



best start
meilleur départ

Ontario's maternal, newborn and early
child development resource centre
Centre de ressources sur la maternité,
les nouveau-nés et le développement
des jeunes enfants de l'Ontario



Woman Abuse in the Perinatal Period

A Resource for Healthcare Providers



Slide and Script Package



Dear Colleague,

This 'slide and script' package is provided for use, in whole or in part, when developing or offering educational opportunities to health care and community service providers. It has been presented in this format to provide background information and select references. A companion PowerPoint presentation is also available.

Funding provided by the Government of Ontario.

The views expressed herein are those of the Woman Abuse in the Perinatal Period Project Advisory and Steering Groups (PPESO) and do not necessarily reflect those of the Government of Ontario.



Woman Abuse in the Perinatal Period A Silent Epidemic

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Many individuals and organizations were instrumental in the development of this resource and it is the result of the collaborative efforts of the following individuals: Ontario Women's Directorate; Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre; Perinatal Partnership of Eastern & Southeastern Ontario (PPPEO) Steering and Advisory Groups; the committee responsible for development of PPPEO's Woman Abuse guidelines; and colleagues at RNAO.

Funding for this initiative is provided by the Ontario Women's Directorate. The views expressed herein are those of the Perinatal Partnership Program of Eastern and Southeastern Ontario (PPPEO) and do not necessarily reflect those of the Government of Ontario.

Agenda

- Woman Abuse - An Overview
 - Prevalence & dynamics
 - Health consequences
 - Barriers to care
- Role of Health Care Providers
 - Screening
 - Initial Response
 - Referrals and Community Resources
 - Documentation
 - The Legal System

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Agenda

- Strategies for Health Care Providers
 - Best Practice Guidelines
 - Policies and Procedures
 - Diverse Settings and Populations
 - Community Development
- Vicarious Trauma
- Wrap-Up

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We would like to acknowledge that this is a difficult subject to discuss and to hear about; and it is very likely that a number of us in the room have experienced violence first hand, have a friend or family member who has experienced abuse or a client who we remember. The discussion today may trigger unpleasant memories and/or feelings. If this is indeed the case, please do whatever you need to do to keep yourself safe and feeling comfortable. We are concerned about you and if you felt it necessary to leave, please let someone know how you are doing.

“Violence has become so pervasive in our society that it is looked upon as, if not exactly normal, perhaps inevitable.”

Ontario Public Health Association -
A Public Health Approach To Violence Prevention

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Definition

Woman abuse involves the intent to intimidate a woman, either by actual or by threat of physical, sexual, financial or emotional abuse, by someone with whom she has an intimate, family or romantic relationship. An intimate partner includes: husband, common-law partner, boyfriend, or same sex partner, as well as ex-husband, ex-partner, or ex-boyfriend.

Best Practice Guidelines, Ontario Hospital Association, 1999
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Woman Abuse is also known as: spousal abuse, partner abuse, domestic violence, family violence and intimate partner violence.

“Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life.”

United Nations Declaration On Violence Against Women

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IT IS NOT JUST PHYSICAL ABUSE

United Nations Declaration states, “Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared to men” & is a human rights issue.

Woman abuse is an issue of control and power. The vast majority of domestic violence is violence perpetrated by men against women. There is however, violence perpetrated by women against women, women against men, and men against men. The discussion today will concentrate on violence perpetrated by men against woman.

Violence:

1. is (*or may be*) life threatening.
2. has no place in the family or in the community.
3. is learned behaviour. It can, therefore, be changed.
4. is a choice.
5. is a power issue.
6. is never justified. No behaviour of any woman justifies or provokes violence.
7. is never the responsibility of the woman being abused. Responsibility for violence rests with the batterer.
8. does not stem from “loss of control”. Control is what the batterer wants.
9. occurs in all classes, races, and cultural groups.
10. is a crime.

VIOLENCE AGAINST WOMEN IS NEVER JUSTIFIED OR ACCEPTABLE.

IT IS A CRIME.

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This list is found on the Education Wife Assault website (http://www.womanabuseprevention.com/html/about_abuse.html).

Education Wife Assault’s mission is ‘to inform and educate the community about the issue of wife assault/woman abuse in order to decrease the incidence of physical, psychological, emotional and sexual violence against women and the effect that woman abuse has on children’.

Woman Abuse ...

- is a social, health, economic and legal issue
- uses isolation and male privilege to gain power and control over a woman
- during pregnancy has been well documented as a major health concern to both mother and her unborn baby

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Prevalence



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Violence affects all women regardless of culture, class, ethnicity, ability, occupation or sexual orientation.

Canadian Violence against Women Survey

12,300 Canadian women >18 years of age

- **51%** of women over the age of sixteen reported at least one incident of physical or sexual assault (in their life)
- **29%** reported having been physically or sexually abused by their partner at some point in the relationship
- **56%** of abused women were aged 18-34

VAWS, 1993

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The Statistics Canada 1993 Violence Against Women Survey randomly selected 12,300 women over 18 years of age, interviewed them by telephone about their experiences with violence and found that:

- One-half of all Canadian women have experienced at least one incident of violence since the age of 16.
- One in four Canadian women were victims of assault by a spouse or partner.
- Four in ten Canadian women were victims of sexual assault.

The Statistics Canada *Homicide in Canada 2000* reported that women were the victims in three of four spousal murders

General Social Survey 1999

- Telephone results of 26,000 respondents over the age of 15 years of age
 - 14,269 women & 11,607 men
- Experiences of violence within
 - a confined time (12 months & 5 years) and
 - a spousal relationship.
- Self report

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Jiwani, Y. (2000). The 1999 General Social Survey on spousal violence: An analysis.
<http://www.harbour.sfu.ca/freda/reports/gss01.htm>

Recommend that participants read the above document. Jiwani cautions re: the interpretation of the results and states that the GSS findings 'are startling' in light of other studies' findings.

Definition of violence was derived from acts defined and described in the *Criminal Code* and therefore does not include sexual harassment and emotional abuse, nor does it track violence against pregnant women, focuses on a finite time and in the context of a spousal relationship.

Findings

- Similar rate of spousal abuse among women and men

HOWEVER,

Women experience more severe forms of abuse, impact of abuse is greater and severity of abuse outweighs the kinds of violence experienced by male spouses

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The GSS findings reveal that the rates of spousal violence experienced by men & women were only slightly different (8% for women, & 7% for men in relationships five years prior; 4% for both women and men in current relationships). At a superficial level, the findings suggest that women & men are equally violent, thus feeding the backlash against the experiences/observations of frontline workers, academics, and policy-makers (Jiwani, 2000). However, others have found the following: 3.4 wives are murdered for every 1 husband killed (Locke, 2000), 98% of sexual assaults & 86% of violent crimes are committed by men (Johnson, 1996); women constitute 98% of spousal violence victims of sexual assault, kidnapping or hostage taking (Fitzgerald, 1999); 80% of victims of criminal harassment are women while 90% of the accused are men (Kong, 1996)

General Social Survey 2004

- Women continue to experience more severe violence than men
- Spousal violence not likely to be an isolated event
- Women are more likely to be injured and fear for their life
- Relation between emotional abuse & violence
 - emotional abuse/controlling behaviours often precursors to physical violence

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Unfortunately ...

Reported figures will not necessarily reflect the true prevalence as many incidents go unreported and undetected

(Health Canada, 1998)



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Health Canada (1998). A handbook for health and social service professionals responding to abuse during pregnancy. Author.

Abuse during Pregnancy

- ~**40%** of cases, abuse began during pregnancy (VAWS, 1993)
- **21%** of women were abused *during* pregnancy (VAWS, 1993)
- **95%** of women who were abused in the first trimester were also abused in the 3-month period after delivery (Stewart, 1994)

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Pregnancy is a time of change in a relationship. It is also a time when the incidence and nature of violence may also change. Violence may begin during pregnancy. Women may experience more severe or specifically targeted forms of violence when they are pregnant (Stewart, 1994). If a woman is abused prior to and during a pregnancy, the abuse is likely to continue after the pregnancy (Stewart, 1994). Campbell, Soeken, Oliver & Bullock (1998) have found pregnancy to be a protective period for abuse.

VAWS = Violence against Women Survey

A look at some of the literature



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Women abused during pregnancy were **4x** more likely as other abused women to report having experienced very serious violence

i.e. beaten up, choked, threatened with a gun/knife or sexually assaulted

Of women who were abused during pregnancy, ~**100,000** reported they suffered a miscarriage or other internal injuries as a result of abuse (Johnson, 1996)

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Johnson, H. (1996). Dangerous domains: Violence against women in Canada. Scarborough: Nelson Canada.

Associated Factors

- 'Social instability'
 - Young, unmarried, lower level of education, unemployment, unplanned pregnancy
- 'Unhealthy lifestyle'
 - Poor diet, alcohol use, illicit drug use, emotional problems
- 'Physical health problems'
 - Health problems, prescription drug use

(Stewart & Cecutti, 1993)

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548 women interviewed - 6.6% reported abuse in current pregnancy and 10.9% before it
 63.9% remained with the abuser
 66.7% received medical treatment for abuse
 2.8% (n=1) told prenatal care provider about the abuse
 Women who were abused:
 1) were significantly more emotionally distressed than non-abused women and
 2) had little 'internal control' over the health of their fetuses and 'chance' played the most important role in the outcome of their pregnancy

Stewart, D.E., & Cecutti, A. (1993). Physical abuse in pregnancy. *CMAJ*, 149(9), 1257-1263.

