MOVING TOWARDS CHANGE:
STRENGTHENING THE RESPONSE
OF BRITISH COLUMBIA'S HEALTH CARE SYSTEM
TO VIOLENCE AGAINST WOMEN

A Report to the Minister of Health
and Minister Responsible for Seniors
and the Minister of Women's Equality
from the Minister's Advisory Council
on Women's Health

BRITISH COLUMBIA

**Ministry of Health and
Ministry Responsible for Seniors**

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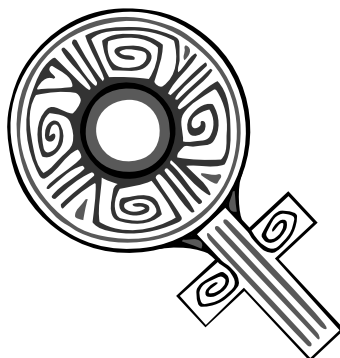
EXECUTIVE SUMMARY

The enormity of the problem of violence against women has been clearly established globally and in Canada. Estimates of the social and economic costs of violence are staggering, but to date social responses have not significantly reduced violence. Disabilities such as chronic pain and hearing loss, diseases such as sexually transmitted diseases and chronic bowel problems, and death are some of the physical consequences of injuries and stress associated with violence. The non-physical effects include a range of emotional effects, drug and alcohol abuse, depression and suicide. Although the costs of these health effects are beginning to be understood, health care systems have been slower to develop responses than the legal and social welfare systems. Over the past decade, however, the health consequences of violence have been increasingly recognized and treated with seriousness within the health care system. Due primarily to the leadership of committed individuals and groups, a variety of responses have been initiated within health care.

The purposes of this paper are to build on those pioneering efforts and to provide a framework for melding such initiatives into a coordinated, systematic effort to deal with violence against women within the health care system. This paper provides guidance for BC's Health Care System by reviewing the current status of the health care response to violence against women and suggesting principles upon which to base future action. It begins to identify important areas for collaboration with other jurisdictions for improving health related responses, and crucial areas in which the Ministry of Health can take action, demonstrate leadership, and develop models of "best practice". The paper points out the critical nature of dealing with diversity in all practices addressing violence against women. The paper also suggests a framework for thinking about "best practices" and an approach to achieving "best practices".

The framework offers a systematic way to think about violence against women and the health care system response, to plan services within health care that complement services in other jurisdictions, and to develop benchmarks against which to evaluate the success of any given program or practice. The concrete actions that can be taken include:

- conducting pilot projects;
- strengthening crucial links throughout the system, between health and other systems, within health regarding specific health care concerns (such as HIV/AIDS and drug and alcohol abuse), and between programs;
- completing evaluations of specific "mature programs" such as hospital-based 'domestic violence' programs;
- setting specific goals such as reducing the number of homicides related to violence against women; and,
- collecting baseline data regarding current 'domestic violence' and sexual assault programs.

INTRODUCTION

Violence against women has only been publicly acknowledged as a problem for a few short decades. For women who are abused in their homes, during this time "there has been both radical change and no change at all" (Dobash & Dobash, 1992, p. 1). The initial responses to violence against women were characterized by the Rape Crisis and Battered Women's Movements. The Battered Women's Movement resulted in increasing public awareness of the problem, concrete strategies such as shelters for women, and calls for further social action. Responses have been gradually professionalized and are now beginning to be evaluated and researched.

Within health care, recognition of the extent and consequences of violence against women has been slow, and violence has not been viewed as an important health issue for women. Responses have been fragmented and have not had the benefit of systematic evaluation. Currently, policy makers, service providers, researchers and women themselves are calling for improved responses and the use of systematic evaluation as a basis for practice. Many areas of practice are mature enough to warrant moving beyond good intentions, ad hoc interventions, and trial and error approaches to the provision of integrated services based on systematic evaluation. The idea of "best practices" offers an approach to such planning and evaluation.

In February 1998, the Minister's Advisory Council on Women's Health (MAC) began a process to draw attention to violence against women as a health care priority. The Council noted that:

- violence in all forms is a barrier to women's health;
- all forms of violence have damaging short and long term effects on the mental, physical and spiritual well-being of women;
- living in fear of violence or with violence is contrary to the fundamental conditions and resources necessary for health; and,
- although large sums of health care dollars have been and continue to be spent in responding to violence against women, in general there is no systematic or sustained response by the health sector for the prevention of violence against women.

British Columbia has the highest reported rates of violence against women of any province in Canada, but at present has no health care strategy for dealing with violence against women. Therefore, the purpose of this project was to look at what the health care system has been doing about violence against women, the barriers to action, and what could be done. What would be "best practices" in this area?

Working toward "best practices" requires an understanding of what is meant by "best practices", a picture of current health care practices, an assessment of the evidence regarding what "best" might be in this area, and a framework for establishing and proceeding toward goals for practice.

"BEST PRACTICES"

"Best practices" combines ideas from quality assurance, evidence based practice, evaluation research (including cost analyses), and technology assessment in order to provide processes for identifying benchmarks against which practices can be judged. The idea arose within commercial industry and has only recently been applied within health care. Within health care, the application of the idea of "best practice" has ranged from simply publishing particular practices under the rubric of "best" (the "Innovative Domestic Violence Program" from the Family Violence Prevention Fund 1997, is an example), to engaging in a systematic identification of what would constitute "best" with a particular health issue or practice area (for example, McLeod & Kinnon's 1996 systematic analysis of 30 'family violence' projects), to a rigorous research based investigation to identify evidence associated with particular practices. The recently published Violence in Families by Chalk and King (1998) is an example of the latter.

"Benchmarking" is an important element of "best practices" and refers primarily to the idea that some organizations will set the standards of practice against which others can measure their own practice. This, of course, presupposes that there are organizations which have the means by which to establish standards.

"BEST PRACTICES" IN VIOLENCE AGAINST WOMEN

At a common sense level, thinking about "best practices" seems like a valuable approach to improving health care in relation to violence against women. Health care practices are well enough developed to warrant moving beyond good intentions to insuring that practices have meaningful consequences. The idea of "best practices" in the more rigorous sense offers the opportunity to identify both a framework for systematic planning and evaluation of services and benchmarks against which to evaluate the success of any given system, program or practice.

Using the idea of best practices in this particular context is not, however, unproblematic. First, the goals of practice in health are as yet unclear and there is insufficient evidence upon which to base recommendations regarding "best". Introduction of the idea of "best" might be done in ways that either preclude creativity and initiative or threaten existing programs without meaningful alternatives being in place. Second, determining "best" is to some extent a matter of perspective. In anti-violence work, the perspective of bureaucrats, professional service providers, advocacy workers, and women who have experienced violence may differ. Third, an over-emphasis on short term cost saving without concurrent analysis of benefits might lead to the use of "best practices" as a cost cutting strategy rather than as a way to improve health outcomes. Finally, examinations of "best practice" typically do not address issues of public policy or funding, both of which will influence whether or not best practices are achieved. Thus, there is a need to concurrently consider both "best practice" and the political and economic resources to implement them. Best practice is not only concerned with programs, but also with an entire system of response.

"BEST" IN RELATION TO WHAT?

"Best practice" presupposes established goals, criteria by which to judge "best", and evidence upon which to base such judgements. Although the goals of health care practices in relation to violence against women might seem self-evident, such goals are rarely made explicit. Health goals specific to addressing violence against women have not been established for BC. However, the "Health Goals for British Columbia" (1997) include the percent of women who report ever experiencing physical or sexual violence, the incidence of 'domestic violence', and the incidence of violence witnessed by children as indicators of progress toward goals. Other jurisdictions have proposed specific goals (see example Box A) which could be used in conjunction with the broader health goals for BC to develop goals specific to violence against women.

In addition, currently we do not have adequate data to determine "best practices". Little evaluation has been done in most areas of practice in violence against women and the evaluation that has been done is not strong enough to make clear recommendations (Chalk & King, 1998; Cooper, 1995). In a comprehensive study of available evaluative studies on all forms of abuse, Chalk and King located 34 experimental or quasi-experimental evaluations concerned with 'domestic violence', only 8 of which were within health care. There are few additional Canadian studies, few evaluations of local programs, and limited resources for evaluation. Proposing that certain practices are "best" without having evidence to support such assertions would only further the problem of trial and error approaches to planning, and would permit unintended and unanticipated consequences to arise from well-intentioned programs and practices.

