Obstetric Guideline 13

INTIMATE PARTNER VIOLENCE DURING THE PERINATAL PERIOD

This guideline addresses the issue of intimate partner violence during the antepartum, intrapartum, and postpartum periods. Please refer to the index below for specific topics.

Section **Page**

INTIMATE PARTNER VIOLENCE GUIDELINE WORKING COMMITTEE

The BCRCP would like to acknowledge and thank the contributions of the following members:

Diane Sawchuck RN, PhD(c) (Chair)	Perinatal Nurse Consultant Clinical Practice Guidelines Coordinator, BCRCP
Jill Cory	Program Coordinator, Woman Abuse Response Team, BC Woman's Hospital and Health Centre
Angela Henderson, RN, PhD	Associate Professor, School of Nursing, University of British Columbia
Patricia Janssen, BSN, MPH, PhD	Department of Health Care and Epidemiology University of British Columbia
Patty Keith, RN, RM, M.A.(Educ.), PhD(c)	Perinatal Nurse Consultant Outreach Education Coordinator, BCRCP
Katheen Mackay, BSc, MSW	Social Worker and Program Planner Domestic Violence Programs, VGH and Providence Health Care; Clinical Instructor, Division of Emergency Medicine, Department of Surgery, University of British Columbia
Joan Reiter, BSN, MBA	Perinatal Nurse Consultant Conference Coordinator, BCRCP
Colleen Varcoe, RN, PhD	Associate Professor University of Victoria

Ad Hoc Members

Betty Braund, RN	Nurse Educator, Woman Abuse Response Team BC Women's Hospital and Health Centre
Jan Christilaw, MD, FRCSC	Department Head, Specialized Woman's Health, BC Women's Hospital and Health Centre Clinical Professor, Obstetrics and Gynecology, University of British Columbia
Sarah Payne, RN	Clinical Manager, Fir Square Combined Care Unit BC Women's Hospital and Health Centre
Dorothy Shaw, MD, MbChB, FRCSC	Medical Director, Diagnostic Ambulatory Program, BC Woman's Hospital and Health Centre; Associated Dean of Equity, Faculty of Medicine, University of British Columbia

1. DEFINITION

*Intimate partner violence (IPV)** refers to a pattern of physical, sexual and/or emotional violence by an intimate partner in the context of coercive control.[1] Physical and sexual assault are usually accompanied by emotional and other forms of abuse, with a significant proportion of women experiencing violence in more than one relationship over their life-span.[2] Contrary to popular belief, there is a heightened risk of violence by intimate partners after women leave those partners.[1,3,4]

*This pattern of abuse is also referred to as *woman abuse*, which does not identify the perpetrator, nor does it include the terms "domestic" or "family" violence which obscure the predominant gender pattern of abuse. The phrase "violence against women in relationships" is also used commonly, but this obscures the fact that violence often persists after the relationship has ended.

2. PREVALENCE

The Canadian Violence Against Women Survey found that 51% of women over the age of 16 had experienced at least one incident of physical or sexual assault, and approximately 25% of women had been abused by their intimate partners.[2,5,6] In recent Canadian and American based surveys, lifetime rates of physical assault by a husband, boyfriend or partner were reported at 25% to 30%.[6-9]

Violence affects all women regardless of culture, class, ethnicity, ability, occupation or sexual orientation. Studies from around the world show that about 25% of women have been abused.[10] Although rates of woman abuse are similar across countries and cultures, some women are more disadvantaged than others in accessing resources, social support and health care.

3. PREVALENCE DURING PREGNANCY

Pregnancy is a time at which the incidence and nature of violence may change in a relationship. Twenty one percent of the women in Canada who reported being abused by an intimate partner said that they were abused ***during*** pregnancy.[2,6,11] This rate of abuse during pregnancy is similar to that reported in other studies.[12,13]

4. DYNAMICS AND PATTERNS OF WOMAN ABUSE

4.1 POWER AND CONTROL

Violence was narrowly defined in the *Canadian Violence Against Women Survey* as "experiences of physical or sexual assault that are consistent with the legal definitions of these offences and could be acted upon by a police officer".[14] Society increasingly recognizes however, that abusive relationships are about one partner wielding power and control over the other.[15-18] Many factors may result in groups and individuals having relatively less power in society and these may play a role in a woman being controlled by her partner, including access to financial and social resources. For example, a woman who has recently immigrated to Canada and is in the process of gaining her citizenship may face barriers to escaping abuse. These may include: a partner who threatens to withdraw sponsorship so that she may face deportation; language

barriers in receiving outside help; and difficulties supporting herself financially if training and/or experience from her home country is not recognized by potential employers.[19]

4.2 THE PATTERN OF ABUSE

While physical violence may be one way that a woman is controlled, women describe an entire pattern of abuse which works to make them feel inferior, have less decision-making power in the relationship, and become increasingly isolated from friends and family. This pattern can include the following types of abuse:

Verbal	Threats, yelling, insults.
Mental	Using tactics to convince her that she's crazy or stupid.
Emotional	Using guilt and other strategies to make her think she's a bad mother/partner/person. Ignoring or neglecting her, using jealousy to control her.
Sexual	Preventing choice about sex, birth control or STD protection. Withholding of sexual affection.
Physical	Hitting, choking, kicking, use of weapons.
Social	Isolating her from friends or family, controlling her whereabouts and whom she can associate with.
Financial	Controlling the decisions about finances, not allowing her access to money.
Spiritual	Belittling her religion, keeping her from practicing her faith.
Cultural	Belittling her culture, racial insults.

Abuse is rarely present at the start of a relationship. The pattern of abuse usually starts with minor incidents that are not generally thought to be abusive, but become part of a pattern that escalates over time. For example, many women describe their partners initially discouraging them from seeing their friends and family. Over time, this leads to women being isolated and more vulnerable to her partner's control.

4.3 PATTERNS OF VIOLENCE DURING PREGNANCY

Violence may begin and/or escalate during pregnancy or it may diminish. Of the Canadian women who reported being abused by a marital partner during pregnancy, 40% said that the abuse ***began*** during pregnancy.[2,6,11] Some studies have shown other patterns during pregnancy. For example, in a study of 199 abused women,[20] 18.1% of the women were abused during pregnancy but not the year before; 30.2% were abused the year before but not during pregnancy, and 51.8% were abused both the year before and during pregnancy.

5. HEALTH CONSEQUENCES OF WOMAN ABUSE

Intimate partner violence is the most common cause of injury to women, occurring more often than the combination of motor vehicle crashes, muggings, and sexual assaults by strangers.[21] It is now widely recognized that all of the forms and dynamics of abuse can seriously impact

women's physical, mental and emotional health. It should be noted that women who have been abused by an intimate partner can continue to experience the health consequences even after the abuse has ended.[22,23] While some health research has focused more on injuries resulting from a battering incident, sexual assault or threat of assault, current research suggests that the major health impacts of abuse result from women being exposed to a constellation of unrelenting and unpredictable abusive tactics. Research also shows that the impact of violence through the woman's life span is cumulative,[24,25] and impacts health generally, with specific impacts during pregnancy[128] (see table below).

