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Intimate Partner Violence Consensus Statement

This document, written by the IPV Working Group, was reviewed by members of the Social Sexual Issues Committee, as well as the IPV Working Group, and was approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

This document supports the previous document dated 1996.

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Abstract

Objective: To provide health care providers with a summary of current knowledge on intimate partner violence (IPV) and to propose recommendations for best practices. To provide tools and resources to support interventions.

Outcomes: Optimizing provider skills in assessing for intimate partner violence (IPV) and responding to disclosure, promoting institutional and community coordination in a public health approach, and improving safety and health for all women.

Evidence: Published and unpublished meta-analyses on screening for violence were reviewed, as well as literature published subsequent to December 2002. To update the 1996 guidelines on domestic violence, key reports and documents produced by governments, professional associations, and coalitions were identified. External stakeholders critiqued a draft document and provided feedback.

Values: The quality of the evidence is rated with the criteria described in the Report of the Canadian Task Force on the Periodic Health Examination. Recommendations for practice are ranked according to the method described in this report.

Recommendations: Comments are to be received from reviewers, and then summary statements and recommendations are to be done.

Summary Statements and Recommendations

IV B. INCIDENCE AND PREVALENCE

Summary statements

1. Canadian surveys of IPV, the most common form of violence experienced by women, have found an annual prevalence between 6% and 8%; this is considered a conservative estimate, owing to underreporting (III).

2. Prevalence rates among pregnant and adolescent women appear to be greater (III).

3. All women, regardless of socioeconomic status, race, sexual orientation, age, ethnicity, health status, and presence or absence of current partner, are at risk for IPV (III).

IV C. IMPACT

i. Physical and mental health

Summary statements

1. Violence is a significant cause of morbidity and mortality for women (II-2).

2. Women experiencing violence have an increased risk for substance abuse, mental disorders, chronic physical disorders, and sexual health complaints (II-2).

These guidelines reflect emerging clinical and scientific advances as of the date issued and are subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the SOGC.

ii. Maternal and fetal health

Summary statement

1. Women abused during pregnancy are more likely to be depressed, suicidal, and experience pregnancy complications and poor outcomes, including maternal and fetal death (III).

iii. Children exposed to IPV

Summary statements

1. Children whose mothers experience IPV are at greater risk of developmental difficulties and may themselves be abused (III).
2. Some provinces require reporting to child protection agencies when children live in households where IPV occurs (III).

Recommendation

1. Health professionals should enquire about the well-being and safety of children whose mothers' are experiencing IPV. When concerned or when obliged by law, they must report their findings to child protection agencies (B).

iv. Groups with special issues or needs

Summary statement

1. Women who are immigrants or refugees, lesbians, women of colour, Aboriginal, and women who have disabilities may experience forms of IPV, may experience IPV differently, and may have more barriers to disclosure than mainstream women (III).

Recommendation

1. Health care professionals should be sensitive to the manifestations of IPV in populations with differing needs (B).

IV D. INTERVENTION

Summary statements

1. At least 3 systematic reviews of "screening" for IPV have found insufficient evidence to recommend for or against routine screening. Asking women about violence is not a screening intervention: victims are not asymptomatic; disclosure is not a test result, it is a voluntary act, and the presence or absence of violence is not under the victim's control; and most interventions required to protect and support survivors are societal, not medical (I).
2. For pregnant women, clinical interventions that included counselling to increase safety behaviours resulted in the adoption of these practices (I) and reductions in abusive incidents (II).

i. Asking about IPV

Summary statements

1. Training of health providers may reduce barriers to asking about violence (III).
2. Most women do not disclose IPV spontaneously because of multiple perceived barriers; however, they often choose to disclose when asked (III).
3. Several validated questionnaires exist for enquiring about IPV; however, the nature of the clinician–patient relationship and how questions are asked seem more important than the screening tool (III).

Recommendation

1. Providers should include queries about violence in the behavioural health assessment of new patients, at annual preventive visits, as a part of prenatal care and in response to symptoms or conditions associated with abuse (B).

ii. Responding to disclosure and nondisclosure

Summary statement

1. Women considered the provision of referrals to useful services (advocacy, job training, and financial support) to be the most important role for health care professionals (III).

Recommendation

1. Application of the Stages of Change Model to the counselling of women experiencing IPV requires further evaluation and research (I).

iii. Documentation and legal issues

Summary statements

1. Proper charting is important when caring for IPV victims. Records made for clinical reasons may be used for legal purposes (III).
2. Unless subpoenaed, records may only be released with the patient's written consent, specifying the information to be released (III).

Recommendations

1. Health care professionals should make clear, legible, and objective clinical notes, using the woman's own words about abuse and adding diagrams and photographs when appropriate (B).
2. When in doubt, physicians should consult the medical records department or their college for advice on the release of records (B).

V. ROLES AND RESPONSIBILITIES

A. Professional Support and Coordination

Summary statements

1. A comprehensive strategy of service development and prevention of IPV requires the coordinated response of health and community workers (III).
2. Administrative support and training sessions improve the ability of residents and professionals to identify and assist abused women (III).

Recommendations

1. Professional organizations, accreditation bodies, and institutions should set standards and support quality control measures for programs addressing IPV (B).
2. Providers need a supportive environment, ongoing training, appropriate human resources (i.e. multidisciplinary teams), strong links to the community, and effective referral networks (B).
3. Institutions and clinicians' offices should have protocols for IPV, handouts for clients, and up-to-date lists of community resources (B).

B. Strategies for Supporting Women Experiencing IPV

i. Creating the environment

Recommendation

1. Secure and confidential environments, well-trained staff, printed and visual patient resources, and provider tools such as checklists, documentation aids, and facilitated referrals are necessary for the facilitation of IPV disclosure (B).

ii. Approaches to asking

Recommendations

1. Providers should be caring, nonjudgmental and respectful in their approach to asking about IPV (B).
2. Questions about IPV should be behaviour-specific (B).

iii. Responding to nondisclosure

Recommendation

1. The decision to disclose or not to disclose should be respected (B).

II. Assessment of risk—Recommendations

1. Essential elements of health sector response include documentation, risk assessment, addressing the safety of children present in the home, facilitation of a safety plan, and effective referral and follow-up (B).
2. Providers should assess women disclosing violence for depression and suicide risk (B).

3. Women disclosing the presence of children at risk should be assisted by the reporting health professional in contacting their local child welfare agency (B).

VI. CONCLUSIONS

Summary statement

1. The SOGC has identified violence as an important determinant of women's health and is committed to supporting its members in their care of abused women (III).

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I. INTRODUCTION

The Society of Obstetricians and Gynaecologists of Canada (SOGC) recognizes that violence against women is a social and public health problem with devastating consequences for women, irrespective of their age, culture, sexual orientation, and socioeconomic status. As health care professionals caring for women in various clinical situations (reproductive health, oncology, emergency care, etc.), SOGC members are regularly in contact with women experiencing intimate partner violence (IPV) and have the opportunity to make a difference in their lives.

Earlier SOGC guidelines raised awareness about domestic violence, addressed popular myths that function as barriers to adequate care, and proposed screening and intervention strategies.[1] Since the Guidelines were published in 1996, additional research and clinical experience have generated greater understanding and new questions, sparking debate and controversy. Despite increasing awareness of family violence, many physicians still feel ill at ease asking patients questions about violence, are often unsure what to do with a positive response, and cite time pressures and lack of privacy as barriers to the provision of appropriate care. Medicolegal issues and concern about potential harm to the patient have also been raised as reasons not to screen. Recent recommendations from both the Canadian Task Force on Preventive Health Care[2] and the United States Preventative Services Task Force (USPSTF)[3] concluded that insufficient evidence exists to recommend for or against the routine universal screening of women for intimate partner violence. These recommendations are based on systematic reviews of the published literature. A 2001 review of interventions[4] relevant to the scope of public health practice in Canada also concluded that, although screening of women in clinical settings led to increased disclosure, there was a lack of evidence to show that disclosure led to an ultimate reduction in important outcomes, such as a reduction of abuse.[5] This research has furthered our understanding of women's responses to violence, raised important questions about the impact of the health care sector's response to violence, and fuelled the need for revised guidelines targeted at achieving significant health outcomes for women identified or presenting with IPV.

This new consensus statement reflects both the emerging evidence and growing international understanding of violence, translating these into practical, timely, and appropriate strategies for health professionals who care for women who experience IPV. The recent literature also highlights important differences in the needs, risks, and sequelae of women who experienced violence in the past, compared with those whose experiences are current. For this reason, this consensus statement addresses only issues for women currently experiencing or at risk of experiencing IPV, including adolescent girls in dating relationships.

