April, 2005

An Effective Approach to Intimate Partner Abuse in Health Care Settings:
A Position Statement developed by the Health Committee of the Woman Abuse Council of Toronto

This document was developed to promote our position on the elements of an effective and comprehensive approach to intimate partner abuse (IPA) in health care settings. WACT believes that health care practitioners will not be able to adequately respond to the health care issues of their patients if they do not ask them about their experience of IPA. Ignoring the issue may lead to problems in diagnosis and treatment.

Health care professionals are regularly in contact with women experiencing IPA and are therefore uniquely positioned to make a difference in their lives. We know from the daily practice of those who work directly with abused women that most women experiencing abuse do NOT go to shelters or to the police and criminal justice system. Most women have little or no contact with any kind of service, counselor or program. The reality is that *the only system* that virtually ALL women have contact with is the health care system.

In the recently released first annual report of the Ontario Provincial Coronor's 'Domestic Violence Death Review Committee'[*], 8 out of the 14 recommendations are directed to health care practitioners. During the year 2003 in Canada, of the 78 spousal homicides committed, 64 men killed their wives (including common-law, separated and divorced persons) and 14 women killed their husbands. Women were much more likely than men to be killed by an intimate partner were. "Among all solved homicides of victims who were 15 years of age and older, almost two-thirds (64%) of females were killed by someone with whom they had an intimate relationship at one point in time compared with 7% of males" (Statistics Canada, The Daily, Wednesday, Sept. 29, 2004. Access at: http://www.statcan.ca/Daily/English/040929/d040929a.htm.) Sixty-nine % of intimate partner femicide victims were abused before being murdered, and 41% of these women had been seen in a health care setting before their death (Sharps et al., 2001).

To provide optimal health care, organizations need to develop an institutional response to intimate partner abuse. Ideally, this includes:

- A Statement of Philosophical Principles
- Policies and Procedures
- Protocols
- Education and Training
- System of Accountability and Evaluation

For a more detailed description of each of these components, see the Woman Abuse Council of Toronto's Best Practice Guidelines for Health Care Providers.

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[*] The Domestic Violence Death Review Committee is an inter-disciplinary group that carries out an in-depth review of intimate femicides in Ontario with a view to making recommendations for systemic change to prevent future deaths. The Committee identified the unique role of health care practitioners in both providing support to abused women but also – a particularly important role in high risk and potentially lethal situations where the victim is at risk for death or serious injury.

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Health care professionals play a key role and have a critical responsibility in addressing the issue of intimate partner abuse and are important members of a coordinated intersectoral response to the issue. It is our position that asking about intimate partner abuse provides an opportunity for:

1. *Creating a catalyst for change*
2. *Educating communities and individuals about intimate partner abuse*
3. *Acknowledging the serious impact that abuse has on women's health*
4. *Providing interventions and referrals to those who may need assistance*

The Canadian Task Force on Preventive Health Care recently concluded that there is insufficient research evidence to recommend either for or against routine and universal screening of women for intimate partner abuse. Currently, the Ontario Women's Health Council is supporting a randomized control trial to determine the effectiveness of universal screening, versus no screening, on women's quality of life, experience of repeat violence, and several secondary health and non-health related outcomes. "No screening" in this trial does not preclude asking women about abuse as part of a diagnostic assessment.

In the interim, however, many of the health sector's governing colleges and associations have published guidelines advising their members to either screen or be particularly attentive to issues of intimate partner abuse in their patients' lives. In Canada, for example, the Society of Obstetricians and Gynaecologists of Canada, the Canadian Public Health Association, Canadian Nurses Association, Canadian Psychiatric Association, Ontario Hospital Association, Ontario Medical Association and Ontario Public Health Association have called for improved detection of IPA, standardized training and policy development. The World Health Organization in its World Health Report 2003 makes similar recommendations. In the 2005 Best Practice Guidelines on Woman Abuse, the Registered Nurses Association of Ontario recommends asking all women over the age of 12 years about their experiences of abuse.

However, asking about abuse should not be confused with screening for a particular condition. Indeed, according to epidemiological definitions, 'screening' is used to detect a target condition in the absence of symptoms and to improve the likelihood of a favorable health outcome when compared with patients who present with signs or symptoms of the disease (Lilienfeld & Lilienfeld, 1980). Asking about IPA differs from conventional screening in a number of significant ways. Firstly, victims are not asymptomatic but the condition (IPA) may not be detected because disclosure is a voluntary act. Secondly, asking about IPA may not necessarily lead to a better health outcome because the condition (violence) is the result of a third person's actions. Lastly, women who are experiencing IPA may not acknowledge or understand that their relationship is abusive.

The goal of asking about IPA is not necessarily to elicit disclosure. However, for some women being asked allows them to disclose the violence in their lives thereby providing

an opportunity to explore options and information about community resources. In a recent study, Kramer et al (2004) found the most significant factor enabling women to disclose abuse was being asked directly by their health care provider. Asking about abuse removes the responsibility for victims of abuse to initiate disclosure. Asking about abuse demonstrates that the health care sector is one of the many systems in the community where women can access assistance for abuse. Research also indicates that women want health care providers to ask about abuse and that they are not offended when asked (Ramsey et al, 2002). Asking about abuse can also create opportunities for interventions to decrease isolation and enhance safety, as well as enhancing accuracy of diagnosis and an effective plan of care (Kramer et al., 2004). Interventions should not be evaluated or considered successful based on whether or not a woman leaves her partner. For many complex reasons (shame, perceptions that healthcare providers are too busy and do not see abuse as a health care issue, confidentiality concerns, language barriers, etc.) women may choose to not disclose abuse when first asked. Some abused women may need to be asked several times before they disclose abuse. This does not indicate that asking about abuse is **not** effective but does contribute to an understanding of why counting disclosures may not be the best measure of effectiveness.

Asking women about abuse is an intervention in and of itself. It indicates recognition of abuse as a health care issue with serious impacts on women's health. For women who have not experienced abuse, asking can serve an educative and preventive function and provide information in the event that it is ever needed in the future.

IPA negatively affects the health and well being of women and their families causing physical and psychological harm including on-going health problems, reduced autonomy, quality of life and ability to care for self and family, and diminished productivity. Some women, including women with disabilities, women without immigration status, pregnant women, as well as young and old women, are more vulnerable to IPA. These women may also experience multiple obstacles in accessing sources of help. Emotionally abused women report more symptoms, somatic disturbances and more medical visits than non-abused women (Wagner and Mongan,1998). Women who have experienced abuse use health care services more frequently than non-abused women including higher rates of physician visits, emergency room visits and hospitalizations (Cohen & Maclean, 2003). Estimates for the annual cost for medical treatment of all forms of violence against women in Canada range from $408 million (Greaves et al., 1995) to $1.5 billion (Day, 1995).

IPA occurs in all countries, irrespective of social, economic, religious or cultural group (WHO, 2002). Yet it is a fundamental human right that every woman has the right live free from intimate partner abuse. As a civil society it is our responsibility to ensure that those who do experience IPA are able to access timely, relevant and appropriate services, resources and emotional support. It should be noted that within the health sector an appropriate response may sometimes involve linking with other sectors including social services, shelters, child protection agencies or the police. In all cases, health care providers need to ensure they provide an optimal standard of care thereby fulfilling their responsibility as part of a coordinated response to the issue.