RESPONDING TO THE HEALTH NEEDS OF WOMEN AND CHILDREN INVOLVED IN DOMESTIC VIOLENCE

"For women under the age of 45 years, intimate partner violence has a greater impact on health than any other risk factors, including obesity, high cholesterol, high blood pressure and illicit drug use." (Cherniak et. al., 2005 as cited in Ursel and Bertrand, 2009). Consistent with this research Alberta shelters find that the health effects on women and children resulting from domestic violence are varied, often severe, and in many cases have gone on for many years without resolution. Domestic violence is not just limited to physical attacks on a spouse or partner. It also includes emotional and psychological abuse, isolation, intimidation, financial abuse, sexual abuse and marital rape, and stalking. Children are also seriously impacted by domestic violence, even when the violence is not directed toward them.

Barriers to improved health outcomes associated with health service access and intervention effectiveness result in unnecessary human and financial costs. After consultation with shelter representatives from across the province regarding how to best address these health issues, the Alberta Council of Women's Shelters proposes the following:

1. Formally establish a guiding principle for health service practice in Alberta that sets the foundation for development of gender-appropriate and culturally competent health system practices.

2. Establish coordinated care teams to implement individualized service planning and case management processes for women and children accessing women's domestic violence emergency shelters. It is expected that this team may vary to some extent from one community to another. However each team should provide the following:
   - Nursing services on-site at domestic violence emergency shelters to provide health assessments and physical check-ups for women and children (including assessment of violence-related injuries or illnesses, overall health, and pap tests), manage medication needs, prescriptions and medication administration protocols, screen for sexually transmitted infections, complete developmental screenings for children, and provide vaccinations and flu shots;
   - Dental repair and dental hygiene for women and children;

- Consultation from a professional qualified to assess mental illness, and recommend treatment; and
- Nursing services that support women and children as they transition from domestic violence emergency shelters to second stage shelters or the community. These services should support women and children to access needed specialists, develop connections with the designated primary care network in their community (see recommendation #3), and follow through on appointments and other recommendations in the health care case plan as they develop connections to community-based services and incorporate positive health care practices into their lifestyle.

3. That Alberta Health designate a primary care network in each shelter community to provide the specialized medical and dental services required for abused women and their children, with a requirement that each network member receive the necessary training on domestic violence as a health care issue (see recommendation #5).

4. Develop and implement protocols throughout the health system to ensure that women are routinely asked at all entry points to health services whether there has been violence in the family.

5. Educate health professionals regarding health issues for women and children involved in domestic violence, both during their post-secondary training and while working in the health system, ensuring an informed understanding of the issues associated with domestic violence and addressing common misperceptions and attitudes. Training development should be informed by representatives from shelter organizations.

6. Increase the coordination and availability of resources as necessary to effectively respond to severe mental health issues of women ensuring appropriate distribution of services throughout all regions of the province, including:
   a) Meet the minimum standards for psychiatric beds of 1/2 bed per 1000 population in all health regions of the province without reducing existing beds in any region;
   b) Review and modify current physician practices related to applying for an Admission Certificate under the Mental Health Act, ensuring an effective response to women's risk resulting from psychosis and related inability to make safe decisions; and
   c) Coordinate resources together with community services as necessary to assist women with severe mental health issues to transition effectively and with support from hospital treatment beds to their home community. This range of services should be accessible to regions across the province.

7. Future pandemic planning needs to consider the security needs of women at risk of domestic violence and their children.

The following sections of this Statement provide background information describing:

- The key health issues experienced by women and children entering Alberta Women's Shelters, with supporting aggregated data from ACWS member shelters, verbal reports by shelter representatives and evidence from the literature; and
- Further details regarding the recommendations made above along with the rationale for each recommendation.

BACKGROUND

This section provides background information as context for the above recommendations. Specifically, a summary of the most common health issues experienced by women and children entering Alberta shelters, and a summary of the issues these women and children are facing in accessing the health system in Alberta are provided.

Women's and Children's Health Issues

The Women's Health Effects Study of 309 Canadian women who had left an abusive relationship within the past 6 years, showed that: 82% had at least one active medical diagnosis, and 33% were experiencing chronic disabling pain. 57.6% had high-level depressive symptoms, and 48% had symptoms of Post-Traumatic-Stress Disorder. In addition, more than half of these women reported fatigue, feeling worried, feeling sad, difficulty sleeping, back pain, headaches, difficulty concentrating, general aches and pains, and bowel problems. (Canadian Institutes of Health Research).