- Abuse during pregnancy was 5.7%
 - perpetrated by husband, boyfriend, ex-husband
- Indicators of high-risk
 - Aboriginal women
 - Partner with a drinking problem
 - Perceived stress & negative life events
 - Minimal support networks

(Muhajarine & D'Arcy, 1999)

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Muhajarine, N., & D'Arcy, C. (1999). Physical abuse during pregnancy: Prevalence and risk factors. *CMAJ*, 160(7), 1007-1011.

Abuse during Pregnancy

- Common sites
 - Head, neck, abdominal region
(McFarlane, 1993; Purwar et al., 1999)
- Stewart & Cecutti (1993) found
 - Abdomen (63.9%)
 - Buttocks (13.9%)
 - Head/neck and extremities (11.1%)
- 67% of women were struck on more than one body part (Stewart & Cecutti, 1993)

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It's not just physical ...

- Emotional Trauma
- Survivors of childhood sexual abuse
 - Physical signs
 - Psychological signs
 - Dissociative Disorders
 - Repressed memories
- May be triggered by labour & birth experiences

Hobbins, 2004

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Hobbins, D. (2004). Survivors of childhood sexual abuse: Implications for perinatal nursing care. *JOGNN*, 33(4), 485-497.

*After adjusting for significant demographic factors (age, ethnicity, education, relationship status) the risk of becoming an attempted or completed femicide victim was **3-fold** higher in women who were abused during pregnancy*

(McFarlane et al., 2002)

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One can see from the above statistics that the both the incidence and prevalence may vary depending upon the setting, parameters used to define abuse or the time period in question and the instruments used. One must critically appraise the studies. However, the variation in statistics should not be taken to minimize the issue. There are many sources that report and recognize the magnitude of this issue.

A 'Window of Opportunity'



'If abuse during pregnancy is predictive of severe and potentially lethal abuse, pregnant women should be so advised

(McFarlane et al., 2002, p. 28)

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Pregnancy has been recognized as a significant risk factor for homicide/femicide (Campbell et al., 1998; McFarlane et al., 1995; McFarlane et al., 2002).

Winnipeg Free Press (Aug 7th, 2005)

- Homicide forms now specifying whether murdered women were pregnant
- Centers for Disease Control study (2005) concluded that homicide is a leading cause of pregnancy associated death in the US
 - Second only to motor vehicle accidents

'For every woman who's been murdered, there are more women who are living in terror ...' C. Varcoe

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Winnipeg Free Press (Aug 7th, 2005)

- Risk of femicide increases when:
 - The man has access to a gun
 - The man has made previous threats
 - There is a step-child living in the home
 - The woman is estranged from the man
- Financial policies that support women are crucial as the main barrier to leaving is economic dependency

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Did you know...

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

(Modeland, Bolaria & McKenna, 1995; Peterson et al., 1997)

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In: Health Canada (1998). A handbook for health and social service professionals responding to abuse during pregnancy. Author.

And ...

The College of Family Physicians of Canada found that....

assaults resulted in more pregnancy complications than motor vehicle accidents or falls

Therefore recommended universal screening

(2000)

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Lent, B., Morris, P., & Rechner, S. (2000). Discussion paper, January 28, 2000.
<http://www.cfpc.ca/english/cfpc/programs/patient%20care/maternity/violence/default.asp>

Risk Factors for Abuse

- Past history of abuse strongest predictor
- Social instability
- Unhealthy lifestyle
 - substance misuse (smoking, drinking, drug use) poor nutrition, stress
- Physical and/or psychological health problems
- Delayed prenatal care



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Factors associated with social instability were:

1) being young; 2) unmarried; 3) not completed high school; 4) unemployed; and 5) unplanned pregnancy.

Other risk factors for abuse are: a partner who drinks or a partner exposed to violence against his mother.

By articulating these risk factors, it is not intended to assign blame to the woman or hold the woman responsible for the situation in which she finds herself – they simply are factors that have been associated with an increased risk for experience abuse.

Health Impact

- General
- Reproductive
- Fetal/Neonatal



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General

- physical trauma and injuries
- stress/anxiety disorders
- depression (including suicidal ideation)
- somatic disorders
- substance abuse
- eating and sleeping disorders
- worsening of chronic medical conditions
- chronic pain
- mental health issues

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Reproductive

- sexually transmitted infections (STIs)
- unprotected intercourse
- unwanted pregnancies
- spontaneous abortions
- inadequate prenatal care
- complications during delivery
- infertility secondary to STIs

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Other reproductive consequences of woman abuse are:

- a) lack of control over decision-making
- b) psychological reaction(s) to past abuse during labour and delivery
- c) sexual assault/forced sexual intercourse

Penny Simkin has written extensively about the birth experience of survivors of childhood sexual abuse. A synopsis of her video *When Survivors Give Birth* (1995) is available at the following link:

<http://www.gentlebirth.org/archives/pennynot.html>

Fetal & Neonatal

- placental abruption
- poor fetal growth (maternal nutrition)
- preterm labour and/or delivery
- fetal injury (fractures/hemorrhage)
- fetal death
- neonatal infection secondary to STIs
- neonatal death
- ↓ in breastfeeding initiation & duration
- bonding/attachment issues

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Additional fetal/neonatal effect are: severe blunt trauma to the abdomen leading to: 1) spontaneous abortion; 2) fetal death; 3) placental abruption; 4) preterm labour & delivery; 5) low birth weight; 6) skull fractures, ICH and bone fractures (College of Family Physicians of Canada (CFPC), 2000; Peterson et al., 1997). LBW is usually secondary to smoking, alcohol, low SES, poor maternal weight gain, stress and lack of support (College of Family Physicians of Canada Discussion Paper, 2000)

Systematic review of literature (Peterson et al., 1997) failed to demonstrate consistent relationship between violence during pregnancy and adverse pregnancy outcomes. Some studies showed a difference between mean BW and incidence of LBW.

The Cost of Woman Abuse



\$4.2 BILLION
annually

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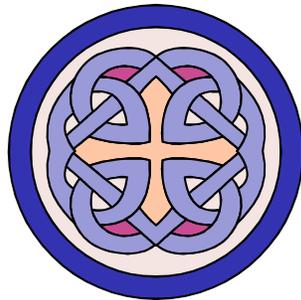
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Center for Research On Violence Against Women and Children Study, 1995

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This study looked at 3 forms of violence against women & children in London, ON: sexual assault/rape; abuse in intimate partnerships; and incest/childhood sexual assault as well as four policy areas: 1) health/medicine, 2) criminal justice, 3) social services/education & 4) labour/employment. Costs estimated at a minimum, to be 4.2 billion dollars annually, 88% of which are paid through tax dollars. **The data clearly indicate that: woman abuse is an urgent public health issue that occurs in epidemic proportions in Canada.** An integrated public health approach based on early identification (universal screening), effective treatment and prevention is long overdue

Centre for Research On Violence Against Women & Children Study (1995),
London, ON

Dynamics of Abuse



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Dynamics

- Abuse is related to power and control
- Abuse is a systematic pattern of behaviour
- Women have the right to make choices about disclosing the abuse, as well as, how and when to accept help

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Violence:

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VIOLENCE AGAINST WOMEN IS NEVER JUSTIFIED OR ACCEPTABLE.

IT IS A CRIME.

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This information has been presented previously. The bolded items speak to the dynamics of abuse.

http://www.womanabuseprevention.com/html/about_abuse.html

Reasons for Staying

- Fear
 - Of losing children
 - Of increased violence
 - Reaction of others
 - Not being believed
- Isolation
- Belief system
- Remorse & regret
 - shown by abuser
- Limited resources
 - lack of employment or education skills
 - lack of financial resources
- Pregnant
 - wonders how she will cope alone
 - hopeful re: future
- Self-esteem issues

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Fear: she will not be believed; will have to leave familiar community (very important for women in small/rural communities); safety – hers and abuser’s (especially if leaving relationship as there is Increased violence); that children will be taken away; deportation

Isolation: from support system, community resources

Belief system (religious, cultural): pressure by family or community to stay with the abuser; abuse as normal or her fault; reluctance to deny her children their father

Self-esteem issues: lack of power and control in her life

Further and fundamentally, the woman loves the abuser.

<http://www.owjn.org/issues/w-abuse/why.htm>

Some other reasons ...

Family, religious or social pressure to stay

Learned helplessness Denial

Guilt/responsibility Wanting to help/pity

Security Love Shame

Ontario Women's Justice Network

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From: <http://www.owjn.org/issues/w-abuse/why.htm>



Barriers to Care

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Barriers to Care

- Provider
- Client
- Institution/Agency
- Fear
- Access
- Time
- Lack of resources

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Women may avoid care as they don't want abuse to come to light.

Fear of:
repercussions – from the abuser
losing children

Access - unable to or denied access to health care

Language – inability to speak French or English

Cultural beliefs/traditions or acceptable behaviours

Geography – rural/isolated

Barriers - Provider

- Subject 'too close for comfort'
- Personal discomfort
- Too personal
- Individual will be offended
- Lack of education/training
- Lack of time to screen and respond
- Futility of screening
- Client will not disclose
- Repercussions of mandatory reporting laws

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Kimberg (2001) outlines the attitudes and reluctance of health care providers to ask questions about abuse. She states that it is a matter of not completely understanding the issue.

