

Coordinator's Update

I am writing this update still feeling the effects of the terrorist attacks in the U-S and it's extremely difficult to provide an update 'as per usual'. Very little seems normal any more and fear of what lies ahead consumes my thoughts.

Our Network and Domestic Violence meetings scheduled that week were cancelled given the events unfolding, the uncertainty of safe travel, and the need to be close to family. The grief and sadness felt by everyone I have talked to is overwhelming. Some of you may have lost family and friends in this violence, others feel immense relief in knowing the safety of friends/family living in New York, Washington, or Pennsylvania. Amidst the anger and need to punish those who committed these terrible acts is one resounding message: Cherish those you love and make the most of every moment you have with them.

Updates

We have a lot of work in progress and many tasks not yet completed. We are waiting for the funding letters from the Ministry of Health which would expand the mandates of all SATC/SACCs to include domestic violence.

We are also waiting for funds to begin our work with the pediatric population.

Two years ago we submitted a proposal requesting funds for the provision of HIV prophylaxis to our clients who were concerned about HIV exposure. The Ontario Women's Health Council supports our request and is working with the Ministry to ensure funding.

Organizing next year's annual conference "Pediatric Population & Sexual Assault" is well underway. The conference will take place on April 11, 12, 13, 2002 at the Toronto Colony Hotel.

Thank-you to everyone who sent back the questionnaire for the Sexual Assault Nurse Examiner review. Your assistance is very much appreciated. The meeting for the SANE review was also cancelled and will be reorganized in the near future.

The Ontario Network of SATC/SACCs will be participating at various events in the next few months. I am co-presenting at the Canadian Coalition of Rape Crisis Centres Conference in Ottawa. The Network will be presenting at the Ontario Hospital Association Annual Convention in November, and at the Women's Health Forum and Expos in January (*in Toronto*).

In these times of such uncertainty, take extra care of yourself and take care of each other.

**Sheila Macdonald R.N.
Provincial Coordinator**

UNIVERSAL SCREENING – How to Implement in ER or '*How to Become Unpopular in Your Hospital, Fast*'

This information is based on practical experience about how we, at Cornwall General Hospital, began *universal screening* in our ER. This is *not* a 'how to' article. Rather it may help those of you trying to implement it at your hospital. For those of you already doing it, you can sympathize and take pity on us.

My experience in the hospital is that anything relating to violence is automatically directed my way and I wanted to change that - so I presented the idea of a *Violence Issues Committee* to senior administration. The Committee would focus on issues of violence as they relate to patient care only, with membership open to any hospital department. After 3 months of being cancelled from their agenda, I was finally invited to present. Agreeing 'in principal' they asked for a 'terms of reference' for their next meeting. Another long period went by while changes were made and approved - about a year in total - but a *Violence Issues Committee* was created. Of course we were 'flooded' with interested members - four to be exact, including myself. The positive aspect is that two members are not from our program and that was my objective.

Our first goal as a committee was to begin Universal Screening in the emergency department. I wanted to screen women only to begin with since they are most at risk. The committee had many constructive discussions about this and the issue of elder abuse came up. We finally agreed that *all* individuals 16 and over would be screened. Now with a target population we had to decide what to ask. We looked at screening tools used by other institutions and chose an adapted version of Renfrew's (*thank you June Stewart*).

Next we had to design a referral path - one where all roads do *not* lead to Sarah Kaplan. We called all related agencies and asked for information regarding their referral process. We then imagined every possible scenario and created a referral path. For example, women 16 and older are referred to shelters, elder women with health concerns or male victims are kept in Emerg until local resources are called in. Of course, something is bound to happen that doesn't fit our path. It's not a perfect system especially when you take into consideration how under-resourced we are in Cornwall. We've done the best with what we have.

Now with all our tools in place, we were ready to begin training - the biggest piece in the puzzle. We trained all the staff of ER: RNs, technicians and secretaries, even though only RNs would do the screening. The manager of Emerg made the training mandatory. We naively thought we'd book 6 or 7 training sessions on different days and get everyone. Well, people were on holidays, or the times didn't work - in short, I did over 15 sessions in all. In some, there was only 1 person! We began the training in May/2001 and the last training took place in July.

Responses to the training varied from, "*This is a good thing to do but I will find it hard,*" to "*I'm not doing it, what are you going to do, force me?*" It is important to expect strong resistance. We are asking people to openly question strangers about domestic violence, something we had been taught was a 'family affair'. Since we know the statistics on domestic violence, it is likely that some of our staff are presently, or have been, victims of domestic violence. This then could be a difficult process for them to enact.

