NETWORK TO ELIMINATE VIOLENCE IN RELATIONSHIPS

MARCH 2024

VIOLENCE SCREENING TOOLKIT

For providers in primary health care settings in B.C. and beyond

TABLE OF CONTENTS

INTRODUCTION TO VIOLENCE

WHAT IS GENDER-BASED VIOLENCE?

The **Inter-Agency Standing Committee** defined gender-based violence in **2015** as **"an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty." Relationship violence which includes domestic violence and intimate partner violence (IPV),** and is a broader term than gender-based violence is defined as: **"any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone who has a bond or relationship with the offender"** (Gurm et al, 2020). The experiences of such violence can oftentimes be very similar for men and women. For example, technology-facilitated sexual violence (TFSV) has shown that women's and men's experiences are similar for most types of TFSV, with similar negative impacts felt – which calls for the need for increased support for all victims of sexual violence (Champion et al, 2022).

Gurm et al (2020) note the following **broad areas in which violence can be classified:**

1. Physical: Physical abuse, including assault, is the intentional use of force against a person without that person's consent. It can cause physical pain or injury that may last a long time.

2. Emotional: Emotional abuse happens when a person uses words or actions to control, frighten or isolate someone or take away their self-respect.

3. Financial: Financial abuse happens when someone uses money or property to control or exploit someone else.

4. Sexual: Sexual abuse of an adult can include sexual touching or sexual activity without consent, continued sexual contact when asked to stop, and forcing someone to commit unsafe or humiliating sexual acts.

5. Spiritual abuse: Spiritual abuse is acting against the spiritual self-determination and the will of the persons concerned, involving violence and coercion and taking advantage of positions of power and authority.

6. Negative Social Control: The concept of negative social control covers systematic attempts to enforce norms – including in the family – that restrict individual freedom and rights under the law and the UN Convention on the Rights of the Child.

7. Neglect: Neglect happens when a family member, who must care for you, fails to provide you with your basic needs.

8. Cyberbullying: Cyberbullying is the use of computers, smartphones or other connected devices to embarrass, hurt, mock, threaten or be mean to someone online.

9. Harassment: Harassment is a form of discrimination – it includes any unwanted physical or verbal behaviour that offends or humiliates someone. Sexual harassment is any unwanted comment, gesture, or action that is sexual in nature (aside from unwanted touching of sexual body parts, which is sexual assault), that makes someone feel afraid, embarrassed, uncomfortable or ashamed.

INTRODUCTION TO VIOLENCE

Although violence can affect all people, certain populations in Canada are at more risk of experiencing gender-based violence: women and girls, specifically young women and girls, Indigenous women and girls, women living in Northern, remote and rural communities, newcomer women to Canada, women with varying abilities, gender & sexual minority (GSM) communities as well as immigrant and refugee women.

For the purpose of this toolkit, the interpretation of the word **consent** as given in the above definitions relates to **the interactions between relationships of trust, power and authority and how this affects the creation of voluntary consent** (Benedet & Grant, 2014).

HOW COMMON IS IT?

The two most common and prevalent forms of **violence that women experience are intimate partner violence (IPV) and non-partner sexual violence (NPSV).**

- **Almost one out of every three women across the world (30% of the global population of women) have experienced either one or both of these kinds of violence** at least once in their lifetimes (The World Bank Gender Data Portal, 2022).
- **In 2022, approximately 48, 800 women and girls globally were killed** by either their intimate partners or family members. That means, more than five women or girls are killed every hour by someone they consider family (United Nations Office on Drugs and Crime and UN Women, 2023, unpaginated).
- **Gender-based violence is also a common reproductive health problem** in developing countries. It is still the number one research priority in Africa identified by the World Health Organization (Mingude & Djene, 2020).
- **In Canada, in 2022, 184 women and girls were violently murdered** mostly by men (Canadian Femicide Observatory for Justice and Accountability, 2022, unpaginated).
- **One in ten women aged 15-24 from the provinces have been sexually assaulted.** Three in ten women aged 15-24 have been emotionally, financially or psychologically abused by a partner (Government of Canada, 2018, unpaginated).

Global Numbers at a Glance:

- Approximately **one billion women could be affected in this generation by gender-based violence** (World Vision, 2020, unpaginated).
- **6% of women have been sexually assaulted by someone other than a partner** (WHO, 2021, unpaginated).
- **200 million women have experienced female genital mutilation/cutting** (The World Bank, 2019, unpaginated).
- **700 million girls were married before age 18** (World Vision, 2020, unpaginated).

INTRODUCTION TO VIOLENCE

Local Numbers at a Glance:

- **In 2019, Ontario had the highest numbers of male and female intimate partner violence victims in Canada** – standing at 5, 892 and 24, 293 victims respectively (Statista, 2019, unpaginated).
- **In 2018, 32% of women and 13% of men were victims of unwanted sexual behaviour while in a public place** (Statistics Canada, 2019, unpaginated).

HOW DOES IT IMPACT HEALTH?

Health impacts of violence can range from **physical harm to long-term emotional distress, to fatalities** (International Rescue Committee, 2022).

Psychological signs & symptoms to watch out for:

- Violence survivors are at a higher risk of **depression, anxiety, substance misuse disorders, post-traumatic stress disorders and suicide attempts** (Substance Abuse and Mental Health Services Administration, 2023).
- Direct exposure to parental violence can **trigger insecure attachment styles in children** (Dutton et al, 1994) and it is seen among intimate partner violence victims who either experienced or witnessed violence in their childhood to have **more difficulty in developing secure attachments in their adult relationships** (Almeida et al, 2023).
- Sexual violence can also affect someone's perception of their bodies, leading to **unhealthy eating patterns or eating disorders** (Office on Women's Health, 2021).
- When looking at elder abuse, it's seen that **abuse occurs more commonly with elders who are already suffering from dementia, leading to lasting emotional damage** among victims (Rosen A.L., 2014).

Physical signs & symptoms to watch out for:

- Issues commonly seen among violence victims include **fatigue, weight loss, nausea and stomach problems and the inability to sleep** (Ontario Human Rights Commission, n.d., unpaginated).
- The **short-term physical effects of violence against women can include vaginal bleeding or pelvic pain, unwanted pregnancy and sexually transmitted infections (STIs) including HIV** (Office on Women's Health, 2021).
- A serious risk of physical abuse is **concussion and traumatic brain injury (TBI) from being either hit on the head or falling and hitting one's head, which can cause: headache or a feeling of pressure, loss of consciousness, confusion, dizziness, nausea and vomiting, slurred speech** (Office on Women's Health, 2021).

INTRODUCTION TO VIOLENCE

COMBINED PSYCHOLOGICAL AND PHYSICAL SYMPTOMS TO WATCH OUT FOR **IN CHILDREN**

For children who have been exposed to adverse childhood experiences (**ACEs**) such as experiencing or witnessing abuse or violence, **their harmful levels of stress hormones can affect their brain development and immune responses** (Dempster et al, 2020; Mcewen B.S., 2006; Shonkoff et al, 2012). Therefore, as a result, the child may face **delayed cognitive development, poor school performance, mental health problems, substance use, suicide attempts, revictimization and the perpetration of violence** (World Health Organization, 2021; Public Health Agency of Canada, 2014; United Nation, 2006).

LEGAL & ETHICAL CONSIDERATIONS

HOW CONFIDENTIALITY CONCERNS POSE A BARRIER TO REPORTING FOR VIOLENCE

Victims commonly share that confidentiality concerns pose a barrier to reporting violence (Mengeling et al, 2014). Some common concerns among survivors about confidentiality in a healthcare setting include:

- **A familiar person may be working in a government agency or hospital from which they can seek help** (Hoare et al, 2021).
- **For women, being present in a waiting area was problematic—especially when in the same area as other people waiting for services** and encountering a lack of privacy (Place et al., 2019).

All healthcare providers should initiate efforts to reduce barriers to help-seeking. Help-seeking behaviour encompasses any action involving an external source of assistance, such as seeking advice, information, treatment or general support in response to the issue being encountered (Satyan et al, 2019). This is especially important, as **in Canada, only 7% of men, as compared to 18% of women, have reported actively seeking out formal services after violent victimization (Sutton D., 2023) - more barriers to help-seeking need to be reduced to encourage more male survivors to reach out to external sources of assistance.**

Akinsulure-Smith (2014) recommends a few ways in which barriers can be removed:

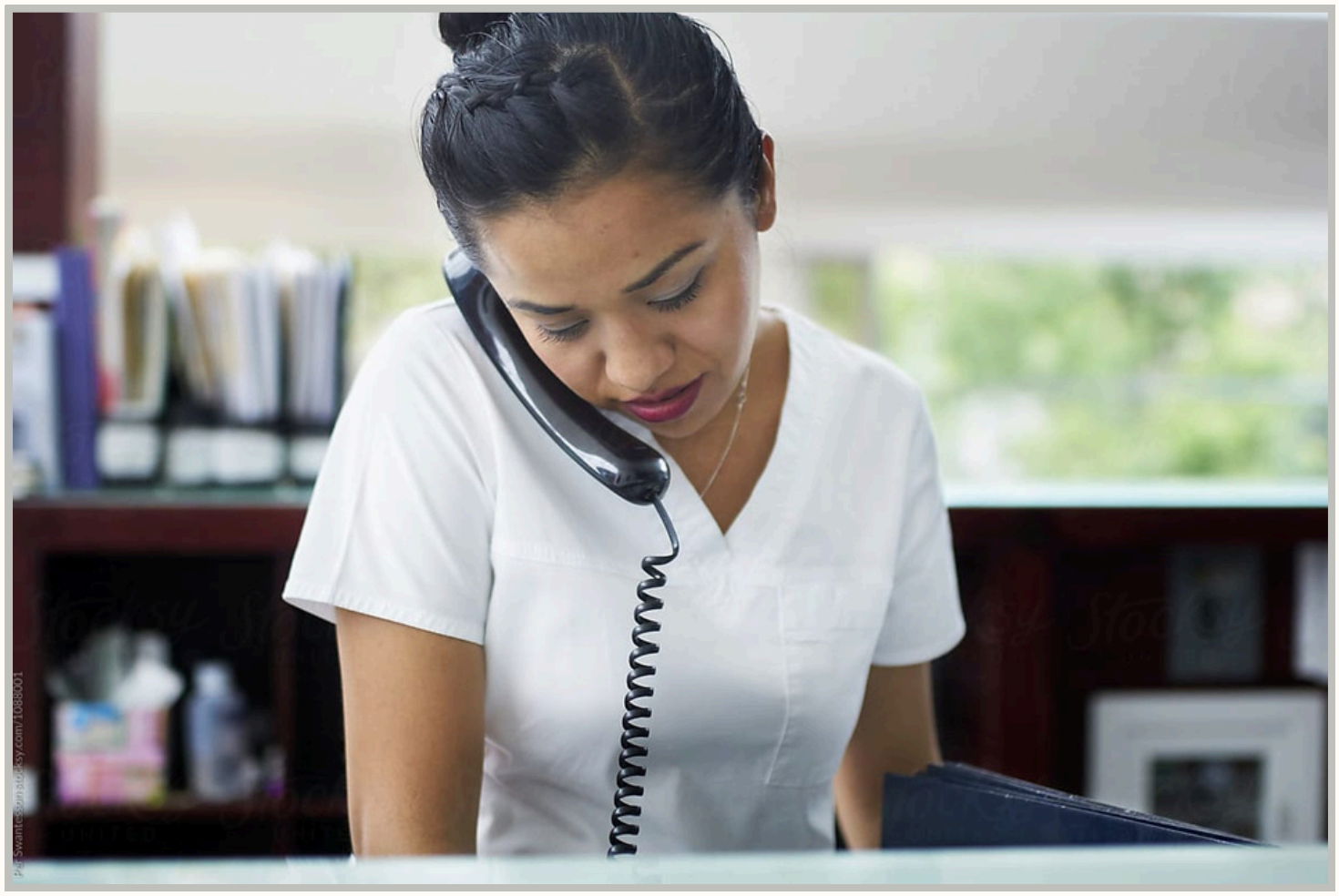
- Share how the medical data of the victim will be collected, used, stored and protected.
- Canadian nurses and social workers can explain the ethics behind confidentiality laws and how certain legislation like the Adult Guardianship Act (for vulnerable adults) and Child, Family and Community Services Act (Children under the age of 19) require one to disclose information in relationship violence situations.
- Directly and repeatedly addressing multiple concerns about confidentiality can serve to enhance trust.

Healthcare providers also need to hold the understanding that violence can happen to anyone and not have pre-conceived notions on what a victim can look like - for example, older adults are very vulnerable to sexual violence, which may involve sexual coercion and assault (Kleinasser et al, 2015).

Delicate balance between harm protection and respecting autonomy

Nurses should understand that the autonomy of one person may endanger another person. Therefore, they need to utilize "professional judgement in deciding to report abuse, neglect or self-neglect under the Adult Guardianship Act, Part 3." (Androus, A.B., 2023).

LEGAL & ETHICAL CONSIDERATIONS



REPORTING REQUIREMENTS FOR HEALTHCARE PROFESSIONALS

Doctors and nurses should be familiar with their hospital or organization's policies when it comes to assessment and reporting when suspected abuse or neglect has taken place, as **the failure to supportively respond may result in:**

- **discipline by the board of doctors/nursing**
- **discipline by the employer**
- **possible legal action taken**

(Androus, A.B., 2023).

When it comes to reporting requirements, there are many barriers faced by health professionals in providing effective services to survivors of violence. These include **missing intra-institutional support such as standardized protocols, documentation forms, or staff training on dealing with survivors of violence and uncertainties about legal obligations, such as confidentiality rules and reporting obligations** (UNFPA-WAVE, 2014). For example, Canadian doctors and nurses should know that it is a reporting requirement when a child is in danger, to take the case to a child protection social worker as per the Child, Family and Community Service Act. **Suppose a protocol or standard operating procedure is in place even before the intervention with the survivor. In that case, quick action can take place for individuals in immediate danger – for example, if a child is in danger, the police should be called to intervene, and a child protection social worker should be contacted to understand whether the child needs protection.**

LEGAL & ETHICAL CONSIDERATIONS

Reporting also relies on the **professional obligation of the healthcare provider to record details as medical records, as medical records can be used in court as evidence. The documentation of health repercussions can help courts with their decision-making as well as provide insights into past and present instances of violence. Providers must understand the links between forensic healthcare and criminal justice to allow for better access of victims to the criminal justice system,** should they seek it (Blank & Rosslhumer, 2015).

Sometimes, **a health professional may not feel equipped to report a case - hence, they should refer the patient to a social worker or other professional within their health setting who can step in immediately to provide support** (Blank & Rosslhumer, 2015).

When the clinical lead, health professionals, and GBV advocates guide a client through a referral system, it enables the client to access further comprehensive and specialized care and support, tailored to her individual needs. **Healthcare professionals should be careful to obtain the consent of the adult client before sharing information about their case with other agencies and service providers and ensure that they too, protect the woman's confidentiality. There are some situations in which sharing information must be done even if the client does not give consent** (Blank & Rosslhumer, 2015).

UNDERSTANDING TRAUMA-INFORMED, CULTURALLY SAFE CARE

A trauma-informed approach to care acknowledges that healthcare organizations and teams need to have a complete picture of a patient's life – both past and present –to provide effective healthcare services with an outlook to heal holistically (Trauma-Informed Care Implementation Resource Center, n.d. unpaginated).

PRINCIPLES OF TRAUMA-INFORMED APPROACHES TO CARE

The main principles of trauma-informed practices include: **building awareness of trauma, establishing safety and trustworthiness, offering choice and open communication and an emphasis on strengths-based and skill-building approaches** (Canadian Centre on Substance Abuse and Addiction, 2014). **Recently, trauma-informed care has been found to play an integral role in the recovery of survivors of violence** (Lewis-O'Connor & Chadwick, 2015; Vitopoulos et al, 2018).

HOW HEALTHCARE STAFF CAN ENSURE TRAUMA-INFORMED, CULTURALLY SAFE SERVICES

- It may be important to **co-design and collaborate with various marginalized groups, communities and organizations to promote culturally safe care and resultant safe spaces** (Brooks et al, 2022).
- **Ensuring that there are private and safe spaces for all survivors to disclose gender-based violence** (Mphephu & Du Plessis, 2021). A useful example, that can be adopted by the healthcare system, includes Women and Girls Safe Spaces (WGSS) – to prevent and respond to violence experienced by women and girls in humanitarian settings, international aid organizations have promoted WGSS as a promising intervention. A Women and Girls Safe Space is defined as a structured place where women and girl's physical and emotional safety is respected and where women and girls are supported through processes of empowerment to seek, share, and obtain information, access services, express themselves, enhance psychosocial wellbeing, and more fully realize their rights (Gender-Based Violence Area of Responsibility and UNFPA, 2019).
- **In case nurses and doctors themselves have been survivors of violence,** and are harbouring feelings of not being able to help - **debriefing sessions should be provided in a safe space,** reflecting on their wellness and their experience of connecting with the needs of women and men and the ability to provide relational care (Mphephu & Du Plessis, 2021).
- To create these safe spaces, there needs to be a **stronger collaboration between healthcare team members, where regular meetings should be held and action plans should be drawn – from a safe space to an improved referral system** (Mphephu & Du Plessis, 2021).
- Given that elder abuse definitions incorporate having a trust relationship, t**he trauma-informed principle of trustworthiness and transparency reinstates the importance of understanding that formal and informal caregivers in the home, institutional and community settings could be a source of abuse and/or care** (Ernst & Maschi, 2018).

CULTURAL SAFETY AND HUMILITY

UNDERSTANDING CULTURALLY SAFE CARE

The Provincial Health Services Authority (PHSA) defines culturally safe care as an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe (B.C. Centre for Disease Control, n.d.). This is **especially critical in Canada as Indigenous men and women are more likely to experience intimate partner violence because of systemic risk factors related to colonization and cultural genocide (Boyce, 2016; TRC 2015), but there is also limited information about men and women from other ethnocultural groups** (Roebuck et al, 2020).