Similar data from the Healing Journey Study of 214 Alberta women fleeing domestic violence, found that 74.5% had a chronic illness or disability, which in 48.1% of cases limited the woman's activities and in 40.3% limited employability. (Ursel and Bertrand, 2009). The numbers are significant, as evidenced when comparing these research estimates with the number of women served. Data collected across 8 ACWS member shelters during the ten month period October 2009 to August 2010 showed that 1890 unique women and 1833 children were served (Alberta Council of Women's Shelters).

Increased health problems for women who have experienced domestic violence, such as injury, chronic pain, gastrointestinal, and gynaecological signs including sexually-transmitted diseases, depression, and post-traumatic stress disorder are well documented by controlled research in abused women in various settings. (Campbell, 2002).

Alberta shelters observe that women and children entering their facilities often experience both poor general health and a number of specific health issues and risks associated with domestic violence. Poor general health issues for women commonly reported by shelters include poor nutrition, high blood pressure, sleep disorders, hormonal imbalance, menstrual disorders, and chronic headaches. Health problems resulting from the long term effects of stress are also common, some of which include decreased immune response, poor appetite and eating disorders. Eating problems range from a tendency to under-eat or over-eat to nausea and vomiting, and a history of bulimia/anorexia. Digestive disorders are also very common, often presenting as irritable bowel symptoms, acid reflux, and susceptibility to vomiting, diarrhoea and constipation. Undiagnosed diseases are often discovered while women are in shelter and have a safe place to consider their health and other personal needs.

Common health issues for children observed by Alberta shelters include poor nutrition, cold and flu, ear, nose and throat infections, allergies, asthma, eczema, needing eyeglasses, and digestive difficulties (often resulting from stress). Children commonly have not had regular annual medical check-ups and often have health needs due to a lack of consistent health care.

Research has shown a relationship between various types of child maltreatment and long-term physical health problems (Dube, Felitti, Dong, Giles, & Anda, 2003; Felitti et al., 1998; Frances, Caldji, Champange, Plotsky, & Meaney, 1999; Goodwin & Stein, 2004). Women abused as children, but not as adults, had significantly more physical health symptoms compared with women who never experienced abuse (McCauley et al., 1997; Humphreys and Campbell, 2011).

Research shows high rates of health service use among Canadian women leaving an abusive relationship. In the Women's Health Effects Study of women leaving an abusive relationship 56% had seen a family doctor and 22% had accessed an outpatient/walk-in clinic within the previous 30 days (Canadian Institutes of Health Research). Consistent with this research, Alberta shelters report that use of health services is high among a percentage of women entering their facilities. However they also find that there is a significant number of women that access health services only in response to a crisis or significant health problem, that have not accessed preventive health care, and in many cases have not accessed health care for many years even in response to a health crisis or problem. While data is not currently available regarding the percentage of women demonstrating each of these patterns of health service use, these trends are clearly evident in shelter descriptions provided below of the most common health issues for women and children entering Alberta shelters.

Following is a description of the specific health issues that are common for women and children entering Alberta’s women’s shelters:

1. Poor Dental Health - Women and Children

"[We're seeing] lots of bottle mouth, children needing dental surgery, children needing extractions."

Dental health is noted by shelters as one of the most common health issues for both women and children. For a variety of reasons (including cost, lack of parent's education about dental care, women's pre-occupation with day to day safety and control of health care choices by the woman's intimate partner) a significant number of women and children entering shelters are not accessing dental care. According to shelters, dental issues for this population are very common and often extreme.

2. Physical Injury and Effects - Women and Children

Serious physical injury due to violent assaults is common for women and children in domestic violence situations. Alberta shelters observe that women and children often have fractures, abrasions and bruising. More often in women, injuries include head injuries, dislocated joints, and the physical effects of strangulation.

"Research shows that abused women frequently (10–44%) report choking (incomplete strangulation) and blows to the head resulting in loss of consciousness, both of which can lead to serious medical problems including neurological sequelae." (Campbell, 2002)

Alberta women's shelters observe that head injuries may be accompanied by symptoms that last for several months after the assault including ringing in the ears, memory problems, headaches, irritability and personality changes. Some women are believed to have had multiple concussions without follow-up care. Indicators of Post-Traumatic Stress Disorder are particularly evident where there have been attempts at strangulation, drowning or other more severe forms of assault.

3. Children's Mental Health, Developmental Delays and Disabilities

Children enter Alberta women's shelters with a range of issues that impact their mental health. Most commonly children exhibit a range of acting out behaviours including aggression, separation anxiety and poor social interactions. For some, these behaviours diminish to an extent after a period of time in shelter, but for others more significant intervention is needed.