Kimberg, L. (2001). Addressing intimate partner violence in primary care practice. *Medscape General Medicine* 3(1).

Barriers - Client

- Fear of retaliation (perpetrator)
- Access to care denied (or fragmented)
- Low self esteem; Shame
- Fear loss of custody
- Family responsibilities
- Socioeconomic barriers
- Healthcare provider seen as 'too busy'
- Negative attitudes of healthcare provider
- Fear of police involvement

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Women may not disclose for a number of reasons – some of which are presented herein. The issue of abuse may not even come to light, as women wish to keep the abuse from being discovered. They either do not access care or visit many different clinics and practitioner (fragmented care).

Interestingly, 50-75% of female patients from clinical settings feel asking about abuse is acceptable and should take place (McFarlane et al., 2002)

Barriers – Institution/Agency

- Lack of training for HCP
- Lack of uniform standards
- Lack of funding for research
- Multiple research issues
- Lack of resources for treatment, prevention
- Legal issues (mandatory reporting)
- Environment not conducive to safe screening

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Solutions & Strategies

- Practice based interventions, outreach visits
- Routine questions
- Standardized tools
- Protocols
- Champions
- Quality improvement initiatives
- On-site counselling
- Posters, buttons, information

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Did you know ...

- a woman will be asked at least 6-8 times before she will disclose abuse
- a woman will be abused at least 28 times before a report to the police is made

(Jaffe & Burris, 1981)

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Role of Healthcare Providers

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Canadian Public Health Association

Violence in Society: Policy Statement

- ✓ Acknowledge violence as a priority issue in the health sector
- ✓ Establish a national health goal on violence
- ✓ Develop new programs to address social and economic inequality
- ✓ Support healthy, violence-free communities
- ✓ Advocate/offer effective treatment
- ✓ Mandatory education for health professionals
- ✓ Document the extent and effects of violence

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(1994) 48

Canadian Public Health Association. (1994). Violence in society: A public health perspective. (Policy & Advocacy – policy statements)
<http://www.cpha.ca/english/policy/pstatem/violenc/page1.htm>

Role of Health Care Providers

Two Types of Responsibility

'Frontline'

1. Awareness
2. Assessment
3. Screening
4. Safety
5. Response

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'Behind the Scenes'

1. Policies & Procedures
2. Staff education
3. Mentoring
4. Partnerships

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All health care providers (HCPs) should be educated about woman abuse. Basic education should consist of the following elements:

Prevalence, Dynamics and Health Consequences
 Screening
 Initial Response to Disclosure and Non-disclosure
 Documentation
 Mandatory Reporting (The Legal System)
 Referrals and Community Resources

Policies/procedures/protocols should be developed within each institution/agency in accordance with their own guidelines. The process of responding to woman abuse in the perinatal period also includes the creation of a practice environment that encourages the identification of abuse (Guest, 2000).

Role of Health Care Providers

- Awareness of the signs of abuse
- Identification of cases of abuse through routine, universal & comprehensive screening
- Ability to deal with disclosure including:
 - appropriate intervention
 - support and referral
- **Safety planning**
 - for the woman, her children and HCP

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When responding appropriately to disclosure, HCPs should: believe the woman, assess immediate health needs, assess immediate safety and complete a safety check, explore immediate concerns, and provide referrals (with the woman's consent) to resources, community services (RNAO BPG, 2005). The HCP can certainly consult colleagues with expertise in the area and should be aware of key individuals within the institution and/or community with expertise in the dynamics of abuse.

Role of Health Care Providers

- Development of written resources and policies/protocols/procedures
- Staff education and support
 - How to ask the question
 - How to intervene appropriately
- Linkages with community resources to provide continuity of care & ongoing support

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Health care providers (RNs, SW, MDs, etc.) are part of an integrated response to woman abuse and should not feel that as an individual they are expected to respond to this issue without the expertise and support of colleagues.

Screening should occur in all health care settings: ERs, primary care settings, walk-in clinics, prenatal classes, obstetrical units, post-partum units and/or neonatal intensive care units, dental offices to name a few.

Recommendations

- 1. Routine, universal and comprehensive screening for woman abuse become the standard of care throughout the region.**
2. Each woman is asked about the presence of violence in her life, especially during the perinatal period. Questions should be raised in a variety of ways and a variety of settings.
- 3. The safety of the woman and any dependent children be assessed whether or not disclosure has been made.**
4. All healthcare providers recognize when the woman's health and safety are at risk and assist in safety planning whether or not a woman is planning to leave the relationship.

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From: PPPEO (2004). Woman abuse in the perinatal period: Guidelines for care providers. Author.

Recommendations

- 5. Healthcare facilities and community service agencies have policies in place to respond to disclosures of abuse.**
- 6. HCP are aware of their obligation to report any and all cases of alleged or suspected child abuse or neglect.**
- 7. Education about woman abuse, especially violence in the perinatal period be addressed in a number of forums.**
8. While recognizing the constraints of the healthcare system, HCP carefully consider whether they can competently care for the woman, the abuser and other family members in their practice. Diligent efforts should be made to refer one client to another provider.

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ABC's of Patient Care

- A – Alone
- B – Belief
- C – Confidentiality
- D – Documentation
- E – Education
- S - Safety

(AWHONN, 2003)

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ALONE: Reassure the woman that she is not alone, others have been in her position and that help is available; reminder to HCP to interview the woman alone
BELIEF: Articulate your belief in the woman, that you know the abuse is not her fault & nobody deserves to be hurt
CONFIDENTIALITY: Ensure the confidentiality of information provided (disclosed) & explain the mandatory reporting laws
DOCUMENTATION: Descriptive documentation with photos, taken with the woman's permission and a verbatim account from the patient's perspective is helpful to accurately capture and record the nature and extent of the injuries
EDUCATION: Know community resources/shelters where you can refer a woman for help. Ask if the woman knows how to obtain a restraining order
SAFETY: Tell the woman to call 911 if she is in imminent danger and to consider alerting neighbours to call the police if they hear or see signs of conflict (Adapted from AWHONN, 2005)

<h2>Confidentiality & Mandatory Reporting</h2> <ul style="list-style-type: none"> • Obligations related to reporting will differ • In Ontario, healthcare providers are mandated to report incidents of domestic violence to Family and Children's Services when there is the threat of abuse or neglect to children under the age of 16. • The woman should be made aware of the mandate to report. <p>2006 PPEESO D. Aylward 55</p>	<p>It is a violation of confidentiality to report a disclosure of abuse without the woman's consent if no threat to children.</p>
<h2>When children are involved</h2> <ul style="list-style-type: none"> • Children and Family Service Agencies and/or Children's Aid Society may be involved • Safety and protection of children is the first priority and mandate of the Children's Aid Society. <p>2006 PPEESO D. Aylward 56</p>	<p>Research indicates that children of all ages who are exposed to situations of family violence are at a higher risk of experiencing developmental lags, behavioural & emotional problems ranging from depression, isolation and withdrawal, to aggression and antisocial behaviours. The duration of the child's exposure to the violence, the nature and extent of the violence and the caregiver's response to the situation, significantly impacts children's ability to cope with parenting issues and adult relationships later in life. Child welfare legislation & the Risk Assessment Model for Child Protection in Ontario have determined that the exposure of children to situations of family violence warrants child welfare intervention. <i>(CASOC Policies and Procedures, "Management of Family Violence Cases", 02/20/02)</i></p>
<h2>Guiding Principles</h2> <ul style="list-style-type: none"> • Working together increases safety for women and children and decreases chances of re-victimization • Neither women nor children are responsible for changing the abuser's behaviour. • Children experience trauma in families where women are abused • Ensuring the safety of children is paramount <ul style="list-style-type: none"> – children are vulnerable & have the least power in our society • Increasing the safety of abused women will increase the safety and well being of children <p>2006 PPEESO D. Aylward 57</p>	<p>Perpetrators must be held accountable for their abusive behaviour. They may: physically or sexually abuse children; endanger children through neglect; prevent women from caring for the children, resulting in neglect; harm children by coercing them into abusing their mothers or adult caretakers; endanger children emotionally and physically by creating environments in which children witness assaults against their mothers; and/or endanger children by undermining the ability of community agencies to intervene and protect children. Perpetrators are responsible for the violence they inflict on their partner and the caustic and bewildering environment that surrounds the children.</p>

Family violence situations which are brought to the attention of Children's Aid Society's include, but are not limited to:

- 1) abusive behaviour by either partner within traditional married & common-law relationships;
- 2) same sex partnerships;
- 3) abuse by adults or older children towards other adults (grandparents/extended family); &
- 4) violence between older children residing in the home.

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These suggestions refer to situations involving children under the age of 16.



Screening

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Wathen and MacMillan (2002) state “(t)here is insufficient evidence to recommend for or against routine universal screening for violence against either pregnant or nonpregnant women ...; however, clinicians should be alert to signs and symptoms of potential abuse and may wish to ask about exposure to abuse during diagnostic evaluation of these patients” (p. 582).

