Domestic Violence Toolkit for Health Care Providers in BC

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PART ONE: INTRODUCTION

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What Is Domestic Violence?

Domestic violence is a major global social and health issue and pertains to violence in relationships. Violence in relationships can be broadly defined as, "A pattern of intentionally coercive and violent behaviour toward an individual with whom there is or has been an intimate relationship. These behaviours can be used to establish control of an individual and can include physical and sexual abuse; psychological abuse with verbal intimidation, progressive social isolation, or deprivation; and economic control" (El-Bayoumi, Borum & Haywood, 1998; Home Office, 2013 as in Trevillion, Agnew-Davies & Howard, 2013).

Who is affected by domestic violence?

Domestic violence is a global issue with negative health outcomes and can impact women and men of all ages, from all backgrounds and all socioeconomic groups (Boyle and Yong 2010, as cited in Allard, 2013). Children are also affected by domestic violence, even if they are not abused or do not witness it directly. Exposure to domestic violence in childhood is associated with severe negative implications on health and development including adjustment problems expressed as externalizing or internalizing (Lee, Kolomer & Thomson, 2012).

Table 1-1: Types of Abuse/Violence

Physical abuse/violence includes behaviors such as:

Hitting, pushing, kicking, burning, throwing objects, stabbing or shooting, sleep deprivation, failure to provide for basic needs, for example food and clothing if partner is dependent on the other for these needs to be fulfilled.

Emotional/psychological abuse/violence includes behaviors such as:

Unremitting criticism, emotional blackmail, enforcement of petty rules, neglectful behaviors such as ignoring signs of distress and pleas for comfort, or prolonged refusal to communicate, isolation from friends, family and other support networks, surveillance of everyday tasks such as grocery shopping, intercepting mail, phone calls and text messages, threats to harm, or stalking behaviors.

Financial abuse includes behaviors such as:

Taking absolute control over all finances and financial decisions, refusal to contribute to family incomes, depriving a person of access to cash and/or credit, running up debts in a person's name, forcing a person to engage in illegal activities such as theft.

Sexual abuse/violence includes behaviors such as:

Rape, forced prostitution and pornography, cutting or disfiguring of genitalia, refusal to practice safe sex, refusal to adhere to religious prohibitions.

Adapted from: Trevillion, Agnew-Davies & Howard, 2013

Prevalence of domestic violence

Domestic violence is underreported which makes it difficult to fully understand the magnitude of this major problem. The 2012 Statistics Canada report, Family Violence in Canada: A Statistical Profile 2010, indicated there were 16,259 police-reported survivors of intimate partner violence (IPV) in BC (Sinha, 2012). The rate of 427 survivors per 100,000 people in BC compares to a Canada-wide rate of 363 survivors per 100,000 (Sinha, 2012). Intimate partner violence, including both spousal and dating violence, accounts for one in every four violent crimes reported to police (Sinha, 2012). According to a Canadian Department of Justice Study, An Estimation of the Economic Impact of Spousal Violence in Canada, the estimated cost of spousal violence in Canada in 2009 was a staggering $7.4 billion (Zhang, Hoddenbagh, McDonald & Scrim, 2012).

The World Health Organization reports that recent global prevalence figures indicate that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime (WHO, 2014). According to The National Coalition Against Domestic Violence, one out of every four women will experience domestic violence in their lifetime (2011). The Statistics Canada Juristat Article, Violent Victimization of Aboriginal Women in the Canadian Provinces 2009, reports that Aboriginal women were almost three times more likely than non-Aboriginal women to report having been a victim of a violent crime, and are significantly more likely to report the most severe and potentially life-threatening forms of violence (Brennan, 2011).

According to BC Coroners Service: In the 10-year period from 2004 through 2013, 13.5% of homicides resulted from IPV. Of the 27 homicides to date in 2014, 25.9% resulted from IPV (2014).

TABLE 1-2 : Global, National and Local Violence Statistics

Global Statistics on Violence against Women:

- Domestic violence is a pattern of controlling behaviors that one partner uses to get power over the other. Including: physical violence or threat of physical violence to get control, emotional or mental abuse and sexual abuse (Siemieniuk, R. A. C.; Krentz, H. B.; Gish, J. A.; Gill, M. J., 2010).
- Domestic violence is the leading cause of injury to women – more than car accidents, muggings, and rapes combined (National Coalition Against Domestic Violence, 2011).
- There are over a 100 million women missing worldwide due to practices such as: female infanticide, sex selective abortions and neglect of girls (Sen, 2003).
- 91.5 million women and girls had been subjected to circumcised (genital mutilation/cutting) in Africa (Yann & Khan, 2008).

Statistics on violence against Women in Canada:

- Women were almost four times more likely than men to be victims of violence (Sinha, 2013).
- In 2011, men were responsible for 83% of police-reported violence committed against women in Canada. 8 in 10 victims of police-reported intimate partner violence were women (Sinha, 2013).
- Females compared to males have double the risk of spousal violence (Sinha, 2012).
- The highest incidence of intimate partner violence, sexual violence, femicide, and criminal harassment (stalking) was experience by younger women who are under the age of 25 (Johnson, 2006).
- "According to police-reported data, about 173,600 women aged 15 years and older were victims of violent crime in 2011. This translates into a rate of 1,207 female victims for every 100,000 women in the population, slightly

TABLE 1-2 Continued: Global, National and Local Violence Statistics

higher than the rate for men (1,151)" (Sinha, 2013).

Statistics on violence against Women in Canada Continued:

- "In 2011, the five most common violent offenses committed against women were common assault (49%), uttering threats (13%), serious assault (10%), sexual assault level I (7%), and criminal harassment (7%). With the exception of sexual assault and criminal harassment, these were also the most frequently occurring offenses against men. Women were eleven times more likely than men to be a victim of sexual offenses and three times as likely to be the victim of criminal harassment (stalking)" (Sinha, 2013).
- 56% of family violence resulted in charges (Sinha, 2012).
- While pregnant 63,300 or 11% of women experienced assault from a marital partner (Sinha, 2013).
- The 2009 GSS shows that women with a disability or activity limitation such as health problem or condition had twice as higher rate of marital violence as compared to other women (Statistics Canada, 2011).
- Immigrants and refugees faces challenges as they try to integrate into Canadian society and may have pressure to maintain their own culture, language, traditions and religious practices. This may lead to domestic violence in homes due to increase of stress, low self-esteem and feelings of marginalization as their own values may conflict with Canadian society (Baobaid, 2010).
- LGBTQ individuals face intersecting oppressions based on gender and their status as a sexual minority. This area is understudied (Faulkner, 2006).
- Lesbian or bisexual were more than three times as likely as heterosexual women to have experienced spousal violence (Sinha, 2013).
- Every year in BC there are over 60,000 physical or sexual assaults against women – almost all of them are committed by men (Ministry of Public Safety and Solicitor General, Police Services Division, 2006).
- Self reported sexual victimization of women, by region, 2009 was highest in western regions - Alberta and British Columbia (Statistics Canada, General Social Survey, 2009).
- Aboriginal women have a higher likelihood of being victimized compared to the rest of the female population (Brennan 2011, Perreault 2011).
- Victimization of Aboriginal women in all provinces was about 2.5 times higher than the rate for non-aboriginal women (279 versus 106 per 1,000 population) (Brennan 2011, Perreault 2011).
- Aboriginal women often reported the most severe forms of violence, including being sexually assaulted, beaten, choked, or threatened with a gun or a knife (Brennan, 2011).
- The issue of missing and murdered Aboriginal women in Canada has been identified at both the national and international levels (Department of Justice Canada, 2010).
- Between 2001 and 2011, at least 8% of all murdered women aged 15 years and older were Aboriginal, double

PART TWO: Domestic Violence and Healthcare Providers

Why is it Important for Healthcare Providers to Learn About Domestic Violence?
Recognizing Clients Experiencing Violence
Assessment & Screening
Advocacy
Cultural Considerations

Why is it Important for Health Care Providers To Learn About Domestic Violence?

