medicine, getting to the bathroom, getting out of bed, getting dressed, or getting food or drink? **YES** **NO**
   If YES, who? (Circle all that apply)

   Intimate partner Care provider Health professional Family member Other

   Please describe: _____

Abuse Assessment Screen Disability (AAS-D) (circle YES or NO)

Source: McFarlane, J., Hughes, R. B., Nosek, M. A., Groff, J. Y., Swedlend, N. & Dolen Mullen, P. (2001). Abuse Assessment Screen – Disability (AAS-D): Measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. *Journal of Women's Health & Gender-Based Medicine, 10* (9), 861-866. Reproduced with permission.

[2] Note: this tool is validated

WOMAN ABUSE SCREENING TOOL[3] (WAST)

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

☐ a lot of tension ☐ some tension ☐ no tension

---

2. Do you and your partner work out arguments with:

☐ great difficulty ☐ some difficulty ☐ no difficulty

---

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

☐ often ☐ sometimes ☐ never

---

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

☐ often ☐ sometimes ☐ never

---

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

☐ often ☐ sometimes ☐ never

---

6. Has your partner ever abused you physically?

☐ often ☐ sometimes ☐ never

---

7. Has your partner ever abused you emotionally?

☐ often ☐ sometimes ☐ never

---

8. Has your partner ever abused you sexually?

☐ often ☐ sometimes ☐ never

Source: Brown, J., Lent, B., Schmidt, G., & Sas, S. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice, 49,* 896-903. Reproduced with permission.

[3] Note: this tool is validated

Appendix D: Framing Introductory Questions

Start with a simple explanation as to why the questions are being asked.

For example:

"Because woman abuse is so common in many people's lives, I now ask all my clients about it."
"Many of the women I see are dealing with abuse in their relationships. Some are too afraid and uncomfortable to bring it up themselves, so I've started asking about it routinely."

Then ask specific questions.

For example:

"Have you ever been hurt or threatened by someone?"
"Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid (or unsafe)?"
"Have you ever been emotionally, physically, or sexually abused by your partner or someone important to you?"

Reference:

1. Department of Health (2000). Domestic Violence: A resource manual for health care professionals. Available: www.doh.gov.uk/pdfs/domestic.pdf

2. Family Violence Prevention Fund (1999). Preventing domestic violence: clinical guidelines on routine screening. Available: http://endabuse.org/programs/healthcare/files/screpol.pdf

Specific Considerations for Teen Women

"Everyone has a right to be safe and choose what happens to their body."
"Sometimes people say and do things to us that can be hurtful and make us feel confused and uncomfortable. Has anyone ever made you feel that way?"

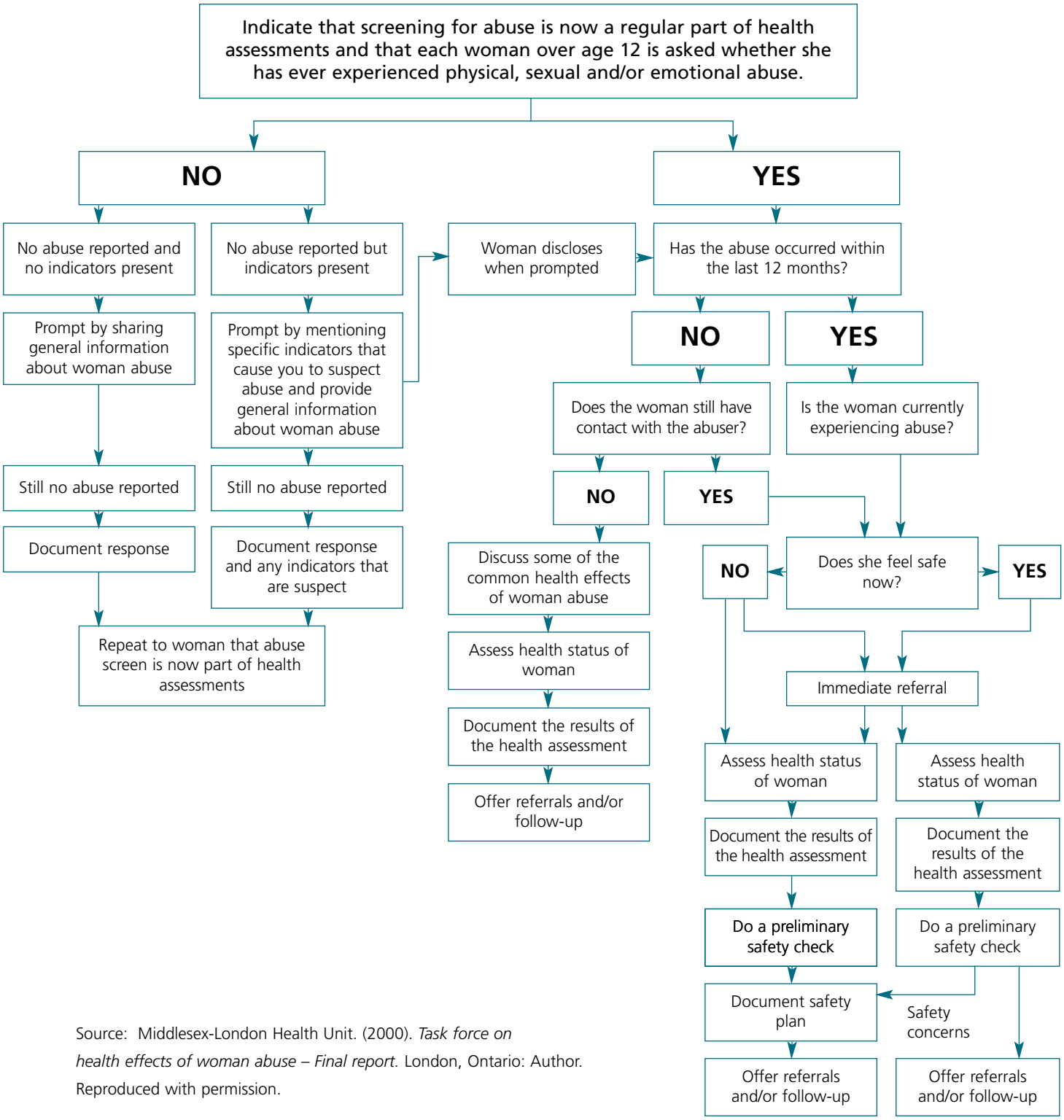
Let the response guide your next question(s).