PRACTICING CULTURAL HUMILITY, SELF-REFLECTION AND CONTINUOUS LEARNING

Cultural humility means admitting that one does not know, but there is a willingness to learn from patients about their experiences while being aware of one's own embeddedness in culture(s). **Healthcare providers' humble disposition counterbalances their authority,** and by equalizing the patient-provider relationship it can improve two-way communication mechanisms and increase chances of providing quality care (Lekas et al, 2020). **Quality care respects people for their unique perspectives and recognizes their cultural contexts** (Health Quality B.C., n.d.) **The BC Patient Safety and Quality Council as part of their Patient Voices Network program, developed eight key principles and corresponding recommended actions to guide healthcare providers in providing culturally safe engagement with marginalized patients. Some of them that can help dispel personal biases and encourage humility & learning include:**

- **Awareness & Understanding: Acknowledge that there is a history of racism in Canada and how this has developed into systemic racism.**
  - It's important to **get to know the people from the territory that the healthcare provider lives and works in.**
  - **Translation exhaustion should be avoided.**
- **Learning & Education: Humility and being open to learning is key.**
  - **There should be mandated cultural safety & humility training** before working with patients.
  - **Research should be undertaken to understand local practices and protocols.**
- **Kindness & Empathy: Being human should be a healthcare provider's first consideration.** It's important to ask oneself continuously: "Am I being empathetic, patient and compassionate?"
  - **Include time at the beginning of a healthcare session for a meaningful welcome/introduction** and to agree upon ways to work together.
- **Listen: A sense of vulnerability and openness should be cultivated.**

CULTURAL SAFETY AND HUMILITY

CREATING EQUAL POWER RELATIONS

Understanding how the social and cultural determinants of health, power and privilege impact the health of various populations and individuals is key to recognizing health inequity and informing strategies to ensure culturally safe care (B.C. Centre for Disease Control, n.d.). For example, **evidence of widespread and systemic racism against Indigenous peoples has resulted in a range of negative outcomes, harm and death** as seen in the 'In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care' report released at the end of 2020. Recommendation 5 in **the report calls on the provincial health system to develop an integrated, accessible and culturally appropriate feedback/complaints process for Indigenous peoples in BC to hold health providers accountable** (Health Quality BC, n.d.). As per the eight key principles and corresponding actions developed by the BC Patient Safety and Quality Council to provide culturally safe care, **the following points may assist healthcare providers in disrupting unequal power relations:**

- **Build Relationships:** Get to know the patient to balance the power dynamic, enable collaboration and foster trust. **It's important to learn about the patient's culture and connect in their context.**
  - **Include enough time during the interaction for relationship-building.** This step can be **critical for fostering trust, especially allowing elder abuse survivors to report that they have been abused, as most of the population is not willing to do so due to various safety and emotional reasons** (Harries et al, 2014; Ranabhat et al, 2022).
  - **Be aware of not triggering generational trauma.** Refer to the tenets of trauma-informed modes of care.
- **Prepare**: **Prepare to be flexible** during the patient-first interaction.
  - **Ask the patient for their preferred mode of communication for follow-up care.**
- **Respect:** Clear expectations about **where a patient's contributions can be meaningful should be outlined.**
  - **Don't be disrespectful by engaging with marginalized groups with a solution that has already been pre-determined.**
  - Treat everyone as equals.
- **Value: Acknowledge the patient's experience as well as their inherent knowledge.**
  - Understand and appreciate how challenging it is for patients to share their health experiences.
  - Always thank patients for coming to you and explain the next steps.

GENDER AND SEXUAL MINORITY (GSM) CONSIDERATIONS IN VIOLENCE SCREENING

GSM communities have a long history of being mistreated by healthcare providers and hence are distrustful of them. **Be it being labelled as 'disordered', attempts at 'conversion therapy' or just being refused to be seen – there are multiple issues that have caused distrust toward healthcare providers.** Healthcare providers need to understand this context when dealing with GSM patients, especially those who have the additional trauma of violence.

CULTURAL SAFETY AND HUMILITY

GSM individuals are much less likely to use primary care services and less likely to be forthcoming with their healthcare providers due to their history of discrimination (Erickson-Schroth et al, 2020). Erickson-Schroth et al (2020) suggest that **when health professionals are in a room with GSM clients, they refer to the following guidelines as best practices:**

- **The healthcare provider should begin the interaction with open-ended questions to establish a comfortable space**, which allows the patient to bring forth their primary concerns on their own accord.
- **Establishing the language that the patient would like to refer to them with is important** – for example, nonbinary clients may prefer gender-neutral pronouns.
- **When taking a medical or mental health history with GSM clients, a balance should be struck between approaching the patient as one would any other person (like the traditional categories and questions) and asking about elements of the history that may be specific to the GSM population.** For example, a physician who is unaware of transgender populations may believe it important to know right away if a patient has had any surgeries, but the best practice would be to ask about past surgeries while documenting the surgical history at the time in the conversation it is asked of all patients.
- **When asking about gender-based violence, a way to put patients at ease is to tell them that it's all right to have conflicted feelings about their own experiences.** For example, men who identify as gay may have complicated feelings that are often rooted in shame about childhood abuse by male perpetrators.
- **During the physical exam, healthcare providers should proceed as they would with other patients – slowly and with consent,** but also with the knowledge that transgender and non-binary clients may have complex relationships with their bodies.
- One way t**o make the physical examination more comfortable for the patient is by asking how the patient prefers their body parts to be named.**

SCREENING PROTOCOLS

TYPES OF VIOLENCE SCREENING

Some of the types of violence screening that can take place in a healthcare setting have been defined by Quarterman (2018) as follows:

- Universal screening uses a standardised question for all symptom-free women according to a procedure that does not vary from place to place.
- Selective screening targets high-risk groups, such as pregnant women or those seeking abortions.
- Routine enquiry involves asking all men and women accessing a facility about violence but the methods vary according to the provider or client's situation.
- Case finding is the use of indicators to lead to questions about experiences of violence.

The World Health Organization (WHO) does not recommend universal screening for violence in men and women attending health care, but WHO does encourage healthcare providers to raise the topic with men and women who have injuries or conditions that they suspect may be related to violence (Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014). **Therefore, case-finding, which is based on careful and selective clinical considerations is deemed the most effective method, especially when healthcare staff are properly trained on how to respond and refer cases** (Blank & Rosslhumer, 2015).

IDENTIFYING VIOLENCE

When first asking about or discussing violence, the following guidelines should be considered according to the Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women (2014):

1) **Find a way to see the client alone.** You can use for example the following approaches:

- Ask the accompanying person to go out to get something
- Ask the client to come with you for a test

2) **Take time to talk to the client**, don't rush the person. **For example, for a man to disclose that he has been sexually abused is showing vulnerability in a society that has encouraged very few models or pathways for the expression of masculine vulnerability** (Public Health Agency of Canada, 2020) – remember that, and understand that **disclosure may take time.**

3) **Don't push a client to reveal the violence**

SCREENING QUESTIONS AND TOOLS

The confidentiality of the questions you're asking must be discussed with the client, as well as the mandatory reporting of child abuse. **Remember that the patient may deny the abuse if they are not ready to deal with the situation** or are in denial.

SCREENING PROTOCOLS

Simple and indirect questions that a healthcare provider can use to hear about a client's problems in the **emergency room**, for example, can include:

Compulsory context-setting statement: It is my job to do a full assessment of you and your home/work environment.

- **Can you describe how your injury occurred?**
- **When you are at home, do you feel anxiety or panic that someone will not be pleased with what you are doing?**
- **Are you afraid of cooking what you want at home?**
- **Do you sometimes feel like you are walking on eggshells?**
- **Are you able to buy products when you need them without having to get permission?**
- **Are you able to visit friends without getting permission?**
- **Do you have time for yourself? If not, do you wish you did?**
- **How is managing your home split up in your family?**
- **How do you feel about the way your finances are currently managed?**
- **Have you signed some documents recently that you do not completely understand or agree with?**
- **Do you feel supported and respected by close family members or friends?**
- **Do you feel that you can freely practice your spiritual beliefs and/or religious practices?**

Indirect questions that a healthcare provider can use to hear about a client's problems in **maternity units**, for example, can include:

Compulsory context-setting statement: 1/3 women and 1/7 men are abused so part of our care is to ensure we provide appropriate resources.

- **When you are at home, do you feel anxiety or panic that someone will not be pleased with what you are doing?**
- **Are you able to buy products when you need them without permission?**
- **Are you able to visit friends without permission?**
- **Is anyone upset about the gender of your baby?**
- **Did you suffer any stress at home during your pregnancy?**
- **Has anyone you know ever touched you without permission or hit any objects/people/pets?**
- **Do you feel safe at home?**
- **Do you feel that your financial decisions are respected by those around you?**
- **How do you feel about your relationships with your family members?**
- **Do you feel comfortable discussing conflicts or differences in views/opinions with friends and family members?**

SCREENING PROTOCOLS

For children, this exercise can take place during the history-taking stage, with the following questions:

Where do you sleep? Where do mommy/daddy sleep? Who bathes you?

Identify hair, eyes, nose, mouth, belly button, breasts, and private parts. **Who gives you kisses? Hugs?**

Show me where kisses go. Hugs? Spankings? How do hugs make you feel? Kisses? Spankings?

(Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, 2014)

SCREENING PROTOCOLS

If the cause of the gender-based violence is suspected to be a case of intimate partner violence post the initial questioning, the healthcare provider can use the following screening tools:

1) **Humiliation, Afraid, Rape, Kick (HARK) screening tool to represent the different components of IPV including emotional, physical and sexual abuse.** One point should be given to every yes answer to the following questions:

- Humiliation (H) - Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?
- Afraid (A) – Within the last year, have you been afraid of your partner or ex-partner?
- Rape (R) – Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
- Kick (K) - Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

A score of one or more indicates that IPV has been experienced by the client in the past year.

2) **Hurt-Insult-Threaten-Scream (HITS) is a four-question self-reported or staff-administered screening tool that looks at the occurrence of certain components of IPV using a five-point Likert scale from 1=Never to 5=Frequently.** The four questions are:

- How often does your partner physically hurt you?
- How often does your partner insult or talk down to you?
- How often does your partner threaten you with harm?
- How often does your partner scream or curse at you?

(Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014; Engender Health, n.d; Futures Without Violence, n.d.)

If there is suspicion in a case involving an elder that they have been abused after the initial conversation, t**he healthcare provider can use the screening tool called the Elder Abuse Suspicion Index (EASI), which uses 6 questions to assess risk and neglect, and any verbal, psychological, emotional, financial and sexual abuse over the past 12 months. It takes 2 minutes to complete and has been validated in both family and ambulatory care settings. Q1 to 5 is asked of the client, while Q6 is answered by the healthcare provider** (McMullen et al, 2014; National Centre on Elder Abuse, 2016).