British Columbia's 2014 Provincial Domestic Violence Plan discusses the importance of training for various sectors, including healthcare professionals, in order to understand and respond to domestic violence as well as better support victims (PODV, 2014). Healthcare providers are in a unique position to make a difference in the lives of women experiencing violence (WHO, 2010; Black 2011). For example, women who experience domestic violence have been shown to have more contact with the healthcare system (Black, 2011; Green & Ward, 2010) including more doctors and pharmacy visits, more surgeries and longer hospital stays (Black, 2011). Additionally, women experiencing domestic violence may actively seek support from a healthcare professional. A Canadian study published in 2010, found one half to two thirds of women experiencing the most severe forms of domestic violence sought formal support from healthcare workers (Ansara & Hindin, 2010). This type of contact with victims of violence allows healthcare workers, the opportunity to create safe and non-judgmental environments where women feel more comfortable disclosing the abuse and gain access and referrals to supports (WHO, 2010; Trevillion, Agnew-Davies & Howard, 2011).

Even if a client or patient does not feel comfortable disclosing or is not ready to seek additional formal supports, the healthcare professional has an important role in documentation of injuries that the woman could use in the future should she decide to seek legal assistance or other social supports (WHO, 2010).

Table 2-1: Professional barriers to enquiry and the need to continue education on domestic violence

- Lacking understanding/knowledge/expertise about domestic violence and the role of the health professional in enquiry
- Priority is medical concerns not domestic violence
- Personal discomfort in discussing domestic violence
- Lack of confidence in approaching the subject
- No indication of violence
- Fear of offending or retraumatizing or upsetting patient
- Time constraints
- No privacy such as partner is present
- No education on resources present on domestic violence

Adapted from: Rose, Trevillion, Woodall, et al., 2011.

Recognizing a Client Who is Experiencing Domestic Violence

While there is no one description of what an individual experiencing domestic violence "looks like", there may be risk factors or signs that a woman is experiencing violence which healthcare providers can be alert to.

Risk Factors

Table 2-2 outlines potential domestic violence risk factors for perpetrators, victims as well as relationships. It is important to note, that although a situation involves one or all of these risk factors, it does not necessarily mean that the woman is experiencing domestic violence, but should be considered as a part of the clinical picture or assessment.

Physical and Psychological Signs of Violence

A woman experiencing domestic violence, may show certain signs and symptoms including injuries where the description of what happened does not match the clinical presentation (Green & Ward, 2010; Perry, Hockenberrym Lowdermilk & Wilson, 2013). These could include abdominal, thoracic or head injuries, bruises, lacerations, fractures, broken teeth, or injuries suggesting attempted strangulation (WHO, 2012). The woman may also have blunt force trauma injuries especially to the head, face or neck (Black, 2011).

In addition to acute injuries, the woman may be experiencing other medical problems which may have no identified cause or are difficult to diagnose such as chronic pain or gastrointestinal symptoms (Black, 2011; WHO, 2012). Other clinical conditions have also been shown to be associated with an individual who has experienced violence, including those in Table 2-3.

Additional factors that may be noted during an assessment include: a history of frequent utilization of health services, missed appointments, unexplainable injuries or previously untreated serious injuries (Green & Ward, 2010; Perry, Hockenberrym Lowdermilk & Wilson, 2013). A woman who is experiencing violence may also have a partner who is intrusive (Black, 2011; WHO, 2010), never leaves the patient's side, who insists on telling the story of how the injury occurred or answering questions for the client (Green & Ward, 2010; Perry, Hockenberrym Lowdermilk & Wilson, 2013). The woman may appear reluctant to answer questions in front of her partner, or may appear afraid or

Table 2-3 Health Conditions Associated with Violence

Acute physical Injuries - Trauma to head, face, neck, fractures and broken bones, orbital fractures, black eyes, bilateral bruising, burns and internal injuries.
Chronic Physical Injuries - headaches, migraines, memory problems, seizures, traumatic brain injuries, cardiac and circulatory condition, complaints of pains and aches, irritable bowel syndrome, pelvic pain and sexually transmitted infection. Angina, high blood pressure, cardiovascular disease.
Obstetric Problems - reproductive issues such as chronic pelvic pain, genital injuries, low birth weight and premature labour (in pregnant women) and miscarriage)
Psychological or psychosocial problems - depression, anxiety, PTSD, sleep disturbances, insomnia, suicidal ideation, self-harm, social isolation, nightmares, alcohol or drug misuse, exacerbation of psychotic symptoms
(Black, 2011 & Trevillion, Agnew-Davies & Howard, 2013).

Table 2-2: Domestic Violence Risk Factors

Perpetrator Risk Factors

- young
- low level of education
- victim of physical or psychological abuse
- witnessed violence or abuse as a child
- abuse of alcohol
- substance misuse
- holds cultural/social norms which view violence as acceptable in relationships
- anger and hostility
- prior history of being physically abusive
- mental health issues

Victim Risk Factors

- low level of education
- witnessed violence or abuse as a child
- holds cultural/social norms which view violence as acceptable in relationships
- sexually abused as a child
- previously exposed to other forms of violence or abuse

Relationship Risk Factors

- dominance and control of one partner over the other
- conflict in or dissatisfaction with the relationship
- economic stresses stressors

Adapted from: *Understanding and Addressing Violence Against Women: Intimate Partner Violence* WHO, 2012**;** *Intimate Partner Violence: Risk and Protective Factors,* CDC, 2013

For more information on risk factors refer to: Research Evidence per Domestic Violence Risk Factors (Appendix B)

Domestic Violence Screening Tools

Domestic violence screening tools are used to identify individuals at risk for abuse or injury. Screening involves routine enquiry, which is directly asking all people within certain parameters about domestic violence regardless of whether or not there are signs or symptoms (Olive, 2007, as cited in Allard 2013). The intention of screening is to identify a problem early, therefore enabling earlier intervention and management to reduce mortality and suffering.

A study reported in the Health Technology Assessment Journal (2009) examined eighteen domestic violence screening tools and found that the HITS (Hurts, Insults, Threatens and Screams) scale was the best of several short screening tools for use in health-care settings (Feder, Ramsay, Dunne, Rose, Arsene, Norman, Kuntze, Spencer, Bacchus, Hague, Warburton & Taket, 2009). HITS was developed as a simple screening tool for use in clinical settings to identify victims of domestic violence. HITS consists of four screening questions that patients respond to with a 5-point frequency format. Score values range from a minimum of 4 to a maximum of 20. A score greater than 10 is considered positive, identifying abuse and highlighting a safety risk. Screening allows for increased violence detection and promotion of safety. A score greater than 10 on the HITS scale highlights a need for targeted interventions by the healthcare team.

Figure 2-1 HITS Scale

Over the past 12 months, how often did your partner:	Never 1	Rarely 2	Sometimes 3	Fairly Often 4	Frequently 5
Physically **HURT** you?					
INSULT you or talk down to you?					
THREATEN you with physical harm?					
SCREAM or curse at you?					

Source: (Sherin, 2003)

Domestic Violence Screening Continued

According to the study the HITS scale had the best "predictive power" (sensitivity ranged from 86% to 100%, specificity ranged from 86% to 99%) (Feder et al., 2009). The study also concluded that most women patients considered domestic violence screening acceptable (range 35-99%), although they identified potential harms, including stigmatization and breach of confidentiality (Feder at al., 2009). Informants of the study concluded that, besides identifying individuals experiencing domestic violence, the goals of screening should also include providing information and showing willingness for clinicians to talk about domestic violence (Feder et al., 2009).

HITS has also been validated as an effective screening tool for males. Shakil, Donald, Sinacore & Krepcho (2005), conducted a study on male patients in the clinical setting and determined that the validity of HITS was good and that the screening tools was able to differentiate between male victimized respondents from non-victims.