Hints:

- You may need to define 'hurt' using age-appropriate language. Refer to *Appendix L* (Eight Types of Abuse).
- Avoid using words such as "bad". A young person could take the word bad as meaning that they are bad or have done something wrong.
- Avoid using leading questions; be direct and to the point; let the young person answer the question in her own words.
- With young women, it will be necessary to proceed more slowly to build trust.
- It may be necessary to explain that if abuse was of a sexual nature, even though it was an unwanted act, it may have resulted in "feeling good". This does not make the unwanted action acceptable.

Appendix E: Clinical Pathways

1. The Routine Universal Comprehensive Screening (RUCS) Protocol

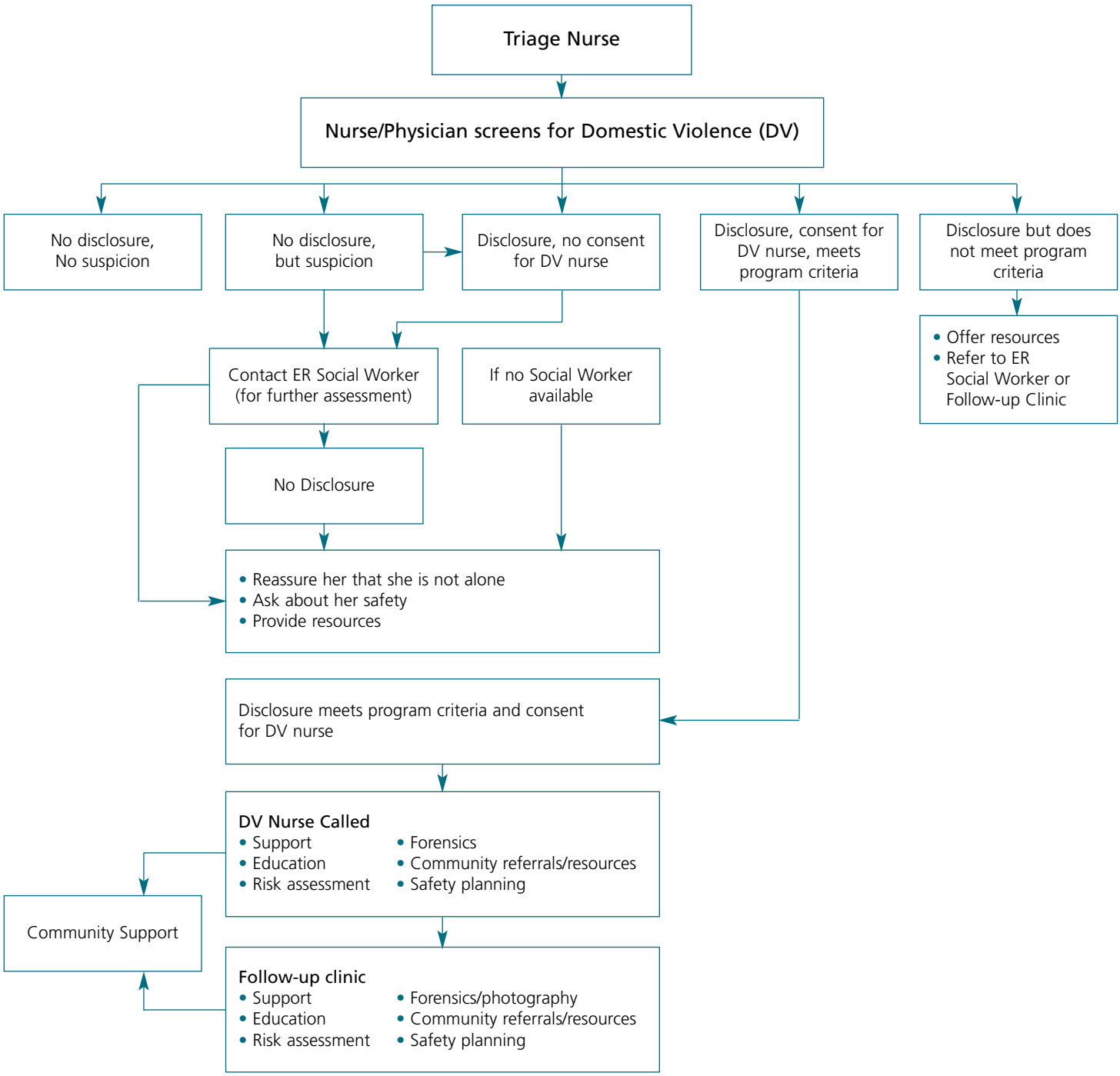


Source: Middlesex-London Health Unit. (2000). *Task force on health effects of woman abuse – Final report.* London, Ontario: Author. Reproduced with permission.