SCREENING PROTOCOLS

RESPONSES TO CLIENT-DISCLOSED VIOLENCE

If a client does reveal that they have been or are a sufferer of violence, the healthcare professional should have the following appropriate responses ready to deliver the care/health interventions that the client needs as per the Ministry of Public Health of Afghanistan (2014):

- **Be sensitive to the emotional distress or fear the client may be feeling.**
- **Affirm that the client has made an important step by talking about the violence.**
- **Reassure confidentiality.**
- **Continue to listen to what they are saying.**
- **Acknowledge what they have told you, by using the following statements: "That must have been so frightening for you." "You are a strong person to have survived that ..."**
- **Validate the client's feelings.** (for example: when a client explains she is angry with her husband, you could say **"It is ok to feel angry..."**)
- **Reassure the client that his/her reaction to the abuse is perfectly normal.**

SELF-CARE STRATEGIES FOR CLIENTS

According to the Mental Health Foundation (2021), there are **a few practical and holistic self-care strategies that can be employed by anyone affected by violence, sexual harassment and abuse – which nurses and doctors can guide clients to when they're feeling overwhelmed and their mental health is deteriorating while at a hospital:**

1**. Becoming grounded:** Ask the client to focus on their feet – do they feel hot or cold? How does the ground feel beneath them? Does it feel hard or spongy?
2. **Taking deep breaths:** Request the client to take a deep breath in, then breathe out slowly, making the 'out' breath last longer than the 'in' breath. This can help refocus the client's mind by making them concentrate on their body.
3. **Setting anger free:** Ask the client to write down their thoughts and feelings on a piece of paper, and then tear up the paper. This activity can help regulate feelings of anger and rage that can most understandably come up for the client.

Self-care strategies that survivors can use beyond the hospital setting can also be shared with the client – like spending time outdoors, exercising, journaling and practising an art form. Reassure the client that even if they're taking care of basic needs, like getting enough sleep and eating healthy food, it is still beneficial (Rape, Abuse & Incest National Network, 2018).

SCREENING PROTOCOLS

PREPARING FOR CLINICAL CARE

The healthcare provider should explain the benefits of undertaking a comprehensive medical history and examination, if appropriate (Ministry of Health - Vanautu Government, 2021):

- **For diagnostics and the provision of supportive treatment.**
- **To create a record of the incident** that will be kept safe in a lockable filing cabinet or an electronic system with a copy provided to the client if they so wish.
- **To document the injuries if the client decides to pursue criminal justice.**

Things to keep in mind during the process of examination and care:

- **Be sensitive about how survivors of sexual violence are often in a heightened state of awareness and very emotional** after an assault (Blank & Rosslhumer, 2015).
- Within the emergency department, **patients who have suffered a traumatic post-sexual event ensure that there are no delays in providing care** (Gurm et al, 2020).
- **Ensure there are no limited interventions in care for the following reasons: deemed as non-urgent due to no obvious physical injuries, provision of care was assigned to a physician who wasn't 24x7 present in the emergency department, nurses only provided nursing care and could not collect forensic samples, etc** (Gurm et al, 2020).
- **Health professionals need to obtain informed consent from the client on all aspects of the consultation and medical examination.** This includes explaining all parts of the consultation to the client, so they can make an informed decision about moving forward and future management of the issue. In a lot of cases, health professionals need the client to sign or mark a consent form (Blank & Rosslhumer, 2015).
- **Begin taking the client's history while recording events to determine which healthcare interventions would be most beneficial** (Blank & Rosslhumer, 2015). **General guidelines for taking the history include:**
  - **Documenting the patient code, area of residence, sex and date of birth**
  - **Date and time of the examination and the names and functions of any staff or support person (someone the client may request) present during the interview and examination.**
  - If the interview is being conducted in the treatment room, **cover all medical instruments until they're required.**
  - **A calm tone of voice should be used while questioning, and eye contact should be maintained if culturally appropriate** to the client.
  - **A detailed description of the assault/emotional violence/coercion should be noted, along with its duration, whether any weapons were used and the date and time of the assault.**
  - Clients may choose to skip recounting the most traumatic aspects of the abuse; however, the healthcare provider must have adequate knowledge of everything that happened to examine the client properly.

SCREENING PROTOCOLS

PHYSICAL EXAM

After taking the history, health professionals should conduct a complete physical examination (head-to-toe; for sexual violence also including the patient's genitalia) if appropriate. This may or may not be a forensic examination, where a forensic examination is defined as a "medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion" (Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014).

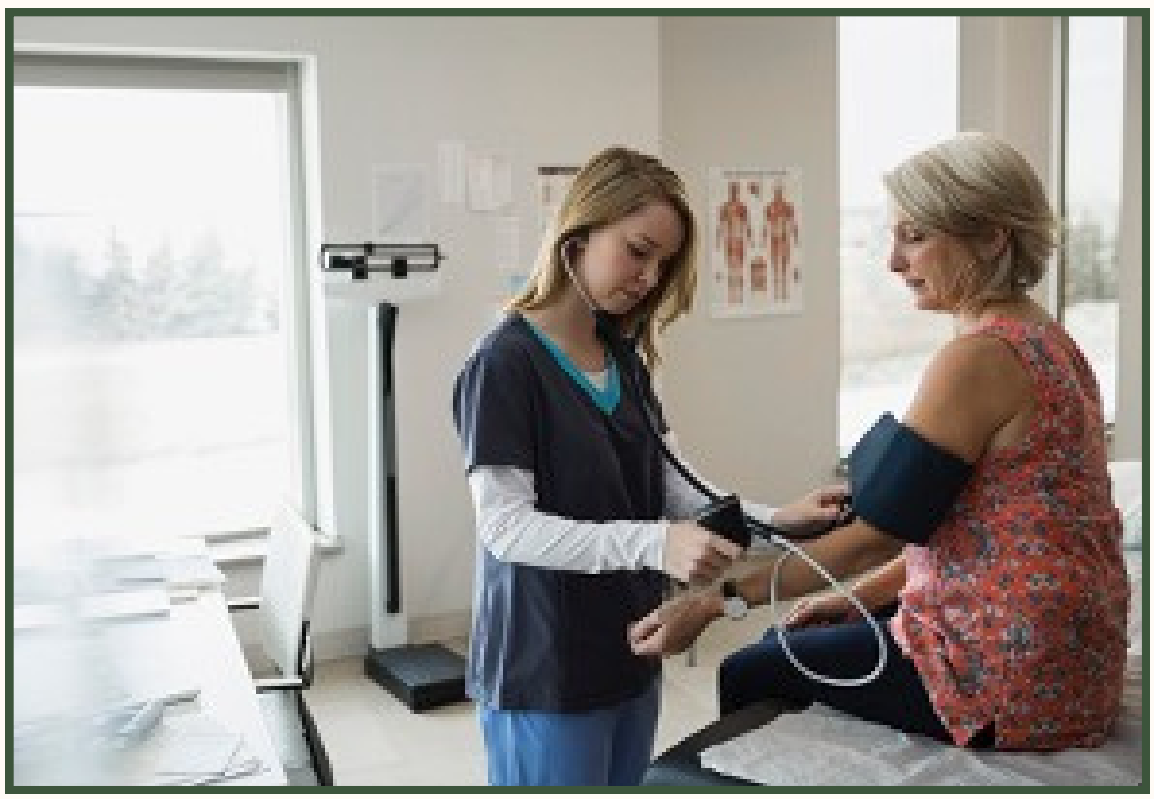
Steps to undertake before conducting a physical examination:

- **Before commencing the physical examination for survivors of violence, the health professional should explain the medical examination,** what it includes, why it is done and how so that it doesn't become another traumatic experience. The client should also be given the chance to ask questions (Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014).
- **Especially in cases of sexual violence, the survivor should be asked if they'd like a doctor of the same sex** (Blank & Rosslhumer, 2015).
- **The patient should not be left alone at any point** (Blank & Rosslhumer, 2015).

Going beyond a general physical examination:

Throughout the physical examination, it's important to explain to the client what is going to happen next, and p**ermission should be asked at every step. Clients should have the option to refuse all or part of the physical examination** (Blank & Rosslhumer, 2015). T**heir choice should be respected,** and care should proceed as needed (Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014).

The client's vital signs should be taken (pulse, blood pressure, respiratory rate and temperature). (Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014).



SCREENING PROTOCOLS

PREGNANCY PREVENTION/MANAGEMENT AMONG RAPE VICTIMS

All clients who are capable of pregnancy should be offered the option of emergency contraception, at the time of their emergency department visit, regardless of gender expression (Massachusetts Sexual Assault Nurse Examiner Program, 2022). **For pregnancy prevention, Plan B can be given up to 5 days after the sexual assault occurs. Clients weighing over 75 kg can be referred to an IUD insertion clinic for emergency contraception** as well. **A copper IUD can be inserted up to 7 days after an incident** of sexual assault (B.C. Women's Hospital + Health Centre, 2017). **When rape results in pregnancy, women are more likely to choose pregnancy termination** than continuation (The American College of Obstetricians and Gynaecologists, 2019).

According to the American College of Obstetricians and Gynaecologists (2019), **obstetrician-gynaecologists and all other women's healthcare providers should screen all women for a history of sexual assault.**

POST-EXAMINATION TREATMENT AND NEXT STEPS

For the first step in medical intervention, **any medical injuries should be treated, and hospitalization should take place as needed if it is necessary for the client and their protection.**

Ask the client
what kind of assistance they would like.

Explicitly ask the client if
they are facing any suicidal thoughts.

Do not tell the clients that they must leave - the decision to leave needs to be their own as leaving can be a dangerous decision to make. **The client should be provided with a risk assessment and safety plan and resources in law enforcement and social services if they do choose** to leave or want to act against their perpetrator.