Women from various ethnic, cultural and socioeconomic backgrounds may experience violence in relationships and have unique vulnerabilities. "In contrast to health care professionals concerns about broaching the subject of domestic violence, patients report feeling comfortable with questioning and suggest that enquiry often assists disclosure." (Trevillion, Agnew-Davies & Howard, 2013, p 39).
Patients find it more difficult to disclose information when not asked questions directly by health professionals. Patients may also experience shame, embarrassment, fear that violence may worsen if the perpetrators finds out of the disclosure and fear they may lose their children if they disclose any information (Trevillion, Agnew-Davies & Howard, 2013). In these moments its vital for health professionals to educate patients on domestic violence cycle, encourage discussion, answer question and concerns that the patient may have while attending to any trauma. (Trevillion, Agnew-Davies & Howard, 2013).

The HITS tool is just one potential screening tool. As a part of their practice, healthcare providers should familiarize themselves with the screening tools

Table 2-7 Barriers to Screening

- Lack of time to deal with screening patients
- Being unable to offer appropriate support and advice
- Not having the appropriate training to deal with disclosures
- Being unable to meet patients' expectations of what you can do to help
- Patients' resistance to accepting help
- Lack of privacy

Strategies to overcome barriers

- Training in how to respond and intervene
- Multi-agency training on what services are available
- A domestic violence policy that staff can access
- Access to a lead domestic violence nurse
- Standardized procedures for dealing with domestic violence
- Directing patients to independent domestic violence advisory services
- Private space or office for questioning without partner

Adapted from: Allard, 2013

TABLE 2-8 Benefits of Screening

Screening is beneficial, even without disclosure because it can:

- Raise awareness
- Remove stigma
- Provide victims with a sense of support
- Lead to disclosure and help-seeking

(Feder at al., 2009.)

Table 2-9 Recommendations for Practice

- Developing an independent domestic violence advisor role in the clinical setting
- Raising awareness of domestic violence in departmental training.
- Developing clinical agency guidelines and referral processes

Adapted from: Allard, 2013

Assessment

The following tables outline some additional tools and examples that can be used during assessment and screening of a client who may be experiencing domestic violence.

Table 2-4: RADAR Acronym for Domestic Violence Assessment

R = Routinely Screen Patients

A = Ask Direct Question - So the patient can answer "yes" or "no"

D = Document Your Findings

A = Assess Patient Safety

R = Review Options and Referrals

Adapted from: Pennsylvania Coalition Against Domestic Violence, 2014

Table 2-5 Examples of Direct Enquiry Questions

- Are you ever afraid at home?
- Has your partner ever hit you?
- Has your partner ever made threats to kill anyone?
- Are you pregnant?
- Do you feel isolated or alone?
- Do you lack support?
- Have you ever had thoughts to self-harm?
- Do you ever feel you have to go along with sex to keep the peace, or does your partner refuse to take no for an answer?
- We know that one in four women experiences domestic violence and that it affects their physical and mental health. Has anyone hurt or frightened you at home?

Adapted from: Trevillion, Agnew-Davies & Howard, 2013

Table 2-6 Examples of Responses to Disclosure

- I am glad you were able to tell me and I'm willing to listen
- You aren't responsible for the perpetrator's actions; the perpetrator is responsible for his/her actions
- I am hearing you blame yourself but the abuse is not your fault
- There is help available when you are ready. I can provide you with more information
- Would you like to speak with the social worker, the social worker can help you access many services
- Everyone has the right to be safe in their home

Adapted from: Trevillion, Agnew-Davies & Howard, 2013

Cultural Considerations

Before beginning this discussion it is important to note that, while there may be significant social or cultural factors in a woman's experience of domestic violence, healthcare providers should recognize diversity within groups and not perpetuate stereotypes based on culture or ethnicity (Ministry of Public Safety and Solicitor General, 2007). Healthcare providers should not form expectations of a woman's (or her family's) experience or attitudes based on her ethnicity or culture of origin, and instead should respect the unique experience of each individual (Ministry of Public Safety and Solicitor General, 2007; Gurm & Cheema, 2013; Gurm et al., 2008). Readers can use the following discussion to inform potential vulnerabilities and barriers that some women from various cultural groups may experience.

BC has a diverse population with many different cultures and traditions. Healthcare providers may encounter many clients with diverse cultural backgrounds and therefore should be aware of cultural and social norms which may influence how a woman experiences violence, seeks support or her willingness/ability to leave a violent relationship, but will not uniformly apply to every woman. Cultural and social norms may influence individual behavior including such as what triggers violence and what are considered "appropriate" responses to violence (Vandello & Cohen, 2003). Examples of such norms include the belief in some cultures that men have a right to control women or that reporting abuse is disrespectful (WHO, 2009). These types of norms and beliefs may make women more vulnerable to physical and other forms of violence, or make a woman experiencing violence less likely to report the abuse or otherwise seek help (WHO, 2009). When norms are identified in the literature, these are experiences of the majority and not necessarily each women so the practitioner must not stereotype, but use this as background knowledge in assessment (Gurm and Cheema, 2013).

Some populations may face additional barriers to disclosure and support when experiencing domestic violence.

Aboriginal women experience an increased prevalence of domestic violence with statistics showing they are almost three times more likely than non-Aboriginal woman to be the victim of a violent crime (Brennan, 2011). In addition to an increased risk of violence, aboriginal women may also face additional barriers in seeking support, some of which are summarized in table 2-11.

Table 2-10 Examples of the Types of Cultural Norms Which May Support Domestic Violence

- A man has a right to discipline or correct a woman's behavior
- Men are socially superior to women
- A man has a right to sexual intercourse in a marriage
- A man's honour is linked to a woman's sexual behavior
- It is acceptable to resolve interpersonal conflicts using violence
- A woman has a responsibility to tolerate violence in order to keep a marriage together
- A woman's freedom should be restricted
- Divorce is shameful
- Talking about domestic violence is taboo

Adapted from: *Preventing Intimate Partner Violence and Sexual Violence Against Women: Taking Action and Gathering Evidence,* WHO, 2010; *Understanding and Addressing Violence Against Women: Intimate Partner Violence,* WHO, 2012

Table 2-11 Aboriginal Women and Barriers to Disclosure of Domestic Violence

- Fear of stereotypical attitudes and stigmatization towards Aboriginal women
- Impact of residential schools including mistrust of institutions (including health care and criminal justice systems) and/or a history of abuse
- Victim's fear of apprehension of her children by social service agencies
- Family or community denial that abuse is occurring or a fear of isolation by community if abuse is reported
- Lack of services or support in remote or rural communities

Adapted from: Ministry of Public Safety and Solicitor General, 2007

Cultural Considerations - Immigrant and Refugee Women

Women who have immigrated from another country and are experiencing domestic violence may also experience barriers to seeking support in addition to some of the cultural norms described above. These may include language and cultural barriers; dependence on partner for immigration status and a fear of deportation if the abuse is disclosed; lack of knowledge of her rights; and/or a mistrust of the authority including the justice system (PODV, 2014; Ministry of Public Safety and Solicitor General, 2007; McDonald, 1999; Kulwicki, Aswad, Carmona, & Ballout, 2010). Other fears such as being rejected or ridiculed by their community, losing her children and/or economic insecurity (Ministry of Public Safety and Solicitor General, 2007; Kulwicki et al., 2010) may also influence a woman's decision to seek support when experiencing domestic violence.

Immigrant and refugee women may also be separated from their families and support systems from their home countries, increasing the isolation experienced by many victims of domestic violence (Ministry of Public Safety and Solicitor General, 2007; Shirwadkar, 2004).
Cross-cultural communication can be improved by utilizing "non-psychological terms" and listening to the patient's perspective. It's important for professionals to "…never accept culture as an excuse for domestic violence. Everyone deserves the right to be safe in their own home" (Trevillion, Agnew-Davies & Howard, 2013, p. 39).