2. Example of Emergency Department Decision Flow Chart

Domestic Violence Mandate Expansion Program Flow

Individual enters Emergency Department (with or without police)



Source: Hamilton Health Sciences, Hamilton, Ontario. Reprinted with permission.

Appendix F: Mnemonic Tool ABCD-ER

Guiding principles for screening will assist the nurse in implementing effective intervention. The Mnemonic Tool **ABCD-ER** (MLHU, 2000) outlines the principles.

A – **Attitude** and **Approachability** of the health care provider
B – **Belief** in the woman's account of her own experience of abuse
C – **Confidentiality** is essential for disclosure
D – **Documentation** that is consistent and legible

E – **Education** about the serious health effects of abuse
R – **Respect** for the integrity and authority of each woman's life choices
Recognition that the process of dealing with identified abuse must be done at her pace, directed by her decisions

A – ATTITUDE AND APPROACHABILITY:

- Treat the patient with respect, dignity and compassion.
- Be sensitive to differences in age, culture, language, ethnicity and sexual orientation.
- State clearly that abuse is not the fault of the victim but the responsibility of the abuser.
- Reinforce that no one has the right to use physical, sexual or emotional abuse to control another person's actions.
- Reinforce that physical and sexual abuse is against the law in Canada.
- Convey a non-threatening, non-judgmental stance in words, facial expressions and body language.
- Express concern for her safety.
- Acknowledge the strength she has shown in surviving abuse and disclosing it to you.
- Offer support.
- Avoid excessive criticism of the abuser.

B – BELIEF:

- Show by your words and your actions that you believe her disclosure.
- Remember that the fear of not being believed silences many women. The abuser may have convinced her that no one will believe her if she discloses.
- Help her to understand that most of us try to block out memories that are too painful to deal with. If she is disclosing retrospective abuse, she may not be sure herself of exactly what happened or where.
- Reassure her to encourage her to have confidence in her own perceptions about the abuse.

C – CONFIDENTIALITY:

- Interview in private, without her partner or family members being present.
- Use a professional interpreter if one is required, not a friend or family member.
- Tell her directly about the policies and procedures used in your practice or institution to protect patient confidentiality.
- Assure her that you will not release the information unless she gives her written permission.
- Outline the exceptions to this pledge of confidentiality: (a) where child abuse or neglect is in question; (b) where the health professional has reason to fear for the safety of a third party; and (c) where a file is subpoenaed by a court order.
- Let her know that you are documenting the information she provides so that it will help you provide appropriate medical services and referrals and so that it will be available to help her later if she should provide you with permission to share it.

D – DOCUMENTATION:

- Document consistently and legibly.
- Distinguish between your observations and her reports.
- Record information on the first, the worst, and the most recent abusive incident.
- If more than one person has abused the woman, distinguish between the abusers and the specific injuries or health effects of each incident.
- Indicate the frequency of abusive incidents, as well as any increase or decrease in frequency and seriousness.
- Avoid subjective statements and speculations that might undermine the woman's credibility.
- Use the woman's own words, in quotation marks, as frequently as possible.
- Use diagrams and/or photographs where possible to document physical injuries.

E – EDUCATION:

- Educate about abuse and its health effects.
- Help her to understand that she is not alone.
- Attempt to engage the woman in long-term continuity of care by offering appropriate referrals and follow-up.
- Know about available community resources and help her choose the services she needs, when she is ready to seek assistance.
- Display posters, brochures and other available information about woman abuse in your office or institution.
- Provide her with information about the Abused Women's Help Line.

R – RESPECT AND RECOGNITION:

- Respect the integrity and autonomy of the woman's life choices.
- Recognize that she must deal with the abuse at her own pace.
- Recognize that an abused woman is an expert about her own abuse and abuser.
- Affirm her strengths and the survival skills she has demonstrated.
- Do not try to tell her what to do but help her understand the options available to her; she must choose the options she decides will meet her own goals and priorities.
- Offer referrals to other specialized services and follow-up with you.
- Do not label her resistant or non-compliant if she decides not to accept your advice; make it clear you respect her right to choose and will continue, as her caregiver, to support her.
- Make sure any medications you offer to help her deal with stress and/or sleep problems do not impair her ability to act appropriately on her own behalf.
- Help her to recognize that she cannot control the actions of others; she can only decide her own.

NEVER!

- **assign blame to the victim**
- **ask her questions about abuse in front of her abuser**
- **minimize, deny or trivialize what she says**
- **confront the abuser**
- **suggest marital or joint counselling**
- **alienate the woman by criticizing her partner**
- **criticize a woman who chooses to remain with an abusive partner**

Adapted from: Health Canada: Family Violence Prevention Unit, (1999) & Middlesex-London Health Unit (2000).

ABCD-ER

Source: Middlesex-London Health Unit. (2000). *Task force on health effects of woman abuse – Final report.* London, Ontario: Author. Reprinted with permission.

Appendix G: Barriers to Screening and Disclosure

There are significant barriers to screening and disclosure from both the client's and clinician's perspective. It is necessary for the nurse to understand these barriers.

Some barriers for screening from the provider's perspective include:

- Fear of opening "Pandora's Box";
- Fear of offending the patient;
- Heterosexism, classism, racism;
- Time constraints;
- Don't know what to do if the abuse is confirmed;
- Believe that attempts to help are futile;
- "Not in my practice setting" mentality;
- Believe the victim caused the abuse; and
- Lack of awareness of woman abuse including:
  - Not recognizing some acts of violence as abuse; and
  - Lack of organizational support.