Many children have symptoms of depression and anxiety disorders. "Two studies by Lehmann (1997) & Devoe & Graham-Bermann (1997, both cited in Rossman & Ho, 2002) found rates of diagnosable PTSD among child witnesses of domestic violence at 56% and 51%, respectively." (Tutty, et.al, 2009)

Developmental delays and disabilities are key issues for children entering Alberta shelters and are also a significant challenge for their mothers. Common examples include speech delays, learning disabilities (sometimes complicated by poor school attendance due to chaos at home). In extreme cases children are notably underdeveloped.

A longitudinal study of 214 women in Alberta who had experienced domestic violence showed that 35.1 % had at least one child with a disability, long term illness and/or special needs.

4. Sexually Transmitted Infection and Injury Resulting from Sexual Violence - Women

Women's shelters report that a significant number of women experience sexually transmitted infections resulting from assaults. When combined with limited or no access to regular physical examinations and other health services, these women are at risk for a variety of health effects.

"According to research, gynaecological problems are the most consistent, longest lasting and largest physical health difference between battered and non-battered women. Differential symptoms and conditions include sexually-transmitted diseases, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain and urinary-tract infections." (Campbell, 2002).

5. Pain - Women

Both chronic and acute pain are common issues for women entering Alberta women's shelters. Acute pain is often related to assault. Chronic pain is common for a number of reasons including:

- Long-term physical effects of assault,
- Hyper-sensitivity to pain, and
- Somatoform disorders in which emotional pain is experienced as physical pain.

Women involved in domestic violence often experience judgement when they try to access community health clinic services for pain. Clinics often assume the woman is drug-seeking, which precludes establishing a good relationship. These assumptions also tend to result in inadequate treatment approaches. Alberta women's shelters observe problems both with excessive and insufficient responses to the treatment of pain.

6. Substance Abuse and Addictions - Women

Substance abuse and addictions are a common issue for this population. Health issues related to overuse of substances in response to stress as well as addictions to illegal drugs, alcohol and prescription medications are significant. Aggregated data (2010) from ACWS member shelters shows that 28% of women reported having an addiction at the time of admission, including 8% identifying multiple addictions. These women were mostly addicted to alcohol (51%) or drugs (41%). Women with children and young women aged 18-24 had the lowest rates of addiction (21% each). (Alberta Council of Women's Shelters).

"It can be difficult to tell how addictions [to prescription medication] develop for these women. In some cases they develop because women overuse medications to mask emotional pain, and in other cases they have been treated so many times with addictive medications that [they become dependent]."

"PTSD symptoms have also been found to increase the risk for illicit drug and alcohol abuse in women experiencing IPV, with each symptom cluster of PTSD uniquely contributing to this risk (Sullivan & Holt, 2008)." (Humphreys and Campbell, 2011).

7. Poor Reproductive Health and Risk of Violence During Pregnancy

A recent study showed that 30% of 214 Alberta women who left an abusive relationship were abused during all of their pregnancies and 47% for some of their pregnancies. (Ursel and Bertrand, 2009). Intimate partner violence has been noted in 3–13% of pregnancies in many studies from around the world, and is associated with detrimental outcomes to mothers and infants. (Campbell, 2002). Aggregated data (2010) from ACWS member shelters shows that 125 women (6.6%) were pregnant at the time of admission. (Alberta Council of Women's Shelters).

Specific challenges related to pregnancy for women in Alberta shelters include:

a. Many women are blamed for the pregnancy by the intimate partner and forced to have an abortion;
b. Intimate partners' control over access to birth control, resulting in unplanned pregnancies;
c. The partner's control over access to health care services resulting in women not accessing prenatal care until months into the pregnancy; and
d. Miscarriage, preterm babies and low birth weight babies.

8. Poor Infant Health

Related to poor reproductive health of women and other complicating factors associated with domestic violence, infants may present with a range of health issues such as infant illnesses that result in respiratory problems. In extreme cases, there are problems with failure to thrive.

9. Fertility Issues

Infertility can place great stress on the individuals involved and on the marital relationship resulting in escalated violence and abuse. Infertility and involvement in fertility assessment and treatment is typically very stressful on the marital relationship. This experience commonly triggers self-blame and blame of the partner, personal identity challenges (related to the fear of not being a parent), financial stress from the costs of fertility treatments, isolation resulting from not wanting to talk about the issue, differences in opinion between partners about when to stop trying to get pregnant, the impact of hormone injections during fertility treatments. Where domestic violence is already an issue in the marriage, or where factors predispose the couple to intimate partner violence, fertility issues can trigger abuse and violence.