II. OBJECTIVES

The goal of this document is to improve the health and safety of women by

- facilitating disclosure for women experiencing intimate partner violence;
- ensuring an appropriate response to disclosure;
- promoting the development and practice of safety strategies by women;
- assuring appropriate referral to services which support women's autonomy; and
- promoting optimal health care for all women.

The objectives of this document for health professionals offering care to women are:

- to update knowledge about intimate partner violence
- to increase skill and comfort in identifying and caring for women in or at risk of abuse
- to increase links with local community resources
- to clarify medicolegal issues, such as documentation and confidentiality, concerning the woman, her children, and the physician.

III. METHODOLOGY

In preparation for these guidelines, the working group reviewed both published and unpublished meta-analyses on screening for violence.[4,6,7] Additional reviews of the literature published between December 2002 and August 2004 were carried out. In addition, working group members identified key reports and documents produced by governments and coalitions in Canada.[2,8–17] Finally, external consultants reviewed the draft document, and their feedback was incorporated. The quality of the evidence is rated with the criteria described in the Report of the Canadian Task Force on the Periodic Health Examination (Table 1). Recommendations for practice are ranked according to the method described in this report.

Table 1. Criteria for quality of evidence assessment and classification of recommendations

Level of evidence*	Classification of recommendations†
I: Evidence obtained from at least one properly designed randomized controlled trial.	A. There is good evidence to support the recommendation for use of a diagnostic test, treatment, or intervention.
II-1: Evidence from well-designed controlled trials without randomization.	B. There is fair evidence to support the recommendation for use of a diagnostic test, treatment, or intervention.
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.	C. There is insufficient evidence to support the recommendation for use of a diagnostic test, treatment, or intervention.
II-3: Evidence from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.	D. There is fair evidence not to support the recommendation for a diagnostic test, treatment, or intervention.
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.	E. There is good evidence not to support the recommendation for use of a diagnostic test, treatment, or intervention.

*The quality of evidence reported in these guidelines has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Health Exam.[150]
†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on the Periodic Health Exam.[150]

IV. LITERATURE REVIEW

A. Definitions

Intimate partner violence, family violence, domestic violence, woman abuse, wife abuse, wife assault, and spouse abuse are all terms used to describe the pattern of abuse of a woman by her partner, her family members, her caregivers, or others with whom she has intimate, familial, or romantic relationships.[18] These terms have in common an understanding of violence as an expression of power, control, and domination that is expressed through a range of ongoing and escalating behaviours. Since 1994, the US Centre for Disease Control has been developing a set of uniform definitions and data requirements to assist in research and prevention in violence against women.[19]

Health Canada defines IPV as follows[10]: Typically, abuse is a pattern of assaultive and coercive behaviours used against a woman that involves the following:

- her intimate partner in a current or former dating, married, or cohabiting relationship;
- the repeated use (sometimes daily) of many different abusive tactics that, without intervention, may increase in frequency and severity over time;
- a combination of physical violence and psychological attacks and other controlling behaviours that create fear and compliance and inflict harm;
- patterned behaviours aimed at controlling her and making her obey the abuser;
- her increasing entrapment and isolation.

A woman may experience abuse in many forms including physical, emotional and psychological, verbal, environmental, social, financial, sexual, religious and (or) spiritual, or ritual abuse.

"Screening" refers to the use of a test in an asymptomatic population to identify persons with early disease, or risk factors for disease, with the aim of preventing morbidity and mortality. Examples of screening include provincial breast screening programs that offer routine mammograms to women aged between 50 and 70 years.

"Case-finding" refers to the practice, by physicians and nurses, of using the clinical encounter as an opportunity to test or screen patients for unrelated reasons, such as checking a blood pressure, ordering a fasting lipid profile, or asking about alcohol use. Both screening and case-finding are related, and both represent clinical prevention interventions.

"Behavioural health assessment" can be part of either screening or case-finding. It can also be a part of an intake, periodic, or problem-specific history. It refers to the disclosure, by a patient or client to a provider, of behaviours that confer protection against or increased risk for health outcomes. When specific behaviours are identified, interventions, including counselling, referrals, testing, and follow-up, can be tailored to meet the needs of the individual. All 3 terms (screening, case-finding, and behavioural health assessment) will be used as they appear in the literature.

"Harm reduction" is another useful term for health providers. Harm reduction was first encountered in literature referring to substance abuse, but is now becoming more widely adopted to refer to interventions aimed at reducing risk when abstinence or avoidance is not possible or realistic. Low-risk drinking guidelines, methadone programs, and

Table 2. Health impacts of IPV

General	Reproductive
• chronic somatic disorders • depression, anxiety disorders, suicidal ideation, and suicide • eating and gastrointestinal disorders • alcoholism and substance abuse • sleeping disorders, chronic fatigue • chronic pain, e.g., headache, back pain, arthritis • neurological symptoms, e.g., numbness, tingling, fainting, seizures • shaken adult syndrome, e.g., blurred vision, vomiting, confusion, headaches • choking (incomplete strangulation), loss of consciousness • cardiac symptoms, chest pains, hypertension • exacerbation of chronic medical conditions or interference with a woman's ability to care for chronic medical conditions such as diabetes, asthma, angina, and pain	• lack of control over reproductive decision making • higher likelihood of engaging in unprotected intercourse • sexually transmitted infections and HIV/AIDS infection • pain on intercourse, vaginal bleeding or infection, decreased sexual desire, genital irritation • unplanned/unwanted pregnancy (forced sex, lack of reproductive control) • threat to maternal and (or) fetal health and risk of death of the mother, fetus or both from trauma • complications of pregnancy and childbirth

Table 3. Effects of violence during pregnancy[5,42,58–64]

Maternal	Pregnancy	Fetal
• delayed prenatal care	• abdominal trauma	• low birth weight
• insufficient weight gain	• miscarriage	• fetal injury
• maternal infections (vaginal, cervical, kidney, uterine)	• antepartum hemorrhage	• fetal death
• exacerbation of chronic illness	• premature rupture of membranes	
• maternal stress	• premature labour and birth	
• maternal depression	• abruptio placenta	
	• complications during labour	

safe injection sites are all examples of a harm reduction approach.[20] For women unable or unwilling to leave abusive relationships, a harm reduction approach would include strategies to prevent injury, maximize safety, plan for escape, and promote health.

B. Incidence and Prevalence

IPV represents the most common form of violence experienced by women, in contrast to men, who are more likely to be attacked by a stranger or acquaintance. Often, various types of abuse coexist in a relationship, with physical violence being only one manifestation. In the National Violence Against Women Survey (VAWS),[20] one-third of women who had been physically assaulted reported fearing for their lives at some point in the relationship.[21] Data from the 1999 General Social Survey of Canada on Victimization (GSS)[22] indicated that an estimated 8% of Canadian women who were married or living common-law experienced violence committed by their partner on at least one occasion during the previous 5-year period. Several factors affect the quality of prevalence data, including the way in which violence is defined, selection criteria for study participants, and the willingness of respondents to talk openly about their experiences with violence.[23] Owing to the sensitivity of the subject, violence against women is "almost universally underreported" and reported levels should be thought of "as representing the minimum levels of violence that occur."[24]

Recently reported data from Canadian police departments (2001) suggest that women aged 25 to 34 years experience the highest rates of "spousal violence"[25] and that in almost 60% of spousal homicides committed in Canada between 1991 and 2001, the police were aware of a history of domestic violence between the accused and the victim.

In 48 population-based surveys done worldwide, in a variety of settings, the prevalence of women reporting physical assault by an intimate male partner at some point in their lives varied from 10% to 69%.[23] International studies of violence against women reveal that most women who are victims of physical aggression usually experience multiple acts of aggression over time. Canadian surveys of violence against women have found an annual prevalence of 8%.[8] In pregnancy, the annual prevalence is between 6% and

8%.[26,27] In Canada, 25% of abused women report episodes of beating, 20% report choking, 20% sexual assault, 40% suffer injury, and 15% require medical care for injuries.[8]

"Pregnancy should be considered as a time of change as IPV may begin, escalate, or even temporarily stop during this period."[28–30] It is estimated that 1.5% to 17% of all pregnant women experience abuse.[27,29,31–34] This is reported in studies from Canada, the US, Nicaragua, Chile, and Egypt.[35,36] Health Canada reported that 21% of abused women surveyed reported violence during pregnancy, and of these women, 40% reported that the violence began during pregnancy.[12] Further, up to 64% of women abused during pregnancy reported that abuse increased during pregnancy.[27] Of those women who experienced violence during their first trimester, 95% reported the violence escalated after the baby was born.[37] When the pregnancy is unplanned or unwanted, women are 4 times as likely to suffer increased abuse than when the pregnancy is desired.[38] However, some studies have found that, for approximately 30% of the women abused in the year prior to pregnancy, the abuse actually stopped during the pregnancy."[28–30]

Studies indicate that 12% to 35% of adolescents will experience violence in dating relationships.[39,40] Up to 65% of battered teens do not disclose the abuse and are even more reluctant to report the violence to adults.[41] Studies from Canada, the US, and Australia found that 23% to 37% of teenage women report physical abuse during the year of their pregnancy.[41–44] A British Columbia survey of high-school students revealed that an average of 32% of female teens have experienced physical and (or) sexual abuse by an acquaintance.[40]

Recent reanalysis of the 1999 GSS data, which examined experiences of violence in the previous 12 months or in the past 5 years, reveals little difference in rates of IPV among women of visible minority status, differing educational levels, living in urban versus rural settings, or with differing numbers of children.[13] Conversely, increased rates of IPV were seen among Aboriginal women, women with activity limitations, women with low incomes, and women without a current partner.