Principles of routine, universal, comprehensive screening have been endorsed by a number of professional groups in Ontario. The Family Violence Prevention Fund’s Research Committee (2004) states (about screening) ‘we know of no research to suggest that assessment and /or interventions in health care setting are harmful to patients’ (p. 5.)

Recommendation 1: Screening

“With so many women experiencing abuse during pregnancy, screening for abuse during pregnancy must be **a routine part of prenatal care.**”



Health Canada, 1999

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It is a difficult question but IT NEEDS TO BE ASKED! Practitioners may wish to preface their question with the following: Because we know that violence against women is so common, I ask all my patients/clients the following question...

... within the past year, or since you have been pregnant, have you been threatened or physically hurt by anyone?

Other questions that may be posed: The injuries you have suggest to me that someone hit/hurt you. Is that possible? Are you afraid of your partner? Are you afraid to take your baby home?

RUCS Protocol

routine universal comprehensive

- Algorithm to address abuse
- If asked and answers no then...
- If asked and answers yes then...

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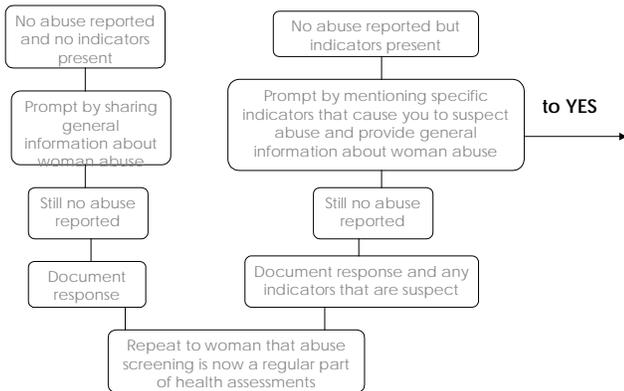
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Routine screening means that questions about abuse are raised on a regular basis whenever women come into contact with any healthcare provider, whether or not indicators of abuse are identified.

Universal screening means that every woman is asked about her current or past experience with abuse. Universal screening is paramount as it lends voice and visibility to the issue.

Comprehensive screening means that women are asked whether they have experienced (as children, adolescents or adults) or are currently experiencing any form of physical, sexual, and/or psychological abuse. (Middlesex-London Health Unit, 2002)

NO

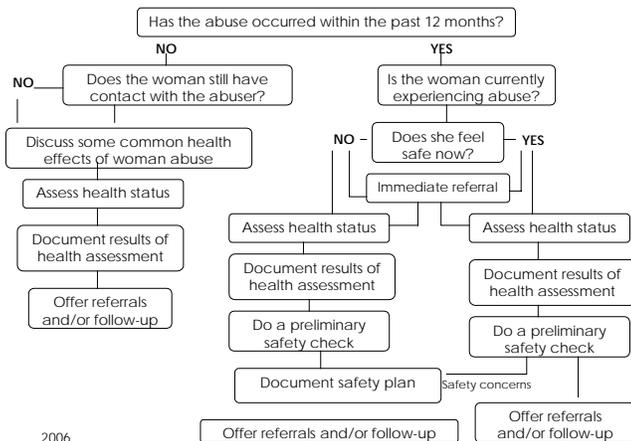


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YES



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Other Tools

- **WAST** (Brown et al., 2000)
- **ALPHA tool** (Reid et al., 1998)
 - Self report ALPHA
- **Danger Assessment Tool**
 - Campbell (1985, 1988, 2004)
 - Assesses the potential for homicide in clients
- **Abuse Assessment Screen**
 - Parker & McFarlane (1991)
 - Brief and effective in identifying abused women in clinical settings
- **Abuse Assessment Screen – Disability**

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All of these tools are provided within the resource package (see 7. Screening Tools)

Other references:

Brown, J. B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice*, 49(10), 896-903.

Brown, J. B., Lent, B., Brett, P. J., Sas, G., & Pederson, L. L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family Medicine*, 28(6), 422-428.

Most participants would recommend the routine use of the ALPHA form for all pregnant women
Of 238 psychosocial issues disclosed, significantly more were disclosed to MDs vs. PHNs
Suggestions on framing introductory questions included

Midmer, D., Carroll, J., Bryanton, J., & Stewart, D. (2002). From research to applications: The development of an antenatal psychosocial assessment tool. *Canadian Journal of Public Health*, 93(4), 291-296.

Reid, A. J., Biringer, A., Carroll, J. D., Midmer, D., Wilson, L. M., Chalmers, B., Stewart, D. E. (1998). Using the ALPHA form in practice to assess antenatal psychosocial health. *CMAJ*, 159(6), 677-684.

Midmer, D., Bryanton, J., & Brown, R. (2004). Assessing antenatal psychosocial health. Randomized controlled trial of two versions of the ALPHA form. *Canadian Family Physician*, 50, 80-87.

Disclosure ... or not

- **General Social Survey** (2004)
 - 22% of individuals had not told anyone about the violence until they disclosed to an interviewer over the phone for the above study
 - 73% of individuals confided in someone close to them (family member, friend, neighbour, co-worker, doctor, nurse, lawyer, clergy)
 - Women more likely to seek 'informal' sources of help and support (doctor/nurse)

2006

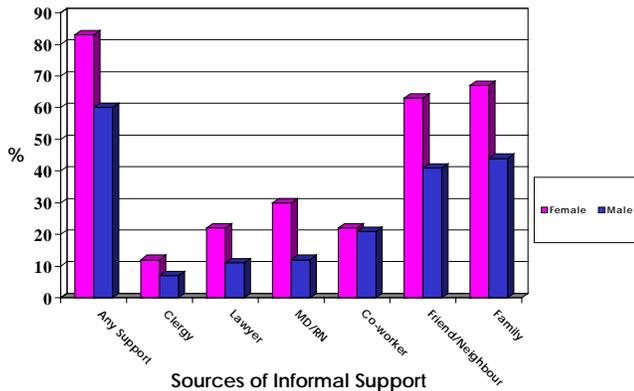
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From: Statistics Canada. (2005). Family violence in Canada: A statistical profile – 2005. Ottawa: Author.

10 questions posed to 1) married/CL respondents at time of survey or 2) married/CL in preceding 5 years and had had contact with ex-partner during that 5 years

Questions included both measures of physical and sexual violence as defined by the Criminal Code.

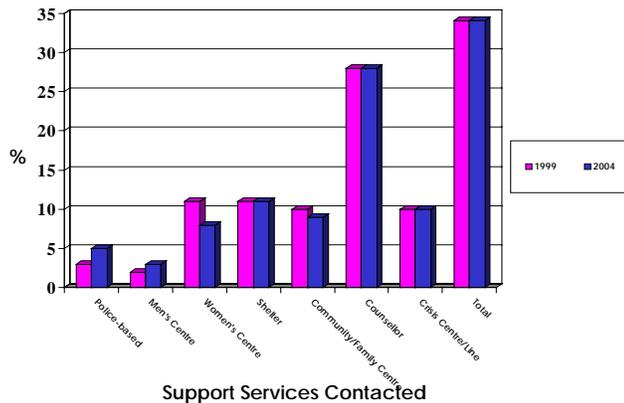


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Data from: From: Statistics Canada. (2005). Family violence in Canada: A statistical profile – 2005. Ottawa: Author.



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Data from: From: Statistics Canada. (2005). Family violence in Canada: A statistical profile – 2005. Ottawa: Author.

Majority of individuals experiencing abuse do not seek help from formal agencies or organizations because: 1) they did not need/want help from a social service agency, 2) they felt incident was too minor and 3) they didn't know such services existed or none was available.

Support for Screening...

Re: Universal Screening

Rates of disclosure might be improved if women are asked about abuse at the time they are asked about other social risk factors (i.e. within the context of a **medical** or **nursing** history)

(College of Family Physicians of Canada, 2000)

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Lent., B., Morris, P., & Rechner, S. (2000). Discussion paper, January 28, 2000.

<http://www.cfpc.ca/english/cfpc/programs/patient%20care/maternity/violence/default.asp>



Initial Response

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Initial Response

4 components

1. Messages of support
2. Education
3. Safety planning
4. Referrals



(Kimberg, 2001)

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Do...

- Believe the woman's account
- Let her know that help is available
- Ensure safety
- Help her to identify her options
- Listen and validate
- Show concern and respect
- Respect confidentiality*
- Document accurately & comprehensively
- Offer in-house and community resources

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- 1) Tell her that the abuse is not her fault
- 2) Use non-gender specific language (i.e. partner, significant other)
- 3) Believe and validate the woman & her experience
- 4) Make the woman aware that if there is any threat of abuse or neglect to children under the age of 16, as a professional, you are obligated to report.**

Do not...

- Ignore the disclosure
- Blame or shame the woman
- Screen women in the presence of others
- Use family members to interpret
- Sacrifice safety and confidentiality in the name of family-centred care
- Assume that you know what is best or what will keep the woman safe
- Take control or attempt to rescue
- Judge the woman's choices

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Do not judge past, present or future choices. Many factors impact on a woman's decision to stay in or leave the relationship. The woman knows her situation intimately; whereas, we as health care professionals do not. We can offer support and validation but must trust the woman's knowledge of her situation.

