RNAO submission re Bill S-249 to the Standing Senate Committee on Social Affairs, Science and Technology

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500-4211 Yonge St., Toronto, ON M2P 2A9 ■ Tel. 416-599-1925 ■ Toll-free 1-800-268-7199 ■ Fax 416-599-1926 ■

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The Registered Nurses' Association of Ontario (RNAO) represents more than 51,650 registered nurses (RN), nurse practitioners (NP) and nursing students across Ontario. For nearly a century, the association has advocated for changes that improve people's health through the full expertise of nurses.

Introduction

RNAO applauds Senator Manning for initiating Bill S-249 and the Senate, as a whole, for ensuring that the bill reached Committee for consideration. We are grateful for the chance to share our views on the Bill through the lens of our expertise on the subject of intimate partner violence (IPV).

RNAO's formal engagement with IPV dates back more than twenty years, when we first developed an evidence-based practice guideline on woman abuse, guided by a multidisciplinary panel of health professionals. The guideline was updated in 2012, and we are now working on the next edition to be issued in 2025.

RNAO supports the bill in principle. We welcome the attention of Parliament and look forward to the development of a national strategy to prevent IPV. The matter is urgent and we must begin, now, with what we already know. Any delay comes at the cost of serious harm, including loss of life.

Summary of recommendations

RNAO offers eight recommendations for the Committee's consideration. The first five recommendations propose amendments to the language used in Bill S-249. Three additional recommendations propose some immediate steps available to the federal government to prevent IPV and for inclusion in a national strategy.

Recommendation 1: Amend to reference all nurses, including and not limited to nurse practitioners.

Recommendation 2: Establish principles to inform the consultation process and strategy development.

Recommendation 3: Expand the consultation requirements to specifically include Indigenous peoples.

Recommendation 4: Expand the consultation requirements to include other equity-deserving communities particularly vulnerable to IPV: 2SLBGTQI+ people, women with disabilities, and women from visible, cultural and linguistic minority groups.

Recommendation 5: Expand the consultation requirements to specifically include the health system.

Recommendation 6: Immediately develop and support the implementation of a national standard for universal screening.

Recommendation 7: Immediately develop and support the implementation of a national standard for integration of primary care and social services, including the implementation of system navigators within the health system.

Recommendation 8: Provide a dedicated federal transfer, with reportable deliverables, to support public health programming that supports IPV prevention, disclosure and/or and intervention.

Background

The World Health Organization defines "Intimate partner violence" (IPV) as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" by both current and former spouses and partners[1]. IPV is largely hidden from view in part because it manifests in forms other than just physical and sexual abuse, including psychological and financial abuse that are not perpetrated through physical contact and are therefore less visible. Even physical and sexual abuse often goes unreported for reasons including fear, shame, lack of trust in the criminal justice system, lack of hope for a way out and the threat of greater harm[2]. While more than 11 million Canadians – 6.2 million women and 4.9 million men – self-reported as having experienced IPV in 2018[3], there were only 107,810 cases of IPV reported to the police in 2019[4].

Any legislation targeting IPV should take into account the following evidence:

1. Its prevalence varies across different age, gender, disability status, ethnicity and culture populations. For example:
    - Young women aged 15 to 24 years were five times more likely than women aged 25 years and older to have been sexually assaulted, three times more likely to have been physically assaulted, and more likely to have been emotionally, financially or psychologically abused by an intimate partner[5, 6].
    - 67 per cent of "sexual minority" women in Canada reported experiencing at least one type of IPV, compared to 44 per cent of heterosexual women[5, 7].
    - More than six in 10 Indigenous women have experienced some form of IPV in their lifetime, compared with four in 10 non-Indigenous women in Canada[8]. There were 497 known victims of intimate partner homicide between 2014 and 2019, 80 per cent of which were women[4]. And, while Indigenous women account for only about five per cent of all women in Canada, they accounted for 21 per cent of all women killed by an intimate partner[5].
    - More than half (55 per cent) of women with disabilities reported experiencing some form of IPV in their lifetime, compared to 37 per cent of women without disabilities[5, 9].
    - Higher IPV prevalence is observed among certain groups designated as "visible minorities" when compared to the total "visible minority population"[5,10]. For example, Arab, Black and Latin American women were more likely to have experienced IPV in higher rates (consistent with the "non-visible minority population") than Chinese and Filipino women[5, 10].