Summary Statements

1. Canadian surveys of IPV, the most common form of violence experienced by women, have found an annual prevalence between 6% and 8%; this is considered a conservative estimate, owing to underreporting (III).

2. Prevalence rates among pregnant and adolescent women appear to be greater (III).

3. All women, regardless of socioeconomic status, race, sexual orientation, age, ethnicity, health status, and presence or absence of current partner are at risk for IPV (III).

C. Impact

The consequences from IPV are extensive and influence almost every aspect of a woman's life. These effects are cumulative, affecting not only the individual but also her family and social relationships.

i. Physical and Mental Health

The most serious outcome of IPV is female mortality. Data from countries such as Canada, Australia, Israel, the US, and South Africa indicate that 40% to 70% of females murdered were killed by intimate male partners, often in the context of an abusive relationship.[23]

A recent summary report of a study assessing the health impact of IPV on women in Australia noted that, for women under age 45 years, IPV is responsible for an estimated 9% of total disease burden and has a greater impact on health than any other risk factor, including obesity, high cholesterol, high blood pressure, and illicit drug use.[45]

Research reviewed and included in the British Columbia Reproductive Care Program's Guidelines[9] summarizes IPV impacts on health (Table 2).

The Family Violence Prevention Fund recently published an expanded picture of health outcomes of IPV, linking the experience of violence with important determinants of health, such as increased tobacco and substance abuse, lack of control over sexual behaviour, and difficulty accessing health care.[46] In addition, they addressed the short- and long-term impacts on children who witness violence (see below).

Although some women will suffer from significant distress[47] or go on to develop posttraumatic stress disorders,[48–50] others have shown themselves to be remarkably resilient in the face of serious physical and or psychological abuse.[51]

Summary Statements

1. Violence is a significant cause of morbidity and mortality for women (II-2).

2. Women experiencing violence have an increased risk for substance abuse, mental disorders, chronic physical disorders, and sexual health complaints (II-2).

ii. Maternal and Fetal Health

Women abused during pregnancy are more likely to be depressed, suicidal, experience complications such as first and second trimester bleeding, and to have low weight gain, anemia, infections, preterm birth, intrauterine growth restriction,[5] and perinatal death.[64]

Recent studies indicate that IPV has become a substantial cause of maternal mortality. This has been shown in the US, India, and Bangladesh.[52–54] Several US states are now quoting homicide as the leading cause of maternal mortality, with two-thirds of these being known or alleged cases of domestic violence.[55,56]

Immigrant and Refugee Women

Some behavioural patterns suggestive of abuse in mainstream women (for example, avoiding eye contact, refusal to completely disrobe, male partners not permitting their wives to be seen alone) may be normative behaviours in some cultural communities.

Immigrant women may also hold different understandings of what constitutes abuse, based on cultural background and to whom one is "permitted" to disclose family matters. In addition, immigrant and refugee women who are abused may face additional barriers in disclosing that abuse and seeking help. Depending on the age at migration, the time since migration, and the access (or lack of access) to opportunities for English- or French-language acquisition, immigrant women may also face significant communication barriers when interacting with health care providers. In situations where family members are providing translation, these women may lack the privacy necessary for safe disclosure. Research with culturally diverse women reveals that language barriers, social isolation, and lack of direct questioning by clinicians act as significant barriers to the disclosure of abuse.[79–80] In disclosing, many women may fear deportation or the breakdown of sponsorship agreements, loss of community status and respect, and loss of child custody. In addition, there may be familial or religious pressure to maintain the sanctity of the marriage and family integrity.[79–80]

Further complicating issues of disclosure are past experiences of war, trauma, and repressive regimes. In fact, in situations of armed conflict and displacement, women and children face multiple risks for violence: prior to flight, during flight, while displaced in countries of asylum, and during repatriation or reintegration.[81] This also complicates the recognition and experience of abuse and adds to fears of disclosing and reporting to authorities.

Lesbian Women

There are some forms of abuse unique to lesbian and gay relationships. For example, abusive partners may use homophobia and heterosexism to exert control over their partner, which may be expressed by "outing" or threatening to "out" their partner to friends, family, employers, police, the church, or others in the wider community. Similarly, abusive partners may attempt to convince a partner that abusive behaviour is normal in gay or lesbian relationships. Abusers may be able to hide the abuse and increase power and control over their partner because many people do not believe that "women hurt women."[82]

Women of Colour

Women of colour may respond to violent and abusive behaviour in ways influenced by the chronic experiences of racism and the social contexts in which they live. These circumstances often provide them with different opportunities for and restrictions on their resistance to violence. Further, previous racist or other negative experiences may prevent women of colour from seeking help from institutional resources, for example, the police, for fear their partners will be victimized by the system because of institutionalized racism. The victim might have witnessed discrimination or brutality against men from her community and therefore hesitate to report cases of abuse.[83–85]

In pregnancy and postpartum, violence is directed most commonly toward the breasts, abdomen, and genitals[57] and can result in significant health risks to the woman and her fetus.

Low maternal age is considered an independent risk factor for intimate partner violence in pregnancy. This will often commence at disclosure of the pregnancy.[65] US studies have also indicated that adolescent mothers are 3 times more likely to be murdered by an intimate partner than adult women during pregnancy and the postpartum period.[21,66]

Summary Statement

1. Women abused during pregnancy are more likely to be depressed, suicidal, and experience pregnancy complications and poor outcomes, including maternal and fetal death (III).

iii. Children Exposed to IPV

Staff in women's shelters recognized some time ago that children accompanying abused women had problems of their own. Researchers had difficulty distinguishing between the direct impact of witnessing violence toward a parent versus the breakdown of care and parenting abilities in the context of violence. For example, children of abused mothers are less likely to be up-to-date for their immunizations.[67,68]

Although some children show remarkable resilience, many show difficulties in several areas, including behavioural, emotional, social, cognitive, and physical difficulties.[69,70] Cross-sectional data from the 1998–1999 National Longitudinal Survey of Children and Youth[71] confirm that 1 in 12 Canadian children between age 4 and 7 years had witnessed violence at home; for 30%, this occurred sometimes and for 5%, often.[17] These children were more likely to exhibit overtly aggressive behaviour, which persisted 2 to 4 years later. Compared with children not exposed to violence, twice as many had high levels of anxiety. Other studies suggest that those exposed to inter-parental violence generally fare poorer both in their youth[72] and as adults.[73]

Children witnessing IPV may themselves be targets of abuse and neglect leading to injury and death[74]; IPV may be the greatest risk factor for such children. Nearly one-half the men who frequently assault their female partners also frequently assault their children.[75] This impact may become intergenerational. Men who as children witnessed their parents' domestic violence are twice as likely to abuse their own wives than are sons of a nonviolent parent.[75]

Summary Statements

1. Children whose mothers experience IPV are at greater risk of developmental difficulties and may themselves be abused (III).

2. Some provinces require reporting to child protection agencies when children live in households where IPV occurs (III).

Recommendation

1. Health professionals should enquire about the well-being and safety of children whose mothers' are experiencing IPV. When concerned or when obliged by law, they must report their findings to child protection agencies (B).

iv. Groups With Special Issues or Needs

The experience of violence is framed by cultural understandings of "normal" relations between intimate partners. It is important to note that there are variations among different cultures "in the amount, frequency, and severity of aggression against women and in what is condoned or disapproved."[76] Such variations may make it more difficult for some women to conceptualize their experiences with their partners as abusive and seek help. Some of those with special issues or needs are discussed.

Summary Statement

1. Women who are immigrants or refugees, lesbians, women of colour, Aboriginal, and women who have disabilities may experience forms of IPV, may experience IPV differently, and may have more barriers to disclosure than mainstream women (III).