In some cases, families place responsibility on the woman to get pregnant and blame her for fertility problems, often due to family dynamics or cultural beliefs. These scenarios contribute negatively to existing unhealthy power imbalance in the marital relationship.

"One woman said, If I don't get pregnant this time, someone is going to die."

10. General Mental Health - Women

The mental health of women involved in domestic violence is complicated by interacting health, family history and situational factors. Alberta shelters observe that a large number of women experience varying levels of anxiety and depression. Many also experience serious long-term effects of physical and emotional trauma. Some women discover while in shelter that they have Post-Traumatic-Stress-Disorder that has gone undiagnosed for long periods of time while they've struggled to understand their symptoms. Shelters find that symptoms of PTSD are often re-activated for women entering emergency shelters immediately following an assault.

"Following a meta-analysis of 11 studies, Golding (1999) reported a prevalence rate of almost 64% for PTSD in women in a violent intimate relationship. Rates of PTSD are as high as 92% in women seeking help at crisis shelters and domestic violence agencies (Woods et al., 2008b). There is also evidence that PTSD is often co morbid with other mental health problems. Women with PTSD often have co morbid depression (Breslau, Kessler, Chilcoat, Schultz, Davis, & Andreski, 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; O'Campo et al., 2006)." (Humphreys and Campbell, 2011).

Panic attacks, night terrors and sleep disorders that result from persistent fear and patterns of hyper-vigilance in response to chronic abuse are also observed to be common for women and children in Alberta women's shelters. One shelter representative comments that women tend to experience sleep disorders at a higher rate during the first 10 days in shelter.

Grief is a problem that can become a significant health issue for women leaving an abusive relationship, particularly when interacting health and situational factors hinder the woman's ability to resolve her grief. Women entering domestic violence shelters may experience a range of circumstances that cause persistent grief, i.e. grief associated with choosing to have an abortion or being forced to have an abortion by their partner, loss of family relationships due to choices to leave an abusive relationship, family conflict and blame and having children apprehended due to children's exposure to violence are just a few examples.

11. Severe Mental Health Disorders - Women

Women experiencing severe mental health problems including psychosis are entering shelters experiencing a range of extreme challenges. This issue confronts shelters across the province but is particularly challenging in smaller communities where resources are even more limited. In many cases, because of insufficient access to the level and range of resources needed, these women return to violent situations or move from shelter to shelter without ever experiencing the level of stability needed to make good choices for their lives. (Discussed below under #15. Mental Health Access Barriers - Women)

Alberta women's shelters see the high human cost of domestic violence and it's health effects in the lives of women and children every day. The financial costs are also high. "Researchers tracking health care costs of women abused by their intimate partners in the United States over an 11-year period found that ongoing physical violence from a male partner resulted in women spending 42% more on health care than non-abused women (Bonomi, Anderson, Rivara, & Thompson, 2009). In addition, women experiencing emotional abuse, but no physical violence, by a male intimate partner had annual health care costs that were 33% higher than non-abused women." (Humphreys and Campbell, 2011).

Barriers to Access and Effectiveness of Health System Services

There are many barriers to effective health care for women and children experiencing domestic violence. For many, these barriers result in inconsistent access at best, resulting in responses that are often uninformed or insufficient to make any positive change in their health. Following are the barriers to access and effectiveness of health services that are frequently observed by Alberta women's shelters:

12. Access Barriers

a) Health System Barriers to Access

- Women not being taken seriously at health services because of judgement regarding their presentation or their circumstances;
- Reluctance by health professionals to acknowledge the existence or incidence of domestic violence and related health implications despite the extensive research-informed evidence and data to the contrary;
- Limited availability of family doctors which translates into a lack of consistent health care
- Difficulty accessing specialists, in particular for children's needs and mental health issues.
- Lack of emergency beds;
- Experiencing long wait times for services at emergency services and community clinics;
- Some Community Clinics refusing Non-Insured Health Benefits Coverage for First Nations peoples;
- Assumptions by health service professionals that the woman is drug-seeking when this is not the case.