Additionally, an expanded assessment needs to continue in follow-up visits to understand the client's general view of their situation. In this continuity of care, the client will need to be asked about the history of violence since the last visit, their coping strategies and access to counselling. It will need to be asked if they've called a hotline, attempted to leave or told anyone trusted about the situation (Futures Without Violence, n.d.).

RISK ASSESSMENT & SAFETY PLANNING

CONDUCTING VIOLENCE RISK ANALYSIS

Violence risk analysis is based on a thorough gender analysis with a focus on specific risk factors that increase the likelihood of GBV (GBV Guidelines, 2015). **Risk assessments created to measure criteria in a violent relationship increase safety planning and help-seeking among women** (Richards et al, 2019), **but standardization can overlook the nuances in various women's experiences** (Kafonek et al, 2022).

Risk factors include:

- **If it is understood that the perpetrator feels like they've lost control or are losing control of a relationship,** this can increase the risk of intimate partner violence turning into something more lethal (Kafonek et al, 2022).
- **Extreme feelings of jealousy or possessiveness by the perpetrator, which is found to be more likely in men** who kill their partners as compared to men who inflict nonlethal violence on their partners (Kafonek et al, 2022). **Male survivors of IPV are more likely than female victims of IPV (7% as compared to 5%) to have a jealous partner who prevents them from talking to others** (Cotter, 2021).
- **The perpetrator has criminal status, previous police records and possession of weapons** (Roeg et al, 2022).
- **The survivor not having safe access to basic needs like food, water, shelter, hygiene supplies, etc.** (GBV Guidelines, 2015).
- **There is gender-inequitable distribution of resources in the survivor's household** (GBV Guidelines, 2015).
- **Lack of income-generating options for the survivor** (GBV Guidelines, 2015).
- **Elder abuse survivors who have functional dependence or disabilities, poor physical health and cognitive impairment/dementia are at an especially high risk of re-victimization** (Rosen et al, 2018).

Questions healthcare providers can ask while conducting a risk assessment to determine the severity of a situation:

- **Does she/he/they (the perpetrator) get physical or is it more verbal?**
- **Do you physically hurt each other or what happens exactly?**
- **Do your fights end with shouting and threats?**

(Roeg et al, 2022)

- **Can you carry out the consultation without harming yourself and others?**
- **Has the perpetrator ever used a weapon or threatened you with a weapon?**

(Ministry of Public Health of the Islamic Republic of Afghanistan, WHO Afghanistan, UN Women, 2014)

RISK ASSESSMENT & SAFETY PLANNING

A few more questions that can help determine risks to finances, emotions, autonomy and spirituality include:

Are you comfortable discussing your finances with family members or caregivers?

How do you feel about your relationships with your friends?

Who is your support system when you are going through a stressful situation or period?

How do you feel about your spiritual beliefs or religious practices?

RISK ASSESSMENT & SAFETY PLANNING

SAFETY PLANNING IN THE GBV CONTEXT

Safety planning in the GBV context is defined as the use of strategies by survivors to protect themselves and their children (Youngson et al, 2021). Survivors of domestic violence often will reach out to their family, friends and community services to access support through these informal avenues (Sayem et al, 2015). **Research suggests that in building a safety plan, a collaborative approach needs to be employed between a woman and a service provider** (Davies et al, 1998; Murray et al, 2015).

In case there are immediate safety and security risks to the client and others, healthcare providers can reach out to protection officers for information and assistance to make a police referral. Based on the survivor's choices and needs, a healthcare professional can help direct them to mental health/psychosocial workers or child protection officers as well. Only reliable and comprehensive information should be shared with the client (National Women's Commission; UNFPA; n.d.) Specific escape strategies need to be collaboratively identified with the client, along with **contact numbers for emergency assistance** (Westwood et al, 2019).

General safety planning strategies include educating survivors about their level of risk, advising changing residence, planning a method to escape, getting an alarm for a higher priority response from the police, getting a different job and arranging readily accessible items to leave one's home in an emergency. However, different situations require different approaches to safety planning with the survivor (Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations, 2019).

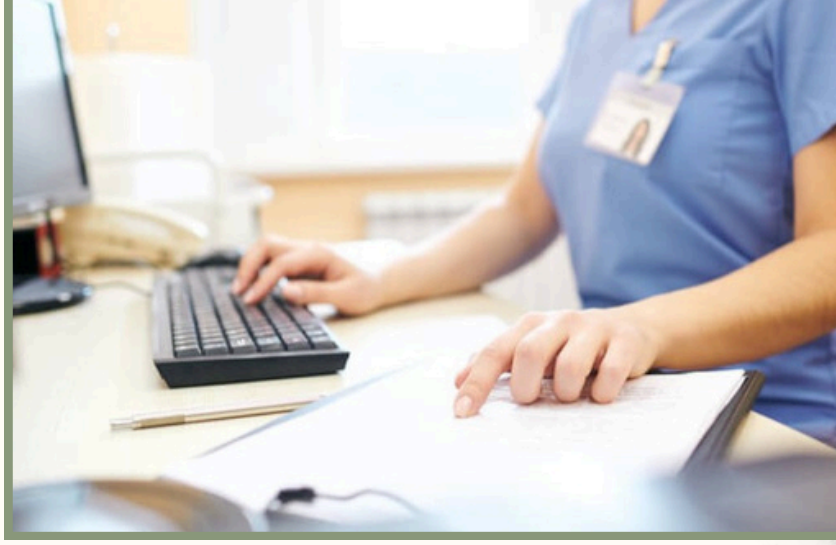
Some barriers to safety planning include:

- **victim blaming**
- **patriarchial attitudes**
- **geographical barriers**
- **issues with confidentiality**
- **distrust in the justice system or community agencies.**

(Kohtala et al, 2023)

The roles of nurses and doctors have evolved, the focus was to safeguard clients and their children, however, now it has broadened to include the identification of family violence among other roles (Adams et al, 2023). As a reminder, family violence refers to violence meted out by spouses, parents, children, siblings and extended family members (e.g., grandparents, uncles, aunts, cousins and in-laws) (Statistics Canada, 2021).

DOCUMENTATION & RECORD-KEEPING



VARIABILITY IN DOCUMENTATION & RECORD-KEEPING

The identification and **documentation of violence in healthcare is still variable. The documentation of injuries, evidence collection and reports are not consistently high quality** (Kivela et al, 2019). **This is very problematic considering substantial evidence that violence is linked to many short and long-term health adversities, including physical disability and death. In a sample of medical records of IPV survivors, the only mention of IPV-related injuries is of the most reductionist kind. Minimalistic entries may showcase a cursory way a patient was dealt with or the overloaded nature of a health provider's caseload, which leaves little time to make substantial notes** (Joyner et al, 2014).

Therefore, it must be considered that **the proper assessment by healthcare professionals in forensic documentation and interpretation of injuries can result in a host of positive benefits for victims, such as favourable court outcomes and prosecution** (Kivela et al, 2019).

Recommendations:

Kivela et al (2019) provide a recommendation in their paper for supporting providers in improving documentation: **Carefully documenting violence and especially the use of proper perpetrator and victim codes to improve the visibility of the problem and its impact on the victims, families and health services.** Other recommendations include:

- Joyner et al (2014) add to this list of recommendations by saying that attention should be given to the documentation of medical records to provide men and women with evidence of abuse sustained in case they require it in the future.
- **The documentation of physical injuries should be done without requiring that a charge be laid with the police** (Artz et al, 2018).
- **For cases involving elder abuse, documenting the differences in stories between the client and caregiver is important, after interviewing both parties separately** (Stanford Medicine, 2024).

DOCUMENTATION & RECORD-KEEPING

INTEGRATING GBV RECORDS INTO ELECTRONIC HEALTH RECORDS

Ending Violence Association of BC (EVA BC) in 2022 shared **some guidelines for storing and sharing sensitive patient files electronically. To look at more best practices and important considerations for storing electronic records and communicating electronically with clients, healthcare professionals should visit the BCSTH Technology Safety Project webpage** (EVA BC, 2022).

Storing:

- **Passwords, firewalls and up-to-date anti-virus protection should be used on systems** as security features.
- **Only the healthcare staff that requires the patient information to do their day-to-day duties should be granted their password to do so. Password attempts should be limited.**
- **The hospital staff should log off or shut down their devices when they are not using them, and devices should not be shared with additional individuals.**
- **There should also be a system put in place to ensure the regular backup of digital documentation.**
- **Emails should be cleared from the trash folder regularly and clients should be encouraged to do the same.**

Sharing:

Email or faxes should NOT be sent to the wrong person - in BC, both PIPA and FIPPA require certain steps to be taken to reduce the risks associated with emailing or faxing personal information (EVA BC, 2022):

- **Emailing or faxing sensitive personal information should be avoided**, such as health information or information about someone's psychosocial history. **This kind of information should only be emailed or faxed when it is necessary to send it promptly, otherwise, this information should be sent by hand.**
- **In case it is necessary to email or fax a patient's sensitive personal information, the hospital staff should consider phoning the intended recipient to check whether they're the right person to receive the email or fax, confirm the recipient's email address and /or fax number and ask the intended recipient to call back to confirm the receipt of the email or fax.**
- When emailing or faxing a client's sensitive personal information, **healthcare agencies should consider using one-of-a-kind identifiers and codes that are made up of numbers or letters in place of names to protect the identities of the persons involved.**
- **If a client asks a healthcare professional to email or fax their personal information to them, it should be explained how emailing or faxing creates a risk of personal information being accidentally disclosed or stolen and get their consent and understanding of this probability before proceeding.**

REFERRAL PATHWAYS & RESOURCES

PROVIDING TAILORED SUPPORT THROUGH A REFERRAL SYSTEM

When the clinical lead, health professionals, and GBV advocate help a client through **a referral system, it helps the client to access more comprehensive and tailored care and support, as per their needs** (Blank & Rosslhumer, 2015). Healthcare professionals should **provide resources to clients when they're ready to receive them.**

According to Blank & Rosslhumer (2015), effective referrals require that health professionals can:

- Assess the individual situation and needs of the client. **If it is deemed that the assessed risk is high and the client requires immediate crisis intervention, the healthcare professional should guide the client to immediate medical/psychological support and/or access to a shelter.** If the assessed risk is not high, referrals to other social, psychological or legal support would be more appropriate.
- **Obtain consent from the client before sharing information about their case with other agencies or support providers while protecting their confidentiality.** However, as seen earlier, **there are situations in which information must be shared even if the client does not give consent.**

GENERAL SUPPORT SERVICES

If a violence survivor needs immediate assistance, they should call 911 or their local police.