Recommendation

1. Health care professionals should be sensitive to the manifestations of IPV in populations with differing needs (B).

v. Other Impacts

Direct costs relate to medical treatment and care, legal services, policing, incarceration, and sometimes, foster care. Indirect costs are lost earnings and time, lost investments in human capital, indirect protection costs, life insurance, productivity, domestic investment, external investment and tourism, and psychological and other nonmonetary costs.[77] Researcher Tanis Day has estimated the direct medical cost of all violence against women as in excess of $1.5 billion yearly.[78]

Aboriginal Women and (or) First Nations Women

In the recent Women's Health Surveillance Report, data from the 1999 General Social Survey (GSS) were reanalyzed, and the authors report higher rates of all types of violence among Aboriginal women than among women who did not identify themselves as Aboriginal.[13] The authors note that these findings are based on data from the western provinces, because the GSS survey data had too few Aboriginal respondents from the eastern provinces. Nevertheless, the reported rate of any intimate partner violence in Aboriginal women was 57.2%, compared with 18.5% for non-Aboriginal women in Manitoba/Saskatchewan; 56.6% and 24% in Alberta; and 42.1% and 22.2% in British Columbia.[13] Although national data on the prevalence or incidence of family violence in Aboriginal communities are still lacking, several provincial and regional studies have been conducted. Among their findings: 8 of 10 Aboriginal women in Ontario had personally experienced family violence. Of those women, 87% had been injured physically and 57% had been sexually abused[86,87]; in some northern Aboriginal communities, it is believed that 75% to 90% of women are battered.[86] Aboriginal women in Canada are more likely than are non-Aboriginal women to experience severe violence and are 8 times more likely to be killed by their partner.[88] Aboriginal women describe themselves as having suffered double discrimination, as women and as Aboriginal people. A recent report by Amnesty International pointed out deficiencies in police protection and investigation of violence against Aboriginal women. When dealing with individual victims of violence, it is important to note that their resources may be very limited, culturally appropriate services may not exist, and their support system may be in the community in which they live. As with other closed communities, there may exist models of holistic healing in their communities that are designed to break the cycle of abuse and restore healing.

Women With Disabilities

In a survey of 245 women with disabilities, it was found that 40% had experienced abuse and 12% had been raped.[89] Perpetrators of the abuse were primarily spouses and ex-spouses (37%) and strangers (28%), followed by parents (15%), service providers (10%), and dates (7%). Less than one-half these experiences were reported, owing mostly to fear and dependency. Ten percent of the women had used shelters or other services; 15% reported that no services were available or that they were unsuccessful in their attempts to obtain services; and 55% had not tried to get services.[90]

D. Intervention

The literature on health care interventions is limited and fraught with methodological problems. There is little evidence to confirm or deny the effectiveness of such interventions as routine inquiry, use of referral and resource information (including shelters and hotline numbers), and safety planning on the ultimate reduction of violent episodes.[91]

Whenever an intervention such as a test or therapy is recommended, its potential harm must be evaluated. For example, screening with mammography generates false positives, false negatives, and complications from the test itself, as well as the intended benefit of averted cancer mortality.

Recent debates about screening have arisen as a result of published meta-analyses and evidence-based guidelines in the UK, Canada, and the US.[3,6,7]

Although the potential for harm has been raised as a reason not to screen, in their response to the USPSTF Draft Recommendation and Rationale Statement on Screening for Violence, 18 researchers in violence against women wrote, "since the 1996 recommendation, we know of no research to suggest that assessment and/or interventions in health care settings are harmful to patients."[92] The USPSTF

researcher's claim that screening is harmful is unreferenced and unsubstantiated.[92]

Studies, including experimental trials, funded by organizations such as the Canadian Institutes of Health Research, the Ontario Women's Health Council, the US Centres for Disease Control and Prevention, and the US National Center for Injury Prevention and Control are currently underway and should clarify the effectiveness of health care–based interventions.[7]

Nonetheless, the existing literature presents initial insights into effective practices. For example, asking about IPV has been considered an effective intervention by interviewed women,[93–96] in that it reduces isolation, validates women's experiences, helps women identify possible links between symptoms and their living situation, provides information, and improves women's self-esteem. Significantly increased rates of safety behaviours[97] and reduced rates of threats and assaults have resulted from screening and intervention during pregnancy.[98] Developing a climate of trust conducive to disclosure, normalizing the topic through waiting room posters and patient resources, responding appropriately to disclosure, and allowing time for the woman to process the information and respond to appropriate referrals are all components of an essential intervention in a health care setting.[3,99]

There is fair evidence to refer women who have spent at least one night in a shelter to a structured, multiphased program of advocacy services.[91] These services include assistance with safety planning and accessing such community resources as housing, employment, and social support.

Summary Statements

1. At least 3 systematic reviews of screening for IPV have found insufficient evidence to recommend for or against routine screening. Asking women about violence is not a screening intervention: victims are not asymptomatic; disclosure is not a test result, it is a voluntary act, and the presence or absence of violence is not under the victim's control. Most interventions required to protect and support survivors are societal, not medical (I).

2. For pregnant women, clinical interventions that included counselling to increase safety behaviours resulted in the adoption of these practices (I) and reductions in abusive incidents (II).

i. Asking about IPV

Studies suggest that lack of training, time constraints, incomplete knowledge of prevalence and treatment, and lack of interest and sympathy are significant barriers for health care professionals. Most commonly cited among these are affective barriers and gaps in provider knowledge. Training to respond appropriately to women who disclose abuse and increasing provider knowledge of resources and support services have been shown to relieve anxiety and concerns about opening up the issue.[100–102]

Embarrassment and shame, for example, have been cited by some women as barriers to disclosure, whereas others report fear of retaliation from their partners.[103] Other reasons women may choose to not disclose include fear they will lose custody of their children, lack of knowledge about supports and services,[103] economic dependency, desire to keep the family intact, fear of community censure, and fear that their partners may be punitively treated by the judicial system. For some immigrant and refugee women, there may be additional fears related to their immigration status and family sponsorship agreements.

Women do not readily seek help when in violent situations. It is only in the last decade that violence has been acknowledged as a health issue. Therefore, women may not recognize it as such until asked by their health professional.[104,105] In qualitative research, women identified barriers to disclosure including concerns about confidentiality and legal consequences and their perception that physicians were too busy or too uninterested to ask. Most women did not disclose spontaneously but did so when asked.[80]

Even before the questions are asked, patients experiencing violence can be assisted in disclosing by creating a safe and supportive environment in which disclosure is more likely to occur. The decision regarding what, when, and how to ask is influenced by the setting of the clinical encounter: in the emergency department, the clinician may enquire about an injury, whereas in prenatal care, questions may address the couple's relationship. The nature of the relationship of the clinician to the patient (a one-time encounter versus ongoing care, for example) also influences how assessment for IPV is done. [46]

In qualitative studies, women have said that being asked about IPV helped them recognize the problem, broke the silence, validated their feelings, and "planted the seed" for change.[106]

Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires.[107] For direct questioning, several instruments have been developed; some have been validated.[108] (See Appendix C for examples.) Research in screening for IPV has shown that a few short questions are most realistic in most health care settings from the health provider's point of view.[109–112] In addition, questions about behaviour, such as a slap or kick, or about sexual intercourse without consent are less ambiguous than those that use words such as "abuse" or "assault."[18,96,113,114]

Qualitative studies suggest that the nature of the physician–patient relationship (trusting, nonjudgmental, respectful, etc.) is more important in achieving disclosure than the particular questions that are asked. Strategies to increase

The Screening Debate

Health care providers are familiar with screening interventions such as Pap smears as components of preventive health care. Screening in a health care setting involves the detection of a disorder at an asymptomatic stage in an individual who consulted for other reasons. Successful screening depends on both the ability of a test to identify the target condition and the ability of a treatment intervention to achieve a favourable outcome. Even if experimental evidence demonstrates efficacy, factors such as the patient population, the skill or compliance of the provider, the financial constraints of health care funding, and the logistics of health care systems will determine whether a screening intervention is effective.

Screening for domestic violence is different from most other health care screening interventions in many important ways: some would argue that it is not "screening" at all, since women are not unaware and asymptomatic, nor is violence a mere risk factor awaiting identification. Examples of clinical prevention services that are similar to identifying IPV are assessment and counselling of adolescents for drinking and drug use or counselling for prevention of unintended pregnancy and sexually transmitted infections.

Disclosure is a voluntary act. Disclosure of violence is not the equivalent of an abnormal test result. Unlike finding and treating hypertension, where the desired outcome is a normal blood pressure, there is no consensus on appropriate outcome measures for disclosure of violence, for example, access to referrals, reduction in episodes of violence, improved self-esteem, improved health, etc. The counselling and referral of women who disclose IPV are examples of secondary or tertiary prevention.

disclosure include normalizing (i.e., I ask all my new patients this), showing connections and concern (i.e., I wonder if abuse is making your headaches worse), and showing an interest and ability to help.[115] Although behaviour-specific questions have been advised, research with abused women suggests that "how" the questions are asked is more important than the actual wording.[116]

Summary Statements

1. Training of health providers may reduce barriers to asking about violence (III).

2. Most women do not disclose IPV spontaneously because of multiple perceived barriers; however, they often choose to disclose when asked (III).