Health Impacts of Abuse: General	**Health Impacts of Abuse: Reproductive**
• chronic somatic disorders[26-28] • depression, anxiety disorders, suicidal ideation, and suicide[14,21,29-35] • eating and gastrointestinal disorders[36-41] • alcoholism and substance abuse[42-47] • sleeping disorders, chronic fatigue[48] • chronic pain, e.g. headaches, back pain, arthritis[14,36,40,41,49,50,51,52] • neurological symptoms, e.g. numbness, tingling, fainting, seizures[14,36,40,41,49,50,51,52] • shaken adult syndrome, e.g. blurred vision, vomiting, confusion, headaches[53] • choking (incomplete strangulation), loss of consciousness[50,54] • cardiac symptoms, chest pains, hypertension[52,55] • exacerbation of chronic medical conditions or interference with a woman's ability to care for chronic medical conditions such as diabetes, asthma, angina, and pain[56]	• lack of control over reproductive decision-making[57,58] • higher likelihood of engaging in unprotected intercourse[59] • sexually transmitted infections and HIV/AIDS infection[41,52,54,60] • pain on intercourse, vaginal bleeding or infection, decreased sexual desire, genital irritation[26,31,40,41,49,50,52,60-63] • unplanned/unwanted pregnancy (forced sex, lack of reproductive control)[38,44,46,50,56,62,64] • threat to maternal and/or fetal health and risk of death of the mother, fetus or both from trauma[18,65,66] • complications of pregnancy and childbirth[40,67-69]

6. POTENTIAL BARRIERS TO CARE[93]

Women abused by an intimate partner may face potential barriers to care that often interact and overlap:

6.1 PARTNERS MAY AFFECT WOMEN'S ACCESS TO CARE OR CONTACT WITH PRACTITIONERS[70-71]

- Partner minimizes her health concerns and influences her decision to not seek help.

- Partner directly prevents woman from obtaining healthcare, e.g. prevents her going to her health care appointment or does not provide funding for prescriptions or needs such as glucose test strips.
- Partner interferes with woman obtaining the care she needs while in the health care system, e.g. never leaves the woman alone.
- Partner describes woman as mentally ill and a danger to herself as a strategy to discredit and control her.[72]
- Disabled women are sometimes forced to rely on their abusive partners as their primary caregivers, rendering them dependent on their abuser to get them the health care they require.[73]

6.2 WOMEN MAY NOT ACCESS OPTIMAL CARE

- Women may have learned to ignore or devalue their needs and may either delay seeking, or not seek health care.
- Women may receive disjointed or inconsistent prenatal care by using emergency room or walk-in clinics rather than visiting her primary care provider.
- Women may worry about police or child protection involvement and therefore avoid revealing abuse to health care providers and other professionals.
- Women may have serious concerns that revealing abuse to health-care providers will escalate the violence in their relationship. Women may fear their health-care providers may put them at greater risk in the following ways:[47,74-82]
  - making referrals without her consent
  - calling the police without her consent
  - speaking to her abusive partner about the abuse
  - prescribing inappropriate medications that may compromise her ability to keep herself safe, or recommending treatment plans that are impossible to adhere to within the constraints of her relationship.

6.3 HEALTH CARE INTERACTIONS

Health interactions themselves may create potential barriers to good health care for abused women. In assessing a woman's health concerns, practitioners can unintentionally add harm by misdiagnosing the woman's problems as problems inherent in *her* rather than her *situation*. Some studies have indicated that when women are identified as abused they report being treated poorly, such as being ridiculed, feeling judged, and feeling pressured to do things that they are unable or unwilling to do.[82-83] Adopting a perspective that shifts the approach from understanding behaviors as "psychiatric symptoms and disorders" to adaptive coping or undertaking safety mechanisms[18] or the impacts of abuse (e.g. low self-esteem, insecure, passive) can result in greater empathy for the woman and lead to more accurate assessments of her healthcare and safety needs. These studies point to the importance of providing care within the context of creating a clear and safe opportunity for discussion (see Create an Environment for Discussion with all Women, page 7), and providing appropriate responses to minimize potential retraumatization of women seeking health care (see Health Care Provider Response When Abuse is Disclosed: Guiding Principles, page 12).

7. THE ROLE OF HEALTH CARE PROVIDERS

The role of the health care provider is evolving as the relationship between violence and health is better understood through clinical practice and research. There is controversy in the literature and there are various clinical approaches regarding best practices for intimate partner violence. These approaches include focusing on a change in practice to include intimate partner abuse as a potential health factor for all female patients, asking direct questions about woman abuse when indicators for intimate partner violence are observed, or routine screening questions for all women. Health care providers should receive education about intimate partner violence so that they practice with an awareness of the issues of IPV and incorporate strategies to address abuse. While clinical practice and research continue to evolve, following the principles outlined below ensures that women's safety remains a focus of the care.

7.1 CREATE AN ENVIRONMENT FOR DISCUSSION WITH ALL WOMEN

The following list describes key health care principles and practices that focus on the dual objectives of improving women's experience of the health care encounter and improving health outcomes. While this approach represents best practices for all women, it is even more critical when providing care for abused women who face immediate safety concerns.

A. Build Trust

Assure confidentiality and privacy, listen non-judgmentally, validate her experience and believe her - even when a woman chooses not to disclose abuse, or leaves and returns to the abusive relationship several times.[17,18,42,47,84-92] This approach will facilitate an increase in trust and will decrease the barriers to women accessing health care services. "The quality of the relationship itself [with the caregiver] is central to any reparative process. In relationships where autonomy and decision-making are taken away, feeling free to make choices without risking retaliation is crucial to regaining a sense of control."[18]

B. Focus on Empowering Women

Recognize and reduce the power imbalances between you as a provider and a woman seeking care. Empowerment strategies include:

- Receive explicit and informed consent for all consultation and referrals.
- Provide information and ensure that she is able to make informed decisions without risk of judgment.
- Take steps to ensure that she remains in control of the information and the process.
- Ensure confidentiality and privacy.
- Acknowledge woman's expertise in knowing what is best for her safety and the safety of her children.
- Be aware of the diversity among women. Health care providers can avoid stereotyping by understanding the complexity of abuse, the many ways that abusive partners assert power and control over women and how gender, race, class, sexual orientation, age and physical or mental ability can shape women's experiences.[18]

- Be knowledgeable about the dynamics and consequences of violence against women and share this information with women.
- Be aware of appropriate resources.