Some barriers for disclosure from the client's perspective include:

- The children;
- Cultural or religious values;
- Fear of violence/retaliation if the abuser finds out about disclosure;
- Isolation;
- Fear about immigration status;
- Concern partner will be arrested;
- Stigmatization if only certain women are asked;
- Hope that the partner will change; and
- Lack of knowledge of available resources.

Reference: The Medical Subcommittee of the Delaware Domestic Violence Coordinating Council (DVCC) (2000). Domestic violence: A resource manual for healthcare providers for the State of Delaware: Part 3: Healthcare provider's response. *Delaware Medical Journal, 72,* 527-534.

Appendix H: Safety Planning

A. Ensure the woman's safety at all times

Think – Where is the abuser right now? If the abuser is in the health care facility now, does the woman believe that the abuser may pose a danger to her, her children or the health care providers? Is it necessary to seek help from the police or security? Is the abuser suspicious about the interview? Has the abuser tried to insist that the interview include him/her? (MLHU,2000)

B. Complete a safety checklist with the woman

The nurse helps the woman assess:

1. Her Level of Danger:
   - How much contact does she have with her partner?
   - Has partner breached a "no contact order"?

2. The Nature of Recent Contact with Partner
   - Is partner threatening?
   - Is partner expressing feelings of desperation? (e.g., "I can't live without you", "You'll be with me or nobody else")
   - How fearful is the woman of not complying with partner's demands?

3. The Nature of the Abuse/Violence
   - Is the frequency or severity of the violence escalating?
   - Is the partner in possession of a weapon or threatening to purchase a weapon?

4. Significant Events
   - Is the woman pregnant?
   - Is she planning to end the relationship?
   - Is she planning to begin a new relationship?
   - Is she starting a new job or going to school?
   - Is there an upcoming court date (for assault charges, separation/divorce, child custody)?

5. Support Networks
   - Is the woman isolated (by language, lack of transportation, mobility)?
   - Do others know about the abuse? Are they supportive?

Reference: London Abused Women's Centre [formerly The Battered Women's Advocacy Centre] (2001). *Safety resource kit for abused women.* London, Ontario: Author.

C. Develop a Safety Plan with the woman

Encourage the woman to:

1. Tell someone about the abuse.
2. Have a list of emergency phone numbers.
3. Plan an escape route – where to go in an emergency situation.
4. Pack a suitcase with essential clothing for self and children. Include comfort items like a favourite toy for the children. Store with someone she trusts.
5. Collect essential documents and keep in a safe place. Include social insurance number, birth certificates, driver's licence, passport/other photo identification, bank account numbers, copy of marriage licence, and any court documents such as restraining orders/peace bonds, or custody and access papers.

For additional information on Safety Plans, contact your local shelter or visit www.shelternet.ca

Appendix I: Community Resources

Community Resource List

Professionals should keep an up-to-date list of referral resources that are available in their own communities to assist abused women. This table contains suggested categories for inclusion.

RESOURCE	CONTACT	TELEPHONE/ADDRESS	COMMENTS
POLICE			
SHELTERS			
■			
■			
■			
VICTIM ASSISTANCE/SERVICES			
■ Police based			
■ Court based			
■ Other			
SEXUAL ASSAULT SUPPORT			
■			
■			
WOMEN'S CENTRES			
■			
CRISIS TELEPHONE LINES			
■			
■			
MEDICAL SERVICES/HEALTH CARE			
■			
■			
WOMEN-CENTRED COUNSELLING			
■			
LEGAL ASSISTANCE			
■ Legal Aid			
■ Lawyer referral service			
■ Other			
ABORIGINAL SERVICES			
■			
■			
IMMIGRANT/REFUGEE SERVICE			
■			
INTERPRETATION SERVICES			
ETHNOCULTURAL ORGANIZATIONS THAT ADDRESS ABUSE ISSUES			
■			
CHILDREN'S AID SOCIETY			
■			
PROGRAMS FOR MEN WHO ABUSE WOMEN			
CLEARINGHOUSES/NETWORKS			
OTHER			

Adapted from: Health Canada (1999b). *A handbook for health and social services professionals responding to abuse during pregnancy.* Ottawa: Author. Reprinted with permission.

Appendix J: Educational Resources

This appendix contains resources that the panel identified as useful but it should not be considered an inclusive or comprehensive list.

Videos

1) *It's Not Like I Hit Her*

Hillary Jones-Farrow and Judith Blackwell. Directed by Hillary Jones-Farrow

Produced for Victoria Family Violence Prevention Society by Educating Toward Change Society, 2541 Empire Street, Victoria, BC. Phone: 250-380-1955

Available: Kinetic Inc., 511 Bloor Street West, Toronto, ON, M5S 1Y4.
Phone: 1-800-263-6910 or 416-538-6613 Fax: 416-538-9984 http://www.kineticvideo.com

We all recognize that physical abuse is wrong, but what about the more subtle forms of emotional abuse? Emotional abuse can destroy self-esteem through a pervasive, constant campaign of criticism, isolation, and intimidation. In *It's Not Like I Hit Her*, actors portray scenes based on real life stories, which show the various forms emotional abuse may take. Recovering male abusers explain how and why they used emotional abuse to control and demoralize their women partners, and women survivors reveal the damaging impact that emotional abuse had on their lives.