It is difficult to be critical of anything done in the area of violence against women. Intentions are usually good and providing any service at all has been a hard won battle. Service providers are often resistant to evaluation partly because such evaluation might interfere with service provision, and partly because the complexity of service provision makes evaluation difficult and is often not well understood by researchers (Chalk & King, 1998). Invoking "best practices" implies that some practices are not "best", or at a minimum, that practices could be better.

"BEST"? FROM WHOSE PERSPECTIVE?

Despite current concern for consumer "voice" and client participation, health care responses are largely professionalized. There are enormous challenges to incorporating the perspectives of women who experience violence (Lawrence, 1996; Winters, 1992). Women in violent relationships are rarely in a position to participate and those who have left such relationships are often struggling just to survive. While many working in anti-violence have experienced violence themselves, the dominant perspectives are professionalized, and there are a wide variety of views.

Clear health goals for practice in relation to violence against women must be established.

Existing evidence must be examined, key areas for further evaluation identified, and such evaluations completed.

To develop confidence that the pursuit of "best practices" will improve rather than threaten services, coalitions between service providers, advocacy workers, women who experience violence, policy makers and researchers are essential.

In particular, women who experience violence must be part of the development of "best practice".

"BEST PRACTICES" AS COST CUTTING OR QUALITY IMPROVEMENT?

Willis and Sutton (1998) point out that the idea of best practice in health care has arisen at the same time as economic rationalization, and that best practice "walks a tight line between cost cutting and improving service". In the area of violence against women, "best" clearly cannot be judged based only on the cost of program delivery. Economic evaluation is particularly challenging, but it is evident from beginning efforts (Day, 1996; Greaves & Hankivsky, 1995; Kerr & McLean, 1996) that little is spent on prevention and treatment in comparison to the costs of violence. Further, dealing with violence is emotional-labour intensive, and as experience in the nursing profession shows, emotional labour is undervalued and easily threatened by cost-cutting (Willis & Sutton, 1998; Yelland, 1994). The scope and nature of the problem is such that short term gains may be difficult to realize.

"BEST PRACTICE" WITHOUT PUBLIC POLICY AND FUNDING?

Determining and implementing "best practice" clearly occurs within a complex and wide ranging network of policy and funding issues. Issues relevant to the health of women who experience violence range from immediate concerns about funding the provision and evaluation of direct anti-violence prevention and treatment services, to larger social policy issues such as the availability of legal aid, immigration policy, and the wage earning capacity of women. Agnew (1998) points out that the emphasis on the provision of services to individual women has in some ways detracted from and delayed efforts toward wider social change. While women are patching one another up in shelters, other women continue to live in fear and violence.

Despite these cautions, the scope of the problem of violence against women demands action. And moving toward "best practice" offers a way to make such action meaningful.

> ### Box A: Example draft health goals[1]
>
> **Reduce rape and attempted rape of women age 12 and older to less than 108 per 10,000 women. (Baseline: 120 per 100,000 in 1986)**
>
> **Reduce physical abuse directed at women by male partners to no more than 27 per 1000 couples. (Baseline: 30 per 1000 couples in 1985)**
>
> **Reduce to less than 10% the proportion of battered women and their children that are turned away from emergency housing due to the lack of space. (Baseline: 40% in 1987)**

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[1] Chalk and King (1998) reproduced the goals from the US Department of Health. These are a few of those goals which pertain directly to violence against women. Baseline data are available in British Columbia for setting these sorts of goals.

VIOLENCE AGAINST WOMEN: THE SCOPE OF THE PROBLEM

Costing models must continue to be developed and short term economic concerns balanced against the long term safety and well-being of women.

"...outcomes are affected by the processes involved in care... [and] the organizational environment in which care is offered and experienced. Both... can be hard to measure and, therefore, could be... omitted from the outcome equation in these economically stringent times" (Carberry, 1998).

Balance is needed between levels of action, between women's immediate well-being and long term social and political change.

In 1993 Statistics Canada conducted a national population survey, the Violence Against Women Survey (VAWS). In this survey, researchers interviewed a randomly selected national sample of 12,300 women by telephone. The data from this study have been analyzed by various researchers, including Rodgers (1994), Ratner (1995), Johnson (1996), and Kerr and McLean (1996), providing the most comprehensive picture of the problem in Canada to date.

The VAWS estimated that one in every two women in Canada over the age of 18 experienced at least one incident of sexual or physical assault, and that 10% were the victims of assault in the year preceding the survey (Johnson, 1996; Rodgers, 1994). In congruence with global statistics on wife abuse (Heise, Pitanguy & Germain, 1994), 29% of women in Canada who had ever been married or lived in a common-law relationship reported being physically or sexually assaulted by a marital partner at least once during the relationship (Johnson, 1996; Rodgers, 1994). Johnson extrapolated these figures to the population, estimating that over 2.6 million Canadian women have experienced physical or sexual assault, and that of the 6.69 million women currently in a marital relationship, 1.02 million (15%) have been assaulted.

In addition to this appalling level of prevalence, the VAWS also provided estimates of the frequency and severity of violence in the context of intimate relationships. In 63% of all cases of wife assault, violence occurred more than once, and 32 % of all cases of wife assault involved more than 10 episodes of violence. In almost half of all relationships with violence, a weapon was used at some point and almost half of those assaults resulted in injury to the woman. In 43% of the situations in which the woman was injured, the woman sought medical attention. In 34% of all cases of assault (physical or sexual), the woman feared for her life.

The prevalence, frequency, and severity of wife abuse in Canada is similar to that in other countries around the globe. Thus, it can be anticipated that the health burden attributable to wife abuse is similar to that of other developed countries.

THE HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN

The impact of violence on health is not fully understood, and understanding is limited by the lack of studies designed to yield generalizable results, and the lack of longitudinal studies to examine associations between exposure to abuse and health outcomes (Dwyer, Smokowski, Bricout & Wodarski, 1995; Ratner, 1995). The impact includes general effects on health, immediate consequences, and long range consequences.

Hiese, Pitanguy and Germain (1994) estimated the general impact of violence on the health of women by calculating the healthy years of life lost due to various conditions attributable to gender-based victimization including sexually transmitted diseases (STD), HIV/AIDS, abortion, depression, alcohol and drug dependence, post-traumatic stress disorder (PTSD) and death from suicide or homicide. It was estimated that sexual assault and violence against women accounted for nearly 20% of the health burden for women ages 15-44 years in developed countries.

Globally, the proportion of health burden estimated to be due to rape and woman abuse was comparable to the burden estimated as incurred by cancer, cardiovascular disease, HIV and tuberculosis (Heise et al., 1994).

The specific consequences of violence against women include both immediate effects and long term consequences of having been previously abused or of currently living under the chronic stress of violence. These consequences include physical and psychological consequences, alcoholism, and drug use.

Physical injury is the most fully explored outcome of violence. Physical injury was initially used to define abuse, to the point of overshadowing non-physical consequences of abuse (Gelles & Straus, 1988). Patterns of injury have been used in various studies to identify the incidence of abuse (e.g. Kurz & Stark, 1988) and physical injury continues to be used to estimate the incidence and severity of abuse. National crime surveys in both the U.S. (e.g. Tjaden & Thoennes, 1998) and Canada (e.g. VAWS) typically report numbers and types of injuries (Campbell, Harris & Lee, 1995; Johnson, 1996).

In an average year in Canada, 78 women are killed by their partners, and in 1993, about 200,000 women were threatened, slapped, kicked, punched, choked, beaten, or sexually assaulted (Johnson, 1996).

In the VAWS, more than 40% of women abused by a partner said "Yes" to each of having been beaten up, kicked, hit or bit, slapped, pushed, grabbed, or shoved - any of which could cause physical injury. In addition, 24% of women reported being hit with something, 30% reported being choked, and 35% reported being sexually assaulted by their partner. Women were physically injured in 45% of all cases of wife assault and in 22% of violent sexual assaults. They sought medical assistance in only 20% of cases of wife assault. Not surprisingly, the severity of injury varied with the severity of the abuse (Ratner, 1995).

