TASK FORCE on the Health Effects of WOMAN ABUSE

MIDDLESEX-LONDON HEALTH UNIT

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Task Force on the Health Effects of Woman Abuse

Final Report

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Executive Summary and Recommendations

The inquest into the March 1996, murder of Collingwood resident Arlene May by Randy Joseph Iles highlighted the need for all partners in the health care, justice, community and private sectors to work together to prevent such tragedies. The jury verdict and recommendations, released in 1998, were a compelling call to action for all sectors.

One of the key recommendations of the jury was for the government to call together a Joint Committee on Domestic Violence, made up of key government decision-makers and community-based experts to devise an effective five-year plan of action to carry out the jury's recommendations. In August 1999, the Joint Committee reported its findings. Many of its recommendations addressed the health effects of woman abuse (See pages 71-73). The Joint Committee urged each community to adopt a multidisciplinary approach to improve the identification and assessment of woman abuse in health care settings, promoting the use of screening tools and protocols.

London, Ontario, is a world leader in the criminalization of intimate partner abuse, the development of service delivery, and research in the area of woman abuse. However, there is a serious gap in services for abused women in the health care sector.

In an effort to address the findings of the Joint Committee and the gap in local health care services, the Medical Officer of Health for Middlesex-London declared woman abuse an urgent public health issue in the fall of 1999. Dr. Graham Pollett also established a Task Force to develop a public health approach to woman abuse. Members of the health care, justice, community service and private service sectors agreed to participate and former Ontario Attorney General Marion Boyd was appointed as Chair of the Task Force.

The mandate of the Task Force was to examine the existing screening tools and protocols for woman abuse, to determine the required elements of an effective model and then to adopt a model to be used routinely and to be applied in a universal and comprehensive manner. The Task Force agreed that the model should:

- Foster early identification of any form of woman abuse experienced by women seen in health care settings;
- Encourage the assessment and documentation of the health effects of woman abuse;
- Address immediate safety concerns; and
- Strengthen the strong integrated referral network developed in London over the past twenty years.

It is important to note that most of the current interventions for woman abuse are indicator-based. For the most part, our health care, justice and community responses consist of aiding an abused woman **after** her situation has become a crisis. Screening allows health care providers to intercept the problem earlier because it attempts to identify abuse whether or not indicators are present.

The Task Force considered a number of different models used for screening in Canada and the United States. While some of the models met many of the requirements of the Task Force, they focused only on intimate partner abuse. **The Task Force felt strongly that the London model needed to be a Routine, Universal, Comprehensive Screening (RUCS) Protocol, in which all women over the age of 12 would be screened for any form of physical, sexual or emotional abuse occurring in childhood, adolescence or adulthood**.

It was agreed that the screening protocol would advocate for simple direct questions regarding abuse to be asked routinely by health care professionals in the following settings:

- Annual or general examinations;
- Emergency room or urgent care examinations;
- Prenatal or obstetrical visits;
- Family planning visits;
- Well child examinations;
- Adolescent school, camp and sports physicals;
- Referral for admission to long-term care facilities or home care; and
- On admission or discharge from hospital.

The Routine Universal Comprehensive Screening (RUCS) Protocol is designed to accomplish more than just the early identification of woman abuse. Elements of the protocol allow for assessment and documentation of a woman's health status and referral to appropriate community resources. In order to assist health care professionals in this task, the Task Force developed the following mnemonic tool to help health care professionals administer the RUCS Protocol:

A B C D - E R

A. ATTITUDE and **APPROACHABILITY** of the health care professional;

B. BELIEF in the woman's account of her own experiences of abuse;

C. CONFIDENTIALITY is essential for disclosure;

D. DOCUMENTATION that is consistent and legible;

E. EDUCATION about the serious health effects of abuse; and

R. RESPECT for the integrity and authority of each woman's life choices and **RECOGNITION** that the process of dealing with the identified abuse must be done at her pace, directed by her decisions.

The Task Force believes that the following pre-conditions are necessary for the RUCS Protocol to be put into practice successfully:

- Professional education at the undergraduate, graduate, continuing education and in-service level for all health care professionals;
- Public education to inform women of the protocol and to encourage their willing participation;
- Acceptance of the protocol as a best practice by all health care professional colleges and accredited institutions;
- A mature referral network with adequate specialized services operating as an integrated community response to woman abuse;
- Respectful interdisciplinary teamwork among the health care, justice, community and private sectors that focuses on the health and safety of abused women;
- A means of collecting data and evaluating both the consistency of implementation and the outcomes of the screening protocol; and
- A means of rewarding the time, effort and contributions of health care professionals who implement the protocol.

In conclusion, the gruesome murders of four women by their intimate partners in Ontario in the summer of 2000, emphasize the need to identify woman abuse before it results in death. The health care sector in Middlesex-London must seize this opportunity to act on the recommendations of the Joint Committee and to address the gap in local health care services. Doing so will significantly strengthen the community's integrated response to woman abuse, increasing the chances that a woman in Middlesex-London will be able to live her life in good health and safety. This final report includes 29 recommendations and a time-line for their delivery to ensure that Middlesex-London moves forward in its efforts to prevent woman abuse by advocating for widespread use of the RUCS Protocol in local health care settings.

The Task Force Recommendations

Local Recommendations:

1. That woman abuse be acknowledged as an urgent public health concern and that a public health approach be adopted to ensure that the complex social interventions required to end woman abuse are implemented in the Middlesex-London community.

2. That the Medical Officer of Health and the Middlesex-London Health Unit continue to play a leadership role in facilitating ongoing cooperation and coordination of the health care, justice, community and private sectors in addressing the health effects of woman abuse.

3. That the Members of the Task Force continue to act as advocates within their own spheres of influence to encourage, monitor and evaluate the implementation of the Task Force recommendations and that, to this end, the Task Force meet quarterly to report on progress.

4. That the London Coordinating Committee to End Woman Abuse and its member agencies and professionals play a key role in implementing the recommendations of the Task Force and that the health care sector become a more active partner in the integrated community response to woman abuse.

5. a) That the Middlesex-London health care community be a pilot site for the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol for Woman Abuse;

   b) That the Routine Universal Comprehensive Screening (RUCS) Protocol developed by the Task Force be accepted in principle by appropriate health care professionals and appropriate health care settings within Middlesex-London by December 31, 2002;

   c) That the Routine Universal Comprehensive Screening (RUCS) Protocol be implemented and evaluated on a phased-in basis within the Middlesex-London community over a further five year period;

   d) That the Medical Officer of Health work with the Director of the Centre for Research on Violence Against Women and Children to develop a comprehensive proposal for data collection and analysis of the application and outcomes of the Routine Universal Comprehensive Screening (RUCS) Protocol to create an ongoing surveillance system for the identification, treatment and prevention of woman abuse.

6. That the Medical Officer of Health, in conjunction with appropriate Task Force members, present the findings of the Task Force to the Thames Valley District Health Council, and request the Health Council to convey its support for the Task Force recommendations to the Minister of Health and Long-Term Care and to the Attorney General. The objectives of this recommendation are:

   a) that the Health Council, in its capacity as an advisory body to the Minister of Health and Long-Term Care, convey its support to the Minister for all the Task Force recommendations, and particularly Recommendation 19;

   b) that the Health Council convey its support for all the Task Force recommendations and particularly Recommendation 18, to the Attorney General as a follow up to Recommendation 14 of the Joint Committee on Domestic Violence, August 1999; and

   c) that the Routine Universal Comprehensive Screening (RUCS) Protocol developed by the Task Force be adopted as a preventive strategy in the Health Council's integrated health system planning.

7. That the Medical Officer of Health implement the Routine Universal Comprehensive Screening (RUCS) Protocol in appropriate programmes within the Middlesex-London Health Unit and develop a method of measuring compliance and outcomes in the public health setting.

8. That the Medical Officer of Health, in conjunction with appropriate Task Force members, initiate negotiations with the London Health Sciences Centre and St. Joseph's Health Care London for the adoption of the Routine Universal Comprehensive Screening (RUCS) Protocol in appropriate programmes offered by their respective institutions. The negotiations shall address a reasonable timetable for implementation as well as a means of measuring compliance and outcomes.

9. That the Medical Officer of Health, in conjunction with appropriate Task Force members, initiate negotiations with the Strathroy Middlesex Hospital, the Four Counties Hospital and the Women's Rural Resource Centre (with which the hospitals have an existing protocol) for the adoption of the Routine Universal Comprehensive Screening (RUCS) Protocol in appropriate programmes offered by their respective institutions. The negotiations shall address a reasonable timetable for implementation and a means of measuring compliance and outcomes.

10. That, pending the transfer of the London Psychiatric Hospital (LPH) and the St. Thomas Psychiatric Hospital (STPH) to St. Joseph's Health Care London, the Medical Officer of Health, in conjunction with appropriate Task Force members, initiate discussions with LPH/STPH about the Routine Universal Comprehensive Screening (RUCS) Protocol and its application to psychiatric treatment facilities and outpatient programmes.

11. That the Medical Officer of Health, in conjunction with appropriate Task Force members, enter into negotiations with the Community Care Access Centre for the inclusion of the Routine Universal Comprehensive Screening (RUCS) Protocol in the intake process for placement in long-term care facilities and/or the initiation of home care services.

12. That the Medical Officer of Health, in conjunction with appropriate Task Force members and the London and District Academy of Medicine implement a joint educational programme for local doctors to be delivered within the next six months that would inform them of the Task Force findings and elicit their endorsement of, and participation in implementing the Routine Universal Comprehensive Screening (RUCS) Protocol.

13. That the Medical Officer of Health, in conjunction with appropriate Task Force members and local branches of the professional associations for the registered health care professions (such as the Ontario Medical Association, the Registered Nurses Association of Ontario, the Psychological Association, the Dental Association), develop joint educational programmes for their local members. The initiative would be delivered over the next eighteen months and would inform them of the work of the Task Force and elicit their endorsement of and participation in implementing the Routine Universal Comprehensive Screening (RUCS) Protocol.

14. That the Medical Officer of Health, in conjunction with appropriate Task Force members and the local bargaining agents for appropriate health care professionals (such as the Ontario Nurses Association, the Ontario Public Service Employees Union, the Canadian Union of Public Employees), develop joint educational programmes for local members over the next eighteen months that would inform them of the work of the Task Force and elicit their endorsement and participation in implementing the Routine Universal Comprehensive Screening (RUCS) Protocol.

15. That the Medical Officer of Health, in conjunction with appropriate Task Force members and the London Coordinating Committee to End Woman Abuse, enter into negotiations with Fanshawe College and the University of Western Ontario and its affiliates to enhance existing course offerings and implement within a two year period appropriate course modules and practical training at both the undergraduate and graduate levels to ensure that all newly graduated health care professionals understand the prevalence, seriousness and health effects of woman abuse and are committed to the prevention of woman abuse in their communities through early identification, assessment and referral of affected patients in their practices.

16. That the Medical Officer of Health, appropriate Task Force members and the London Coordinating Committee to End Woman Abuse develop and deliver within a six month period an effective public education campaign to inform the community about the findings of the Task Force and implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol.

17. That the Medical Officer of Health, the Task Force members, the London Coordinating Committee to End Woman Abuse and the Centre for Research on Violence Against Women and Children work together to solicit funds to promote wide distribution of the Task Force Final Report and to develop educational materials for public and professional education.

Provincial and National Recommendations:

18. That the Attorney General of Ontario respond to the deliberations and recommendations of the Task Force by:

    a) endorsing the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol as an appropriate response to the health care system recommendations made by the Joint Committee on Domestic Violence in 1999 regarding the May/Iles Inquest;

    b) creating a joint working group to set out provincial guidelines for the documentation of abuse and the acceptance of affidavit evidence from health care professionals adhering to those guidelines.

19. That the Minister of Health and Long-Term Care of Ontario respond to the deliberations and recommendations of the Task Force by:

    a) creating a provincial working group, including experts in public health, to advise on the provincial implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol for woman abuse based on a multi-disciplinary integrated community response model that includes health care, justice, community and private sector service providers;

    b) requiring the Joint Committee to approve an OHIP code to cover the application of the Routine Universal Comprehensive Screening (RUCS) Protocol by fee-for-service health care professionals paid through OHIP;

c) requiring the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol for woman abuse to be reflected in the funding and service contracts for community health centres and primary care reform projects;

d) approving and fully funding the Domestic Violence Programmes at Regional Sexual Assault Centres across the Province;

e) approving the Routine Universal Comprehensive Screening (RUCS) Protocol as an element of health system planning for District Health Councils;

f) funding public and professional education initiatives to support the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol.

20. That the Minister of Colleges and Universities of Ontario respond to the deliberations and recommendations of the Task Force by:

a) encouraging the development and delivery of undergraduate, graduate and continuing education about routine universal comprehensive screening for woman abuse for health care and social service professionals at Colleges and Universities in Ontario;

b) funding curriculum development initiatives to support such courses;

c) requiring private vocational colleges with training programmes for health care professionals to include education about routine universal comprehensive screening for woman abuse as a condition of accreditation.

21. That the Minister Responsible for Women's Issues of Ontario respond to the deliberations and recommendations of the Task Force by:

a) funding the widespread distribution of the Task Force Final Report to health care professionals, community service providers and the public;

b) encouraging the implementation of routine universal comprehensive screening for woman abuse through a major public and professional education campaign;

c) funding the evaluation of the implementation and outcomes of routine universal comprehensive screening for woman abuse in selected pilot communities.

22. That the Minister of Community and Social Services of Ontario respond to the deliberations and recommendations of the Task Force by:

a) encouraging the multidisciplinary integrated community response to woman abuse by funding the development and activities of coordinating committees in all fifty-four court catchment areas of Ontario;

b) guaranteeing funding for community-based services for abused women, including shelters, second-stage housing, counselling and advocacy services, based on a combined formula of base funding and actual referrals and utilization of services;

c) ensuring that the area offices of the Ministry support the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol across the province.

23. That the issue of woman abuse be addressed by those bodies entrusted with certifying, licensing and re-credentialling the health care professions. This would include:

a) ensuring that licensing and certifying examinations include questions that deal with the issue of woman abuse;

b) developing best practice guidelines within each profession for the early identification, assessment, treatment and referral of abused women;

c) creating continuing education credits for approved courses to practicing health care professionals;

d) adding consistent application of routine universal comprehensive screening for woman abuse to the list of required elements included in routine file audits and peer reviews.

24. That the bodies that accredit health care institutions and agencies, as well as those that accredit post-secondary educational programmes, require that policies, procedures and programmes be in place to ensure that universal comprehensive screening for woman abuse becomes a routine aspect of health care delivery by health care and social service professionals.

25. That the Ontario Hospital Association, the Catholic Health Association of Ontario, and the Ontario Association of Community Health Centres require their members to:

    a) design and deliver ongoing educational programmes about the health effects of woman abuse for their staff;

    b) implement the Routine Universal Comprehensive Screening (RUCS) Protocol for woman abuse in every facility;

    c) require that the protocols include referrals to available community-based services as well as appropriate health care services;

    d) develop a method to measure compliance with and the outcomes of the screening protocol;

    e) support the inclusion of screening protocols in both accreditation reviews and the OHA "report cards" on hospital effectiveness.

26. That the Ontario Public Health Association encourage a public health response to woman abuse throughout Ontario and lobby for the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol in every community.

27. That provincial professional associations (such as the Ontario Medical Association, the Registered Nurses Association of Ontario, etc.) and provincial bargaining agents (such as the Ontario Medical Association, the Ontario Nurses Association, the Ontario Public Service Employees Union, the Canadian Union of Public Employees) endorse the implementation of routine universal comprehensive screening for woman abuse and that they establish policies, educational programmes, and best practice guidelines for the benefit of their members.

28. That the federal Minister of Health and Health Canada declare routine universal comprehensive screening for woman abuse a major initiative across the country as part of the federal government's response to the Canadian Panel on Violence Against Women (1993) recommendations and that, in conjunction with other federal Ministries, such as Status of Women Canada, it fund collaborative projects to implement and evaluate the outcomes of screening initiatives.

29. That national health and professional organizations (such as the College of Family Physicians of Canada, the Canadian Nurse's Association, the Canadian Medical Association, the Canadian Health Coalition) endorse the implementation of routine universal comprehensive screening for woman abuse and that they establish policies, educational programmes and, where appropriate, best practice guidelines, for the benefit of their members.

Chapter I: Task Force on the Health Effects of Woman Abuse

a) A Public Health Initiative:

> *Public health…is a broad social enterprise, more akin to a movement, that seeks to impact on the health status of a population. It does so through identifying problems that call for collective action to protect, promote, and improve health, primarily through preventive strategies. This public health is unique in its interdisciplinary approach and methods, its emphasis on preventive strategies, its linkage with government and political decision making, and its dynamic adaptation to new problems placed on its agenda. Above all else, it is a collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and it is the composite of efforts and activities that are carried out by people committed to these ends.*[1]

Society's acknowledgement of the prevalence and the seriousness of woman abuse is relatively recent. Although we now understand that women have been the subjects of gender-based violence in a majority of cultures throughout known history, little had been researched or written on the subject until the mid-1960's when the feminist movement began to explore the condition of women within society and to demand equal rights and protections for women under the law. The recognition of women and children as individual citizens, with full human rights, has only come about very gradually over the past century and continues to evolve as our Canadian Courts interpret the 1982 Constitution, which includes the Charter of Rights and Freedoms. Once citizens achieve equality before and under the law, they can demand that governments take action to provide appropriate protections for them and effective measures to ensure their health and safety. Since 1980, we have seen not only the criminal and civil laws but also the social policies of our country and our province change dramatically. The issue of woman abuse has become a focus for legal and societal change, as we search for ways to help the victims of violence and to end the violence itself.

A similar evolution of understanding has occurred within the health care sector. The imperative to care for and cure illness and injury continues to be a major focus of our health care system. However, we have come to understand that we must also address the causes of disease and injury, the determinants of health, if we are to improve the overall health status of our population. The work of the Premier's Council on Health in Ontario and the National Panel on Health stressed the importance of dealing directly with the root causes of ill health by adopting measures to identify health problems early, to treat them effectively at an early stage and then to prevent further recurrence through legal, social and community action. The health care system has responded by instituting routine screening programmes for many health conditions such as diabetes, breast cancer, blood pressure and cholesterol levels.

Violence against women began to be seen as a public health issue that must be addressed in a similar way. International health organizations focused on the issue during the last decade.

> *The health community has begun to mobilize to meet this challenge. In 1993 the Pan American Health Organization (PAHO) became the first international health institution to recognize violence against women as a high-priority concern, when it passed resolution CD39.R8, urging all member governments to establish national policies and plans for the prevention and management of violence against women. In 1996 the 49th World Health Assembly followed suit, declaring violence a public health priority. Both PAHO and WHO initiated programs on violence against women in the mid-1990's.*[2]

In Canada in1994, the Canadian Public Health Association (CPHA) published an issue paper entitled Violence in Society: A Public Health Perspective. In 1997, at its Annual Meeting, the Ontario Public Health Association (OPHA) passed a resolution formally recognizing violence as a public health issue. OPHA set up a work group to provide direction regarding the implementation of violence prevention initiatives. Its report, A Public Health Approach to Violence Prevention was published in 1999.

In the fall of 1999, Dr. Graham Pollett, Medical Officer of Health for Middlesex-London, heeding the substantial research that describes the seriousness, the prevalence and the health effects of woman abuse, declared woman abuse to be an urgent public health issue for women that must be addressed with

prevention and health promotion strategies. Dr. Pollett called together an interdisciplinary Task Force to identify the necessary steps required by the Middlesex-London community to create an effective, pro-active protocol to deal with the health effects of woman abuse.

The Mission Statement of the Board of Health mandated the Health Unit's leadership of the Task Force on the Health Effects of Woman Abuse:

> *"The mission of the Board of Health of Middlesex-London Health Unit is to promote optimal health with and for the people of our community through leadership in the provision of public health programs and services including education and research."*

The Value Statements of the Board of Health and Health Unit staff underpin this Mission and also suggested the context within which the Task Force would operate:

- *We believe public health planning is strengthened by community involvement.*
- *We believe community partnerships are essential to the achievement of our goals.*
- *We believe challenges provide opportunities to seek creative solutions.*
- *We believe our staff is our most important resource.*
- *We believe in fairness in health opportunity.*
- *We believe when individual rights and community rights conflict, the health of the community is the first priority.*
- *We believe every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or handicap. (Human Rights Code, 1990, RS0)*

As a Teaching Health Unit (THU), the Middlesex-London Health Unit (MLHU) has a mandate for education and research. The THU designation is applied by the Ministry of Health to provincial health units that are funded to provide community based education for students in the health care field. As well, Teaching Health Units are expected to conduct applied public health research activities. As part of its THU mandate, the MLHU has a formal agreement with the University of Western Ontario to provide teaching and practical experience for health care students.

The London community was particularly well prepared to join with the Middlesex-London Health Unit on this new endeavour. For over twenty years London has assumed a leadership role in the development of service delivery and research in the area of woman abuse.

> *Nearly twenty years ago, in the City of London Ontario, an Integrated Model of Service Delivery was developed by a group of organizations working together through a coordinating group, the London Coordinating Committee to End Woman Abuse. The intent of the Integrated Model is to ensure that abused women encounter consistent responses at each point of access in the formal help network. Through the deliberate fostering of relationships between service providers, the Integrated Model is designed to facilitate communication, information and resource sharing, accountability, and coordination among the various components of the social, medical and justice systems to the benefit of abused women.*[3]

The Task Force was designed to build on this successful history. (See Appendix 7 on pages 87-88 of this report for a full list of the current members of the Coordinating Committee.) Always eager to bolster its success in achieving the ideal integrated approach, the Coordinating Committee participated in an evaluation of the Integrated Model undertaken by the Centre for Research on Violence Against Women and Children, located at the University of Western Ontario. Released in the fall of 1999, the study found that improvements were needed with respect to the participation of the health care system in the integrated approach to woman abuse. The Coordinating Committee pledged to support the Task Force; many of its members became active on the Task Force as well.