It is important to remember that abuse is about power and control. Because abuse is about power and control being exerted over a woman in her intimate relationship, power and control being exerted over her in a health-care setting may potentially exacerbate or perpetuate her problem.

C. Create a Clear and Safe Opportunity for Discussion

All women should be provided with a safe and confidential opportunity to discuss intimate partner violence and the health impact of that abuse with their health care provider. In order for women to talk to a health care provider about abuse, they must perceive that the practitioner can be entrusted with this information and can respond appropriately to such disclosures.

- Demonstrate that you and your agency/unit are aware of the issue of intimate partner violence by having posters and resource materials on woman abuse available in waiting rooms and patient bathrooms.
- Ensure that you, as the care provider, have some time alone with the woman in case she needs to talk to you in confidence.
- If the woman's partner is reluctant to leave her alone, then consider this a sign that she may be at risk for abuse. Avoid confrontation with the partner but consider other ways to provide assistance to the woman.
- Demonstrate that you are comfortable and knowledgeable about the issue of abuse, e.g. wearing a button related to abuse, asking questions, providing information that is readily accessible such as a resource card or information brochure.

7.2 EVALUATE CLINICAL INDICATORS OF POSSIBLE INTIMATE PARTNER VIOLENCE

Use these indicators to facilitate discussions about a woman's safety or health care. Observations that you might share with a woman when raising concerns could include:

- A delay between the time of injury and time of seeking help.
- Reports vague, chronic, non-specific health concerns.
- Changes in her story with different interviews.
- Injuries sustained are not likely to have been caused by the accident reported.
- An overbearing or dominant/controlling partner.
- Partner focused more on himself rather than her injuries, her labour, her health concerns.
- Repeat visits to health service providers possibly with increasing frequency and severity of concerns.
- Reluctant to have community health nurse visit.
- Difficulty following recommended treatment.
- Minimum response to a serious injury.

- Detached or overly concerned about pregnancy, childbirth and/or postpartum.
- Slower recovery from injury, illness, labour or surgery.
- Defers decisions to her partner regarding her health.
- Expresses reluctance to be hospitalized, follow-treatment.
- Not able to recall aspects of her health care concerns and treatments.
- Expresses concerns about possible serious health problems that can't be detected.
- Confusion or memory loss of incident or medical history – trauma vs. "vague historian".
- Treatments not yielding expected outcomes.

Based on the above clinical observations and indicators, ask women further questions about the possible link between violence and their health.[18]

- When recommending a treatment, ask what is feasible within her situation to keep herself and her children safe from harm, e.g. bedrest must not add to the stress and negative outcomes for her and her children.
- Ask if she can afford the cost of prescriptions, and whether she has access to funds to make purchases without her partner's approval.
- If a woman reports being unable to sleep, assess whether this is part of 'normal' pregnancy or related to abuse. Ask if she feels safe at night when she is in her bed, or if her partner ever disturbs her sleep.

7.3 ASK QUESTIONS RELATED TO ABUSE

A. The Literature

The literature related to the efficacy of assessing for intimate partner violence with respect to improving the safety of women is evolving. While there is evidence that women who are provided with safety planning are able to reduce the number of battering incidences throughout pregnancy and postpartum,[94] assessment for intimate partner violence has not yet been widely adopted by nurses and physicians.[95] What is known is that women are willing to be asked direct questions about violence,[96,97] that they will use information provided to them,[98] and that the ability of women to leave violent relationships is related to access to resources.[99] The act of asking about abuse may itself be an intervention[100] in that it portrays a message of compassion and concern, and provides an opportunity to share information such as resource cards. One recent systematic review found that insufficient evidence exists to show whether screening and intervention can lead to improved outcomes for women identified as abused.[97] However, anecdotal evidence of benefit has been described in the literature.[101-103] It is important to note that "absence of proof is not proof of an absence of effect",[122] and many prominent professional organizations support and recommend routine screening for intimate partner violence by use of direct questions. These include:

- Health Canada documents "A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy"[104] and "Family-Centred Maternity and Newborn Care: National Guidelines.[105]
- The Society of Obstetricians and Gynaecologists of Canada Policy Statement "Violence Against Women".[106]

- The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) document "Violence Against Women: Identification, Screening, and Management of Intimate Partner Violence".[107]
- The College of Family Physicians of Canada document, "The Effect of Domestic Violence on Pregnancy and Labour".[123]
- American College of Obstetricians and Gynaecologists Educational Bulletin No. 255.[124]
- American College of Nurse-Midwives, "Violence Against Women" Position Statement.[125]

B. Asking Questions

There are a variety of approaches to asking questions about intimate partner violence. These approaches range from more general open-ended, non-specific questions to closed-ended, abuse-specific questions.

Regardless of the approaches used, assessment must be done in a place that is safe and private where an abuser, family member, other patients, and/or staff cannot overhear questions or discussion. Family members, including children, should not be used as translators.

Before asking questions related to abuse, the woman should know the reason for asking the question, and that all women are provided an opportunity to talk about abuse. For example:

- "Because abuse happens to so many women, we ask everyone about exposure to violence."
- "At our agency we ask all patients/clients about their safety at home. Is anyone you live with threatening you or your children, or making you feel unsafe?"
- "Because violence at home is so common I routinely ask patients if they feel safe in their relationships."
- "Pregnancy can be a time of stress in relationships. I ask all my patients if they are feeling safe with their partners before, during and after pregnancy."

Some examples of questions about intimate partner violence include:

- "How are you getting along with your partner/husband?"
- "Can you tell me how your partner's behaviour has changed towards you since you were pregnant?"
- "Can you tell me a bit about how safe you feel in your relationship?"
- "Can you tell me whether you've ever felt afraid or threatened by your partner/husband?"

A number of standardised assessment tools exist to screen for abuse.[108,126] The common principle in all is to ask direct and simple questions that women can easily respond to. For example, the Abuse Assessment Screen[108] includes the following questions:

- "Have you ever been emotionally or physically abused by your partner?"

- "Within the last year have you been hit, slapped, kicked or otherwise physically hurt by a current or former partner?"
- "Since you've been pregnant, were you hit, slapped, kicked, or otherwise physically hurt by someone?"
- "Are you afraid of your current or a former partner?"

C. Timing of Questions

Asking of questions related to abuse should occur at any opportunity, and preferably as early in pregnancy as possible. Since abuse can begin *during* pregnancy, opportunity for discussion should occur at a later point as well. If the assessment has not been conducted by the time a woman delivers, it should be completed before her discharge.

Asking about abuse that may have occurred during the last year may identify women for whom violence existed prior to pregnancy but has stopped during the pregnancy. These women are likely to experience violence again during the postpartum period.

7.4 RESPECT CHOICES

It is crucial to involve women in decisions affecting their health or safety. At the same time, she may not feel safe making decisions. The impact of living in constant fear can compromise a woman's ability to make decisions or choices. This could be interpreted as reluctance or an inability to make decisions rather than a fear of the consequences of making choices independent of her abusive partner.

