GLUE TAB

Best Practice Guideline

WOMAN ABUSE: SCREENING, IDENTIFICATION AND INITIAL RESPONSE

Guideline Supplement

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Supplement Integration

This supplement to the nursing best practice guideline *Woman Abuse: Screening, Identification, and Initial Response* is a result of a scheduled revision of the guideline. Current literature has been summarized to provide the reader with current evidence to support practice. Similar to the original guideline publication, this document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. This supplement should be used in conjunction with the guideline to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

Background

The World Health Organization [WHO] (2008) continues to recognize as part of Primary Health Care, that screening for abuse in all health care settings is instrumental in identifying and raising awareness of this public health problem. Within all health care settings nurses and other health professionals are in a privileged position to assist women experiencing intimate partner violence.

There continues to be epidemiological data that indicate the incidence of woman abuse is still a presence within our communities. There are economic, health, and social costs to women (and their families) experiencing intimate partner violence which in turn have a profound effect on the quality of life for women and the community as a whole.

> While the term "woman abuse" has been used, the woman experiencing "intimate partner violence (IPV)" is the primary focus of this guideline, in terms of screening, identification and initial response.

Since the publication of the original guideline, research has indicated that asking questions about abuse in the lives of women continues to be a step in the process of addressing woman abuse. Recent studies by MacMillan and colleagues (2006), Rhodes and colleagues (2006), Kataoka, Yaju, Eto, & Horiuchi (2010) and Koziol-McLain and colleagues (2010) indicate that screening approaches like routine universal screening should be standard practice for nurses and other health care practitioners in all health care settings.

RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Revision Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that this practice guideline is based on the best available evidence. In order to meet this commitment, a regular monitoring and revision process has been established for this guideline.

An expert panel was assembled for this review, comprised of members from the original development panel as well as other recommended individuals with particular expertise in this area. The revision panel members were given a mandate to review the guideline focusing on the recommendations and the original scope of the guideline.

Based on the focus of the original guideline, the revision panel members developed the following three questions to guide the literature search for this review:

1. a. What is the most effective approach for screening for woman abuse/intimate partner violence?

   b. What validated tools are available for screening for woman abuse/intimate partner violence?

2. What is the most appropriate age to initiate screening?

3. What are the most effective interventions in response to a disclosure of woman abuse/intimate partner violence?

A structured evidence review based on the scope of the original guideline was conducted to capture the relevant literature and other guidelines published since 2005. The results of the evidence review were circulated to the review panel, which convened to reach consensus on the need to revise the existing recommendations in light of the new literature.

Review of Existing Guidelines

One individual searched an established list of websites for guidelines and other relevant content. The website list was compiled based on existing knowledge of evidence-based practice websites and recommendations from the literature.

While the search yielded many results, four guidelines met the established inclusion criteria.

After appraising these international guidelines using the "Appraisal of Guidelines for Research and Evaluation Instrument II" (Brouwers et al, 2009), the revision panel identified the following guideline to inform this revision:

Society of Obstetricians and Gynaecologists of Canada (SOGC) (2005). *Intimate Partner Violence Consensus Statement.* Journal of Obstetrics and Gynaecology Canada (JOGC), April (157), 365 – 388.

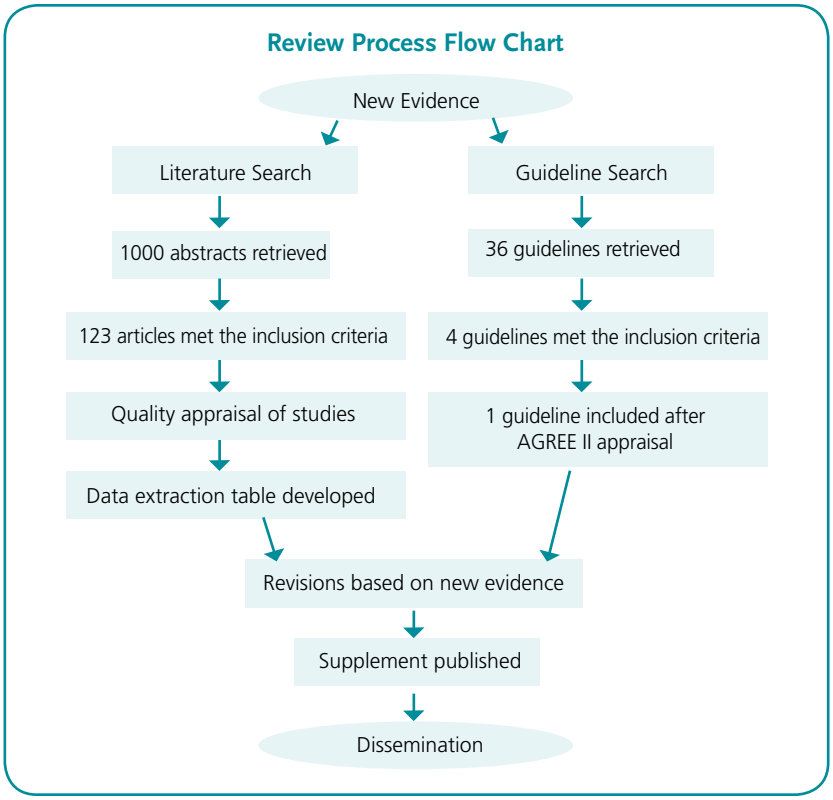
Literature Review

Concurrent to the guideline search, a search for published literature relevant to the scope of the guideline was conducted by a health sciences librarian using the following electronic databases: CINAHL, Medline, EMBASE and Web of Science.

A research assistant with Master's preparation in nursing, conducted the inclusion/exclusion review, quality appraisal and data extraction of the included articles, and prepared a summary of the literature findings. The comprehensive data tables and summary were provided to all review panel members.

Review Findings

A review of the most recent literature since the publication of the original guideline does not support changes to the original recommendations, but rather provides additional support to the recommendations related to screening, indentifying and responding to woman abuse.



Summary of Evidence

The following content reflects revisions made to the original publication (2005) based on the consensus of the review panel. Only changes made to the recommendation and/or discussion of evidence are shown below.