Interventions

- Efficacy (promote self-efficacy)
- Empower
- Educate
- Ensure Safety

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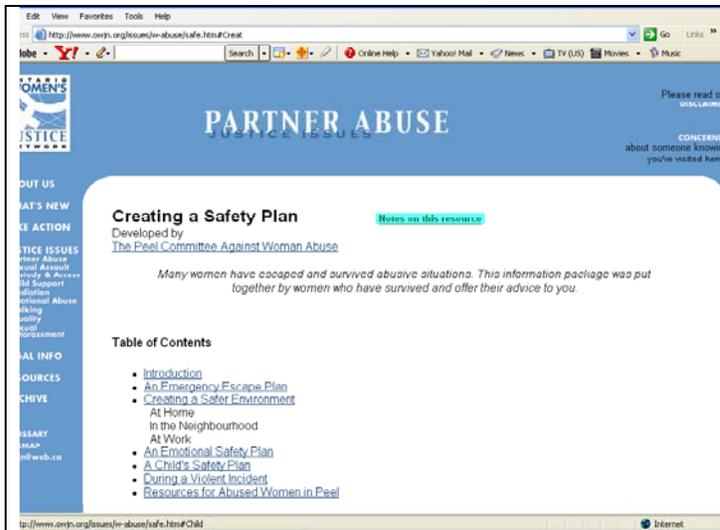
74

Re: self-efficacy: Interventions to help foster transition from abuse – retrieved August 14, 2003 from http://www.medscape.com/viewarticle/459382_3 Topics in Advanced Practice Nursing eJournal 3(3), 2003. Recommendations:

1. Screen
2. Define abuse for clients
3. Validate abuse
4. Give information
5. Always remember SAFETY is paramount
6. Refer
7. Review treatment options
8. Empower women
9. Encourage use of legal system

The screenshot shows a web browser window with the URL http://www.womanabuseprevention.com/html/safety_planning.html. The page has a red header with the text 'Education Wife Assault' and 'Safety Planning'. Below the header, there is a section titled 'Safety Planning In Situations Of Woman Abuse' with a list of links: 'Safety During An Explosive Incident', 'Safety When Preparing To Leave', 'Safety In Your Home', 'Safety With A Restraining Order', 'Your Safety & Emotional Health', 'Safety On The Job And In Public', 'If You Are A Teen In A Violent Dating Relationship', 'Checklist-What You Want To Take When You Leave', and 'Important Phone Numbers'. There is also a section titled 'Safety During An Explosive Incident' with bullet points: 'If an argument seems unavoidable, try to have it in a room or area that has access to an exit. Avoid the bathroom, kitchen or anywhere near weapons.', 'Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairs would be safe and easily accessible.', 'Have a packed bag ready. Keep it in a secret but accessible place in order to leave quickly.', 'Identify a neighbour you can tell about the violence and ask that they call the police if they hear a disturbance coming from your home.', and 'Make up a code word to use with your children, family, friends, and neighbours when you need the police.'

Canadian website dedicated to education about woman abuse. Member of the United Way; information about custody/access, different kinds of abuse, FAQs and safety planning. Information up to 2001. Provides links to following safety plans
Safety during a crisis
Safety when staying
Safety when planning to leave
Safety on your own
Safety at work
Personal supports and skills
Safety with a restraining order
Rural safety
http://www.womanabuseprevention.com/html/safety_planning.html



Ontario Women's Justice Network is an online legal resource for individuals and women's organization working on violence against women and children and related justice issues. Mandate is to 'demystify' the legal system. Legal information and resources are provided on the site. Information re: safety planning is also available.

www.owjn.org/index.htm
www.owjn.org/issues/w-abuse/safe.htm

Current as of January 5, 2006.



Sheltersnet is a multilingual website that provides information about abuse, shelters, internet safety and safety planning.

Safety Planning

- Avoid rooms with ↑ potential for violence
 - kitchen/bathroom
- Have a code word
- Teach children how to call for help
 - Collect calls to police, etc.
- Have neighbour call police if suspicious
- List of safe refuges
- Leave extra cash, documents, keys with friend

Haggerty, L.A., Kelly, U., Hawkins, J., Pearce, C., & Kearney, M.H. (2001). Pregnant women's perceptions of abuse. *JOGNN*, 30(3), 283-290.

Assessing Danger

- *Perceptions of danger differ*
- Women had **subjective** indicators
 - Lability of partner's moods
 - Level of stress in relationship
 - Intuition
 - Changes in values of themselves or partners
- Practitioners
 - Evaluations based on escalation of acts

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(Stuart & Campbell, 1989)

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The Danger Assessment Tool (Campbell, 1985, 1988) is designed to measure a woman's risk in an abusive relationship. (Available: <http://www.dangerassessment.org/WebApplication1/pages/da/DAEnglish.pdf>)

Campbell et al. (2003) found 1) a score of 8 or higher on the Danger Assessment Tool indicates a 'very grave risk' for a woman being murdered by her partner and 2) women did not recognize their level of risk.

- Women's **danger assessments** were not consistent with agency workers' assessments
 - intuition/moods vs. acts
- No relationship between severity of abuse and ability to control abuse
- Assessments of abuse severity and danger were positively correlated

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(Haggerty et al, 2001)

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Haggerty, L.A., Kelly, U., Hawkins, J., Pearce, C., & Kearney, M.H. (2001). Pregnant women's perceptions of abuse. *JOGNN*, 30(3), 283-290.



Resources

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Women's Help Lines – see front of local phone book

If you have been threatened with harm or death, or are being stalked (followed & harassed) by your partner or ex-partner, you can call the police. Dial 911, or in a rural area, find out the emergency number. If you are considering leaving, especially if you have children, see a lawyer. In Ontario you can call, 1-800-268-8326, for referrals to a lawyer and be entitled to a free half-hour visit.

Abused women are at the greatest risk of being harmed or killed when they leave. Ensure that you have a safety plan in place.

<h2 style="text-align: center;">Resources</h2> <ul style="list-style-type: none"> • Shelters or transition homes • Police departments • Victim's services • Crisis centre or crisis line • Women's centres • Social service agencies • Health care centres, clinics or hospitals • Counsellors • Community or family centres <p>2006 PPPEO D. Aylward 82</p>	<p>Shelters do accept women who are emotionally abused and have not been physically abused. The help line can refer you to the one nearest you. Use the Bell Relay Service if they do not have a TTY. If you have a disability, ask where there is an accessible shelter in your area.</p>
 <h2 style="text-align: center;">Documentation</h2> <p>2006 PPPEO D. Aylward 83</p>	<p>In eastern and southeastern Ontario efforts have been made to include woman abuse on a number of tools. For example, the Regional Intrapartum Documentation Tool (PPPEO, 2005) has added a section on woman abuse. This tool will be available to hospitals in our region. In addition, the Regional Neonatal Transport Team (Children's Hospital of Eastern Ontario) has added the subject to its Transport Log and the NICU at CHEO has incorporated questions around abuse to its Discharge Planning Critical Pathway.</p> <p>Documentation is an integral aspect of safe, responsible and effective nursing practice. It may be used as evidence in the case of legal proceedings.</p>
<h2 style="text-align: center;">Documentation</h2> <ul style="list-style-type: none"> • The record needs to contain <ul style="list-style-type: none"> - A safety check - Statement in woman's own words <ul style="list-style-type: none"> direct quotation of what the woman describes <p>Direct observations made by the nurse Referrals (discussed and made) & information given</p> <p>Non-biased non-judgmental language If no disclosure – do not document 'no abuse' rather 'no disclosure to abuse screening'</p> <p>2006 PPPEO D. Aylward (RNAO, 2005) 84</p>	<p>Documentation should be: legible and accurately reflect the screening process (Health Canada, 1999).</p> <p>Some examples of non-biased terms: 'chooses', 'declines', 'client states' as opposed to 'alleges', 'refuses', or 'victim'.</p> <p>For example: "Client states 'my boyfriend hit me'" instead of "Victim alleges she was assaulted by partner" (RNAO, 2005)</p>

Documentation (cont)

- More detailed documentation
 - Relevant health history
 - History of abuse (first, worst, most recent)
 - When and where it took place
 - Name and relationship of abuser
 - Detailed description of injuries
 - Photos are very useful
 - Health care provided, information and referrals made

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Referral services and secondary intervention may include a more detailed history as described herein.

From: RNAO, 2005

The Legal System



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The legal system is made up of 2 systems:
Family Court and Criminal Court.

A brief description of both will be provided.
Legal Aid Ontario (<http://www.legalaid.on.ca/en/>) has information about both family and criminal law services.

In addition, Community Legal Education Ontario has a resource entitled: *Do you know a woman who is being abused? A legal rights handbook*. It is available at www.cleo.on.ca or 1-416-408-4420.

The Legal System

There are 2 systems:

1. Family Court
2. Criminal Court

Operate independently of one another

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New resource available from CLEO re: custody and access

http://www.cleonet.ca/instance.php?instance_id=1428

Family Court

- Deals with
 - Separation & Child Support/Access Issues
 - Child Protection issues
- *Women should seek legal advice if she is planning to leave the relationship*
- *Women can request a Restraining Order under the Family Law Act*

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Once abuse is reported, the process is guided by the legal system. This may be a precarious situation for a woman who may already feel powerless and without control in her life.