Dr. Pollett invited Marion Boyd, former Ontario Attorney General and Minister Responsible for Women's Issues and a former executive director of the London Battered Women's Advocacy Centre, to chair and coordinate the Task Force. Together they then recruited additional representatives from the health care, justice and community service sectors. (The full membership of the Task Force is outlined on pages 4-6.)

The timing for the inception of the Task Force was particularly fortuitous: a number of concurrent developments specifically urged new and creative actions in the area of woman abuse as the year 2000 approached. The full impact of the final Report of The Canadian Panel on Violence Against Women was beginning to be felt by policy makers and service providers alike. The Report, Changing the Landscape: Ending Violence ~ Achieving Equality,[4] was released in 1993. The Panel provided a context within which woman abuse can be understood and made a series of recommendations with respect to dealing with the health effects of woman abuse. The Report contained indisputable statistical evidence of the scope, the seriousness and the effects of violence against women in Canada. Its recommendations highlighted the need for a stronger commitment by the health care professions to integrated efforts to identify, treat and prevent woman abuse.

The National Forum on Health published in 1997 a synthesis of reports and issue papers entitled Canada Health Action: Building on the Legacy.[5] Two papers prepared for the National Forum, the "Determinants of Health Working Group Synthesis Report" and the "Overview of Women's Health" provide key insights into the health effects of woman abuse and provide recommendations for action to ensure that health providers are positive partners in an integrated response to woman abuse.

The inquest into the March 8, 1996, murder of Collingwood resident Arlene May by Randy Joseph Iles and his subsequent suicide highlighted the need for all partners in the health, justice, community and private sectors to work together to prevent such tragedies. The jury verdict and recommendations are a compelling call to action for all sectors.[6] One of the key recommendations of the jury was for the government to call together a Joint Committee on Domestic Violence, made up of key government decision-makers and community-based experts to devise an effective five-year plan of action to carry out the other jury recommendations. This Joint Committee was established; one of its community members was Dr. Peter Jaffe of the London Family Court Clinic, a founder of the London Coordinating Committee to End Woman Abuse.

The Joint Committee reported its findings in the fall of 1999. Many of its recommendations address the health effects of woman abuse.[7] The Joint Committee recommended that each community adopt a multi-disciplinary approach to improve the identification and assessment of woman abuse in health care settings, promoting the use of screening tools and protocols. The report urged that the provincial Colleges and Associations work together to put standards and procedures in place to screen for abuse and that the screening protocols should be enforced through the Canadian Council on Health Services Accreditation and the Ontario Hospital Association's new "report card" process. (The full text of the recommendations pertinent to the work of the Task Force is included in this report as Appendix 1, pages 71-73.)

As we enter the new millennium, health services in Ontario are rapidly changing as primary care reform and hospital restructuring occur at a rapid pace. There is pressure from all levels of government to improve efficiency in the delivery of health care services in order to protect universal medicare in the face of soaring costs. Utilization rates for health services have come under intense scrutiny. Health care is now required to be more results-oriented and to address the satisfaction rate of patients with the service delivery they receive. The Ontario Hospital Association in response has initiated a "Report Card" system for hospitals. The "Report Card" includes a gender screen in response to criticisms by women's advocates that hospital services may not respond to the needs of women, particularly those who experience abuse, as effectively as is necessary. A change-oriented environment is often a more fertile ground in which to grow the relationships, the trust and the shared commitment necessary for collaborative protocols to end woman abuse.

A 1999 Ontario government initiative, Healthy Babies, Healthy Children,[8] has been entrusted to the health unit for delivery in the Middlesex-London area. The programme involves universal screening of every newborn in Ontario to identify at birth those children who fall into an "at risk" population. Those at risk are offered a range of prevention and early intervention services designed to provide early, targeted support to children and families. The programme depends on its universal screening component because families are not stigmatized or labelled as a result of subjective determinations of their being "at risk." The same tool is used for every newborn in every family in every community, regardless of socio-economic status, race, culture, family status, religion or other factors. Supports are offered based on the specific needs of each newborn and his or her family. Violence within the family is also an aspect of the screening tool. The programme, enthusiastically embraced by public health in Ontario and communities, provides a convincing paradigm for universal screening when public health issues are identified and made priorities by our communities.

London has experienced strong leadership within the health care community on the issue of woman abuse. Dr. Barbara Lent was one of four founding members of the Ontario Medical Association

Committee on Wife Abuse, which published educational articles and guidelines for practising physicians during the late 1980's. A strong research programme has been undertaken by clinicians and researchers affiliated with the Thames Valley Family Practice Research Unit, focusing on the experience of family doctors and the development of a screening tool that would be useful in a family medicine context.[9]

As part of the London community's integrated approach to woman abuse, a number of efforts have been made to establish protocols in the health care sector. In 1994, Victoria Hospital published a document entitled "Abuse in Relationships: Client Care Guidelines and Staff Reference Manual"[10] which was intended to guide staff responses to abuse within a family context and to encourage more pro-active identification and intervention of abused intimate partners and children. These guidelines were indicator-based and assumed ongoing professional and public education around the issue of woman abuse. Despite the vigorous efforts of many staff proponents, the guidelines are not consistently applied and, according to the research,[11] when they are utilized do not result in referrals to the community based agencies specializing in woman abuse issues.

Similarly, in 1998, the London Battered Women's Advocacy Centre published a report outlining a comprehensive protocol for health care professionals to help them identify women in their practices who are experiencing abuse from intimate partners and to refer these patients to appropriate community resources.[12] Although very thorough, the protocol was also highly prescriptive and did not win support from the health care community.

In many other jurisdictions, protocols to screen for woman abuse have been developed and put in place in recent years. (Appendix 2, pages 74-78 provides a brief assessment of the models examined by the Task Force and a number of other tools are referenced in "Works Cited and/or Consulted.") In many of these jurisdictions, the protocols make screening for at least some forms of woman abuse mandatory; intimate partner abuse is usually the priority for screening. Tools have been designed and tested and they are available for adaptation to local needs. Research is being undertaken to determine the relative effectiveness of such screening mechanisms in identifying abused women at an earlier date and providing them with support, as they struggle to survive.

Experience elsewhere has shown that early identification of abuse is not, on its own, sufficient to end woman abuse. Effective interventions within an integrated community response are essential. An integrated response requires all involved professionals to follow an agreed protocol that includes a range of screening, referral, safety planning, training/education and documentation elements if it is to address woman abuse effectively. The creation of the Task Force provided an opportunity for the Middlesex-London community to choose among the range of models available and to tailor a comprehensive protocol for local use. There was no need to "re-invent the wheel" but every opportunity to adapt its use to ensure a smoother journey toward a future free of woman abuse.

When many different elements appear within the same time-frame to converge together to urge a forward movement, the phenomenon is known as "synchronicity." Given the time, the place, the expertise and the leadership, health care services in Middlesex-London have the advantage of synchronicity to move forward in their efforts to serve abused women promptly, safely, effectively and with sensitivity. The Task Force was established by the Middlesex-London Health Unit to catch this moment and this momentum.

b) Membership of the Task Force:

(Note: The members of the Task Force are listed by primary affiliation. Many are also engaged in academic and community activities that cross the boundaries of these designations.)

Chair and Coordinator:
Marion Boyd
Crosshealth Consultant Services

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London Psychiatric Hospital

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Family Physician
Byron Family Medical Centre
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Dr. Peter Fendrich
Dentist
Private Practice

Dr. Barbara Lent
Family Physician
Victoria Family Medical Centre
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Dr. Fred Sexton
Past President
London Academy of Medicine

University of Western Ontario:
Dr. Helene Berman
Professor of Nursing
School of Nursing

Dr. Tom Freeman
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Terri Streefkerk
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(Dr. Peter Jaffe, Executive Director of the London Family Court Clinic, provided encouragement and advice to the Task Force. Chief Al Grammolini of the London Police Services, Tony Dagnone, CEO of the London Health Sciences Centre and Cliff Nordal, CEO of St. Joseph's Health Care London agreed to support the work of the Task Force and sent representatives to be active participants in the Task Force process.)

c) Mandate of the Task Force:

The Task Force was designed to develop a public health approach to the issue of woman abuse. Specifically, the mandate was:

1. To examine existing screening protocols to determine the required elements for an effective model;

2. To adopt a universal screening protocol which:

   - Fosters early identification of any form of woman abuse experienced by women seen in health care settings;
   - Encourages the assessment and documentation of the health effects of abuse on disclosing women;
   - Addresses the immediate safety issues faced by disclosing women; and
   - Strengthens the integrated referral network so that all women are made aware of services for abused women in the health care, criminal justice, community service and private sectors.

As the work of the Task Force progressed, a number of other issues were identified that were also incorporated into the mandate of the Task Force:

3. To identify the necessary preconditions, including public and professional education strategies, for the successful implementation of the chosen protocol.

4. To make recommendations to the appropriate bodies on the changes required to ensure the successful implementation of the chosen protocol.

5. To obtain commitments from health care institutions and practitioners in the Middlesex-London area to implement the chosen protocol locally within an agreed time frame.

6. To develop an evaluation plan to measure the effectiveness of the protocol in achieving early identification of woman abuse.

7. To report back to the community on the process and the outcomes of the Task Force deliberations.

d) Why the Mandate Excludes Consideration of Abuse of Men:

The Task Force chose to deal only with the issue of woman abuse, even though its members recognize that men may also be victims of abuse. In July 2000, Statistics Canada reported on the results of the 1999 General Social Survey[13] that showed an estimated 8% of women and 7% of men who were married or living in a common-law relationship during the previous five-year period experienced some type of violence committed by their partner on at least one occasion. However, the survey also clearly demonstrated that the nature and consequences of spousal violence were more severe for women:

- Women were more than twice as likely to have been beaten;
- Women were five times more likely to have been choked;
- Women were five times more likely to fear for their lives;
- Women were three times more likely to have been physically injured;
- Women were five times more likely to have required medical treatment;
- Women were seven times more likely to have experienced sexual assault;
- Women were twice as likely to have been threatened with a gun or knife;

- Women were twice as likely to have been assaulted more than ten times in the previous five years;
- Three times as many wives as husbands have been killed by a partner over the past two decades; and
- Men were more likely to report being slapped, having something thrown at them, having been kicked, bitten or hit than any other form of violence.

The good news out of the survey is that violence against women appears to have decreased since the last survey in 1993 from 12% to 8% and that there has been a slight but significant decline in the severity of spousal abuse against women. Nevertheless, available data for intimate partner abuse that are based on criminal justice statistics and community-based services, indicate that men are identified as the abuser in more than 90% of cases.

> *Regarding the physical abuse of men by women, evidence supports our conclusion that the incidence is low. The research that has claimed to show similar levels of violence between men and women does not adequately distinguish between abusive and self-protective behaviour or between frightening and annoying violence. This work has also relied heavily on self-reporting, which causes the results to be distorted because of the abusers' high level of denial. Even in these studies, most of the serious violence and injury were inflicted on women....We are not suggesting that men alone have the capacity to batter (nor did we state that men perpetrate most child abuse.)...However, there are important biologic and social realities that make it difficult for a woman to instil in her male partner the kind of pervasive fear that gives abuse its powerful effect.*[14]

> *Violence against women is different from interpersonal violence in general. The nature and patterns of violence against men, for example, typically differ from those against women. Men are more likely than women to be victimized by a stranger or casual acquaintance. Women are more likely than men to be victimized by a family member or intimate partner. The fact that women are often emotionally involved with and financially dependent upon those who abuse them has profound implications for how women experience violence and how best to intervene.*[15]

Although women have taken concerted political and social action to develop and deliver abuse services to women over the past twenty-five years, no similar movement has yet arisen to pressure governments and communities to provide abuse services to men. Consequently, extensive work on effective interventions for abused men has yet to be done and a body of expertise is only beginning to be developed. While there are a few private, health care and community services available in some communities that do accept abused male clients, such services remain scarce in most places. There is little point in screening for a health condition when no referral resources are available to serve the needs of those identified or when the health condition itself may be uncommon. The screening protocol recommended by the Task Force could easily be adapted to screen men as well if, in future, there is a demonstrated need to do so.

e) The Task Force Process:

Dr. Graham Pollett and Marion Boyd began to recruit members of the Task Force in September of 1999. The Task Force was to be made up of committed individuals who already had knowledge and experience of the issue of woman abuse or who held crucial decision-making positions. Task Force members came from the following sectors: health care, justice, community service, and the private sector. Prospective members were approached individually and the objective of designing a universal screening protocol to fit the service needs of the Middlesex-London community was clearly set out as the goal of the Task Force. Some individuals who were not initially included in the Task Force, asked to join and their expertise added greatly to the collective knowledge of the group. Although it was acknowledged from the beginning that such a diverse and large Task Force would find it challenging to develop a unified position on a screening protocol, the members were enthusiastic about attempting to do so.

The Task Force was designed to carry out its mandate as expeditiously as possible. The Task Force members committed to work over a six-month period, meeting approximately once every three weeks between the beginning of October 1999 and the end of March 2000. Meetings were well attended, with more than two thirds of participants present at each session and each sector was well represented. The Task Force was provided with written materials either prior to or at each meeting and draft materials were circulated for written input on each topic. Notes were kept of comments and concerns raised during the meetings, and, where agreement seemed to have been reached on specific items of discussion, the elements of agreement were

also noted. Several members of the Task Force brought forward additional materials of interest for circulation to the group and offered perspectives from their own specialized areas that added to the overall understanding of the challenges involved in achieving the Task Force mandate.

The Task Force worked to achieve consensus on the many issues it discussed. Efforts were made to reach conclusions that all members of the Task Force could live with, even if some may have argued against one or more aspects of the position eventually adopted. This was indeed a challenging process as the interests and perspectives of individuals and the sectors from which they were drawn often differed substantially. Where consensus was not achieved, every effort has been made to acknowledge the various viewpoints in this report. Most importantly, consensus was achieved with respect to the Recommendations of the Task Force.

As the discussions of the Task Force proceeded, several members of the Task Force had the opportunity to discuss the draft protocol in different venues. For example, the Task Force presented to Internists during Grand Rounds at both hospitals, to a fourth year class of nursing students and to the London Coordinating Committee to End Violence Against Women. In each case, suggestions and concerns were noted and every effort has been made to address them in this report.

The final report of the Task Force is based largely on material presented to or developed by the Task Force during its deliberations and on research materials collected to inform the work of the Task Force. Although drafts of many chapters of the report were circulated to all Task Force members for input, and extensive editing resulted from that process, it was not possible, given the pressure of time constraints, to circulate the entire final version for approval by all Task Force members. A small editorial sub-committee, made up of five members of the Task Force, did provide input to the final draft. However, the responsibility for the report and any errors or omissions it may contain, rest solely with the author, Chair and Coordinator of the Task Force, Marion Boyd.

Chapter II: Woman Abuse as an Urgent Public Health Issue

a) The Definition of Woman Abuse:

The Task Force chose to use the definition of woman abuse set out in Article 1 of the United Nations Declaration on the Elimination of Violence Against Women:

> *"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."*[16]

b) Putting the Definition of Woman Abuse in Context:

The United Nations Declaration goes on to set the context for woman abuse:

> *"[Violence against women] is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and which have prevented women's full advancement. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared to men."*[17]

> *Article 2 of the UN Declaration clarifies that the definition of violence against women should encompass but not be limited to, acts of physical, sexual, and psychological violence in the family and the community. These acts include spousal battering, sexual abuse of female children, dowry-related violence, rape, including marital rape, and traditional practices harmful to women, such as female genital mutilation (FGM). They also include non-spousal violence, sexual harassment and intimidation at work and in school, trafficking in women, forced prostitution and violence perpetrated or condoned by the state, such as rape in war.*[18]

The London Battered Women's Advocacy Centre uses a more detailed definition that stresses the dynamics of woman abuse:

> *"[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 or the other person's behaviour or external events."*[19]

With respect to intimate partner abuse,

> *Worldwide, studies identify a consistent list of events that are said to "trigger" violence. These include: not obeying her husband, talking back, not having food ready on time, failing to care adequately for the children or home, questioning him about money or girlfriends, going somewhere without his permission, or expressing suspicions of infidelity…All of these constitute transgression of gender norms.*[20]

The objective of woman abusers is to exercise power and control over their victims. Appendix 3, pages 79-80 provides a list of behaviours, based on reports by abusive men themselves, as to how they controlled or harmed their intimate partners. Similar tactics are used by abusers in other circumstances. Figure 1, page 13 is a teaching tool developed originally by the Domestic Abuse Intervention Project in Duluth, Minnesota and adapted by the London Battered Women's Advocacy Centre for use in client counselling, public education and professional education.

c) The Prevalence of Woman Abuse:

Early advocates on the issue of woman abuse estimated that at least one in ten women experienced gender-based abuse during their lifetime.[21] However, extensive research done to support the work of the Canadian Panel on Violence Against Women (1993), shows a much higher incidence than had previously been suspected.[22] A Statistics Canada survey of over 12,000 women and

an in-depth study of more than 400 women for the "Women's Safety Project" showed a prevalence rate that stunned even seasoned service providers. The "Highlights of the Findings of the Women's Safety Project" show that, depending on the particular type of violence being measured, between 27% and 51% of women have survived one or more physically or sexually abusive incidents, as defined by the Criminal Code of Canada. (See Figure 2, page 14.)

A recent review article in the New England Journal of Medicine[23] noted the following statistics from various American studies:

- 1 in 4 women seeking care in the emergency room (E.R.) for any reason is a victim of violence;
- 37% of female patients who are treated in the E.R. for violent injury have been injured by an intimate partner;
- 1 in 3 women treated for trauma in the E.R. has been injured by an intimate partner;
- 1 in 6 pregnant women is abused during pregnancy;
- 1 in 4 women seen in primary care settings has been abused at some time in her life;
- of this 25%, 1 in 7 reports abuse within the preceding 12 months;
- 1 in 4 women who attempts suicide is a victim of abuse; and
- 1 in 4 women who is treated for psychiatric symptoms has been abused.

These numbers do not include abuse by perpetrators other than intimate partners nor do they include psychological, emotional or financial abuse within the domestic context.

Sexual harassment is another form of violence experienced by women. The National Panel on Health Care in its "Overview of Women's Health" estimates that anywhere from 42% to 80% of women experience sexual harassment in the workplace during their working lives.[24] Women also experience sexual harassment from others who have power over their livelihood, their health and their security: landlords, teachers, counsellors, lawyers, financial advisors or health care professionals are among the perpetrators.

d) The Cost of Woman Abuse:

The human costs of violence against women are incalculable; it is simply not possible to measure the pain and suffering, the forfeited opportunities and the lives lost as a result of gender-based abuse.

> *In addition to its human costs, violence against women hinders women's participation in public life and undermines the economic wellbeing of societies. Although techniques of estimating the economic and social costs of violence are imperfect, studies have begun to provide insights into the ways that gender-based violence undermines women's participation, reduces their productivity, and drives up costs to the economy, including medical care costs.*[25]

In 1994, the Canadian Public Health Association lamented that no comprehensive analysis of the cost of woman abuse had yet been done.[26] In 1995, a study prepared for the Centre for Research on Violence Against Women and Children in London, entitled, "The Health Related Costs of Violence Against Women in Canada: The Tip of the Iceberg" conservatively set the direct and measurable health costs of women abuse to be at least $l.54 billion (CAN) per year.[27] This same study estimated the costs of psychiatric interventions, based on hospital admissions, emergency care and ambulatory/day clinics, at over half a billion dollars alone.

Building on the health cost information, a more comprehensive study prepared by the Centre estimated the economic costs of three forms of violence against women: sexual assault/rape; abuse in intimate partnerships; and incest/childhood sexual assault. Looking at only four policy areas (health/medicine, criminal justice, social services/education and labour/employment) and having only partial data, the study estimated the costs at a minimum of $4.2 billion (CAN) annually, with 87.5% of those costs paid through tax dollars.[28]

Although it has been known for many years that women access health care services more frequently than men, utilization rates are only beginning to be studied with respect to woman abuse. Repeated visits to physicians and hospitals because of chronic pain, for example, are very possibly the result of undiagnosed health effects of woman abuse.

> *Although the numbers may underestimate the true prevalence, the proportion of women in this clinical sample who reported experience with severe violence was still twice the expected number.... Women who have been severely*

abused have ongoing health needs that bring them to outpatient settings at higher rates than women who have not had the same experiences….Physicians often perform exhaustive searches for an organic basis for these symptoms without recognizing their cause.[29]

An American study,[30] done by a large Health Management Organization (HMO) in Minnesota in 1994 compared women who had disclosed abuse by intimate partners with those who had not experienced such abuse and found that abused women cost their health organization 92% ($1,775.00 US) more annually than those reporting no abuse. Another study found significant increases, a range of from 15 to 24%, in physician visits among criminally victimized women as compared to those not disclosing abuse. The increase was particularly noticeable in the first year after an incident.[31] In a third study, undertaken at another large HMO, the individual costs were more modest but the cumulative effect was still significant:

Women who reported any abuse or neglect had median annual health care costs that were $97 (95% confidence interval, $0.47 - $188.26) greater than women who did not report maltreatment. Women who reported sexual abuse had median annual health care costs that were $245 (95% confidence interval, $132.32 - $338.93) greater than costs among women who did not report abuse. Women with sexual abuse histories had significantly higher primary care and outpatient costs and more frequent emergency department visits than women without these histories. Although the absolute cost differences per year per woman were relatively modest, the large number of women in the population with these experiences [42% in this sample] suggests that the total costs to society are substantial.[32]

In the United States, where universal medicare is not available, such studies have led to the de-insurance of abused women and a reluctance on the part of health care professionals to chart abuse in patient records because such notations may result in the patient's having restricted access to health care.