Advocacy

Feder et al. (2009) examined eleven studies that looked at the effectiveness of the use of advocacy for individuals experiencing partner violence. Advocacy included issues like education and safety planning, choice-making and problem-solving, referrals to community resources, and assistance to accessing services such as housing, employment, legal assistance, transport and childcare (Feder et al. 2009). The report concluded that advocacy increased social support and quality of life, increased usage of safety behaviors, increased use of community resources, improvements in physical and non-physical abuse measures, increased self-esteem, improved coping with stress, and improvement in psychological issues , including depression, PTSD, self-esteem, and global self-efficacy (Feder at al. 2009).

Table 2-12-: Patient barriers to disclosure and the importance of engagement between patient and professional

- Shame and embarrassment
- Fear of discussing violence
- Guilt or self-blame
- Fear professional won't believe them or will minimizes domestic violence
- Fear of consequences
- Fear of government involvement or disruption to family
- Cultural differences
- Lack of social supports
- Isolated from family and friends

Adapted from: Rose, Trevillion, Woodall, et al., 2011.

PART THREE: Legalities and Documentation

Legal considerations
Confidentiality
Reporting
Documentation

Legal Considerations

Domestic violence is a crime in Canada. It's against the law for anyone to physically, sexually, financially, emotionally, spiritually abuse threaten or harass another person under the Criminal Code of Canada. Any person that does the following regardless of relationship status whether it's intimate, familial or emotional is committing a crime and can be charged with assault (Department of Justice Canada, 2013).

The following are offenses under the Criminal Code. The Criminal Code applies to all Canadians citizens and immigrants (Department of Justice Canada, 2013):

- Assault: intentionally applying force to another without that person's consent, or threatening to do so. Injury is not required (hitting, shoving, kicking, restraining, slapping).
- Sexual Assault: unwanted sexual contact (rape).
- Criminal Harassment: harassment that causes someone to fear for their own, or another person's safety (stalking or threatening).
- Uttering Threats: threatening to cause death or bodily harm, threatening to cause death or bodily harm to pets or to damage or destroy property.
- Forcible Confinement: confining, forcibly seizing or imprisoning someone.

Every person has an obligation to prevent, stop and report domestic violence. It is important to know that health care workers are mandatory reporters for children. A child is anyone under the age of 19 in In British Columbia, under the Child, Family and Community Service Act (CFCSA). (CFCSA, 2014). With adults on the other hand it's the professional's position to educate the patient on his or her rights and the decision of reporting domestic violence to police is up to the person if there are no children involved. Under the law, police and legal services promote safety of all its citizens. Health care workers should work closely together with other agencies to promote patient safety. Victims may also be able to obtain a restraining order for protection under the provincial family violence legislation (The Family Law Act in British Columbia). Social workers may help patients obtain a restraining order and refer patients to other legal services and resources.

Health care and community professionals (doctors, nurses, social workers, dentists, physiotherapists, RMTs, police, probation officers, school workers, childcare providers, family support workers, etc), have a crucial role to play in their work in hospital and community settings with patients and their children's who are victims of abuse or violence in a domestic situation.

Health care workers are often the first to notice or recognize signs of domestic violence situations. It is very important that patients receive appropriate, sensitive, accurate and empowering care from health professionals. This front line position allows health professionals to offer help if they can recognize the problem and recommend appropriate resources and proactively prevent violence. Service providers can support and make an impact in the health of victims that are suffering from domestic violence through multi-agency collaboration. Health Care providers should offer counseling services. In the hospital they can refer to social worker so plans can be made to ensure health and safety of the person. While health care professionals are in an ideal position to offer information, supports and assistance with access to services, it is important to remember that it may not be safe for the women to carry written information home, so informal discussion or alternative formats may be more useful (Green & Ward, 2010).

Confidentiality

Once the victim discloses information it is important to remind them that all information shared is confidential so a trusting relationship can be formed. Table 3-1 outlines the duties and roles of a nurse with regards to confidentiality and the client experiencing domestic violence.

Table 3-1 Confidentiality and Clients Experiencing Domestic Violence

- Health care professionals have a duty of confidentiality to patients
- Nurses will only disclose information with consent or when there is specific ethical or legal obligation to do so. Legislation that requires you to disclose information in domestic violence situations include: the Adult Guardianship Act (vulnerable adults), Child, Family and Community Services Act (children under age 19)
- Ethically nurses are obligated to disclose if there is a situation where the patient or others are risk of harm. It's important to utilize "professional judgment in deciding to report abuse, neglect or self-neglect under the Adult Guardianship Act, Part 3." It's important to consult with supervisors or more knowledgeable and experienced colleagues when unsure
- Get familiar with your hospital or organization's policies for assessing and reporting situations where suspected abuse or neglect for children and adults.
- Obtain consent for taking any photographs.
- Anytime children are involved the abuse or suspected abuse and neglect must be reported. Health care professionals have the duty to report under the Child, Family and Community Services Act.
- Always talk to patients alone to ensure safety
- Utilize interpreters services as necessary
- Do not provide written information unless it's completely safe to do so as a perpetrator may access information
- Assess immediate risk and create safety plan
- Allow access to telephone if necessary to make confidential call to services if desired

(Adapted from: College of Registered Nurse of British Columbia, 2012, Practice Standard for Registered nurses and nurses practitioners, Privacy and Confidentiality., Ministry of Children and Family, 2014 &Trevillion, Agnew-Davies & Howard, 2013)

Reporting

Any time children are involved or are in danger, the concerns must be reported to a child protection social worker (Child, Family and Community Service Act). If a child is in immediate danger, police should be called to intervene and a child protection social worker should be contacted to determine whether the child is in need of protection. Reporting of abuse of adults is not mandatory however vulnerable adults in situation of abuse, neglect or self-neglect can be reported under the Adult Guardianship Act, Part 3 (College of Registered Nurses, 2012, Practice Standard for Registered Nurses and Nurse Practitioners, Privacy and Confidentiality). As decision making in these situations is difficult and not always straight forward, health professionals should discuss, consult, seek support and ask for guidance from their health team and managers as necessary, if possible.

It is important to inform the patient of his or her rights, confidentiality, safety and education on how to report violence to the police. Provide adult patients with information on how to contact the local police and explain procedure. For example, if police are contacted, a statement will be taken from the patient and a formal investigation will be launched. If patient consents (gives permission) the health professional may report for the adult.

Remember, if the case is ever reviewed, the health professional's records may be looked at. Therefore, "the healthcare professional's duty of care may be met if there is a domestic homicide review" (Trevillion, Agnew-Davies & Howard, 2013).

Table 3-2 What to Report

You need not have details or proof prior to calling. You will be asked for as much information about the concern as you can provide. This will include:

- your name and phone number (although you may call anonymously if you prefer)
- relationship to child
- any immediate concerns about the child's safety
- the location of the child
- the child's age
- information on the situation including all physical and behavioral indicators observed
- information about the family, parents and alleged offenders
- the nature of the child's disabilities, if any
- the name of a key support person
- other child(ren) who may be affected
- information about other persons or agencies closely involved with the child and/or family
- and any other relevant information concerning the child and/or family such as language and culture

(Ministry of Children and Family Development, 2013)

Table 3-3 After Reporting

After you report, the child protection social worker will:

- determine if the child needs protection;
- contact the police if a criminal investigation is required;
- coordinate a response with other agencies, if necessary.

(Ministry of Children and Family Development, 2013).

Documentation

Clear, legible, full, accurate, timely records need to be documented to provide the court with clarity regarding the client's experience and history of abuse: (Coalition for Woman Abuse Policy and Protocol Prince Edward Island, 2002 & College of Registered Nurses of British Columbia, 2013 & Isaac & Enos, 2001). The following table outlines some of the factors that are important to include in documentation when working with clients experiencing domestic violence. You should familiarize yourself with your hospital or health authority policy regarding documentation in these circumstances.

