

# Guidelines, Policies, Education and Coordination

## Better Practices for Addressing Violence Against Women

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*Dans cet article, les auteures présentent des « meilleures pratiques » qui ont émergé dans le secteur des soins de santé pour répondre aux abus envers les femmes. On trouve des stratégies de prévention aux niveaux primaire et secondaire et des interventions depuis la clinique jusqu'à la population de base. Elles discutent des politiques, d'éducation et présentent deux exemples de mobilisation communautaire et de coordination intersectorielle.*

In this paper we present a range of “better practices” that have emerged within the health care sector to respond, in particular, to intimate partner violence (IPV)<sup>1</sup> in Canada. These include both primary and secondary prevention strategies and interventions ranging from the clinical to the population-based. The paper is divided into three parts. In part one we examine two recently published clinical practice guidelines, one by the Society of Obstetricians and Gynecologists of Canada (SOGC), the other by the Registered Nurses Association of Ontario (RNAO). Both sets of guidelines refer to the importance of developing policies, ensuring adequate education and forming a coordinated response to IPV. Thus, in part two we look at the importance of education for health care providers. Finally, in part three we explore two different examples of community mobilization and intersectoral coordination.

### Background

Canadian prevalence data about IPV draws from two different national studies. The 1993 Violence Against Women Survey (VAWS) (Statistics Canada 1993), considered the “gold-standard” of Canadian violence research surveys, asked women about both their experiences of abuse and the context of those experiences, while the General Social Survey on Victimization (GSS) (Statistics Canada 2000) asked respondents to consider a single episode of violence experienced in the previous 12 months or five years. The different questions and inclusion or

exclusion of contextual factors resulted in very different prevalence rates. The VAWS reported that 25 per cent of Canadian women had been exposed to some form of abuse by their marital or common-law partner. Six years later, the GSS estimated that in the five-year period prior to the survey, eight per cent of women and seven per cent of men, experienced violence by a current or former partner. While the GSS found men and women experienced violence at similar rates, women reported more serious forms of violence and more serious consequences of the violence than did men (Patterson; Bunge and Locke). For example, women were more than twice as likely to have been beaten, five times more likely to have been choked, and almost twice as likely to have been threatened with or to have had a knife or gun used against them (Patterson). Women were also three times more likely to be injured by their partners and five times more likely to require medical attention for their injuries, than were men.

The formal health care system is often the first and only outside contact for women and children who are experiencing IPV. Health care professionals thus have a critical role to play in recognizing, responding appropriately, treating and referring victims of IPV (Greaves, Hankivsky and Kingston-Riechers). A decade ago the costs for the medical treatment of abused women were estimated at \$408 million (Greaves *et al.*) while medical plus related costs (such as judicial system, lost wages, etc.) totalled approximately \$1.5 billion annually (Day). Primary prevention strategies such as early identification and treatment of victims and potential victims have been suggested to reduce health care costs (Wisner, Gilmer, Saltzman and Zink). Although controversial as to whether or not early identification or screening actually improves women's health and reduces IPV (Ramsay, Richardson, Carter, Davidson, and Feder; MacMillan and Wathen; United States Preventive Services Task Force), advocates argue that such screening provides an opportunity for women to receive support, discuss their options, develop strategies to

improve personal and family safety and receive referrals for counselling, shelters or other resources (Family Violence Prevention Fund).

Currently, screening practices vary widely across and within provinces. For example, only 13 per cent of hospitals that participated in a cross-sectional survey of 230 Canadian hospitals with emergency departments reported screening *all* patients for IPV (Hotch, Grunfeld, Mackay and Cowan). And a recently completed survey of Ontario's hospitals (N=91) found that although 45 per cent of hospitals claimed they regularly screened women for

In 1996 the SOGC first developed Clinical Practice Guidelines in the form of a Policy Statement on Violence Against Women. In April 2005, revised Guidelines, in the form of a Consensus Statement, were released. Key recommendations of the 2005 Consensus Statement and the level of evidence awarded each statement appear in Table 1. Particularly noteworthy are the consideration of IPV as a component of a behavioural health assessment and the suggestion that the Stages of Change Model (Prochaska and Di Clemente) can be a useful model in working with women who have experi-

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IPV, in fact just 20 per cent screened *all* women. The remainder relied on visible indicators of abuse and/or professional judgement about who should be screened (Education Wife Assault, Ontario Hospital Association, and Woman Abuse Council of Toronto). Given the range of responses across health care settings, there is a clear need for guidelines to standardize practices for responding to IPV in health care settings.