Nationally, family violence incurs medical costs of almost $2 billion per year... A 1994 survey by the staff of the United States House of Representatives Judiciary Subcommittee on Crime and Criminal Justice found that half of the nation's 6 largest insurance companies use domestic violence in making underwriting decisions, including whether to issue or renew insurance and what to charge for it….In May 1995, the Insurance Commissioner of Pennsylvania reported the results of a formal survey of accident, health and life insurers regarding their underwriting practices relating to domestic violence. Overall, 24% of the responding insurers reported that they took domestic violence into account in determining whether to issue and renew insurance policies. Domestic violence was reported to be a criterion in deciding whether to accept new applications by 65% of the responding health insurers. Health insurers involved in the underwriting practices were primarily indemnity Health insurance providers. Well after a year after these practices received unfavourable public attention, the Pennsylvania surveys found that few insurers had changed their practice. Even now, although Pennsylvania law has defined the practice as illegal, some insurers continue to discriminate against victims of domestic violence…[33]

In Canada, where the publicly funded health care system is under attack because of high costs (still at least 5% below American costs when measured against the GDP) one way to preserve universal medicare may be to address such utilization issues with more pro-active and effective early identification, treatment and prevention of woman abuse.

e) The Public Health Approach to Woman Abuse:

The Maxcy-Rosenau-Last textbook, Public Health and Preventive Medicine, is regarded as a classic guide to public health.[34] It defines different degrees of prevention:

We customarily distinguish several layers of prevention. The aim of primary prevention is to preserve health by removing the precipitating causes and determinants of departures from good health. To put it in epidemiological terms, the aim of primary prevention is to reduce the incidence of disease and injury…

The aim of secondary prevention is to detect and correct departures from good health as early as possible; in other words, to reduce the prevalence of disease and disability. We can often accomplish this with screening procedures that detect disease before it is manifested by symptoms or signs…Screening needs to be combined with counselling about reduction of risks to health if it is to be fully efficacious. (pp 4-5)

In the public health context, Stark and Flitcraft, writing specifically about spouse abuse (pp 1042-1043), outline the appropriate interventions with respect to abuse:

> *Interventions: Preventing [woman] abuse requires protecting victims; stopping violence; expanding the resources available to victims and assailants; and early identification, referral and public education. Thus far emphasis has been placed on shelters, police and legal action and legislation.*
>
> *The traditional medical model provides an adequate (sic) framework for a health care response to [woman] abuse for the following reasons:*
>
> - *It greatly undervalues the psychological and social costs of abuse.*
> - *It underplays the complex social origins of abuse.*
> - *It is based on outdated notions of prevention.*
>
> *Intervention must instead target social behaviours; health providers must form working alliances with community-based services and with disciplines outside health; and emphasis should be placed on non-medical policies and interventions that can reduce the violence and improve health. We term this complex social intervention.*

The paper goes on to outline the primary and secondary prevention modes that fit this new type of intervention:

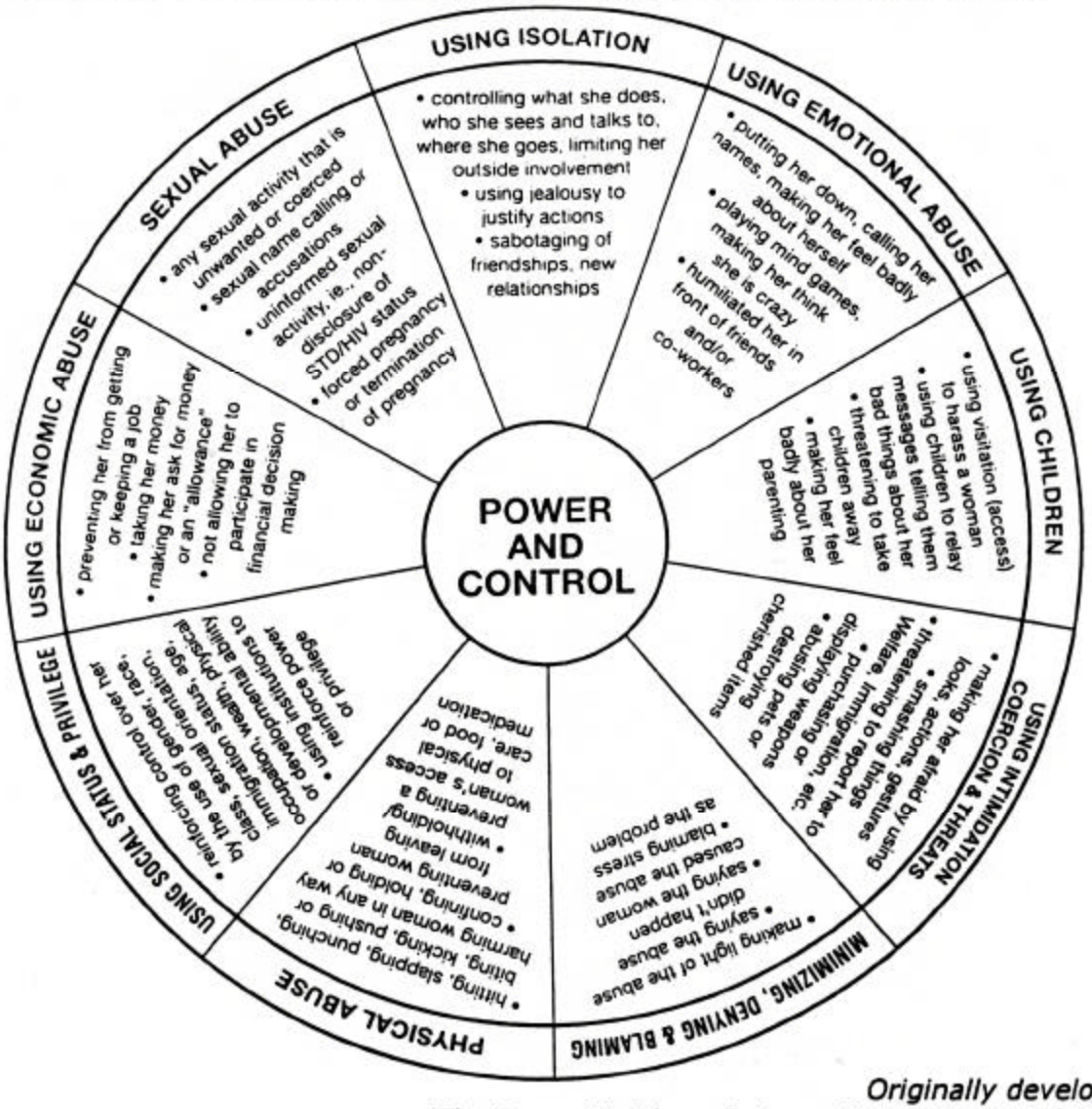
> *Primary Prevention: These interventions are designed to prevent [abuse] by enabling health institutions to respond more effectively to interpersonal conflict before it escalates:*
>
> 1. *Establish and implement model protocols for the early identification and referral of abuse victims in health settings.*
> 2. *Introduce model curricula on [woman] abuse and gender bias into the professional education, training and continuing education of health and social service providers, school counsellors and criminal justice groups.*
> 3. *Develop and distribute public information on [woman] abuse and available services to the media.*
>
> *Secondary Prevention:*
>
> 1. *Support the development of [woman] abuse protocols in secondary treatment sites dealing with rape, alcohol and drug abuse, suicide prevention, emergency psychiatric problems, child abuse and the homeless.*
> 2. *Extend the range of options available to [abused] women.*
> 3. *Expand the counselling, treatment and life-style options available to violent men.*

The Task Force Final Report and Recommendations clearly reflect this public health approach to dealing with woman abuse. The data clearly indicate that woman abuse is an urgent public health issue that occurs in epidemic proportions in our country and that both the personal and the public costs are enormous. An integrated public health approach based on early identification, effective treatment and prevention must be undertaken if we are to stop the suffering caused by this health threat and stem the costly spread of this epidemic.

Figure 1:
Power and Control Wheel

BATTERING IN INTIMATE RELATIONSHIPS
"THE POWER AND CONTROL WHEEL"

Woman abuse in adult relationships is generally defined as: The intentional and systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a woman. The tactics can include, but are not limited to, the examples below.



Originally developed by
The Domestic Abuse Intervention Project, Duluth, USA

Further Adapted by
The London Battered Women's Advocacy Centre

Figure 2:
Prevalence of Woman Abuse in Canada 1993

THE CONTEXT

HIGHLIGHTS OF THE FINDINGS OF THE WOMEN'S SAFETY PROJECT

The following information is based on 420 in-depth interviews with women between the ages of 18 and 64.

SEXUAL ABUSE OF GIRLS (AGE 16 AND UNDER)

- **More than one half (54 percent) of the women** had experienced some form of unwanted or intrusive sexual experience before reaching the age of 16.
- **24 percent of the cases** of sexual abuse were at the level of forced or attempted forced sexual intercourse.
- **17 percent of women** reported at least one experience of incest before age 16.
- **34 percent of women** had been sexually abused by a non-relative before age 16.
- **43 percent of women** reported at least one experience of incest and/or extrafamilial sexual abuse before age 16.
- **96 percent of perpetrators** of child sexual abuse were men.

SEXUAL ABUSE OF WOMEN (AGE 16 AND OVER)

- **51 percent of women** have been the victim of rape or attempted rape.
- **40 percent of women** reported at least one experience of rape.
- **31 percent of women** reported at least one experience of attempted rape.
- Using the Canadian Criminal Code definition of sexual assault (this includes sexual touching): **two out of three women**, have experienced what is legally recognized to be sexual assault.
- **81 percent of sexual assault cases** at the level of rape or attempted rape reported by women were perpetrated by men who were known to the women.

PHYSICAL ASSAULT IN INTIMATE RELATIONSHIPS

- **27 percent of women** have experienced a physical assault in an intimate relationship.
- **In 25 percent of the cases,** women who were physically assaulted reported that their partners explicitly threatened to kill them.
- **In 36 percent of the cases,** women reporting physical assault also reported that they feared they would be killed by their male intimate. Typically, women reported that the fury and violence exhibited during attacks made them fear for their lives.
- **50 percent of the women** reporting physical assault also experienced sexual assault in the context of the same relationship.
- **All of the physical assaults on women** were perpetrated by male intimates.

Chapter III: The Health Effects of Woman Abuse

a) General Comments:

The health effects of woman abuse listed below are compiled from the research findings of many professionals working in many different health care settings. (See "Works Cited And/Or Consulted, pages 59-66.) **While many of these health conditions may result from causes other than woman abuse, the frequency and consistency of these health effects in women who have been abused suggest they are highly symptomatic of abuse**. Women who are abused experience high levels of stress and anxiety, often over long periods of time. Stress is known to trigger or exacerbate many other health conditions such as cardio-vascular conditions, migraine head-aches, reproductive disorders, asthma and some autoimmune diseases. Some women who have been abused show very few symptoms while others show many. The illnesses, injuries and conditions of abused women need appropriate medical treatment, in addition to assistance with dealing with the abuse; **identifying abuse may alleviate some distress, but the medical conditions presented must still be addressed by health care professionals**.

b) <u>Fatal Health Effects</u>:

In a shocking number of instances, woman abuse results in death. In Canada, in 1991, two hundred and seventy (270) women were killed; of the two hundred and twenty-five (225) cases that were solved, two hundred and ten women (210) were killed by men and one hundred and twenty-one (121) were killed by intimate partners.[35] From 1991 to 1994, an average of forty women (40) were killed in Ontario each year by current or former legal spouses, common-law partners or boyfriends, accounting for 75% of all female homicides. Of these women, 40% were living apart from their partner at the time of death and nearly one third had previously sought police assistance because of violence in their relationships. In a number of cases, children were also killed or witnessed their mother's death. The risk of being killed by an intimate partner is particularly high at the time of separation.[36]

> *In at least half the killings of women, the men committed the murders because they could not accept the women leaving them; in other cases they committed the murder as revenge for having 'lost control' over their wives' lives…[Woman abuse] accounts for one in every four suicide attempts by women.*[37]

c) <u>Physical Health Effects</u>:

- **Broken bones:** wrist, rib, ring finger, jaw, clavicle, cheek
- **Bruises**: bilateral or multiple contusions, arms, legs, 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, necks
- **Lacerations:** on skin over bony areas, internal tearing
- **Concussions, Skull Fractures or "Shaken Adult Syndrome"**[38]
- **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**

d) <u>Sexual Health Effects</u>:

- **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**

e) <u>Psychological Health Effects</u>:

- **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**
- **Uncommunicativeness**
- **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**

f) <u>Psychiatric Health Effects</u>:

- **Depression**
- **Suicidal Ideation**
- **Dissociation**
- **Eating Disorders**
- **Post Traumatic Stress Syndrome**
- **Adjustment Disorder with Depressed Mood**
- **Obsessive Compulsive Disorder**

Chapter IV: The Indicators of Woman Abuse

a) General Comments:

In addition to the specific health effects noted in the health effects section, there are a number of specific indicators, which can alert health care professionals to the possibility of woman abuse as a factor in their patients' lives. The presence of multiple indicators may be particularly helpful in suggesting a diagnosis of woman abuse. The indicators of woman abuse, once known and understood, can assist health care professionals to identify woman abuse as an important factor when diagnosing a presenting health problem and can help ensure that treatment and/or referral is both appropriate and effective.

b) Incidental Indicators of Abuse:

- History of recurrent trauma involving frequent use of emergency services, often during the night,
- Explanations of injuries that do not fit the physical evidence,
- Delay between the occurrence of the injury and seeking medical assistance,
- An unexplained flare up of a previous condition aggravated by stress.

c) Physical Indicators of Abuse:

- Presentation of injuries to multiple sites, particularly to areas not usually affected by accidents,
- Injuries to the head, neck, torso, breasts, abdomen or genitals,
- Symmetrical and bilateral injuries, which do not often occur in accidents,
- Old, untreated injuries as well as new injuries,
- Fingerprint bruises on arms, neck or breasts or strangulation bruises on neck,
- Mid-arm or hand injuries that could be defensive injuries,
- The "accident prone" patient who seems to fall frequently, has car accidents or injures herself with no medical explanation,
- Sudden loss or gain in weight or unusual neglect of hygiene or appearance.

d) Sexual Indicators of Abuse:

- Sexually transmitted diseases, including HIV with no indication of multiple sexual partners or intravenous drug use,
- Multiple miscarriages,
- Bruising, cuts, abrasions or tears in the genital or anal area,
- Female genital mutilation,
- Frequent infections or unexplained vaginal bleeding,
- Lack of appropriate sexual boundaries or sexually addictive behaviour,
- Disinterest or dysfunction in sexual relationships,
- Frequent pregnancies when contraindicated or unwanted by woman, often coupled with her partner's refusal to practice birth control,
- Explicit sexual behaviour out of context.

e) Indicators of Isolation Associated with Abuse:

- Frequent change of health care providers within the same geographic area,
- Frequent family moves, often to increasingly isolated locations,
- Little or no contact with family of origin,
- No longer maintaining previous contacts with friends, faith community, or social activities,
- No access to identification, health cards, passport, etc.,
- No driver's license and/or no access to transportation,

- Seldom going anywhere unless her partner or another family member accompanies her,
- Sporadic or no follow up on referrals to specialist care, physiotherapy, counselling or self-help groups,
- Children and/or parents noticeably aligned with the abuser against the woman.

f) Behavioural Indicators of Abuse:

- Evasive and guarded in interactions, maintaining poor eye contact, displaying either a flat affect or an inappropriate affect (laughs or cries inexplicably or out of context),
- Infrequent or frequently cancelled or missed medical appointments,
- Lack of consistent prescription use or frequent requests of prescriptions, particularly tranquillizers, anti-depressants or pain-killers,
- Hypervigilant, constantly monitoring location, condition or needs of partner or another person,
- Difficulty in maintaining appropriate adult relationship with health professional: overly submissive or non-assertive; easily angered; highly cautious and reluctant to communicate; anxious and fearful when alone with another adult,
- Excessively deferential to partner; unable to commit to any decision without permission,
- Tends to be either overprotective of children or remote from them,
- Unwilling to discuss relationship issues,
- Constant concern about age and appearance; constant changes in appearance,
- Symptoms of anorexic, bulimic or voracious eating behaviours,
- Displays other addictive behaviours (substance abuse, sexual promiscuity, gambling, shoplifting, etc.).

g) Social Indicators of Abuse:

- Sudden change in family socio-economic status that undermines a dominant partner's self-esteem and control,
- Rigid family structure based on gender stereotypes,
- Chaotic family structure without appropriate boundaries,
- Abuse of mother may indicate a risk to the children and vice versa,
- Previous history of abuse in relationships or family of origin,
- Familial attitudes about gender, power and control, possibly culturally based, that demean women and their autonomy,
- Arranged or forced marriages,
- Runaway children or youth,
- Reluctant caregiver to elderly, ill or disabled person,
- Disability or long-term health condition that may make a woman more vulnerable to abuse.

h) Financial Indicators of Abuse:

- Woman has no control over her own finances and has no access to disposable income,
- Woman must beg for money for necessities for herself and her children,
- Chronic history of partner using money for gambling, substance abuse, credit cards, entertainment and running up debts for which the woman is legally responsible,
- Prolonged and bitter disputes about custody, access and child support,
- Refusal to honour immigration sponsorship of woman,
- False reports brought against the woman alleging social assistance fraud, child abuse or some other criminal activity.

Chapter V: Developing a Screening Protocol for Woman Abuse

a) Terminology

Most of the literature that discusses a public health approach to woman abuse uses the terminology of a **"screening protocol"** even though, strictly speaking, much more is involved than screening in the protocols adopted. We will also use the term "screening protocol" for simplicity but need to explore the terminology so that there is no misunderstanding of what is involved.

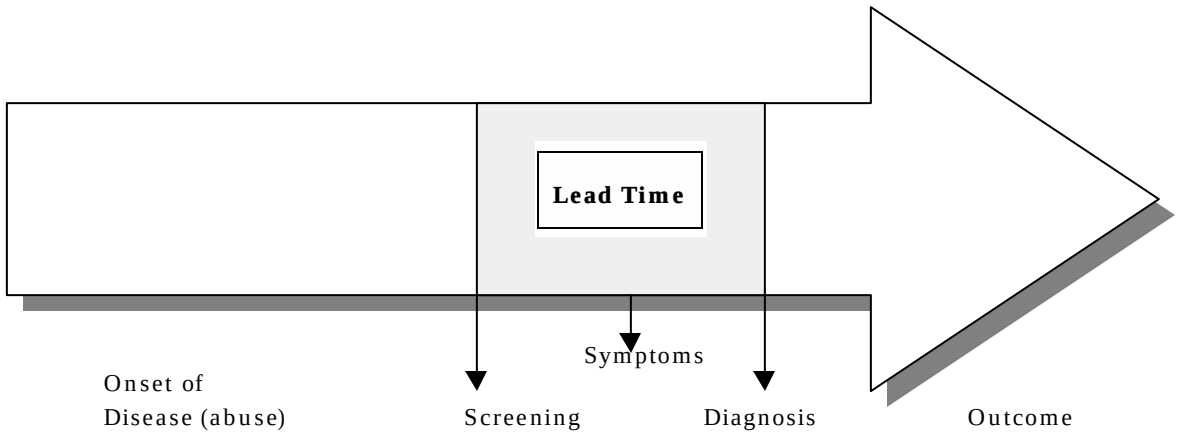
Screening is "the presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures that can be applied rapidly. Screening sorts out apparently well persons who have a disease or condition from those who probably do not. Screening is not intended to be diagnostic; thus assessment, documentation and follow-up are needed. "[39]

Lead time is the period of time between when a medical condition can be found by screening and when it ordinarily would have been diagnosed because an individual experienced symptoms and sought medical care. The lead time may provide the possibility of intervening to prevent illness or injury.

Mass or **universal screening** is the application of screening tests to large, unselected populations. The persons applying the screening test are not usually responsible for the follow-up and treatment (e.g. hearing and vision screening in schools, blood pressure screening in malls, phenylketonuria and thyroid screening in newborns.)

Case finding occurs when clinicians search for disease with screening tests among their own patients who are consulting/attending for unrelated symptoms/reasons. The person applying the screening test is responsible for the follow-up (diagnosis) and treatment.

When signs and symptoms have appeared, the challenge for health care providers is to make a correct diagnosis regarding their cause. The health care provider considers which conditions might account for the patient's signs and symptoms. These are then ruled out through history, physical examination, the application of diagnostic tests and clinical judgement, to arrive at a final diagnosis—a process known as making a **differential diagnosis.**



Lead Time Gained by Early Diagnosis during Screening
Fletcher, R.H., Fletcher, S.W., and Wagner, E.H. Clinical Epidemiology—The Essentials. William and Wilkins, 1982.

b) Identification of Woman Abuse:

There are two different issues related to the identification of woman abuse:

- The need to consider abuse as part of the differential diagnosis when women present with one or more symptoms suggestive of abuse;
- The need to provide early detection and intervention to those with no apparent signs or symptoms of abuse who have experienced or are currently experiencing abuse (i.e. mass screening or case finding).

In clinical settings, the key for the indicator-based process is to educate health care providers regarding the indicators (signs and symptoms) of woman abuse, whereas for the mass screening or case finding process, the aim is to have health care providers ask about woman abuse as part of their regular history taking/systems review, regardless of the reason for the patient's visit.

c) Meeting the WHO Principles for Screening:

According to the World Health Organization (WHO), any screening program should be able to demonstrate that it meets a standard set of principles.[40] Does screening for woman abuse meet the WHO principles?

Principle 1: The problem should be important, (i.e. pose a threat to health).
Research has established the prevalence, the serious health effects and the costs of woman abuse; the problem is indeed an important one.

Principle 2: There should be an effective treatment available for persons with identified disease.
While the term "disease" is seldom used by those who are expert in the provision of specialized services to abused women, there are a number of specific "health care treatments" available: treatments for injuries and other health problems, medication and/or psychiatric therapy when appropriate. Effective health care interventions that address the physical and mental effects of abuse depend upon successful identification of the abuse in the first place. Non-health care based services, such as shelters, counselling programmes, criminal and civil justice interventions, peer support groups, income support programmes, and so forth are also available to varying degrees in different jurisdictions. Most of these "treatments" fall outside the health care sector but have developed effective interventions to assist abused women to meet the complex social challenges they face.

Principle 3: There should be facilities available for diagnosis and treatment and they should be more effective when applied early.
All women require health care services of one form or another throughout their life cycle; locating a screening programme in already established health care practices and institutions ensures the wide-spread availability of the screening programme itself. Health care professionals who identify abuse have the skills to diagnose and treat some health effects themselves; they may refer patients to other health care specialists for specific medical treatments and may refer to the community services which specialize in woman abuse to address safety, supportive counselling, income security, housing, child care, family law or criminal justice interventions. Early identification leading to effective criminal justice interventions has been shown to dramatically reduce the number of times a woman is abused before she seeks help. When criminal charging in intimate partner abuse became the rule in London, Ontario, the average of thirty-five incidents of abuse before police intervention was reduced to an average of five incidents.[41] Advocates believe that early identi-fication and intervention in the health care sector would be similarly effective.