The long term physical consequences of violence include chronic pelvic pain and other forms of chronic pain, irritable bowel syndrome, arthritis, neurological damage, pelvic inflammatory disease and STD's (Bohn & Holz, 1996; Campbell, 1993; Koss & Heslet, 1992). The psychological impacts of abuse have been variously described. They include a range of emotional effects, intrusive symptoms encompassed by the psychiatric diagnostic category "Post Traumatic

Stress Disorder" (PTSD)[2], and suicidal ideation and suicide. The emotional consequences of wife abuse, not surprisingly, include anger, loss of trust, fear, and lowered self esteem (Gelles & Straus, 1988; Johnson, 1996). Among women who seek help in relation to abuse, intrusive experiences such as fear, anxiety, disturbances in self-concept, depression, sexual dysfunction, nightmares, intrusive memories, and hyperarousal are common (Herman, 1992; Saunders, 1994). Saunders found that in previous research the mean rate of PTSD among women who had been abused was 56%. In his own study of 192 women, the prevalence was over 60%. Gelles and Straus (1988) found that women who have been abused are much more likely than non-abused women to contemplate and attempt suicide. This finding was subsequently supported by other studies (e.g. Abbott, Johnson, Kozoil-McLain & Lowenstein, 1995). In general, the psychological consequences of abuse explored in the studies cited above tend to be worse with the severity and frequency of abuse.

Violence against women interacts with other health issues such as HIV and AIDS, drug and alcohol use, and mental health.

Alcohol and the use of prescription drugs have been proposed as coping mechanisms for dealing with abuse (Ratner, 1993, 1995; Stark, Flitcraft, & Frazier, 1979). In the VAWS, one quarter of women turned to alcohol, prescription or other drugs to help deal with their situations (Rodgers, 1994). Groenveld and Shain (1989) suggest that the use of prescription drugs to sleep and relieve anxiety is much higher among women who have been battered than those who have not. Interestingly, Ratner's (1995) analysis of the VAWS revealed that the strongest determinant of whether a woman took drugs or medications to deal with the abuse was contact with physicians or nurses. This finding is congruent with earlier criticisms of health care responses (e.g. Stark et al., 1979; Warshaw, 1993).

In BC the 1995/96 cost of alcohol and drug treatment services for women with addiction problems who had also been victims of physical or sexual abuse was about $7.3 million, one sixth of the total addiction treatment budget (Kerr & McLean, 1996).

The impact of wife abuse extends beyond women to their children (Jaffe, Wolfe, Wilson, & Zak, 1986; Peled, Jaffe, & Edleson, 1995; Stark & Flitcraft, 1991). Twenty one percent of Canadian women who said they were abused by a marital partner were abused during pregnancy and 40% of these women said that the abuse began during pregnancy (Johnson, 1996; Rodgers, 1994). Children who witness violence are traumatized by the violence indirectly, and are likely to also be abused. Children in homes where there is violence have been found more likely to have a variety of problems, including having troubles in school and difficulty in problem solving, being aggressive and using drugs and/or alcohol, and learning to use violence (Gelles & Straus, 1988; Jaffe, Wolfe & Wilson, 1990). Berman (1996) found that children from families in which there was violence were similar to children who experienced war in terms of PTSD. In Bennett's (1991) study of adolescents who witnessed abuse, the girls were

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[2] PTSD is a diagnostic category included in the DSMR-III-R, the classification system of the American Psychiatric Association. Many who work with women who are abused believe that any psychiatric diagnosis misrepresents the social circumstances of battering and implies that a woman's problems are associated with some internal pathology, rather than a response to external violence. Treatments are often prescribed on the basis of the disorders and neglect the abuse and the trauma violence causes. Moreover, the stigma associated with many diagnoses may be used against women in divorce and custody litigation (Gondolph, 1998).

traumatized by witnessing violence and were also likely to be direct victims of abuse. Although other estimates are lower (Stark & Flitcraft, 1991), Bowker, Arbitell and McFerron (1988) found, in their study of 1000 women who had been battered, that the men also abused the children in 70% of the families where children were present.

Child abuse has been identified in up to 70% of wife abuse situations.

The consequences of victimization extend long beyond assault and are reflected in the significantly greater use of health services in comparison to non-victimized people (Koss, 1994). Violence against women causes tremendous suffering, and social, economic, and health costs which can only be partially quantified in economic terms. The costs of the health consequences of violence against women can only be estimated, and are assessed to be staggering (Day, 1996; Hankivsky & Greaves, 1995; Kerr & McLean, 1996).

The quantifiable costs of violence against women in BC exceed $400 million per year (Kerr & McLean, 1996).

Every year, more than 40,000 BC women are physically injured as a result of violence, of whom an estimated 15,000 seek medical treatment for their injuries (based on VAWS data). Most of these injured women did not disclose the violence or abuse to a doctor or nurse. Of the women who did talk with a doctor about an incident of sexual or physical assault, only one in six said the doctor was especially helpful. An additional unknown number of women seek assistance for mental health, addictions and/or other health problems caused or worsened by abuse.

MOVING FORWARD

It is urgent to develop a meaningful, comprehensive, accountable system of response within the health care system. Although definitive statements regarding what constitutes "best" would be premature due to the lack of evidence, some steps can be taken toward determining and fostering "best practices".

The remainder of this paper begins those steps by:
- identifying a framework for examining existing programs and practices;
- examining existing programs and comparing those programs to the evidence regarding what works;
- identifying principles which might guide practice and evaluation toward "best practice"; and,
- outlining the next steps in achieving "best practice".

A Beginning Framework

Chalk and King (1998) conceptualize the social response to 'domestic violence' as interrelated strategies to deal with interacting forms of abuse including child abuse, violence against women, and elder abuse. They view these strategies as occurring within social services, law enforcement and health care institutions. Further, they see the social responses as encompassing a range of strategies including prevention, identification, protection, treatment, legal separation and deterrence. Chalk and King offer a typology of programs within each service area.

This framework offers a beginning way to think about health care responses. First, it suggests considering health care as an integral part of the larger network of social responses. Second, examining the way different service areas use each strategy to deal with particular forms of abuse offers a way of examining how the health care system overlaps with other systems. Finally, the typology identifies types of programs to be considered.

Meaningful health care responses to violence against women must include attention to child abuse and elder abuse, attention to health care services, and attention to services offered in other jurisdictions.

Considering the interactions between forms of abuse and between social institutions responding to abuse is important when designing health care because barriers to meaningful responses may come from policies and programs working at cross purposes, and from the fragmentation of care. For example, the health of a woman receiving care from the health care system may be jeopardized by the requirement to be in contact with her abuser in parenting seminars mandated by another component of the system (see Ministry of Attorney General, 1998). In another example, concern has been expressed widely within community groups that Ministry of Human Resources field staff are putting women at risk by pursuing violent men for support payments and demanding that women provide information to assist this collection process. Officially, MHR has a policy of not pursuing non-custodial parents for maintenance payments if the custodial parent or children would be endangered.

DEALING WITH VIOLENCE AGAINST WOMEN:
THE SOCIAL RESPONSE

The social response to violence against women has not reduced violence. Despite numerous reports with comprehensive recommendations (e.g. BC Task Force on Family Violence, 1992; Canadian Advisory Committee on the Status of Women, 1991; Canadian Public Health Association, 1994) and increasing public awareness of the problem, there is no evidence of a decrease in the terrorism many women experience. Many of the recommendations have never been implemented, and the resources that have been allocated are primarily for direct services, not for evaluation of those strategies.

The Importance of Attention to Diversity

Although violence is known to occur at very similar rates in most countries and among all peoples (Heise, 1994; Heise, et al., 1994), people who are marginalized in various ways – particularly by poverty, racism, age, ability, and language – face challenges which are magnified exponentially. First, access to services is impeded. Second, the costs of disclosure are much higher. Within communities and throughout the research it is clear that accessibility and appropriateness of services for less privileged women are the major challenges.

"Financial and psychological independence are key factors that deter women from entering or staying in abusive relationships" (Gurr et al, 1996, p. 25).

Women's vulnerability to violence is increased by economic and social disparities between men and women. Women's lack of economic independence often limits their ability to leave abusive situations, and poverty limits access to services in multiple ways. The effects of racism, cultural norms, language, disabilities, and age magnify the economic barriers to living violence free (see Health Canada, 1996b).

Women seeking health care services in relation to abuse commonly encounter racism and classism (Campbell, Pliska, Taylor, & Sheridan, 1994; Dobash & Dobash, 1992; Hampton & Newberger, 1988; Varcoe, 1997), factors which likely deter access and disclosure. Dobash and Dobash note that seeking assistance is sometimes seen by women of colour as unacceptable because responses (such as arrest of the perpetrator) are experienced as "further act(s) of racial oppression against men of color"(p. 52).

Racialized women "are in fact being expected to bear the brunt of gender violence within a racial or ethnic group in order that the group itself or its violent members not be exposed to further racial oppression" (Dobash & Dobash, 1992, p. 53).

