

**Report on the
Prenatal Early Intervention Response to Violence Against Women: Survey and
Interviews
February 2002**

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INTRODUCTION

The connection between violence and substance use is not unheard of. In our work with women many of us have remarked on the link between women substance use and the level of violence in their lives yet only recently has this connection been more fully explored. A 1997 Report on the Health of British Columbians, Provincial Health Officers Annual Report states "the incidence of drug affected babies has risen six fold in the last decade. Typically these babies are from "families of inter-generational drug users or from dysfunctional families with a history of sexual and physical abuse".

Research recently initiated through the BC Center of Excellence on Women's Health will document levels of alcohol and other drug use/misuse on the part of women accessing transition house services and possible changes in the level of women's use at a three month interval.(for further in formation contact Nancy Poole at 250-213-8144 in Victoria or npoole@cw.bc.ca or Renee Cormier 604-875-2424 or rcormier@cw.bc.ca).

In working to address the determinants of health for women and to prevent substance use and FASD, our community has continued to explore the issues that women struggle with in providing for their health and that of their children. Violence against women particularly during the perinatal period is one such issue that required further examination.

Our Perinatal Violence initiative, funded through National Crime Prevention Committee's Community Mobilization dollars, has allowed us to work further "upstream" work in developing Best Practices in our community that respond to the abuse of women as a health issue and as a particular problem during the perinatal period.

We have included here our literature review, [Violence against Women During the Perinatal Period](#) and a copy of our interim survey and interviews *Report on the Perinatal Early Intervention Response to Violence Against Women* to determine our communities current best practice responses to this problem. Based on this document and the response of our community, Northern Family Health Society in conjunction with VAWIR (Violence Against Women in Relationships) have initiated a training project with our community and health care workers, supported by the B.C. Women's Hospital and their ongoing work with violence responses. In June of 2002 we begin our training to respond to violence against women as a health issue, and our plan is to have 20 trained teams for community

training by early in the fall. If you wish to know more about this initiative please contact chris@nfhs-pg.org.

A Final Report on this training initiative will be available on line in the late fall of 2002.

GENERAL TRENDS IN COMMUNITY RESPONSES

In our preliminary research, many of the surveys returned by health care providers indicated that their agencies have no tools or information in place to address violence against women during pregnancy or for that matter violence against any woman. Most agencies have no screening process for abuse. A limited number of agencies have pamphlets or posters on violence but most receive no training within their organizations and few receive violence information during their formal post secondary education. Agencies that do engage in screening primarily refer to community services for intervention and follow-up. The vast majority of health care providers use personal visual observation of injuries or feelings of 'suspected violence' as a cue to ask about violence in the relationship.

We found that the violence information gathered from women who are in contact with health care providers are dealt with on a continuum of responses from no formal recording of the information to charting and sharing information with and without the woman's permission.

Most services fully address violence as it pertained to children and their safety. However, this same concern does not extend to women especially with pregnant women who have no previous children and who receive no services from government protection agencies.

The majority of health care providers surveyed stated that currently, training is the most important need. The vast majority of services have no in- house training or access to training specific to violence during pregnancy or in most cases relevant to violence in relationships and how health care providers should respond. The three key themes that arose from the data was the need for greater awareness and training, integration of services and communication between systems that will provide a continuity of care for women.

COMMUNITY HEALTH CARE PROVIDERS

Community health care providers expressed a number of issues and barriers such as not asking is better than asking the wrong thing and doing harm.

" Actually I know the other workers don't ask that question [about violence]."

Organizations provide very limited screening questions or opportunities for asking questions. In some agencies there are no questions asked about violence in relationships or the questions that are asked are poorly placed and poorly worded. Some agencies have formal protocols in place to deal with this issue but most are lacking.

" We need to find different ways...to either raise their comfort level, ask the question in a more sensitive way, normalize it, and let them understand...that sort of information that would be really important to

them."

Racism is an issue for women accessing health services and it is known to be a regular issue to deal with between clients and the medical system.

"Every time I call a doctors office and talk to the MOA, all I have to say is that I am a counsellor and they tell me everything I want to know...they don't even question who I am and take what I say at face value...well I have never called for someone who isn't First Nations and there is such a disrespect for them and this is this sign like by the way they talk about them, there is an inherent "they are just such a pain in the ass".

Community workers acknowledge that some women know how to ask for just enough help to get their needs met but not too much that it brings the system down on them. This balancing act is a delicate one that they must try to support but not openly.

"We are in a position in this agency to be, we could potentially be in a position to really change how this is handled, because we have the power to do that yet we don't. We follow the guidelines that are given to us by somebody else."