Principle 4: The natural history of the condition should be understood.
A great deal of research has been done over the last twenty-five years that has revealed the "natural history" (i.e. the nature, prevalence, effects and dynamics) of woman abuse.

Principle 5: There should be a recognizable latency period or early symptomatic stage.
The literature on woman abuse shows that there may be a lengthy period of time between the onset of abuse and its disclosure. Often, particularly in the case of childhood or adolescent abuse and intimate partner abuse, it may last for many years during which the reason for physical or mental symptoms may not be apparent.

Principle 6: There should be a suitable test or examination to detect disease with a high degree of sensitivity and specificity.
In the case of woman abuse the most suitable test is simply to inquire routinely of each woman patient whether abuse has been part of her experience. While the response could be a false negative, it is unlikely to be a false positive, given the reluctance of women to disclose. Once abuse is established as a factor, the health care professional can address specific health concerns and make appropriate referrals.

Principle 7: The test should be simple and cheap.
The simplest and most cost effective way to screen for woman abuse is for health care providers to ask about abuse.

Principle 8: The test must be safe.
Asking about abuse is safe only if safety issues are addressed directly as part of the process and confidentiality is carefully maintained.

Principle 9: The test must be acceptable to providers and clients alike.
The major challenge of initiating screening for woman abuse is to convince both health care providers and patients that it is in the best interest of patients to address woman abuse as early as possible within the health context. Public and professional education will be essential as will the support of professional colleges, health care institutions, educators, accrediting bodies and governments. Resource issues must also be addressed.

Principle 10: There should be an agreed upon policy as to whom to treat as patients.
Those who disclose abuse and who are willing to accept assistance are to be treated as patients.

Principle 11: The cost of early diagnosis and treatment should be balanced against the benefit of early treatment in terms of prevention of disability or death (benefits must outweigh costs).
A definitive cost-benefit analysis has yet to be done. While there is a strong belief among advocates that early intervention ameliorates the health effects of abuse and may prevent further violence and even death, a longitudinal study, based on all women who are screened and taking into account all costs, human and financial, associated with all forms of abuse, is required to determine the extent to which the benefits of screening outweigh the costs.

In general, then, screening for woman abuse does meet most of the principles of screening set out by the World Health Organization. Only by the implementation and rigorous evaluation of a screening protocol over a period of time can the remaining questions be answered.

d) What Screening Protocols Currently Exist?

A number of different screening protocols have been developed in Canada and the United States. (See Appendix 2, pages 74-78 for a summary of the protocols considered by the Task Force.) In some jurisdictions, government policy and legislation have given impetus to the development of screening protocols (e.g. California, Ohio and Pennsylvania). In others, the initiative has been taken by health care professional groups (e.g. the Canadian Nurses' Association, the American Medical Association), by health care institutions (e.g. the Vancouver Hospital and Health Sciences Centre) or by practitioners (e.g. those associated with the Thames Valley Family Practice Research Unit).

Most of these existing protocols focus on one type of abuse. Primarily, protocols have addressed current or recent intimate partner abuse or the broader definition of "family" or "domestic" violence, which includes familial child abuse. This focus is partly because the research has focused on this very difficult area of woman abuse and partly because of the sheer numbers of women who are abused in intimate partnerships or other types of "family" situations. A particular focus in many protocols is the routine screening of all pregnant women as recommended by best practice guidelines of both Canadian and American obstetricians and gynaecologists.

Many protocols depend almost entirely upon indicator-based diagnosis, rather than mass screening. If a health care professional notices symptoms identified as common indicators of abuse, the professional applies the protocol. This type of screening requires ongoing professional education to ensure that every health care professional recognizes the indicators and is proficient in eliciting information about abuse from each identified patient. A study reported in the Annals of Emergency Medicine in 1989 found that a baseline survey of an urban emergency department showed 5.6% of women were identified as abused by their partners. Following an educational programme and the adoption of a clinical screening protocol, the detection rate rose to 30%. When the educational programme was discontinued, the detection rate fell precipitously, to 7.7%.[42]

Many protocols are institutionally based, covering only in-hospital interventions, primarily in the emergency or urgent care area. Thus the many women who never attend at these facilities are not screened. In many cases, although health care professionals identify abuse from indicators, they rely on social workers or other personnel, such as pastoral care workers, to complete the safety checks and referrals that are integral to the protocol. Unfortunately, if those workers are not available at the time abuse is identified or disclosed, essential aspects of the protocol may not be completed or appropriate non-medical interventions offered.

With the cutbacks in health care budgets, collateral professional partners like social workers may not be available on every shift in the institutional setting and so a significant number of patients may be asked about and disclose abuse without having the benefit of appropriate and immediate professional assistance with non-medical issues. The consistency of application of the protocols appears to depend upon the commitment of the institution to the protocol and to monitoring its implementation.

Some protocols seem to be based on theories about violence against women that are not comprehensive enough to elicit truthful responses from all abused women. For example, if the assumption is that intimate partner abuse arises out of the disagreements that occur in any marriage, a woman may be asked about how she and her partner resolve arguments. Even when clinicians have a much more sophisticated and comprehensive understanding of violence against women and issues of gender power, this question may be chosen because it allows the practitioner to move smoothly from typical family medicine questions into questions about abuse.

While an initial question about intra-familial conflict may help some women to disclose, other women who are beaten while they sleep, who are attacked suddenly without any verbal warning, or who are criminally harassed by a former partner may not relate the question to their experience. Similarly, if the question is about abuse by an intimate partner, a woman who experienced child or adolescent sexual abuse within her family of origin or sexual assault by a stranger, may not hear the question as applying to her abuse. While it is a challenge to devise one or two questions that will address the many possible forms of woman abuse, the goal of screening requires questions that are both inclusive and comprehensive.

Some protocols require health care professionals to complete specific forms to document the abuse, as well as any health care interventions and any referrals that they make. Others assume that documentation will be made in the patient file according to usual practice. Where mandatory reporting of abuse is the policy, documentation usually follows a prescribed format accepted by the justice system. In some cases, confidentiality is seen as the priority and care is taken not to note abuse in any file that might be seen by anyone other than the responsible health care professional. This guarantee of absolute confidentiality is not, however, achievable in the majority of settings and so it is important for all personnel working in the health care setting to understand the importance of confidentiality to a woman's health and safety.

The Task Force was determined to learn as much as possible from the existing screening protocols and the available research so as to devise a protocol that would incorporate the accumulated knowledge and skill of jurisdictions and professionals throughout North America. There are a number of approaches to screening; the Task Force explored them in detail.

e) Four Approaches to Screening:

Indicator-based diagnosis means that a health care professional notices one or more indicators that a patient may have been abused and, referring to the indicator(s), asks the patient whether abuse has caused that injury or condition.

Routine screening means that screening is done on a **regular** basis when women come in contact with health care professionals, whether or not indicators of abuse are recognized.

Comprehensive screening means that women are asked by health care professionals whether they have experienced or are currently experiencing **any** form of physical, sexual and/or emotional abuse as children, adolescents or adults.

Universal screening means that **every** woman over an agreed age is asked about her current or past experience of abuse by health care professionals with whom she comes in contact.

Routine universal comprehensive screening combines all of these elements.

f) Indicator-Based Diagnosis vs Universal Screening:

Most current interventions for woman abuse respond to indicators that abuse has occurred. Using the analogy of a river, our current health care, justice and community responses to woman abuse are "downstream" approaches that consist of aiding an abused woman after her situation has become "public." Indicator-based diagnosis is a "downstream" approach, a response to recognized symptoms. Obviously, at the very least, health care professionals should be inquiring about the possibility of abuse when indicators are recognized.

However, even with this "downstream" approach, abuse is frequently missed by health care professionals as the cause of a woman's injury or distress. The Canadian Public Health Association observed in 1994 that

> *"There is abundant evidence that violence is often overlooked in primary health care contacts. A recent study of Ontario doctors indicated that, by their own estimate, they identified fewer than 50% of abused patients in their own practices."*[43]

In 1992, the American Medical Association passed and published its "Diagnostic and Treatment Guidelines on Domestic Violence:"

> *Physical and sexual violence against women is a public health problem that has reached epidemic proportions…*
> *Battered patients often present with repeated injuries, medical complaints and mental health problems, all of which result from living in an abusive situation. [Medical care providers] in all practice settings routinely see the consequences of domestic violence and abuse, but often fail to acknowledge their violent etiologies.*[44]

Different methods of screening for abuse elicit somewhat different responses. However, there is a remarkable consistency in the research that supports the Canadian Panel on Violence Against Women statistics included as Figure 1, page 13 in this report.

In one study of intimate partner violence, 394 women who attended a family medicine centre in a small city were asked directly about abuse. Of these, 23% reported physical violence within the last year; 39% reported physical violence in their lifetime; and only 1.3% reported ever being asked about partner violence by a physician.[45]

In another study of 290 pregnant women receiving prenatal care at a large hospital, 8% reported physical violence during pregnancy, 23% reported physical violence during or prior to pregnancy and not one had been asked about partner abuse by any health care professional.[46] A similar study of 691 women receiving prenatal care in public clinics found 17% reported physical or sexual assault during pregnancy and 55% reported physical or sexual assault during the past year. Again not one woman had been asked previously about partner abuse.[47]

When 900 California physicians were asked about their practice in screening for woman abuse, 69% replied, including family physicians, internists, obstetricians and gynaecologists. Of these, 79% indicated that they ask injured patients about abuse, 10% screen new patients, 9% screen at periodic check-ups and 11% screen during pregnancy.[48] This result, occurring in 1999, is particularly surprising given that in California, Assembly Bill 890, under Chapter 1234, amending sections of the Business and Professions Code and Health and Safety Code, was passed in 1993 and requires that all licensed clinics and specified hospitals adopt written policies and procedures to screen patients to detect partner abuse. The policies are to include procedures for identifying and documenting partner abuse, providing patient information about community resources and educating staff on handling these cases.[49]

Obviously the "upstream" goal with respect to woman abuse would be to create and maintain a non-violent society, which neither teaches nor tolerates woman abuse. This was the ultimate goal proposed by the Canadian Panel on Violence Against Women. While that goal should continue to be the long-term focus of efforts to end woman abuse, there is a "midstream" intervention, more effective than the "downstream" approach now prevalent in the health care sector.

Universal screening is that "midstream" approach, where health care professionals routinely ask all women they treat about their experience of abuse, whether or not indicators of abuse are present. The research shows that indicator-based identification is not nearly as effective or as consistent in achieving early identification as a screening protocol that employs a universal approach.[50] As is the case with the Healthy Babies, Healthy Children initiative,[51] using a universal approach avoids any sense of stigmatization that might occur. When all women are asked, no one is singled out and everyone has an opportunity to disclose without prejudice.

g) Routine Universal Screening:

If the universal approach were adopted, how should it be carried out? Most literature and practice guidelines suggest that adopting a routine screening approach is most effective. The screening protocol would set out the circumstances in which all women patients would be asked routinely about abuse in their lives.

For example, there has been an effort to build a general consensus among obstetricians, gynaecologists and family physicians that routine universal screening during pregnancy is a best practice but as yet a majority of clinicians in the field do not routinely screen. The increased vulnerability of pregnant women and the effects of abuse on the developing fetus add urgency to the issue of early identification. In March of 1996, the Society of Obstetricians and Gynaecologists of

Canada published a policy statement, passed by its Council in December 1995, on Clinical Practice Guidelines with respect to Violence Against Women:

> *Despite there being a high incidence of violent acts against women, only three percent are identified by primary care physicians. Presumably, even fewer cases are identified by consulting obstetricians and gynaecologists. Given the potential for morbidity and mortality, it is essential that physicians become more adept at identifying victims of physical abuse..**Ask the questions.** Direct, while sensitive questioning regarding physical abuse should be part of history taking. This is not seen as intrusive by most women, and will indicate an openness to discuss the issue of violence, if not at this interview, then in the future should it become necessary.*[52]

A new publication from Health Canada, A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy, reinforces this advice:

> ***Ask every woman about abuse.*** *Universal screening means asking **every woman** about abuse, not just asking women whose situations raise suspicions of abuse. Pregnant women should be asked about abuse as early as possible in their pregnancies.*
> *Pregnant women are at higher risk for abuse than for many other medical problems—pre-eclampsia, gestational diabetes and placenta previa—for which they are routinely screened (Modeland, Bolaria and McKenna, 1995, Petersen et al., 1997) With so many women experiencing abuse during pregnancy, screening for abuse during pregnancy must be **a routine part of prenatal care....***
> *Furthermore, it is necessary to ask about abuse **in early pregnancy and again throughout the pregnancy and after the baby is born** because abuse may begin again after the "protection" provided by pregnancy is over (Guard, 1997). After the baby is born, **include questions about the safety of the infant and other children. Repeat the questions when a woman starts a new relationship** (Guard, 1997).*[53]

Similarly, a paper commissioned by the Maternal and Newborn Health Committee of the College of Family Physicians of Canada addressed the issue of screening:

> *Because of the high prevalence of abuse in the general population, all pregnant women should be screened for past or current history of abuse. Rates of disclosure might be improved if women are asked about abuse at the same time that they are asked about other social risk factors. Some clinicians prefer to ask about abuse during history-taking, while others prefer to use standardized tools. The Woman Abuse Screening Tool is reliable and valid and has been shown to be effective in identifying abuse in adult women patients attending their regular family physicians for prenatal care or periodic health examinations or for assessment of particular health problems. It has been included in the Antenatal Psychosocial Health Assessment (ALPHA) form, an evidence-based screening tool that can be used as a checklist for psychosocial enquiry and will soon be incorporated into the Ontario Antenatal Record.*[54]

Since 1992, the American Medical Association has advocated for routine universal screening of all women for domestic abuse.

> *Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal and mental health settings. Because some women may not initially recognize themselves as "battered," the physician should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, medical history, review of systems or history of present illness, as appropriate.*[55]

Nurses have taken a particularly active role in urging routine universal screening for intimate partner abuse. The Canadian Nurses Association has issued a best practice guideline for nurses to encourage them to be pro-active in identifying and intervening with abused women.[56] Through the Association of Women's Health, Obstetrical and Neonatal Nurses in the United States, a number of research projects and policy papers were published in one volume, Empowering Survivors of Abuse: Health Care for Battered Women and their Children. Jacqueline Campbell, a recognized expert on research and policy formation, writes:

> ***Universal screening for abuse at all health care visits should be routine**. All women coming to a health care setting for any reason should be routinely screened for abuse....Universal screening of all women (including adolescents) for intimate partner abuse*

at each health care system is warranted as routine practice for the following reasons: (a) the general prevalence of abuse is greater in young women than are other conditions routinely screened (e.g. hypertension); (b) the change in abuse status over time (during pregnancy, before and after pregnancy, and throughout the woman's life)... (c) the variety of physical and mental health problems (most often without injury) battered women experience... (d) the lack of consistently identified personal or demographic characteristics (risk factors) that can identify women more likely to be abused in any setting...or more likely to continue in battering relationships than other abused women...and (e) abuse can aggravate an existing condition or compromise the treatment of an existing condition as well as directly or indirectly cause a health problem. [57]

In contrast, another new publication from Health Canada, A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians, is quite cautious about routine screening versus screening only in suspicious cases:

Several groups, including the American College of Obstetricians and Gynecologists and the American Medical Association, support routine screening of all female patients for woman abuse. Others suggest that the benefits of routine screening have not been assessed directly and favour greater efforts to detect it or recommend screening in suspicious cases. Those who support routine screening argue that clinical signs of physical abuse can be subtle and if physicians are limited to asking only in suspicious cases, they might miss the subtle signs. It can also be argued that physicians vary in their degree of awareness and sensitivity about woman abuse and many do not become suspicious even when the signs are clearly visible.
The support for routine screening has mostly been through consensus and is based largely on the recognition of the prevalence of the abuse and the number of undetected cases. Unfortunately, we do not have sufficient evidence that, in direct comparison, shows one method to be more effective than the other in terms of identification of cases, or the cost or quality of care. So far there is little evidence that routine screening will result in victims either divulging or confirming the abuse; that is, cases may be missed no matter what screening method is used.[58]

Similarly, there appears to be no international agreement about the best form of early identification:

There is no international consensus on whether all women should be routinely screened for violence when they visit a health care facility. Some advocates argue that failure to screen is a serious breach in the quality of health care. Others feel that screening all women on every visit may not be feasible, particularly where budgets are low and personnel are overworked.[59]

Further research is required to evaluate the relative effectiveness of routine universal screening versus indicator-based diagnosis in achieving early identification and appropriate interventions. As with any preventive measure, such research would need to be longitudinal because the results might take several years to become evident. Most research with respect to screening abused women has been quite localized and has tended to focus on the actual identification as opposed to the long-term outcomes of the identification and intervention. Most of the research has been conducted among women who have already disclosed abuse and have sought assistance to deal with it. What is required is a long-term implementation strategy that tests the routine universal approach for effectiveness among a large and diverse general population of women over a number of years using agreed definitions of success.

h) The Routine Universal Comprehensive Screening (RUCS) Protocol:

If it is difficult to reach agreement about indicator-based diagnosis versus routine universal screening, an even greater challenge is to consider the need for comprehensive screening; that is, screening not just for intimate partner abuse but screening for the entire range of physical, sexual and emotional abuses a woman may experience throughout the course of her life. In a significant number of cases, when women disclose abuse from an intimate partner, they will also disclose retrospective abuse, either in childhood or adolescence, or in a previous relationship. Often women who are not experiencing intimate partner abuse but who have been abused in other contexts find it difficult to disclose unless health professionals clearly invite them to do so by asking about any and all abuse they may have experienced.

The data provided by the Canadian Panel on Violence Against Women (See Figure 2, page 14) shows how frequently childhood and adolescent sexual abuse affects Canadian women. These statistics confirmed a study completed ten years earlier:

> *The most extensive study on child sexual abuse in Canada found that 53% of females and 31% of males had been victims of unwanted sexual acts and that 80% of these incidents occurred when they were children or adolescents (Committee on Sexual Offences Against Children and Youth, 1984). Most professionals, however, believe that this is an underestimate.*[60]

The health effects of early abuse may be lifelong if not treated appropriately:

> *Empirical evidence suggests that adult females who were sexually victimized as children experience a variety of long-term negative sequelae including sexual disturbances, depression, anxiety, fear and suicidal ideas and behaviour (Beitchman, Zucker, Hood, DaCosta, Akman, and Cassavia, 1992). Some research has indicated that women with a history of childhood sexual abuse may be particularly vulnerable to adult sexual assault.*[61]

In an unpublished paper prepared for the Task Force, Morella Yepez-Millon, Counselling Coordinator at the Sexual Assault Centre London states:

> *...frequently sexual abuse cannot be separated from other types of abuse, mainly physical abuse. Both forms of abuse and the feelings and emotions that accompany them are pervasive and endemic problems of many patriarchal societies due to its transferral of abuse as victims or perpetrators to upcoming generations. Another sad statistic that links together different types of abuse is that "the adult survivor is at great risk of repeated victimization in adult life. The data on this point is compelling, at least with respect to women. The risk of rape, sexual harassment, or battering, though high for women is approximately doubled for survivors of childhood sexual abuse" (Herman, 1997, p.111).*[62]

Many of the health effects are worsened if both sexual and physical abuse have been part of the childhood experience.[63] Mental health is particularly affected by childhood physical and/or sexual abuse. Diagnoses of post-traumatic stress syndrome, dissociative disorder, mania, somatization are positively correlated with childhood abuse:

> *Psychiatric samples usually reveal higher rates of sexual abuse survivors. Six studies of female inpatients or outpatients report sexual abuse rates were between 36% and 51% (Briere,1992).*[64]

In addition to adult victimization, childhood abuse is also linked to substance abuse and unsafe sexual practices. An abstract of a study completed in 1996 summarizes the findings:

> *College women who report childhood sexual abuse were compared with women who do not report abuse on a number of variables concerned with problems in living. Multivariate Analysis of Variance revealed that, compared with non-abused women, sexually abused women reported significantly more negative attitudes about sexuality, less sexual assertiveness about birth control or refusing unwanted sex, less efficacy concerning HIV prevention, more anticipation of a negative response from a partner concerning safer sex, more hard-substance use, and more sexual victimization in adulthood.*[65]

Using the patient base of a Health Management Organization, where all health care interventions, performed by employees of the HMO as well as outside providers, are recorded in the patient record, Walker, Gelfand et. al used validated instruments to compare women who have been abused with those who have not:

> *A history of childhood maltreatment was significantly associated with several adverse physical health outcomes. Maltreatment status was associated with perceived poorer overall health, greater physical and emotional functional disability, increased numbers of distressing physical symptoms, and a greater number of health risk behaviours. Women with multiple types of maltreatment showed the greatest decrements for both self-reported symptoms and physician coded diagnoses.*[66]

Kathleen K. Furniss urges that routine comprehensive universal screening may actually assist the health care professional to provide more thorough diagnoses and more sensitive approaches to abused women:

> *Physical examinations can be positive patient experiences, providing reassurance, education and case finding. However, examinations also can be extremely anxiety provoking because of feelings of shame and embarrassment about visible injuries from an abuser. They may also provoke flashbacks related to incest, child sexual abuse, and rape. [Health care professionals] involved in clinical assessment of any kind need to be aware that a patient's history often affects her response to clinical evaluation. Asking a patient about abuse before evaluation is*

respectful and empowering and often establishes a valuable opportunity for intervention….Screening all women before a clinical examination for a history of abuse is essential.[67]

Some advocates, while acknowledging the importance of screening in primary and emergency care settings, also advocate its use in specialty settings:

This study had demonstrated that those with a history of CSA (childhood sexual abuse) report more chronic pain and greater utilization of some aspects of health care particularly related to pain issues, compared to controls of similar age and sex. For some patients, complaints of painful symptomology and revelation of a history of CSA during clinical examination may be the first step toward a successful combination of medical and psychosocial interventions.[68]

Sexual and physical abuse history seem to be common among women in a referral-based gastroenterology clinic. Fully 50.6% of our sample had experienced forced touch, rape, and/or life threatening physical abuse. As many as 66.5% of women in our study report sexual or physical abuse when using a broader definition (including also attempted sexual abuse and experiences of being beaten, hit, kicked, burned or otherwise hurt). Like other studies, we find that those with a history of sexual abuse, also tend to have been physically abused….The relationship of abuse history with long-term medical sequelae points to a larger theoretical model which is at the heart of psychosomatic and behavioural medicine, and consultation liaison psychiatry; that is, the relationship of stress and health. As one category of stresses, sexual and physical abuse have clearly been associated with a wide variety of negative health consequences. In light of this relationship, it is reasonable that asking about ***present and past abuse become an essential part of history taking in medical practice.***[69]

Because of the serious and ongoing effects of some forms of abuse over the lifetime of a survivor, screening comprehensively for abuse is indicated:

…Our study demonstrates that sexual trauma is associated with lifetime suicide attempt, that this association is not explained by other risk factors, and that it is particularly strong in women who reported a sexual assault before age 16 years….We need to maintain awareness that a relation does exist between suicide attempt and sexual trauma and that this is not confined merely to treatment seeking clinical samples, but that it holds true in community samples as well….Our findings are of importance to practitioners, given that suicide attempts are associated with increased health service utilization (e.g. emergency department and hospitalization services) and, in 10% of cases, eventually associated with a completed suicide. Victims of sexual assault also visit health care providers more often for physical and mental health symptoms. In assessing suicide potential, it may be important to ask about earlier sexual assault.[70]

Many more references can be found in the "Works Cited and/or Consulted" section of this report on pages 59-66. The overwhelming evidence is that comprehensive screening for all forms of childhood and adolescent physical and sexual abuse is required if health care professionals are going to identify abuse in women patients early and use that identification to ensure appropriate and effective interventions with respect to the health effects of woman abuse.

i) Task Force Response:

A majority of Task Force members favoured a routine universal comprehensive approach to screening for woman abuse. Some, however, expressed strong concerns about the complexity and the time-consuming nature of dealing with all forms of abuse, particularly past abuse. There were also questions about the appropriate health care settings for such screening. Some Task Force members felt that it should be done in every setting, at every encounter and others were strongly of the opinion that some settings and some encounters are more appropriate and conducive to successful screening than others. The Task Force recognized the need to develop consensus on guidelines for the application of the Routine Universal Comprehensive Screening (RUCS) Protocol.