### **Guidelines for Responding to IPV**

Practice guidelines, such as those recently published by the Society of Obstetricians and Gynaecologists of Canada (Cherniak, Grant, Mason, Moore and Pellizzari) and the Registered Nurses Association of Ontario, attempt to bridge the evidence-practice gap by providing clinicians with the information and tools necessary to identify and effectively respond to disclosures of IPV by their patients. After extensive reviews of the literature and evaluation of the quality of the research literature, the organizations involved in developing clinical practice guidelines develop recommendations and provide information about the level of evidence assigned each recommendation. The level of evidence is based on Evaluation of Evidence criteria as outlined in the Report of the Canadian Task Force on "The Periodic Health Exam" where the best quality evidence is the result of at least one randomized control trial and assigned Level I. Levels II-1, II-2 II-3 are evidence from control trials without randomization, comparison studies and cohort studies, while Level III is reserved for expert opinion. Recommendations may be made with letter grades from A – E, on the basis of the evidence supporting a given recommendation (Canadian Task Force on the Periodic Health Examination; Woolf *et al.*).

enced IPV. The Stages of Change Model is described later in this paper.

The *RNAO Best Practice Guidelines, Woman Abuse: Screening, Identification and Initial Response* were released in March 2005. Key recommendations and the corresponding level of evidence for each statement also appear in Table 1. Particularly noteworthy are recommendations for the routine universal screening of every woman over 12 years.

One clear difference between the two guidelines is the declaration by the SOGC authors, that asking women about violence is *not* a screening intervention. The authors warn that: "disclosure is a voluntary act" (Cherniak *et al.*) and that the decision to disclose, or not disclose, should be respected. However, both sets of guidelines recognize the importance of a supportive institutional environment (SOGC recommendation grade B; RNAO recommendation level IV) and ongoing training for health care professionals on the issue. In addition, both emphasize that professionals need to be linked with partners in the community to strengthen and advocate for social and economic supports to enable women to leave violent relationships (SOGC recommendation grade B; RNAO level I-b).

### **Education**

Despite the fact that most health care professionals agree that IPV is an important health care issue (Greaves *et al.*; Alpert, Sege, and Bradshaw; Cole; Garcia-Moreno), it has been notoriously difficult to provide them with the necessary knowledge and skills to competently discuss IPV with their patients (e.g., Cole). Health care professionals have repeatedly claimed they lack the education and training to respond to disclosures of IPV (Goff, Shelton, Byrd, and

Table 1				
Type of Recommendation	RNAO	Level of Evidence	SOGC	Level of Evidence
Practice Recommendations	Nurses should implement universal screening in all health care settings	IIB	Providers should include queries about violence in assessments of new patients, at annual preventive exams, as part of prenatal care, and in response to symptoms or conditions associated with abuse	III
	Routine universal screening should be implemented for all females 12 years of age and older	IV	Providers should be sensitive to the manifestations of IPV in populations with different needs (e.g. refugees, Aboriginal women, women with disabilities)	III
Education	Mandatory workplace programs should increase Nurses skills and foster awareness and sensitivity about woman abuse	IB	Training of health providers may reduce barriers to asking about violence	III
	All nursing curricula should incorporate content on woman abuse in a systematic manner	III	Secure environments, well-trained staff, printed and visual patient resources, provider tools such as checklists and facilitated referrals are necessary for IPV disclosure	III
Organizational and Policy	Organizations should develop policies and procedures that support routine universal screening	IV	Professional organizations, accreditation bodies, and institutions should set standards and support quality control measures for programs addressing IPV	III

Parcel; Hinderliter, Doughty, Delaney, Pitula and Campbell; Glowa, Frasier, and Newton; Gerbert *et al.*) and identify the lack of education as a barrier to changing their practices (Waalén, Goodwin, Spitz, Petersen, and Saltzman). While numerous education and training programs about IPV have been developed for health care professionals, few have been evaluated. Those that have been evaluated have shown that it is difficult to change practice and that if practice behaviours do change, those changes are short-lived especially when there is little institutional support to maintain the new practice behaviours (Waalén *et al.*; Coonrod *et al.*).