2. IPV victims were more likely to be economic disadvantaged and receive social assistance as compared to those without IPV exposure[11,12]. In a vicious cycle, the economical disadvantage further exacerbates victims' financial dependence on the perpetrator, making them in turn more susceptible to IPV. Indeed, one in five women leaving a "residential facility" – that is, safe shelter designated for victims of IPV – had to return to live with their abuser[13]. This has been attributed to factors including housing unaffordability, inability to support themselves and/or their children financially, lack of social family and/ or and other social supports[14].

3. The incidence of IPV rose dramatically during the pandemic due to the emotional and economic stresses of the pandemic, restricted access to services and alternative housing and other public health measures, including isolation[15]. Police-reported cases of IPV (aged 12 years and older)

reached up to 117,093 in 2022, an increase of 9,283 cases over pre-pandemic levels[5,16]. It is too early to determine the longer-term implications of the pandemic for IPV.

4. IPV has both profound health and economic impacts, including:
   - **Physical health impact on victims:** IPV causes varying degrees of physical harm to its victims, from physical symptoms and "minor" injuries (such as bruises and abrasions) to more serious injuries and even death[17,18]. Sexual abuse increases the risk of gynaecological disorders such as infertility, pelvic inflammatory disease, pregnancy complications and miscarriage – or sexually transmitted diseases that can affect women's ongoing sexual and reproductive health[17]. In addition, IPV can lead to longer-term chronic diseases, including chronic pain, disability, fibromyalgia, gastrointestinal disorders, and cardiac disease[18].
   - **Mental health impact on victims**. IPV damages victims' self-esteem and confidence and increases their sense of insecurity; it is associated with depression, anxiety disorders (especially PTSD) and panic disorder, sleep disorders, phobias, psychosomatic disorders, eating disorders, substance dependence, self-harm and suicidal behaviour[17,18]. IPV exposure is also linked to health risk behaviours including substance abuse, smoking, unsafe sexual behaviour and physical inactivity[17].
   - **Impact on children's health.** Effects of witnessing IPV on children's physical and mental health are as detrimental as being direct victims of IPV. Canadian children were present during almost 40 per cent of wife assault cases[19], and "mother being treated violently" has been recognized as one type of adverse childhood experiences (ACE)[20] associated with a set of psychological, social, emotional, behavioral and physical problems in the life-course trajectories of children and youth. Negative impacts include: mental health issues (e.g., eating disorders, substance abuse, anxiety, depression, suicide attempts) and some long-term physical problems (e.g. cardiovascular disease, diabetes, lung diseases, liver diseases, cancer)[20]. Moreover, children who witness IPV are more likely to become either victims or perpetrators in future intimate relationships as adults, resulting in an intergenerational cycle of violence[21].
   - **Economic impact.** IPV has significant economic impacts on individuals, the health-care system and society as a whole. Research shows that women with a history of IPV have more frequent periods of unemployment, lower personal incomes, greater job turnover, and more physical and mental health problems that affect job performance; they were more likely to receive public assistance benefits than women who had not experienced IPV[11,12]. Moreover, the economic costs related to IPV are staggering and place a tremendous burden on society, both with respect to lost productivity and increased demands on the health care system and social services. There is increased utilization of health care services in the immediate and long-term aftermath of IPV[11]. Women who have experienced physical or sexual assault have a greater number of surgeries, visits to health providers, hospital stays, and mental health consultations than those who have not been similarly victimized[22]. An estimated $7.4 billion was lost to society because of IPV incidents that occurred in 2009, in which victim costs (e.g. pain and suffering and loss of life) accounted for the largest portion (80.7 per cent), and third-party costs such as social service operational costs for preventing and responding to IPV accounted for 12 per cent[23].

Recommendations specific to language used in the Bill

RNAO recommends the following amendments to Bill S-249:

Recommendation 1: Amend to reference all nurses, including and not limited to nurse practitioners.

Amend section 2 to replace “nurse practitioner” with “nurse”. The term “nurse” should be defined as “a nurse of any classification, registered and entitled to practice under the laws of the province”. Make any consequential amendments, including section 3(2)(c).

Rationale: Nursing is the largest regulated health profession in Canada, representing nearly half of the total health work force. Nurses work in all settings and sectors across the health care system, are often the first point of contact for health services, and are sometimes the only health professional that an individual will see. Restricting the bill’s language to “nurse practitioners” drastically limits opportunities and strategies in the health system for addressing and preventing IPV:

- The distribution of nurses in Canada varies by license type across jurisdictions[24]. Some jurisdictions have as few as 300 NPs[25].
- The specialized nature of NP work means that nurses within other classifications – for example, RNs, registered practical nurses, licensed psychiatric nurses etc. – are far more likely to have initial contact with a given patient, meaning more opportunities for IPV screening and disclosure[24].