A Family Lawyer can assist the woman to obtain a restraining order from Family Court. The purpose of the order is to prevent the abuser from having contact with the woman or her children at home, work and/or school. The lawyer can request a detailed restraining order to address the particular issues that a woman may have with her partner. The lawyer should request that the restraining order be enforced by the police (CLEO, 2004).

Criminal Court

- Deals with Criminal Code of Canada offences
WOMAN ABUSE IS A CRIME
- The woman does not require a lawyer; the Crown prosecutor prosecutes the charges
- Victim Support Line provides information about the Criminal Justice System (1-888-579-2888)
- Women may apply for a Peace Bond under Section 810 of the Criminal Code

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In layman's terms a Peace Bond is 'a promise in writing to keep the peace and be of good behaviour' (CLEO, 2004, p. 33). Under Section 810 of the Criminal Code of Canada, an information may be laid before a Justice by, or on behalf of, any person who **fears on reasonable grounds** that another person will cause personal injury to him/her; his/her spouse, common-law partner or child; or damage his/her property. A Peace Bond is in effect for 12 months. It is a criminal offence to breach any conditions of a peace bond, punishable by a sentence of up to 12 months in jail (CLEO, 2004). Breaches can be reported to the police or the Justice of the Peace.

Examples of Charges

- **Assault**
 - with a weapon
 - causing bodily harm
 - aggravated assault
 - **Criminal Harassment**
 - stalking or making threats
 - **Homicide**
 - **Sexual Assault**
 - with a weapon
 - causing bodily harm
 - aggravated sexual assault
 - **Mischief**
 - **Uttering Threats**
 - **Dangerous Driving**
- ~1/3 'victims' sought restraining or protective orders*

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Specific charges that may be laid in a case of woman abuse include:

Assault; criminal harassment; aggravated assault; assault causing bodily harm; sexual assault; aggravated sexual assault; sexual assault causing bodily harm; uttering threats; threatening to cause death or bodily harm; sexual assault with a weapon; Intimidation; forcible confinement; attempted murder; and/or murder

When a police report is made

- Police investigate reports and lay charges (not the woman)
- Crown Attorney's office makes decisions about the charges and then prosecutes the charges
- Victim Witness Assistance Program (VWAP) contacts the woman and provides support, referrals, information about the process and advocacy

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The Woman Abuse Council of Toronto (2005) has produced a report entitled *Women Charged with Domestic Violence in Toronto: The Unintended Consequences of Mandatory Charge Policies*. It describes the challenges faced by women who are living in or trying to leave violent relationships. It is available at:
<http://www.womanabuse.ca/womenchargedfinal.pdf>

The woman may ...

- Be ambivalent about the court process
- Have many fears
- Require emotional support
- Need relevant information about the legal process
- Need access to community resources

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Women may feel they will be believed and get justice or they may be skeptical about receiving justice – as professionals, we need to help women navigate the system and follow up with the our clients.

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It is important to remember that once abuse is reported the process is guided by the legal system. It can be a complex and lengthy process. It is important for both women who have experienced abuse and health care providers to know the reality of what to expect as well as the resources and supports available.

? police service stats on domestic calls and if charges were made – inquiry made – response pending

Resources

- Legal Aid
- Help/Crisis lines
- Health Units & Departments
- Children's Aid Society/Child and Family Services
- Victim Support Line
- Police
- Victim Witness Assistance programs
- Sexual Assault/Domestic Violence Treatment Centres
- Shelters
- Crown Attorney

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Strategies for Health Care Providers



- Best Practice Guidelines
- Policies/Procedures/Protocols
- Diverse Settings & Populations
- Community Development

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RNAO has been involved in the Best Practice Guidelines project since 1999 with 29 evidence-based guidelines available to date. Each of the guidelines was created by a panel of experts from various disciplines across Ontario. For more information on the project and/or the individual guidelines go to http://rnao.org/bestpractices/about/bestPractice_overview.asp

The Society of Obstetricians and Gynaecologists of Canada (SOGC)

Clinical Practice Guidelines

The following SOGC national clinical guidelines are available free of charge to health care practitioners and the public. These guidelines, based on the foremost scientific knowledge available, advance the obstetric and gynecology specialties and promote informed choice for women in Canada and abroad. All guidelines are posted after they have been published in our peer-review journal, *Journal of Obstetrics and Gynaecology of Canada (JOGC)*.

Select a link below to view all available guidelines in that category.

- Aboriginal Health
- Maternal-Fetal Medicine
- Medical-Legal Issues
- Obstetrics
- Oncology
- Reproductive and Infertility
- Social and Genetic Issues
- SOGC/SOGCISCC Policy & Practice
- Urogynaecology

Aboriginal Health

Many other provincial or national professional associations have evidence-based guidelines. The Society of Obstetrician and Obstetricians of Canada (SOGC) is once such association. Their consensus statement on Intimate Partner Violence is available at: http://sogc.medical.org/guidelines/pdf/JOGC-april05-ipv-CPDrevised_000.pdf

PERINATAL PARTNERSHIP PROGRAM OF EASTERN AND SOUTHEASTERN ONTARIO

Working Together for Quality Perinatal Care.

The Perinatal Partnership Program of Eastern and Southeastern Ontario (PPESO) works together with hospitals, health departments, community agencies, academic institutions, private practitioners, and consumers to effectively link perinatal care, education, and research.

The mission of PPESO is to promote optimum perinatal care of childbearing families in Eastern and Southeastern Ontario in order to improve health and to achieve excellent perinatal health outcomes. To accomplish this mission, the Program offers professional development tailored to meet the needs of perinatal care providers.

What do we Provide?

Health Status & Performance Measurement

- Niday Perinatal Database
- Reports on the Perinatal database
- Audits of practices
- Benchmarking projects
- Performance assessment tools
- Risk Management
- Collaboration on perinatal research initiatives
- Collaboration on health-promotion initiatives

Partnership Regional Support

PPESO (2004) developed guidelines for health care providers and recommended the following:

- 1) routine, universal and comprehensive screening for woman abuse become the standard of care throughout the region;
- 2) the safety of women and children be assessed whether or not a disclosure has been made;
- 3) proposed the following recommendations;
- 3) health care facilities and community service agencies have policies in place to facilitate response to disclosures of abuse;
- 4) education about woman abuse be provided in a number of forums;
- and 5) HCPs are aware of their obligation to report all cases of alleged or suspected child abuse or neglect.

RNAO's key recommendations are described below.

Best Practice Guideline:

Woman Abuse: Screening, Identification and Initial Response

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.

Download:

- Complete Guideline (PDF - 2.72 MB)
- Summary of Recommendations (PDF - 148 KB)

To order hard copies
Hardcopies of this guideline will be available soon.

Development Panel Members

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- Dorothy Lohrstofer, RN, BScN, MScN

Practice

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

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

nurses develop skills to foster an environment that facilitates disclosure

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

nurses use reflective practice to examine how their own beliefs, values, and experiences influence the practice of screening

nurses know what to document when screening for and responding to abuse

nurses know their legal obligations when a disclosure of abuse is made

Summary of Recommendations

- Practice
- Education
- Organization & Policy

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Education

mandatory educational program in the workplace be designed to: increase nurses' knowledge and skills and foster an awareness and sensitivity about woman abuse
all nursing curricula incorporate content on woman abuse in a systematic manner

Organizational & Policy

health care organizations develop policies and procedures that support effective routine universal screening for and initial response to woman abuse
health care organizations work with the community at a systems level to improve collaboration and integration of services between sectors

Policy, Procedure and Protocol Development



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The terms policy, procedure and/or protocol are often used interchangeably – there are, however, differences.

Policy – a definitive statement of an organization's position on an issue of concern to the effective operation of the organization

Procedure – a detailed step-by-step description of the sequence of activities necessary for the achievement of the policy

“Not having comprehensive, collaborative and appropriate policies in place to respond to woman abuse, or having gaps in existing policies, can result in inappropriate and unsafe responses by service providers.”

PEI Woman Abuse Protocols

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Lack of policies can also result in women not receiving the support they need and can also discourage them from talking about the abuse. It can also lead to a delay in intervention and result in further abuse.

A coordinated response can ensure that women receive safe and respectful responses from service providers.

- The protocol should be set within a philosophical framework which defines the mission, goals, and objectives of the **involved organizations** as well as defining an ongoing review process.

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Protocols should be ...

- available,
- accessible,
- easy to 'follow',
- up-to-date and
- identify intra- and interagency resources

All staff should know it exists and have received education about it

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One should consider resources other than just medical services – for instance, psychological support, counselling, education, witness/victim assistance programs to name a few. It is important to consider intra and interagency resources for children and perpetrators.

Intra- & Inter Agency Linkages

- Family Court Services Protocol
- Hospital Protocol
- Income Assistance Protocol
- Priority Placement Protocol
- Probation Services Protocol
- Community Justice Resource Centre
- Victim Services Protocol
- Police Protocol

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Some examples of resources and linkages considered by the Coalition for Woman Abuse Policy and Protocol in Prince Edward Island.