Chapter VI: Guidelines for the Screening Protocol

a) The Purpose of Screening:

The two major purposes of routine universal comprehensive screening for woman abuse are:

1. To identify any abuse experienced by the patient, either in the past or in the present, so that this history can inform any health care interventions she may seek;

2. To decrease the incidence and prevalence of woman abuse by ensuring that primary care, emergency and other health care services identify and respond appropriately to cases of woman abuse with effective treatment, documentation, safety measures and referrals.

b) The Elements of a Successful Screening Protocol:

It is essential to determine which of many possible elements will form the most complete and most consistent basis for a successful screening protocol. Determining what the health professional needs to know is the first step in designing the appropriate questions and assessment procedures. Having studied a range of available tools, the Task Force turned its attention to what information is essential and how it should be recorded.

The first and most crucial piece of screening information is:

- **Whether the woman has ever in her life experienced any form of abuse, including childhood, adolescent or adult physical, sexual or emotional abuse?**

If she has not, then her medical record need only show that the screen has been applied and the result is negative. If she has experienced abuse, the next pieces of information needed are:

- **Whether, within the last year, the woman has experienced physical, sexual or emotional abuse? If so, by whom? Is the abuse continuing to happen now?**

- **Does the woman feel safe now? If not, what safety planning and referrals are required?**

The medical record needs to include the answers to these questions. Once there is a diagnosis of abuse, the medical record should include:

- **A thorough baseline assessment of the woman's physical and mental health status, detailing any current injuries or illnesses the health care professional observes or the patient reports as having occurred in the past, as well as any health care interventions she has sought and received with respect to the abuse she has experienced. The first, the worst, and the most recent incidents of abuse are particularly important to document.**

- **Referrals to appropriate health care, justice or community services and follow-up plans by the referring health care professional.**

- **A notation that she has been offered educational material about the nature, prevalence, dynamics, and health effects of woman abuse, including information about community services specializing in woman abuse issues.**

c) The Guiding Principles for Applying the Screening Protocol: ABCD-ER (See Figure 3, page 34).

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 are 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 her 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, as 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. (In London 642-3000 or 1-800-1576).

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 to support her as her caregiver.

- 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.[71]

A B C D - E R

d) Who Should Routinely be Screened for Woman Abuse?

Different screening protocols set different requirements for who should routinely be screened for abuse by health care professionals. The Task Force decided that in Ontario, **every woman over the age of 12 years should routinely be screened for woman abuse.**

Given the statistics on the prevalence of woman abuse among children and adolescents, the Task Force preferred an early age to begin screening. In making the choice, the Task Force took into account the range of ages now in effect under various legislation and in case law. In Ontario, under the Health Services Consent Act, no specific age is set for considering patients capable of making health decisions. An age of consent, even if set out in law, is rebuttable if the patient can demonstrate to a court that she is capable of making the decision. Although for health care purposes, the custom is to assume anywhere from age 10 to 16 is appropriate, children as young as 8 have been deemed capable to make their own health care decisions by the courts. The age of 14 is the age of consent for women to engage in sexual activity. The age of 16 is when they are no longer covered by the child protection laws.

At the urging of the police, the Crown Attorney's Office, the Executive Director of the Children's Aid Society and the community-based services, the Task Force decided to set the age of 12 as the most appropriate age at which to begin screening for physical, sexual and emotional abuse, being mindful that, under the Child and Family Services Act, reporting of abuse is required if the person is under 16 years of age.

e) Who Should Screen for Woman Abuse?

This topic was a difficult one for the Task Force to determine. A majority of members advocated for every health care worker, particularly those in the regulated health professions, to screen for woman abuse. Others felt that the emphasis, at least initially, should be on primary care, emergency/ urgent care, and some specific specialties. The major concern expressed was that the level of training might not be adequate and the scope of practice might not support the application of the screening protocol by some health care providers.

Another concern was that this type of detailed history taking is unusual and might be considered intrusive in some health care settings, such as dentistry or pharmacy. In the end, the Task Force

opted to recommend that "appropriate" health care professionals in "appropriate" programmes pilot the Routine Universal Comprehensive Screening (RUCS) Protocol.

Nevertheless, the Task Force agreed that appropriate educational programmes for all health care professions could resolve the issue of knowledge and expertise. The majority of the Task Force also felt that the specifics of the protocol as it applies to each regulated health profession should be determined by the College which governs that profession or the institution that employs the individual professional. Best practice guidelines, designed by the College or institution, would adapt the protocol in such a way as to meet the practice setting and the scope of practice of each profession. Thus the protocol devised by the Task Force would need to be flexible enough to allow such adaptation to particular professional requirements.

Those who should routinely screen:

- **Primary health care providers** (would include family physicians, registered nurses, nurse practitioners, midwives, naturopaths, chiropractors, and assigned members of primary care multidisciplinary teams in Community Health Centres or Health Service Organizations).
- **Emergency department or urgent care providers** (physicians, surgeons, registered nurses, nurse specialists, nurse practitioners, social workers, pastoral care workers, as assigned by the health care institution).
- **Mental health care providers** (psychiatrists, psychologists, registered nurses, nurse specialists, nurse practitioners, therapists, social workers, community mental health workers and pastoral care workers).
- **Specialist physicians and surgeons.**
- **Public health nurses and physicians** (particularly within appropriate programs on safe sex and family planning, Healthy Babies/Healthy Children, prenatal services, and school health programmes).
- **Education and/or employer-based health service providers.**
- **Community Care Access Centre assessment staff and long-term care providers (both facility and home-based care).**
- **Other Appropriate Regulated Health Professionals (as directed by the best practices of their regulating Colleges).**

f) Basic Requirements for Successful Screening:

The Task Force took seriously the need to ensure that professionals who screen for woman abuse have the scope of practice, the appropriate training, and the necessary skills to perform this task with expertise and commitment. There was a clear acknowledgement that, although many health care professionals have expertise on abuse issues, some now in practice do not have either the knowledge or the skills required to screen successfully. Although considerable progress has been made in making health care professionals aware of some of the indicators of abuse, routine comprehensive universal screening requires a higher standard than most health care professionals now meet. The Task Force made an effort to determine what the minimum and the optimum requirements might be to ensure the success of a screening protocol.

At <u>minimum</u> health care professionals who screen must:

- Be educated about the prevalence, seriousness, dynamics and health effects of woman abuse;
- Set as a priority the safety and autonomy of the abused woman;
- Be aware of the impact of cultural attitudes on the issue of abuse and practice cultural competency;
- Be trained in how to ask about abuse;
- Be trained in providing abused women with medical assessments and interventions within their scope of practice;
- Be authorized to record findings in the main body of the woman's health record;
- Be familiar with and respectful of the services and professionals in other sectors of the service delivery system who specialize in woman abuse issues;
- Be prepared to refer disclosing women to community specialists who offer justice, support, counselling and advocacy services when appropriate;

- Be prepared to offer follow-up to disclosing women to ensure continuity of care.

At the optimum, health care professionals would also:

- Have the capacity to offer health care services in the language of the patient or to obtain professional interpreting services when care in the primary language is not available;
- Be prepared to enter into formal referral arrangements with specialized community services, providing for an exchange of pertinent confidential information (with the patient's written permission) so that all abuse information resides in the permanent medical file;
- Regularly participate in public education about best practices on screening for woman abuse;
- Regularly participate in data collection, evaluation and reviews of screening practices;
- Be prepared to consider using a prescribed format for documentation of abuse for legal purposes;
- Be prepared to advocate on behalf of patient's medical and community service needs with governments and other funders.

g) How Should Screening Occur?

The literature on screening strongly suggests that face-to-face interviews with health care professionals elicit the most reliable results when screening for woman abuse. Direct, compassionate questions are the most encouraging for abused women. The interview needs to be confidential and private; every effort should be made to ensure that women are seen alone by the health care professional as the presence of others could inhibit disclosure. Occasionally, it may be difficult to see the patient alone, especially if a partner or parent insists on being present. The best approach is a calm, definite presentation of the need to have some time alone with the patient as a matter of routine in the practice setting.

> *I basically tell all partners this is just our policy, we always have some time alone, if your partner wants to come back in later, they can come back in later, but this is just what we do. He was uncomfortable with me having private time with her, but gave in when he believed it was some kind of official exam policy.* [72]

If an interpreter is required, that person should be a trained interpreter, familiar with the language, dynamics and health effects of woman abuse. Avoid having family members or untrained members of the woman's cultural community act as interpreters; these people could inhibit her response or even change the meaning of her words to protect the community or the family.

In some practice settings, the first step when a new patient is seen is to have her fill out a written self-report on her health status and previous health conditions. In this instance, the professional may decide to include a general question about any history of abuse as part of the self-report. Research has shown that self-reports can sometimes elicit disclosure, although the response rate is not as high or as reliable as it is with a face-to-face interview:

> *Planned Parenthood of Houston and Southeast Texas added four self-reported abuse assessment questions to their standard intake form completed by all initial and annual-visit clients. After one month of self-report by 477 women, the prevalence of physical abuse was 7.3%. To compare self-report to nurse interview assessment, the same four questions were asked of 300 women coming to the same clinic for initial or annual visits. The reported prevalence of abuse after a nurse interview was 29.3%...regarding abuse during pregnancy, only 1.5% answered yes on self-report, whereas, during the nurse interview, 8.3% did. Of the 44 (14.7%) reporting yes to forced sexual activities, 16 responded no to physical abuse; although they had been sexually abused, they did not consider themselves physically abused. When they were added to the total number of women reporting physical abuse, the true prevalence was 34.6%.* [73]

Usually, even where a written self-report is part of the usual history taking, a discussion of the components of the report takes place between the health care professional and the patient prior to assessment or treatment of the patient. If a woman indicates abuse on the written form, it is an obvious opening for the health professional to talk to her about the health effects of abuse and to matter-of-factly follow through with the protocol. If the patient indicates there is no abuse, the health care professional might explain that, because abuse is such a common experience of women, and the health effects of abuse are so serious, every patient is asked questions about any type of abuse, either current or in the past. Because of the dramatic difference between self-reports and interviews noted in the research, it is not wise to simply accept a self-report without some additional direct questions,

particularly if there are any indicators that arouse suspicion about abuse.

Often it is helpful with reluctant or hostile patients to mention other forms of screening and diagnosis that have only recently become routine practice. Breast cancer, blood pressure and diabetes screens are now done routinely. Similarly, questions about alcohol consumption, tobacco use and sexual practices are good examples of questions now asked routinely by health care professionals to aid in diagnosis, even though they were not normally asked twenty-five years ago. The Task Force chose the symbol of the stethoscope in its logo to convey to health care providers and patients alike that the goal is to have the application of the Routine Universal Comprehensive Screening (RUCS) protocol become as routine and familiar as the use of the stethoscope.

h) When to Screen Routinely for Woman Abuse:

The Task Force agreed on a number of obvious occasions on which screening routinely for woman abuse would be appropriate and helpful, at least for those health care professionals appropriate for screening:

- Annual or general examinations;
- Emergency room or urgent care settings;
- Prenatal or obstetrical visits;
- Family planning visits;
- Well child/adolescent examinations;
- Adolescent school, camp and sports physicals;
- On admission or discharge from hospital; and
- On referral for admission to a long-term care facility or home care services.

There were three issues that remained unresolved because the Task Force was unable to reach consensus:

a) Initial visit of a first-time patient: Although a majority of the Task Force favoured routine screening at an initial visit of a first-time patient, others felt that health care professionals should have discretion about the appropriateness of screening prior to a relationship having been established between the patient and the professional.

b) With the onset of a major disabling or chronic disease or condition: A majority of the Task Force felt that routine screening should occur with the onset of a major disabling or chronic disease or condition, because chronically ill and disabled women are far more vulnerable to abuse than those without physical or mental challenges. Others expressed concern about asking questions of abuse in the acute phase of a disease, when a person is trying to come to grips with a difficult diagnosis. They remained unconvinced by an argument that discretion could be used by the health care professional in determining an appropriate time to inquire.

c) When the patient has entered into a new relationship: Some Task Force members felt that a health care professional would not likely know that a patient had begun a new intimate relationship. Others suggested that most patients would disclose a new relationship, if they were asked, “How are things with you?” or “What’s new with you?”

i) Developing a Personal Style:

The Task Force members identified the need for screening protocol to be flexible so that it can be altered to fit the context of the particular encounter between the health care professional and the patient. The process will likely vary, depending upon the health care setting, the relationship of the professional to the patient, the presenting problem, the patient’s history, and the role of the particular professional in meeting the patient’s health needs. It is very important for each health care professional to develop an approach that feels appropriate so that the comfort level in asking questions about abuse encourages patients to be frank and open in their response.

Here are a few suggestions:

- Develop a methodology that is appropriate to the practice style and the clinical context of the interaction with patients.
- Try out a number of approaches, choosing one or more that feel “right” in the circumstances.
- Remember that the comfort level and empathy of the health care professional is the strongest influence on the willingness of the patient to disclose abuse.

- Ask simple, direct questions.
- Maintain a matter-of-fact tone of voice and a relaxed demeanour.
- Be sure that the body language, facial expression and words all say the same thing: "I am willing to hear whatever you have to tell me; I am willing to help; and I will not judge you because of your abuse."
- Emphasize that all women are screened routinely for abuse and that she is not being singled out, stigmatized or stereotyped because of her lifestyle or her history.
- Convey the impression that the abuse screen is simply a routine part of the health care interaction.
- Use the screening process as an opportunity to educate the patient about the prevalence, dynamics and health effects of woman abuse.
- Use neutral terms in asking about abuse; although most abusers are male, some are not. Someone of the same sex may have abused the woman.

Figure 3:

Short Form ABCD-ER Mnemonic Tool

Guiding Principles for Screening - A B C D - E R

- ✓ **A** **ATTITUDE** and **APPROACHABILITY** of the health care professional;
- ✓ **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; and
- ✓ **R** **RESPECT** for the integrity and authority of each woman's life choices and **RECOGNITION** that the process of dealing with the identified abuse must be done at her pace, directed by her decisions.

Chapter VII: A Step by Step Guide to the Screening Protocol

a) The Routine Universal Comprehensive Screening (RUCS) Protocol: The Flow Chart

The Task Force discussed the need to devise a simple, graphic tool that would walk health care professionals quickly through the process to be followed in the screening protocol, reminding them at each step what needs to be done, depending on the response of the patient. It was agreed that a flow chart would be the best method to accomplish this goal. The words in each information box remind the health care professional what needs to be done at each step or the possible response of the patient. The arrows lead the professional to the appropriate next step, depending upon the response of the patient. The Task Force envisioned the flow chart as part of a brochure with the essential elements of the RUCS Protocol outlined for quick reference. The flow chart is included in the report as Figure 4 immediately preceding this Chapter.

b) Introductory Question:

The introductory question, set out at the top of the flow chart, sets the tone for the application of the RUCS Protocol. The professional wants to know whether or not the female patient over 12 years of age has ever experienced physical, sexual or emotional abuse. What the professional actually asks as an introductory question will depend very much upon the practice situation, the relationship to the patient, the clinical issues, and personal style. Patients need to know that every woman is asked these questions as a matter of routine and that their answers will be respected by the professional. It may be necessary to reassure women that you are not required to report abuse unless the abused person is a child under age 16. Calm matter-of-fact direct questions elicit the best response.

The following suggestions are only that: suggestions. They anticipate a number of different possible settings and contexts for the health care encounter:

"I'm going to ask you a few questions now about any experiences you might have had with physical, sexual or emotional abuse. I have found that many of my women patients have been hurt by one or more types of abuse, and I'm wondering if you have ever experienced abuse, either as a child or adolescent or as an adult?"

"In this hospital, we always ask women patients about any history they may have had with abuse. Because women so often experience physical, sexual or emotional abuse as children or adolescents or as adults, we have begun to realize how seriously abuse affects women's health. Every woman who is treated in the Emergency Department or is admitted to the hospital is asked these questions. Have you ever experienced any form of abuse, either within the past year or ever in your life?"

"My colleagues and I have been learning more about the health effects of woman abuse on our women patients, and we have decided it is important to ask each patient whether she has experienced physical, sexual or emotional abuse, either as a child or adolescent or as an adult. Have you ever been hurt by someone else in any of these ways?"

"You have been my patient for a long time, but I see from your record that we have never discussed the issue of woman abuse. We now know that abuse is a factor in a majority of women's lives and that it causes serious health effects. It is now my practice to ask every woman about whether she has ever been hurt or frightened by physical, sexual or emotional abuse, either as a child or adolescent or as an adult. Has anyone ever abused you?"

"I am very concerned about the chronic pain you have been suffering, and I am as disappointed as you are that the treatments we have tried don't seem to be giving you any relief. I realized the other day that we had never explored any experiences of abuse you may have endured in your life. We know that, sometimes, chronic physical pain is made much worse by the unresolved anguish of physical, sexual or emotional abuse. Do you think abuse could be an issue for you?"

"I'm really concerned about how unhappy you seem to be. We've tried a number of things to ease your depression but, so far, nothing seems to be helping. Have you ever felt this way before or is it something that has begun only lately? Can you think of anything that may have hurt or upset you in your life that would be causing you to feel this way now?"

"I am very concerned about the injuries you have experienced. It is very unusual for these kinds of

[bumps, bruises, fractures, loosened teeth, cuts, etc.] to have resulted from the kind of [fall, trip, accident, etc.] you describe. In fact, these injuries look to me as if someone else, someone who is hurting you, has caused them. Is that what happened to you?"

"It's time to update your medical history. I see that we have never completed the questions I now ask all my women patients about their experiences of abuse, either as children or adolescents or as adults. Statistics tell us that a majority of women experience some form of physical, sexual or emotional violence during their lives. Because there are serious health effects that arise as a result of abuse, I need to know if you have experienced any form of abusive treatment that may be affecting your health."

"You may have heard recently about a project done by the Middlesex-London Health Unit on the health effects of women abuse. As a physiotherapist, I have had many patients who were injured through violence and I have decided to be a part of that project. I am now routinely asking all my women patients about their past or current experience of abuse. Have you ever been physically hurt or threatened by another person?

c) When She Says "No Abuse":

If your practice follows the statistical norm, approximately half of your women patients will not have experienced abuse. When there are no recognizable indicators of abuse present, acknowledge and accept her response. However, as a health educator, take the opportunity to have a conversation about the various forms of abuse and the common health effects of abuse. Many women do not recognize that what they experience is abuse; the behaviour has become normalized for them.

Prompt Gently:
Give a couple of milder examples as a prompt when the patient answers negatively. Ask her whether she has ever been frightened by someone who "has lost his or her temper" or who has asked her to participate in a sexual activity against her will.

When the Answer is Still "No":
If the patient continues to report no abuse, believe her. Document her response, offer her literature on the issue of woman abuse, and let her know screening for abuse will be a regular feature of future health examinations. Let her know she can always approach you for information and support, should she need assistance.

When the Answer is "No" but the Indicators Make You Suspect Abuse:
Discuss the indicators you have observed frankly with her and ask her if she knows what has caused these symptoms. Share information about how these symptoms are often associated with physical, sexual or emotional abuse. Offer educational information about the health effects of abuse.

Prompt Gently:
Ask directly but compassionately whether the patient's symptoms are a result of abusive behaviour. Explain why you continue to be concerned about her health and safety.

When the Answer is Still "No":
Accept her response. Offer her literature about abuse, making sure to point out the referral services available in your area. Provide her with information about the Abused Woman's Hotline. Let her know you and other health care professionals now routinely screen all women for abuse on a regular basis. Let her know she can always approach you for information and assistance. Document her responses and the indicators that cause you concern. Flag the file for early follow-up.

d) When She Discloses Abuse:

Express compassion, belief and support, in words, body language and facial expression. Encourage the patient to continue to share her experiences with you. Let her know that you have a number of questions you would like to ask and that you will be documenting her responses in her medical file. This would be the ideal time to discuss any confidentiality issues she may have. If you have other patients waiting you may wish to let them know you will be delayed. This will signal to the woman that you are prepared to take the time to deal with her issues.