3. Several validated questionnaires exist for enquiring about IPV; however, the nature of the clinician–patient relationship and how questions are asked seem more important than the screening tool (III).

Recommendation

1. Providers should include queries about violence in the behavioural health assessment of new patients, at annual preventive visits, as part of prenatal care, and in response to symptoms or conditions associated with abuse (B).

ii. Responding to Disclosure and Nondisclosure

Studies exploring women's desired responses following disclosure suggest that women want health care professionals to ask direct questions about abuse, to listen and believe them, express concern, to be nonjudgmental and supportive, and to make referrals to shelters, counselling, and social and legal services.[96,117,118]

Although the research on outcomes of clinical intervention is still in progress, most professional and community organizations have protocols recommending a series of steps for working with women when violence is suspected or disclosed[44,119] (OMA, CFPC, ACOG). These protocols suggest that clinicians document the abuse, do a physical examination if appropriate, validate the woman's right to live without abuse, discuss safety, and make referrals to social and legal services. If there are children in the home, additional interventions may be necessary to protect and care for them.

A recently published study using focus groups with women who had experienced abuse identified the provision of referrals to useful services (such as advocacy, job training, and financial support) as the most important role for health care professionals.[120] At least one study has shown that when pregnant women are provided with information on ways to increase their own safety, they quickly adopt and implement the suggestions, irrespective of whether they choose to leave their partner.[121] If a woman is planning on leaving her partner, she should be warned not to tell her abuser, because "women are at greater risk of severe violence or even of being murdered just after they leave their husbands or partners."[10,122]

The Stages of Change Model was initially developed by Prochaska in the 1980s as the Transtheoretical Model of Health Behaviour Change from an examination of psychotherapy and behaviour change theories.[123–125] Initial refinement of this model took place in research on smoking cessation, but it has been found to be applicable to other behaviour change areas in research on obesity, addiction, safe sex practices, and delinquent youth.[125] It has also been proposed as a tool for clinicians to use with women experiencing IPV,[126,127] to assess readiness for change and to tailor interventions appropriately. This may facilitate more efficient and effective office visits and increased physician and patient satisfaction. Studies have supported consistency between the Stages of Change Model and how women describe surviving their abusive situations[105,127–129] and have described specific processes and constructs used by women as they progress through these stages.[127] Notably, in the case of IPV, the abusive behaviour lies outside the victim's control; she can control only her own behaviour, choice, and decisions.[121] Stage-based interventions have been proposed[105,127,128] but further research is needed to define, implement, and evaluate these interventions.[130]

The Stages of Change Model

The Stages of Change Model assumes that changing behaviour is a dynamic process and describes a progression through a continuum of predictable stages as individuals try to modify their behaviour.[123–125]

- Precontemplation—not aware of or minimizing the problem
- Contemplation—acknowledging the problem and considering possible changes
- Preparation—making plans
- Action—following through with plans
- Maintenance—keeping the new actions as a part of daily activity

These stages indicate an individual's readiness for change. Returning to a previous stage is an expected and integral part of the change process, and stages are not necessarily sequential.[123–125] Returning to a previous stage should not be considered a failure but rather a normal step in the change process. As people revisit earlier stages, they learn from their mistakes and gain a deeper understanding of themselves and the problem, getting closer to resolution each time.[126,128] Anecdotal reports suggest that women experiencing IPV leave an average of 7 to 8 times before making a permanent break.[126]

Assessing for Stage

Once an individual has disclosed abuse, her readiness for change can be assessed by asking 2 questions[128]:

1. "Have you thought of making any changes in your current situation within the next 6 months?"
2. "Have you thought about making changes within the next 30 days?"

Precontemplation: not considering change or in denial

During the precontemplation stage, the individual may be unaware or in denial about the abuse, may minimize the seriousness of the situation, or may express hopelessness in the situation. They may rationalize their partner's behaviour or blame themselves for the abuse. At this time, the woman generally has no intention of changing the environment or the relationship.[123–126]

The focus of intervention at this stage is to raise the patient's consciousness about the dynamics of abuse.[128] It should be affirmed that nobody deserves to be abused. Information may be provided, although women at this stage may refuse printed material. The patient should be encouraged to consider her safety and that of her family with a discussion about what the patient might do if ever there were a need to leave in an emergency situation. It should be emphasized that there is no pressure on her to leave the situation. A follow-up visit should be considered.

Contemplation: aware of the problem but only vague plans for change

During the contemplation stage, patients are aware of the problems in their relationship. They may disclose the abuse to friends or family. Although they have not made a commitment to change at this time, they may have indefinite plans to act within the next 6 months. They are currently weighing the pros and cons of the current situation and may be worrying about the consequences of the current environment or of changing it. This phase may be prolonged.[123–126,144]

Effective intervention at this stage should again include reassurance and encouragement of safety planning. Discussion may focus on reasons she may consider changing her current relationship and on facilitating construction of a list of pros and cons. Review of any previous attempts to make change may be useful. Referral to community resources may assist her in gaining understanding and support.

Preparation: planning for action within the next month

During the preparation stage, individuals are consciously aware of the abuse and are committed to taking action within the next month. Small changes may currently be underway, and the patient may report encouraging her partner to seek counselling, seeking legal advice, or obtaining necessary documents. She may report having attempted changes in the last year but are recycling. This stage may be especially dangerous for the patient and her family.[123–126,144]

Intervention at this time should mainly be supportive, and the physician may offer any help necessary.[128] The patient should be encouraged to have a concrete plan for change. The safety plan should be carefully reviewed. Appropriate referrals should be made.

Action: actively making changes

During the action stage, individuals make the changes for which they have been preparing. Change may include any action that improves their current environment and does not necessarily mean leaving the partner. Training or looking for work outside the home, attending personal or group counselling, or requesting that the partner seek treatment are some activities that may been seen at this stage. These actions are more visible to others than those during previous stages. There is generally a sense of strong commitment and high energy at this stage. This stage is again especially dangerous for the individual and her family. This is also when a woman is at highest risk of relapse because temptations or challenges may lead her back to her previous situation.[123–126,144]

Regular follow-up visits to offer support and monitor safety are useful at this stage.[128] Ongoing referral to appropriate resources should be made.

Maintenance: consolidation, resisting, and relapse

During maintenance, the individual continues to struggle to avoid returning to her previous environment. Success is improved by a strong and continuous support system.[123–126,144] Physician follow-up and ongoing referrals can enable this.[128] Safety is still a concern and must be constantly assessed.

Termination of the problem occurs when there is no further temptation for relapse and the individual has absolute confidence about her new environment.[126]

Summary Statement

1. Women considered the provision of referrals to useful services (advocacy, job training, and financial support) to be the most important role for health care professionals (III).

Recommendation

1. Application of the Stages of Change Model to the counselling of women experiencing IPV requires further evaluation and research (I).

iii. Documentation and Legal Issues

Health care professionals are responsible for documenting encounters with patients according to the standards of their profession and their clinical setting. Charting serves many purposes.

It aids in developing diagnostic hypotheses and treatment plans, in following the evolution of chronic conditions, in providing data for quality control studies, and in creating historical record for medicolegal purposes.[131] Release of records to a third party requires the patient's written consent, unless subpoenaed by the courts.[132] Proper documentation is considered an essential component of both long- and short-term interventions with victims of IPV.[133]

A recent Canadian study exposes dilemmas when medical charts are used for legal purposes and how their use is perceived by legal and health professionals, advocates for abused women, and abused women themselves. Although health records sometimes have helped women in court, they are often used to reduce their credibility or in the hopes that the woman will drop charges to protect her privacy. The authors conclude that both the health and legal systems uphold normative views of sex that can act as filters to colour patient–physician interaction, record taking, and subsequent use of records.[134]

The authors of a US study on charting in cases of IPV made the following recommendations:

> Health care providers can improve record keeping in a number of ways, such as by documenting factual information rather than making conclusory or summary statements; photographing injuries; noting the patient's demeanour; clearly indicating the patient's statement as her own; avoiding terms that imply doubt about the patient's reliability; refraining from using legal terms; recording the time of day the patient was examined; and writing legibly.[135]

Health care providers are not obligated to report abuse of adults. However, in some instances when a woman is the victim, any child in the home may also be experiencing abuse. In Canada, professionals are required by law to report abuse or suspected abuse of children to a child protection agency. In addition, many jurisdictions require reporting in situations where children may be at risk of either physical or emotional harm. Most jurisdictions consider children who witness physical abuse in the home to be at risk of emotional harm or neglect, and some require reporting to a child protection agency.[11]

For a complete review of legal obligations, access Health Canada's *A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians*.[10] (Also available at http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/physician_e.pdf.)