As a result of these barriers, shelters often resort to sending women and children to emergency health services for health problems that could otherwise be sufficiently addressed in the community, creating an unnecessary added burden on this area of high demand for health services.

b) Women's Barriers to Access

- Women being overwhelmed by their circumstances and experiencing anxiety about interactions with health professionals (i.e. a reluctance to go to Emergency as they are vulnerable and afraid of the questions they might be asked.
- Losing their Alberta Health Care card;
- Struggling to keep follow-up medical appointments because they are overwhelmed and have to manage child care and transportation;
- Being afraid to leave the shelter due to being stalked by their partner and/or being at high risk for re-assault by their partner;

- Accessing transportation to health services (for themselves and for their children) when they are injured or unwell;
- A sense of helplessness to resolve health problems (often related to their partner's control over choices, and/or frustration with navigating the health system); and
- Lack of child care coupled with fear of leaving children with perpetrator.

c) Barriers Related to Partner's Control of Health Care Choices

In some cases women and children involved in domestic violence have had insufficient or no health care for long periods of time due to control over their personal health care choices by the abusive partner. In these cases Alberta women's shelters have often observed personal health choices being controlled in the following ways:

- Choice over the type and amount of food they eat;
- Access to dental care;
- Access to health services in general as well as specialized treatment (i.e. cancer treatment);
- Access to prenatal counselling;
- Cancelling their Alberta Health Care card; and
- Reproductive choices and health, (i.e. forced abortion, not allowed to use birth control, access to pregnancy health services).

> "[One woman saw] a physician for the first time at 39 weeks [of pregnancy] because her partner wouldn't allow her to access health services. The assumption is that you must not be a concerned mom if you haven't accessed care up to this point...Some obstetricians have set a limit and won't serve women after 26 weeks of pregnancy if they haven't received previous prenatal care."

In these cases, the effects of poor health habits and a lack of access to health care often result in significant and compounding health issues.

d) Cost Barriers

Cost barriers limiting access to health care for a large percentage of women and children entering shelters include:

- The cost of medications and supplies (i.e., crutches, prenatal vitamins, bandages, etc).
- The cost of dental care;
- Fees charged for health care visits at community clinics for women from out-of-province, and
- The cost for transportation.

The Women's Health Effects Study showed that out of 309 Canadian women who had left an abusive relationship, 50% reported that it was "very or extremely difficult" to live on their current income, and 22% had used a food bank within the previous month. (Canadian Institutes of Health Research)

13. Medication Prescription and Monitoring

In many cases medications are prescribed for various mental health problems, such as depression and anxiety without follow-up, referral or ensuring access to other supports. At best this leaves women with treatment that is likely to produce poor outcomes. In too many cases this results in the development of a chemical dependency when women continue to take medications unchecked, particularly if distortions in thought and mood persist.

Insufficient follow-up and monitoring of medications often leads to women taking prescription medications without an accurate understanding of their purpose and limitations. This also results in errors in medication administration by women including over-medicating, under-medicating, and taking medications at the wrong time. In one recent example a woman entering the shelter had been taking anti-depressants only when she experienced pain, believing she was taking a pain medication.

"There's no consistent follow-up. [These women] need the counselling piece. [Community clinics are often] not willing or able to take that extra step. [So women] get medications but nothing else. It's hit and miss how they are treated..."

14. Medication Administration

Administration of medications is a significant challenge for shelters. Without on-site medical personnel qualified to administer medications and determine protocols, shelters experience a range of difficulties associated with responsible management of medications, including:

- Women entering shelters in crisis without necessary medications for themselves and/or their children;
- Lack of clarity regarding dosage and protocols for administration of prescriptions;
- Issues associated with women having multiple prescriptions from more than one doctor;
- Storage and control of medications;
- Monitoring women's self-administration of medications;
- Reporting and responding to errors in self-administration and potential related health risks;

Addressing and/or reporting concerns regarding medications prescribed by physicians (i.e. excessive prescriptions of pain medication).

15. Mental Health Access Barriers - Women

An insufficient number of psychiatric beds, particularly in smaller communities of Alberta leave women with severe psychosis in women's shelters without proper assessment and treatment.

The lack of sufficient psychiatric beds in some communities is resulting in:

- Pressure on physicians to discharge patients prematurely, before they are adequately assessed, treated and prepared for successful transition to the community;
- When a psychiatric bed is able to be accessed in another community, the individual must overcome the added barriers associated with stabilizing away from family and community and transitioning successfully to their home community from a distance; and
- Some shelters are regularly housing women with severe mental illnesses including psychosis. These shelters have insufficient resources to assist these women effectively and to maintain security for those who are suicidal and a possible threat to others. Shelters are seeing very poor outcomes for these women including:
    - Continued involvement in violence and other negative lifestyle options resulting from mental health factors that prevent them from making good choices for their life;
    - An inability to see the need for treatment as a result of persistent delusions and hallucinations; and
    - Premature death resulting from various risk factors associated with their inability to make good choices for their life.