Table 3-4 Examples of What to Include When Documenting an Assessment of a Client Experiencing Domestic Violence

- Description of situation (in patient's own words)
- Your own assessment objective and subjective demographic data per hospital policy (age, ethnic background)
- The patient's condition on arrival to hospital or community services including injuries
- Relationship to alleged perpetrator
- Any photographic evidence or other evidence taken with patient consent and hospital policy
- Medical history
- Detailed case history (clear, legible, full, accurate, timely records need to be documented to provide the court with clarity regarding the client's experience and history of abuse)
- Any weapons used
- Medical treatment and interventions provided
- If anyone witnessed or is also directly experiencing abuse in the family (children)
- Support services teaching done (counseling services, women's health centers)
- Details of police involvement if applicable
- Advocacy undertaken by the nurse on behalf of the client
- What safety planning was done, list of emergency numbers provided and options of safe accommodation discussed
- Referrals initiated prior to discharge (social worker, women's health centre , shelters and victims services)
- Record your name and signature as the practitioner who attended the patient

(Coalition for Woman Abuse Policy and Protocol Prince Edward Island, 2002 & College of Registered Nurses of British Columbia, 2013 & Isaac NE & Enos VP., 2001; Royal College of Nursing, 2000;).

Table 3-4 Documenting Physical Injuries

Include body maps with a x to indicate findings on body diagram.

These terms are commonly used, but please refer to your institutions policy regarding acceptable and non-acceptable abbreviations:

A Abrasions

AU Amputation

B Bruise

BU Burn

D Deformity/ Fracture FO Fracture Open

L Laceration

P Pain

PW Penetrating Wound

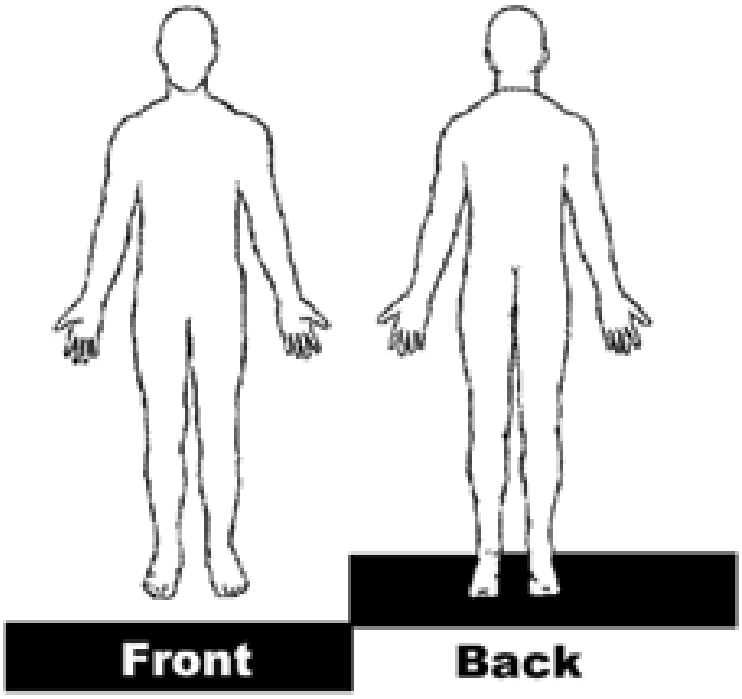
PA Pressure Area

R Redness

S Swelling

T Tenderness

Other Specify



Special Considerations:

- Any evidence needs to be collected, labelled and handled and documented appropriately
- Check your hospital or unit policy to see if photographic record can be made of injuries. If not be as descriptive as possible in case the patient decides to take legal action against the abuser.
- Remind patient that they may access health records if they need in to the future.

Adapted from: Isaac & Enos, 2001

Figure 3-1 Documentation Example

July 1, 2014 @ 0900hrs

Patient presented into ER at 0830 hrs alone. States she lives close by and walked to the hospital. Complaining of abdominal pain. On a pain scale pt rates her pain 5/10 (1=low, 10=high) Pt currently sitting quietly in the corner chair looking at the floor. VSS stable, afebrile, respirations easy regular. Appears anxious however denies same. Will continue to monitor. -------PG, *RPN*

July 1, 2014 @ 1000hrs

Pt taken to private interview room for 1:1 assessment, Pt presents with disheveled hair and wearing casual clothes. Pleasant upon approach. Minimal eye contact, looking at the floor. VSS, afebrile. Lab work done and within normal range. Pt states she's having stomach pain. Abdomen soft and bowel sounds presents in all quadrants. Tenderness and redness noted on left lower quadrant. Pt has dark blue quarter size bruise on right cheek. At first minimizing the bruise on cheek and redness and tenderness on stomach stating she bumped into the wall. However with further questioning and reminding pt of confidentiality pt became very tearful and opened up to telling writer about situation at home. Pt informed writer that pt's husband Joey is increasingly stressed since they bought a new house 3 months ago. They are struggling financially and Joey's drinking is worsening and he has become more verbally abusive. Pt voiced that due to increasing stress Joey for the first time punched her in the face and stomach. Pt minimizing the situation by saying "it's my fault, I shouldn't have told him to purchase the house." With patient's consent writer did a full head to toe assessment and there was a 1 inch laceration noted on left shoulder. Left shoulder cut cleaned with normal saline and 4x4 gauze with tape applied. Pt very tearful during the whole process stating please don't tell anyone "I don't want him to get in trouble." Pt informed of confidentiality again and reminded that as an adult it's her personal choice if she wants to report the abuse. Education and teaching done that no one deserves abuse in anyway, physical, sexual, financial and she could press charges under the criminal code. Pt given resource information to victim services. Given number for emergency services and victim services incase pt changes her mind and wants to report abuse and or receive further counseling. A safety plan created with patient and copy placed on chart. Pt reminded she may access hospital files by going to health records if she decides to press charges. Pt currently waiting for female friend to pick her up. ----------PG, *RPN*

July 1, 2014.

Pt appreciative of care provided and states she might call victim services for counseling. Positive feedback provided and pt discharged from ER to home with female friend @ 1030hrs. PG, *RPN*

Conclusion

Domestic violence does irreparable damage to all involved and its destructive nature is an epidemic when witnessed in childhood as it continues to affect them as they become adults. The cycle of violence continues generation to generation and all of society suffers. Health professionals must take a coordinated approach to educate, advocate and provide resources to patients and assist people in situations of domestic violence. This is the only way we can make a critical difference and be effective change agents and hope for a better future.

Mark Green (Colorado, DHS, 2010) stated "If the numbers we see in domestic violence were applied to terrorism or gang violence, the entire country would be up in arms, and it would be the lead story on the news every night."

"Safety and security don't just happen: they are the result of collective consensus and public investment. We owe our children—the most vulnerable citizens in any society—a life free from violence and fear. In order to ensure this, we must become tireless in our efforts not only to attain peace, justice and prosperity for countries, but also for communities and members of the same family. We must address the roots of violence." --Nelson Mandela

PART FOUR: Resources

VictimLink BC: 1-800-563-0808

VictimLink BC is a toll-free, confidential, multilingual telephone service available across BC and Yukon 24 hours a day, 7 days a week at 1-800-563-0808. It provides information and referral services to all victims of crime and immediate crisis support to victims of family and sexual violence, including victims of human trafficking exploited for labour or sexual services.

VictimLink BC provides service in more than 110 languages, including 17 North American aboriginal languages. In 2012-2013, VictimLink BC assisted more than 10,700 people.

VictimLink BC is TTY accessible. Call TTY at 604-875-0885; to call collect, please call the Telus Relay Service at 711. Text at 604-836-6381. Email VictimLinkBC@bc211.ca

Victim service workers can provide information and referrals to all victims of crime and crisis support to victims. Even if you're not sure if you have been a victim of crime, you can call VictimLink BC at 1-800-563-0808 for assistance. Your call will be completely confidential. All VictimLink BC staff are trained victim service workers and can connect people to a network of community, social, health, justice and government resources, including victim services, transition houses, and counselling resources. They also provide information on the justice system, relevant federal and provincial legislation and programs, crime prevention, safety planning, protection order registry, and other resources as needed.