Summary Statements

1. Proper charting is important when caring for IPV victims. Records made for clinical reasons may be used for legal purposes (III).
2. Unless subpoenaed, records may only be released with the patient's written consent, specifying the information to be released (III).

Recommendations

1. Health care professionals should make clear, legible, and objective clinical notes, using the woman's own words about abuse and adding diagrams and photographs when appropriate (B).
2. When in doubt, physicians should consult the medical records department or their college for advice on the release of records (B).

V. Roles and Responsibilities

A. Professional Support and Coordination

A public health approach to a problem like IPV helps health professionals better understand their role and responsibilities. Because violence, including IPV, is not only a medical problem but also a social one, its primary prevention is not a clinical intervention. Even secondary prevention, such as responding to a woman who has disclosed violence, must include interventions outside the scope of a medical clinic.

The most important change in how communities approach woman battering is the development of a coordinated response that links health and social service providers to develop and implement a comprehensive strategy of service development, policy change, and prevention. This approach is based on the reality that changing one facet of the service response without changing the system can actually worsen the situation. For example, a battered woman can be identified, but not protected, or an offender be arrested, but not prosecuted.[136]

Such a prevention-oriented approach complements activities considered as secondary prevention, including efforts by the criminal justice system and the social service sector and the response of those who provide health care.

Physicians attain a certain comfort level when faced with medical emergencies because the infrastructure (equipment, staff, protocols, etc.) is there to support their actions. This is often not the case for responding to IPV. Research

suggests that administrative support for IPV intervention programs improves health care professionals' efforts at identifying abused women.[137–139] Training sessions for residents and faculty also improve their professional comfort and ability to assist abused women.[128,140,141] Technicians and other paraprofessionals can be trained to reduce physical and emotional discomfort during certain intrusive or intimate procedures, such as transvaginal sonography and mammograms.[142]

To support health care professionals, health care institutions and systems must become engaged partners in an intersectoral and societal response. Professional organizations and accreditation bodies have an important role in setting standards for clinical intervention.

Within the health sector, providers need a supportive physical environment, ongoing training, appropriate human resources (i.e. multidisciplinary teams), strong links to the community, and effective referral networks. Institutions should have written protocols for IPV, handouts for clients, and up-to-date lists of community resources. Such programs can be evaluated (rates of enquiry, rates of referral, client and professional satisfaction, etc.) to encourage ongoing improvements.[46] Outside the clinical setting, health care professionals need to work as advocates at the local, provincial, and national level.[143]

Given the state of knowledge and considering the prevalence of the issue, health care professionals should play an active role in supporting women experiencing IPV, by asking, documenting, and providing referrals.

Summary Statements

1. A comprehensive strategy of service development and prevention of IPV requires the coordinated response of health and community workers (III).

2. Administrative support and training sessions improve the ability of residents and professionals to identify and assist abused women (III).

Recommendations

1. Professional organizations, accreditation bodies, and institutions should set standards and support quality control measures for programs addressing IPV (B).

2. Providers need a supportive environment, ongoing training, appropriate human resources (i.e. multidisciplinary teams), strong links to the community, and effective referral networks (B).

3. Institutions and clinicians' offices should have protocols for IPV, handouts for clients, and up-to-date lists of community resources (B).

B. Strategies for Supporting Women Experiencing IPV

i. Creating the Environment

Printed materials, including visuals such as posters, should be visible and strategically placed to facilitate access to resources (i.e. patient washrooms and examining rooms). All staff, including reception and administration, should be trained in policies and procedures to protect the privacy and safety of abused women. (See Appendix B.)

A secure and confidential environment should be available for history taking. Chart tools and referral information should be reviewed at regular intervals, i.e. annually, to ensure they are up to date. (For a sample chart/tool, see Appendix A.)

Recommendation

1. Secure and confidential environments, well-trained staff, printed and visual patient resources, and provider tools such as checklists, documentation aids, and facilitated referrals are necessary for the facilitation of IPV disclosure (B).

ii. Approaches to Asking

A caring, nonjudgmental, and respectful approach may facilitate disclosure. Health care professionals should be aware that women who are being examined are more vulnerable and less likely to disclose. Many providers facilitate disclosure by personalizing language and questions. Enquiries about specific behaviours such as slapping, kicking, pushing, having forced sex, and so on are preferable to general enquiries about abuse. (For examples of questions to be used, see Appendix C.) If a woman has children, she should be advised of any child welfare obligations prior to asking any questions about violence in the home.

Providers may choose to include questions about violence in their behavioural health assessment of new patients or at annual preventive exams. The trusting relationship that develops between a patient and caregiver during maternity care creates an ideal environment for direct questioning.

Some providers ask the following in relation to symptoms: "Some of my patients with these symptoms (headache, injury) are experiencing problems at home. Could this be the case for you too?" Problems such as substance abuse, depression, sexual complaints, injuries inconsistent with explanation of mechanism, multiple visits for ill-defined complaints, frequently missed appointments, evasiveness, and fear or frequent crying are all indicators associated with higher risk of violence. The presence of an overbearing partner who refuses to leave the examining room should trigger the need to question about violence (this may not be applicable in a cross-cultural setting).

Recommendations

1. Providers should be caring, nonjudgmental, and respectful in their approach to asking about IPV (B).

2. Questions about IPV should be behaviour-specific (B).

iii. Responding to Nondisclosure

Some women may answer "no" to direct questions, even when there are strong indicators that they are experiencing abuse. There may be many reasons for her decision not to disclose at this time. If you believe a patient may be at risk but she chooses not to disclose or says "no" when you ask direct questions, you should

- Respect her decision not to disclose and let her know that you are available should her situation ever change.
- Tell her where pamphlets or other resources may be found.
- Encourage her to return for preventative measures (Pap tests, etc.) and medical follow-up.
- Even if a woman has chosen not to disclose, your question might have made a difference. It may take several attempts before she feels comfortable enough to disclose. (Refer to Table 4, in Appendix D.)

Recommendation

1. The decision to disclose or not to disclose should be respected (B).

iv. Responding to Disclosure

A clinician's approach and intensity of intervention with a woman who discloses abuse will vary, depending on the context in which the disclosure occurs (emergency department versus labour ward) and the nature of the professional relationship (long-term client versus one-time encounter).

When a woman confirms or discloses abuse, remember that you may be the first person she has chosen to tell. Validate her feelings. Tell her that the abuse is not her fault. Ask how she thinks the abuse has affected her emotionally and physically. Talk to her about the potential impact of the abuse on her and on her child or children's physical, emotional, and psychological well-being.

The essential components to include in the visit are as follows:

- Documentation of the history and physical findings
- Assessment of risk
- Development of a safety plan
- Provision of appropriate referrals and follow-up
- Interventions on behalf of children and adolescents

iv.a. Documentation of the history and physical findings

Because interventions with victims of IPV take place over time, clinicians working alone or in groups should determine how the evolving information about abuse, the woman's response to the abuse, and the physician's efforts to assist her are to be recorded. Some prefer to integrate the information in their regular notes; others choose to use special forms.

To use the Woman's Abuse Checklist (Appendix A), download the Word document onto your computer. Decide when the document is to be reviewed next (annual revisions are recommended), and insert that date into the expiry date on the lower right hand side. Insert your practice-specific information in each box where indicated. Once the checklist has been composed, save it. To make copies, print on both sides of coloured paper, so that it will be easy to spot in a patient's medical record.

In a case where there is physical injury associated with IPV, providers should

1. Record only objective information about injuries and about the patient's mental status. Avoid speculation about the cause of an injury, the woman's behaviour, or her emotional state.

2. Use the woman's own words to describe events. Avoid phrases such as "patient alleges" or "patient claims." Use neutral language, for example, "patient says."

3. Note when the explanation is inconsistent with your assessment of the injury's cause (for example, "patient said she banged her stomach opening the car door, which is inconsistent with the injury pattern. Bruising appears on both sides of the abdomen and there is a small laceration at corner of the left eye").