For many women, including Caucasians[3], disclosure of abuse is constrained by religious beliefs, family pressures and cultural norms. For women who are also immigrants and/or speak limited English, the barriers of language, citizenship, and unfamiliarity with institutional systems compound the problems.

Women with disabilities are even more vulnerable to violence, and are vulnerable to a larger range of people. They routinely encounter access problems. Approximately 15% of women in Canada have disabilities (Health Canada, 1993), and up to half of these women have experienced violence (DisAbled Women's Network, 1989).

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[3] This point is important because "culture" is often thought of only in relation to people of colour, a common feature of Canadian democratic racism (Henry, Tator, Mattis & Rees, 1995) that is especially problematic within the context of violence.

Improving access and appropriateness for all women is not merely a matter of providing services to special groups; it is also a matter of making all services accessible and appropriate.

Lesbian women commonly encounter barriers to health care (Hall & Stevens, 1988). In addition, with the well placed emphasis on men as batterers, violence in lesbian relationships has only recently been acknowledged (Hamberger, 1994) and evidence exists that health care in relation to violence for lesbian women may be particularly compromised (e.g. Wise & Bowman, 1997).

Both young women and elderly women face particular barriers that magnify other forms of marginalization. Both have limited economic and social power, and services are often not particularly appropriate for either age group. Many women occupy multiple positions of disadvantage. For example, First Nations women often face poverty, racism and geographic disadvantages simultaneously.

Strategies for dealing with diversity must be actively anti-racist, anti-classist, anti-ageist, ant-homophobic, and so on.

Attempts to address accessibility and appropriateness generally take the form of providing services for particular groups, and of promoting cultural sensitivity in mainstream services. However, given the number of women for whom such improvements are required, all services must be addressed. Given the scope of the problem, relying on individuals to voluntarily become "culturally sensitive" will be inadequate. Throughout the remainder of this paper, issues of diversity will be considered within each service area.

DEALING WITH VIOLENCE AGAINST WOMEN:
HEALTH CARE RESPONSES

Although women frequently seek assistance within health care, the system has been largely unresponsive, and perhaps detrimental, to the welfare of women who have been abused (Goldberg & Tomlanovich, 1984, Lempert, 1997; McLeer & Anwar, 1989; Rodgers, 1994; Ratner, 1995; Stark & Flitcraft 1991; Stark et al., 1979; Warshaw, 1993). Health care system responses have been characterized by a lack of recognition of abuse and the prevalence of negative attitudes and responses.

The rates of recognition of violence against women by health care professionals are extremely low. Most research on recognition rates has been done in Emergency Units, where 2%-8% of female trauma patients are clinically recognized as abused, whereas approximately 30% of the same population can be identified as abused through various research strategies and identification protocols (Abbott, Johnson, Kozoil-McLain & Lowenstein, 1995; Grunfeld, Ritmiller, MacKay, Cowan & Hotch, 1994; Kurz & Stark, 1988; McLeer & Anwar, 1989; Olson et al., 1996; Roberts, O'Toole, Lawrence, & Raphael, 1993; Roberts, O'Toole, Raphael, Lawrence & Ashby, 1996; Stark, et al.,1979; Tilden & Shepard, 1987). Recognition of abuse during pregnancy is also poor (Campbell, Oliver & Bullock, 1993; Campbell, Poland, Waller & Auger, 1992; McFarlane, 1993). This is a problem of grave concern given that up to 23% of obstetrical patients are estimated to be abused (Warshaw, 1993). Recent Canadian statistics show that 21% of women abused by a partner were abused during pregnancy (Johnson, 1996; Rodgers, 1994). Similar recognition problems have been identified in primary care settings (e.g. Bullock, McFarlane, Bateman & Miller, 1989; McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991; McCauley et al., 1995).

Responses by health care providers when abuse has been recognized have been characterized as narrowly focused on the physical consequences of abuse and on victim-blaming (Kurz and Stark, 1988; Dobash & Dobash, 1988; Stark & Flitcraft, 1991; Warshaw, 1993, 1994). McMurray and Moore (1994) found that women admitted to hospital for abuse-related injuries experienced disengagement from hospital staff, loss of status, lack of control and disempowerment, stigma and social isolation, and a sense of being misunderstood. The women told of being humiliated, blamed, judged, and made to feel unworthy. Such experiences may have a negative impact on women's health. Ratner's (1995) analysis of the VAWS data concluded that contact with health care providers did not improve health outcomes, and was, in fact, slightly negative. Ratner suggests these findings may be due to the professional's focus on physical injuries and disregard for the woman's experience.

Not surprisingly, when Brendtro and Bowker (1989) interviewed or surveyed 1000 women who had been battered, they found that the women rated health care as less effective than any other formal system.

Making the health care system responsive must include strategies that address both the attitudes of health care providers and the resources that make meaningful responses possible.

Explanations are incomplete regarding why responses are negative. Shields, Baer, Leininger, Marlow and Dekeyser (1998) studied the medical records of 153 women and suggested that women may have negative outcomes due to a lack of knowledge, negative attitudes and a lack of collaboration among care providers. Studying 31 women's experiences of the health care system, Gerbert et al. (1996) reported that the women perceived health care providers to be disinterested and unsympathetic. This finding is supported by research which has consistently shown negative attitudes by health care providers toward women who have been

battered (Chung, Wong, & Yiu, 1996; Cochrane, 1987; Easteal, & Easteal, 1992; Renck, 1993; Rose & Saunders, 1986). In the study by Gerbert et al., women also thought that the health care system did not allow providers to deal with anything beyond immediate physical injury. This finding is supported by Varcoe's (1997) ethnographic study of Emergency Units in which patterns of practice obscured violence as an issue. In the BC Emergency Units examined in this study, nurses were so focused on the "efficient processing" of patients, physical problems, and cost saving that only blatant physical injuries were dealt with and violence was otherwise obscured.

Dealing with Violence Against Women: The Provincial Context

At present, the BC Health Care System and other related systems are in a state of flux. Regionalization of health care is underway, presenting significant challenges regarding how policy will be uniformly enacted and regional disparities overcome. Other systems with important responsibility related to violence against women are also undergoing major change. For example, the Ministry for Children and Families has been only recently created, and is still grappling with multiple service delivery issues.

Within this unsettled context, violence against women is dealt with by an informal and uncoordinated network of government departments and government-funded institutions, private and non-profit organizations, and community-based advocacy organizations. Although groups often collaborate in ways that cross professional and organizational boundaries, there is no mandate to do so, no central organizing body, and such work is not necessarily sanctioned within individual organizations. Relationships among these various groups are highly complex. Funding and working relationships are sometimes ongoing, and are sometimes based on time-limited, project-specific grants. Groups may come into or fade from existence depending on funding. Understanding this network of groups offers opportunities to build on existing expertise and initiatives and to strengthen links. Perhaps most difficult to know are the number of community-based groups and survivor groups. These groups are often outside of the formal network of organizations and institutions, yet provide essential support for women experiencing or healing from violence.

Dealing with Violence Against Women: Current Health and Health-related Responses in British Columbia

The extent of concern and action within health is difficult to estimate. Up until this point, the health response to violence against women in BC has been fragmented, uncoordinated and often informal. The response encompasses a wide range of activities and formal programs both within the Ministry of Health and other jurisdictions. This report does not provide a comprehensive inventory of services focusing on violence against women, but outlines a number of programs to illustrate current initiatives or highlight key areas for further development.

Health care personnel participate in many groups and programs concerned with violence, but the extent of this work is unknown. For example, most coordinating committees on violence against women include community health nurses or hospital personnel such as social workers, physicians or nurses, but such work is rarely formalized within organizational mandates or individual job descriptions.

Thus, all activity in BC in relation to health and violence against women is difficult to capture, and therefore challenging to exploit as a strategy for change. However, some formal programs are more readily identified.

Formal programs dealing with violence against women in British Columbia are funded primarily by various provincial ministries. The government funded programs that are concerned with health occur both under the auspices of the Ministry of Health and other ministries.

The health response, then, can be considered to include "**health-related responses**" (those not under the auspices of the Ministry of Health, but in which health is a significant concern), and "**health responses**" (those areas under the auspices of the Ministry of Health). Using Chalk and King's typology, both health related and health responses will be examined with regard to a selection of current programs in BC, what is known about their effectiveness, and the evidence available regarding "best practice".

HEALTH-RELATED RESPONSES

Health-related responses cover a range of strategies from primary prevention to deterrence, and overlap with many ministries and organizations. Although it is beyond the scope of this paper to provide an exhaustive description of all health-related programs that deal with violence against women, key areas of health-related activity at system and program levels will be considered.