The need for supportive institutional policies, protocols, and education figures prominently in many of the guidelines developed by governing colleges including the SOGC

and RNAO.

Recently the provincial government of Ontario launched its Domestic Violence Action Plan (March 2005) a component of which is the development of curricular materials on IPV for specific audiences. Two initiatives are directed at education for health care providers—one is the development of a curriculum for prehospital care providers (paramedics), the other a curriculum for those who work in hospital emergency departments. Both initiatives are utilizing a computer based e-learning platform to present learners with animated scenarios about IPV.

Several years ago the Ontario College of Family Physicians recognized the need for education on the issue and developed a train-the-trainer program. By offering profes-

sional development credits, the College recruited both physician-leaders and workshop participants to disseminate information and skills in an interactive approach. The educational program adapted to IPV Prochaska's transtheoretical model of health behaviour change. The Stages of Change model, first developed in the 1980s, has been applied to smoking cessation, and the treatment of addictions and obesity.

In recognizing that changing behaviour is a dynamic process, The Stages of Change elaborated the many steps involved: Precontemplation, Contemplation, Preparation, Action and Maintenance. It clarified that change does not necessarily follow a linear pattern; retracing earlier states is an expected part of the process. Each stage is distinguished by characteristic thoughts making it easier to design interventions specific to where the individual is in their process.

Qualitative studies of abused women's experiences in extricating from abusive relationships describe a similar process. However, it should be remembered that unlike other areas of behaviour change, in cases of interpersonal violence it is the abuser who should change, yet women are often called upon to act to protect themselves and their children. Applying The Stages of Change model to women experiencing IPV can help health and social service providers understand the woman's current thinking and offer appropriate counsel. For example, during Precontemplation the individual may be unaware or in denial about the abuse in her life. She would not be considering changing either her living arrangements or her relationship. Asking if she would like information about shelters at this point would not be meeting her needs. Instead, the focus of the intervention would be to help her acknowledge her situation, alerting her to the dynamics of abuse and discussing safety issues. Follow-up visits would be recommended.

To date, the training for family physicians has been offered 34 times across the province of Ontario.

### **Community Mobilization/Coordination**

The third example of "better practices" draws upon two examples of community mobilization and coordination: Ontario's public health system, and the Woman Abuse Council of Toronto.

The Canadian Public Health Association (CPHA) acknowledged violence as a public health issue in 1990 and again in 1994 in an issue paper, *Violence in Society: A Public Health Perspective*. In it, violence was recognised as a complex issue and the authors claimed that reducing it, requires "a thorough understanding of violence ... its epidemiology, the social values underlying human relationships and effective strategies used to prevent violence and reduce its effects." In short, violence prevention requires a health promotion approach.

The Ottawa Charter for Health Promotion described

health promotion as the "process enabling people to increase control over, and to improve, their health" where health is seen as a resource for every day life, not the objective of living." Key health promotion strategies include developing healthy public policy, reorienting health care systems to include secondary, as well as tertiary prevention, and community action through the involvement of key community stakeholders and the integration of services. Despite this promising start, little movement on a national, public health violence prevention strategy was made until the fall of 2005 when the issue was raised at the CPHA's 96th Annual Conference. A meeting was organized by the Ontario Public Health Association (OPHA) Violence Prevention Workgroup, which has been working on advancing violence prevention within the context of public health since 1999. At this meeting the need for a national violence prevention strategy was again articulated and a Foundational Committee established.

In Ontario, some public health agencies have been addressing the prevention of violence under their injury prevention mandate while others have incorporated IPV into their early child development programs. In either case, Ontario public health staff have been addressing both the primary and secondary prevention of violence. Primary prevention involves educating people about the issue, associated risk factors and lifestyle changes that may reduce risk while secondary prevention involves improving detection of the condition. Public health primary prevention of violence initiatives include school-based programs for young children, and the development of healthy dating relationship modules for older youth. Secondary prevention interventions have been implemented targeting high-risk families for extra support, and training health professionals to improve detection and referral for women disclosing violence.