- Women who are abused may choose not to disclose, even though you ask in a caring and supportive way. Respect her choice and tell her she can come back to you if abuse does happen. If that is not appropriate to your setting, then provide information on where she or a friend or family member might go if abuse were to happen to them.
  - be aware when suggesting treatments or procedures for use at home as her freedom to follow through on these may be compromised by her partner's demands
  - provide community resource information if it is safe to do so

- Women experiencing intimate partner violence may disclose abuse but may not be ready to take any other steps at that time.
  - convey awareness regarding the complexity of abusive relationships
  - reinforce the health impacts of abuse for her and her children if appropriate
  - talk about her safety, if she is willing
  - provide information about community resources and safety planning

- Women who have lived in abusive situations over a long period of time are likely experiencing chronic problems that may include confusion, inability to think clearly and make decisions, and inability to trust others.
  - provide support and reassurance. Tell her that no one deserves to be abused
  - recognize that your role may be limited to keeping her safe in your agency

- Women may take the opportunity you are able to offer them, and may decide to leave the relationship and seek shelter elsewhere.
  - women often leave and then return to the abusive relationship several times before they leave for good
  - women may feel safer within the abusive relationship than outside it, as the partner may harass and threaten her (risk of harm to the woman increases after she has left the relationship)
  - women may be forced to return to the relationship due to financial constraints, lack of social support, or pressure from family members on both sides

7.5 HEALTH CARE PROVIDER RESPONSE WHEN ABUSE IS DISCLOSED: GUIDING PRINCIPLES

When a woman confirms or discloses that she is in an abusive relationship, there are some guiding principles that researchers have identified as important in the health care providers' response to these women. Many researchers, health care providers and program planners are becoming more sensitive to improving the health care encounters of women in abusive relationships. This requires an approach that recognizes both the health and social impacts of violence against women. The following approaches are recommended once abuse is identified, over and above the universal approaches outlined on page 7.

A. Be Supportive When Abuse is Disclosed

- Express an appreciation of the disclosure.
- Demonstrate an understanding and sympathy of the women's experiences in her abusive relationship.[42,109-110]
- Listen to her and validate her story.
- Assure her that the information is confidential.
- Ask her what type of supports she has and if she is aware of community support services.
- Ask about her safety.
- Avoid potential retraumatization. Do not berate her for staying or advise her to leave despite the risks of doing so. Do not ignore a disclosure, minimize or discredit her story or the health impacts of abuse.[47,74-76,82,111-115]

B. Link Presenting Health Concerns with Abuse and Consider Other Health Impacts (see page 5)

C. Assess for and Minimize Potential Barriers to Care (see page 5)

- Ask, "What are the things that would help you to get some help?" and "What are the things that stop you from seeking some support?"

D. Provide Women with Information about Community and Legal Services

Health care providers should be aware of the community, regional, and provincial support services provided by women's anti-violence support services and legal services (see Appendix I, page 22). Women can benefit from the support and advocacy transition houses, specialized victim assistance workers or "stopping the violence" counseling programs that

may exist in each community. These services can provide your health care organization with a complete list of resources in your community.

E. Develop a Safety Plan

Safety planning has been shown to reduce exposure to violence during pregnancy independent of whether women choose to leave their partners.[94,116] Safety planning involves having a safety kit stored outside the house which includes a change of clothing for a woman and her children, extra car and house keys, medication, cash, banking documents, and legal documents. The woman should have a plan detailing whom she will call or where she will go (regardless of time of day), if violence is anticipated or has occurred. She must know where to find the numbers of 24 hour telephone crisis lines. Women may need to be reminded to take their children with them when they leave.

8. DOCUMENTATION[117-119,121]

It is important to be aware that documentation of care may be a sensitive issue for women who have been abused. The issues of documentation therefore must be considered from both the professional accountability perspective and from the women's perspective.

From the perspective of professional accountability, care providers are professionally and legally required to document the care or services provided to a client. This includes written information about relevant observations and assessments. In doing this, care providers are expected to distinguish between relevant and irrelevant information. At the outset of care, care providers should explain to the client the reason for gathering and documenting information.

From the perspective of the woman, a client may request that specific relevant information not be documented. In such a case, the care provider should explore the issues with the client and ways to address them. This may include providing more detailed information to the client about why the information is documented and how it will be kept and used. It should be explained that information is placed in the chart for continuity of care and so questions will not be repeated. However, it should be remembered that **the particulars of her story are not as important as the process of her getting help**. It is acceptable to document her request that details not be documented in the chart. Care providers should be sensitive to the needs of the patient without compromising their professional practice standards.

Documentation of abuse must be undertaken in such a way as to ensure that:

- **Safety is guarded**.
- **Confidentiality is protected**.
- **Data is objective and free of bias**.
- **The degree of detail reflected in the documentation is consistent with the woman's wishes**.

Documentation should be limited to those areas that are relevant to the woman's health and health care. Documentation should include the discussion of intimate partner violence and how the provider has responded if the answer was affirmative, e.g. referral to community agencies,

safety planning, provision of emergency phone numbers. Detailed documentation on the antenatal form could put the woman at risk if she has the form in her possession.

8.1 INFORMATION SHARING BETWEEN HEALTH CARE PROVIDERS AND COMMUNITY REPRESENTATIVES

Requests for information between providers should always be accompanied by a written consent. Referrals involve an implied consent.

- Any time a provider requests information from another provider regarding a particular patient, the patient's written consent should accompany it. In certain circumstances a verbal consent may be sufficient if the situation is urgent and the process is well documented. A written consent can always be forwarded at a later date.

- Referrals from one provider to another are most often by the patient's request. Although there is no legislation governing this process, there is an implied consent that information will be shared between care providers unless otherwise specified by the client. Exceptions to this most often involve emergent situations where a person is unable to provide permission for referral of their own accord.

8.2 CONFIDENTIALITY

A. PHYSICIANS

The Canadian Medical Association (CMA) Code of Ethics section 22 states that a physician must "respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when the maintenance of confidentiality would result in a significant risk of substantial harm to others… in such cases, take all reasonable steps to inform the patient that confidentiality will be breached".[127]

B. EMPLOYEES OF HOSPITALS AND PUBLIC HEALTH CARE BODIES

Hospital and public health employees must also respect confidentiality however, information sharing can and must occur in certain circumstances. The collection and disclosure of information in the custody and control of a public body is governed by the *Freedom of Information and Protection of Privacy Act*. In this act, chart records and files are for the most part considered private information except when a request is made by a child protection social worker under Section 96 of the CFCS Act.

9. INTIMATE PARTNER VIOLENCE AND LEGAL ISSUES[120]

Not all forms of abuse are punishable as criminal offences. Physical assault, sexual assault, threats to kill and fraud are criminal offences, but emotional abuse is not.