✓ unchanged
✎ changed
\+ additional information
NEW new recommendation

Practice Recommendations

Recommendation 1 Nurses implement routine universal screening for woman abuse [intimate partner violence] in all health care settings. Level of evidence: IIb	✓
The first paragraph in the discussion of evidence on page 22 of the original guideline has been revised with additional literature support: **Discussion of Evidence** Woman abuse has serious health consequences and is a significant public health problem. The health care system plays an important role in identifying and preventing public health issues. The World Health Organization's (2008) report ''Primary Health Care: Now more than ever'' states that nurses should focus on screening for woman abuse and treating abused women within a healthcare setting as well as within the community. Routine universal screening, with a focus on early identification of women experiencing abuse, whether or not symptoms are immediately apparent, is a primary starting point for this improved approach to health care practice for woman abuse (Asher, Crespo, & Sugg, 2001; Department of Health [DH], 2000; Duncan, McIntosh, Stayton & Hall, 2006; Family Violence Prevention Fund [FVPF], 2004; Middlesex-London Health Unit [MLHU], 2000; Poirier, 1997; Perinatal Partnership Program of Eastern and Southeastern Ontario [PPPESO], 2004; Punukollu, 2003; Trabold, 2007). Studies have shown that women believe "health care providers should routinely ask all women about difficulties in home life and relationships" (Koziol-McLain et al., 2010, p. 241). Furthermore, studies have shown that: no harm or adverse effects were linked with this type of questioning (Houry et al. 2004; Koziol-McLain et al., 2010; MacMillan et al., 2009); there was no difference in rates of abuse disclosed to a male or female researcher or by self-completion of a questionnaire (Boyle & Jones, 2006); and most abused women would not disclose unless asked directly and may find it a source of huge relief to be able to disclose in a confidential setting (Boyle & Jones, 2006). Routine universal screening, as opposed to indicator-based screening, increases opportunities for both identification and effective interventions; validates woman abuse as a central and legitimate health care issue; and enables providers to assist both victims and their children (FVPF, 2004; PPPESO, 2004).	+

Recent work by MacMillan and colleagues, (2006), Rhodes and colleagues, (2006), Kataoka and colleagues, (2010) and Svavarsdottir (2010) examined screening approaches including questionnaires, telephone interviews and automated data collection. While all techniques have been shown to have merit, one-on-one interviewing continues to be the technique chosen for its capacity to give voice to victems of woman abuse (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009). This finding is consistent with previous studies (Kozial-McLean et al., 2010; McFarlane et al., 2001). While different methods of screening may be necessary in different settings (Svavarsdottir, 2010), routine universal screening should be standard practice as a component of a complete nursing health history.	
## Recommendation 2 Routine universal screening be implemented for all females 12 years of age and older. Level of Evidence: IV	✓
The discussion of evidence on page 23 of the original guideline has been revised to reflect additional literature support: ### Discussion of Evidence The panel reached consensus on the age of 12 for the implementation of routine universal screening, recognizing that this statement adds to the complexity of implementing this recommendation. Twelve-year olds are involved in relationships, and the Criminal Code of Canada (Department of Justice, 2011) recognizes that young women between the ages of 12 and 16 are able to consent to sexual activity. A cross sectional survey by O'Donnell, Agronick, Duran, Myint-U & Stueve (2009) found that one in five young women had initiated sexual intercourse by eighth grade, and three in five had reported at least one type of aggressive behaviour during middle school. O'Donnell and colleagues, (2009) reported that there are "links between behaviors in adolescence and intimate partner violence during the teenage and young adult years" (p. 84). This is a concern for urban young women, who report "relatively high levels of peer-directed violence, especially during middle school, a time when such behaviors as fighting often peak among both boys and girls" (O'Donnell et al., 2009, p. 84). In addition, O'Donnell and colleagues, (2009) reported that those who engage in aggressive behaviour during the middle school years are particularly vulnerable to dating violence during adolescence, as well as adult partnership violence, and that those who experience intimate partner violence once are at risk of repeat occurrences. Six percent of respondents reported no sexual partners by the last survey (10 years after the first survey), 22% reported one or two, and the rest said they had had three or more. A study by Wiemann, Agurcia, Berenson, Volk, and Rickert (2000) examined prevalence rates for physical assault by intimate partners among 724 pregnant adolescents 12-18 years of age. Of the individuals interviewed, 29% had experienced some form of physical violence in the previous 12 months and almost 12% reported being physically assaulted by the father of their baby. Young girls are at the beginning of their dating experience and often do not understand the relationship dynamic of control. For example, a study of adolescent girls found that violence was misunderstood as being about anger (71%), confusion (40%) and love (27%) (Hyman, 1999). Therefore, screening for violence at an early age provides an opportunity for early intervention to reduce violence in young women's lives, increase awareness about the dynamics of abusive relationships and foster healthy relationships between young women and their dating partners.	+

Recommendation 3

Nurses foster an environment that facilitates disclosure. This necessitates that nurses:

- ask about woman abuse/intimate partner violence; and
- respond to disclosure

Level of Evidence: IV

Recommendation 3 has been changed to reflect specific actions that nurses can carry out related to woman abuse/IPV.

The second and third paragraphs in the discussion of evidence found on page 24 of the original guideline have been revised to reflect additional literature.

+

Discussion of Evidence:

In addition to the nurse creating an environment of openness, safety and trust, Amar and Gennaro (2005), Johnson and colleagues (2009), and McCord-Duncan, Floyd, Kemp, Bailey, & Lang (2006) suggest that the nurse do the following to aid in creating an environment conducive to abuse disclosure: (1) treat the woman with respect; (2) protect the woman; (3) document the interaction; (4) give the woman control; (5) respond immediately to any disclosure; (6) offer the woman options; and (7) be physically present. In addition, 'how' questions are asked is more important than the actual wording (SOGC, 2005). Strategies of how questions are asked include use of "normalizing (i.e., I ask all my new patients this), showing connections and concerns (i.e., I wonder if abuse is making your headaches worse), and showing an interest and ability to help" (SOGC, 2005, p. 374).

It is paramount for nurses to develop an approach that feels appropriate and comfortable to each client in order to encourage clients to be "frank and open in their response" (MLHU, 2000, p. 33). Empathetic and nonjudgmental listening should be the first priority for the nurse when dealing with abused women in any healthcare setting (WHO, 2008).

Additional Literature Support:
Campbell et al., 2009

Recommendation 4

Nurses develop screening strategies and initial responses that reflect the needs of all women taking into account differences based on culture, race, ethnicity, class, religious/spiritual beliefs, age, ability and/or sexual orientation.

Level of Evidence: III

Recommendation 4 has been changed with the addition of the term "culture" to more closely reflect the discussion of evidence found on page 26 of the guideline.

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Additional Literature Support:
College of Nurses of Ontario, Culturally Sensitive Care, 2009
College of Nurses of Ontario, Quality Assurance Reflective Practice, 2011

Education Recommendations

Recommendations 5, 6 and 7 have been moved from "Practice Recommendations" to "Education Recommendations" in an attempt to streamline the practice recommendations as directives to the nurse and/or healthcare professional as to what to do in practice.

✓ unchanged
changed
\+ additional information
NEW new recommendation

Recommendation 5 Nurses use reflective practice to examine how their own beliefs, values, and experiences influence the practice of screening. Level of Evidence: IIa	✓
Additional Literature Support: College of Nurses of Ontario, Culturally Sensitive Care, 2009 College of Nurses of Ontario, Quality Assurance Reflective Practice, 2011	+
Recommendation 6 Nurses know what to document when screening for and responding to abuse. Level of Evidence: IV	✓
Additional Literature Support: Ontario Ministry of Information and Privacy [OMIP], 2011 College of Nurses of Ontario [CNO], Documentation, 2008 Canadian Nurses Protective Society [CNPS], 2008	+
Recommendation 7 Nurses know their legal obligations when a disclosure of abuse is made. Level of Evidence: IV	✓
The discussion of evidence found on page 30 of the original guideline has been revised to incorporate new literature. **Discussion of Evidence** There are four main considerations when a disclosure of abuse is made: • Reporting woman abuse • Young women and disclosure of abuse • Children who witness woman abuse • Work-place violence as it relates to domestic violence [woman abuse/IPV] Respecting client confidentiality is a critical aspect of the nurse-client relationship. It is important for nurses to realize when there are ethical, professional and legal exceptions to client confidentiality within client relationships (CNPS, 2008). Nurses need to be aware of their professional Code of Ethics (Canadian Nurses Association [CNA], 2008) and the practice standards related to confidentiality and health information (CNO, 2004). Nurses also must have knowledge and understanding of their respective workplace polices related to confidentiality. The Personal Health Information Protection Act (OMIP, 2011) has implications related to documentation and disclosure of personal health information as discussed in Recommendation 6.0 of the original guideline.	+

Reporting Woman Abuse

In Canada, there is no mandatory obligation to report woman abuse to the police. It is the woman's right to choose if she wishes to have police involvement and she must consent to this involvement prior to the nurse initiating such action. Nurses must respect the woman's decision and advocate for her right to choose (Health Canada, 1999).