At the ministerial level, there are a number of initiatives addressing violence against women that have clear relationships to health. The Ministry of Women's Equality, (Stopping the Violence Project), works in cooperation with the Ministries of Aboriginal Affairs, Education, Skills and Training, Health, and the Attorney General. With the Ministry of Women's Equality's emphasis on health and the health care system, there are natural links that could be formalized and strengthened. The Inter-Ministry Committee on Violence Against Women has not met for several years and there currently is no inter-ministerial mechanism for the overall coordination of initiatives related to violence against women.

Areas that are currently causing major problems for women experiencing violence such as:
- mandatory parenting after separation,
- custody and access issues, and,
- pursuit of non-payment of maintenance and support,

point to an urgent need for mechanisms for attending to health concerns with both the Ministry of the Attorney General and Ministry of Human Resources. The way specific policies impact the health and safety of women and their children must be anticipated before potentially harmful policies are put into action. There are no studies regarding the impact on health by policies and practices in other jurisdictions, and currently there is no group charged with responsibility for examining such issues.

PRIMARY PREVENTION

School-based Prevention Programs on dating and violence against women are currently the primary strategies for preventing violence against women. At present in BC, there are at least four different school-based programs offered. Data are available regarding the number of students served, but none of the programs have been evaluated. There are no known formal links to health care with regard to these initiatives, and the extent to which such programs serve students of diverse experiences has not been examined.

Chalk and King (1998) found that the four evaluations of such programs have reported positive effects on attitudes and knowledge, especially on girls, but point out that there are no longitudinal studies, and no studies examining the impact of these programs on violence.

Public Health Prevention Programs are undertaken by many groups, but a comprehensive inventory is not available. There is a variety of prevention-oriented initiatives underway throughout the province, many of them funded by the Ministry of Women's Equality through the "A Safer Future for BC Women" program. For example, some communities have developed public education campaigns and safety awareness programs that are aimed at preventing sexual assault. Some communities have mounted media and public events aimed at increasing awareness about and prevention of wife abuse. Building Blocks is a promising public health initiative being funded by the Ministry for Children and Families (MCF). The program includes lay home visitors for mothers who have just given birth and are considered to be at high risk (isolated or with low coping skills), and interventions with pregnant women to prevent fetal alcohol syndrome.

Although many of these initiatives are guided by groups with health representatives, the extent of such participation is unknown. Such activity is largely informal and depends on the interests and commitment of the individual. There is little evidence of the impact of these programs and little evidence in the literature regarding what "works" (Chalk & King, 1998).

SECONDARY PREVENTION: IDENTIFICATION AND TREATMENT

Health-related areas tend not to actively seek to identify women who are experiencing violence. Rather, women are self identified as abused, or are identified through mechanisms that are not specific to violence, such as police reports. Thus, secondary prevention efforts outside of direct health care are focused on treatment, protection, legal action and deterrence.

Transition Houses offer programs in numerous communities (BC & Yukon Society of Transition Houses, 1998). While these services provide a necessary safe place for women and their children, the impact that these services have on women's health is as yet unknown.

In BC, each transition house compiles monthly statistics regarding the number of women served and the number of women "turned away" or placed elsewhere.

However, baseline data regarding the health of women are not available. Although comprehensive evaluation of the impact of transition houses on the women and communities they serve has not yet been done, there has been some initial work to develop program standards and a framework for program evaluation.

Many transition houses have connections with community health nurses, mental health workers and physicians from within the health care system. The advisory for the Society of Transition Houses has representatives from the Ministries of Women's Equality and Human Resources, but no representation from the Ministry of Health.

Particular challenges arise for women who require transition house services and, in addition, have mental health issues, drug and alcohol abuse issues or physical health issues, an increasing reality as the population ages. Transition houses are often unable to accommodate the particular needs of women with such issues. In response to the needs of women with mental health issues who are seeking safety from violence, Peggy's Place, a transition house, opened last year in Vancouver. Staff at Peggy's Place work closely with the 'women and violence worker' for Greater Vancouver Mental Health Services and a community mental health team. This team provides consultation, training, assessment, and follow-up for some residents. Funding is provided by the Ministries of Health and Women's Equality and the BC Housing Management Commission. The extent of similar needs in other communities has not been estimated, and Peggy's Place has not been evaluated.

The appropriateness and accessibility of transition houses for women of colour, women who speak little English, and lesbians has been questioned (Agnew, 1998). Agnew conducted an extensive study of community-based services in Canada (primarily Eastern Canada), and describes a variety of models and strategies for improvement. However, as yet there are no such formal initiatives in BC.

Although it is clear that transition houses provide crucial services for women, their full effect has not been evaluated. Chalk and King (1998) found one evaluative study indicating that shelters limit new incidents of violence in the six weeks following shelter stays, and another suggesting that shelters helped women find appropriate support services. Transition houses were identified by Chalk and King as one of nine areas which are sufficiently promising and mature to warrant immediate evaluation.

Children Who Witness Abuse Programs are an important aspect of treatment offered under the auspices of transition houses in BC. CWWA programs are early intervention initiatives to prevent violence against women and provide support to children who have witnessed abuse. Such programs are offered as children's groups, and as child-parent or child only sessions. At present, there are 56 programs in BC offering time limited counseling services, ranging in duration from 18-26 hours (personal communication, Melody Augustine). A proposal for funding has been developed to examine the effect of the programs on children's

feelings of safety, self esteem, knowledge about abuse, and feelings of responsibility for violence. The tool from the evaluation of Children Who Witness Abuse programs in London Ontario (Marshall, et al., 1995) will be used for the evaluation (personal communication, Helen Dempster).

There are no formal connections between Children Who Witness Abuse programs and health services or mental health services, including those provided for children who have been abused or witnessed violence. Relationships depend on individual workers and programs, and the time available for liaison.

Marshall et al. (1995) conducted a pilot evaluation of the London, Ontario program with a sample of 31 children, and found positive effects on children's knowledge and safety skills. Chalk and King (1998) found two evaluations of a counseling program, (similar to those offered in BC) both of which found positive, but conflicting results. One study reported a positive impact on safety and support skills and no impact on children's sense of responsibility for abuse. However, the other study found the reverse. Chalk and King also note that a more comprehensive program is offered at the Boston Hospital, but it has not been evaluated.

HEALTH RESPONSES

At present there is no overall strategy in BC for dealing with violence against women, and no specific strategy within the health care system. Health responses in BC include system level activities and programs that are under the auspices of, and primarily funded by, the Ministry of Health. Existing health responses in BC are primarily secondary prevention programs which focus on screening, identification and follow up within hospitals. This report highlights a selection of the health initiatives focusing on violence against women. This selection is not meant to represent "best practices" but to offer examples of the health care system response and provide suggestions for further development.

SYSTEM LEVEL ACTIVITIES

Without an overall strategy, activities and programs in health care are uncoordinated and not comprehensive.

At a system level, there are some funded organizations and activities within health. The BC Institute on Family Violence has an education and research mandate. The Center for Excellence in Women's Health has a health research mandate and a focus on violence. The Minister's Advisory Council on Women's Health, the initiators of this project, has an advisory capacity, and a sub-committee on violence. However, there are no system level organizations concerned with practice around violence against women in health, with the exception of the Sexual Assault Task Force.

Initiatives related to HIV/AIDS, drug and alcohol abuse, and mental health present ideal opportunities to address violence.

There are areas within the Ministry of Health that have great significance for violence against women but do not necessarily have clear relationships to violence-related initiatives. For example, the relationship between HIV and AIDS includes both violence as a predisposing factor to HIV/AIDS, and HIV/AIDS as a factor keeping women living in violent situations (Kirkham & Lobb, 1998; Summers, 1997). The Ministry of Health's Provincial HIV/AIDS

strategy (BC Ministry of Health, 1998) does not address issues of violence. In addition, although policy documents identify the links with violence (e.g. Minister's Advisory Council on Women's Health, 1997; Ministry of Health, 1998), at a program level, services such as drug and alcohol programs and mental health services are not clearly connected to anti-violence programs.

Although a complete inventory of BC programs is unavailable, comparing some existing BC programs with the framework offered by Chalk and King suggests areas to inventory and possible areas for further development.