Further, RNAO believes that nurses, in particular, are central to IPV prevention and intervention in all health settings, because:

- Nurses are frequently the first member of the health team to interface with patients experiencing IPV[11]. They are a common point of contact with clients during times of stress and illness, as well as during developmental transitions such as adolescence, pregnancy, parenthood and life-long trajectories[11].
- Survey data shows that nursing is one of the most respected occupations in Canada[26] – the trustworthiness of nurses and nursing is an intangible asset in building the trusting relationships essential to facilitating disclosure and impacting outcomes[11, 27].
- Nurses are accessible and work in all settings and sectors across the health-care system[11]. And, their specific knowledge and skill sets are valuable assets in screening, recognizing and addressing IPV.
- Nurses do not impose potentially intimidating relationships of coercion and control. They rely instead on holistic health promotion frameworks which incorporate empowerment and advocacy strategies, which research suggests is especially important when intervening with abused women[11].

Recommendation 2: Establish principles to inform the consultation process and strategy development.

Amend section 3(1) of the bill to add a set of core principles to guide the development of the national strategy and the consultation process that informs it. These principles should include requirements to:

- build upon what has come before,
- focus on both primary and secondary prevention,
- follow the evidence, and
- recognize cultural diversity and the need for cultural safety.

Rationale:

1. *Building on what has come before*

The development of a national strategy on IPV ought not to be considered a wholly new undertaking. Commitments related to IPV have already been made to Indigenous peoples and incorporated into legislation. According to the preamble of the United Nations Declaration on the Rights of Indigenous Peoples Act, implementation must include "concrete measures to address injustices, combat prejudice and eliminate **all forms of violence**, racism and discrimination, including systemic racism and discrimination, against Indigenous peoples and Indigenous elders, youth, children, women, men, persons with disabilities and gender-diverse persons and two-spirit persons [emphasis added][28]".

As a consequence, the action plan in Bill S-249 is explicitly "informed by, builds upon and should be read in harmony with" recommendations made by the National Inquiry into Missing and Murdered Indigenous Women and Girls, the Truth and Reconciliation Commission and the Royal Commission on Aboriginal Peoples[28]. It sets out the federal government's specific commitments to end violence against Indigenous women, girls and gender-diverse people. Those commitments will have implications for the proposed national strategy.

It is also important that this bill account for the many provincial-level inquests into acts of IPV. Recommendations resulting from these inquests – as well as any provincial legislation or regulation based on these recommendations – must be fully considered when developing a national strategy. Specifically, the 86 recommendations flowing from the Ontario Coroner's Inquest into the deaths of Carol Culleton, Anastasia Kuzyk and Nathalie Warmerdam are an invaluable precedent for any national strategy to prevent IPV[29].

2. *Focusing on primary and secondary prevention*

Primary prevention includes targeted and broader strategies intended to avoid IPV altogether, such as:

- preventative education, and
- eliminating and/or mitigating the social and economic circumstances predictive of IPV, such as poverty, financial dependence and core housing need.

Adopting primary prevention as an approach broadens the consultation process to include the whole of government, with consequential implications for the language in s.3(2) of the bill.

Secondary prevention focuses on early detection for the purpose of avoiding a next incident in the cycle of violence and/or greater harms. Secondary prevention includes:

- activities such as screening, and
- preventative actions such as therapies, counselling and/or appropriate referrals to assist with exit strategies.

Secondary prevention points to particular sites of intervention such as health settings, social services, legal aid services and the justice system, with implications for the language in s.3(2) of the bill.

3. *Following the evidence*

A large body of research across several sectors informs the understanding of IPV and identifies likely circumstances, perpetrators and victims of IPV. The principles of prevention demand that we urgently

develop strategies to address the predominant causes and most prevalent forms of IPV, with an understanding of the communities most vulnerable to IPV.

4. *Recognizing cultural diversity and the need for cultural safety in consultation and strategy development*

Owing to historical and ongoing colonialism and systemic racism, discrimination and prejudice, many people living in Canada experience or perceive the health, justice and social services systems as sites or perpetrators of violence. These views and experiences are – shamefully and understandably – prevalent within many diverse communities particularly vulnerable to IPV. Both the consultation process and the development of strategy must recognize and accommodate the diversity of experience of people in Canada with the state institutions/organizations intended to govern or support them. Any national strategy must also ensure culturally-safe avenues for preventing and responding to IPV.

Recommendation 3: Expand the consultation requirements to specifically include Indigenous peoples.

Amend section 3(2) to include Indigenous peoples.