> In Canada there is not a duty to report assaults to police or other authorities, unless they involve children under 19 years of age. Preserving the woman's confidentiality has higher importance than reporting to police. If police ask for information, health care workers are not able to provide it without the woman's consent.

It is therefore imperative that health care workers follow the directives of the woman in deciding whether or not to involve the police. In British Columbia, Crown Council upon recommendation of law enforcement officers may lay charges in cases of intimate partner violence if they believe an assault has occurred, regardless of the wishes of the woman.

The decision to involve child protection workers of the BC Ministry of Children and Family Development (MCFD) is determined on a case-by-case basis. A woman being abused by her partner is not sufficient criteria for child protection services to be involved. Contact should only be made with child protection if there is risk of harm to the child. When such a referral is necessary, involving the woman in the referral is optimal, as she will likely share concerns about her children's safety.

Documenting all clinical evidence that pertains to injuries is very important. If a woman decides it would be helpful to her, recent or healing injuries should be photographed, with photographs dated and signed. Consent for taking pictures should also be documented. Copies of photographs should be offered to the woman in case she wishes to give them to a lawyer or other advocate. Collecting and preserving evidence, such as torn clothing, for court is also important. Should the case go to court, the medical record will be a source of evidence (See Section 8: Documentation).

If a health care worker is the victim of threats, assaults or fraud from an abuser who may also be a patient, they are not expected to maintain patient confidentiality.

10. HARM REDUCTION

The goal of any contact between a woman being abused and a health care provider is to reduce the harm caused by the abuse. Providing supportive care that takes into account her need for privacy, safety, confidentiality and respect will increase the possibility of seeking health care and reduce the health impacts of abuse.

11. PREVENTION

Primary prevention of intimate partner violence involves taking a proactive approach within a community to support zero tolerance. Examples of zero tolerance for violence include provision of a violence free work environment, teaching of non-violent child-rearing skills to parents, education of students about intimate partner violence, and taking a public stand against violence in the media. It involves analysis and debate of local, provincial, and federal government initiatives designed to end violence and promote individual human rights.

Secondary prevention involves early identification and intervention, and should include advocacy for necessary services. Assessment as part of routine history-taking can occur in the

context of health units, clinics, hospitals, and physician/dentists' offices. Provision of educational materials such as pamphlets and resource cards in health care settings is a means of raising awareness among the general public. Individual health care providers can assist with coordination of relevant services and agencies within their communities, and can facilitate interdisciplinary approaches to care.

Tertiary prevention involves working with families who have experienced violence. Safety planning has been shown to reduce exposure to violence during pregnancy whether or not women choose to leave their partners.[94,116] Women are at highest risk for violence during the year after leaving their abusive partner. Women attempting to leave may need information about safe housing, legal assistance, employment, transportation, childcare, health services, and social support.[121] Children may require referral to support programs for children who witness abuse. Women and children may require support to mourn the loss of their family constellation. Health care providers need to have information about currently available resource services in their community (see Appendix A, page 22). To the extent that women are respected and supported in their decision making, they will be empowered to enhance their safety and the safety of their children.

REFERENCES

1. Tjaden, P., & Thoennes, N. (1998). Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
2. Rodgers, K. (1994). Wife assault: The findings of a national survey. Juristat: Service Bulletin, 14(9), 1-22.
3. Campbell, J., Rose, L., Kub, J., & Nedd, D. (1998). Voices of strength and resistance: A contextual and longitudinal analysis of women's responses to battering. Journal of Interpersonal Violence, 13(6), 743-762.
4. McFarlane, J., Campbell, J., Wilt, S., Sachs, C., Ulrich, Y., & Yu, S. (1999). Frequency and type of stalking before attempted and actual intimate partner femicide. Homicide Studies, 3(300-316).
5. Canadian Centre for Justice Statistics. (1993). Violence Against Women Survey highlights and questionnaire package. Ottawa: Statistics Canada.
6. Johnson, H. (1996). Dangerous domains: Violence against women in Canada. Scarborough, ON: International Thomson Publishing.
7. Dekeseredy, W. S., & McLeod, L. (1997). Woman abuse: A sociological story. Toronto: Harcourt Brace.
8. Jones, A. S., Gielen, A. C., Campbell, J. C., Schollenberger, J., Dienemann, J. A., Kub, J., O'Campo, P. J., & Wynne, E. C. (1999). Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. Women's Health Issues, 9(6), 295-305.
9. Ratner, P. (1993). The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta. Canadian Journal of Public Health, 84(4), 246-249.
10. Heise, L. L., Pitanguy, J., & Germain, A. (1994). Violence against women: The hidden health burden: World Bank discussion papers (255). Washington, DC: International Bank for Reconstruction and Development/World Bank.
11. Canadian Centre for Justice Statistics. (1993). Violence Against Women Survey highlights and questionnaire package. Ottawa: Statistics Canada.
12. Sharps, P. W., Koziol-McLain, J., Campbell, J., McFarlane, J., Sachs, C., & Xu, X. (2001). Health care providers' missed opportunities for preventing femicide. Preventive Medicine, 33(5), 373-380.