HOSPITAL-BASED PROGRAMS

Hospital-based programs focusing on violence against women range greatly in structure and scope. The Family Violence Prevention Fund (1997) reviewed programs that range from those that emphasize screening to those that emphasize advocacy. Some programs are implemented by regular hospital staff, some have staff who are specific to the program. Some programs are integrated with other care, some are separate. Some programs have paid staff, some have volunteers, some staff are professionals, some are lay advocates.

At present in BC, there are at least 3 or 4 hospital-based programs focused on violence against women in relationships. However, it is unknown how many other hospital-based programs exist, what variety of approaches are being used, and the stage of development of such programs.

Histories of abuse among health care personnel must be considered in developing any anti-violence program.

At BC Women's Hospital, the intention of the Violence Against Women in Relationships Program is to train each department to understand the dynamics of violence against women and to become advocates for abused women. This training started with the high-risk pregnancy ambulatory unit, which includes the diabetes clinic. The program may be extended to the breast implant clinic where women have disclosed that partners have threatened violence if they have their implants removed and the osteoporosis clinic where women may have falls or bone injuries resulting from abuse.

Initiators of the Vancouver Hospital Domestic Violence program have done considerable initial evaluative work. The program has been found to increase the number of patient records on which 'domestic violence' was recorded (Grunfeld, Hotch, & Mackay, 1995). Data have also been collected regarding the number of women who are asked about violence, the number who disclose abuse and the number who are provided follow up services.

Training and protocols can enhance recognition of abuse...

However, the benefits of increased recognition of abuse must be evaluated and weighed against potential risks.

What is not known is the impact of these programs on health outcomes, the immediate use of treatment and preventive services, the long term use of health care and costs. The impact on nurses and other health care providers who have histories of abuse is also not known, although such histories were found to have a profound influence on the practice of emergency nurses in BC (Varcoe, 1997). It appears that, at present, only about 35% of women presenting at the Vancouver Hospital ER are asked about violence. Interviews with nurses working in seven BC hospitals, many of whom work in hospitals with screening protocols, suggest

that nurses do not screen for a wide variety of reasons (Varcoe, 1997). Nurses' own histories of abuse, nurses' lack of education, lack of time to respond appropriately and lack of resources for support and follow up are some of the issues identified. Importantly, assumptions about poor women, women of colour and First Nations women led nurses to anticipate abuse among certain women and feel more or less comfortable with asking questions of women along racial and class lines.

As noted earlier there are a large number of studies examining the rates of recognition of abuse. Chalk and King (1998) were able to identify four such studies (Tilden & Shepard, 1987; Olsen et al, 1996; McLeer & Anwar, 1989; McLeer, et al., 1989) which they considered rigorous evaluations of the impact of such programs. These studies used time series designs and clearly illustrate that training and protocols can enhance rates of recognition of abuse.

Current evaluation of the program "WomanKind" will offer further evidence toward "best practice" in hospital-based programs.

However, there are no studies examining the potential benefits of such programs against the potential risks (Chalk & King, 1998). The benefits may include improved access and use of treatment services, the reduction of harm, improved health outcomes, decreased health costs, and increased community awareness and primary prevention efforts. The risks they identify include false negatives and false positives in "programs characterized by inadequate staff training and responses" (p. 306), the lack of follow up services, the inability of other services to manage the increased case loads generated by screening, and the risk of labeling of women and exposure to negative attitudes.

Knowledge about programs in primary care and rural settings is particularly important for the BC context.

In addition, there are no studies comparing different models of delivery. There are various programs being offered that are currently under evaluation. One such program is WomanKind, a program developed and currently operating in Minnesota (Hadley, Short, Lezin, & Zook, 1995). The program is a comprehensive approach to wife assault that combines case management and advocacy to provide crisis intervention, assessment, evaluation, and ongoing assistance. This program is currently under study to compare three hospitals that use the program with three hospitals that do not. The evaluation will compare the knowledge, skills and attitudes of staff and volunteer advocates, the frequency of referrals, patient satisfaction, the number of repeat visits and the use of community services (Chalk & King 1998). This evaluation may offer further evidence toward "best practice" in hospital-based programs.

The BC survey recommends developing a provincial strategy, a network of care providers, collaboration between health care workers and the RCMP, and significantly more education and training (Webster, 1996).

It is important to note that all available evaluative data, including both the rigorous studies cited by Chalk & King and the local evaluations, are based on work in urban Emergency Units. There are no rigorous evaluations of programs in rural settings nor in other settings in which screening programs have been initiated, such as primary care or maternity. The need for attention to rural settings is particularly acute given the evidence suggesting unique needs and the current move to regionalization (e.g. Merrit-Grey & Wuest, 1995, 1998; Van Hightower & Gorton, 1998).

HOSPITAL-BASED SEXUAL ASSAULT PROGRAMS

The Ministry of Health has funded sexual assault services through money provided to hospitals for their base budgets and through Medical Services Plan payment of doctors' fees (assuming the woman has MSP coverage). There are various levels of service provided throughout the province by police, physicians and other health care workers, and counselors. There are at least four "comprehensive" programs that are well developed in BC: one at Surrey Memorial Hospital, one in Victoria, one at BC Women's Hospital, and another in Vernon. It is unknown how many other programs are developed, what models are used and what the stage of development is for each program.

The programs in BC already represent several different "models". Some programs use physician examiners, others use nurse examiners; some emphasize forensic evidence collection, others include advocacy services. There are advantages and disadvantages to each, and these vary with the context. For example, one community was unable to sustain a physician-based program at least partly because the physicians were not called upon often enough to feel that they could maintain their skills and perform exams in a timely enough fashion to warrant the remuneration provided (Varcoe, 1997).

Little evaluation of current services has been done. A systematic survey of sexual assault services offered in communities throughout BC was conducted in 1996 (Webster, 1996). Although this report does not detail the types of services offered, care providers were interviewed regarding barriers to care and the report offers thoughtful recommendations based on a synthesis of that feedback.

BC Women's Hospital is planning to undertake an evaluation of sexual assault services, and some initial data is available from Surrey Memorial Hospital. These data, which have not been analyzed, include information regarding the increasing numbers of women who are examined, the age ranges of women seen, and the rates at which women choose not to initiate criminal charges (personal communication, Sandi Schenstad). The number of women has steadily increased, but it is not known if this represents an increase in sexual assaults, increased awareness of the program within the community, or other factors. The age range of the women is startling, though congruent with recent US data (Tjaden & Thoennes, 1998), with 26-30% of the women per year being aged 13-16 years. Finally, the high rate of "unreported" assaults (30% per year) is highly problematic. Although the exam is conducted, if a police report is not made, the costs must be borne out of the regular hospital budget, creating a deficit.

Critical questions that arise from the program at Surrey and others include:
- how can care for women be balanced against the need for legal evidence? Nurses in some areas are currently warned against developing relationships with the women, that it might be used to detract from their legal testimony, which makes support of the woman difficult. For some programs, links with local Rape Crisis programs ensure that women receive some support and counseling in the community;

- what is the level of vicarious victimization (Johnson & Hunter, 1997) among examiners? How can the emotional and physical stress for examiners be decreased and how can recruitment and retention be improved? Examiners are on call, are often called in the middle of the night, and have no particular support program;
- how should training for examiners be funded? There is an understandably high turnover among examiners; and,
- who should bear the operating costs? The exam is primarily an evidence gathering exam, but there are, of course, health components. Although an agreement has apparently been reached between the Ministries of the Attorney General and Health with regard to "unreported" cases, many questions remain. Apparently, at least one hospital trained examiners but was unable to continue the program due to lack of funding.

Most importantly, the outcomes of these programs are not known. Some questions related to outcomes include:

- what is the rate of conviction through evidence obtained in various programs?
- what are the outcomes for women? What are their experiences of the programs, what supports do they receive, and what are their health outcomes? and,
- how does the impact of being seen in one Emergency Unit, then sent to another for a sexual assault exam compare with other alternatives (such as no exam available, or an exam by an untrained examiner)?

The literature on sexual assault programs is primarily descriptive, with few evaluations. Research on SANE (Sexual Assault Nurse Examiner) programs in the US indicates high rates of conviction, and good HIV medication treatment follow up (Craven, 1998). One study indicates low levels of follow up but significant health problems for those who did return for follow up (Holmes, Resnick & Frampton, 1998). Sexual assault prevention programs have received marginally more attention, with some studies showing changes in knowledge, dating behaviours and service use (Baylis & Myers, 1990; Hanson & Gidycz, 1993).