The example below highlights the obligation of pressing charges of woman abuse:

If the police were dispatched to a home as a result of a call related to domestic violence concerns and the police determine the situation is a case of domestic violence, they have a legal obligation to place such charge(s). The woman involved is not the one to press charges, contrary to popular belief. The police will: (1) encourage the woman to seek medical care; (2) provide information to community services; and, in some situations, (3) make a referral to community resources.

Young Women and Disclosure of Abuse

Since the best practice guideline recommends screening for woman abuse for females ages 12 and over, disclosure of abuse by a young woman may necessitate the involvement of the local Child and Family Services (CFS) agency. The following information is a general guide to assist in this practice.

According to the Criminal Code of Canada (Department of Justice, 2011) young women over the age of 12 are able to consent to sexual activity in the following circumstances:

- When she is between the age of 12-14 and the age difference between the two people is not more than 2 years; and the person is not in a position of trust/ authority or in a relationship of dependency or an exploitive relationship; or
- When the young person is between 14 – 16 years of age and the other person is less than 5 year older and not in a position of trust/authority or in a relationship of dependency or an exploitive relationship.

While teens having sex may pose a moral/ethical challenge for the individual nurse, it is not necessarily a reportable event as illustrated in the above circumstances. The factors that define a report to CFS are:

- When the young woman is less than 16 years of age and the alleged abuser is a person in a care-giving role; or
- When the young woman is less than 16 years of age and the alleged abuser is in a role of authority or trust.

Assaults (physical and/or sexual) by a boyfriend are reportable only if the above conditions apply or if the teen who is 16 years or younger where the parent(s)/caregiver(s) know of the abuse and do nothing to provide appropriate supervision to protect the young woman from harm. If the young woman is 17 years or older and being assaulted by a boyfriend, only with her consent can a report to police be made regardless if she is living at home with parents/caregiver.

There is no age of consent for healthcare/treatment or for collecting health information to establish a health record, so young women are entitled to make their own health decisions (OMIP, 2011; Rozovsky & Inions, 2003), provided the healthcare professional feels the young woman understands the circumstances and can make an informed choice. Once the young woman has made a treatment choice, parent(s)/caregiver(s) or CFS cannot force the young woman to undergo a treatment/examination. Also the parent(s) or caregiver(s) cannot have access to the young woman's health record unless the nurse has written consent of the young woman. If CFS is involved and doing an investigation they may request access to the health record. Consultation with your agency's privacy officer or manager is advised.

Children Who Witness Woman Abuse

The Child and Family Services (CFS) Act of Ontario (2003) contains legislation that outlines the duty to report as it relates to the protection of children who have been exposed to woman abuse. In the Act, exposure is described as a child who sees, hears or knows of the violence whether it is verbal, emotional or physical. Even if the child is not in the home at the time of the abuse, they often are exposed to the pre and/or post effects of the violence and this too is considered exposure.

There is a legal obligation for nurses to report children's exposure to woman abuse* to the local CFS. The nurse should advise the woman of this obligation and ask her some key questions:

- Has the abuser threatened to call CFS to indicate she is a "bad mother"?
- Are CFS involved already and if so who is their worker?
- What has the woman done already to keep the children safe?

When discussing the involvement of CFS, the woman and children may not always view it as a positive offer of assistance. The woman is often afraid that she will lose her children and be viewed as not adequately caring for and protecting the children. The child often fears separation from his/her parent(s), home, family and friends (Berman, Hardesty, and Humphreys, 2003; Jaffe, Wolff, and Wilson, 1990). Children often fear they are to blame because they were not "good" and may have a sense of guilt and/or insecurity. Often in these abusive situations the welfare of the child/children is strongly linked to the non offending parent (Jaffe et al, 1990).Therefore, it is important to explore the above key questions before making the call to CFS. It is important that the woman appreciate that CFS can assist in making a positive link to services and assistance such as helping to meet their needs such as food/clothing when going to a safe place.

It is important to document a child's reaction to violence. Reactions such as crying, clinging to a parent, increased anxiety if separated and any verbal disclosures about the abuse should be noted. Often when a child makes a disclosure about abuse he/she is revealing what is often a family secret and is indicating that help is needed (Baker & Cunningham, 2005). If healthcare providers fail to listen and to respond to the child's disclosure, it may discourage the child from ever telling anyone about the abuse thus putting him/her at further harm (Baker & Cunningham, 2005).

*Consultation with and education from the local CFS agency is strongly advised to gain better understanding about the legislation with regards to children's exposure to woman abuse. Collaboration between agencies to have protocols in place helps to ensure the safe and successful referral for services to protect the children and woman.

Workplace Violence as it relates to Domestic Violence (IPV/Woman abuse) With the recent introduction in Ontario of the bill Violence and Harassment in the Workplace (Occupational Health & Safety Amendment Act [OHSA], 2009) there is now a requirement for employees and employers to have education on violence including domestic violence that occurs in the work place setting. Nurses need to be knowledgeable about their facility's policies and procedures when a situation of IPV occurs in the work place or disclosure of woman abuse is made by a coworker. Key to this legislation is the understanding that a nurse needs to make a report to his/her supervisor/manager. If a critical incident happens that results in physical injury to the worker(s) by the abuser, then there are required reporting obligations that the employer must follow as set out by the OHSA (2009).	
## Recommendation 8 Mandatory educational programs in the workplace be designed to: • increase nurses' knowledge and skills; and • foster awareness and sensitivity about woman abuse. Level of Evidence: Ib	✓
The discussion of evidence on page 31 of the original guideline has been revised with the addition of the following paragraph: ### Discussion of Evidence Hamberger and colleagues (2004) reported increased self-efficacy, increased endorsements of the role of nurse, and increased comfort in making appropriate community referrals in identifying and helping victims of IPV as a result of training that involved a variety of techniques and messages. Johnson and colleagues (2009) also reported improved nurse self-efficacy for screening, decreased fear of offending IPV victims, and improved perception of resources available for nurses to manage IPV, following a self-efficacy theory based curriculum. Neither study, however, measured behaviour changes in nursing practice. Hamberger and colleagues (2004) noted that while the follow-up levels at 6-months were still high there was a significant drop in the levels. Johnson and colleagues (2009) noted that education alone was insufficient to maintain nurses' knowledge and skills. Hamberger and colleagues (2004) noted on-going booster sessions are necessary to reinforce self-efficacy and comfort in identifying and helping IPV victims.	+
## Recommendation 9 All nursing curricula incorporate content on woman abuse in a systematic manner. Level of Evidence: III	✓