2) *One Hit Leads to Another*

Produced for Victoria Family Violence Prevention Society by Educating Toward Change Society, 2541 Empire Street, Victoria, BC. Phone: 250-380-1955

Available: Kinetic Inc., 511 Bloor Street West, Toronto, ON, M5S 1Y4.
Phone: 1-800-263-6910 or 416- 538-6613 Fax: 416- 538-9984 http://www.kineticvideo.com

In order to effectively relate its message about the true nature of spousal abuse this video makes use of superior and compelling dramatizations that keep viewers' attention. Men's chronic violence against women in relationships is about a whole lot more than just anger and stopping it takes a lot more than just saying NO!!!

3) *Time To Change*

Hillary Jones-Farrow and Judith Blackwell. Directed by Hillary Jones Farrow

Produced by Victoria Family Violence Prevention Society
2541 Empire Street, Victoria, BC. Phone: 250-380-1955

Available: Kinetic Inc., 511 Bloor Street West, Toronto, ON, M5S 1Y4.
Phone: 1-800-263-6910 or 416- 538-6613 Fax: 416-538-9984 http://www.kineticvideo.com

Time to Change is the sequel to *One Hit Leads to Another*. The docudrama explores the causes of family violence and the nature of group treatment options for men.

4) *The Voices of Survivors: Domestic Violence Survivors Educate Physicians*

Produced by: ACP-ASIM 1999 American College of Physicians – American Society of Internal Medicine, Philadelphia, PA

Available: American College of Physicians, Philadelphia, PA. Phone: 215- 351-2400 http://www.acponline.org

The Voices of Survivors points to the importance of screening and can be used to educate several health care disciplines.

5) *Universal Screening for Domestic Abuse as Standard of Practice: The Emergency Room Nurses' Experience*

Jude Poirier 2001

Available: Domestic Violence Program, Vancouver General Hospital: Vancouver, BC
Phone: 604-875-4924 or vlymburn@vanhosp.bc.ca

6) *Woman Abuse Training Video*

Produced by the Ontario Network of Sexual Assault / Domestic Violence Treatment Centres
Available: http://www.satcontario.com Phone: 416-323-6400 x4472

An 11-minute video aimed at educating health professionals on woman abuse as a health issue; a diversity of women and health providers are shown in different situations illustrating woman abuse and responses by the health care system. Screening questions, responses and resources in the community are presented. The health care setting shown is in the hospital and emergency department vs. the community but the content is applicable to both settings.

Websites

College of Nurses of Ontario. Fact Sheet: Quality Assurance Reflective Practice
http://www.cno.org/docs/qa/44008_fsRefprac.pdf

Department of Justice – Family Violence
http://canada.justice.gc.ca/en/ps/fm/index.html

National Clearinghouse on Family Violence
http://www.hc-sc.gc.ca/hppb/familyviolence

Ontario Women's Directorate
www.gov.on.ca/citizenship/owd/index.html

Sexual Assault/Domestic Violence Treatment Centres in Ontario
http://www.satcontario.com

Statistics Canada
http://www.statcan.ca

Statistics Canada – Statistics on Family Violence
http://www.statcan.ca:8096/bsolc/english/bsolc?catno=85-224-X

The Ontario Network of Sexual Assault and Domestic Violence Care and Treatment Centres
http://www.sacc.to/gylb/satc/Listing.asp?ProvinceID=9

Appendix K: Teaching Scenarios

Scenarios for Screening for Woman Abuse – Orientation/Professional Development Session

1. Public Health Scenario

You are the Public Health Nurse (PHN) assigned to a local high school. A 17-year-old student comes to see you. She presents with a sore throat and cold and asks what she could do to feel better. You give her general advice about how to take care of herself.

As a means to get to know the student better, you ask about her general health, how her courses at school are going, her friends, and whether she is in an intimate relationship. You invite her to address any other concerns she might have at this time. The young woman asks about condoms and talks about difficulties with her present method of birth control.

How would you screen for woman abuse in this interview?

If the student answered "yes" to your screening question, how would you follow up?

2. Hospital Scenario

You are a triage nurse in an emergency department of a hospital. A woman arrives in obvious distress accompanied by her husband. The woman is hyperventilating, and keeps saying, "I can't breathe". The husband states his wife has a history of anxiety attacks, and "often has to come to the Emergency Department to get help, because she does this hyperventilating thing". He states she is depressed and was recently put on medication. He also states that in the past the doctor has given her a white pill to put under her tongue and sends her on her way and this usually helps.

You thank the husband for the information, reassure the patient and ask the husband to take a seat in the waiting room while you complete your assessment. The husband does not want to leave his wife's side. You explain that it is the hospital policy to have family wait in the waiting room until they find a room for the patient and settle her in. The husband again states he does not want to leave; "my wife needs me during these attacks". You again reiterate that the policy is to have the patient settled prior to allowing visitors or family in the room. You tell the husband, "Please take a seat in the waiting room, I will come and get you as soon as she is settled". The husband goes to the waiting room.

How would you screen for woman abuse in this interview in light of her husband's behaviour?

If the woman answered "no" to your screening question, how would you respond? How would you follow up?

If the woman answered "yes" to your screening question, how would you respond? How would you follow up?

Appendix L: Sample Policies

Sample Policy #1 – Organizational Policy

Source: Middlesex-London Health Unit, London, Ontario. Reprinted with permission.

PURPOSE

To ensure that staff in the relevant Services Areas understand their responsibility to identify and effectively respond to women who have been abused.