13. Stewart, D., & Cecutti, A. (1993). Physical abuse in pregnancy. Canadian Medical Association Journal, 149(9), 1257-1263.
14. Canada, S., The violence against women survey. 1993. The Daily. Statistics Canada.
15. Sleutel, M.R., (1998). Women's experiences of abuse: a review of qualitative research. Issues in Mental Health Nursing. 19, 525-39.
16. Brendtro, M. and L.H. Bowker, (1989). Battered women: how can nurses help? Issues in Mental Health Nursing, 10, 169-80.
17. Alpert, E., (1995). Violence in intimate relationships and the practicing internist: New "disease" or new agenda? Annals of Internal Medicine. 123, 774-781.
18. Warshaw, C., (1997). Intimate Partner Abuse: Developing a Framework for Change in Medical Education. Academic Medicine. 72(Supplement), S26-S37.
19. MacLeod, L. & Shin, M. (1990). Isolated, afraid and forgotten: the service delivery needs and realities of immigrant and refugee women who are battered. National Clearing House of Family Violence, Ottawa: Health and Welfare Canada.
20. McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reed, S. (1999). Research exchange. Severity of abuse before and during pregnancy for African American, Hispanic, and Anglo women. Journal of Nurse Midwifery, 44(2), 139-144.
21. Stark, E. and A. Flitcraft, (1991). Spousal Abuse, in Violence in America: A Public Health Approach, M. Rosenburg and M.A. Fenley, Editors. Oxford University Press: New York.
22. Programs, N.C.o.A.-V., (1998). The annual report on lesbian, gay, bisexual, transgender domestic violence. National Coalition of Anti-Violence Programs.
23. Margolies, L. and E. Leeder, (1996). Violence at the Door: Treatment of Lesbian Batterers. Violence Against Women, 2(3), 139-57.
24. Bohn, D. K. (2001). Lifetime and cumulative effects of violence against women. Paper presented at the 11th Nursing Network on Violence Against Women International Conference, Madison, Wisconsin.
25. Herman, J. (1992). Trauma and recovery. New York: Harper Collins.
26. Currie, D., (1990). Women's liberation and women's mental health: towards a political economy of eating disorders, in Women and well-being, V. Dhruvarajan, Editor. McGill-Queen's University Press: Montreal.
27. Root, M.P. and P. Fallon, (1988). The incidence of victimization experiences in a bulemic sample. Journal of Interpersonal Violence. 3, 161-73.
28. Stark, E. and A. Flitcraft, (1996). Women at Risk: Domestic Violence and Women's Health. London: Sage Publications. 264.
29. Straus, M.A. and R.J. Gelles, (1990). Physical violence in American families: risk factors and adaptations to violence in 8145 families. New Brunswick, N.J.: Transaction Publishers.
30. Liebschutz, J.M., K.P. Mulvey, and J.H. Samet, (1997). Victimization among substance-abusing women: worse health outcomes. Archives of Internal Medicine, 157, 1093-7.
31. Atwood, J.D., (1991). Domestic violence: the role of alcohol. Journal of the American Medical Association, 265, 460-1.
32. Warshaw, C., (1989). Limitations of the medical model in the care of battered women. Gender & Society, 3(4), 506-17.
33. Stark, E., A. Flitcraft, and W. Frazier, (1979). Medicine and patriarchal violence: The social construction of a "private" event. International Journal of Health Services, 9, 461-89.
34. Gielen, A.C., et al., (1999). Women's opinions about domestic violence screening and mandatory reporting. American Journal of Preventive Medicine, 19(4), 279-85.
35. Cohen, S., E. DeVos, and E. Newberger, (1997). Barriers to Physician Identification and Treatment of Family Violence: Lessons from Five Communities. Academic Medicine, 72(Supplement), S19-S25.
36. Carmen, E., Rieker, P., & Mills, T., (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 141, 378-83.

37. Heise, L.L., A. Germaine, and J. Pitanguay, (1994). Violence Against Women: The Hidden Health Burden., World Bank: Washington, DC.
38. Gondolf, E.W., (1998). Assessing woman battering in mental health services. Thousand Oaks, CA: Sage.
39. Walling, M.K., et al., (1994). Abuse history and chronic pain in women. Obstetrics and Gynecology,. 84, 193-9.
40. Drossman, D.A., J. Leserman, and G. Nachman, (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. Annals of Internal Medicine, 113, 828-33.
41. Jacobsen, A. and B. Richardson, (1987). Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry. American Journal of Psychiatry, 144, 908-13.
42. Kimberg, L., (1997). Draft Working Paper: Domestic Violence Screening. Family Violence Prevention Fund, U.S. Department of Health and Human Services.
43. Warshaw, C., (1996). Domestic violence: changing theory, changing practice. Journal of the American Medical Women's Association, 51, 87-91,100.
44. Ratner, P.A., (1991). The health problems and health care utilization patterns of wives who are physically and/or psychologically abused, in School of Nursing. University of Alberta: Edmonton, AB.
45. Plichta, S.B., (1992). The effects of woman abuse on health care utilisation and health status: a literature review. Women's Health Issues, 2, 154-8.
46. Koss, M.P., P.G. Koss, and W.J. Woodruff, (1991). Deleterious effects of criminal victimization on women's health and medical utilization. Archives of Internal Medicine, 151: p. 342-7.
47. Campbell, J.C., et al., (1994). Battered women's experiences in the emergency department. Journal of Emergency Nursing, 20(4), 280-8.
48. Drossman, D.A., J. Leserman, and G. Nachman, (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. Annals of Internal Medicine, 113, 828-33.
49. Wiist, W.H. and J. McFarlane, (1998). Severity of Spousal and Intimate Partner Abuse to Pregnant Hispanic Women. Journal of Health Care for the Poor and Underserved, 9(3), 248-61.
50. Sorenson, S., (1996). Violence against women: examining ethnic differences and commonalities. Evaluation Review, 20, 123-45.
51. Walling, M.K., et al., (1994). Abuse history and chronic pain in women. Obstetrics and Gynecology, 84, 193-9.
52. Fischbach, R. and B. Herbert, (1997). Domestic Violence and Mental Health: Correlates and Conundrums within and across cultures. Social Science and Medicine, 45(8), 1161-76.
53. Carrigan, T., Walker, E. & Barnes, S. (2000). Domestic violence: The shaken adult syndrome. Journal of Accident and Emergency Medicine, 17(2).
54. Bohn, D.K. and K.A. Holz, (1996). Sequelae of abuse. Health effects of childhood sexual abuse, domestic battering, and rape. Journal of Nurse-Midwifery, 41(6), 442-56.
55. Wiist, W.H. and J. McFarlane, (1998). Severity of Spousal and Intimate Partner Abuse to Pregnant Hispanic Women. Journal of Health Care for the Poor and Underserved,. 9(3), 248-61.
56. Kimberg, L., (1997). Draft Working Paper: Domestic Violence Screening., Family Violence Prevention Fund, U.S. Department of Health and Human Services.
57. Evins, G., & Chescheir, N. (1996). Prevalence of domestic violence among women seeking abortion services. Women's Health Issues, 6(4), 204-209.
58. Heise, L. L. (1993). Reproductive freedom and violence against women: Where are the intersections? The Journal of Law, Medicine & Ethics, 21(2), 206-216.
59. Russo, N. F., & Denious, J. E. (2001). Violence in the lives of women having abortions: Implications for practice and public policy. Professional Psychology: Research and Practice, 32(2), 142-150.
60. Carmen, E., Rieker, P., & Mills, T., (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 141, 378-83.
61. Margolies, L. and E. Leeder, (1996). Violence at the Door: Treatment of Lesbian Batterers. Violence Against Women, 2(3), 139-57.