SPECIALIZED WOMEN'S SUPPORT SERVICES

The participation of women's organizations in the multi-sectoral response to violence is very important as these organizations often possess long-standing experience in responding to various violence-related issues. **As they are direct and specialized service providers, they are well positioned to not only provide many of the services needed themselves but also to accompany survivors throughout the entire process. They complement but cannot replace the general support services offered by public authorities. Specialized women's support services for survivors of violence may include women's shelters, women's helplines, women's centers, sexual assault support centers and non-residential support** (Blank & Rosslhumer (2015).

REFERRAL PATHWAYS & RESOURCES

RESOURCES

The following are some of the healthcare-specialized services in B.C. for forensic nursing care:

1) **Fraser Health Forensic Nursing Services**

a. **Location 1:** Surrey Memorial Hospital, 13750 96th Avenue

b. **Location 2:** Abbotsford Regional Hospital and Cancer Centre, 32900 Marshall Road

c. **Location 3:** Embrace Clinic, Shirley Dean Pavilion, 9634 King George Blvd, Surrey

d. **Language:** English, with translation services available on-site

e. **Themes:** Sexual assault, intentional relationship violence

f. **Population served:** People of all genders, aged 2 years and older who have experienced sexual assault within the past 7 days

g. **Services:** Trauma-informed medical and forensic care, urgent treatment by a professionally trained nurse examiner

2) **BC Women's Hospital** + **Health Centre** - **Sexual Assault Services**

a. **Location 1:** Vancouver General Hospital's Emergency Department (24 hours) 920 West 10th Avenue (near Broadway & Oak)

b. **Location 2:** UBC Hospital Emergency Department Koerner Pavilion, 2211 Wesbrook Mall (only operates between 8 a.m. and 10 p.m.).

c. **Language:** English, interpreters are available for deaf persons or those who have difficulty with English

d. **Themes:** Sexual assault, intentional relationship violence

e. **Population served:** People of all genders, aged 13 years and older who have experienced sexual assault within the past 7 days

f. **Services:** Trauma-informed medical and forensic care, urgent treatment by professionally trained nurse examiner, support worker accompaniment

3) **Island Health** (**Forensic Nursing Services in Emergency Departments across hospitals in Vancouver Island**)

a. **Locations:** Campbell River General Hospital, Cowichan District Hospital, Chemainus Urgent Care Centre, Lady Minto Hospital, Ladysmith Urgent Care Centre, Nanaimo Regional General Hospital, Port Hardy Hospital, Tofino General Hospital, Victoria General Hospital, Victoria Sexual Assault Centre, West Coast General Hospital, Oceanside Health Central, Comox Valley Hospital

b. **Language:** English

c. **Themes:** Sexual assault, intentional relationship violence

d. **Population served:** Anyone who has experienced sexual assault or relationship violence over the past 7 days

e. **Services:** Forensic nurse examination, medical care, police reporting

REFERRAL PATHWAYS & RESOURCES

According to Women and Gender Equality Canada (n.d), the following are some resources that victims of violence in British Columbia can use:

1) **Victoria Sexual Assualt Centre**

a. **Service Access Line:** 250-383-3232

b. **Location:** 201-3060 Cedar Hill Rd, Lkwungen and WSANEC Territories, Victoria, BC

c. **Language:** English

d. **Themes:** Youth helpline, hotlines and crisis support, sexual violence and consent

e. **Population served:** 14 to 24 year old youth, men and boys, women and girls, gender and sexual minorities (GSM), Indigenous

f. **Services:** Trauma counselling and group counselling sessions for all women, trans, two-spirit and gender non-conforming people.

2) **Youth Against Violence**

a. **Service Access Line:** 1-800-680-4264 OR text 604-836-6381 (for deaf or hard of hearing persons)

b. **Location:** No physical location

c. **Language:** English, multi-lingual (any language, use professional interpreters when needed from CanTalk Canada)

d. **Themes:** Youth helpline, hotlines and crisis support, sexual violence and consent

e. **Population served:** 14 to 24-year-old youth, men and boys, women and girls, Black, Racialized, Immigrant and Newcomer

f. **Services:** Crisis support line that operates 24/7.

3) **BWSS Battered Women's Support Services**

a. **Crisis & Intake Line:** 1-855-687-1868

b. **Location:** 1424 Commercial Drive, Vancouver, BC

c. **Language:** English

d. **Themes:** Youth helpline, hotlines and crisis support, sexual violence and consent, safe dates and healthy relationships

e. **Population served:** 14 to 24-year-old youth, men and boys, women and girls, GSM, Black, Racialized, Rural

f. **Services:** Crisis line, factsheets

REFERRAL PATHWAYS & RESOURCES

Resources for pregnant women include:

1. **Sheway Pregnancy Outreach**

a. **Service Access Line:** (604)216-1699

b. **Location:** Unit 101 - 533 East Hastings, Vancouver

c. **Language:** English

d. **Themes:** Community help for women and children, pregnancy outreach, health and social service supports

e. **Population:** Pregnant women and women with infants/children

f. **Services:** Daily hot lunches, weekly food bags and milk support, nutritional counselling and prenatal vitamins

2. **Maxxine Wright Community Health Centre**

a. **Service Access Line:** (877) 483-6456)

b. **Location:** 2 - 13733 92nd Avenue in Surrey

c. **Language:** English

d. **Themes:** Violence and abuse, community help for women and children, pregnancy & infant care outreach

e. **Population:** Pregnant women and infants up to six months old for fresh intake

f. **Services:** Daily hot lunch program, donations of clothing/household/food and baby items, assistance with housing

Well-established resources beyond Metro Vancouver and Victoria in B.C. include:

1. **Kamloops Sexual Assault Counselling Centre**

a. **Service Access Line:** 250-372- 0179

b. **Locations:** Kamloops, Chase, Logan Lake, Ashcroft

c. **Language:** English

d. **Themes:** Sexual assault, childhood sexual abuse, domestic violence, sexual harassment

e. **Population:** Women, men, children

f. **Services:** Sexual assault counselling, crisis services for domestic violence and sexual assault/harassment, public education

2. **Central Okanagan Elizabeth Fry Society**

a. **Service Access Line:** 250-763-4613

b. **Locations:** 649 Leon Avenue, Kelowna

c. **Language:** English

d. **Themes:** Sexual assault, child abuse, recent or historical sexual abuse

e. **Population:** Adult women and men, youth, children, gender and sexual minorities (GSM)

SELF-CARE FOR HEALTHCARE PROVIDERS

NEED FOR SELF-CARE FOR HEALTHCARE PROVIDERS

Professionals working with victims of violence are exposed to highly stressful situations that can cause physical (tics, headaches, musculoskeletal), psychological (restlessness, insomnia, anxiety) and emotional health problems (Perez-Tarres et al, 2018). **Healthcare providers should be given access to support resources like counselling services** to enhance resiliency, alleviate burnout and improve the quality of care (Dobbins, S., 2019). **Employee Assistance Programs (EAPs) are only used by some employers to help their employees gain access to short-term counselling or therapy services** as well as provide some types of psychological assessment (Marschall, A., 2023).

As per the 2022-2025 collective bargaining agreement released by the Nurses Bargaining Association (NBA) between them and the Health Employers Association of BC (HEABC) in April 2023, every healthcare employer needs to promote psychologically healthy and safe working conditions and practices. The Health Authorities and Providence Health Care (PHC) also continue their implementation of the Canadian Standards Association (CSA) Psychological Health and Safety Standard in all their workplaces.

All healthcare workplaces and employers need to consider thirteen factors as defined in the CSA Psychological Health and Safety Standard:

- Organizational Culture
- Psychological and Social Support
- Clear Leadership & Expectations
- Civility & Respect
- Psychological Demands
- Growth & Development
- Recognition & Reward
- Involvement & Influence
- Workload Management
- Engagement
- Balance
- Psychological Protection
- Protection of Physical Safety

(Health Sciences Association of BC, n.d.)

SELF-CARE FOR HEALTHCARE PROVIDERS

The pandemic has accelerated the mental health and burnout crisis among health workers (U.S. Public Health Service, 2022).

RECOGNIZING BURNOUT AND VICARIOUS TRAUMA

Job burnout is defined as a state of physical or emotional exhaustion caused by excessive and sustained levels of work-related stress (Cao et al, 2022). **In 2019, the World Health Organization recognized burnout as a significant issue among healthcare providers and included the syndrome in their 11th Revision of the International Classification of Diseases as an occupational hazard** (Converso et al, 2021). B**urnout adversely affects healthcare providers as well as clients as it can cause emotional exhaustion, cynicism, depersonalization (distancing from patients) and reductions in personal achievement** (Deng & Naslund, 2020). Burnout can also cause absenteeism and attrition (George et al, 2020).