For more information:

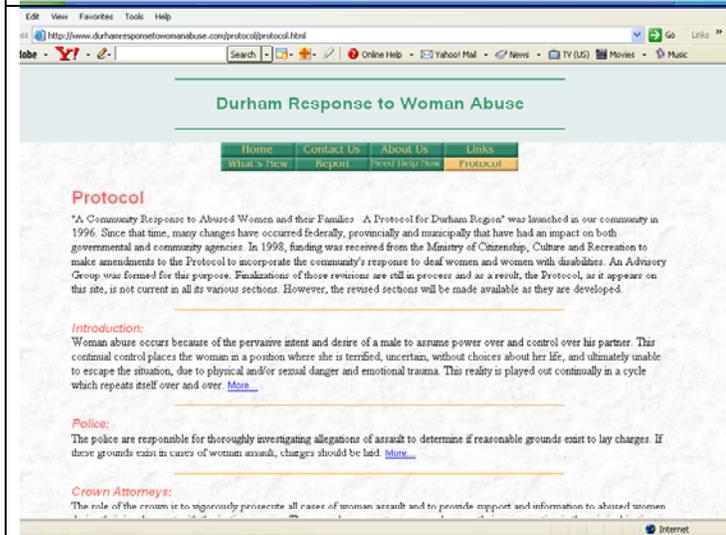
<http://www.isn.net/cliapei/womanabuse/>



During Phase 2 of the *Response to Woman Abuse Initiative*, the following protocols were developed:

- [Income Assistance](#)
- [Victim Services](#)
- Police
- [Family Court Services](#)
- [Probation](#)
- [Turning Point Program](#)
- [Priority Placement Protocol](#)
- [Community Justice Resource Centre](#)
- Hospital Emergency

<http://www.isn.net/cliapei/womanabuse/hospitalprotocol.pdf>



Sample protocols are also provided on the above site.

<http://www.durhamresponsetowomanabuse.com/protocol/protocol.html>

- "Not having comprehensive, collaborative and appropriate policies in place to respond to woman abuse, or having gaps in existing policies, can result in inappropriate and unsafe responses by service providers."

PEI Woman Abuse Protocols



Immigrant women, women with disabilities, aboriginal women, lesbian women and pregnant women face particular challenges with respect to woman abuse – examples of pertinent websites are listed below.

- 1) Immigrant women http://www.womanabuseprevention.com/html/custody_immigrant_women.html
- 2) Disabled women <http://dawn.thot.net/>
- 3) Aboriginal women <http://www.sistersinspirit.ca/enghome.htm>
<http://www.nwac-hq.org/violence.htm>
- 4) Lesbian women <http://www.womaninc.org/>
- 5) Pregnant women <http://www.cyberparent.com/abuse/pregnancy.htm>
http://www.phac-aspc.gc.ca/rhs-ssg/factshts/abuseprg_e.html

General Social Survey 2004

- Vulnerable populations
 - Young
 - Common-law relationships
 - Relationship < 3 years
 - Aboriginal
 - Partner is a heavy drinker
- Income and place of residence had little effect
- Alcohol use elevates risk of spousal violence
- Some data to suggest that homosexual individuals experience more violence than their heterosexual comparators

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Diverse Populations

Immigrant women and children face specific problems, such as:

- racism
- immigration policy/laws
- language barriers
- service access/lack of availability
- lack of experience with social services
- distrust of the judicial system
- isolation
- low economic status

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The issue of violence is complex. We need to understand the social, personal, economic, political, cultural, and religious dimensions of violence in a multicultural context.

The community has the right and the responsibility to get involved. The more that is known about violence, the more effective the community can be in intervening and preventing violence, and the less it will happen.

http://www.womanabuseprevention.com/html/about_abuse.html

Immigrant & Refugee Women

- Fear of jeopardizing Canadian status
- Lack of information about Canadian laws and their rights as women
- Fear of losing their children for good
- Fear of being ostracized from their community
- Fear and distrust of police
- Lack of professional support from home community
- Fear of vulnerability without male protection
- Experiences of prejudice, discrimination, or racism when they have interacted with various institutions

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Immigrant & Refugee Women

- Isolation from others
- Fear of bringing shame to family
- Lack of knowledge about or experience with social service agencies
- Lack of availability of culturally appropriate services
- Difficulties living within a shelter environment.
 - racial issues; food preferences/differences
- Differences about what is socially accepted behaviour
- Child care/parenting issues
- Feels like another prison or refugee camp
- In many cases, low economic status

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Aboriginal Women

- **75% - 90%** of women in some northern Aboriginal communities are abused
- **40%** of children in Northern communities had been physically abused by a family member
(Dumont-Smith & Sioui-Labelle, 1991)
- **8 of 10** Aboriginal women in Ontario had personally experienced family violence, **87%** had experienced physical injury and **57%** had been sexually abused
(Ontario Native Women's Association, 1989)

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The data presented is somewhat dated but does present the state of affairs in the 1980's and 1990's. Statistics Canada (2005) reports that aboriginal people were: 3 times more likely to be victims of spousal violence than were those who were non-Aboriginal (nA) (21% vs. 7%); twice as likely as nA people to have reported experiencing some form of stalking in the previous five years (17% vs. 9%); more likely than spousal violence victims to state that they were either beaten, choked, threatened with or had a gun or knife used against them, or sexually assaulted (41% vs. 27%); more likely to experience emotional abuse than nA people (36% vs. 17%). For more information: <http://www.statcan.ca/english/freepub/85-224-XIE/85-224-XIE2005000.pdf> and <http://web.amnesty.org/library/Index/ENGAMR200012004>

More disturbing statistics:

Aboriginal women experience higher rates of spousal abuse

Aboriginal children witness violence at a higher rate

Aboriginal peoples experience higher rates of victimization

Aboriginal victims experience more severe forms of violence

Over the past 20 years, ~500 Aboriginal women have gone missing in communities across Canada

(Native Women's Association of Canada)

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Leaving an abusive situation can be difficult for victims of abuse in Aboriginal communities because they must often abandon their kinship ties, support network, cultural, community and sense of identity.

In a report, *Assessing Violence Against Women: A Statistical Profile*, released by the Status of Women (2002) notes that, "Aboriginal women are also particularly vulnerable to violence, spousal homicide rates of Aboriginal women were more than eight times the rate for non-Aboriginal women."

http://www.swc-cfc.gc.ca/pubs/0662331664/200212_0662331664_e.pdf

Community Development



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Community Development (CD)

- Way of mobilizing resources/skills
- Process of **planned change** that helps build healthy communities
- Distinct strategy characterized by a **partnership** of 'community' members to build strengths, self-sufficiency and well being

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It involves ...



- ✓ Identifying the issues/problems
- ✓ Developing plans, skills, capacity and ability to act on concerns
- ✓ Identifying available/required resources
- ✓ Implementing plans for change
- ✓ Informing other organizations of work
- ✓ Open communication
- ✓ Participating in community initiatives
- ✓ Awareness of community resources

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Information from Graham (1991) The Report to Andsooha Membership.

Community development is a strategy or tool to get things done in communities; a way to facilitate change; and empower communities.

Communication is critical
One must build on successes

Challenges to CD

- Professional
- Community
- Organizational

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Professional: Feeling incompetent as facilitators; different expectations (yours/groups); lack knowledge/skill re: CD; lack of flexible hours; often try and solve problem ourselves without going to community; need for ownership and power; ethnic, cultural social backgrounds of community may differ from the professional's

Community: May not want CD strategy to be used; community leaders derail efforts; legitimate leaders in transient population; building trust; conflicts re: priorities; funding

Organization: Priorities/perspectives/agendas differ; time consuming (long term); difficult to measure impact at times

Overcoming challenges

1. Strike a task team/interagency committee
2. Come together in a community forum
3. Dialogue with like and invested agencies

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It is very important to decide how decisions will be made within the group – for instance, will decision – making be by consensus or authority.

Rural areas may have challenges related to geography and/or isolation but many rural communities have many established organizations to address the issue of woman abuse.

For example...

Tasked with implementing best practice guidelines around woman abuse



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Well,...



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Where to start

- Establish a 'task team'
 - Establish 'terms of reference'
 - mandate and accountability
 - size, structure, roles, responsibilities, chair
 - Define guiding principles, key concepts
 - Mission statement
 - Identify immediate priorities & long term goals

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Other suggestions for success

An advisory committee may be helpful;
Existing collaborations should be consulted/invited to participate;
Identify existing resources and gaps at the outset;
May need to seek special funding to support the initiative; and
Current education programs may need to be repeated, revised, and re-allocated. Programs need to address not only content related to woman abuse but the emotion associated with the issue as well (for both women and health care professionals).

What else?

- Define
 - Target population and/or area
 - assess needs for info, education, support &/or RX
- Identify resources and gaps
 - Strategies for filling gaps
- Set priorities
- Develop a communication strategy

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Immeasurable amounts of flexibility, consultation, communication and humour will be necessary.

What else?

- Generate a checklist
 - What do we need to do?
 - How are we going to do it?
 - Who is going to do it?
 - How long should it take?
 - How do we know it is working/worked?

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Remember ...

- Community wide partnerships
- Multifaceted approach
 - education, support, intervention
- Collaboration between services
- Avoid quick fixes – look to the long term
- Build on strengths while recognizing limitations

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Collaboration can...