Organization And Policy Recommendations

✓ unchanged
✎ changed
\+ additional information
NEW new recommendation

Recommendation 10 Health care organizations develop policies and procedures that support effective routine universal screening for, and initial response to, woman abuse. Level of Evidence: IIb	LOE changed IV → IIb
The following paragraph is added to the beginning of the discussion of evidence found on page 33 of the original guideline. **Discussion of Evidence** According to Haggblom, Hallberg, & Moller (2005), more effort needs to be made by health administrators to prepare point of care nurses in providing care to female abuse victims. Furthermore, health administrators need to demonstrate their "responsibility in evaluating and readdressing the implemented interventions" (Haggblom, Hallberg, & Moller, 2005, p. 241).	+
Recommendation 11 Health care organizations work with the community to improve collaboration and integration of service between sectors. Level of Evidence: Ib	✎
The recommendation above has been changed with the deletion of "at a systems level". The discussion of evidence on page 34 of the original guideline has been revised to reflect additional literature. **Discussion of Evidence** Care provided to victims of woman abuse can be greatly enhanced through interventions that are informed by these individuals and provided in collaboration with community services. Developing such an approach can increase a victim's comfort level towards disclosure, reduce fears of re-victimization by the health care system (Postmus, Severson, Berry & Yoo, 2009) and ensure that services are culturally competent (Arnette, Mascaro, Santana, Davis & Kaslow, 2007). Organizations should recognize that services viewed important by health care providers may differ from what clients value the most (Krugman et al., 2004). Victims of woman abuse are more likely to seek tangible services including shelter and financial support more so than services such as counselling and legal assistance (Postmus et al, 2009).	+

Understanding the vastness of supports and services required by victims of woman abuse speaks to the importance of collaboration among care providers. Allen, Bybee and Sullivan (2004) stress the need for advocacy that is individualized and comprehensive to optimize a victim's ability to utilize community resources. Moreover, Pollack and colleagues (2010) noted that client satisfaction was highest when Employee Assistance Program (a workplace benefit that assists employees with a variety of issues that may negatively affect job performance) professionals assisted with referrals to other services compared to those that simply provided information regarding community services. Similar findings were echoed in a multi-community study in which clients deemed domestic violence and sexual assault services to be more helpful when services were linked with other agencies (Zweig & Burt, 2007).

Implementing a systemic approach to addressing woman abuse can have a positive impact for health care providers. Healthcare providers voiced a higher level of confidence to provide service in an environment that prioritized woman abuse as an important issue as demonstrated through the implementation of policies and procedures and through the availability of training and having resources on hand for distribution (Chang, et al., 2009).

Recommendation 12

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to implementation.
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Dedication of a qualified individual to provide the support needed for the education and implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the Toolkit: Implementation of Clinical Practice Guidelines based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline Woman Abuse: Screening, Identification and Initial Response.

Level of Evidence: IV

Appendices

Only appendices that have been changed are listed below.

Appendix C: Assessment Tools for the Nurse

The following tools are in addition to the tools provided on page 60-62 of the original guideline. The panel selected the following tools to provide options for various practice setting. All the tools identified below have been validated:

Assessment Tool	Reference
Abuse Screening Inventory (ASI): Composed of 16 items concerning four types of abuse: psychological, physical, sexual, and abuse in healthcare.	Swahnberg, K., & Wijma, K. (2007). Validation of the Abuse Screening Inventory (ASI). *Scandinavian Journal of Public Health*, 35, 330-334. DOI:10.1080/14034940601040759
Humiliation, Afraid, Rape, Kick (HARK): The four HARK questions identify women experiencing IPV in the past year and may help women disclose IPV in general practice.	Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: A diagnostic accuracy study in general practice. *BMC Family Practice*, 8:49. DOI: 10.1186/1471-2296-8-49. See sample 1.
Hurt, Insulted, Threatened with harm, Screamed at (HITS): A short domestic violence screening tool for use in the community and/or family practice settings.	Sherin, K.M., Sinacore, J.M., Li, X.Q., Zitter, R.E., & Shakil, A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30*(7), 508-512. See sample 2.
Ongoing Violence Assessment Tool (OVAT): A four item instrument designed to measure ongoing IPV; used typically in emergency rooms.	Weiss, S.J., Ernst, A.A., Cham, E., & Nick, T.G. (2003). Development of a screen for ongoing intimate partner violence. *Violence and Victims, 18*(2), 131-141.
Partner Violence Screen (PVS): A short tool consisting of three questions about past physical violence and perceived personal safety.	Feldhaus, K.M., Koziol-McLain, J., Amsbury, H.L., Norton, I.M., Lowenstein, S.R., & Abbott, J.T. (1997). Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *Journal of the American Medical Association, 277*(17), 1357-1361.

Sample 1: HARK Questions

H ➔ HUMILIATION

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

A ➔ AFRAID

Within the last year, have you been afraid of your partner or ex-partner?

R ➔ RAPE

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

K ➔ KICK

Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

One point is given for every yes answer; a score of ≥ 1 is positive for IPV.

Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: A diagnostic accuracy study in general practice. *BMC Family Practice,* 8:49. DOI: 10.1186/1471-2296-8-49.

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Sample 2: Hurt, Insulted, Threatened with harm, Screamed at (HITS)

Please read each of the following activities and fill in circle that best indicates the frequency with which you partner acts in the way depicted.

How often does your partner?	Never	Rarely	Sometimes	Fairly often	Frequently
1. Physically hurt you	❍	❍	❍	❍	❍
2. Insult or talk down to you	❍	❍	❍	❍	❍
3. Threaten you with harm	❍	❍	❍	❍	❍
4. Scream or curse at you	❍	❍	❍	❍	❍
	1	2	3	4	5

Each item is scored from 1-5. Thus, scores for this inventory range from 4-20. A score of greater than 10 is considered positive.

Sherin, K.M., Sinacore, J.M., Li, X.Q., Zitter, R.E., & Shakil, A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30*(7), 508-512.

Appendix D: Framing Introductory Questions

Additional information has been added to the existing appendix on page 63 of the original guideline:

Always interview the woman alone and in private and start with a simple explanation as to why the questions are being asked.

For example:

"Because woman abuse is so common in many people's lives, I now ask all my clients about it." *May I ask you a couple of questions?*

"Many of the women I see are dealing with abuse in their relationships. Some are too afraid and uncomfortable to bring it up themselves, so I've started asking about it routinely." May I ask you a couple of questions?

If woman says "No" respect her decision.

If "*yes*" to the question above, then ask specific questions.

For example:

"Have you ever been hurt or threatened by someone?"

"Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid (or unsafe)?"

"Have you ever been emotionally, physically, or sexually abused by your partner or someone important to you?"