TRAINING OF HEALTH CARE PERSONNEL

Training for health care personnel includes education within professional curricula, continuing education, and specific training associated with clinical programs. Almost all analyses of violence against women and health care call for more training and education of personnel. Curricula have been developed for Canadian health care professionals (Hoff, 1994), and educational materials have been evaluated against carefully developed criteria (Greaves and Hannington, 1994). However, the usage of such materials is not known.

The extent to which violence is addressed in the preparation of personnel such as nurses, physicians, social workers, physiotherapists and dentists in BC is not known. Training of health care personnel in relation to violence against women and sexual assault is occurring in a variety of ways throughout the province, but again, the full extent of this activity is unknown. Any clinical programs that have

been implemented include a training component. It is also known that the program staff from Vancouver Hospital have undertaken many training sessions in practice and educational settings. Recently, the Ministry of Health approved funding for the Sexual Assault Service of BC Women's Hospital to expand training for health care workers and to strengthen links to community services regarding both sexual assault and violence against women in intimate relationships.

Evaluations and descriptions of training programs typically measure the number of people who attend. What are needed are evaluations of the impact of such programs. To some extent, the impact of training related to clinical programs can be inferred if the clinical program is evaluated. For example, the increase in documentation found by Grunfeld, Hotch, and Mackay, (1995) in their study of the Domestic Violence program at Vancouver Hospital may be partially attributable to the training component of the program. However, it is unknown what impact these programs have on the knowledge, attitudes and practices of health care providers, and how that impact may in turn affect outcomes for women.

As noted earlier, education in combination with protocols has been demonstrated to increase rates of violence recognition. However, such effects may not persist over time. McLeer, Anwar, Herman and Maquiling (1989) replicated McLeer and Anwar's (1989) earlier study to examine the extent to which the effect of training health care personnel had persisted. Disappointingly, although the recognition rate rose from 5.6% to 30% of female trauma patients during the initial study, eight years later, the rate had dropped to 7.7%. Further, as noted earlier the relationship between increased recognition rates and health outcomes has not been adequately examined.

MENTAL HEALTH SERVICES

Mental health services that are relevant to violence against women include both programs specific to abuse and the integration of understanding of violence throughout mental health services. Specific programs include services for women who have experienced childhood physical and sexual abuse, and services for women who have experienced abuse as an adult. For children, there is the sexual abuse intervention program (under the jurisdiction of the Ministry for Children and Families), which supports children and adolescents who have been sexually abused. This program also provides some support to non-offending parents, many of whom are women who may be survivors of abuse themselves.

There were some minor improvements in mental health services for women in 1993, when through the Victims of Violence funding, Mental Health received some additional resources targeted for addressing woman abuse. The following year, the Ministry of Women's Equality's Stopping the Violence Counseling Initiative provided funding for 80 STV Counseling programs. Funding for these programs were initially administered through three ministries: Health (Mental Health), Social Services and the Attorney General, although management was eventually transferred to the Ministry of Women's Equality. Since these initiatives, Mental Health has not expanded services addressing violence against women.

Outside of institutional settings, services for women experiencing violence may be

sought from private psychologists and therapists, and through psychiatrists. Services from psychiatrists are covered by the Medical Services Plan. Some employee benefits programs cover counseling by psychologists, but such counselors may not be knowledgeable about violence, and many women who are experiencing violence will not have such benefits.

Although there are programs for children who witness violence, as noted earlier, the links between those programs and mental health services are informal and inconsistent. Because resources in mental health have not kept pace with the growth in need, mental health services in hospitals and government mental health centres have narrowed their mandates to deal primarily with people who are most seriously mentally ill. Violence-specific programs for women within mental health services are rare, and links to programs in other systems are not established.

Even for women diagnosed with "serious" mental illnesses, responses to violence issues may be inadequate and inappropriate. In a study of trauma histories and clinical sequelae of people at Riverview Hospital, Fisher (1998) found that although 58% of women had been sexually abused and 38% physically abused before the age of 17, and 46% had been sexually assaulted and 54% physically assaulted as adults, few had disclosed the abuse and even fewer had received any assistance after disclosure. According to Fisher, "the current mental health system, as it applies to women with serious mental illness, is essentially not addressing the issue of trauma (p. 7)".

In community mental health work, resources are very limited for both prevention and work with people whose emotional problems are not severe enough to warrant hospitalization. As a result, women who have mental health problems, but who are not diagnosed as seriously mentally ill are often left without adequate services, especially in relation to violence issues. One mental health worker told those doing background interviews for this project that funding was cut in one centre when workers started diagnosing PTSD, so workers went back to using the label "schizophrenic".

There were some improvements in mental health services for abused women with severe emotional problems when, as part of the "Stopping the Violence" initiative, Mental Health received additional funding. In some mental health centres, specialist positions were created to respond to violence against women. In many parts of BC, there were not enough resources to create specialist positions, so each mental health centre was to designate a worker to liaise with the transition houses, contract for counseling programs, and make sure there were mental health resources available for the most serious cases.

Simon Fraser and Vancouver/Richmond Health Boards are both funding a community counselor in a police-based partnership to do follow-up in wife assault cases within 24 to 48 hours. One objective is prevention of long-term mental health impacts. In New Westminster the program has operated for several years with no formal evaluation but with positive outcomes reported by women who have been served (personal communication, members of Women In Action survivor's social action group).

Evaluations of mental health services which deal with violence against women are rare. Chalk and King (1998) found only four reasonably rigorous evaluations, each of which examined a different type of program: Emergency Room counseling for women, group counseling for women, and group and couples counseling, thereby limiting conclusions.

PROGRAMS FOR ABUSIVE MEN

Programs for abusive men include both voluntary and court mandated programs. Men's programs are offered by a wide range of social service agencies, with funding coming from the Corrections Branch of the Attorney General. The Ministry of Health, through Forensic Psychiatric Services, administers correctional institutionally based assaultive men's programs, with funding from the Ministry of Women's Equality.

In 1994, a national inventory of programs identified 22 such programs in BC (Health Canada). At that time, the programs offered groups which ranged from 12-40 weeks in duration and used a variety of approaches, most often combining approaches within programs. Debate has been heated regarding the merits of cognitive-behavioural or psycho-educational models in which anger management and other social skills are taught versus other approaches that address the social inequities and beliefs that sustain violence. Few programs offered groups in any language but English: MOSAIC (in Vancouver) offers programs in Hindi, Punjabi, and Urdu; and the Terrace program sometimes uses Aboriginal languages. SUCCESS (in Vancouver) has recently begun to offer anger management programs in Chinese languages.

In the 1994 survey, six programs indicated that they were doing some form of evaluation. These evaluations ranged from client satisfaction surveys to involvement in formal research. Comparative evaluation of the Confronting Abusive Beliefs (CAB) program and an anger management program showed positive changes in men's behaviour (Russel & Frohberg, 1996).

Evaluations have been conducted on a variety of batterer programs, leading Chalk and King (1998) to conclude that a variety of approaches seem to have positive effects, drop out rates remain high, court mandates do not seem to improve completion rates, and there is little evidence to guide standard setting. Edleson (1995), a prominent researcher in this area, concluded that programs often seem to reduce violence by men who complete such programs, but that drop out rates are high and views of what "works" and what constitutes "success" are varied and contentious.

UNCHARTED ACTIVITY

The programs described represent only part of the response to violence against women in British Columbia. There is also activity within health care that is not captured by examining only formal programs. For example, some physicians have active strategies to ensure that women in their practices can disclose abuse if they wish. Many community health nurses incorporate understanding of violence in their practice, and participate in community networks.

TOWARD "BEST PRACTICES"

Major Challenges to "Best Practice"

Major challenges:
- *knowing what is "best"*
- *dealing with diversity*
- *overcoming organzational barriers*
- *providing the resources to know and do what is best.*

Key Characteristics of "Best Practices"

The above illustrates that there is limited evidence upon which to base recommendations for "best practice". The next major challenge is to make violence a health care priority. Despite the fact that the health burden of violence can be shown to be as significant for women as many other health issues that receive significant funding (such as cancer, cardiovascular disease, HIV/AIDS), violence receives relatively few resources. Providing suitable services to women who experience the greatest barriers to service is another significant challenge. Despite our diverse population in BC, services are provided primarily in English, are not often suitable for all age ranges of women, rarely make accommodation for physical and mental health issues, are often Euro-centric, and are primarily aimed at heterosexuals. Finally, promoting collaboration between different individuals, disciplines, organizations, groups and sectors is an enormous challenge, but essential to avoid duplication of effort, to eliminate service gaps, and to limit the negative impact of one sector on another.