62. Straus, M.A. and R.J. Gelles, (1990). Physical violence in American families: risk factors and adaptations to violence in 8145 families. New Brunswick, N.J.: Transaction Publishers.
63. Liebschutz, J.M., K.P. Mulvey, and J.H. Samet, (1997). Victimization among substance-abusing women: worse health outcomes. Archives of Internal Medicine, 157, 1093-7.
64. Heise, L.L., A. Germaine, and J. Pitanguay, (1994). Violence Against Women: The Hidden Health Burden. World Bank: Washington, DC.
65. Seniors, B.M.o.H.a.M.R.f., (1997). Health goals for British Columbians, December. Ministry of Health and Ministry Responsible for Seniors: Victoria:.
66. McLeer, S.V. and R.A. Anwar, (1987). The role of the emergency physician in the prevention of domestic violence. Annals of Emergency Medicine, 16, 1155-61.
67. Campbell, J.C., Poland, M. L., Waller, J. B., & Ager, J., (1992). Correlates of battering during pregnancy. Research in Nursing and Health, 15, 219-26.
68. McCauley, J., Kern, D.E., Kolodner, K., Dill, L, Schroeder, A.F., DeChant, H.K., Ryden, J., Bass, E.B., & Derogatis, L.R., (1995). The 'battering syndrome': Prevalance and clinical characteristics of domestic violence in primary care international medicine practices. Annals of Internal Medicine, 123, 737-46.
69. Walling, M.K., et al., (1994). Abuse history and chronic pain in women. Obstetrics and Gynecology, 84, 193-9.
70. McFarlane, J., Parker, B., & Soeken K. (1996). Abuse during pregnancy: Associations with maternal health and infant birth weight. Nursing Research,45(1), 37-42.
71. Taggart, L., & Mattson, S. (1996). Delay in prenatal care as a result of battering in pregnancy: cross-cultural implications. Health Care for Women International, 17(1), 25-34.
72. Gondolf, E. (1998). Assessing woman battering in mental health services. London: Thousand Oaks.
73. McFarlane, J., Hughes R., Nosek M., Groff Y., Swedland N., & Mullen, P. (2001). Abuse Assessment Screen-Disability (AAS-D): Measuring frequency, type, and perpetrator or abuse toward women with physical disabilities." Journal of Women's Health and Gender Based Medicine, 10(9), 861-6.
74. Pinn, V.W. and M.T. Chunko, (1997). The Diverse Faces of Violence: Minority Women and Domestic Abuse. Academic Medicine, 72(Supplement), S65-S71.
75. Moore, M.L., D. Zaccaro, and L.H. Parsons, (1998). Attitudes and Practices of Registered Nurses Toward Women Who Have Experienced Abuse/Domestic Violence. Journal of Obstetrical, Gynecological and Neonatal Nursing, 27(2), 175-82.
76. Rodriguez, M.A., S.S. Quiroga, and H.M. Bauer, (1996). Breaking the silence: battered women's perspectives on medical care. Archives of Family Medicine, (5), 153-8.
77. Gerbert, B., et al., (1999). How health care providers help battered women: the survivor's perspective. Women & Health, 29(3), 115-35.
78. Caralis, P.V. and R. Musialowski, (1997). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. Southern Medical Journal, 90(11), 1075-80.
79. McMurray, A. and K. Moore, (1994).Domestic violence: Are we listening? Do we see? The Australian Journal of Advanced Nursing, 12(1), 23-8.
80. Chalk, R. and P. King, (1998). Assessing family violence interventions. American Journal of Preventive Medicine, 14(4), 289-92.
81. Health, M.s.A.C.i.W.s., (1999). Moving towards change: strengthening the response of British Columbia's health-care system to violence against women. A report to the Minister Responsible for Seniors and the Minister of Women's Equality. Minister's Advisory Council in Women's Health: Victoria.
82. Chez, N., (1994). Helping the victim of domestic violence. American Journal of Nursing, July, 33-37.
83. McLeer, S.V., et al., (1989). Education is not Enough: A Systems Failure in Protecting Battered Women. Annals of Emergency Medicine, 18, 651-3.

84. Eisenstat, S.A. and L. Bancroft, (1999). Primary care: domestic violence. New England Journal of Medicine, 341(12), 886-92.
85. Brendtro, M. and L.H. Bowker, (1989). Battered women: how can nurses help? Issues in Mental Health Nursing, 10, 169-80.
86. Boychuk Duchscher, J.E., (1994). Acting on violence against women. The Canadian nurse, 90(6), 21-25.
87. Henderson, A.D. and J.R. Ericksen, (1994). Enhancing nurses' effectiveness with abused women. Journal of Psychosocial Nursing, 32(6), 11-15.
88. Ratner, P., (1995). Societal responses as moderators of the health consequences of wife abuse, in School of Nursing. University of Alberta: Edmonton.
89. Janssen, P.A., M.C. Basso, and R.M. Costanzo, (1998). The prevalence of domestic violence among obstetrical nurses. Women's Health Issues, 8(5), 317-23.
90. Gremillion, D.H. and E.P. Kanof, (1996). Overcoming barriers to physician involvement in identifying and referring victims of domestic violence. Annals of Emergency Medicine, 27, 769-73.
91. Warshaw, C. and E. Alpert, (1999). Integrating routine inquiry about domestic violence into daily practice. Annals of Internal Medicine, 131(8), 619-29.
92. Varcoe, C.M., (1998). From "Better-than-nothing" to "Best Practice". Background paper on "Best Practices" in Health Care in Relation to Violence Against Women. Prepared for the Minister's Advisory Council on Women's Health. British Columbia Ministry of Health.: Vancouver, BC.
93. Loring, M.T. and R.W. Smith, (1994). Health Care Barriers and Interventions for Battered Women. Public Health Reports, 3, 328-38.
94. Parker B, McFarlane J, Soeken K,, Silva C, Reel S. (1999). Testing an intervention to prevent further abuse to pregnant women. Research in Nursing & Health 22, 59-62.
95. Janssen P, Holt V, Sugg N. (2002). Domestic violence assessment. A model for implementation. Maternal Child Health Journal, 6, 195-203.
96. Hayden S, Barton E, Hayden M. (1997). Domestic violence in the emergency department: How do women prefer to disclose and discuss the issue. The Journal of Emergency Medicine 15, 447-451.
97. Ramsay, J., Richardson, J., Carter, Y., Davidson, L., and Feder, G. (2002). Should health professionals screen women for domestic violence? BMJ 325, 314.
98. McFarlane J, Soeken K, Wiist W. (2000). An evaluation of interventions to decrease intimate partner violence to pregnancy women. Public Health Nursing 17, 443-451.
99. McFarlane J, Soeken D, Reel S, Parker B, Silva D. (1997). Resource use by abused women following an intervention program: Associated severity of abuse and reports of abuse ending. Public Health Nursing 14, 244-250.
100. Chamberlain L. (2001). Your words make a difference: Broader implications for screening. Family Violence Prevention Fund Health Alert. 1, 1-66.
102. Randall, T. (1991). Hospital – wide program identifies battered women; offers assistance. JAMA. 266, 1177-1180.
102. Herman J. (1997). Trauma and Recovery. 2nd ed. New York, NY: Basic Books.
103. Kimberg L. (1999). Screening for domestic violence changed my practice. Health Alert. San Francisco, CA: Family Violence Prevention Fund; Summer.
104. Health Canada. (1999). "A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy". Minister of Public Works and Government Services Canada. http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/pregnancy-e.pdf
105. Health Canada (2000.). "Family-Centred Maternity and Newborn Care: National Guidelines. Ottawa. http://www.hc-sc.gc.ca/hppb/childhood-youth/cyfh/child_and_youth/physical_health/maternity.html
106. The Society of Obstetricians and Gynecologists of Canada. Policy Statement No. 46, March 1996. "Violence Against Women" http://www.sogc.org/SOGCnet/sogc_docs/common/guide/pdfs/ps46.pdf