Specific Considerations for Young Women

"Everyone has a right to be safe and choose what happens to their body. In my practice I see many young women who are experiencing difficulties in their relationships and with their friends/boyfriends. May I ask you some questions?"

If "*yes*" to the question above, then ask specific questions.

"Sometimes people say and do things to us that can be hurtful and make us feel confused and uncomfortable. Has anyone ever made you feel that way?"

Let the response guide your next question(s).

Hints:

- You may need to define 'hurt' using age-appropriate language. Refer to Appendix L (Eight Types of Abuse).
- Avoid using words such as "bad". A young person could take the word bad as meaning that they are bad or have done something wrong.
- Avoid using leading questions; be direct and to the point; let the young woman answer the question in her own words.
- With young women, it will be necessary to proceed slowly in order to build trust.
- You may need to explain that if abuse was of a sexual nature and resulted in "feeling good", it does not make the action acceptable.

Appendix H: Safety Planning

The following has been inserted at the beginning of this appendix on page 70 of the original guideline:

Always ask what the woman needs to be safe and be willing to listen to her needs. Some key principles to remember are:

- Safety is the priority – is she and/or children in danger; what has she done so far and what does she need.
- Each woman is her own expert on her life - respect it.
- Each woman is unique – do not make assumptions about her safety.
- Offer support, information and choices - NOT ADVICE.
- Provide information on local resources like shelter and crisis/help lines.

Remember your response or lack of response could put the woman and her children at greater risk for harm.

Appendix J: Educational Resources

The following education resources have been added to the list found on page 73 of the original guideline:

Websites:

Community Legal Education Ontario
http://www.cleo.on.ca/

International Association of Forensic Nurses
http://www.iafn.org/

Inventory of Spousal Violence Risk Assessment Tools Used in Canada
http://www.justice.gc.ca/eng/pi/rs/rep-rap/2009/rr09_7/index.html

Making a Difference Canada: Communities Giving Voice to Sexual Assault Victims
http://www.makingadifferencecanada.ca/index.html

National Online Resource Centre on Violence Against Women
http://www.vawnet.org/

Ontario Network of Sexual Assault Domestic Violence Treatment Centres
http://www.sadvtreatmentcentres.net/

Ontario's Domestic Violence Action Plan
http://www.citizenship.gov.on.ca/owd/english/resources/publications/dvap/index.shtml

Ontario's Sexual Violence Action Plan
http://www.citizenship.gov.on.ca/owd/english/women/svap2011.pdf

Shelternet
http://www.shelternet.ca/splashPage.htm

World Health Organization
http://www.who.int/topics/gender_based_violence/en/

Education:

Responding to Violence in Clinical Settings
www.dveducation.ca

Recommended Reading:

Johnson, M.P. (2008). *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance and Situational Couple Violence*. New Hampshire: Northeastern University Press.

Appendix K: Teaching Scenarios

The following scenarios are in addition to those provided on page 76 of the original guideline. These scenarios and subsequent questions may provide the nurse with guidance on his/her interaction with the client and family.

1. Community setting – Healthy Babies/Healthy Children Program (Ontario)

You are the Public Health Nurse making a postpartum follow-up home visit. The baby and mother were discharged from the hospital two days ago following an uncomplicated delivery. The mother is 24 years old who has one other child – a four year old boy. You notice the house is in disarray with a broken lamp and chair in one corner along with clothes seemingly thrown around. The young child stays right by Mom's side, watching your every move. The mother appears very tired, favouring her right arm as she sits very stiffly on the sofa. The baby is sleeping beside the mother on the sofa.

During the conversation with the mother, the child states, "Daddy hits mommy". The Mom bursts into tears, looking terrified.

How would you respond to this disclosure?

What legal obligations should you consider?

What safety planning would you discuss with the mother?

2. Hospital Scenario

You are an emergency room nurse at your community hospital. A woman arrives by ambulance in obvious distress with blood on her face and head. She is being triaged when her husband arrives demanding to be let in to be with his wife. You explain that his wife is being triaged/assessed and once this is done you will come to get him. You ask that he wait in the waiting room.

He continues to loudly demand to be with his wife saying that she is always falling down and hurting herself and that she is an accident prone person. You again explain that the hospital policy is to have family remain in the waiting room until the person is initially assessed and settled into a room. Once this is done you will let him know. He goes to the waiting room issuing threats to report you and the other staff to senior management.

You inform the triage nurse of this situation with the husband. The triage nurse informs you that the wife has stated she was hit, choked and pushed down the stairs by the husband and that she does not want to see him.

Given the husband's behaviour and the woman's disclosure how would you respond?

What further screening would you do?

What safety issues must you consider for the woman and hospital staff while she is in the emergency room?

What services and information would you provide?

What safety planning should take place?

How would you provide follow up care?

3. School Scenario

You are the Public Health Nurse at a local junior high school. A 14 year old female student is brought to you by a teacher as she was found crying in the bathroom. As you get to know the student you notice several hickies around her neck. When asked about them, she hesitantly indicates that her boyfriend, the assistant coach (aged 17) of the local hockey team, did this to her on the weekend. He also placed some pictures of her on the internet today – and this is why she was crying.

How would you screen for woman abuse?

What legal obligation must you consider?

Who should you consider contacting? Do you need the student's permission to do this?

What safety planning should you consider?

Who should be providing follow up?

Appendix L: Sample Policies

The following policies are additional examples to those identified in pages 77 to 87 of the original guideline. While the content of the policies may not align completely with the recommendations of this best practice guideline, it may provide some guidance on developing policies for other organizations. Some terminology used may be specific to the organization from which the sample policy originated.

Sample Policy #1: Organization Policy

Source: Middlesex-London Health Unit, London, Ontario. Reprinted with permission.

PURPOSE
To ensure that staff in the relevant Services Areas understand their responsibility to identify and effectively respond to women who have been abused.

POLICY
Staff in the relevant Services Areas:

- Are knowledgeable about the dynamics of woman abuse, and its impact on the abused woman and her child(ren).
- Are skilled in responding effectively to disclosures of abuse
- Are knowledgeable about community resources for abused women and their children
- Will, where appropriate, routinely screen all women over the age of 12 for woman abuse using the Routine Universal Comprehensive Screening (RUCS) Protocol.

PROCEDURE
1.0 Each Services Area will, where appropriate, develop procedures for the routine screening and early identification of woman abuse.

Sample Policy #2: Hospital Policy

Source: Cornwall Community Hospital (2010). Patient Care Policies and Procedures, Cornwall, Ontario. Reprinted with permission.

PURPOSE:

To establish a process for all patients 12 and over to be screened for intimate partner violence because most victims of domestic violence who present to hospitals report that if asked, they would be prepared to discuss their history of abuse.

Early intervention is likely to increase the probability of stopping the violence before it escalates to more serious harm. The goal is to improve the care provided to victims of intimate partner violence by recognizing and referring patients to the appropriate resources.

DEFINITIONS:

Intimate Partner Violence: a behavioural pattern used by one person to gain/maintain power and control over another. This occurs in all types of intimate partner relationships including common-law and same sex. It may or may not include physical abuse. Abuse can include other forms of mistreatment and cruelty such as constant threatening, psychological, emotional, and verbal abuse.