As well as training, we focused on motivators. Large brightly coloured posters were placed on the inside doors of every patient room in emergency, stating the first of our screening questions. It tells patients to ask a nurse or physician for help and offers my phone number. I also posted various forms of information on screening around the department. A large feedback board was placed in the ER staff room so nurses had a venue to express their feelings about this process.

Since the screening began there's been a significant increase in the number of domestic violence cases. In August, we had 11 reported cases. It seems that although all roads do not lead to my telephone, many do. This is to be expected. No matter how clear you are in giving referral information, when people are in a hurry they are going to tell patients to call you. I would rather that happen than a patient not receive the information.

As for current challenges: we know we have to develop some way to collect data on the screening. We need to know the outcome of the screening and also who was and was not doing the screening. This is where we are presently. We are trying to design a form that does not add too much work to the already taxing duties of the RNs, but that gives us the information we need. Once this form is designed then a database will be created to enter the data and we can look at the information. We would probably only gather this data for a 6-month period and then re-initiate it if desired

It has been a long stressful process but we've all learned a lot. Mostly, I have learned that whenever I have a bright idea, I expect that many hours of grueling work will accompany it!

**Sarah Kaplan, Coordinator
Cornwall SA/DV Response Team**

Increasing Awareness – Award & New Pilot Project

In the spring of 2001 a small group of committed women from Women's College won an award for education from the Peter Boyd Academy at the University of Toronto. This group formed when several women from different departments in the hospital (*including SACC*) - all committed to anti-violence work - found each other. Their goal was to create an awareness and ability throughout the institution to identify and respond to violence as a women's health issue.

This group developed the *Intimate Partner Abuse Policy* which is now part of hospital policy and procedure. The next step was to develop a workshop for staff that provided information on woman abuse – indicators, screening, response and resources. So far this small group, with *no funding*, has provided this education to almost 1000 staff! This initiative also lead Sunnybrook emergency staff to *ask for more* – we are planning a day long workshop for next year!

Sunnybrook & Women's is also part of a fantastic pilot project that will make emergency contraceptive pills available to women in pharmacies across Toronto. Participating pharmacists are specially trained and have an agreement with a supporting physician to allow them to provide emergency contraception to women without a prescription.

It is anticipated that this project will increase access to emergency contraception for women – that it will provide access to women who wouldn't normally go to a sexual health clinic, GP, or hospital. In addition to information on regular methods of contraception and sexual health clinics, women will receive information on sexual assault and a referral to the nearest SACC.

What makes this project great is that it recognizes that not being able to protect oneself from pregnancy and STD's during sex is often not an accident, but part of the pattern in an abusive relationship or a result of coercion or force by a stranger or date.

**Deidre Bainbridge, Clinical Coordinator
Sunnybrook & WCH SA/DVCC**

RURAL CHALLENGES – Building A Solid Foundation

We have a diverse and varied population of 150,000 in Hastings and Prince Edward Counties. Our SARP responds to a vast area: from the southeastern border of Algonquin Park down to Picton on Lake Ontario. Included in our catchment area are: urban and rural areas, a Canadian Forces Base, a large Deaf community linked to Sir James Whitney School for the Deaf, and the Tyendinaga First Nations Territory. We also have additional challenges in Hastings County: our residents experience a high poverty rate of 12.2%; there's an extremely high unemployment rate of up to 25% in some rural areas; we have the second highest school-leaving rate prior to grade 9 in Eastern Ontario; the rate of alcohol hospitalization is 50% higher than the provincial average.

With an area as large as this along with additional needs, our staff performs a lot of work linking and connecting, as well as supporting. We have four different hospital sites, as far as two hours apart. We have seven police services involved in this large area, as well as different detachments of the OPP. Last December we implemented a protocol that was over 2 years in the planning. Many different agencies were involved in the development: several Crown Attorneys, police, victim witness, shelter, rape crisis centre, counselling agencies, and the Children's Aid Society. A total of 125 individuals attended the one-day panel and presentation in Belleville.

Since then, we have seen an almost 100% increase in our numbers. I believe that agencies are referring more consistently and that victims hear about our program and want medical and emotional support. We

are glad to be able to offer more victims a wide range of support. We know there are still victims of sexual assault who do not ask for help and we continue to reach out to them in our community.

As we move toward responding to victims of domestic violence as well, we recognize that we have a strong foundation: a team of nurses and sexual assault workers who join together to offer medical and emotional support, as well as linkages to ongoing support. We are proud of our team's hard work and glad to see so many more victims reaching out for help in our area.