Outreach worker

INSTITUTIONAL HEALTH CARE PROVIDERS

Hospital health care providers encounter barriers and issues that are not vastly dissimilar from community workers. For some health service providers not asking is better than asking and doing harm.

"We know it's not right but what do we do with it? We need to promote her safety; yet it is arbitrary as to what nurses will do. Some nurses respond and some don't".

Nurse

In speaking with various workers throughout the hospital we found that different departments have different levels of screening however there is generally no screening process for perinatal violence.

Not on peds, no screening.

Nurse

"...I think the thing that most of us could do better is perhaps the recognition of the violence. Sometimes it's very obvious, of course there is bruising or the mother appears threatened, but I'm sure there are certain things that we would recognize if we were aware of what we should be recognizing. I think we would really benefit from certainly more training as far as women's violence goes."

Nurse

The issue of formal protocols for violence being used inconsistently was brought up as a problem to sustainable behavioural change.

" On any given day you might have some who are very familiar with abuse protocol and on another day no one who knows about it"

Doctor

The one area that all respondents were in agreement on is the identified lack of training available around the issue of violence and the intervention options.

" I would say we don't ever get any training. I guess we are self-trained".

Nurse

Lack of available and appropriately trained staff are considered to be a major reason for not having a better response to violence against women.

" I would say there is one resident in ten who has a natural gift for thinking about the context, the social context, of what' happening with a pregnancy and would be better at it. We don't teach it very well partly we have trouble teaching attitudes. It's a lot easier to teach technical skills."

Doctor

The usual response of hospital staff to issues of violence is to refer to the hospital social work department. Despite these referrals there are identified inconsistent responses on the part of community services and the lack of a single point of entry for referral to community.

" I think that if any of us suspect that there is any violence taking place we certainly will try to ask the appropriate questions to see whether there is violence happening. We would refer to social work [hospital]".

Nurse

The hospital itself is a closed system with concerns regarding violence often reported within the teams but seldom out side of the hospital unless there is a child protection concern. Then it is usually the hospital social worker that makes the report to the government agency.

" We are a short-term process; four walls inhibit us from extending care beyond the institution and mom's are gone within 24 hours".

Nurse

Emergency room physicians report there is no consistent triaging of patients. Clerks see them sometimes and there is no confidential area for interviewing women in emergency. This coupled with time constraints and work pressures prevent medical personnel from doing appropriate work in screening for violence.

" If trouble doesn't come looking for us, we don't go looking for trouble. We're swamped on an average day so you're not going to think, oh, I really should follow up on that problem with that patient and we don't have time to sit and contemplate about that sort of proactive thing".

Doctor

"I had this young gal...she came in saying that she was bleeding and looking very, very scared...it just wasn't connecting what all she was saying. So she came in on her own so I had a chance to really sit and chat with her. It was obvious that she had been violently injured. She finally admitted to me that her boyfriend had taken his work boots to her crotch and I think that's the one that had the biggest impact on me."

Nurse

WOMEN ACCESSING HEALTH CARE SERVICES

Pregnant women accessing services identified a number of barriers that prevent them from having their health and safety concerns adequately addressed. Women report they can't get to services because their controlling partners prevent them or they lack resources that provide transportation and childcare. For women in abusive relationships it is unsafe to access health care and they fear for their safety if their partners find out they have gone for help.

"I had my eyes open and my mouth shut throughout the whole pregnancy and I had to be obedient to him. It was very unsafe. He has a very controlling family and he was very controlling".

The fear of the Ministry Of Children & Family Development removing their children is an area identified by women. They believed that the Ministry was not there to help them but would side with the partner, blame her for failing to protect the children and remove the children

"...I sort of just wanted to handle it my own way and I just didn't want the Ministry to be like watching me all the time and stuff. Like I'm just scared that they might take away my kid when it's born because I've been in an unhealthy relationship."

Woman

Shame is the second largest barrier to receiving health care for perinatal women in abusive relationships. Women are judged and ridiculed when they identify as being abused. They are also blamed for not leaving.

"I think the biggest barrier for me was first of all, shame. Everybody made huge assumptions about what my life was like. That was confirmed for me once I finally left him and people would say to me 'you?', 'I can't believe you lived like that' or 'I can't believe you' almost judgmentally, almost like I let people down."

Woman

"I don't think I would have accessed a center for domestic violence, probably not because of my position in the community. I was very afraid of the stigma attached and the shame and the judgement. That's why I agreed to do this because I think more professional women need to speak out because I know there's more than just me in this community."