Possibly due to the lack of psychiatric beds in some communities and/or for other reasons, a significant number of women who present at serious risk of harm to themselves are not being issued an admission certificate under the Alberta Mental Health Act. In many cases, this may become a missed opportunity to prevent further deterioration and premature death.

We are aware that there are very good treatment approaches available to control hallucinations and delusions and to eliminate the self-destructive tendencies that are often inherent in psychosis; however women's shelters observe that it is too often assumed that women experiencing these symptoms are competent to decide what is best for them when this is not always the case. There is a great variation in the level of understanding among physicians regarding these issues. Ensuring that all regions have physicians with the knowledge to serve this population, sufficient psychiatric beds and access to the range of services to effectively support

this population is essential to making a difference in health outcomes for these women.

Should women be able to access psychiatric services and be admitted the welfare of their children creates additional complications. Reuniting the child with their mother's abuser during treatment can be dangerous for both the mother and the child.

16. Need for Understanding and Education Regarding Issues of Domestic Violence and Abuse

Women and children experiencing domestic violence are vulnerable to judgement and discrimination in their interactions with various systems including the health system. This may be especially true for those who also experience poverty, mental health, addictions, and/or chronic circumstances that hinder positive health outcomes. Education to address attitudes and beliefs related to women's and children's involvement in domestic violence is needed.

The chaos that commonly results from fear of re-assault or death, fear of losing one's children, emotional distress, mental health factors, control of personal choices by one's partner, and/or a sense of hopelessness can result in a variety of barriers to treatment. Women experiencing violence for significant periods of time may have a range of health needs and may struggle to follow through consistently with recommendations. Without the range of support needed to address case-specific barriers and effectively engage these women in health promotion, expecting them to implement health recommendations (i.e. medications, appointments, tests, personal lifestyle changes) will continue to be ineffective.

Alberta shelters have observed examples of health professionals denying that patients were ever present at their clinic or service with domestic violence related injuries. This is inconsistent with both the research as well as emergency shelters' experience of frequently sending women to these services with finger point bruising on the neck and various head and bodily injuries consistent with their reports of violence. One Canadian study reports that as many as thirty percent of all women who come into hospital emergency rooms are there with injuries related to intimate partner violence. (Basen, 2004)

In addition to a general need for education within the health system to promote understanding and tolerance, there is a need for specialized training in areas where women and children present with specific risks associated with domestic violence including emergency health services, fertility services and pregnancy services.

RECOMMENDATIONS - DESCRIPTION AND RATIONALE

This section provides a description of the six recommendations made and a summary of the related rationale for each recommendation.

RECOMMENDATION #1

Formally establish a guiding principle for health service practice in Alberta that sets the foundation for development of gender-appropriate and culturally competent health system practices.

Such a principle is needed to build knowledge and practice that ensures health assessments, diagnoses and treatments are informed by research and evidence regarding population-based differences. (i.e. research-informed health services appropriate to women). In *Assessing the Danger* (ACWS, 2009), Aboriginal women were found to be significantly more likely to report increased physical violence, including violence when the woman was pregnant, thoughts of suicide, partner unemployment and partner's use of illegal drugs or addiction to alcohol. Given the high rates of violence against aboriginal women it is imperative that we have health responses that specifically meet their needs in an appropriate manner.

RECOMMENDATION #2

Establish coordinated care teams to implement individualized service planning and case management processes for women and children accessing women's domestic violence emergency shelters. It is expected that this team may vary to some extent from one community to another. However each team should provide the following:

- Nursing services on-site at domestic violence emergency shelters to provide health assessments and physical check-ups for women and children (including assessment of violence-related injuries or illnesses, overall health, and pap tests), manage medication needs, prescriptions and medication administration protocols, screen for sexually transmitted infections, complete developmental screenings for children, and provide vaccinations and flu shots;
- Dental repair and dental hygiene for women and children;
- Consultation from a professional qualified to assess mental illness, and recommend treatment; and
- Nursing services that support women and children as they transition from domestic violence emergency shelters to second stage shelters or the community. These services should support women and children to access needed specialists, develop connections with the designated primary care network in their community (see recommendation #3), and follow through on appointments and other recommendations in the health care case plan as they develop connections to community-based services and incorporate positive health care practices into their lifestyle.