Routine Universal Screening: Routine refers to the frequency with which screening is carried out. Routine screening is performed on a regular basis regardless of whether or not signs of abuse are present. Universal refers to the characteristics of the group to be screened and occurs when nurses ask everyone over a specific age about experiences of abuse.

POLICY:

1) All patients who are 12 years old or older will be asked about intimate partner violence with each visit to the hospital. Staff will use the Routine Universal Screening Assessment Tool (appendix D)[1] to guide the process.

2) Routine Universal Screening (RUS) will be done by trained health care professionals who have completed the mandatory in-service on RUS. This education will include:

    a) the dynamics of partner abuse
    b) impact of abuse on men, women and children
    c) effective responses to disclosure
    d) how to refer to the Assault and Sexual Abuse Program (ASAP)
    e) information about community resources
    f) how to convey the prevalence of abuse, potential health impact to a patient
    g) how to document on the health record
    h) where to locate the emergency telephone numbers

3) Prior to the screening, the health professional must advise the patient that if there are children, the Children's Aid Society (CAS) will be notified.

4) RUS by the health care professional will be done:

    a) When the patient's condition is stable
    b) By asking questions face-to-face to ensure privacy (patients are not given forms to fill in)
    c) Considering the immediate safety of the patient before, during, and after the assessment
    d) When the patient is alone (not in the presence of others, including children over the age of 3 years)
    e) Only by a trained cultural interpreter, if there is a language barrier

5) If the patient discloses and answers yes to the screening question(s):

    a) Offer a referral to ASAP
    b) Leave a message for ASAP that referral was initiated

[1] Appendix D is not included

c) If patient declines referral, offer the emergency telephone numbers card
d) f the patient is under 16 years of age, the health professional has the legal obligation to report the disclosure verbally to the CAS [see discussion of evidence for recommendation#7 for more information].

PROCEDURE:
The health professional doing the assessment will:

1. Complete the screening process as outlined in the mandatory training.

2. Complete the Self Learning Package on an annual basis.

3. Ensure the health record reflects:

   a) The question was asked
   b) The patient's response
   c) Any actions, including referrals made

Sample Policy #3: Department Unit Policy

Source: Middlesex-London Health Unit, London, Ontario. Reprinted with permission.

PURPOSE

To ensure that all female clients, 12 and over, are made aware of the various forms of abuse, and potential health effects of abuse during any assessment in The Clinic.

POLICY

- Staff members and other health professionals are aware of the various types of abuse to which women can be subjected.
- Staff members and other health professionals are knowledgeable about health effects of woman abuse.
- Staff members and health professionals utilize the above knowledge during health assessments of female clients, 12 years of age and over.

PROCEDURES

1.0 Guiding Principles for Screening Women

1.1 Through attitude and approachable demeanor, staff and other health professionals treat the client with respect, dignity, and compassion, being sensitive to differences in age, culture, language, ethnicity, and sexual orientation.

1.2 Through words, actions, and facial expressions, staff and other health professionals project a non-threatening, non-judgmental atmosphere, so that the client feels cared for and supported. Moreover, staff members should avoid criticism of the abuser.

1.3 Staff and other health professionals demonstrate belief in the woman's account of her experience.

1.4 As appropriate, staff and other health professionals consistently reinforce to women clients that:

a) abuse is not the fault of the woman but rather the responsibility of the abuser
b) no one has the right to use abuse on another person,
c) physical and sexual abuse are criminal offences in Canada.

1.5 Staff and other health professionals inform the client about the policies and procedures used in The Clinic to protect confidentiality and can clearly outline those instances where this pledge of confidentiality would be exempt.

1.6 Staff and other health professionals document in a clear and concise fashion.

1.7 Staff and other health professionals provide education to the client about the serious health effects of continued abuse and information about community services and resources.

1.8 Staff and other health professionals demonstrate respect for the client's right to make her own decisions and recognize that the woman must be allowed to deal with the identified abuse at her own pace and in her own terms through her own decisions.

2.0 Application of the RUCS[2] Protocol in the Clinic for Public Health Nurses

2.1 Any female, 12 years of age and over, who presents at The Clinic for health services will be assessed using the screening question in the RUCS protocol (F1). These health services would include attendance at any of the regularly scheduled Clinics and/or other services provided on a drop-in basis, such as ECP. Clients who visit to purchase contraception will not be assessed unless there are reasonable grounds to suspect abuse.

2.2 During the intake assessment of a female client, 12 and over, the PHN[3] asks if the individual has experienced any form of abuse within the last year or at any time in her life. Prior to this assessment, the PHN must ensure that the client fully understands the legal obligation to report suspected abuse of any person under the age of 16 to the CAS and explains the procedure for reporting, should there be a disclosure (see policy A-300) [see discussion of evidence for recommendation#7 for more information].

[2] See sample policy #5

[3] PHN refers to the public health nurse

2.3 If no disclosure of abuse is made and the PHN does not observe any indicators of actual/potential abuse, the PHN documents the client's response on the initial health assessment form in the appropriate RUCS box.

2.4 If a woman does not report abuse, but demonstrates certain behaviors or actions that might lead the PHN to suspect abuse, the PHN will document the client's response on the initial health assessment form in the appropriate RUCS box. The RUCS Assessment Protocol form will then be used to document all relevant aspects of the abuse and any interventions taken.

2.5 If a female, 12 years of age and over, discloses actual/potential abuse, the PHN will document the client's response on the initial health assessment form in the appropriate RUCS box. The PHN will then use the RUCS Assessment Protocol form to document all relevant aspects of the abuse and any interventions taken.

2.6 If abuse of a female client under the age of 12 is disclosed, the PHN has a legal obligation to report this disclosure verbally to the Children's Aid Society (CAS) immediately. See Policy A-300 "Detection and Follow-up of Individuals Potentially Being Abused".

3.0 Application of the RUCS Protocol for Clinical Assistants

3.1 If a female, 12 years of age and over, discloses abuse to a clinical assistant or the clinical assistant has reasonable grounds to suspect abuse, that assistant should first ensure that the client is comfortable and safe.

3.2 The clinical assistant reports her concerns to either the physician or a PHN immediately.

3.3 The clinical assistant records her observations and actions in the progress notes.

3.4 If abuse of a female client under the age of 12 is disclosed to the clinical assistant, that clinical assistant has a legal obligation to report this disclosure verbally to the Children's Aid Society (CAS) immediately under the guidance of a PHN.

4.0 Application of the RUCS Protocol for Other Health Professionals

4.1 Physician or other health professional should first check the client record for any disclosures prior to commencing a physical examination. A client who has experienced abuse is more likely to react negatively to a pelvic exam.

4.2 If a client has already disclosed abuse, the physician should be particularly attentive to any signs of abuse that might not have been visible to the PHN. A body map should be used to record any relevant physical signs of abuse. The physician will then document any additional information acquired during the examination as well as any interventions taken.

4.3 The physician should report his/her findings to a PHN. The physician and the PHN will collaborate with the client to formulate a safety plan and initiate community referrals.