Use chart tools and pictograms to document bruising and injuries. Describe other bruises or wounds in various stages of healing. Sometimes it may be necessary to reassess in 24 to 48 hours, because bruising might not be evident immediately following an assault. If you have a camera, with permission, you may use photographs in the chart. Remember to place rulers or tape measures next to the lesions to accurately record their sizes. (See Appendix E for a sample of body maps.)

iv.b. Assessment of risk

Risk assessment may be as simple as asking, "Do you feel safe to return home today?" or as elaborate as the questions used in Ontario's Sexual Assault Centres (See Appendix F). Performing a risk assessment allows providers to triage the patient to receive urgent or nonurgent referrals. If a woman does not feel safe returning home, if she states that there has been an escalation in severity or frequency of violence, or if she is assessed as being at high risk for injury or homicide, it is imperative to take immediate and definitive action, with the woman's consent and cooperation.

iv.c. Development of a safety plan

A woman should be assisted in identifying safety measures she can take to prepare for the possibility of further

violence. A safety plan includes specific actions to be taken, either while a woman is still living with the abusive partner or after she has left, when risk of danger often escalates. It is important that she familiarize herself with the plan by reviewing and (or) revising it regularly. Although in most cases it is best to refer women to an experienced counsellor for assistance in creating a safety plan, health care professionals should be familiar enough with its components to provide support and reinforcement. In some circumstances, the referring health professional may be the only source for safety planning.

For a woman still living with an abusive partner, encourage her to think through a plan that details exactly what she would do and where she would go, should she need to escape.[9,145] Suggest that she develop a code with a neighbour or her children, should she require police assistance, and ensure that she knows where to find the telephone number of the local crisis line or shelter.

Safety during an explosive incident can be increased by choosing a room with access to an exit; by avoiding the bathroom, kitchen, or any other rooms where a weapon might be available; by making as much noise as possible; and by training children to call the police.

Many organizations also advise women to have the following items hidden, left with a friend or family member, or left with her lawyer:

- passports, birth certificates, immigration papers for all family members (originals or photocopies)
- school and immunization records
- identification cards such as Social Insurance, driver's licence and registration, health cards, banking cards, credit cards
- as much cash as possible, bank accounts, cheque book
- medications and prescriptions
- lease or rental agreement, house deed, mortgage payment book, insurance papers
- divorce papers, custody documentation, court orders, restraining orders, marriage certificate
- keys for house, car, safety deposit box
- photo of spouse or partner
- address and (or) telephone book

Women can also prepare a suitcase with a change of clothes for her and her children, special toys or comfort items, and jewelry etc, keeping it hidden at a friend's home. If she is planning to leave, she should take her children if she can.

For women and children not living with the abusive partner, the safety plan should include steps to create a safer environment in the home, in the neighbourhood, and at work. Neighbours and key people at work should be told of the situation and instructed on how and when to notify police. Children can and should be trained to protect themselves and their custodial parent. (Refer to Appendix G for a sample emergency escape plan.) The Peel Committee Against Woman Abuse also has a safety planning booklet, which can be accessed at http://www.netrover.com/~pcawa/.

iv.d. Provision of appropriate referrals and follow-up

Women who have disclosed should be provided information about local shelters, legal counsel, and personal counselling. If there is a local distress or helpline, the phone number should be noted. For a list of shelters in your community, refer to Appendix I or visit http://www.shelternet.ca.

Ensure that a follow-up appointment is scheduled. At the next visit, ask whether the patient made contact with any of the referrals, whether the referral was worthwhile, and whether the information was helpful. Women who do not disclose, as well as those who are not experiencing IPV, may also benefit from knowing about local resources.

Women with acute injuries, contusions, bruising, lacerations, and more serious sequelae often require reassessment in 24 to 48 hours. Photographs for documentation should be considered as injuries become more evident. Women accessing shelters may benefit from more frequent appointments to manage the emotional, psychological, and social impacts of the emergency upheaval to her and her children.

Most provinces in Canada have some type of criminal injuries compensation developed to provide victims of violent crimes with monetary compensation. These injuries can include pregnancy and mental, as well as physical, trauma. In some jurisdictions, indirect victims such as children can also apply. The Canadian Resource Centre for Victims of Crime (http://www.crcvc.ca) provides bilingual information on compensation programs in each province and territory.

iv.e. Interventions on behalf of children and adolescents

If you must call a child protection worker, first inform your patient of your obligation to report; offer to support her while she telephones on her own behalf. Should she refuse to make the call and if you have concerns about a child's safety and well-being, you are obligated to report.

Recommendations

1. Essential elements of health sector response include documentation, risk assessment, addressing the safety of children present in the home, facilitation of a safety plan, and effective referral and follow-up (B).

2. Providers should assess women disclosing violence for depression and suicide risk (B).

3. Women disclosing the presence of children at risk should be assisted by the reporting health professional in contacting their local child welfare agency (B).

VI. Conclusion

Intimate partner violence is a multifaceted, societal problem. While IPV does not fit easily within the traditional medical/disease model, it does have important individual and public health sequelae, and as such, falls within physicians' purview. The fact that there is no simple recipe to reduce violence at its source and no straightforward flow sheet to empower its victims, is not an excuse for inaction. Health care providers are in a privileged position to assist women experiencing IPV: they have credibility, a relationship based on concern and trust, access to institutional and community resources, and the discernment to offer timely and personalized assistance. Most importantly, women who consult health care providers have expressed the view that IPV affects their well-being and that they would welcome sensitive enquiries in a confidential environment.

In its discussion paper, "SOGC and Women's Health: 2000 and Beyond," the SOGC recognized that "women's health … is determined by the social, political and economic context of women's lives, as well as biology." The SOGC identified violence as one of the important determinants of women's health and committed itself to an action plan that included support for its members in their care of abused women. This consensus statement answers part of that commitment; its impact will be measured by the extent to which the recommendations are appropriated by its members and applied creatively in practice.

Summary Statement

1. The SOGC has identified violence as an important determinant of women's health and is committed to supporting its members in their care of abused women (III).

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Appendix A

	STEPS/ACTIONS	INTERVENTIONS
1.	<u>**Reinforce the Positive Steps She may be Taking**</u> Discuss resources in community and support systems she has established	
2.	<u>**Encourage a Safety Plan if Your Client Discloses**</u> <u>**Assess the Risk**</u> to the woman, by asking questions to determine whether there may be imminent danger, i.e., “Do you feel safe now?” Encourage the woman to create and implement a safety plan. A safety plan should be individualized and developed in tandem with her. A woman should have ready a planned emergency exit, house keys, money, and access to joint bank accounts, birth certificates, health cards, passports, medical and legal documents. <u>**Reassure confidentiality,**</u> **and do not discuss her disclosure with the abusive partner.**	
3.	<u>**Legal Information**</u> <u>**Drop In Information / Advice Lawyers**</u> *Insert your information here.* <u>**To Apply for Legal Aid**</u> *Insert your information here.* <u>**Other Legal Services**</u> *Insert your information here.*	
4.	If there are child welfare issues, **The Children’s Aid Society of** <u>*insert your information*</u> must be contacted: *Insert your information here*. **Facilitate client calling CAS herself.**	
5.	<u>**Referrals Made**</u> *Insert your information here.* ***Shelters*** *Insert your information here.* ***Safety Planning*** *Insert your information here.* ***Counselling*** *Insert your information here.*	
6.	<u>**Resources / Pamphlets Given**</u> Ensure that it is safe for your client to take this information home	
7.	<u>**Follow-Up Plan**</u>	
8.	<u>**Date of Next Visit**</u> _____ / _____ / _____ **Consider Computer Reminder.**	

Notes for next visit

Date (YYYYY/MM/DD) _______________/ ______/ ______

Appendix B–Environmental Checklist

Administrative Support

- ❑ Involve management and institutional board in commitment to offer services
- ❑ Clarify existing and desired staff availability and roles

Community Liaison

- ❑ Link with community resources for appropriate referral and trouble-shooting

Training

- ❑ Include training on IPV intervention for all new staff
- ❑ Offer regular in-service training
- ❑ Know resources for employee assistance for personal difficulties

Clinical Protocols

- ❑ Create flow sheets for assessment, intervention, and referral, including specifics of institutional and community resources
- ❑ Define documentation procedures, in particular when different professional see same woman
- ❑ With medical records, clarify procedures for release of records
- ❑ Institute evaluation or quality control measures

Physical Environment

- ❑ Have culturally appropriate posters, brochures and pocket cards with information on impact and resources
- ❑ Provide space for confidential interviewing
- ❑ Have access to professional interpreters as necessary
- ❑ Assure staff and patient safety
- ❑ Make the environment child friendly

Appendix C– IPV Assessment Tools

Partner Violence Screen (PVS):

- "Have you been hit, kicked, punched, or otherwise hurt by some-one within the past year? If so, by whom?"
- "Do you feel safe in your current relationship?"
- "Is there a partner from a previous relationship who is making you feel unsafe?"

ALPHA Tool[146]:

- Contains a section on witnessing abuse (woman and partner); current or past woman abuse; previous child abuse by woman or partner; child discipline. This tool has been assessed and has provincial approval/endorsement. The questionnaire can be administered over several prenatal visits. Sample questions include the following:
- "How do you and your partner solve arguments?"
- "Do you ever feel frightened by what your partner says or does?"
- "Have you ever been hit/pushed/shoved/slapped by your partner?"
- "Has your partner ever humiliated you or psychologically abused you in other ways?"
- "Have you ever been forced to have sex against your will?"