Woman

There is an assumption by professionals that women who "look" okay are okay. "Middle class" women are seen as being capable of taking care of themselves and when women present as articulate and educated there is a bias that they are not in an abusive relationship.

"I presented well and was well spoken, an upper class woman who was very involved with her children and very involved in my prenatal education... So I was really quite informed and there was a lot of assumptions made that it wasn't happening to me"

Woman

When we asked women what services or information they received during pregnancy that helped them deal with the violence, women described community based care from social service agencies but little help from the health care sector.

She [Family Doctor] knew the family quite intimately and knew the family history of violence and so I sort of thought back to that and no..., she didn't ask me any of those questions.

There was a lack of accessible information about services for women in abusive relationships. Women discussed the lack of information from doctors during prenatal visits or from prenatal classes. Medical personnel don't ask questions or discuss this area with their women patients.

" I've again seen my GP, who is a new GP, but who knows that I left an abusive relationship, and I saw a specialist yesterday actually and again, not one piece of information has been given to me about perinatal violence. I know, I know no information will be given to me...nothing and I'm looking for them now, I'm sort of scanning that so I'll pay closer attention throughout the pregnancy but no, nothing. I'll be willing to lay money that nobody talks to me about it!"

Woman

There is very little routine screening during a prenatal visit or in the community.

"If they had more information that was just built into prenatal packages or if doctors just routinely screened for that or as part of your prenatal information."

Woman

Women also don't disclose due to a lack of confidentiality and an uncertainty about who will be accessing this information.

" They actually shared it [information] with my protection worker...my social worker and other workers have share information amongst each other ...that could get me into a lot of trouble."

Because of these barriers women in our community fail to access care or if they do it is in crisis after the abuse and at women-centered services in the community where there is less ability to address their health concerns. Removing barriers to care involves establishing trust relationships and responding with empathy to assist women to feel they are valued and heard.

"Just be there for me and don't talk so much to everybody else about

it...just keep it between us I guess cause it kind of just breaks trust."
Woman

Attitude shifts and practice change are necessary for the full integration of this initiative. An integrated model that facilitates health care workers changing their views and asking questions differently would not require that we do more with less but would encourage a more effective use of time and resources.

" Any initiative that isn't 24- 7 won't work"
Doctor

Health care providers require knowledge of how to empower women to care for own health and safety as well as knowledge that address a more women-centered care model with more opportunities to challenge established responses.

"I think that rather than standardized questionnaires or anything we should be looking at better training around the full context of violence".
Social Worker

" I actually really think we need to revamp our questionnaires and all that stuff, it needs to be way more feminist, way more women centered because we are dealing with women!"
Community Worker

Other recommendations in the community feedback included:

- Integrated community protocols within the health care system
- Education programs for young men in the schools
- Accessible anger management [sic] programs for men
- More enforcement of laws for abusive men
- More access to shelters for under age women
- Ongoing funding for women's programs
- Continuity of care for women
- More immediate counselling response for women
- Discussion about important issues like legislation, duty to report, accountability, liability and parental rights.
- Augmentation of existing supports to enhance services.
- Change in attitude that reflects the need to hold the offender accountable and not punish the woman by taking her children
- Financial choices that would allow women to leave abusive relationships.
- Begin to access hospital through outpatient clinics.

Although many of these practice responses and recommendations address the issue of screening as a first step, some go beyond the screening model to a larger societal shift in attitudes and behaviors in both service provisions and accountability. These recommendations begin to address an area beyond the medical focus, which starts to look at the context of women's lives and the replication of the disempowering relationship in the physician-patient model.

DISCUSSION

In our surveys and interviews here in Prince George, many respondents talked about needing "better screening tools". Although this addresses the issue of direct questions about violence in the relationship, we have learned in the past few years that screening alone, though widely used, is not very effective. We are all acutely aware that during these fiscally restricted and politically uncertain times, we must consider the environment that we are requesting this change to occur in. However, we need to be cognizant that we are not asking health care providers to spend more time and energy. We are asking them to do their work differently which may ultimately result in the saving of time as women return less for health care needs that are a result of living in an abusive relationship.

We know there are a great number of women passing through the health care setting who are in abusive relationships but very few are identified as such and therefore are not offered help to address the violence. Although a woman's physical injury may be addressed, the most serious threat to a woman's well being is left unaddressed and the woman is often left in danger. Given this reality, health care providers must consider three key issues in addressing violence against women.