POLICY

Staff in the relevant Services Areas:

- Are knowledgeable about the dynamics of woman abuse, and its impact on the abused woman and her child(ren). (APPENDIX: STATEMENT OF BELIEFS ABOUT WOMAN ABUSE);
- Are skilled in responding effectively to disclosures of abuse;
- Are knowledgeable about community resources for abused women and their children; and
- Will, where appropriate, routinely screen all women over the age of 12 for woman abuse using the Routine Universal Comprehensive Screening (RUCS) Protocol.

PROCEDURE

1.0 Each Services Area will, where appropriate, develop procedures for the routine screening and early identification of woman abuse.

APPENDIX: STATEMENT OF BELIEFS ABOUT WOMAN ABUSE

We believe…

- All women have the right to live free of abuse.
- Woman abuse can result in significant physical and psychological harm, including death.
- Woman abuse is an abuse of power.
- Woman abuse is not the fault of the woman; offenders must be held accountable for their actions.
- Woman abuse is against the law.
- The safety of abused women and their children is the fundamental priority of intervention.
- Women who have been abused have options and the right to choose.
  At the same time, service workers have the responsibility to:
  i. create conditions where a woman is given an opportunity to make informed choices; and
  ii. assist in safety planning.
- Health care workers are not responsible for finding solutions to an incidence of woman abuse, but instead are a part of a coordinated community response.

Sample Policy #2 – Departmental/Unit Policy

Source: Middlesex-London Health Unit, London, Ontario. Reprinted with permission.

Purpose

To ensure that staff members are aware of roles and responsibilities related to the Routine Universal Comprehensive Screening Protocol (RUCS).

Policy

- All staff in Family Health Services comply with Organizational Policy (sample policy #1).
- All staff members working in Family Health Services understand the purpose of the RUCS protocol.
- All staff members implement the RUCS protocol with female clients, 12 and over, who receive a comprehensive assessment: Healthy Babies, Healthy Children Program, Child Health Program and Young Adult Program.

Procedures

1.0 Application of the RUCS Protocol for Public Health Nurses

1.1 Any female, 12 and over, who has a comprehensive assessment will be assessed for abuse. These would include the Healthy Babies, Healthy Children and the Child Health and Adolescent Programs.

1.2 During the intake assessment of a female client, 12 and over, the PHN routinely asks if the individual has experienced any form of abuse within the last year or at any time in her life. This assessment will be applied to all clients, whether they are new or are in a long term program.

1.3 The Public Health Nurse documents on the individual client record or log sheet that: (1) the question was asked and (2) the client response.

1.4 If abuse of a female client under the age of 12 has been disclosed, the PHN has a legal obligation to report this disclosure verbally to the Children's Aid Society (CAS).

1.5 Education about prevalence of woman abuse, the potential health impact and the types of abuse will be a part of this interview, regardless of disclosure. See p. 79-85 for information on types of abuse and the health effects. The degree and depth of the information shared will be determined by the client situation.

Sample Policy #2 – Departmental/Unit Policy: The Eight Types of Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

A bullet (♦) indicates actions that are clearly criminal acts, or may be criminal acts depending upon the circumstances (Martin & Younger-Lewis, 1997).

1. ♦ Emotional/psychological/verbal abuse

- being forced to do illegal things
- false accusations
- name calling, finding fault
- verbal threats
- yelling
- intimidation
- accused of being stupid
- playing on emotions
- disbelieving
- bringing up old issues
- inappropriate expression of jealousy
- degradation
- turning a situation against her
- brainwashing
- mockery
- silence
- refusal to do things with or for
- insistence on always being most important
- neglect
- expectation to conform to a role
- real or suggested involvement with other women
- invoking a sense of guilt
- certain mannerisms, such as finger snapping
- threats to get drunk or stoned unless…
- manipulation
- argumentative
- withholding of affection
- punishment by not sharing in household chores
- never forgiving, holding grudges
- lying
- treatment as though a child
- saying one thing, meaning another
- denying/taking away her responsibilities
- failure to keep commitments
- threats with the loss of immigration status
- deliberate creation of a mess for her to clean up
- threats to report her to the authorities

Sample Policy #2 – Departmental/Unit Policy: The Eight Types of Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

- forces her to drop charges
- tells jokes that belittle or indicate hatred toward women
- refusal to deal with issues
- minimizes her work or contribution
- puts pressure on her to stay while drugs or alcohol are being abused
- not coming home
- coming home drunk or stoned
- possesses pictures that indicate hate or violence again women
- egging her on, challenging her to engage in physical violence
- friendship or support of men who are abusive
- demands an accounting of her time and routine
- takes advantage of her fear of something
- puts her on a pedestal
- ridicules her food preferences
- threatens suicide unless…

Emotional abuse surrounding reproduction, pregnancy and childbirth

- refuses to allow or forces her to use contraception
- forces her to have an abortion
- refuses sex on the grounds that her pregnant body is ugly
- denies that the child is his
- refuses to provide support during the pregnancy
- refuses to provide support during the birth
- denies her access to the newborn child
- refuses to provide support or help out with the baby
- demands sex soon after childbirth
- places blame because the infant is the "wrong sex"
- refuses to allow her to breast-feed
- sulks/makes her feel bad for the time spent with the baby

2. Environmental abuse in home or vehicle

Home Abuse

- ♦ harms pets
- rips clothing
- locks her in or out
- throws/destroys her possessions
- slams doors
- throws objects or food
- denies her use of the phone
- punches walls
- mows over her garden

Sample Policy #2 – Departmental/Unit Policy: The Eight Types of Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