**Susan Young, Coordinator
Belleville SART**

CENTRE FOCUS – Update & New Guide

The Care Centre of Guelph General Hospital has been very busy over the past 6 months, both providing services to clients and in the community. The Guelph-Wellington Action committee on Sexual Assault and Domestic Violence has focused on producing a comprehensive Guide for the community - detailing resources and information for victims of sexual violence and woman abuse. Many community agencies collaborated on this project (content & funding). We hope to launch it during Woman Abuse Month, November 2001.

Currently we have 10 SANEs and 5 consulting physicians covering our roster - a very dedicated team. We feel especially thankful for this in the midst of the many changes occurring at the Guelph General Hospital. With renovations nearing completion, many departments have moved and staff from St. Joseph's Hospital and Home have been blended with our staff during the final stages of amalgamating services.

This fall will see a renewed focus on working closely with our community partners such as Victim Services Wellington, the Guelph Police Services, OPP in Wellington County, and Women In Crisis. One area we hope to expand in is our involvement in volunteer training sessions at agencies referring to our service.

We also welcome a new member to our team: Karen Suk-Patrick joins the team with extensive experience in community-based counselling services to women - in particular with women who have survived childhood trauma, and violence in their intimate relationships.

**Liz Stevens, Admin. Assistant
Guelph-Wellington County SACC**

RURAL SUCCESS – Challenges and Solutions

The S.A./D.V. treatment team at Dufferin Caledon Health Care Corporation is the acute medical care component of the Sexual Assault Treatment Program of Dufferin County, offering treatment and care to men, women and children. Our hospital is a 108 bed acute and chronic care facility located on two sites 18 kilometres apart. Our treatment program operates out of the emergency department. On average, we provide care and treatment for 35-40 cases of sexual assault annually.

Our hospital has limited resources and as such we do not have security present in the building. This was an item of concern when we developed the Domestic Violence Treatment Program this year. However we have excellent rapport & support from the five police services we deal with. Our town police respond STAT to *any* request from the hospital, and we have had the pleasure of sharing training programs/sessions with them. (*Anne: not all officers are men with big guns. We work with some incredibly special women who also carry big guns!*)

Working in a smaller facility means that peer support is usually close at hand for team members. We have made it a practice to debrief one another within 24 hours - you don't have to go far for an understanding ear. This 'glue' is important to the fabric of our program. We work at caring for one another to soften the oft times harshness of what we deal with.

Small towns provide close neighbours, and sometimes caregivers are well known to the victims. This can present a difficult situation, for both patient and staff. The on-call nurse checks the identity of the patient, and the name of the on-call nurse is not given to the patient prior to the nurse's arrival. This allows team members the flexibility to call in an alternate.

This past March we held a two-day open house at our hospital - to reinforce our Sexual Assault services and to launch our new Domestic Violence Program. The response was incredible! What amazed our team was the spin-off effect. In the past there had always been hallway consultations between team members and fellow hospital staff re 'friends, distant relatives, etc.' with regards to past sexual assaults and the need for counselling. Following the open house many people and staff came forward and sought advice re: present situations for themselves or their adult children and friends. As a result, every new employee at our facility now receives an inservice re: SATP and identification/effects of Domestic Violence.

We are currently conducting a study re: the use of alcohol either by the assailant or the victim - it has been a factor in each adult case for the last 2-1/2 years. This information was shared with our community when we did the coaster/poster drug and alcohol awareness campaign in May. We plan to incorporate these findings into our next high school presentation.

Our team feels very fortunate that we have the support and understanding of our hospital administration. They wear our buttons, use our coasters, distribute our literature, and wear our Team logo t-shirts. Our community partners are a phone call away, or you get to see them in the grocery store (*aisle consultation and information exchange in 'rural Ontario'*).

We are proud and thankful of the opportunity to be able to provide this much needed service to the citizens of our community, and are pleased to be part of a larger provincial network of fellow service providers.

**Ronnie Inglis, Coordinator
Renfrew SA/PAP**

P.S. A special thanks to Ronnie from her team who recognizes how many 'hats' she wears and a job *very* well done!

FOR YOUR INFORMATION

Ontario Hospital Association Annual Convention

When: November 5, 6 & 7, 2001 **Where:** Metro Toronto Convention Centre

For Information: www.oaha.com

Articles of Interest

Building Bridges between Domestic Violence Advocates and Health Care Providers (a 29 page document)

Janet Nudelman MA & Helen Rodriguez Trias, MD

www.vaw.umn.edu/FinalDocuments/bridges.asp

Violence, Injury & Presentation Patterns in Spousal Sexual Assault

Lana Stermac & Gianneta Del Bove

Violence Against Women Journal (In Press)

SANE: Advocate, Forensic Technician, Nurse

Linda Ledray & Diana Fugno & Pat Speck

Journal of Emergency Nurse 2001: 27:91-3