Vicarious trauma is an occupational challenge for persons working and volunteering in fields where there is continuous exposure to survivors of trauma and violence. The **work-related trauma can occur from these experiences such as listening to an individual patient recount their victimization, reviewing case files, hearing about or responding to the aftermath of violence and other traumatic events every day as well as responding to mass violence incidents that have caused multiple injuries and deaths. Responses to vicarious trauma can be negative, neutral or positive, can change over time and can differ from person to person, especially when it comes to prolonged exposure** (Office for Victims of Crime, n.d.).

As per British Medical Association (2022), some common negative signs of vicarious trauma include:

- experiencing lingering feelings of anger, rage and sadness about a client's victimization
- being preoccupied with thoughts of clients even outside the workplace
- distancing, numbing, detachment, cutting clients off, staying busy
- difficulty in maintaining professional boundaries with the client such as trying to do more than what is needed in one's role

SELF-CARE STRATEGIES

Self-care can be practised individually – **through awareness, balance and connection (ABCs) to ensure feelings of rest, recovery and stability.** By being aware, the healthcare provider can be attuned to their personal needs, limits, emotions and resources. Through balance, the provider can find stability when juggling various responsibilities at work, home, rest and leisure. Through connection, the healthcare provider can maintain positive relationships with co-workers, friends and family members to reach out for support and avoid isolation (Thomas et al, 2021).

TRAINING AND CONTINUING EDUCATION

ACCESSING FURTHER TRAINING OPPORTUNITIES

Registration for online GBV training is often free, whereas many face-to-face initiatives incur a cost (Etherington & Baker, 2016). Further, the convenience and flexibility of online training (which can be completed at home or around one's work schedule) contribute to the ease of access for healthcare workers who oftentimes have demanding schedules (Heck et al, 2015). This may be of value to those in the GBV sector who juggle competing work and family demands (Etherington & Baker, 2016).

The W.H.O. released new e-learning resources in November 2023 to help health workers provide better care and support for women subjected to violence. It has been designed especially for healthcare providers, health managers, facility administrators and policymakers. The free-to-access online course was launched ahead of the International Day for the Elimination of Violence Against Women and Girls 2023 (World Health Organization, 2023).

A free Coursera course developed by John Hopkins University titled 'Confronting Gender Based Violence: Global Lessons for Healthcare Workers' is available. It is taught in English, however, 20 other languages are available. 27, 165 people have enrolled in the course so far (Coursera, n.d.).

The Canadian Nurses Association has developed Violence-Evidence-Guidance-Action (VEGA) resources addressing family violence with funding from the Public Health Agency of Canada and in collaboration with 22 national organizations. The VEGA resources are free and publicly available. They include learning modules which include care pathways, scripts and how-to videos, interactive educational scenarios and a handbook (Canadian Nurses Association, n.d.)

The BC Ministry of Health, BC Women's Hospital + Health Centre and the Ending Violence Association of BC (EVA BC) 2023 designed an online learning series titled 'Gender-based Violence: We All Can Help' to assist healthcare workers in identifying, responding to and addressing violence. It also helps address the impacts of vicarious trauma which may arise for some healthcare workers. It also includes a dedicated course on addressing sexual assault titled, "Introduction to Sexual Assault" (B.C. Women's Hospital + Health Centre, n.d.).

One can also pursue a Post Graduate Diploma in Gender Based Violence in Emergencies offered by the Africa Center for Humanitarian and Development Studies.

TRAINING AND CONTINUING EDUCATION

CONTINOUS LEARNING AND **STAYING INFORMED ON EVOLVING PRACTICES**

It's important to keep learning, as violence towards men and women tends to follow different patterns. Usually, when a man experiences violence – it is a random act that is perpetrated by a stranger while when women experience violence, it is commonly from someone they know as a pattern or extension of aforeseen behaviour (University of Nottingham, n.d.). **Elder abuse persists because of a lack of awareness and education made available to key professionals** (Patel et al, 2021) – so sometimes, **it can be up to healthcare providers to also teach each other and evolve practices based on experience.**

Healthcare professionals can participate in the generation of new knowledge through a variety of research methods and processes to ensure that research is well-informed, and is the right pathway to policy, practice and the public. Healthcare providers can also look to their professional associations like the Nurses and Nurse Practitioners of British Columbia (NNPBC), Canadian Nurses Association (CNA) and Canadian Association of Schools for Nursing (CASN) for opportunities for continuing education. Social workers can look to the B.C. Association of Social Workers (BCASW), the British Columbia College of Social Workers and the Canadian Association of Social Workers (CASW) for relevant opportunities.

CONCLUSION

GRACA MACHEL, SOUTH AFRICA'S FORMER FIRST LADY AND FORMER CHANCELLOR OF THE UNIVERSITY OF CAPE TOWN, SPOKE AT A STUDENT'S MEMORIAL IN 2019 AND SAID THESE POWERFUL WORDS: "IF WE ARE HERE IN SOLIDARITY, WITH THIS BEAUTY OF UNITY, IN OUR PAIN, WE HAVE TO PLEDGE TO DO SOMETHING TO MAKE THIS COUNTRY OF OURS A COUNTRY WHICH IS SAFE."

Healthcare professionals must also understand that **the effectiveness of interventions to prevent violence and its effects are limited by the larger circumstances of survivors' lives. The capacity of providers to respond to experiences of violence is reduced when they do not take these circumstances into account.** Therefore, healthcare professionals should consider that structural forms of violence filter down to everyday experiences and therefore, **a survivor's experience with health services should be as violence-free as possible.** For example, class-based assumptions and stigma should be erased when working with patients from extremely poor backgrounds – and this needs to be a conscious, ongoing practice by healthcare professionals to provide the most violence-informed, equity-promoting and culturally safe care (Equip Health Care, n.d.).

Healthcare professionals, therefore, **must make Canada and whichever country they go to – safe once a violence survivor is in their care. Within healthcare settings and without it, every healthcare professional needs to pledge to take a stand against violence. Hospitals need to become a safe space. You can make this happen.**

REFERENCES

- Adams C., Hooker L. & Taft A. 2022. *A systematic review and qualitative meta-synthesis of the roles of home-visiting nurses working with women experiencing family violence.* JAN Leading Global Nursing Research.
- Akinsulure-Smith A. M. 2014. Displaced African Female Survivors of Conflict-Related Sexual Violence: Challenges for Mental Health Providers. *Violence Against Women, 20(6),* 677-694.
- Androus, A.B. N.d. *What should a Nurse do if they suspect a patient is a victim of abuse?* Registerednursing.org.
- Artz, L., Meer, T., & Aschman, G. 2018. Legal duties, professional obligations or notional guidelines? Screening, treatment and referral of domestic violence cases in primary health care settings in South Africa. *African Journal of Primary Health Care & Family Medicine, 10(1).*
- BC Centre for Disease Control. N.d. *Culturally Safe Care.* Bccdc.ca.
- BC Women's Hospital + Health Centre. N.d. *Gender-based Violence: We All Can Help.* Bcwomens.ca.
- BC Women's Hospital + Health Centre. N.d. *Clinic-based care for survivors of sexual assault.* Bcwomens.ca.
- Benedet J. & Grant I. 2014. *Sexual Assault and the Meaning of Power and Authority for Women with Mental Disabilities.* The Peter A. Allard School of Law.
- Blank K. & Rosslhumer M. 2015. *Training Manual on Gender-based Violence for Health Professionals.* Austrian Women's Shelter Network.
- British Medical Association. 2022. *Vicarious trauma: Signs and strategies for coping.* Bma.org.uk.
- Canadian Nurses Association. N.d. *Family Violence (VEGA).* Cna-aiic.ca.
- Cao Y., Gao L., Fan L., Jiao M., Li Y. & Ma Y. 2022. The Influence of Emotional Intelligence on Job Burnout of Healthcare Workers and Mediating Role of Workplace Violence: A Cross Sectional Study. *Frontier Public Health, 10.*
- Champion, A. R., Oswald, F., Khera, D., & Pedersen, C. L. 2022. Examining the Gendered Impacts of Technology-Facilitated Sexual Violence: A Mixed Methods Approach. *Archives of Sexual Behavior, 51(3),* 1607–1624.
- Converso D., Sottimano I. & Balducci C. 2021. Violence exposure and burnout in healthcare sector: mediating role of work ability. *Med Lav, 112(1),* 58-67.
- Cotter, A. & Savage, L. 2019. *Gender-based violence and unwanted sexual behaviour in Canada, 2018: Initial findings from the Survey of Safety in Public and Private Spaces.* Juristat: Statistics Canada.
- Dawson M., Zecha A., Angus H., Boyd C., Graham E. Hendren T., Mitchell A. & Rohn E. 2022. *#CallitFemicide: Understanding sex/gender-related killings of women and girls in Canada, 2018-2022.* Canadian Femicide Observatory for Justice and Accountability.