Using this model, the coordinated care team would work together to develop and facilitate the implementation of health care case plans for women and children entering women's domestic violence shelters.

Women's domestic violence emergency shelter services are generally available for approximately 21 days in Alberta. Involvement of the coordinated health care team would begin at domestic violence emergency shelters in Alberta. Services would continue to support the implementation of the health care case plan as women and children move to second stage shelters or other community housing, assisting women and children to develop and maintain connections to community-based health services and apply positive health-promoting practices.

The health effects of domestic violence for women and children are often long term, and research supports that longer duration of intimate partner violence is associated with incrementally worse health (Bonomi, et. al., 2006). By engaging women and children involved in domestic violence in health promoting practices and providing a focused and coordinated response to case-specific health issues, improvements in health outcomes can be expected to result in decreased human and financial costs.

A coordinated case management approach that includes both provision of direct health care services by the team and supporting access and relationships with community health resources based on case-specific needs, would reduce the many barriers to accessing needed services and increase efficiency in the use of health resources.

"So now they're four [years old] and have never seen a doctor, never had a vaccination or a check-up"

This approach would also promote timely provision of services by:

- Responding to acute health needs while women and children are in emergency shelters and are addressing a range of crisis needs, and
- Later, supporting consistent use of preventive and health-promoting practices once they are past the initial crisis period and able to put greater energy into making and sustaining such changes in their lives.

Other specific benefits that are anticipated include:

- Support for women's understanding of the links between the violence at home and their children's health resulting in increased motivating factors for women in making positive choices for themselves and their children;
- Improved assessment and management of mental health issues including prescription monitoring and medication administration processes, reducing associated risks and errors;
- Increased safety for women and children by providing core health services on-site at the shelter during a period of heightened risk for re-assault in the community that occurs in early stages after the woman leaves the relationship;
- Reduced burden on emergency health services;
- Reduced duplication of services and other efficiencies realized by ensuring treatment protocols that are informed by the awareness of the violence and details of related incidents;
- Increased opportunity to address root causes by increasing women's health protective factors and improving the likelihood that they will choose a violence-free lifestyle;
- Preventing progression of disease and long term health effects that are common among abused women and children; and
- Reduction in health care costs.

RECOMMENDATION #3

That Alberta Health and Wellness designate a primary care network in each shelter community to provide the specialized medical and dental services required for abused women and their children, with a requirement that each network member receive the necessary training on domestic violence as a health care issue (See Recommendation #5).

This approach is needed to ensure that community-based health services are available to abused women and children and that they are able to respond in an informed and educated manner to the health needs of this population. This approach can be expected to support the development of positive relationships between women and community health resources as women and children transition back to the community and to facilitate the use of preventive health care practices by:

- Increasing consistent follow through on treatment recommendations,
- Encouraging timely access to resources,
- Preventing repeated unsuccessful and costly efforts to access informed and appropriate treatment services, and
- Promoting overall health.

RECOMMENDATION #4

Develop and implement protocols throughout the health system to ensure that women are appropriately and routinely asked at all entry points to health services whether there has been violence in the family.

By implementing protocols that ensure women are routinely asked about violence in the family at all patient entry points to the health system, opportunities to identify, prevent, and respond to risks of further violence will be more effectively and efficiently addressed. Providing a simple protocol that helps health professionals to understand how to ask about and respond to patients' experience with domestic violence in a clear manner that is appropriate and manageable within their role will help to reduce employee anxiety about the subject matter and increase the quality of approach. Asking the question alone creates opportunities to save lives by identifying the involvement of many women and children in domestic violence who would otherwise not disclose.

Research from Boston University School of Medicine and the Boston Medical Center finds that individuals who initially disclose intimate partner violence (IPV) to their primary care physician or obstetrician/gynaecologist experience the best outcomes. (Nauert, 2008)

Several factors inform the need to routinely and repeatedly ask about women's experience with domestic violence:

- The high incidence of spousal assault - 10% of women in Alberta were victims of spousal assault in 2004 (Statistics Canada, 2005 as cited in Ursel and Bertrand, 2009);
- In a study of 456 U.S. women who had been killed by an intimate partner, 47% had been seen in the health care system for something during the year before they were killed. While 14.1% had been in the health care system for injuries from domestic violence, a greater percentage were accessing the system for general health problems or mental health problems including substance abuse (Campbell, 2004); and
- The health effects of involvement in domestic violence are many and varied, suggesting that women and children in these circumstances are likely to present frequently at all entry points to the health system.