Rationale: As discussed above under Recommendation 2, the United Nations Declaration on the Rights of Indigenous Peoples Act affirms Canada's recognition of the rights of Indigenous peoples, including the right to self-determination and self-government. It further commits Canada to taking effective measures these objectives – which includes ending violence against Indigenous peoples – in consultation and cooperation with Indigenous communities. Further, article 22(2) of the Declaration commits Canada to taking measures together with Indigenous peoples "to ensure that Indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination[28]."

Recommendation 4: Expand the consultation requirements to include other equity-deserving communities particularly vulnerable to IPV: 2SLBGTQI+ people, women with disabilities, and women from visible, cultural and linguistic minority groups.

Amend section 3(2) to include, at a minimum, 2SLBGTQI+ people, women with disabilities, and women from visible, cultural and linguistic minority groups.

Rationale: The evidence demonstrates that the prevalence of IPV is not evenly distributed across the population, as discussed above. For example:

- 2SLBGTQI+ people are particularly vulnerable to IPV - they are more likely to face family and social isolation, and with less financial, social and emotional support[30]. Further, the lack of safe and inclusive space in health and social service settings discourages reporting and adds to a sense of social isolation[30].
- Women with disabilities may have an increased reliance on an intimate partner and an increased risk of isolation, which increases their vulnerability to IPV[9].
- Visible minority women, especially immigrants, face specific barriers in reporting IPV and accessing services, such as discrimination and racism, social and cultural isolation, language barriers and lack of culturally sensitive services[10].

Recommendation 5: Expand the consultation requirements to specifically include the health system.

Amend section 3(2) to include representatives of provincial governments who are responsible for health. Also, section 3(2)(b) re partnerships requires inclusion of health perspectives re functionality of partnerships.

Rationale: The gap between self-reported and reported rates of IPV clearly suggests the need for greater and safer opportunity for disclosure. Given that IPV manifests in the form of physical injury or mental health issues for both victims and children of victims, RNAO proposes that health settings present ideal sites for both primary and secondary prevention strategies. For example, RNAO's best practice guideline, *Woman Abuse: Screening, Identification and Initial Response*, was created to facilitate routine universal screening for woman abuse by nurses in all practice settings.

Recommendations based on what we already know

In light of what we know about IPV and the urgency with which we need to respond, RNAO recommends the following:

Recommendation 6: Immediately develop and support implementation of a national standard for universal screening.

Rationale: The high prevalence of IPV in Canada justifies implementing universal screening in all health settings across the country. When performed in culturally-safe ways, universal screening can be used as both primary and secondary measures allowing for immediate interventions, including referrals to any available and appropriate services and supports[11].

RNAO proposes that a national standard for universal screening be developed using an evidence-based guideline such as RNAO's *Woman Abuse: Screening, Identification and Initial Response* best practice guideline. Indeed, this guideline informed a ground-breaking IPV universal screening program established by Toronto's St. Michael's Hospital in 2010[31]. Intended outcomes: increased opportunities for disclosure, which in turn promotes health, wellbeing, and safety for women.

This would greatly help, nurses, physicians and other frontline health-care providers and would facilitate disclosure and education at the time of patient encounters[11,32].

Recommendation 7: Immediately develop and support a national standard for integration of primary care and social services, including the implementation of system navigators within the health system.

Rationale: Effective universal screening in health settings implies navigation to a range of culturally safe services and supports both inside and outside the health system. These include legal services, counselling programs, economic supports, safe shelters, affordable and accessible housing, sexual assault centres and child care[33]. Effective system navigation from within the health system is needed to ensuring that individuals receive access to the right services in a timely way[34].

Recommendation 8: Provide a dedicated federal transfer – with reportable deliverables – to support public health programming that supports IPV prevention, disclosure and/or intervention.

Rationale: IPV was recently described as a "major public health problem" by the World Health Organization (WHO)[35] because of its prevalence and its profound health and social impacts. Public health can play an important role in IPV prevention and intervention. For example, pregnancy and post-partum periods are crucial transitional times when women are more vulnerable to IPV – postpartum is associated with increased IPV incidence[36], and IPV during pregnancy has significant detrimental health consequences for women and children[37].

We need well-resourced programs to capture and address instances of IPV during these vulnerable periods for women and persons experiencing pregnancy and childbirth. One example: Public Health

Ontario's Healthy Babies Healthy Children is a program that provides universal screening for health risks, including IPV, with targeted assessments and interventions for families and children from the prenatal period until their transition to school[38]. Research shows that this program has been effective in identifying vulnerable clients (including IPV victims) and improving health outcomes (including a reduction in IPV) through home visitations[38, 39]. However, the effectiveness of the program has been hampered by insufficient funding[38].

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