Has the Abuse Occurred Within the Past Year?
This is an important question because it tells you how fresh the memory and the effects of abuse will be for the patient. If the patient spontaneously begins to provide details of either past or current abuse, document as she discloses, being sure to address the rest of the essential questions on the flow chart at a later point in the interview. Always ask for details about the first, the worst, and the most recent incidents of abuse. Always ask where the abuse occurred and who the abuser was/is. Document using her words in quotation marks as much as possible. Do not speculate.

When No Abuse has Occurred in the Past Year:
Ask whether the patient continues to have contact with the abuser and, if so, the frequency and nature of the contact.

Whether or Not She has Contact with the Abuser:
Provide the patient with information about the possible health effects of the type of abuse she has experienced. Ask whether she is feeling safe **now**.

If the Patient DOES NOT Feel Safe:
She may express fears that seem out of proportion to the likelihood of additional abuse; validate those feelings, and help her to do a reality check on how much risk she continues to face. The risk may be from the abuser or from her own emotional response to the disclosure of abuse, which often leads to self-destructive impulses. Inform her that you will assist her with a preliminary safety check and some preliminary safety planning before she leaves the health care setting. (See (f), page 39 for details about Safety Check/Safety Planning.) Proceed to ask her more about the abuse.

If the Patient Indicates She Feels Safe:
Proceed with the health assessment and documentation. If, as a result of discussing the details of the abuse and its health effects you perceive some safety concerns, incorporate the Safety Check/Safety Planning section (f), page 39 into the interview before she leaves. Proceed to ask her more about the abuse.

Important Issues to Keep in Mind About Disclosure:
If the abuser is an intimate partner who lives with the patient and any children, the safety of all people in the household needs to be assessed. Experts believe that abuse within intimate relationships is often more devastating to women because the abuse gets confused with their love for the abuser and the abuse happens most frequently in the home, the place we regard as a safe retreat. Breach of trust is an integral part of partner abuse.

It is important to remember that the woman doesn't love the abuse even if she still loves the abuser. She may understand from her abuser's background and feelings about himself that he is in great pain, too, and she may imagine that she can "cure" him by sticking with the relationship. She lives in constant hope that the abuser will change, and she will usually give her partner many opportunities to reform. Many women also feel bound by religious and cultural imperatives to remain in a marriage no matter what pain that entails. Those beliefs need to be respected and considered, no matter how strenuously a health care professional disagrees with them.

The health professional must be careful not to alienate the woman by too vigorously criticizing her partner. Always focus on the abuse itself and how to end it, rather than on the character of the abuser or the future of the relationship.

Although in most cases the following issues would only be explored in depth by a specialist in woman abuse, health care professionals should be aware of these issues in case a referral is not available or the health care professional chooses to work with the patient her/himself.

If the abuser is a former partner, other issues arise. How long have they been separated? What form did the abuse take? Is it still going on? Does the partner stalk her? Has she got a restraining order? Does she have to deal with him around custody and access of children? Does the partner use the children as a threat or form of emotional abuse? Has the abuser threatened or actually harmed property or pets? Have weapons or threats of death been part of the abuse pattern? Does the woman hope to get back into the relationship? Does she blame herself, rather than the abuser, for the break-up? Is she considering returning because of economic distress or because her children are unhappy without her partner? Is she minimizing or denying the abuse in order to convince herself that the relationship can resume safely? These are very tough issues for most women and most require specialized counselling to sort them out successfully. It is not helpful for the health care professional to be over-persuasive with the woman—in either direction—as she will then be able to blame the professional for the outcome rather than taking responsibility for her own choices.

If the abuser is an acquaintance, a member of her family of origin, a workmate, a boss, a neighbour, a landlord, a teacher or other professional, recognize that these relationships may also be power relationships that seem as difficult as an intimate relationship for the woman to get into perspective and to escape. In some cases, the abuser has control over the essentials of her life, such as her home or her livelihood. In others, the woman may have genuine concerns about the damage that could occur to her reputation or to the opinions others have of her and their support for her. In many cases, emotional or psychological abuse leads women to question whether the abuse is actually imagined or exaggerated by them. Your reassurance as a health care professional is crucial in helping her

to do a reality check when she doubts her own perceptions.

If the abuser was a stranger, the woman's response may be affected by the type of abuse she experienced. Both physical and sexual assaults can result in serious trauma and lasting emotional effects. Did she ever tell anyone about it and what, if any, assistance did she get? What lasting effects does she identify? Did she take any legal action and did the process validate or further humiliate her? Did the abuser ever face the consequences of the abuse? For abused women the incident itself may seem less abusive than the aftermath.

e) Health Assessment and Documentation:

Document the details of the disclosure in the permanent medical record with special attention to the first, the worst, and the most recent incident of abuse. Try to find out the geographic location where the assault took place, the name and relationship of the abuser, and the date (approximate if not exactly known). If the patient is disclosing past abuse, particularly if it is childhood abuse, she may not know the precise answers to these questions. Document what she says, in quotation marks. Avoid any speculation that might reflect on her credibility later.

> *Sometimes, what the health care provider writes contains pejorative (biased) statements. It is critical to avoid writing phrases such as "patient refuses to talk with the police or call the shelter," "the patient is noncompliant with treatment plan of being admitted to the hospital," or "the patient allegedly was beaten by her boyfriend." Instead, words such as* ***chooses, declines****, and* ***patient states or said*** *are nonpejorative, nonbiased descriptors of patient behaviour.*[74]

Assess her health status according to your usual practice, paying particular attention to the common health effects of the type and extent of abuse she has experienced. Assess her mental status as well as her physical health. Document the results of the health assessment. Document only direct quotes from the woman and your direct observations and medical opinions; distinguish between what she reports and what you observe. If she refers to other visits when she has been suffering the effects of abuse but did not disclose, cross-reference any corroborating notations made at that time. Document any assistance or referrals the patient has sought in the past to deal with the abuse and the outcomes of these interventions.

> *Clear and detailed descriptions of the specifics of the assault, the history of violence, and the pattern of injuries are of tremendous clinical value. Knowledge of the details of the attack guides the diagnosis and treatment, and may be important in detecting seemingly unrelated direct medical sequelae months later....*
> *Thorough documentation makes it more likely that the problem of domestic violence, often chronic, is called to the attention of future medical providers....many injuries might be diagnosed earlier or even prevented if health care personnel routinely assessed for abuse and included adequate documentation in the medical record.*[75]

Documentation is extremely important to the success of the protocol. The woman is aware that someone has carefully recorded the information she has shared and that it will be available in the medical record should she require it at a later date. Women may require their record for civil or family court purposes or for an application to the Criminal Injuries Compensation Board. Documentation needs to be consistent, legible and clear so that the record can be copied, read and comprehended should it be needed in the future for health care, justice or other reasons. A body map should be used to indicate the site of any injuries, and details about the size, shape, colour, approximate age and rate of healing of any bruises, cuts or abrasions should be noted. Language such as, "The location and nature of the injury is consistent (or inconsistent) with the patient's account of how it occurred" is best. Appendix 4, page 81 provides a sample for progress notes that may help illustrate these abuse documentation principles.[76]

If the patient has been recently sexually assaulted or abused by an intimate partner and there may be medical evidence that can be retrieved, she may be willing to undergo a forensic examination by the Regional Sexual Assault and Domestic Violence Centre at St. Joseph's Health Care London. The clinicians at the Centre are trained to preserve evidence and document both sexual and physical assault to standards acceptable to the courts. The services are available in the hospital setting on an on-call basis.

Note About Documentation:
In most screening protocols, documentation is done on a specific form. The majority of the Task Force expressed a preference for the screening protocol used in the San Francisco Domestic Violence Project and adapted for use by the Family Violence Prevention Fund. (See Appendix 2, pages 74-78 for the assessment of the protocols considered by the Task Force.) The Task Force considered the sample form in Appendix 5, pages 82-84 which is a

composite of a number of forms in use in the screening protocols we studied. The sample form includes the essential information that is helpful for future health care interventions, as well as interventions by the justice system. Although the justice and community representatives on the Task Force urged the adoption of consistent, form-based documentation, the medical representatives were concerned that insistence on a specific format would prevent adoption of the protocol by their colleagues. The medical professionals pointed out that each practitioner already has a particular method of documenting in his or her own medical record system and would resist any imposition of a form by an outside body. They provided examples of such resistance with respect to other screening tools. The Task Force agreed to drop the requirement for a specified reporting form in the early stages of implementation of the protocol, but saw the potential value of recommending further consultation between the medical and justice community on this matter.

f) Safety Check/Safety Planning

A Preliminary Safety Check:
It is important for health professionals to be aware of the safety issues for abused women, particularly if the disclosing woman, herself, identifies that she does not feel safe at the present time. The danger is highest for women who continue to live with the abuser or see the abuser frequently. Safety concerns include not only the danger from the abuser but also the danger she may face from self-destructive impulses.

Health professionals recognize that safety and security in the face of abuse are not areas of expertise for them and many worry about whether or not they can assess risk adequately. The health care professional is well advised to consider whether it is more appropriate to refer the patient to the police or a community agency which specializes in woman abuse to complete the risk assessment and safety plan. If the patient is unwilling to accept such a referral, the health care professional may at least do the preliminary checklist with the woman and strongly encourage her to consider both short and long-term safety planning.

The following twelve questions will help her to begin to consider her safety and the answers will help the professional determine the urgency of immediate referral for safety assistance.

1. Does the woman have contact with the abuser? If yes, how frequently?
2. Does the abuser try to isolate the woman and/or attempt to control her finances and her activities?
3. Has the woman ever been injured physically by the abuser?
4. Has the woman ever been forced to perform sexual acts against her will?
5. Has the woman and/or her children ever been threatened with a weapon?
6. Has the woman and/or her children ever been attacked with a weapon?
7. Has the woman and/or her children ever been threatened with death by the abuser?
8. Has a pet belonging to the woman and/or her children ever been hurt or killed by the abuser?
9. Has the woman ever felt like committing suicide? If yes, has she ever attempted to kill herself?
10. Has the abuser ever threatened to commit suicide? If yes, has the abuser ever attempted to do so?
11. Has the abuse increased in frequency during the past 12 months?
12. Has the abuse increased in severity during the past 12 months?

Immediate Risk
A number of questions help determine immediate risk:

1. If the abuser is in the health care facility now, does the patient believe that the abuser may pose a danger to her, her children or 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? **The immediate danger increases if** the woman has decided not to remain with the abuser or to call the police.
2. If the abuser is her intimate partner, does the woman plan to return home and what is her own assessment of the risk? It's important to note that an intimate partner often senses a change in a woman who has disclosed abuse and begun to deal with her feelings about it.

3. Has the woman recently separated from an abusive intimate partner? Has the partner ever threatened to kill her or given her reason to believe that the partner might kill her if she left? Has the abuser stalked or harassed her since the separation?

4. **Does the abuser have access to a gun?** Has the abuser ever threatened the woman with a gun? There are always other weapons that are readily available such as knives. Has the abuser ever threatened the woman with another type of weapon?

5. Does the abuser have a history of substance abuse? Is the abuser more violent when under the influence of drugs or alcohol?

Longer-Term Risk
A number of questions help determine the longer-term risks:

1. What is the patient's state of mind toward the abusive situation? Has disclosure of the abuse triggered significant anger or depression? Is she blaming herself for the abuse? Is she expressing any suicidal or homicidal thoughts?

2. If the abuse was in the past, does the woman have any contact with the abuser? She may fear reprisals because she has revealed the abuse. If she does not know the identity of her abuser, she may experience particular fear and terror, wondering if the abuser may be someone who is around her on a daily basis.

3. How has the abuse affected the patient's health? Does she have significant health problems that seem connected to the abuse? Does she require treatment for these health issues that may be compromised by her relationship with the abuser? Does the patient have a history of substance abuse?

4. Does the patient have children who have witnessed the abuse? Have the children shown any signs of physical injury or sexual abuse that could be related to their mother's abuse, such as eating or sleeping disorders, somatic complaints, bad dreams, bed-wetting, aggressive behaviour, depression, or problems at school? Is the patient concerned about the physical and emotional safety of her children? Is the patient concerned about a possible intervention from Children's Aid? As a health care professional you are required to report to the Children's Aid any concerns you have about child abuse and neglect.

Assessing the Risks:
Generally speaking, the more elements of risk that exist for a woman, the more dangerous her situation is and the more urgent it is to ensure that she understands the options open to her, and the possible consequences of choosing each one. The more immediate the danger, the more important it is for the health care professional to make her aware of the services that are available in the community to help her keep herself and her children safe. Health professionals should never hesitate to encourage contact with the police for a professional assessment of risk.

What Assistance Does the Patient Want?
The patient must make her own decisions and live out the consequences of the choices she makes. Therefore, it is important to help her sort through what she wants to do and what assistance she will accept, no matter how fearful the professional is about her safety.

Asking her directly is the best plan:

- What changes would she like to make for herself and her children?
- If she intends to remain in an abusive intimate relationship, what is she prepared to do to keep herself and her children safe?
- What would help her to make these changes?
- What action is she prepared to take now?
- What action would she like to plan over a longer period of time?
- Has she ever sought outside assistance before? If so, from where and from whom?
- Was she able to follow the advice she received? What worked? What didn't?

Short-Term Safety Planning:
A short-term safety plan is composed of a set of strategies that can increase the immediate safety of an abused woman and assist her to be prepared in advance for the possibility of further violence and abuse. An initial safety plan worked out in a health care setting will most likely deal only with the immediate situation: what she will do when she leaves the health care setting; whether she will seek intervention and protection from the police and the courts; how she will ensure her children's safety; and whether she will accept referrals to help her in her longer-term safety planning. The role of the

health care professional is to explore the immediate options with the patient, affirm the survival skills that she has shown herself to possess, and respect the decisions she makes.

An Emergency Escape Plan:
If a woman is in an abusive intimate relationship or abusive family of origin and intends to return to her home from the health care setting, she needs to have an emergency escape plan in case the abuse erupts again. The health care professional can work with her to help her determine what her "bottom line" is with respect to her safety and that of her children. Once that "bottom line" is reached, she must be prepared to leave with her children.

To prepare for such a possibility, there are important items she should gather together and keep in an accessible hiding place or at a friend's home in case she has to leave in a hurry:

- Important documents such as birth certificates, passports, social insurance cards, driver's license, health cards, vaccination records, any pertinent court documents such as restraining orders, mortgage/lease documents. (**Note: If she has no access to these documents, it indicates a very high risk situation.)**
- Some money, a credit card, bankbooks, cheque book.
- Clothing for herself and her children.
- Keys to her house, car and office, if applicable.
- Medication.
- A familiar and favourite toy or blanket for each child.

Other measures to take in anticipation of, or in response to, a violent episode:

- Plan possible escape routes out of the house and out of the neighbourhood.
- Teach children to call 911.
- Alert a trusted and supportive family member or friend to her situation.
- Arrange for a neighbour to call 911 on her behalf if there are signs of violence.

How to Assist Her to Carry Out Her Safety Plan:

- Provide the patient with emergency numbers, particularly the Abused Women's Help Line, and a list of the resources in the community. Keep brochures on hand in the languages used by patients using your health care setting.
- Encourage her to call any of the referral agencies from your office or other location, particularly if she is seeking shelter at a hostel or with supportive family and friends. Help her problem solve about transportation.
- In the acute care setting, consider admission or delay discharge if there is a serious concern for the patient's safety.

Safety is Never Guaranteed:
Both the health care professional and the patient need to be aware that even the most detailed safety plan cannot guarantee that the violence will end. The abuser is responsible for the violence and is also responsible for ending the violence. Occasionally, even the safe shelters in our communities are breeched by determined abusers and women seeking self-determination are attacked and even murdered by their abusers. A woman is most vulnerable if she has an illusion of safety because some well-meaning professional has provided a model to follow that bears no relation to the realities of her life. **The best safety plan is one that is the woman's own plan, one that she sees as achievable in her circumstances and one she has a personal commitment to follow.**

In a crisis, the health care professional can provide ideas and information, can help the woman weigh the benefits and drawbacks of each component of the plan, and can refer her to the community resources who may help her implement her plan. Longer-term planning can only occur when the crisis is over and the woman is able to gradually improve her emotional and physical strength, build a support network, improve her economic independence and increase her ability to act autonomously.

Safety Issues for Health Care Professionals:
Because of the nature of woman abuse, those who assist a woman to deal with abusive behaviour may find themselves threatened as well by an abuser. An abuser who is obsessed with maintaining control over his victim may see anyone who helps her as undermining that control. While most abusers choose to prey on those who are weak and apparently defenseless, some have been known to focus their rage on professionals who intervene. Threats from a known abuser should never be

ignored. The police are always prepared to advise anyone who feels threatened, particularly if the suspect is known to have been violent in the past.

g) Referral and Follow-up

The Importance of Appropriate and Timely Referrals:
Appropriate and timely referrals are an essential element of the Routine Universal Comprehensive Screening (RUCS) Protocol. One objective of the protocol is to identify abuse. But the other objective is to decrease the overall incidence and prevalence of woman abuse by taking concerted and effective action within an integrated service delivery model. Referrals to medical and community specialists in woman abuse should be treated routinely and similarly to other referrals a health care professional might make as a result of an assessment.

Between the referral and the actual intervention by the specialist, the referring health care provider monitors the patient's health and safety, providing as much support as possible. In the case of woman abuse, the most appropriate specialist may be another health care provider, a community-based service provider, a private sector professional or a justice system agency or professional.

The Immediate Referral:
The timing of referrals once a disclosure of abuse has occurred will vary according to practice situations and the particular needs of the patient. Naturally, the health professional will need to triage the situation to determine the urgency of the problem. If a woman is feeling unsafe, requires shelter, assistance with her children or criminal justice intervention, immediate referrals are clearly indicated and the health assessment and documentation may be postponed until the emergency situation passes.

Documenting the health effects and attending to safety are time consuming. It may be best for the health care professional to refer immediately to another professional who specializes in abuse issues to complete the history of the abuse, and to sort out the options available to the woman in her particular circumstances.

In some health care settings, an internal referral may be appropriate. In this case, the health assessment may be done by that health care professional and become part of a woman's permanent medical record. That health care professional would offer appropriate referrals and document those recommendations. In other cases, a referral to a specialized community agency may be the best intervention.

If the police are involved in an incident of sexual assault or abuse by an intimate partner and the collection of forensic evidence is at issue, a referral to the Regional Sexual Assault and Domestic Violence Centre for forensic examination is appropriate. Again, the assessment is thorough and consistent; a medical record is kept and is available for the police, courts or Criminal Injuries Compensation Board if the patient consents. Following the forensic examination, the Centre then makes referrals to community service providers to ensure that the safety, emotional support and counselling needs of the patient are addressed. Additional resources would be required if the Centre were to be the primary referral source for all health care professionals upon a disclosure of abuse under the screening protocol.

Some health care professionals prefer to refer immediately upon disclosure to available community services. Community service providers urge that all women who are screened, whether or not they disclose abuse, be provided with information about the referral network and, in particular, be provided with the number for the Abused Women's Help Line. Community service providers encourage early referral to their specialized services but recognize that their current resources may limit the availability and timeliness of their services for someone who has just disclosed. They point out the necessity for health care professionals to have the skills, knowledge and willingness to deal with immediate issues until community service is available.

Community service providers also note that only health care professionals can arrange for appropriate treatment of serious emotional stress or the physical outcomes of abuse, whether these are urgent or chronic. Even if a referral is appropriate to ensure that a full history is taken, that options are laid out for a woman's consideration and that safety planning is completed, the issue of the health effects of woman abuse remains within the scope of medical practice.

Community service providers need reassurance that an immediate referral from the health care professional does not imply that the woman's health status will not be assessed and properly documented in her medical record. As part of the screening protocol, it should be routine for community services to encourage women to follow up with primary health care providers on the health effects of woman abuse. Information exchanges, with the permission

of the patient, may be an effective way to ensure that all the information required is duly documented and taken into account by both the referring and the receiving provider. **Even if an immediate referral is made to community services, it remains essential to ensure that a health assessment is completed as soon as can be arranged and is properly documented in a woman's medical record.**

When a disclosure of abuse is made to a health care professional who is not a primary care provider, the professional is wise to encourage a woman to disclose to her primary care provider. Similarly, if a primary care provider is referring a woman to a specialist or another registered health care professional for treatment of a health issue related to or possibly related to her experience of abuse, a woman could be asked whether she wants the specialist informed of her history of abuse. In that way, continuity of care can be fostered throughout the network.

The most serious concern about an immediate referral to either a community service provider or another health care provider is that the woman may get the message that the health care professional doesn't want to know about the abuse and is simply passing her on to someone else rather than dealing with her issues. This outcome would be entirely contrary to the goals of the Routine Universal Comprehensive Screening (RUCS) Protocol. The referring health care professional is wise to explain to the woman why an immediate referral is in her best interests and to make a follow-up plan with her to demonstrate that the referral is not a dismissal. There will always be patients who refuse to accept or follow up on a referral; in these cases, health care professionals have a particular duty to continue to monitor the health effects and offer support to the abused woman.

Referral After the Health Assessment:
In non-emergency situations, many primary care providers will choose to complete the health assessment and to document the results prior to referring a woman to other services. The primary advantage of waiting until the health assessment is completed is that referral decisions may be more appropriate when informed by the assessment. Another advantage is that a woman may be more likely to follow through with the referral because of the demonstrated concern of her primary care provider. As long as she sees that the health care professional takes the abuse seriously and is making a strong effort on her behalf, she may be more willing and able to wait for non-emergency community services.

The most frequent need identified by abused women is the need for support and counselling to deal with the effects of abuse. The Centre for Research on Violence Against Women and Children found that, of the 50% of abused women who had disclosed to family physicians, 75% described their physicians as an excellent source of emotional support.[77] The current limits on counselling under OHIP for family physicians put more pressure on physicians to make early referrals; it is simply not possible to provide an adequate level of support to disclosing patients under the current funding mechanisms.