Antenatal Psychological Health Assessment (ACOG)[147] recommends that physicians "screen" all patients for intimate partner violence. They suggest that, for women who are pregnant, "screening" should occur at various times over the course of the pregnancy because some women do not disclose abuse the first time they are asked, and abuse may begin later in pregnancy. Questions should be asked at the first prenatal visit, at least once per trimester, and at the postpartum check-up. The following is an introductory script:

- "Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every patient about domestic violence." Questions include the following:

1. "Within the past year, or since you have become pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?"

2. "Are you in a relationship with a person who threatens or physically hurts you?"

3. "Has anyone forced you to have sexual activities that made you feel uncomfortable?"

SAFE Tool, cited in several Health Canada publications.[148]

Questions include the following:

S "How would you describe your **S**pousal relationship?"

A "What happens when you and your partner **A**rgue?"

F "Do **F**ights result in you being hit, shoved, or hurt?"

E "Do you have an **E**mergency plan?"

Two-question ED Screening Tool[149] :

Questions include the following:

"Have you ever been hit, slapped, kicked or otherwise physically hurt by your male partner?"

"Have you ever been forced to have sexual activities?"

The Woman Abuse Screening Tool:[110]

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

- a lot of tension
- some tension
- no tension

2. Do you and your partner work out arguments with

- great difficulty
- some difficulty
- no difficulty

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

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

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

6. Has your partner ever abused you physically?

7. Has your partner ever abused you emotionally?

For questions 3 to 7, respond

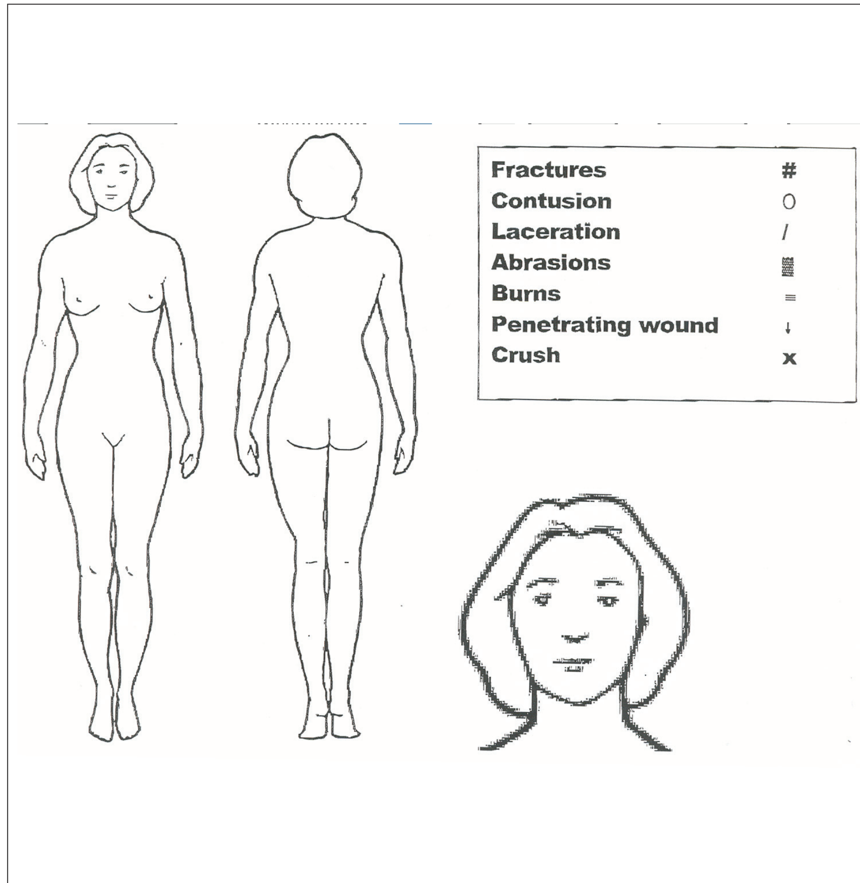
- often
- sometimes
- never

Appendix D
Table 4. Effective Intervention Matched With Stages of Change

Stage	Characteristics	Intervention
Precontemplation	Denial of need to change situation Avoidance in discussing problem Minimization of seriousness Defending batterer Scapegoating Hopelessness Belief that abuse is victim's fate	Acknowledge that victim is not ready for change Emphasize that you do not plan to 'pressure' victim to make changes Affirm that no person deserves to be hit or abused Indicate that other victims have started where the patient is now Urge the patient to think about reasons she might consider a change Reaffirm you are there to help Help patient develop a safety plan
Contemplation	Awareness of problem Seeking information Asking questions Planning to take action within 6 months Struggling to understand why Procrastination Anxiety "what if"	Ask if patient has ever tried to make a change in the past If so, what happened Ask what problems the patient anticipates Solicit pros/cons (document) Discuss options to overcome barriers
Preparation	Planning to take action within 30 days Publicly acknowledges plans to safe individuals/ organizations Some ambivalence, with last-minute resolution Careful detailed planning	Ask the patient how you can help Mutually set a definite date to prevent premature or prolonged planning Offer information on community resources, referrals Review safety plan
Action	Very busy High commitment level for specific change	Schedule follow-up visits to reinforce patient's behavior Referrals to group support of necessary and mutually agreeable Check for symptoms of 'return'
Maintenance	Strong commitment to activities to prevent return	Be alert to danger signs that patient may be contemplating return
Termination	Confident Problem no longer present or a threat	

¨Permission granted by Pamela York Frasier, PhD, MSPH, MA, Associate Professor, Department of Family Medicine, University of North Carolina

Appendix E



Appendix F—Risk Assessment

1. When did the violence start?
2. How often does the violence/abuse occur?
3. Has the violence increased in frequency or severity in the past year?
4. Have you recently separated from or stopped seeing your partner?
5. Have you ever felt afraid for your physical safety or life?
6. Has your partner threatened to kill you, your children, your relatives, or themself?
7. Has your partner planned or attempted suicide?
8. Does your partner have access to weapons? Is the weapon in the home?
9. Does your partner abuse alcohol or use drugs?
10. Is your partner violent outside the house?
11. Does your partner harm the family pet(s)?

APPENDIX G–Emergency Escape Plan

How To Help Her:

- Ask her directly what assistance she wants
- Provide emergency numbers, shelters, and resources
- In acute care setting, consider admission or delay discharge if she is in serious danger

Ensure She Has:

- Important documents, i.e., birth certificates, passports, social insurance, health card, driver's licence, vaccination records, court documents
- Some money, credit card, bankbooks, cheque book
- Keys for house, car, and office
- Medication
- Familiar toy / blanket for each child
- Clothing for self and children
- Planned possible escape routes
- Taught children to dial 911
- Alerted a trusted and supportive family member or friend to her situation
- Arranged for a neighbour to call 911 on her behalf if there are signs of violence

Adapted from the Task Force on the Health Effects of Woman Abuse, Middlesex-London Health Unit and Windsor–Essex County Health Unit Fact Sheet for Health Care Professionals.

Appendix H—Web Sites for Transition Houses in Canada

PROVINCES AND TERRITORIES

British Columbia: www.mcaws.gov.bc.ca/womens_services/transition-houses/
www.bcysth.ca

Alberta: www.violetnet.org
www.acws.ca

Saskatchewan: www.abusehelplines.org

Manitoba: www.crm.mb.ca/lifestyl/advoc/maws.html

Ontario: www.casac.ca/avcentres/rccs_on.htm

Quebec: www.maisons-femmes.qc.ca www.fede.qc.ca

Newfoundland: http://www.abusehelplines.org/Canada2/nfld.htm

Nova Scotia: www.thans.ca

Prince Edward Island:
http://www.gov.pe.ca/infopei/index.php3?number=56690

New Brunswick: http://www.abusehelplines.org/Canada2/nb.htm

Atlantic Provinces: http://www.echo-chn.net/circle/alinks.htm

Yukon: www.mcaws.gov.bc.ca/womens_services/transition-houses/
www.bcysth.ca

Northwest Territories:
http://www.abusehelplines.org/Canada2/nwt.htm

Nunavut: http://www.abusehelplines.org/Canada2/nunavut.htm

GENERAL WEB SITES (SHELTER INFORMATION FOR MOST PROVINCES)

- http://relocatecanada.com/abusive.html
- http://www.hotpeachpages.net/canada
- http://www.abusehelplines.org
- http://www.casac.ca/avcentres/women_centres.htm
- National Clearinghouse on Family Violence: www.hc-sc.gc.ca/nc-cn