Care Provider Experience of Working with Family Violence

Method:

A questionnaire was created for care providers (physicians, nurses, nurse practitioners, social workers, mental health workers) and completed via email or an informal in-person interview. Questions included:

1. What organization do you work for?
2. What is your role with the organization?
3. How often is family violence brought up in your practice?
4. How is violence brought up?
5. How well do you think you support individuals/ families experiencing violence?
6. What have you noticed about your client's approach to family violence?
7. What or your go to resources?
8. What are the barriers preventing clients from receiving help?

Responses to these questions were compiled to determine the most common responses and the breadth of answers. Parentheses indicate how many people gave a response to a question. The results were then used to generate a summary of what care providers (CPs) were seeing and suggestions of how to approach family violence moving forward.

Results:

17 surveys were completed by nine physicians, three nurses, two mental health workers, one social worker, one nurse practitioner and one community facilitator. By location four were from Mt. Carmel, three at Eaton Place Medical, three My Health Team Downtown/ Point Douglas, two Bridgecare, two Access Downtown, two Klinic, one with the Addiction Foundation of Manitoba and one with the Healthy Aging and Resource Team. Of the respondents not everyone responded to each question and not each person focused on the same type of family violence e.g. partner violence vs. elder abuse.

The most common response to question 3 was 4-8x a month, but responses varied from 2-3x a year at BridgeCare to daily at mobile withdrawal management, the Addiction Foundation of Manitoba and the experience of one practitioner at each of Mt. Carmel and Access Downtown. Most CPs described violence as being brought-up indirectly in most situations. This was through being normalized into conversation or slipped into discussion by describing an argument or concerns about feeling unsafe (6x). The next most common response was through injuries that don't make sense (3x). The third most common was through screening women with questions (3x), such as: Do you feel safe? Any relationship troubles? Controlling behaviour? Less common responses STI screening leading to identification of sexual assault (1x) or a client directly bringing up violence (1x).

In regard to supporting clients, six CPs responded they thought they supported clients well, while four answered not well. Interestingly in both cases most CPs responded they were limited by gaps in the system and the availability of resources. This is encapsulated by one CPs response: "As an individual I support them very well, as a system I think we support them poorly." For those who thought they did a good job, reasons included providing empathy and validation, educating the client that violence is not ok and being non-judgemental, including towards the client if they are not ready to leave

their partner. One physician described telling their clients “you can stay with this person and I won’t judge you, but how can we make sure you are safe?”

Most CPs described hesitance or reluctance for their clients to do anything. The most common reasons were violence being normalized so that the client didn’t see it as an issue and difficulties associated with leaving the abuser, such as isolation and dependency. Isolation and dependency were particularly notable in regard to elder abuse, as all three CPs who discussed this form of abuse said elders worried about dependency or loss of the relationship. Other reasons listed were lack of success, denial and thinking help won’t make a difference. Some CPs described how they thought their approach could influence a client’s response. By telling the client what they should do, they were more likely to experience shame or shut down and not receive follow-up help. Four CPs cited warm-hand offs as being beneficial. For example, referring to walk-in or on-site services that are immediately able to provide support.

When partner violence was experienced, the most common resources mentioned were counselling (7x) and shelters (7x). The most mentioned counseling services were Klinic Evolve counselling and on-site mental health counselling and social work at sites that offer these services e.g. Mt. Carmel. For shelters the most common organization referred to was Willow Place (5x). Other locations included IKWE (Aboriginal Crisis Shelter), Tina’s Safe Haven, 75 Martha (MSP shelter) and Rachel’s House. After these the next most referenced resources were crisis lines (2x) police non-emergency lines (2x), the crisis response center if there are concomitant complex health needs (2x) and education (2x). One CP stated that they used educating clients on the cycle of violence as a resource, while another CP helped people create a safety plan.

For specific situations, different resources were utilized. For non-salaried physicians, all three surveyed listed the My Health Team as a resource. When elder abuse was the topic, Safe Suite and Senior Resource Finders were mentioned. Resources for men included Klinic Evolve Counseling, Men’s Resource Centres and Mt. Carmel Men’s Group. When violence led to child involvement or parenting struggles, resources included Family Dynamics (x2) and Little Warrior’s (x1), an organization that works to reduce child sexual abuse.

The most common barriers described by CPs were a lack of resources (9x), lack of awareness/ identification (7x) and lack of transportation (5x). Specific resources lacking were counseling services (in one case trauma-counseling was specified), shelters that people would want to stay at as most are like homeless shelters, transport more outreach programs, more walk-in services, more programs for men, more long-term programs and improved community psychiatry services. Other issues included complex family dynamics, no fixed address or insecure housing, complex social and health history e.g. addictions, financial dependency or low income, shame, fear, denial, CFS, incarceration and normalization of abuse. A lack of trust also exists between individuals and people in positions of authority. This was highlighted in the context of indigenous people and fear of police or CFS involvement.

Some CPs offered ideas for how to provide better help to clients experiencing violence. On an individual CP level these included normalizing the identification of violence through regular screening, increasing knowledge of services available, being transparent about what leads to CSF involvement (2x) and increasing cultural competency (1x). On a systemic level, ideas included increasing resources and promoting more awareness of violence at a young age. To increase awareness suggestions included awareness campaigns and education in middle school to reduce stigma. This was also suggested to reduce ageism and elder abuse.

Conclusion:

Most of the violence seen by practitioners is brought-up indirectly through conversation and less commonly through inquiring about suspicious injuries. This means it is important to screen for violence by asking questions about relationships and safety. When violence is acknowledged, clients need to be provided with empathy and not pushed. If they are willing to seek help in the moment, they need to be supported promptly with a warm hand off to a professional trained in family violence or set up with a team that can provide more comprehensive support e.g. My Health Team. As practitioners it is recommended to be aware of the resources available in your area and also how to create a safety plan for clients. Clients experiencing violence often grew up in situations where violence was normalized, or they have other issues in their lives that need to be properly addressed before they are comfortable leaving a violent person. This means providing them access to programs that can deal with co-occurring issues like homelessness, lack of transportation, no fixed income, addictions and lack of social support.