Vehicular Abuse

- ♦ drives too fast
- ♦ drives recklessly, pounding the steering wheel
- ♦ drives while intoxicated
- ♦ forces her into a vehicle
- ♦ pushes her out of a vehicle when it's in motion
- ♦ threatens to kill her by driving into an oncoming car, etc.
- ♦ chases/hits her with a vehicle
- ♦ kills/injures her in a deliberate accident
- ♦ hits her while she's driving
- - prohibits her from using a vehicle by tampering with the engine, taking the keys, etc.
- - puts his foot over hers on the gas pedal
- - grabs the steering wheel while she's driving

3. Social Abuse

- - controls what she does, who she sees and talks to, what she reads and where she goes
- - fails to pass on messages
- - puts her down/ignores her in public
- - blocks access to family or friends
- - interferes with her family or friends
- - change of personality with others
- - is rude to her friends or relatives
- - dictates her behaviour
- - habitually chooses friends, activities or work rather than being with her
- - makes a "scene" in public
- - makes her account for herself
- - censors her mail
- - treats her like a servant
- - refuses to give her space or privacy
- - insists on accompanying her into the doctor's office

Social abuse involving children

- ♦ assaults her in front of the children
- - initiates false child-abuse charges against her
- - makes her stay at home with the children
- - teaches children to abuse their mother through name calling, hitting, etc.
- - embarrasses her in front of the children
- - does not share responsibility for the children
- - threatens to abduct the children or tells her she'll never get custody
- - puts down her parenting ability

Sample Policy #2 – Departmental/Unit Policy: The Eight Types of Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

Social abuse during separation or divorce

- buys the children's affection with expensive gifts
- does not show up on time to pick up children or does not have them back on time
- pumps children for information about their mother's boyfriends, etc.
- tells children their mother is responsible for breaking up the family
- uses children to transport messages
- denies her access to the children
- fails to supply a valid phone number

4. Financial abuse

- ♦ takes her money
- ♦ forges her name
- gives her false receipts
- cancels her insurance
- sabotages her efforts to attain economic freedom
- withholds money
- spends money foolishly or beyond means
- pressures her to take full responsibility for finances
- does not pay fair share of bills
- does not spend money on special occasions
- spends money on addiction, gambling, sexual services
- pressures/controls her working conditions
- keeps family finances a secret
- prevents her from taking a job

5. Ritual abuse

- ♦ mutilation
- ♦ animal mutilation
- ♦ forced cannibalism
- ♦ human sacrifices
- suggests/promotes suicide
- forces her to participate in rituals
- forces her to witness rituals

6. Physical abuse

- ♦ any unwanted physical contact
- ♦ kicks, punches, pinches, pulls, pushes her
- ♦ slaps, hits, shakes her
- ♦ cuts, burns her
- ♦ pulls her hair, head butts
- ♦ squeezes her hand, twists her arm
- ♦ chokes, smothers her
- ♦ force-feeds her

Sample Policy #2 – Departmental/Unit Policy: The Eight Types of Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

- ♦ spits on her
- ♦ throws her or throws things at her
- ♦ hits with objects, whips her
- ♦ restrains her in any way
- ♦ urinates on her
- ♦ breaks her bones
- ♦ knifes, shoots her
- ♦ threatens to kill/injure her
- - ignores her illness or injury
- - denies/restricts food or drink, pressures/tricks her into alcohol or drug use
- - stands too close/intimidates her
- - hides/withholds necessary medication

7. Sexual abuse

- ♦ any unwanted sexual contact
- ♦ forces her to have sex; hounds her to have sex
- ♦ forces her to have sex with others, with animals
- ♦ utters threats to obtain sex
- ♦ pinches, slaps, grabs, pulls her breasts or genitals
- ♦ forces sex when she is sick, after childbirth or surgery
- - sleeps around
- - knowingly transmits sexual diseases
- - treats her as a sex object
- - pressures her to pose for pornographic photos
- - displays pornography that makes her feel uncomfortable
- - uses sex as the basis or solution for an argument
- - criticizes her sexual ability
- - unwanted fondling in public
- - purposely does not wash and expects sex
- - name calling (whore, slut, frigid, bitch)
- - accusations of affairs
- - degrades her body parts
- - tells sexual jokes or makes sexual comments in public
- - demands sex for drugs or alcohol, as payment or trade
- - administers drugs or alcohol for sexual advantage
- - insists on checking her body for sexual contact

8. Religious abuse

- - uses religion to justify abuse or dominance
- - uses church position to pressure for sex or favours
- - uses her, then demands forgiveness
- - prevents her from attending church
- - requires sex acts or drug use as religious acts
- - mocks her beliefs

Sample Policy #2 – Departmental/Unit Policy: Health Effects of Woman Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

Physical Health Effects:

- broken bones: wrist, rib, ring finger, jaw, clavicle, cheek
- brusies: bilateral or multiple contusions, arms, leg, buttocks, breasts, chest, abdomen, head, eyes, lips, cheeks, neck, back
- burns: cigarette burns, scalding, burns from stove/fireplace, acid
- cuts and stab wounds: anywhere on body
- abrasions: scrapes, friction burns, fingernail scratches or punctures, ring imprints, mouth cuts
- bites: often on breasts and other sexual areas, arms, legs, neck
- lacerations: on skin over bony areas, internal tearing
- concussions, skull fractures or "shaken adult syndrome"
- sprains
- perforated ear drums
- chipped or lost teeth
- loss of hair
- internal injuries
- chronic gastro-intestinal pain/discomfort
- irritable bowel syndrome
- chronic back, neck or other musculoskeletal pain
- chronic headache
- hypertension
- palpitations
- chronic hip or knee pain
- scarring
- detached retina
- voice box injuries
- firearm wounds
- hyperventilation
- substance abuse problems