Any time of the day or night, every day of the year, VictimLink BC is as close as your phone or the Internet and can provide you confidential support and information you can trust. (Description from: http://www.victimlinkbc.ca/)

Youth Against Violence Line: 1-800-680-4264

Call the Youth Against Violence Line at 1-800-680-4264 and talk one-on-one to a YAV Line support worker 24 hours a day, 7 days a week, or e-mail us at info@youthagainstviolenceline.com.

If you're in any way concerned about your safety or the safety of others, we can help. Anything you say is kept completely confidential and you remain totally anonymous - we don't have call display either. And, because the YAV Line is a multilingual service, we can talk to you in your language.

Concerned parents, teachers, caregivers, service providers and others are also welcome to call for information and assistance. (description from: http://www.youthagainstviolenceline.com/)

Crime Stoppers: 1-800-222-TIPS (8477)

Crime Stoppers is an independent non-profit society and registered charity managed by a civilian Board of Directors working in partnership with the police, the media and local citizens.

As an organization, Crime Stoppers is a vehicle that allow citizens to ANONYMOUSLY supply the police with information about a crime or potential crime of which they have knowledge without fear of reprisal.

Leave a Tip

If you become aware of criminal activity, you can call Crime Stoppers at ***1-800-222-TIPS(8477)*** *from anywhere in British Columbia and report what you know. Or you can leave a secure tip online.*

When you leave a Crime Stoppers tip , you are never identified. You never have to give your name or phone number. We don't use call display and you never have to testify in court. You could receive a cash reward of up to $2000 upon an arrest and charge.

Crime Stoppers is available 24 hours a day, 7 days a week. (Description from: http://www.bccrimestoppers.com/about_us.php)

Kids help Phone: 1800 668 6868

There for kids, day and night

To reach a Kids Help Phone professional counsellor, kids, teens and young adults, from any community in Canada, can call or go online 24 hours a day, 365 day a year.

Anything goes

From trouble with homework to dealing with loss and grief to thoughts of suicide, kids can talk to Kids Help Phone about anything. Professional counsellors provide anonymous, confidential and non-judgmental support.

Support right at home

We are the only organization that has access to a database of over 37,000 local resources. That means that no matter where a kid is calling from, our professional counsellors can connect them to a service right in their community, whether they need a place to stay for the night, a way-home or a sexual health clinic (Description from: http://org.kidshelpphone.ca/en/about-us/)

Helpline for Children in BC: 310-1234

Know a Child Who Needs Help?

If a child is in immediate danger, call 9-1-1 or your local police.

If you think a child is being abused or neglected, you can call the ***24-hour Helpline for Children toll-free at 310-1234*** *(no area code is required).*

Anyone Can Call

Children
A child who is being abused at home, at school, in the play ground - anywhere - can call for help.

Parents
Parents who are afraid they might hurt their child can call for help.

Community Members

If you know a family where a child is being abused, call the Helpline. You can call anonymously.

On the Other End of the Phone

There is always a social worker at the end of the phone willing to listen, someone to take action, someone who cares.

You Are Responsible

If you are aware of a possible case of child abuse, you are required by provincial law to contact the Ministry of Children and Family Development. Your immediate action can prevent further child abuse and help the family. As long as your report is made in good faith, you are not liable for any loss or damage. Your call can help stop child abuse.

Child Abuse

Abuse can be physical, emotional or sexual. Abuse can be abandonment, desertion, neglect, ill-treatment, or failure to meet the physical, emotional needs or medical needs of a child. Abuse can be stopped.

For more information, contact your local Ministry of Children and Family Development office. (Description from: http://www.mcf.gov.bc.ca/getting_help/help.htm)

Provincial Office of Domestic Violence

In March 2012, British Columbia established the Provincial Office of Domestic Violence. The office is the permanent lead for the B.C. government in coordinating and strengthening services for children and families affected by domestic violence. The office is accountable for ensuring all provincial policies, programs and services related to domestic violence are effective and delivered in a comprehensive and unified way across government. It is responsible for monitoring, evaluating and regularly reporting progress as well as consultation with stakeholders to support a coordinated, systemic approach to domestic violence

If you or somebody you know is being abused, help is available. For more information visit:

http://www.mcf.gov.bc.ca/podv/index.htm

http://www.domesticviolencebc.ca/

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Appendix A - Abstracts of Literature Review

The following abstracts were collected as part of our team's literature review for this project using the Kwantlen Polytechnic University Library databases.

Allard (2013) Abstract:

"Domestic abuse can affect anyone and is recognized as a global problem that results in physical, psychological and economic harm. People who experience domestic violence often attend emergency departments after an incident, but many victims go unnoticed by healthcare professionals. This article identifies and discusses some of the challenges faced by emergency nurses in recognizing and managing patients affected by domestic violence. It also discusses how addressing these challenges can improve Identification of, and support for, those who have been affected."

Ansara & Hindin (2010) Abstract:

"While numerous studies have documented the prevalence, correlates, and consequences of intimate partner violence (IPV); most of this research has used a criminal justice framework that has focused on acts of physical violence. However, critics argue that this narrow conceptualization of IPV belies the heterogeneity in this experience with respect to the nature of coercive control in the relationship. Moreover, they contend that the different types of abusive and controlling relationships not only have a different etiology, health consequences, and help-seeking characteristics, they also have a different relationship by gender. This study examined the extent to which different patterns of violence, abuse, and control were differentially associated with formal and informal help-seeking in a national Canadian sample. Data from the 2004 General Social Survey were analyzed, which included 696 women and 471 men who reported physical or sexual violence by a current or ex-spouse or common-law partner. The most commonly reported formal sources for women and men were health professionals (i.e., doctors, nurses, counselors, psychologists) and the police. For women, informal sources (i.e., family, friends, neighbors) were commonly reported across all IPV subgroups. However, the importance of almost all of the formal sources (e.g., health professionals, police, lawyers, shelters, crisis centers) increased as the severity of the violence and control increased. Shelters and crisis centers were also reported by a notable proportion of women who experienced the most severe pattern of violence and control. For men, both formal and informal sources were more commonly reported by those who experienced moderate violence and control compared with those who experienced relatively less severe acts of physical aggression. The results suggest that research that more sensitively examines people's experiences of violence and control can help identify their health, social, and safety needs; and ultimately better inform the development of programs and services aimed at addressing these needs."

Black 2011 Abstract

"Nearly 1 in 4 women and 1in 13 men experience intimate partner violence (IPV) at some time in their life.Victims of IPV suffer significant negative health consequences because of the physical, sexual, and emotional abuse they have experienced. Elevated risks havebeen observed for a wide range of adverse health outcomes. Research has substantially improved our understanding of the physiology that underlies the association between violence victimization and an array of adverse health outcomes. Given the high prevalence of IPV and the associated medical consequences and costs of IPV, it is critical to address this public health problem. IPV prevention and intervention can substantially decrease the public health burden of IPV and greatly improve the health of patients being seen in the medical system. Primary care and family physicians are in an ideal position to diagnose victims of IPV and provide the victims and their families the appropriate care that is needed. However, to accomplish this goal, there remains an urgent need to integrate information on IPV into medical and health care curricula, and to train future physicians and other health care providers about the pervasiveness of IPV and the far-reaching implications for patient health"

Brennan (2011) Abstract:

"In Canada, numerous programs and policies have been developed to address violence against women (Johnson and Dawson 2010; Status of Women Canada 2002). Despite these efforts, previous studies have shown that violence against women in Canada continues to be a persistent and ongoing problem, one that is compounded for Aboriginal women (Brzozowski 2006). Given these findings, it is important to differentiate between Aboriginal and non-Aboriginal women's experiences of victimization, to better understand the extent of violence against Aboriginal women and the context in which it occurs."

El-Bayoumi, Borum & Haywood (1998) Abstract:
"Domestic violence is a significant public health issue affecting women. Numerous medical organizations have recommended that routine screening of women be conducted to assist in the prevention, identification, and care for victims of violence. This article

examines the scope of domestic violence in women, reviews ways to recognize abuse, examines the potential impact of abuse upon health and discusses the management of victims."