The frequency, duration and severity of health effects associated with domestic violence and the level of interaction women and children in these situations have with the health system provides a compelling case for implementing protocols that ensure consistent efforts to identify and respond to domestic violence at all entry points to the health system, minimally including emergency health services, community clinics, family physicians, fertility clinics and pregnancy services.

RECOMMENDATION #5

Educate health professionals regarding health issues for women and children involved in domestic violence, both during their post-secondary training and while working in the health system, ensuring an informed understanding of the issues associated with domestic violence and addressing common misperceptions and attitudes.

a) Educate regarding the complex nature of domestic violence and resulting barriers to treatment.
b) Educate to address reluctance to acknowledge the existence of domestic violence-related injuries and health issues at entry point to the health system, and to treat health issues related to domestic violence.
c) Educate to ensure understanding of the confidentiality risks specific to this population, including the sensitivity to issues of confidentiality associated with cultural community (to allay women's fears of breach of confidentiality within their cultural community), and the special circumstances and added confidentiality risks experienced by those in smaller communities.
d) Educate to ensure understanding of concurrent disorders and interacting factors associated with domestic violence, including implication for prescription medication protocols.
e) Educate to ensure that health professionals in areas of particularly high risk for domestic violence are aware of the specific risk issues for women and children associated with their area of specialization (i.e. pregnancy services, fertility clinics, emergency services).
f) Educate to ensure health professionals understand the available options for access to supports and services to address their own experience with domestic violence.

By educating health professionals regarding issues of domestic violence, both in University and through workplace training, the health system's approach to these cases can be expected to result in a safer environment for women to disclose and use of more evidence-based and effective treatment protocols.

Perceptions and attitudes of doctors, nurses and health service managers overseeing patient points of entry directly influence the tone of the environment and approach to serving this population. By educating these professionals to ensure an informed understanding of the key issues, individual and systemic barriers to providing effective health services for victims of domestic violence may be dramatically reduced.

RECOMMENDATION #6

Increase the coordination and availability of resources as necessary to effectively respond to severe mental health issues of women and children ensuring appropriate distribution of services throughout all regions of the province.

a) Meet the minimum standards for psychiatric beds of 1/2 bed per 1000 population in all health regions of the province without reducing existing beds in any region;
b) Review and modify current physician practices related to applying for an Admission Certificate under the Mental Health Act, ensuring an effective response to women's risk resulting from psychosis and related inability to make safe decisions; and
c) Coordinate resources together with community services as necessary to assist women with severe mental health issues to transition effectively and with support from hospital treatment beds to their home community. This range of services should be accessible to regions across the province.

Women's shelters observe extensive challenges related to both the availability of services and the approach to treatment of women's mental health. These challenges are significantly greater outside of the larger cities, where access to the range of health expertise and psychiatric beds is more limited.

By supporting physicians to carry out the spirit of the Alberta Mental Health Act in cases where women are at serious risk of harm due to psychosis, and ensuring sufficient psychiatric beds across all regions of the province, women's risk of violence and death in these cases may be prevented. Dialogue with physicians is needed within each region to ensure the availability of resources with a thorough and consistent understanding of the current Mental Health Act including that imminent risk of suicide or harm to others is no longer a requirement of the Act, but rather that an admission certificate may be issued when the person is "suffering from mental disorder; likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment; and unsuitable for admission to a facility other than as a formal patient."

Coordination of services for the severely mentally ill is needed throughout all regions of the province. Coordinated access to a continuum of services based on case-specific needs is available in some regions, but is not accessible throughout the province to the extent needed. Support for women with severe mental illness to transition from psychiatric care to their home community requires access to appropriate housing and health supports such as home care nursing, connection to a family doctor or clinic and access to other needed health services. Coordinating and providing this range of services based on case-specific needs will support the ability of these women to sustain independent living and a safe and stable lifestyle.

RECOMMENDATION #7

Future pandemic planning needs to consider the security needs of women at risk of domestic violence and their children.

H1N1 pandemic planning in 2008-2009 did not address the security needs of abused women, whether in shelter or not. In some smaller communities in Alberta, shelters were supported by their local health units but this was not a widespread experience. Nor were the front-line workers in Alberta's emergency, second-stage and seniors shelters on Alberta Health Service's list to receive the H1N1 vaccine, though their work is on-par with other 'first responders' (fire fighters, police, provincial peace officers) and health care workers who were given high priority for the vaccine. Pandemic planning needs to recognize the safety considerations for women, as well as her abuser's risk to others, when mass immunization occurs.

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