Once the Routine Universal Comprehensive Screening (RUCS) Protocol shows how extensive and serious abuse issues are for their patients, physicians will have both a strong argument for improved OHIP funding to deal with the issue and also a real stake in ensuring that adequate community services are available to provide the counselling and support their patients require. They will also have an added incentive to work together with community service providers to strengthen the integrated referral network.

Inappropriate Referrals:
It is essential for health care professionals to know what services are available in their community and to understand their mandates and policies. Community services need to ensure that they make information and literature about their services available to health care professionals in hospitals and in private practice. Health care professionals need to follow up with their patients to determine their level of satisfaction with the referrals made. They also need access to research results about what types of assistance are generally most helpful in preventing further incidents of abuse.

In the recent study by the Centre for Research on Violence Against Women,[78] for example, couple or marriage counselling proved distinctly unhelpful to most women who experienced intimate partner abuse. They found that this method of counselling tended either to blame them or to attribute equal responsibility for the abuse to the victim.[79] Most effective were counselling methods that were non-judgmental, that clearly identified the power dynamics of abuse and that focused on empowering abused women to understand and choose among the options available to them to end the abuse.

Follow-up:
It is important for health care professionals to follow-up regularly on any history of abuse disclosed to them by a patient. A patient who has disclosed and has accepted a referral to another specialist for assistance may reasonably expect the referring

professional to inquire about her progress. Similarly, if the woman has been unwilling to accept a referral, she may expect the health care professional to whom she disclosed to inquire about her well being on a regular basis and to offer referrals again. **It is very important for women who disclose to know that the disclosure has not negatively affected their relationship with health care providers.**

It may be helpful to the health care professional to have some sort of flagging system in the health record to indicate whether screening for abuse has been completed and whether abuse was disclosed, particularly if the details of the disclosure are part of the regular file format. The Task Force considered the possibility of non-identifying stamps or stickers. If the file had no stamp, the professional would know the screen had not yet been completed. If screening was done and no abuse was disclosed, the health care professional could briefly follow-up at subsequent visits by saying, "I see we discussed woman abuse the last time you were here and you said that you hadn't experienced any form of abuse in your life. Has anything come up since that you'd like to discuss today?" Alternatively, if abuse was disclosed, the health care professional would be able to follow up more directly on the health effects and to inquire about the effectiveness of any referrals that were made.

Chapter VIII: The Referral Network as an Essential Ingredient

a) Achieving an Effective Integrated Referral Network:

The problem of woman abuse is so complex and widespread that no one professional group can expect to be able to deal with all aspects of the issues faced by abused women. In Middlesex-London, an integrated response has been developed over the past 20 years. Community-based services for abused women, services for abusive men, community mental health and addiction service providers, a family physician, the police, a judge, family lawyers, the Crown Attorney's Office, Victim/Witness Services, the Children's Aid Society, Madame Vanier Children's Services, Boards of Education, the Middlesex-London Health Unit, and the Family Court Clinic have met together on a regular basis to resolve issues related to women abuse. (See Appendix 7, pages 87-88 for a list of current members.) The London Coordinating Committee to End Woman Abuse (LCCEWA) has formulated community-wide protocols, has fostered the criminalization of woman abuse, has provided public and professional education, has strengthened their members' mutual understanding of each other's mandates, programmes and problems, has supported new services to meet identified needs and has advocated with all levels of government to improve social policies and funding.

The London Coordinating Committee to End Woman Abuse has identified the need for all service providers to participate fully in the referral network because abused women may enter the service system through any of the major sectors: the health care, justice, community service and private service sectors. The objective is to ensure that wherever her abuse is disclosed or identified, the professional dealing with her is able to direct her to the most appropriate service to deal not only with the presenting problem but also with the myriad other issues that affect her health, safety and well being. (Appendix 8, page 89 provides a diagrammatic outline of the vision for the integrated referral network.)

A report produced by the Centre for Research on Violence Against Women and Children in 1999 studied the integrated referral system in London by interviewing 105 women who had sought formal assistance with intimate partner abuse and made a number of observations.

With respect to the Integrated Model itself, foremost among the findings is that abused women in this community rely on a combination of the criminal justice, health care, and social service systems in their attempts to cope with violence by an intimate partner. The broad use of services, i.e. multiple efforts to seek help from a variety of sources is consistent with findings reported in other studies (e.g., Hutchison and Hirschel, 1998) and suggests that coordinating all sectors of the service community through LCCEWA continues to be an important and worthwhile objective.[80]

The report goes on to evaluate the success of the integrated model. The results suggest that the LCCEWA has achieved modest success in promoting coordination between the justice, health, and social service systems. The majority of women received at least one useful referral from the service provider they contacted first in response to a specific incident of violence. The findings indicate that many of those who work in the formal help system are knowledge-able about the activities and services of different community organizations and able to make appropriate, helpful referrals to abused women.[81]

The report notes that 70% of the women in the study were provided with referrals when they sought assistance from the formal help system. Of those referred, 83% followed up with at least one of the agencies or professionals recommended. This high level of referral acceptance is encouraging as it shows the utility of referral. The majority of those not following up decided they were unable to talk about the abuse or make a change at that point; inability to make contact with the agency or belief that the referral was inappropriate were the other reasons cited.[82]

However the report pinpoints some serious shortcomings in the integrated referral system, some of which are of particular importance to the Task Force. With respect to the health care sector, the report indicates that:

> *Approximately half the women spoke to their family physician about the abuse. In fact, family doctors were the second most frequently mentioned source of counselling, and most of the women who looked to their doctors for help were*

very satisfied with the service they received. Although they were a popular source of support, it is important to note that family physicians offered the women only limited assistance in gaining access to help available in other sectors of the formal help network. Doctors made most referrals only to other sources of counselling or therapy, not to services such as women's shelters.

...the quality of the women's experiences with hospital emergency services was largely dependent on the responses of the particular nurse or doctor assigned to their care. It is noteworthy that one in five women who went to a hospital emergency department was not asked about the source of her injuries, a pattern similar to that reported in other studies.[83]

The report recommended that, from the consumer's point of view, the following improvements need to be made in the health care system:[84]

Family Physicians

- More time taken by physicians to discuss abuse;
- More referrals;
- A clear message about the lack of acceptability of abusive behaviour.

Emergency Departments

- More consistent, compassionate treatment;
- More emotional support;
- More information and referrals;
- Elimination of blame and disbelief when responding to abused women.

Although the Middlesex-London Health Unit and some individual health care professionals (a family physician, a representative from the Regional Sexual Assault Centre and a medical social worker) have been part of the Coordinating Committee and have worked hard over many years to build an integrated approach, the hospitals, physicians and other regulated health professionals have not, in general, been very active in the referral network. Individual community service providers have developed close relationships with individual health care professionals or clinics and have achieved cross referrals as a result. Individual health care workers within the hospital setting have been strong advocates and have worked tirelessly within the hospital system to encourage more consistent and appropriate responses and referrals. As Appendix 5, pages 82-84 shows, the health sector is an extremely important resource for abused women, but "the results suggest that abused women do not necessarily find a consistent referral response at different points of access in London's formal help network."[85] Appropriate and timely referrals are an essential element if a routine universal comprehensive screening protocol is to lead to a decrease in the incidence and prevalence of woman abuse.

b) Future Considerations:

Once the community accepts the Routine Universal Comprehensive Screening (RUCS) Protocol, the demand for services is likely to escalate rapidly, at least initially. It will be even more urgent for all sectors and all participants in the referral network to be knowledgeable and committed to an integrated response. Sharing of information and cross-sectoral education must be put in place to ensure that all health care professionals and community service providers learn how to work effectively together. Mutual support to ensure the most effective and efficient delivery of services will be essential; it may become necessary for some services to stop doing some of what they now do and for others to take on new tasks. All sectors will have to advocate together to ensure that the necessary resources are available in each part of the system. All sectors will have to participate in the evaluation of the outcomes of the protocol to ensure that the objectives are being met.

London has taken the lead before, with respect to the criminalization of intimate partner abuse, at a time when there was little public or justice sector support for an integrated effort to end woman abuse. Each year, new efforts have been made to expand the referral system; the latest initiative is the joint commitment of addiction services and woman abuse services in Middlesex and the surrounding counties to inquire about abuse and addictions and to cross-refer clients to one another's services. The most serious gap in services continues to be the health care sector. That gap can be closed if all service providers are prepared to work together.

Chapter IX: The Challenges of Implementation

a) Recognizing the Challenges:

Often, when ideas for new ways to approach old problems are proposed, there is no recognition of the very real challenges that make the implementation of those proposals difficult to achieve. For community service providers on the Task Force, given the evidence available through research, study and many years of experience, it was difficult to appreciate the substantial difficulties anticipated by the health care members in implementing the Routine Universal Comprehensive Screening (RUCS) Protocol. Some Task Force members, however, could recall similar problems in the early 1980's with the criminalization of woman abuse. They remembered how necessary it was to appreciate the context and circumstances of those working in the justice system and the barriers they faced in finding effective and collaborative ways to improve the justice response to woman abuse. The Task Force undertook a similar process to try to address the concerns of the health care sector regarding implementation of the screening protocol.

There are many potential blocks to learning that may relate to the role, skills, motivation, traits, talents and context of the learner. Many of these obstacles may be addressed through specific policy and programme changes. Others may be more difficult as they relate to the attitudes, personality and talents of individual health care professionals. Still others differ between the different practice settings and the scope of practice of different health care professions. The health care professionals on the Task Force were deeply concerned that any efforts to implement the screening protocol not be jeopardized by unrealistic expectations on the part of the Task Force. The Task Force was determined to try to address as many of these concerns as possible in its recommendations.

> ***Be strategic about where you start***. *Changing health systems is difficult. Thus the best practice is usually to start where success is most likely. Often this strategy means choosing to undertake pilot interventions first in settings where there is substantial internal and external support for change.*
> *Internally it is important to gain the commitment and support of top managers early….institutional support is absolutely essential to program success.*
> *Externally, it is best to undertake pilot interventions where support and referral services for abuse victims already exist. This will not be possible in all instances, but, given that there are so few pilot initiatives yet in resource-poor settings, it makes sense to begin where there are community resources.*[86]

Given the make-up of the Task Force and London's twenty-year history of activism in building resources, it was agreed that the Middlesex-London area would be an ideal location for a pilot project to implement and evaluate the merits of the Routine Universal Comprehensive Screening (RUCS) Protocol on woman abuse.

b) Professional Education and Skill Training:

Virtually all the literature about screening for the health effects of woman abuse stresses the need to provide appropriate education to health care professionals about the nature, prevalence, dynamics, health effects and helpful interventions with respect to woman abuse, at the undergraduate, graduate, post-graduate and continuing education levels.[87] Health professionals also need assistance in building the interviewing techniques that will help build their comfort level about asking intimate and emotionally charged questions about abuse. Both information and practical skills are helpful in encouraging the health professional to develop positive attitudes toward their role in identifying, treating and referring women who have experienced abuse. Professional education and skills training are the key elements in addressing many of the obstacles to learning.

While the literature is unanimous about the need for education and training, there are many different perspectives on how these tasks are currently being achieved and what is needed to support routine universal comprehensive screening for woman abuse.

> *Many pointed to the complexity of the problem and the fact that they had no "tools" to help. "I think we tend to look more on the technical side of medicine, things we can help, like appendicitis. Domestic violence is a big morass which we will never escape. I get a headache thinking about it. And that attitude translates into the type of care we give those patients."…Many pointed to their lack of training on this issue, with 62% revealing*

that they had no training on intimate-partner violence in medical school, residency, or continuing medical education courses, as opposed to 8% who expressed that they had received good training in this area. [88]

The link between a lack of education about family violence, either in undergraduate medicine or among practicing physicians, and physicians' readiness—and ability—to respond effectively and sensitively to victims has continued to be a major theme.... [89]

In spite of nursing research and the research of other disciplines about the consequences of domestic violence for both perinatal and women's health, only slightly more than half of all nurses reported having any education related to abuse. [90]

Family violence has been underrepresented in medical education. Leaders in medicine and public health have advocated for greater emphasis on family violence education for health care professionals. However, the majority of physicians report having received no education about any aspect of family violence during medical school, residency training, or continuing medical education....The first study to examine medical school curricula in adult domestic violence found that the majority of American and Canadian medical schools did not provide any instruction on this topic in the 1987-88 academic year. [91]

A second 1998 study, which unfortunately did not include Canadian medical schools, went on to survey both deans and students at U.S. medical schools and matched the responses of each to the survey. The following tables show the responses about the extent to which violence is taught in the curriculum and the perceived barriers to instruction about abuse: [92]

Table 3. Dean (D)student (S) matched comparisons (N = 87 paired responses)

	Curriculum present (%)		No. of course (%)										Median required hours (range)	
			0		1		2		≥3		No data			
	D	S	D	S	D	S	D	S	D	S	D	S	D	S
Adult domestic violence	74 (86)	49* (57)	12* (14)	37 (43)	30 (34)	29 (34)	18 (21)	15 (17)	21 (24)	3 (3)	6 (7)	3 (3)	2.0 (0–25)	2.0 0–35)
Child abuse and neglect	81 (94)	73** (85)	5 (6)	13 (15)	29 (33)	42 (49)	31 (35)	19 (22)	18 (20)	7 (8)	4 (6)	6 (6)	2.0 (0–81)	2.0 (0–10)
Elder abuse	60 (71)	35* (42)	24 (29)	49 (58)	34 (39)	27 (31)	12 (14)	6 (7)	10 (11)	2 (2)	7 (7)	3 (2)	1.0 (0–28)	1.0 (0–8)

*$P = 0.001$.
**$P = 0.033$.

Table 4. Perceived barriers to instruction

	Adult domestic violence		Child abuse and neglect		Elder abuse	
	D (N = 15)	S (N = 32)	D (N = 6)	S (N = 13)	D (N = 33)	S (N = 47)
Lack of faculty expertise	1 (7)	10 (31)	0 (0)	1 (8)	1 (3)	12 (26)
Lack of faculty approval	3 (20)	5 (16)	1 (17)	1 (8)	4 (12)	4 (9)
Lack of institution endorsement	2 (13)	14 (44)	1 (17)	4 (31)	3 (9)	14 (30)
Lack of finances	5 (33)	4 (13)	3 (50)	1 (8)	5 (15)	3 (6)
Not school's role	0 (0)	3 (9)	0 (0)	1 (8)	0 (0)	5 (11)
Clinical clerkships	5 (33)	9 (28)	3 (50)	1 (8)	10 (30)	15 (32)
Residency training	2 (13)	2 (6)	1 (17)	1 (8)	4 (12)	2 (4)

The good news about this study is that it reveals an absolute increase of 18% in the number of U.S. medical schools reporting required education on abuse seven years later. However, the median amount of instructional time (2 hours) had not increased.

> *While most schools offer education in all aspects of family violence, instruction still occurs predominantly in the first 2 years. However, it is primarily during the clinical years that students integrate and apply knowledge of medical and social problems to the clinical assessment and care of patients. Instruction that occurs in the preclinical years only, and is not adopted, as a component of routine patient care by the residents or attendings with whom the students interact, might not be interpreted as important to patient care….*[93]

The study showed a disparity between the number and the nature of courses between deans and students. The author suggests that this disparity may be because the course offerings may be provided in "off hours" in the schedule, such as late in the day or the term, or that the entire offering is provided in one stand-alone session rather than integrated throughout the duration of the educational process. The article goes on to advise:

> *Instruction should be integrated throughout all four years of medical education, delivered using a multidisciplinary approach within and across courses and clerkships, and seek the expertise and collaboration of a range of individuals and organizations that comprise a community-based response network. Medical schools can expand upon this collaboration by fostering partnerships with community and direct service organizations where service-learning opportunities to reinforce teaching about family violence can occur. The involvement of community-based professionals, particularly in law enforcement, legal services, victim advocacy, batterer intervention, elder services, and child protection, among others, should be sought in all phases of medical education.*[94]

In the past few years, very extensive efforts have been made at the University of Western Ontario to design a new curriculum focused on producing "Patient-Centred" doctors. Students now have an opportunity to do a project in the community that helps them to learn from community-based professionals about the specialized services available in the community. The idea is to strengthen the interdisciplinary respect and knowledge of physicians so that they will know when referrals are appropriate and which services are best suited to providing their patients with needed care. Some members of the Task Force have played key roles in developing the new curriculum. While a majority on the Task Force have been very supportive of the new curriculum, others have been critical, advocating for a greater role by community agencies providing specialized woman abuse services in the design and delivery of the new curriculum. There continues to be some controversy about the value of having community service providers as well as physicians involved in teaching about woman abuse.

> *The medical and health communities need to legitimize their request for intervention with domestic abuse by integrating the topic into university curricula, residency programs, and continuing education. Developing universal protocols for identification and intervention would create a united front against abuse, bringing together service providers and the medical, legal and law enforcement communities. Most of the doctors in the study were misinformed about state laws regarding domestic abuse. They were singularly unaware that documentation of domestic abuse can be a powerful tool for the victim if the case is prosecuted. Training seminars for office staff could provide improved partnerships with physicians to increase quality care to domestic abuse victims. Networking with the community at large would enhance the effectiveness of each segment.*[95]

While the most extensive discussion was around educational needs of physicians, the Task Force was aware of similar needs among other registered health professionals, social workers and other health care providers who might be required to apply the screening protocol. The Task Force agreed to recommend that the Medical Officer of Health and appropriate Task Force members would initiate negotiations with Fanshawe College and with the University of Western Ontario and its affiliates around curriculum design and delivery to deal with screening protocol issues. The Task Force also agreed to advocate for continuing educational and train-the-trainer programmes in conjunction with the Colleges of the regulated health professions, professional associations and bargaining agents.

c) Woman Abuse: A Psychosocial Issue

One of the issues consistently raised as a challenge to the appropriate identification, treatment and referral in cases of woman abuse is how to understand the determinants of health with respect to violence. We have already noted that the issue of woman abuse does not fit neatly into the medical

model. The National Panel on Violence Against Women noted:

> *The bio-medical approach practiced in health care separates the human body from its social environment. For women survivors of violence this means that the issue of violence is isolated from its context, and, in effect, makes them responsible for their condition. Health care practice also tends to ignore the link between the mind and the body. Consequently, the multi-faceted nature of violence is not recognized. Violence is often considered an illness requiring a medical response. The symptoms of violence are the only focus; the underlying causes are ignored. Survivors are attended to with medication or considered mentally ill and referred for psychiatric treatment.*[96]

The National Forum on Health identified four determining factors related to gender that are particularly important in providing effective efforts to address violence against women:

- ***The social context of power imbalances:*** *People who lack power in society are the most likely victims of violence because they lack the means to resist abuse and to escape from dangerous situations.*

- ***Attitudes and values:*** *Violence is condoned by Canadian social values that see violence as a natural expression of aggression or an inevitable result of stress, anger and frustration. One in five people think that wife abuse is acceptable, and most people do not want to get involved (Strauss, 1989). Gender stereotyping of females and males in television, radio, video games and other entertainment media reinforces and condones both subtle and overt violence against women.*

- ***Isolation and alienation:*** *Child poverty, school failure and other blocked opportunities for youth are major risk factors for young men to become persistent offenders. The loss of a sense of community because of greater mobility, larger urban centres and the changing nature of the family are also creating a sense of isolation. These factors may result in greater concern for individual survival and a lesser sense of social responsibility for others (Canadian Public Health Association, 1994).*

- ***Vulnerable individuals and groups:*** *Particular groups of girls and women are more vulnerable to abuse than others:*

  - *Girls and young women are especially vulnerable to abuse by parents, adult caregivers, acquaintances and boyfriends.*

  - *About 80% of women with a disability will be sexually assaulted in their lifetime (Stimpson and Best, 1991).*

  - *Women with a household income under $15,000 are twice as likely to be battered as women in general (Canadian Centre for Justice Statistics, 1994).*

  - *One in 10 older people experience abuse and at least two-thirds of these are women (Canadian Panel on Violence Against Women, 1993).*

  - *In many aboriginal communities, economic changes, cultural losses and male domination of political life have compromised the traditional social structure. Historical abuse in church schools and high levels of alcohol abuse exacerbate the problem. Among Aboriginal women, the rates of abuse may be as high as 80%, and in some communities all women have a history of abuse (Ontario Native Women's Association, 1989).*

  - *Immigrant women, women of colour, refugee women, live-in domestic workers and women from linguistic minorities often encounter barriers in gaining access to appropriate services and therefore bear a greater burden from violence than other women (Shin, 1992).*

Most of the analysis of woman abuse has been done from a feminist perspective, a psychosocial approach unfamiliar to many health care professionals. Through this lens, woman abuse is seen as a power and control issue, where

> *"informal social norms and stereotypic gender roles still legitimate control of one partner over the other and may allow us to rationalize abuse in adult relationships"(Flitcraft, 1992, p. 3195). Within the context of the medical system, "The medical approach reduces male violence—a social process rooted in gender inequality—to biological, individual or situational factors" (Kurz & Stark, 1989, p. 262).*[97]

While it is difficult to reframe the diagnostic approach to deal with the psychosocial realities of vulnerability to power and control by others, particularly if one is fortunate enough to be among the more powerful by virtue of education, profession and socio-economic status, many medical educators

concerned about violence, gender issues and power, have succeeded in this reframing. Balancing out the power between patient and health care provider is essential in order to facilitate appropriate identification and intervention in woman abuse situations.

Adopting a routine universal comprehensive screening protocol that disregards the social inequities of women seeking services allows the professional to approach each woman on the same non-stigmatizing basis, without assumptions about how her race, income, education, religion, etc. may have affected her vulnerability to abuse. If routine universal comprehensive screening is adopted as a new group norm and performance is rewarded by the system, the obstacle of dealing with woman abuse as a psychosocial issue would be lowered.

d) Redefining Success: Relinquishing the Need to "Fix It"

One of the barriers to a diagnosis of woman abuse is the difficulty of understanding how to define success once abuse is identified.