5.0 Training of new staff

5.1 New staff of any profession will be trained in the RUCS protocol during orientation.

Sample Policy #4: Department Unit Policy

Source: Middlesex-London Health Unit, London, Ontario. Reprinted with permission.

PURPOSE

To retain a permanent paper record of all RUCS interviews following a disclosure. This RUCS form will become part of the client record.

PROCESS

1. Write the client record number and indicate clinic attended at the top of the form.

2. Record the information solicited from the client after a disclosure has been made. Documentation can continue on the back of the form as needed.

3. Indicate intervention provided including arrangements for client follow-up as applicable in section 2 of form.

4. In cases of recent sexual assault or violence, ensure completion of Section 3, documenting details of the situation and PHN intervention. Documentation can continue on the back of the form as needed.

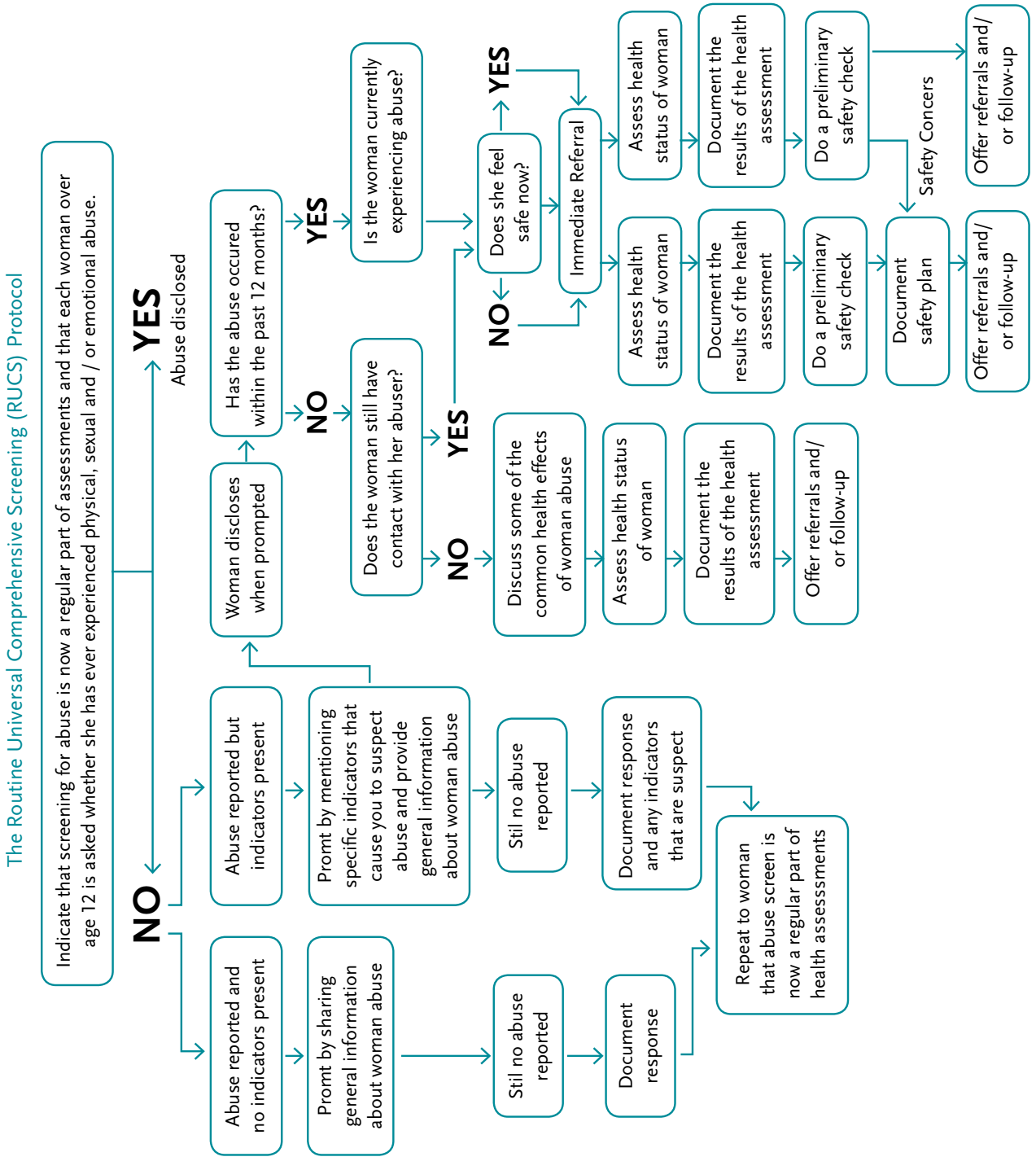
5. In cases where the client does not disclose abuse, but indicators are present, the PHN should discuss the indicators causing the suspicion of abuse and record in Section 4 of form.

6.The RUCS form shall remain in the client chart. For statistical purposes, cases of abuse shall be tracked on the "RUCS Tracking Form" kept in each PHN office. RUCS Tracking Forms will be collected, and statistical data entry completed by the CTA on a quarterly basis.

7. For more detail see Section 7-30 Women Abuse-Guiding Principles and Implementation of RUCS Protocol.

Sample Policy #5: The Routine Universal Comprehensive Screening (RUCS) Protocol

Source: Middlesex-London Health Unit, London, Ontario. Reprinted with Permission.



The following two appendices are NEW:

Appendix M: Responding to Disclosure

The following two scenarios represent situations that could be found in mental health nursing. The questions proposed are to act as guides during the course of the interaction and may need rephrasing (open-ended vs. closed-ended) according to the situation, the clinical setting, and/or the scope of practice of the health care provider.

When responding to a disclosure of woman abuse/IPV, keep the following tips in mind:

Always interview in private
Believe the client
Assess for safety
Offer support
Ask permission to refer to another resource person

Scenario #1:

Elizabeth, a 23 year old woman is brought to the Emergency Psychiatric Services after neighbours who were concerned about her safety called police. Neighbours report that Elizabeth appeared to be repeatedly walking out in front of traffic. Elizabeth is angry and insists that others are not keeping her safe. The nurse determines from her old case file that Elizabeth has a history of sexual, physical and emotional abuse. The nurse also notes that Elizabeth has scars on both arms and fresh cuts on both arms. Elizabeth discloses to the nurse that she remembers something bad that happened in her past.

Response:

- Always interview in private:
  - *"Let's go into the interview room or the office to talk about this"*
- Believe the client:
  - *"Would you like to talk with me about what you are feeling?"*
  - *"Did something happen to you before that you are remembering now?"*
  - *"Do you recall what happened to you in your past? Yes/No…" It's OK if you don't remember, that happens sometimes"*
  - *"I notice you have cuts on your arms, do you want to talk to me about that?"*
- Assess for safety: (never assume that a past history of abuse precludes a present history as well)
  - *"Elizabeth, you say 'others are not keeping you safe', do you feel safe now?"*
  - *"Did something happen to make you feel unsafe?"*
- Offer support:
  - *"Are you receiving any support in the community for these feelings?"*
  - *"What other supports do you need/require?"*
- Ask permission to refer to another resource person:
  - *"Can I refer you to someone who can help you with your feelings?"*

Scenario #2:

A nurse is completing an assessment on a woman with a diagnosis of Schizophrenia, Paranoid Type who is being admitted to a mental health facility. The patient is wringing her hands and looks distressed. The patient frequently stares intently at the nurse but does not seem interested in conversing. The nurse finds it challenging to engage the patient. After several hours, the patient comes up to the nurse and tells her that she was assaulted in her apartment last night and she wants to call the police.