Faulkner (2006) Abstract:

"Responses show that over half of the women (56.4 per cent) are somewhat affected by the potential for homophobic sexist violence. For example, women took self-defense classes, avoided certain locations, censored their speech and dress, or avoided contact with friends or lovers in public places. Toronto, Calgary, and Fredericton women used terms such as "fearful," "hesitant," "uncomfortable," "worried," "anxious," "secretive," "angry," "more cautious," "careful," "nervous," "wary," "embarrassed," "defensive," "more covert," "conservative," "constantly alert," "more attentive," and "guarded" to describe their behaviour when they feel they may be at risk because others perceive them to be queer (Faulkner 1997; 1999: 174; 2003; 2004). Transgendered participants are more likely to be greatly affected compared to queer women and men. (24 per cent trans, 16.9 per cent women, 14.6 percent men)."

Feder, Ramsay, Dunne, Rose, Arsene, Norman, Kuntze, Spencer, Bacchus, Hague, Warburton, Taket (2009): Abstratct:

Objectives: "The two objectives were: (1) to identify, appraise and synthesise research that is relevant to selected UK National Screening Committee (NSC) criteria for a screening programme in relation to partner violence; and (2) to judge whether current evidence fulfils selected NSC criteria for the implementation of screening for partner violence in health-care settings."

Results: "The lifetime prevalence of partner violence against women in the general UK population ranged from 13% to 31%, and in clinical populations it was 13-35%. The 1-year prevalence ranged from 4.2% to 6% in the general population. This showed that partner violence against women is a major public health problem and potentially appropriate for screening and intervention. The HITS (Hurts, Insults, Threatens and Screams) scale was the best of several short screening tools for use in health-care settings. Most women patients considered screening acceptable (range 35-99%), although they identified potential harms. The evidence for effectiveness of advocacy is growing, and psychological interventions may be effective, but not necessarily for women identified through screening. No trials of screening programmes measured morbidity and mortality. The acceptability of partner violence screening among health-care professionals ranged from 15% to 95%, and the NSC criterion was not met. There were no cost-effectiveness studies, but a Markov model of a pilot intervention to increase identification of survivors of partner violence in general practice found that such an intervention was potentially cost-effective."

Garcia-Moreno, Jansen, Ellsberg, Heise & Watts (2006) Abstract:

"Background

Violence against women is a serious human rights abuse and public health issue. Despite growing evidence of the size of the problem, current evidence comes largely from industrialised settings, and methodological differences limit the extent to which comparisons can be made between studies. We aimed to estimate the extent of physical and sexual intimate partner violence against women in 15 sites in ten countries: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.

Methods

Standardised population-based household surveys were done between 2000 and 2003. Women aged 15–49 years were interviewed and those who had ever had a male partner were asked in private about their experiences of physically and sexually violent and emotionally abusive acts.

Findings

24 097 women completed interviews, with around 1500 interviews per site. The reported lifetime prevalence of physical or sexual partner violence, or both, varied from 15% to 71%, with two sites having a prevalence of less than 25%, seven between 25% and 50%, and six between 50% and 75%. Between 4% and 54% of respondents reported physical or sexual partner violence, or both, in the past year.

Men who were more controlling were more likely to be violent against their partners. In all but one setting women were at far greater risk of physical or sexual violence by a partner than from violence by other people.

Interpretation

The findings confirm that physical and sexual partner violence against women is widespread. The variation in prevalence within and

between settings highlights that this violence in not inevitable, and must be addressed."

Green & Ward (2010) Abstract:

"One incident of domestic violence is reported to the police every minute and up to 30% of domestic abuse starts during pregnancy. However domestic violence remains a subject that health professionals find difficult to discuss.

Patients in violent relationships may present in a wide variety of ways including a disastrous obstetric history with repeated miscarriages, stillbirth or pre-term labour.

If a woman discloses abuse, put her at ease so she talks about her experiences. Support and reassure her and be non-judgmental. Concentrate on her safety and that of her children. Never advise her to leave her partner as this may be more dangerous than staying. Give her information about relevant agencies (see DOH handbook). If there is any doubt about the safety of her children, contact Child Protection Services. Careful documentation of her history and injuries is required but should never be documented in her hand-held records."

Gurm, B & Cheema, J. (2013) Abstract:

Canada continues to grow as a multicultural country but the number of people employed in healthcare does not reflect the increasing population diversity. In addition there are no set Canadian standards in providing Culturally Safe health services. Hence, there may be a lack of safe cultural practices when communicating with patients and/or colleagues. The purpose of this survey study was to determine if there is inconsistency between the written and practiced policy on cultural safety in an urban hospital on the west coast of British Columbia. The study examined whether there were any discriminatory practices based on diversity as judged by the recipients of the interactions, patients and staff. The results indicate that discrimination and equality barriers do exist within the hospital even though Canada has equity legislation. The hospital needs to adopt policy changes in practice and establish bench marks to create a more culturally safe environment through programs and services that meet the diverse needs of staff and patients.

Kulwicki, Aswad, Carmona & Ballout. (2010) Abstract:

"Ten focus group discussions were conducted with Arab American community leaders who had experience with victims of violence in the Arab American population and issues related to domestic violence. Community leaders were selected from an array of backgrounds,ranging from health and human service providers, legal and law enforcement service providers, religious and grass roots community organizations. Focus group discussions explored the role of personal resources, family, religion, culture and social support system in the utilization of domestic violence services by Arab immigrants experiencing domestic violence. In addition, issues related to personal, socio-cultural and institutional barriers in domestic violence service utilization were addressed along with identifying culturally competent policy strategies in reducing barriers for service utilization by Arab immigrants experiencing domestic violence"

Lee, Kolomer, & Thomsen (2012) Abstract:

"This study documents the preliminary program evaluation of a 10-session group intervention designed to address the needs of children exposed to domestic violence. The program was developed to promote five primary outcomes: (a) alleviation of guilt/shame, (b) improvement of self-esteem, (c) establishment of trust/teamwork skills, (d) enhancement of personal safety and assertiveness skills, and (e) abuse prevention. A series of pre- and posttest intervention measures provide comparison data. Study findings indicated an overall decrease in depressive symptomology, symptoms of psychosocial impairment, and certain problematic behaviors and as a result, supports continuation of the program. Despite a small sample and other limitations, the program offers a promising framework for intervention with children exposed to domestic violence. Findings both highlight the need for accessible, appropriate measures and reinforce the need for the intervention planning phase to include careful consideration of clear intervention goals, evaluation instrumentation, participant selection, and strategies to solicit participation, sustain membership, and secure posttest data. Implications are relevant to practitioners and researchers in the field."

Litten (2014) Abstract:

"The article reports on the prevalence of domestic violence in England and Wales and discusses guidelines on its prevention which have been released by Great Britain's National Institute for Health and Clinical Excellence (NICE). A discussion of the signs, symptoms, and risk factors for domestic violence is presented. Strategies that nurses can use to help domestic violence victims are discussed."

McDonald (1999) Abstract:

“Immigrant women who have been abused by their intimate partners have numerous needs, including legal needs. There are studies, more studies, academic writing, and unpublished reports detailing these legal needs. A review of this body of literature will find a notable absence of studies and statistics on the prevalence of domestic violence in immigrant communities. This article will argue that Canadian society, as well as advocates and service providers need such statistics in order to allocate resources appropriately to address the legal and other needs of immigrant women in domestic violence situations.

There is a small, but growing body of literature looking at immigrant women in domestic violence situations and their unique social, legal, and economic problems. Most of the writing in academic journals is American and appears to serve the purpose of awareness and sensitizing the legal (and other) professionals who represent battered immigrant women using the liberal legal system. Some of the writing appears in grassroots publications (Canadian African Newcomer Aid Centre of Toronto; Aboriginal Family Healing Joint Steering Committee; Sy and Choldin; Mothers on Trial). There are also some studies ([Linda MacLeod] and Shin; Godin; Law Courts) that focus on the needs, including the legal needs, of immigrant women. A review of this writing reveals an absence of statistics on the prevalence of domestic violence in immigrant communities.