First, screening for violence is a first step in addressing women's health. A major part of screening is to ask women directly and privately about the abuse. But it does not stop there. The second issue is the medical model, which focuses solely on women's bodies and fails to look at the context of their lives. This prevents the health care providers from seeing the violence even when there are obvious signs of abuse. The third aspect of our work should begin to address the relationship between physician and patient as the physician primarily controls it. This dynamic parallels the dynamics of the abusive relationship, which can leave women feeling further victimized by their treatment in the health system.

The question then becomes, how do we ensure that these three key issues are addressed in our community?

The following information taken from the Woman Abuse Response Program Manual (2001) by Jill Cory and Betty Braund's literature review, clearly demonstrates the need for an approach that goes beyond screening.

- Health care providers feel uncomfortable asking screening questions and are not screening even when policies to do so are in place.
- One-time education initiatives do not produce sustainable responses over the long term.
- Screening may ask the question but only results in a yes answer 1 in 5 times, when women are known to be in abusive relationships.
- Screening perpetuates stereotypes as protocols are applied differently when the woman is of colour, Aboriginal, substance using or working class. Screening questions and intervention often targets these women.
- Health care providers do put women at greater risk particularly if they fail to address the context of women's lives,, prescribe inappropriate medication or treatment that compromises safety, refer or report her without her consent, speak to her abusive partner about the abuse or place expectations on the woman that are impossible for her to accomplish

- Screening identifies women and they are then treated poorly. Women report being ridiculed and feeling judged or pressured to do things they are unable or unwilling to do. Often their experiences are minimized, confidentiality is broken, they are treated as less worthy, laughed at and humiliated when they are identified as an abused woman.
- There still is not evidence that screening is effective in improving women's health or safety.

A physician referring to family practice residents stated:

"I don't think they are as anxious or as aware of what other factors out there could be affecting the outcome of this pregnancy; like nutrition, or family violence or poverty and so on and so forth."

Doctor

How can our community create best responses that consider the realities of women's lives? Our best responses need to recognize that our health care system can no longer reduce women to mere bodies, that it must take into account their lives and the reality of those lives. We must also realize that issues of power and control are as relevant to the health care setting as they are to the society at large. Simply asking women about abuse does not help them if we do not consider the larger context of the situation in which she receives care. Are we truly 'helping' if women feel belittled, judged or controlled in the health care setting where she comes for care? Are we meeting women's health care needs by making referrals to social service organizations for intervention?

Our community's response is still in its infancy, where the general trend is to call for training in screening, assessments and referral as the solution. Responses in our Prince George community survey and interviews indicate that most health care providers view woman abuse mainly as a social issue and refer them to community social programs while continuing to provide the same standardized health care. This suggests that we do not yet fully acknowledge the health impact of abuse and the need to practice health care differently.

We need to make health care providers aware that screening is only one step in a process of care and we need to develop a further understanding of the next steps required to shift attitude as well as behavior towards a contextual understanding of women and the realities of their lives.

In interviews with physicians, they described scenarios where once the abuse was disclosed, they referred women to community organizations and continued to provide standardized medical care...

"... if she reports violence that's severe enough that she's got to get out of the house, I organize her going off to a shelter and call the cops and tell her that it's okay to call the police and it's important for her safety and the safety of her unborn child. So if it's less then I'm basically involved in a woman's issue."

Was this woman's safety increased by her physician calling the police or not? Was he aware enough about the risks from her partner that he could determine the 'okayness' of her safety status? What if this physician had worked with the woman to determine the best possible health care response? Could the outcome have been safer, more effective and more empowering? We are still seeing referrals as a health intervention.

In learning from others who are actively engaged in this work, we know that practice change can not happen without organizational change and that organizational change requires a huge commitment in a larger process. Treating woman abuse within a health context means not referring out to social service agencies as the first line of response. Not referring women out immediately also addresses an area of concern that physicians find stressful which is ineffective government response and sporadic community intervention.

"If I have concerns about the welfare of the baby and make a referral to family and children service, because I am not sure about what will happen I think that may actually be a barrier to me making a referral, because I'm really...I don't want to unleash a process that is harmful. So it's a real dilemma because on the one hand you don't want to ignore a situation that is dangerous but on the other hand you don't want your patient...to be treated unkindly or unfairly."

CONCLUSION

Our community is aware of the need to ensure our best response for pregnant women and violent relationships and we are all aware that ensuring women's safety is paramount in our work. Screening seems like a logical response yet we are now more aware that it's effectiveness is greatly limited. We need to think and act differently around women's health and safety.

It is not a simple solution. In fact it one of the most complex issues we as service providers will come across. Yet if what we are doing is compromising women's health and well being then we need to not just try harder but learn to do our work differently, in both our practice and our attitudes about perinatal care and women in violent relationships.