Local public health agencies in Ontario have often provided leadership and support for the establishment of inter-sectoral coalitions of professional and community representatives to organize and advocate in the area of violence against women. This activity draws upon the framework established in the Ottawa Charter for Health Promotion to mobilize partnerships between local public health agencies, boards of education, and community coalitions to reorient health services, strengthen community action, create supportive communities, build healthy public policy and enhance personal skills. Coalitions at the municipal, county and regional levels exist in many Ontario communities to identify gaps, strengthen supports, and advocate for increased resources. Some coalitions have been instrumental in piloting new interventions to increase a woman's safety. In general, community coalitions act as magnets for targeted funding, as the referral network for health professionals, to whom women may disclose, and as a major source for ongoing community awareness and education on IPV.

Another example of effective coordination is found in the Woman Abuse Council of Toronto (WACT). WACT, like other such coordinating committees, brings together senior level representatives from key sectors in the community to work toward the development of a coordinated response to woman abuse across Toronto. The Council is comprised of representatives from the justice system including the police, crown attorneys' office, and probation; shelters and transitional housing; social and community service agencies, including agencies that serve ethno-specific communities; hospitals, community health centres, and the public health department; survivors, educators, and those who work with perpetrators. The Council addresses issues that occur at the interface of two or more systems or that impact upon two or more systems. One recent example of such an issue were the discussions and resulting actions that were taken in response to women known to be in "high risk" situations.

WACT's High Risk Response began as a pilot project funded by the United Way in 2001. It developed out of the recommendations of the 1998 Coroner's inquest into the high profile murder of Arlene May by her estranged boyfriend and the murder in 1999 of Sandra Quigley by her boyfriend. Three member agencies of WACT had been involved with Ms. Quigley and believed her death could have been prevented had they strategized together. The model is based on three key ideas: 1) murder of a woman by her intimate partner is not a random act but is a predictable crime with predictable indicators; 2) an accountable response includes both the containment of men who may kill their intimate partners and emergency safety planning strategies with women at risk; and, 3) an inter-sectoral response is critical to success as there are often a number of sectors/agencies/institutions involved with the woman, the abuser and possibly the children (WACT).

Evaluations of the pilot project emphasized the importance of using risk assessment tools to convince the woman that she is at risk and to provide convincing evidence to other sectors that her situation demands serious action. A key recommendation was the need for a standing high-risk consultation team, recently implemented with funding from the Trillium Foundation. The high-risk consultation team is multidisciplinary and intersectoral. Its mandate is to provide innovative and creative recommendations on how to keep the woman safe and how to hold the man accountable. Advertisements about the team's availability to provide consultation have been circulated to diverse organizations and agencies and cases may be presented from any sector or agency. In addition, the high risk project provides training to community organizations, probation offices, shelters, and family service organizations on how to complete high risk assessments in the belief that women's lives can be saved when all sectors of society collaborate, work to hold men accountable, and share critical information.

## Conclusion

Efforts to prevent and address IPV must be comprehensive and coordinated. Although violence is a social problem, the health care sector has been identified as an important stakeholder for many reasons. First of all, primary prevention of violence requires a population perspective which can be mandated to and addressed by local public health agencies, in collaboration with community coalitions, where existing. Secondly, women are the prime users of health care services, and health care professionals can play an instrumental role in facilitating disclosure and effective referrals for their patients. However, clinicians require training, institutional supports, and strong and current links to community resources in order to optimize their role. Recent guidelines and growing recognition for the need of a systematic approach, linked to quality assurance and accreditation efforts, demonstrate a developing sophistication and commitment within the health care sector in Canada to decrease the occurrence and impact of violence against women.

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<sup>1</sup>As the Centres for Disease Control in the U. S. have been advocating for the use of the term "intimate partner violence" in order to promote uniformity in definitions that will assist in research and prevention of violence against women, we will use intimate partner violence" (IPV) in this article to refer to the pattern of assaultive or coercive behaviours used by a current or former partner.

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