REFERENCES

- Decker M. N.d. *Confronting Gender Based Violence: Global Lessons for Healthcare Workers.* Coursera.org.
- Dobbins, S. 2019. *Caring for the caregiver: Implementation of a design thinking framework for burnout prevention among hospice professionals.* ProQuest Sociological Abstracts.
- Ending Violence Association of BC. 2022. *Records management guidelines – Protecting privacy for victims/survivors of violence.* Endingviolence.org.
- Ernst, J.S. & Maschi, T. 2018. Trauma-informed care and elder abuse: a synergistic alliance. *Journal of Elder Abuse & Neglect, 30 (5),* 354-367.
- Futures without Violence. N.d. *Guidelines for Clinical Assessment and Intervention.* Futureswithoutviolence.org.
- GBV Guidelines. N.d. *Data Collection for Gender-based Violence Risk Mitigation.* Gbvguidelines.org.
- George A.S., McConville F.E., de Vries S., Nigenda G., Sarfraz S. & McIsaac M. 2020. Violence against female health workers is the tip of the iceberg of gender power imbalances. *BMJ (371),* 3546.
- Gurm B., Salgado G., Marchbank J. & Early, S. 2020. *Making Sense of a Global Pandemic: Relationship Violence and Working Together towards a Violence Free Society.* Kwantlen Polytechnic University.
- Health Quality BC. N.d. *Cultural Safety and Humility.* Healthqualitybc.ca.
- Health Quality BC. 2021. *Culturally Safe Engagement: What Matters to Indigenous (First Nations, Metis, Inuit) Patient Partners?* Healthqualitybc.ca.
- Health Quality BC. 2022. *Sharing Care Concerns: Improving the Patient Feedback Process for Indigenous Patients and Families.* Healthqualitybc.ca.
- Health Sciences Association. 2023. *Comprehensive Report: On the Tentative Agreement between the Nurses Bargaining Association (NBA) and the Health Employers Association of BC (HEABC).* Hsabc.org.
- Hoare, I., Agu, N., Falope, O., Wesley, C. A., & Coulter, M. 2022. A Multiple Streams Framework Approach to Access to Domestic Violence Services in an Indigenous Community. *Violence Against Women, 28(9),* 2080-2097.
- International Rescue Committee. 2022. *What is gender-based violence – and how do we prevent it?* Rescue.org.
- Joyner, K., & Mash, B. 2014. Quality of care for intimate partner violence in south african primary care: A qualitative study. *Violence and Victims, 29(4),* 652-69.
- Kafonek, K., Gray, A. C., & Parker, K. F. 2022. Understanding Escalation Through Intimate Partner Homicide Narratives. *Violence Against Women, 28,* 3635-3656.
- Kivelä, S., Leppäkoski, T., Ruohoniemi, J., Puolijoki, H., & Paavilainen, E. 2019. The documentation and characteristics of hospitalized IPV patients using electronic medical records data: A follow-up descriptive study. *Journal of Family Violence, 34(7),* 611-619.

REFERENCES

- Kohtala, S., Jaffe, P.G., Chiodo, D. et al. 2023. Barriers to Safety Planning for Female Victims of Domestic Violence in Canadian Rural, Remote, and Northern Communities. *Journal of Family Violence.*
- Lekas H.M., Pahl K. & Fuller Lewis C. 2020. Rethinking Cultural Competence: Shifting to Cultural Humility. *Health Serv Insights, 13.*
- Marschall A. 2023. *What to Know About Employee Assistance Programs (EAPs).* Verywellmind.com.
- Mengeling M.A., Booth B.M., Torner J. C. & Sadler A.G. 2014. Reporting Sexual Assault in the Military: Who Reports and Why Most Servicewomen Don't. *American Journal of Preventive Medicine, 47,* 17-25.
- Mental Health Foundation. N.d. Self-care techniques for women impacted by exposure to sexual violence media coverage. Mentalhealth.org.uk.
- Mingude A.B. & Dejene T.M. 2020. Prevalence and associated factors of gender based violence among Baso high school female students. *Reprod Health, 18,* 247.
- Ministry of Public Health of the Islamic Republic of Afghanistan, W.H.O. Afghanistan Country Office & UN Women. 2014. *Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan.* Ministry of Public Health Afghanistan.
- Mphephu A. & Du Plessis E. 2021. Professional nurses' experience in providing nursing care to women experiencing gender-based violence: A caring presence study. *Health SA = SA Gesondheid., 26,* 1–8.
- National Center on Elder Abuse. 2016. *Elder Abuse Screening Tools for Healthcare Professionals.* Eldermistreatment.usc.edu.
- National Women's Commission & UNFPA. N.d. *Gender Based Violence (GBV) Referral Pathways.* Paho.org.
- Office for Victims of Crime. N.d. *What is Vicarious Trauma?* Office of Justice Programs, United States Government.
- Ontario Human Rights Commission. N.d. *Policy on preventing sexual and gender-based harassment – Summary (fact sheet).* Ohrc.on.ca.
- Patel K., Bunachita S., Chiu H., Suresh P. & Patel U.K. 2021. Elder Abuse: A Comprehensive Overview and Physician-Associated Challenges. *Cureus, 13(4).*
- Pérez-Tarrés, A., Cantera L. M. & Pereira, J. .2018. Health and self-care of professionals working against gender-based violence: an analysis based on the grounded theory. *Salud Mental, 41(5),* 213-222.
- Place J. M. S., Billings D. L. & Valenzuela, A. 2019. Women's post-rape experiences with Guatemalan health services. *Health Care for Women International, 40(3),* 278–294.
- Plett, M. & World Vision. 2020. *Gender-based violence: facts and how to help.* Worldvision.ca.

REFERENCES

- Public Health Agency of Canada. 2020. *ARCHIVED: Chapter 3: Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse – what survivors bring to health care encounters.* Government of Canada.
- Quarterman, L. N.d. *Review of available evidence and guidance on routine-screening for gender-based violence in healthcare settings.* Gender-based Violence AoR: Global Protection Center.
- Rape, Abuse & Incest National Network. 2018. *Self Care Tips for Survivors.* Rainn.org.
- Roebuck B., McGlinchey D., Hastie K., Taylor M., Roebuck M., Bhele S., Hudson E., & Grace Xavier, R. 2020. *Male survivors of intimate partner violence in Canada.* Victimology Research Centre, Algonquin College.
- Roeg, D. P. K., Hilterman, E. L. B., & Van Nieuwenhuizen, C. 2022. Professionals' perception of the needs of female victims of intimate partner violence: A vignette study. *Journal of Interpersonal Violence, 37,* 21-22.
- Rosen, A. L. 2014. Where mental health and elder abuse intersect. *Generations Journal, 38(3),* 75-7.
- Rosen T., Stern M.E., Elman A., Mulcare M.R. 2018. Identifying and Initiating Intervention for Elder Abuse and Neglect in the Emergency Department. *Clin Geriatr Med, 34(3),* 435-451.
- Stanford Medicine: Elder Abuse. N.d. *Documenting in the Medical Record.* Elderabuse.stanford.edu.
- Statista. 2021. *Number of male and female intimate partner violence victims in Canada in 2019, by province.* Statista Research Department.
- Statistics Canada. 2019. *Gender-based violence and unwanted sexual behaviour in Canada, 2018: Initial findings from the Survey of Safety in Public and Private Spaces.* Government of Canada.
- Substance Abuse and Mental Health Services Administration (SAMHSA). 2023. *Gender-based Violence and the Effects on Behavioural Health.* Samhsa.gov.
- Sutton, D. 2023. *Victimization of men and boys in Canada, 2021.* Juristat: Canadian Centre for Justice Statistics.
- The American College of Obstetricians and Gynecologists, Floyd S. & Anderson J. 2014. *Sexual Assault.* Acog.org.
- The World Bank. 2022. *Violence against women and girls – what the data tells us.* Genderdata.worldbank.org.
- Thomas R., Webster H., Perlson S. & Cunningham J. 2021. *Mental Health Wellness in GBV Prevention and Response: From the Individual to the Systems Level.* Igwg.org.
- Trauma-informed Care Implementation Resource Center. N.d. *What is Trauma-Informed Care? Traumainformedcare.chcs.org*.
- UN Women. 2023. Facts and figures: *Ending violence against women.* Unwomen.org.

REFERENCES

- UNFPA East and Southern Africa. N.d. *Gender-based violence.* Esaro.unfpa.org.
- University of Nottingham. N.d. *Why is it important to consider gender based violence?* Nottingham.ac.uk.
- U.S. Public Health Service. 2022. *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce.* Hhs.gov.
- Westwood, T., Wendt, S., & Seymour, K. 2020. Women's Perceptions of Safety After Domestic Violence: Exploring Experiences of a Safety Contact Program. *Affilia, 35(2),* 260-273.
- World Health Organization. 2021. *Devastatingly pervasive: 1 in 3 women globally experience violence.* Who.int.
- World Health Organization. 2023. *A WHO e-Learning for health care providers to respond to violence against women (VAW).* Vawhealthresponse.org.
- World Health Organization. 2024. *Violence against women.* Who.int.
- World Vision. 2022. *Facts, FAQs, History, what you need to know about gender-based violence.* Wvi.org.

ACKNOWLEDGEMENTS

A SCOPING REVIEW WAS CONDUCTED FROM JANUARY TO FEBRUARY 2024, TO GATHER RELEVANT KNOWLEDGE THAT HAS EMERGED IN THE PAST DECADE REGARDING VIOLENCE SCREENING IN HEALTHCARE SETTINGS.

An internship by the Network to Eliminate Violence in Relationships (NEVR) was established to create the scoping review and update the 2014 toolkit that was developed by the organization and nursing students to educate healthcare professionals regarding domestic violence screening tools. This toolkit showcases the research findings of the scoping review and serves as a practical, modern guide for healthcare professionals in B.C. and beyond.

The scoping review and toolkit were created by Nikita Mitra, Intern, NEVR. The process of building the resources was overseen end-to-end by Balbir Gurm, Facilitator, NEVR and Hanieh Ghaderi, Project Coordinator, NEVR. Special thanks need to be given to the following persons who helped in the formation of these resources with their advice and hands-on guidance:

- Jennifer Marchbank, Professor, Simon Fraser University
- Moninder Lalli, Librarian, Simon Fraser University
- Alexandra (Sasha) Lysova, Associate Professor, Simon Fraser University
- Sheila Early, Forensic Nurse Consultant and Owner, SDE Forensic Nursing Education Services
- Jatinder Nijjar, Nursing Instructor, Kwantlen Polytechnic University
- Gurjeet Minhas, Nursing Professor, Kwantlen Polytechnic University