Although specific programs and models have not yet been shown to be "best", the above analysis, and the extensive literature on violence against women suggests that there are some key characteristics of systems and programs that are likely to lead to "best practices".

At a system level, best practice is likely to be facilitated by:
- requiring collaboration within and between sectors, groups and organizations at all levels and demonstration of coordinated effort;
- providing sustained, secure program funding;
- assigning responsibility for dealing with violence at all levels;
- allowing flexible mandates so that service gaps can be rectified; and,
- requiring evaluation as part of all services.

At a program level, best practice is likely to be facilitated by:
- putting the safety of women and their children first;
- providing services that are woman-centered (Hills & Mullet, 1998);
- planning based on multiple perspectives, including those of women who experience violence;
- providing services based on an understanding of gender, the power dynamics of violence, the barriers women face and the power of professional disciplines;
- providing services that are consciously antiracist, anti-homophobic, anti-classist, etc.;
- providing services that are age-specific and appropriate to a range of age groups; and,
- building evaluation into all services.

NEXT STEPS:
RECOMMENDATIONS FOR STRENGTHENING THE HEALTH CARE SYSTEM'S RESPONSE TO VIOLENCE AGAINST WOMEN

To date, the health care system has been the weakest link in the response to violence against women. Developing a systematic and sustained response to violence against women will require a shift in the practice of health care and in our thinking. Violence must be recognized as fundamentally related to women's health and well-being. It is this recognition that will lay the foundation for change.

The health response to violence against women has been initiated across the province. Multiple programs have been developed by the efforts of a variety of health care providers, advocates, and community workers. These initiatives could provide the basis for establishing a coordinated, comprehensive, and effective health care approach. A community of committed people are ready to participate in taking the next steps toward "best practices" for dealing with violence against women.

1. Expand Programs and Initiate Pilot Projects in Key Areas

There is sufficient evidence to suggest that existing programs should be expanded and that pilot programs should be initiated in key areas. In existing programs, evaluation planning needs to be incorporated into the expansion to ensure that further program development in based on "best practices".

• **PILOT PROJECTS WITHIN THE HEALTH REGIONS**
Action on violence against women could be stimulated in the regions by allocating resources for pilot projects addressing violence against women in the health sector. The WomanKind program could be promoted widely with start up kits being developed and introduced to the regions. As one of the purposes of this program is the education of health care workers, it could address a number of key issues: the poor identification of violence by health practitioners, the focus on physical injury and attitudinal issues (e.g. victim blaming by health care providers). Existing programs like the one at BC Women's Hospital could provide training on an outreach basis, supporting regions in the development of projects that would fit their unique needs.

• **PERINATAL PROGRAMS ADDRESSING VIOLENCE AGAINST WOMEN**
Given the evidence that shows the high risk for violence during pregnancy, a comprehensive perinatal violence against women program should be initiated. The program at BC Women's Hospital is currently severely constrained by a lack of resources. This program, with additional support, could provide training and support for regions wanting to develop hospital-based programs. In Vernon (North Okanagan Health Region), a unique perinatal program has been developed that offers early intervention and support for survivors of physical and/or sexual abuse. Aspects of this program could be integrated into existing perinatal programs throughout BC. A provincial training program, jointly funded by MCF and MoH, would facilitate this sharing.

- **HOSPITAL-BASED 'DOMESTIC VIOLENCE' PROGRAMS**

As existing programs are predominantly in urban areas, the development of rural hospital-based wife assault programs is needed. This would ensure that the unique needs of rural and isolated communities were met. Existing programs could be resourced to provide assistance in staff and program development. Training should address issues of diversity and practice issues such as the identification of violence and psycho-social aspects of women's experience.

Before being expanded, existing programs could be evaluated to examine the health outcomes for women, and the impact on service providers who may have a history of abuse themselves. Evaluation could also assess the cultural appropriateness of wife assault programs and provide direction for dealing with issues of diversity.

- **HOSPITAL-BASED SEXUAL ASSAULT PROGRAMS**

Existing sexual assault programs could be expanded to provide more comprehensive services, with specific, separate health care and advocacy components. This would lessen the conflict current programs often experience due to the emphasis on evidence collection. Support of the regional outreach by the Sexual Assault program at BC Women's Hospital should be continued. This collaborative model utilizes existing expertise while addressing the unique needs of smaller communities.

Some of the hospital-based sexual assault programs are sufficiently mature to warrant evaluation. This could begin with analysis of existing data, and continue with a longitudinal study of the health outcomes of women. Such evaluation should be done and funded in collaboration with the Ministry of the Attorney General so that the impact of evidence collection and conviction rates can be concurrently examined.

2. Strengthen Links in Key Areas

To strengthen the health care system's response to violence against women, linkages need to be developed and supported. Most reports and studies recommend the development of formal relationships at all levels for the purpose of collaborating on efforts regarding violence. Key strategies for such development are:

Interministerial links are required for prevention initiatives, policy analysis, and the coordination and evaluation of related services.

BETWEEN MINISTRIES

- re-establish the Inter-Ministry Committee on Violence Against Women; and,
- seek Ministry of Health representation on committees that deal with violence against women. For example, the Joint Management Advisory Committee for transition house and children who witness abuse programs has representation from the Society of Transition Houses, the Ministry of Women's Equality and the Ministry for Children and Families, but no representation from the Ministry of Health.

WITHIN THE MINISTRY OF HEALTH

Links within the Ministry of Health are required for the coordination of services related to violence and the coordination of efforts addressing inter-related health issues.

- locate responsibility for violence against women with a particular group within health;
- create links between the group responsible for violence against women and those responsible for related health areas, especially HIV/AIDS, Senior's Health, Drug and Alcohol Programs, Aboriginal Health, and Mental Health Services; and,
- require responsibility for the implementation of "best practices" in services related to violence against women be designated within each Health Authority.

BETWEEN HEALTH AND HEALTH-RELATED PROGRAMS

- require coordination of services and collaboration with programs in health-related areas. Community coordinating committees serve as an existing venue, to which health representatives could be assigned.

BETWEEN HEALTH PROGRAMS

Links between programs must be formalized and legitimized to limit gaps, overlap and fragmentation of services.

- create links between mental health services for children and children who witness abuse programs;
- create links among all sexual assault and woman abuse programs (within regions and within province);
- create links between hospital and community health services within each region; and,
- create links between mental health services and drug and alcohol services.

3. Set Specific Health Care Goals

Goals for British Columbia in relation to violence against women are needed to provide direction. Goals of practice in health could be drafted from existing data and validated using existing reference groups (the Violence and Health Network of the BC Centre for Excellence in Women's Health, for example). Provincial goals in relation to violence (e.g. goal to reduce the number of homicides related to violence against women) would require collaboration between many ministries.

4. Establish A Monitoring System

Goal setting is a critical step because the goals are often unclear in practice and research, are often stated only in terms of process (e.g. "to train x number of people"), or are stated in terms of what providers of service will do, rather than in terms of outcomes for women. Further, the process of obtaining consensus regarding such goals will help identify where baseline data is missing (for example, a goal to reduce the number of women turned away from shelters for health related reasons by 20% would require knowing the baseline data).

Record keeping with regard to violence against women needs to be improved and strengthened within health settings. This would mean setting up a coding item to facilitate data collection on women's experience of violence and health care utilization. Such record keeping could eventually lead to the development of ways to monitor program outcomes.

I am a mother of two children (ages 12 and 14) who has experienced violence and seen the effects of living with violence on my children. Four years ago my children and I fled our home. At that time I was also living with the fear that the stress of living in an abusive situation was a prime factor in creating hypertension. There was a concern that the effect of the hypertension had enlarged my heart. My cardiologist warned of possible kidney failure. I lost weight. I weighed 85 pounds.

I would have died through direct physical violence if I had stayed. He would have beaten me up with physical violence or beat me up emotionally until my heart and kidneys gave out. I wanted to live.

I am telling my story because I believe it is representative of many. Women living with abuse have the problem of attending to the financial, emotional and health issues of themselves and their children. It takes the ultimate courage to leave. Therefore, it is imperative that when a woman makes the effort to get help, the first attempt will link her up to the services she needs. She does not have the energy or self esteem to tell and retell her story.

<div align="right">Emily Lui, Women In Action [4]</div>

<div align="center">*****</div>

Behind each of the statistics cited in this paper are real women and children. Behind each terrible death there are years of abuse. Behind each woman who receives services there are many more who do not.

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[4] Excerpted with permission from a letter written to support research on improving services for women in health.

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