107. The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). 2002. "Violence Against Women: Identification, Screening, and Management of Intimate Partner Violence" http://www.awhonn.org/cms/pdf/Violence%20Against%20Women%20CE%20Resource.pdf
108. McFarlane J, Parker B. (1994). Preventing abuse during pregnancy: An assessment and intervention protocol. MCN 19, 321-324.
109. Health, N.Z.M.o., (1998). Family Violence: Guidelines for health sector providers to develop practice protocols. Ministry of Health: Wellington, New Zealand.
110. Frank, J.B. and M.F. Rodowski, (1999). Review of Psychological issues in victims of domestic violence seen in emergency settings. Emergency Medical Clinics of North America, 17(3), 657-77.
111. Gerbert, B., et al., (1999). How health care providers help battered women: the survivor's perspective. Women & Health, 29(3), 115-35.
112. Caralis, P.V. and R. Musialowski, (1997). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. Southern Medical Journal, 90(11), 1075-80.
113. McMurray, A. and K. Moore, (1994). Domestic violence: Are we listening? Do we see? The Australian Journal of Advanced Nursing, 12(1), 23-8.
114. Chalk, R. and P. King, (1998). Assessing family violence interventions. American Journal of Preventive Medicine, 14(4), 289-92.
115. Health, M.s.A.C.i.W.s., (1999). Moving towards change: Strengthening the response of British Columbia's health-care system to violence against women. A report to the Minister Responsible for Seniors and the Minister of Women's Equality, Minister's Advisory Council in Women's Health: Victoria.
116. McFarlane J, Parker B, Soeken D, Silva D, Reel S. (1998). Safety behaviours of abused women after an intervention during pregnancy. JOGNN, 64-69.
117. Registered Nurses Association of British Columbia. (1999). Nursing Documentation. RNABC; Vancouver.
118. Registered Nurses Association of British Columbia. (2002). Verbal and written correspondence.
119. Ferris L, McMain-Klein M, and Silver L. (1997). Documenting wife abuse: a guide for physicians. CAN MED ASSOC J. April. 156(7), 1015-1022.
120. Ferris,L.E., Nurani,A., and Silver,L. (1999). Chapter 4: The Role of Medical Documentation in Providing High-Quality Care and in Legal Procedings, in A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians, pages 11-13. The National Clearinghouse on Family Violence, Family Violence Prevention Unit, Health Canada.
121. Sullivan C, Basta J, Tan C, Davidson W. (1992). After the crisis: A needs assessment of women leaving a domestic violence shelter. Violence and Victims 7, 267-275.
122. Health Canada. (1994). The Canadian Task Force on the Periodic Health Examination. The Canadian guide to clinical preventative health care. Ottawa: Canada Communications Group: 158-65.
123. Maternity and Newborn Care Committee: The College of Family Physicians of Canada. (2000).The effect of domestic violence on pregnancy and labour. January 28.
124. The American College of Obstetricians and Gynecologists. (1999). Educational Bulletin No. 255.
125. American College of Nurse-Midwives. (1997). Position Statement: Violence Against Women. Aug.
126. Jacquelyn C. Campbell, Ph.D., R.N. (1998). Danger Assessment Tool. The Johns Hopkins University School of Nursing. Baltimore. **http://www.son.jhmi.edu/research/CNR/Homicide/DANGER.htm**
127. Canadian Medical Association. 1997. Code of Ethics.
128. Janssen P, Holt V, Sugg N, Emanuel I, Critchlow C, Henderson, A. Intimate partner violence and adverse pregnancy outcomes: A population-based study. American Journal of Obstetrics & Gynecology 2003;188: in press.

APPENDIX A

PROVINCIAL AND NATIONAL RESOURCES

A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians. Lorraine Ferris, Asifa Nurani and Laura Silver. Health Canada, 1999.
http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/physician-e.pdf

A Handbook for Health and Social Service Professionals Responding to Abuse during Pregnancy. Wanda Jamieson and Liz Hart. Health Canada, 1999
http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/pregnancy-e.pdf

BC Association of Specialized Victims Assistance and Counselling
Suite 728 – 602 West Hastings Street
Vancouver, BC V6B 1P2
Tel: (604) 633-2506

BC Institute Against Family Violence
Suite 551 – 409 Granville Street
Vancouver, BC V6C 1T2
Tel: (604) 669-7055
www.bcifv.org

BC Women's Hospital and Health Centre
Provincial Violence and Health Initiative
Woman Abuse Response Program
E408 4500 Oak Street
Vancouver, BC V6H 3N1
Tel: (604) 875-3717 (604) 875-2881 (Sexual Assault Service)

BC/Yukon Society of Transition Houses
Suite 507 – 475 Howe Street
Vancouver, BC V6C 2B3
Tel: (604) 669-6943
Fax: (604) 682-6962
http://www.bcysth.ca

Domestic Violence Program, Vancouver General Hospital
855 West 12th Avenue
Vancouver, BC V5Z 1M9
Tel: (604) 875-4924
Fax: (604) 875-5460
DVClinic@vanhosp.bc.ca
http://www.vanhosp.bc.ca/html/wellness_domestic_violence.html

National Clearinghouse on Family Violence
Room 706, Brooke Claxton Building
Tunney's Pasture
Ottawa, ON K1A 1B5
Tel: (800) 267-1291
Fax: (613) 957-4274
http://www.hc-sc.gc.ca/hppb/familyviolence/index.html

Providence Health Care Domestic Violence Intervention Program
St. Paul's Hospital
1081 Burrard Street,
Vancouver, BC V6Z 1Y6.
Tel: (604) 682-2344 local 62093
Fax: (604) 806-8268
http://www.providencehealth.bc.ca/programs/domestic.htm

Transition Houses and Shelters for Abused Women in Canada.
Government of Canada. 2002.
http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/2002-Transition%20Houses.pdf

Vancouver Lower Mainland Multicultural Family Support Services Society
5000 Kingsway Plaza, Phase 3
305 – 4980 Kingsway
Burnaby, BC V5H 4K7
Tel: (604) 436-1025
Fax: (604) 436-3267
http://www.vlmfss.ca/main.html

Woman's Equality,
Ministry of Community, Aboriginal and Women's Services
Government of British Columbia
http://www.gov.bc.ca/mcaws/default.asp

Resources Specific to Your Community

Name **Phone**

1. _____

2. _____

3. _____

4. _____

5. _____