Response:

- Always interview in private:
  - *"Let's go into the interview room or the office to talk about this"*
- Believe the client:
  - *"That must have been a terrifying experience for you, thank-you for sharing this with me" or "Your experience must have been very frightening"*
  - *"It is not easy to talk about this type of thing."*
  - *"It is not unusual to feel angry, embarrassed and fearful afterward"*
  - *"How can I help you now?"*
  - *"Are you experiencing any pain?"*
  - *"Would you like me to sit and talk with you?"*
- Assess for safety:
  - *"What needs to happen to help you feel safe?"*
- Offer support:
  - *"Would you like some support when speaking with the police?" If yes, then:*
- Ask permission to refer to another resource person:
  - *"Can I refer you to someone who can support you when speaking with the police?"*

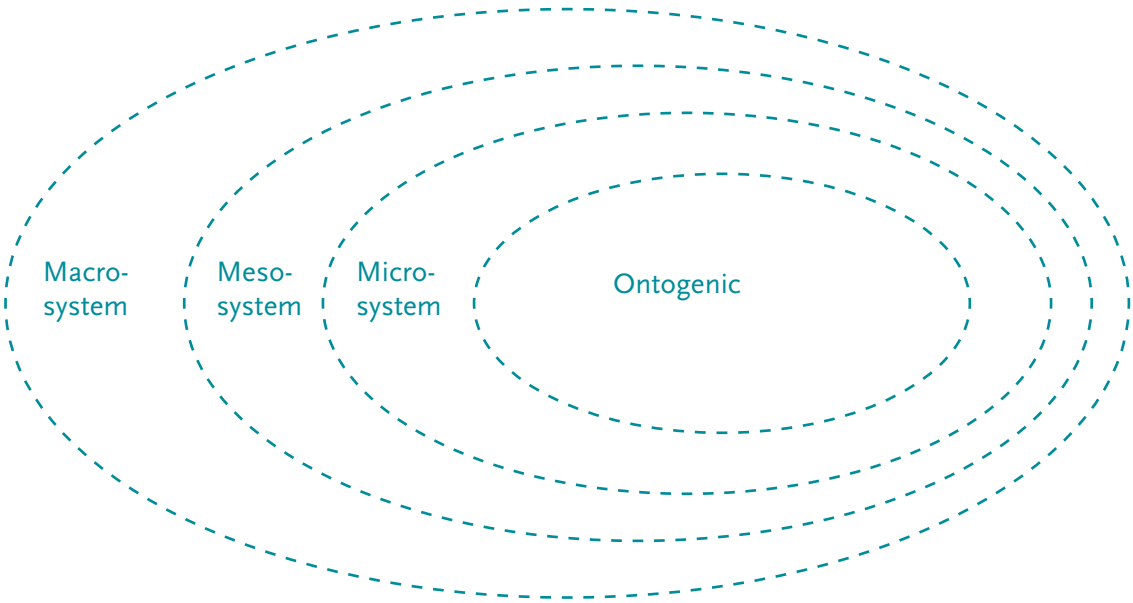
Appendix N: Ecological Framework

The following appendix introduces a framework that offers a novel approach to understanding family violence.

By far the most comprehensive approach to understanding and addressing family violence in both local and international contexts is the ecosystemic/ecological framework (Guruge, Tiwari & Lucea, 2010). The ecological/ecosystemic approach was first used to help organize various research findings on the etiology of child abuse (Belsky, 1980), but since has been applied to woman abuse (Carlson, 1984; Dutton, 1988; Edleson & Tolman, 1992). Belsky's ecological framework draws on Tiorbergen's (1951) idea of ontogenic development as well as on Bronfenbrenner's (1977, 1979) idea of the ecological framework of human development. Bronfenbrenner (1977, 1979) hypothesized that in order to understand human behaviour, one needs to move beyond the immediate situation of the individual to consider the environment within which the individual is situated. Garbarino (1977) and Belsky (1980) viewed a person's environment as a series of settings/systems, each nested within the next broader setting/system in the following order: from the micro-environment of the family to the meso/exo-environment of the immediate social network, to the macro-environment of the society-at-large.

Loue and Faust (1998) proposed a framework to understand woman abuse that consists of the following four levels: (a) ontogenic (the individual history of the partners), (b) micro-system (the family setting in which the abuse occurs), (c) meso-system (the social networks in which the family participates), and (d) macro-system (the culture and society-at-large). People and their environments are understood in the context of their continuous and reciprocal relationships (Guruge, Khanlou, & Gastaldo, 2010).

Figure 1. Depiction of an Ecosystemic Framework (Based on Guruge, 2007; Heise, 1998)



Individual or ontogenic factors refer to "those features of an individual's developmental experience or personality that shape his or her response to micro-system and [meso]exo-system stressors" (Heise, 1998, p. 267). Examples of individual factors include: witnessing domestic violence as a child and experiencing abuse as a child, mental illness, and substance use/abuse.

The micro-system refers to "those interactions in which a person directly engages with others as well as to the subjective meanings assigned to those interactions" (Heise, 1998, p. 269). Some of the micro-systemic factors highlighted in the literature include male authority and dominance in the family, male control of wealth in the family, marital conflict, stress, and use of alcohol (Guruge, 2007).

The meso-system includes people and structures that have an immediate influence on the family to determine what occurs at home (Belsky, 1980). This system includes the neighbourhood, schools, workplace, both informal and formal social networks, and identity groups in one's own community (Guruge, 2007). One of the key meso-systemic factors is social support or lack thereof (both as a contributing factor and a by-product) (Guruge, 2007).

The macro-system refers to "the broad set of cultural values and beliefs that permeate and inform the other three layers of the social ecology" (Heise, 1998, p.273). Examples of macro-systemic factors include: (a) the society's identification of masculinity with dominance, toughness, and honour; (b) rigid gender roles; (c) a sense of male entitlement, authority, and ownership over women; (c) religious approval of physical chastisement of women; and (d) a cultural ethos that condones violence as a means of settling interpersonal disputes (Brownridge & Halli, 2002; Heise, 1998).

"An understanding of the interconnectedness of the factors operating at various levels allows us to view how any given situation is largely determined by factors beyond the individual level" (Guruge, 2007, p. 68). It helps to move the analysis beyond the individual or the micro-level to the macro-level to explore the complex historical, socioeconomic, and political nexus within which individual experience is embedded (Guruge & Khanlou, 2004). Although there appears to be room for interpretation and debate as to exactly where a particular factor might fit within the framework, more important than the location of any single factor is the dynamic interplay between factors operating at multiple levels (Guruge, 2007). "Unbalanced power relations imbedded in private and public spaces contribute to woman abuse at home and limit women's choices and responses to abuse" (Guruge, 2007, p.69).

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