> *Physicians struggled between their awareness of the recommendation to screen routinely for abuse and their reluctance to comply with that advice. They were caught in a double bind of being remiss for not diagnosing abuse and for not improving the patient's condition if they made the diagnosis. The doctors shied away from screening for domestic abuse because they did not know how to effectively respond to the patient once the diagnosis was made. Training in the medical model taught the doctors to diagnose and treat only obvious physical symptoms of abuse and to feel successful only if the abuse was "cured" by having the patient leave the abusive environment.*[98]

Many health care professionals expect to be able to resolve an identified problem by providing prescriptive advice about what the patient should do or take to stop the symptoms. Dealing with abuse is different from "curing" abuse; surviving abuse is a process similar to coping with the effects of a chronic illness that is always present but that may be ameliorated by certain means that require the patient to assume a level of risk.

> *Many abused women are not passive victims but use active strategies to maximize their safety and that of their children. Some women resist, others flee, and still others attempt to keep the peace....What may seem to an observer to be a lack of response to living with violence may in fact be strategic assessment of what it takes for the woman to survive....and to protect herself and her children.*

> *Leaving an abusive relationship is a process. The process often includes periods of denial, self-blame and endurance before women come to recognize the abuse as a pattern and to identify with other women in the same situation. This is the beginning of a disengagement and recovery. Many women leave and return several times before they finally leave once and for all.*[99]

The fully informed patient must examine the relative benefits and drawbacks of possible choices but she is the one who must live with the inevitable consequences of the choice she makes.

> *Relinquishing the need to fix it required physicians to break away from the traditional methods of healing that were ingrained in their education. This was accomplished in three phases: redefining what would constitute a successful intervention, revising the physician's role, and forming partnerships with the patient, the medical community and society.*[100]

Redefining the role meant that making the diagnosis became the goal of the intervention:

> *This required doctors to examine and often relinquish their own agenda for the patient, let go of the need to fix it, and incorporate routine screening into their history taking....Once doctors accepted making the diagnosis as their primary goal, they were committed to routine screening: "Our problem is to identify, diagnosis." When physicians "have already developed a history taking flow...it's hard to add something else to that," but doctors determined to screen for domestic abuse were willing to find the place to add it.*[101]

Revising the physician's role meant taking on the role of health educator, presenter of possible options and making appropriate referrals.

> *Effective intervention required more than handing out referral numbers. "They need some sympathy" and validation of the reality of the abuse....Perhaps the hardest part of relinquishing the need to fix it was respecting the patient's choice of action....trusting the patient's judgement to know what to do and when to do it.*[102]

The medical model that set up the physician to "cure" the abuse also set up the patient to relinquish control and expect that cure. Doctors who relinquished the need to fix it shifted the responsibility for change to the patient, and their primary responsibility became making the diagnosis and offering options and support.[103]

Forming partnerships requires health care professionals to work together within the medical community but also to reach beyond the medical community to work with community and private services as well as the justice sector.

Obstetrician/gynecologists expressed concern that referring the patient to community resources might make the patient feel "dumped." Explaining the reason for the referral and stressing their continued interest in the patient's progress made it easier for the doctor to let go of trying to provide all the intervention alone.[104]

Building mutually respectful partnerships between the service sectors is essential for a screening protocol to be effective. In some instances, it will require professional education for both health care professionals and community service providers about the mandates, the ethical codes, the best practices and the limits on service of one another's services. Relinquishing the urge to "fix" also means relinquishing ownership of the patient: no one sector alone can deal with the complex social issue of woman abuse and women seeking assistance need a range of skills, supports and interventions in order to survive.

Once their goal shifted from fixing the problem to recognizing it, offering options and respecting the patient's choices, the physicians' energies were redirected toward advocating for awareness and societal reform. Here on the micro level of one patient at a time and the macro level of united community effort, physicians and other health care professionals can begin to break the cycle of abuse.[105]

Learning to relinquish the need to fix it allows the role of health care professionals to become more defined with respect to woman abuse and also helps the professional to become more committed to the screening role. The professional no longer feels the need to control the results of the performance of the screening task: the control and the responsibility is deliberately shifted to the patient.

Ironically, backing off from a rescuing role and instead respectfully appreciating someone's strengths and giving messages of support, my relationship with my patients becomes more important in their lives. That paradigm shift from rescuer to supporter and empowerer has been a very important one….Before I started doing this work, I felt somewhat overwhelmed and powerless in dealing with the violence that exists in this world. Now I know I'm helping to relieve some of the suffering.[106]

e) Time and Resources:

Most health care professionals resist adding yet another task to their busy agendas.

Repeatedly, the image of opening Pandora's box was used by physicians to describe their reaction to exploring…violence with patients…(According to Greek mythology, Pandora was the first woman. Her creation was part of Zeus' revenge against Prometheus for providing mankind with fire. She single-handedly opened a box and unleashed the spites of aging, labour, sickness, insanity, passion and vice into the world.) "I think that some physicians, and I do the same thing, if you are very busy and have lots of patients waiting, you just don't ask a question that you know is going to open Pandora's box. Even if it crosses your mind, you don't ask."[107]

Many health care professionals, in these times of constraint, feel pressured to make their interactions with patients as focused and "efficient" as possible. Institutions are short-staffed; fee-for-service professionals must see a critical mass of patients in order to make a living. However streamlined the protocol, asking about abuse does take time, particularly if the disclosure is complex and the health care professional is unfamiliar with the referral network. Documentation may seem particularly onerous.

The only real comfort comes with recognizing the potential benefits that balance off the cost of screening. As with any other early identification of a health condition, woman abuse screening may foster more informed and effective treatment and interventions in the future and may prevent injury, illness and even the death of the patient. Many emergency room visits and many unfruitful efforts to resolve somatic and/or emotional distress may be rooted in the unrecognized abuse the woman has experienced.

We believe the initial time spent in addressing domestic violence may be offset later by avoiding the evaluation of symptoms that are not well

understood outside the context of the violence. In our own experience, although providers were wary at first of asking about domestic violence, our group continues to use this screening question.[108]

This may be initially uncomfortable for any physician, but the discomfort rapidly fades with the experience of seeing patients relieved by the unlocking of secrets. Having complex cases become clear is a further reinforcement for asking questions in areas typically avoided.[109]

Screening for domestic violence has actually made my practice more efficient and more effective. Screening very early on in the patient-provider relationship deepens the relationship, makes it more trusting and therefore makes it more efficient in the sense that I'm able to understand how the psychological and physical stress of domestic violence is playing a role in this person's health and I'm able to see risk factors for illness that I might not have seen. This, in turn, has made my practice more effective. Certain visits may take longer, but the depth that I achieve is worth it. Really, screening does not take very long. If there's a negative answer, the screening is over immediately, and you've let the patient know that if that ever happens, you're open to hearing the answer. If someone comes in in the midst of an incredibly violent relationship, that visit will not be brief, and I view that the same way as I would crushing chest pain. I must stop what I'm doing and deal with that situation…[110]

Once committed to woman abuse screening, health care professionals paid through government allocations must advocate within their institutions, their professional bodies and their bargaining units for a reallocation of public resources to meet this prevention priority. Those health care professionals who depend upon private payment may find it difficult to take on an additional task without charging the patient directly for the service, a problematic practice if the patient has not requested such a service. These compensation issues require discussion within the affected professional bodies as part of the consideration of best practices. Dealing with the time/resource issue is important if professionals are to see their changed practices as valued or rewarded. The Task Force agreed to make recommendations to address some of these issues.

f) What if the Abuser is Also My Patient?

In many situations, a health care professional may be required to provide services to both an abused woman and her abuser. Often the reluctance to screen for abuse is blamed on an ethical dilemma perceived by a professional with a dual relationship. Until recently, there has been surprisingly little written about how to deal with these issues. The National Clearinghouse on Family Violence publication, A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians,[111] provides the most complete information available to date:

In 1997, the first set of guidelines[112] *for physicians dealing with these so-called dual relationships clearly stated that it is not a conflict of interest for the physician to deal with the abused female partner when both partners are patients. Both patients have a right to autonomy, confidentiality, honesty and high quality care.*

[It is] recommended that physicians deal with each patient independently and that they not discuss the possibility of abuse with the male partner without the consent of the abused female partner. Referring one or both partners to another qualified physician was preferred if a physician feels unable to deal effectively with either patient because of this dual relationship.[113]

The Handbook includes a list of recommendations about ensuring confidentiality, assessing risk, avoiding joint marital counselling, and being clear about the duty to inform a third party. (See Appendix 6, pages 85-86 for the full list.)

g) The Effect of Woman Abuse Screening on Patient Relations:

One of the major concerns expressed by health care professionals is that screening for abuse may destroy their relationship with their patients.

Offending patients was a primary concern inhibiting direct inquiry: "I find that some people take that as an offense, so I have to be very careful." The ultimate, unbearable consequence of offending women was losing them as patients. Nearly all of the obstetricians/gynecologists cited cases in which a patient had left their practice after being questioned about abuse.

> *The fear that direct questioning would bother patients far outweighed the possibility expressed by some doctors that patients might appreciate the direct approach: "If it's approached tactfully, most patients prefer to be asked rather than not to be asked because they feel that you are looking after the whole individual." Another physician acknowledged that answering questions about domestic abuse was "probably no less embarrassing for the patient than talking about some of the things we* ***do*** *ask.*[114]

This attitude is reflected in research designed to discover patient preferences and physician practices about victimization inquiries. The findings were summarized in the abstract:

> *Among patients, routine physical abuse (PA) inquiry was favoured by 78% and routine sexual abuse (SA) inquiry was favoured by 68%. Only 7% were ever asked about PA and 6% about SA. A history of PA was reported by 16% and a history of SA by 17%. Ninety percent believed physicians could help with problems from PA and 89% felt that physicians could help with problems from SA. Among Physicians, one third believed that PA and SA questions should be asked routinely. However, SA inquiries were never made by 89% at initial visits or by 85% at annual visits. Physical abuse inquiries were never made by 67% at initial visits, or by 60% at annual visits. Eighty-one percent believed they could help with problems associated with PA and 74% with SA.*[115]

In another study done of registered nurses working in three practice settings, 80% of public health nurses, 59% of private office nurses, and 72% of hospital nurses disagreed with the statement: "I believe I may offend my patients if I ask about abuse."[116]

If a woman should become angry and hostile at the screening questions, acknowledge her anger and offer support services. Do not insist on completing the entire process. Such responses may indicate some underlying reasons for such a hostile response. If the screening protocol is followed, women always have the option of simply denying abuse if they are reluctant to discuss the issue with a health care professional. Often the asking of the question is a signal that it may be all right to disclose; disclosure may not happen the first, second or even third time a woman is asked. But she will have a message that the health care professional is concerned about abuse, willing to deal with it, and willing to let her deal with the questions at her own pace.

Validation is an important way in which health care providers can help abused women. One research study did in-depth interviews with 25 women to determine what they had found most helpful from their doctors and over half cited validation of the reality and the danger of their situations most helpful in encouraging them to deal with abuse:

> *Carolyn: This was the relationship bottom. This person was going to kill me, but I needed the validation, I needed to hear it from a doctor, that, yeah, "These injuries, I can stitch them, patch them and we can keep our fingers crossed, but then the next time he's going to kill you because he was pretty intent on doing it that time."*

> *Elizabeth: I think it helped me take it seriously. And to stay with the process of "this is serious, he needs to be held accountable, I need protection, I need support." As soon as he [provider] did that, there was something that just happened that turned me completely around…life as we knew it has completely changed! Something just shifted. Big…that was a HUGE turning point.*[117]

If screening is done in a routine and universal way and if women understand that all health care professionals with whom they come in contact will inquire about abuse, there is less prospect of their being offended. If, however, questions are only asked when a woman is perceived to be in a particular risk category because of the demographics presented in some research, then screening may be seen to be stigmatizing and labelling:

> *The evidence of difference in the prevalence of domestic violence according to class, educational level, urban or nonurban residence, or marital status is highly contentious in the published research. All studies of this subject show that levels of domestic violence are high in all categories, so the usefulness of making these distinctions is small.*[118]

The more public education that is done to inform women of the Routine Universal Comprehensive Screening (RUCS) Protocol, the less likely it is that problems will arise between health care professionals and their patients. The Task Force highlighted public education as a pre-requisite for the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol.

h) The Legal Implications of Screening:

Many professionals may worry that asking questions about and documenting abuse in the patient's record will increase their likelihood of being embroiled in legal actions. In Ontario, there is no requirement for health care professionals to report abuse of adult women (i.e. women over age 16) as long as abuse and neglect of children under 16 is not suspected or known. Medical records can be subpoenaed for use in court and, for that reason, should be as clear, consistent and legible as possible.

Being able to rely on her medical records may enable a woman to corroborate subsequent claims of an incident or a history of abuse, particularly if the health effects are noted in the record. This corroboration can be important in criminal cases, family court, in civil actions and in applications to the Criminal Injuries Compensation Board. A London Court Clinic study shows that the availability of corroborating evidence is the number one factor affecting police officers' willingness to lay charges in cases of domestic abuse.[119]

If a patient should be killed or seriously injured by an abuser, the information in her medical record may help to convict her abuser. In many cases, clear records may not require a health care professional to testify in court actions. Success in developing a documentation protocol that would be accepted in most instances as affidavit evidence would lessen the prospect of time consuming court support by health care professionals.

As is the case with any medical record, information about abuse should only be released with the written permission of the patient or upon service of a court order. A subpoena may require the health care professional to appear at court on a specific day and to bring to court any records of documents in the professional's possession. Documents should be released only in court by order of the presiding judge. Documents subpoenaed by the court should be photocopied prior to being handed over to ensure that a full copy remains available to the health care professional and the patient. In Canadian courts, the information shared by a patient with a physician is compellable; the physician cannot refuse to answer questions on the grounds of either patient-doctor confidentiality or patient objection. Health care professionals who are in doubt about their legal obligations should contact their professional college or legal counsel.

i) The Imperative to "Do No Harm":

Health care professionals are always anxious that a new protocol may in some way put them in conflict with the imperative to "do no harm" to the patient. Some express the concern that screening for abuse and documenting the information may in some way harm their patients in the future. Certainly, in the safety section, we talked about the possible repercussions from abusers if abuse is disclosed. It is true that a medical record may sometimes be used by an opposing lawyer to attack the credibility of the patient in a civil or criminal matter. However, in most instances, a carefully documented record will support, rather than harm, the survivor of violence. It is the lack of corroborating evidence that is much more likely to be harmful.

Health care professionals must consider the harm they may be doing their patients by **not** screening for abuse. As this report has already shown, more than half of women experience some sort of abuse during their lives and many of them may remain untreated for the health effects of that abuse, if health care professionals do not proactively intervene. Some advocates foresee a day when society may regard health care professionals as negligent if they **do not** screen for such a common, yet potentially serious, health problem.

One of the most contentious issues in the abused women's service network is the issue of mandatory reporting. Given some very high profile cases that identified failures to report child abuse and the consequent increased legislative pressure on professionals to report knowledge or suspicion of child abuse, it is not surprising that some might believe mandatory reporting of woman abuse should also be instituted to protect vulnerable women and/or to detect crime. Some justice officials, sickened by the injuries and death caused by woman abuse, advocate for both mandatory screening and mandatory reporting.

In the United States:

> *All but five states have laws that, to varying extents, may require health practitioners to report cases of domestic violence....Most states have general laws mandating providers to report injuries involving a weapon or criminal act. The presumed purpose of these laws is to detect crime. With the growing recognition of domestic violence as a crime, these laws may be increasingly applied to domestic violence cases....Five states have mandatory reporting laws specifically addressing reporting where domestic violence or abuse is suspected. In*

> *California, practitioners must report to the police if they provide medical services to a patient who may be suffering from a physical injury caused by "assaultive or abusive conduct." In Kentucky, any person having reasonable cause to suspect an adult has suffered abuse, neglect, or exploitation must report it to the Cabinet for Human Resources. The Cabinet must notify police, investigate the complaint and provide services where necessary, except if the adult refuses them.* [120]

New Mexico, New Hampshire and Rhode Island **require** reporting in specified instances and under particular limits. Mississippi and Pennsylvania **allow** any third party to report abuse. There are great differences between states as to who must report and who may report, what triggers the obligation to report, what department receives the report and what actually is done once a report is received. For example:

> *Health Practitioners are required by California State Law (Penal Code Section 11160 et. Seq.) to report certain cases of domestic violence to law enforcement.* ***This is <u>different</u> from a patient's voluntary request for an official police report and/or request for police assistance.... If you or the patient want police intervention or follow-up you <u>must</u> call 911 for emergencies...or to ask that an <u>official police report be made.</u> Your mandatory report is not an official police report.***[121]

Mandatory reporting of domestic violence may seem attractive for a number of reasons: it might enhance patient safety; it might improve the response of the health care system; it might result in holding perpetrators responsible for their abuse; it certainly would improve data collection and documentation about the prevalence of abuse.

But are these possible benefits outweighed by drawbacks? Hyman and Schillinger believe they are:

> *Mandatory reporting may put battered patients at risk of retaliation by the perpetrators. Batterers often escalate the violence if their partners increase help-seeking measures or attempt separation.... Many battered women believe that calling the police is not a safe or preferred response to their situation. If they fear that reporting will place them and their children in greater danger and will be carried out despite their objections, battered women will likely refrain from telling their providers or from seeking care at all.... Mandatory reporting alone does little to ensure that practitioners will provide appropriate care to battered patients...clinicians who rationalize that if they report, the problem will be taken care of may abdicate responsibility for ongoing care.... Responses to reports vary depending on state law and local policy and practice.... Mandatory reporting of domestic violence may...result in disproportionate reporting of low-income and minority patients and the perpetuation of stereotypes.... Documentation in the medical record of the abuse serves this goal [documenting for criminal and civil court] while better preserving confidentiality and privacy.* [122]

Campbell shares these concerns but adds another perspective:

> *Civilian criminal justice authorities already have difficulty in responding to all the domestic violence 9-1-1 calls and are not equipped to handle more reports of domestic violence. If the criminal justice response to such calls is uncertain, it is problematic to make the reports. Finally, mandatory reporting takes away the battered woman's agency to make her own decisions about what should be done next. It may be that it would be helpful for a health care professional to make the report to the criminal justice system, because it would take the onus of responsibility off the woman. In fact, that can and should be one of the options offered to her. But she is in the best position to make that decision—it is her life and well-being that are on the line, and she is empowered only if she is facilitated in making her own decisions.* [123]

The Task Force did not discuss the issue of mandatory reporting at any length, although the justice representatives would have liked to consider the pros and cons in more detail. The majority of the Task Force expressed the concern that implementing the Routine Universal Comprehensive Screening (RUCS) Protocol would be much more difficult, even impossible, if mandatory reporting were the law in Ontario. Health care professionals have particular concerns:

> *Health care providers may experience conflicts between a mandate to report cases of domestic violence, their judgement of what is in the best interests of the patient, and the patient's desire not to report the abuse. Practitioners may be caught between their obligations to society and their duties to the patient. In analyzing these dilemmas, clinicians need to keep in mind the basic ethical principles of nonmaleficence, beneficence, autonomy and confidentiality.* [124]

In Ontario, the Medical Expert Panel on Duty to Inform has recommended that the province's Medicine Act be changed to reflect a mandatory duty to inform when a patient makes a serious threat of violence against a third party and it is more likely than not that the violence will occur. That recommendation is being implemented. The Task Force endorsed that recommendation and included the information in those sections of this report that deal with limits on patient confidentiality. The Task Force did not make any recommendation regarding other forms of mandatory reporting.

Chapter X: Evaluation and Measurement

The Task Force recognized the strong tendency of the health care community to undertake new tasks and practices only when evidence-based research is available to show that the benefits outweigh the costs. In the case of routine universal comprehensive screening for woman abuse, such definitive evidence has yet to be produced. Many of the screening protocols currently in place are quite recent; most have been implemented within the last three to five years. None that we could find are as comprehensive in scope as the Task Force is recommending. Although much qualitative research and many anecdotal reports suggest that screening is effective in assisting abused women, the Task Force could not find any longitudinal studies that provide the quantitative and qualitative information required to meet evidence-based criteria.

The Task Force is proposing instead that Middlesex-London be the pilot site in which such measurement and evaluation could take place. In conjunction with the Middlesex-London Health Unit, the Centre for Research on Violence Against Women and Children has prepared a detailed joint proposal that could be implemented as soon as a sufficient number of health care professionals commit to the Routine Universal Comprehensive Screening (RUCS) Protocol and, of course, funding is found to support the joint project.

The proposal includes both quantitative and qualitative measures. In brief, a baseline survey of both health care professionals and patients would be undertaken initially and then measured against repeated testing over the course of the project, a period of at least five years. The goals would be to determine changes in practice on the part of professionals, willingness to disclose on the part of patients, the utilization of the integrated referral network, the consistency of documentation, actual changes in the incidence, type, severity and frequency of violence experienced by individuals and throughout the community, and the satisfaction rates of both health care professionals and their patients as a result of the implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol. The Task Force members agreed to support such a project and to act as advisors to it.

London already has some experience of going ahead with an innovative change in policy and practice with respect to woman abuse prior to the availability of hard evidence that such a change would be effective. In 1981, the London Police Service, in response to a baseline research study[125] that indicated abused women's strong dissatisfaction with the intervention of the criminal justice system in domestic abuse cases, a dissatisfaction that was shared by the justice personnel involved, adopted a policy of police charging in these cases, "wherever there were reasonable and probable grounds." Soon after, the Crown Attorney adopted a consistent policy-based practice to prosecute these charges. There was no other jurisdiction that had taken a similar step at that time. Many women and justice system employees were very skeptical that such a change would really work to intervene successfully where abuse has occurred and to prevent further violence in the future. Research was undertaken in 1986[126] and 1991,[127] and the ten-year experience showed that from both the police and public perspective, charging and prosecuting perpetrators of wife abuse is an effective intervention. A policy of criminalizing wife assault is now in place in many jurisdictions in North America, including Ontario.

The Task Force recommendation that Middlesex-London become a pilot project for the Routine Universal Comprehensive Screening (RUCS) Protocol is based on the strong health care, academic, justice and community resources available and the committed efforts of the London community for more than twenty years to end woman abuse. The recommendations to various levels of government, to regulating Colleges, to professional organizations, health care institutions, and bargaining agents are intended to encourage each to join with the Task Force in taking this next bold and innovative step toward ending violence against women.

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