Sexual Health Effects:

- sexually transmitted diseases, such as HIV
- miscarriages
- chronic pelvic pain, chronic vaginal or urinary tract infection
- bruising or tearing of the vagina or anus
- female genital mutilation
- frequent pregnancies (when contraindicated or unwanted)
- vaginismus
- early hysterectomy
- chronic genital or pelvic pain
- sexually addictive behaviour
- infertility

Sample Policy #2 – Departmental/Unit Policy: Health Effects of Woman Abuse

Source: Middlesex-London Health Unit, 2000. London, Ontario. Reprinted with permission.

Psychological Health Effects:

- low self-esteem
- self-abusive behaviour
- difficulty in forming and maintaining healthy relationships
- dysfunctional parenting
- acute anxiety
- frequent crying
- lack of appropriate boundaries
- arrested development (i.e., behaviours in adults that are infantile or adolescent as opposed to mature)
- sexual dysfunction/fear of sexual intimacy
- passivity
- evasiveness
- self-degradation
- uncommunicative
- unusual or pronounced fear responses
- hypervigilance
- chronic Stress
- uncontrolled or rapid anger responses
- insomnia/sleep disturbances/nightmares
- flashbacks
- phobias
- memory loss
- loss of concentration and productivity

Psychiatric Health Effects:

- depression
- suicidal ideation
- dissociation
- eating disorders
- post traumatic stress syndrome
- adjustment disorder with depressed mood
- obsessive compulsive disorder

Sample Policy #3 – Hospital Emergency Room Policy

Source: Cornwall Community Hospital (2000). *Partner Abuse Sexual Assault Care Team Policy and Procedure Manual.* Cornwall, Ontario. Reprinted with permission.

The Hospital Emergency Department conducts routine universal screening for domestic violence. When it is a case of intimate partner abuse, the patient is referred to the Partner Abuse Sexual Assault Care Team.

Universal Screening:

- To document reason for Emergency Department visit.
- To recognize and refer to appropriate resources.
- Because most victims of domestic violence who present to hospitals report that if asked, they would be prepared to discuss their history of abuse.
- Because earlier intervention is likely to increase the probability of stopping the violence before it escalates to more serious harm.

Indicators of Partner Abuse:

- Delay in coming in for treatment;
- Injuries not consistent with story;
- Overbearing partner;
- Partner answering for patient or controlling visit, and insisting patient not be seen alone;
- Repeat ER visits with physical complaints;
- Lacking physical etiology after investigation;
- Demonstrated fear of partner, worrying about timelines in relation to partner;
- Child abuse – children in ER; and
- Poor medical care (e.g., old injuries).

Sample Policy #3 – Hospital Emergency Room Policy

Procedure:

I. The triage nurse shall ask all individuals about abuse/violence in routine assessment/treatment. The following question is an example:
   I.1. "It is our duty to be patient advocates and screen for abuse. We know that many individuals experience problems in relationships, which can result in health problems. Are you in a relationship with someone who threatens to or has hurt you in any way?"

II. It is not necessary to ask the above question verbatim providing that the central screening message is clear.

III. If the triage nurse is unable to complete this task s(he) will ensure that the patient is screened before leaving the emergency department.

IV. The nurse shall:
   IV.1. Interview the patient alone;
   IV.2. Convey that the patient is believed; and
   IV.3. Convey an attitude of concern, respect and confidentiality.

V. If abuse is strongly suspected ask: "I'm concerned about how you got these injuries. Did someone do this to you?" or "We often see injuries/symptoms like yours when a patient has been hurt by a spouse/partner. Is this happening to you?"
   V.1. Offer the Partner Abuse Sexual Assault Care Team (PASACT)

VI. If patient refuses the PASACT:
   VI.1. Let the patient know that abuse is a crime that she/he is not alone and it is not her/his fault
   VI.2. Assess immediate safety of the patient and develop safety plan – use OPP handout (can be obtained from local OPP department);
   VI.3. Provide patient with list of community resources; and
   VI.4. Document information on patient's chart and complete the Domestic Violence screening form with the patient's consent.

Appendix M: Description of the Toolkit

Toolkit: Implementation of Clinical Practice Guidelines

Best practice guidelines can only be successfully implemented if there are adequate planning, resources, organizational and administrative support as well as appropriate facilitation. In this light, RNAO, through a panel of nurses, researchers and administrators has developed *Toolkit: Implementation of Clinical Practice Guidelines* based on available evidence, theoretical perspectives and consensus. The *Toolkit* is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

The *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. Specifically, the *Toolkit* addresses the following key steps in implementing a guideline:

1. Identifying a well-developed, evidence-based clinical practice guideline
2. Identification, assessment and engagement of stakeholders
3. Assessment of environmental readiness for guideline implementation
4. Identifying and planning evidence-based implementation strategies
5. Planning and implementing evaluation
6. Identifying and securing required resources for implementation

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process.

The *Toolkit* is available through the Registered Nurses' Association of Ontario. The document is available in a bound format for a nominal fee, and is also available free of charge from the RNAO website. For more information, an order form or to download the *Toolkit*, please visit the RNAO website at www.rnao.org/bestpractices.

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Nursing Best Practice Guidelines

Woman Abuse: Screening, Identification and Initial Response

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