Yet, a quantitative study of domestic violence in immigrant communities can be harmful as well. Studies have suggested correlations between poverty and other stress factors such as alcohol abuse, unemployment, and isolation and domestic violence (Zorza; Marguiles). Studies that indicate the prevalence of domestic violence in immigrant communities may do harm by further stereotyping immigrant groups as poor, unemployed, and fraught with social problems such as alcoholism. Crenshaw argues that some women's advocates "have ... transformed the message that battering is not exclusively a problem of the poor or minority communities into a claim that it equally affects all races and classes" (1259). She also notes that while there are no reliable statistics to support this claim, there are statistics that suggest there is a greater frequency of violence among the working class and poor. Crenshaw concludes that the desire to maintain integrity in the African American community, or to discourage stereotypes of black men as uncontrollably violent, may have led to the minimization or suppression of the problem of domestic violence in that particular community.”

Rose, Trevillion, Woodall, Morgan, Feder, & Howard. (2011) Abstract:

“Mental health service users are at high risk of domestic violence but this is often not detected by mental health services. To explore the facilitators and barriers to disclosure of domestic violence from a service user and professional perspective. A qualitative study in a socioeconomically deprived south London borough, UK, with 18 mental health service users and 20 mental health professionals. Purposive sampling of community mental health service users and mental healthcare professionals was used to recruit participants for individual interviews. Thematic analysis was used to determine dominant and subthemes. These were transformed into conceptual maps with accompanying illustrative quotations. Service users described barriers to disclosure of domestic violence to professionals including: fear of the consequences, including fear of Social Services involvement and consequent child protection proceedings, fear that disclosure would not be believed, and fear that disclosure would lead to further violence; the hidden nature of the violence; actions of the perpetrator; and feelings of shame. The main themes for professionals concerned role boundaries, competency and confidence. Service users and professionals reported that the medical diagnostic and treatment model with its emphasis on symptoms could act as a barrier to enquiry and disclosure. Both groups reported that enquiry and disclosure were facilitated by a supportive and trusting relationship between the individual and professional. Mental health services are not currently conducive to the disclosure of domestic violence. Training of professionals in how to address domestic violence to increase their confidence and expertise is recommended.”

Sherin (2003): Abstract:

“Domestic violence is an important problem that is often not recognized by physicians. We designed a short instrument for domestic violence screening that could be easily remembered and administered by family physicians. The HITS scale showed good internal consistency and concurrent validity with the CTS verbal and physical aggression items. The HITS scale also showed good construct validity in its ability to differentiate family practice patients from abuse victims. The HITS scale is promising as a domestic violence screening mnemonic for family practice physicians and residents.”

Shakil, Donald, Sinacore & Krepcho (2005): Abstract:

“To date, screening tools for domestic violence have been validated only for use with female patients. A four-item HITS (Hurt-Insult-Threaten-Scream) screening tool is one of those instruments. The purpose of the current research was to validate the HITS screening tool in a population of male patients. Concurrent validity of the HITS was good. ODA found that the score of 11 on the HITS differentiated between non-victims and victims. Sensitivity and specificity were 88% and 97%, respectively. Predictive values were 97% for non-victims and 88% for victims. The positive and negative likelihood ratios were 34.41 and 0.12, respectively.”

Shirwadkar (2004) Abstract:

“This article explores the problems of Indian immigrant women who face cultural constraints in accessing the benefits of Canadian policies for domestically abused women. Findings from an exploratory study of abused immigrant Indian women and community social workers in Ontario, Canada, are presented. They expose the pressures of cultural, social, and family ties that prevent these women from getting necessary help for domestic violence. The limitations of Canadian policies and programs for these women and the means to improve their access to these policies and programs are discussed. The conclusion suggests how binational research is needed to improve the situation of abused Indian immigrant women in Canada and in India.”

Siemieniuk, Krentx, Gish & Gill (2010) Abstract:

“There is a strong association between domestic violence victimization and HIV infection. This may lead to poor health outcomes including mental health disorders and reduced access to care. A standardized domestic violence screening interview was incorporated into ongoing care in the large and diverse population living with HIV in Southern Alberta, Canada. Results from May through December 2009 are reported, including the prevalence and outcomes of abuse. Thirty-four percent of 853 patients screened reported abuse. Of these, 16% reported abuse in their current relationship, 58% in a previous relationship, and 57% reported a history of childhood abuse. High-risk groups for abuse included females (43%), gay/bisexual males (35%), and Aboriginals (61%). We found an association between a history of domestic violence and delayed access to care ($p < 0.05$), missed appointments ($p < 0.001$), and an increased use of clinic resources such as social work ($p < 0.0001$) and psychiatry ($p < 0.001$). Mental health conditions prior to HIV diagnosis, including depression ($p < 0.0001$), suicidal ideation ($p < 0.0001$), and anxiety disorder ($p < 0.0001$) were associated with abuse at any time, while a history of adjustment disorder was associated with childhood abuse ($p < 0.05$). A simple domestic violence screening tool was helpful for identifying patients experiencing abuse in our diverse HIV-infected population. This high prevalence of domestic violence among our HIV patients was associated with poor outcomes and an increased use of medical resources. HIV caregivers should be aware of domestic violence in order to optimize care and refer patients to appropriate support professionals as needed.”

Sinha (2012) Abstract:

“Defining family violence is integral to accurately profiling the issue. While there is no universally accepted definition of family violence, two elements must be considered in any definition: the forms of violence to be included and the types of family relationships. Within the Family Violence Initiative, family violence has been conceptualized as “a range of abusive behaviours that occur within relationships based on kinship, intimacy, dependency or trust” (Family Violence Initiative Performance Report, 2008). This definition is far-reaching and can encompass physical, sexual, verbal, emotional, and financial victimization, or neglect. Within this publication, analysis of violence within the family is primarily based on statistical data that are consistent with Criminal Code definitions, unless otherwise stated.”

Trevillion, Agnew-Davies & Howard (2013) Abstract:

“Victims of domestic violence have increased contact with healthcare services, but the abuse may not always be identified as a causal factor in their physical and mental health problems. Guidelines advocate that healthcare professionals should enquire about abuse and respond appropriately to any disclosures with pertinent messages and referral to domestic violence specialists if required. This article

provides an update on the guidance to health professionals and examines how improved identification and responses to domestic violence by healthcare professionals can improve care for patients”

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Vandello & Cohen (2003) Abstract:

“Two studies explored how domestic violence may be implicitly or explicitly sanctioned and reinforced in cultures where honor is a salient organizing theme. Three general predictions were supported: (a) female infidelity damages a man's reputation, particularly in honor cultures; (b) this reputation can be partially restored through the use of violence; and (c) women in honor cultures are expected to remain loyal in the face of jealousy-related violence. Study 1 involved participants from Brazil (an honor culture) and the United States responding to written vignettes involving infidelity and violence in response to infidelity. Study 2 involved southern Anglo, Latino, and northern Anglo participants witnessing a "live" incident of aggression against a woman (actually a confederate) and subsequently interacting with her.”

Zhang, Hoddenbagh, McDonald, & Scrim (2012) Abstract:

"This report provides an estimate of the economic impact of spousal violence that occurred in Canada in 2009. Spousal violence is a widespread and unfortunate social reality that has an effect on all Canadians. Victims of spousal violence are susceptible to sustaining costly and long-lasting physical, emotional, and financial consequences. Children who are exposed to spousal violence suffer in many ways and are at increased risk of developing negative social behaviours or disorders as a result (Dauvergne and Johnson 2001). The victims' family, friends, and employers are also affected to varying degrees. Every member of society eventually feels the impact of spousal violence through the additional financial strain imposed on publicly funded systems and services.

Appendix B – Research Evidence of Domestic Violence Risk Factors

The following document provides up to date research on domestic violence risk factors including relationship history, complainant's perception of risk, suspect's history and access to weapons and firearms.

Research Evidence of DV Risk Facters.pd