- Reduce system induced trauma
 - ie. ↓ repeated 'interviews'
- Create better methods of preventing and detecting abuse
 - higher reporting rates & earlier intervention
- Ensure individualized, comprehensive and responsive management
- May minimize 'burnout' / vicarious trauma
- May keep women and children safer

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Collaboration can also:

1. provide protection, support & empowerment for women by reducing system induced trauma
2. impact conviction rates

Case management, intra- and interagency teams, informal linkages between professionals, coordinating committees for information sharing, planning, implementing, and monitoring programs, as well as interagency protocols for service delivery and community wide programs or initiatives can enhance collaboration.

Can be hindered by...

- Territorialism
- Undue concerns re:
 - reporting process, who to report to
 - limits/boundaries of confidentiality
- Inadequate resources
- Historical boundaries between groups
- Lack of training
- Lack of supportive policies and procedures

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Don't let territorialism and competition for resources prevent you from collaborating/uniting your efforts for a common cause.

Goal

- Reduce violence toward women through screening, early identification and appropriate response (support &/or referral)
- Develop policies, procedures and protocols to encourage safe, effective & appropriate responses to woman who disclose abuse
 - as well as those who don't
- Plan strategies for effective implementation and sustainability

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Collaboration, commitment and coordination are paramount.

Recipe for Success

- Involve all key players
- Have a realistic strategy
- Establish a shared vision
- Agree to disagree
- Keep your eye on the 'ball'
- Encourage ownership at all levels
- Institutionalize/formalize partnership

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Don't be discouraged by minor setbacks. Try and have a realistic estimation of work involved and timelines. Disagreement and discussion are healthy and can bring richness to the project. Facilitate learning and empower practitioners at all levels to 'buy-in' to the initiative – information and knowledge are key. A formalized partnership between/among institutions may be in the form of a policy and/or procedure identifying linkages/partnerships.

Recap

1. Identify a core group to facilitate change
 - involve women who have experienced abuse
2. Create opportunities to develop a shared understanding of woman abuse
3. Encourage individuals to express different points of view
4. Start with a manageable task
5. Have '**champions**' to facilitate change
6. Provide education, training and support
 - staff and families
7. Measure change and evaluate outcomes

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Adapted from Health Canada. (2000). Family-Centred Maternity and Newborn Care: National Guidelines. Ottawa: Author.

Vicarious Trauma

Compassion fatigue
Secondary traumatization
Secondary stress disorder
Insidious trauma



Label, define what happens, why it happens and how to live healthily with the experiences

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Many HCPs may have personal experience with: 1) abuse and/or trauma and 2) the resulting issues faced by the women with whom they work.

HCPs or staff members with a history of abuse may have disruptions in self-trust and self-esteem when compared to their colleagues who don't have these same experiences.

Working with women who have been abused may trigger unpleasant memories and emotions.

Richardson, J. (2001). Guidebook on vicarious trauma: Recommended solutions for anti-violence workers. Ottawa: Health Canada.

Available: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/trauma_e.pdf

Vicarious Trauma (VT)

- Outcome of anti-violence work
- Effects are cumulative
- Built upon memories of repeated stories of inhumane acts of cruelty
- Permanent, subtle or marked change in the personal, political, spiritual and professional outlook of the counsellor or advocate
- Life-changing effect on individuals
 - can affect view of the world, relationships and connections to families, friends & communities

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Richardson. J. (2001). Guidebook on vicarious trauma: Recommended solutions for anti-violence workers. Health Canada, Author.

Some of the Effects

Physical Reactions Pain Illness Isolation

Anxiety Rage Sadness Confusion

Despair Anger Helplessness Fear Grief

Apathy Identifying with the woman

Angst re: letting woman walk out the door

**Drains strength, confidence, desire,
friendship, calmness, laughter**

Personal Impact of Vicarious Trauma

Yassen, 1995

Cognitive	↓ concentration, confusion, spaciness, loss of meaning, ↓ self-esteem, preoccupation with trauma, apathy, rigidity, disorientation, self-doubts, perfectionism, minimization
Emotional	Powerlessness, anxiety, guilt, survivor guilt, shutdown, numbness, fear, helplessness, sadness, depression, hypersensitivity, emotional roller coaster, overwhelmed, depleted
Behavioural	Clingy, impatient, irritable, withdrawn, moody, regression, sleep disturbances, appetite changes, nightmares, hypervigilance, elevated startle response, use of negative coping, accident proneness, self-harm behaviours
Spiritual	Questioning the meaning of life, loss of purpose, lack of self-satisfaction, pervasive hopelessness, ennui, anger at God, questioning of prior religious beliefs
Interpersonal	Withdrawn, ↓ interest in intimacy or sex, mistrust, isolation from friends, impact on parenting (protectiveness, concern re: aggression), projection of anger or blame, loneliness
Physical	Shock, sweating, ↑ heart rate, breathing difficulties, somatic reactions, aches and pains, dizziness, impaired immune system

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From: Richardson, 2001

Professional Impact of Vicarious Trauma

Yassen, 1995

Job Tasks	↓ in quality & quantity, low motivation, avoidance of job tasks, ↑ in mistakes, setting perfectionist standards, obsession about detail
Morale	↓ in confidence, loss of interest, dissatisfaction, negative attitude, apathy, demoralization, lack of appreciation, detachment, feelings of incompleteness
Interpersonal	Withdrawal from colleagues, impatience, ↓ in quality of relationship, poor communication, subsume own needs, staff conflicts
Behavioural	Absenteeism, exhaustion, faulty judgment, irritability, tardiness, irresponsibility, overwork, frequent job changes

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From: Richardson, 2001

Healthy Stress



- Good concentration, motivation & energy
- High quality of work
 - good attendance; deadlines met
- Cooperative behaviour; cheerful manner
- Effective problem solving
- Clear & confident decision making
- Concern & care for others and self
- Constructive criticism given and rec'd

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Stress exists in everyone's life. There is healthy stress and unhealthy stress – some of the features of both are outlined. Stress and vicarious trauma are different although, in some cases, the manifestations may be the same. HCPs working with women who experience abuse, may experience stress as well as vicarious trauma. It is important to differentiate between the two.

Gentry (2005) provides some suggestions for dealing with compassion fatigue
<http://onlinece.net/courses.asp?course=212&action=view>

Unhealthy Stress



- The opposite of all of the previous +
 - Regularly working late
 - Constantly taking work home
 - Lower standards accepted
 - Overly self-critical
 - No sense of humour, easily disgruntled
 - Extreme mood swings
 - Greater use of alcohol, caffeine, nicotine



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Vicarious Trauma

A CLEAR AND PRESENT DANGER

Organizational and Personal strategies

Self-care	Immediate Support
Self-reflection	Debriefing
Integrity	Healthy balance

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In the event of vicarious trauma, the HCP may need:

- Supportive supervision
- Peer consultation
- Debriefing
- Personal therapy

Personal Solutions

- Limit number of clients/day
- Vary major work responsibility
- Take REAL breaks
- Be able to differentiate the following:
 'crisis', 'problem' and 'situation'
- Protect administrative time

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Richardson (2001) suggests that anticipatory guidance may be helpful for those working with women who experience abuse and has provided examples of self-assessments that can be used to monitor one's coping and well-being. Copies have been provided for you in the folder entitled 'Self Evaluations'. It has been suggested that these self-assessments be completed on a yearly basis – more often if necessary.

Personal Solutions

- Set realistic goals
- Seek ongoing training/education
- Develop realistic safety plans
- Develop a personal debriefing plan
- Use alternative therapies
- Make a commitment to yourself

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Organizational Solutions

RETREATS AND CELEBRATIONS

- Semi annual celebrations
- Display positive images on the walls
 - Children's art
- Random & regular events to celebrate births/birthdays/special events
- Quiet room for staff
- Include time for positive experiences at staff meetings

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ABCs

- Awareness
- Balance
- Connection



*Consider the 3 realms of your life
professional, organizational, personal*

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Creative Selfishness

- Behaviour that allows you to care for yourself without feeling guilty
- Taking time to live your life with respect for yourself.
- Self-nurturing activities

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To Review...

We have talked about ...

- the consequences of woman abuse
- the role of health care providers
- strategies to become part of an integrated response to woman abuse
- taking care of yourself

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Remember, asking about abuse

gives women a strong message that:

there are serious health effects of woman abuse to both women and children

HCPs recognize that woman abuse is a serious personal and societal issue, and

health care providers are prepared to help.

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Awareness of woman abuse, its prevalence, unique dynamics and consequences for women is paramount if health care providers and community service agencies are to respond in such a way as to safeguard women and their dependent children from physical injury, psychological distress and further incidents of abuse. Routine screening, early identification and intervention, appropriate referrals and treatment offer strategies to address woman abuse in the perinatal period. By responding appropriately to disclosures of woman abuse, health care providers are in a position to enable women to reduce risk to themselves and their children (PPPEO, 2004).

"I refuse to remain silent about violence against women because it is about power and prejudice... above all it is about the absence of political will."

Irene Khan, Amnesty International



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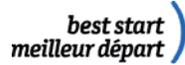
Finally ... remember, health care providers are not **exclusively** responsible for finding solutions to woman abuse, but instead, should see themselves as part of a **community response system** (PPPEO, 2004).



I thank you ...

for attending and sharing
your wisdom ...

and especially I thank you
for your commitment to women,
children and families.



Ontario's maternal, newborn and early
child development resource centre
Centre de ressources sur la maternité,
les nouveau-nés et le développement
des jeunes enfants de l'Ontario

