



Canadian Psychiatric Association  
Association des psychiatres du Canada

# Brief on Bill S-249, An Act respecting the development of a National Strategy for the Prevention of Intimate Partner Violence

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SUBMISSION TO THE SENATE COMMITTEE ON SOCIAL AFFAIRS,  
SCIENCE & TECHNOLOGY

APR. 26, 2024

## Summary of Recommendations

- Under section 3(2) Consultations of the bill, in addition to consulting on the national strategy with federal ministers and representatives of provincial governments who are responsible for social development, families and public safety, as well as representatives of groups who provide services to or advocate on behalf of victims of IPV, consider also consulting with public health and education.
- Under section 3(2)(a) of the bill, the assessment of the adequacy of current programs and strategies aimed at preventing IPV and protecting and assisting victims of IPV would benefit from specific reference to assessing the extent to which the prevention strategies employed and the treatments and services offered are *evidence-based* and *evidence-informed*.
- Ensure consultations:
  - Pay special attention to the adequacy of prevention strategies, treatments and services that target populations at greater risk of IPV.
  - Assess the adequacy of training among those providing IPV services.
  - Identify the critical knowledge needed to improve services to establish research priorities.
- Under section 3(2)(b) of the bill, consider explicitly naming schools, the legal profession and Indigenous organizations as partners.
- CPA does not recommend that representatives of health care facilities, medical practitioners and nurse practitioners be required to provide information on access to legal assistance to patients who they suspect may be victims of IPV. Rather, consider mandatory education of clinicians about how to refer to advocacy services.
- CPA does not support extending the requirement for mandatory reporting of IPV to the adult population due to the lack of research indicating the effectiveness of this approach as a preventive strategy and the risk of potential harms (e.g. escalations of abuse, reluctance to seek care from clinicians) associated with mandatory reporting.
- To aid in developing best guidance around mandatory reporting, support research into the factors that preserve the safety of the victim.

## Introduction

The Canadian Psychiatric Association whole-heartedly supports the development of a National Strategy for the Prevention of Intimate Partner Violence.

Intimate partner violence (IPV) is an underrecognized problem that can have an enormous impact on the health and well-being of children, youth and adults. It is a major public health and social problem globally that results in significant personal, health, economic and social costs. The costs arising as a result of IPV experienced by women aged 19 to 65 years who have left their partners have been estimated at \$7.2 billion annually for Canada.

## What is IPV?

IPV refers to behaviour by an intimate partner or ex-partner that can cause or causes physical, sexual or psychological harm. These behaviours include physical aggression, sexual coercion, psychological abuse and controlling behaviours. Stalking and financial abuse have now been included in the list of IPV behaviours by some authorities.

Although IPV can occur in any intimate relationship, including dating relationships, it disproportionately affects women and gender/sexual minorities but can also be directed toward men. Exposure to IPV also has deleterious effects on children and other family members. The term “intimate partner” does not require that individuals exposed to this form of violence have a history of sexual intimacy or a marital relationship.

## Prevalence of IPV and populations at greater risk

Canadian data from 2018 indicate that more than four in ten women and one-third of men in Canada aged 15 years of age and older who have been in an intimate relationship, report experiencing some type of IPV in their lifetime. However, overall women are more likely than men to report severe IPV, to report chronic violence or to be killed. They are also more likely to be criminally harassed or killed after the relationship ends.

Some populations are at greater risk for IPV. These include **Indigenous women, gender/sexual minorities, people with disabilities, those in dating relationships, those with alcohol and other substance use disorders, those with low-income and those who have a previous partner that was abusive**. There are also higher rates of IPV reported by **women living in rural areas** where confidential services may be harder to access.

There are other populations and situations that require special consideration.

Deep-seated cultural values about the relative priority of one’s own goals and autonomy (individualism) and those of the society (collectivism) are thought to be related to IPV rates. **Collectivist cultures that are also patriarchal have rigid gender roles**, subscribe to men’s control of women’s behaviour, link masculinity to dominance, control, honour and aggression, and are suggested to condone the use of violence as a way of resolving conflict in intimate relationships. Similarly, qualitative research with women residing in communities with collectivist cultures report being urged to endure rather than reject IPV, as a way of preserving cultural values, the family and honour. A recent meta-analysis examining cultural or structural factors in the risk for IPV reports emerging longitudinal, quantitative evidence supporting these claims.

Statistically, **migrant populations** (immigrants and refugees) face the same types of IPV as their non-migrant peers. They face additional challenges related to their migration status. These include fear of deportation, loss of refugee status, social isolation, threats of forced marriage, inability to speak either official language, economic exclusion, or collectivist or religious values that support and privilege men’s power, keeping the family together, and (or) not disclosing “private matters.” These factors may prevent these individuals from reporting their abuse exposure in surveys or to the police.

**Psychiatric patients.** Higher rates of IPV have been found among women in out- and in-patient psychiatric services in several countries. Individual studies report increased risk for both women and men for all psychiatric diagnostic categories, including psychoses, with a higher prevalence reported for women.

**Gender and sexual minorities.** Lesbian, gay, bisexual, transgender, queer, questioning, intersex and two-spirited people generally experience higher rates of all forms of IPV and face unique risk factors such as the threat of outing, disclosure of HIV status, social stigma and a lack of emergency shelters for sexual minority victims.

IPV may begin, escalate or decrease **during pregnancy or the postpartum year.** Canadian studies report IPV rates between six per cent and 10.5 per cent during pregnancy. Risk factors for perinatal IPV exposure include prior abuse, age under 20 years, low income, single status, stressful life events, depression, substance and alcohol use. IPV exposure is four times more likely to be reported by women if the pregnancy was unplanned or unwanted.

**Senior age.** Better data are now available for Canadians who are 65 years of age or over and who experience IPV, including neglect, physical, sexual, emotional and financial abuse. It is estimated that only 20 per cent of incidents among this age group are reported to police due to language, culture, health, transportation and technology barriers. Police reports of violence against seniors reveal that victimization by a spouse was the most common type of abuse (33 per cent) for women.

## Protective factors

Protective factors identified in some studies include gender equality, monitoring and enforcement of effective policies against IPV, services for victims, safe environments, formal marriage and higher social economic status and education.

## Mental health and physical health problems associated with IPV

IPV is a major determinant of mental health. **Mental health problems** associated with IPV include depression, anxiety disorders, posttraumatic stress disorder (PTSD), chronic pain syndromes, eating disorders, sleep disorders, psychosomatic disorders, alcohol and other substance use problems, suicidal and self-harm behaviours, psychosis, some personality disorders and harmful health behaviours, such as risk taking and smoking. Depression and PTSD are the most prevalent mental health disorders associated with IPV (3.5 and 5 times the general female population rates, respectively), and often co-occur. Children's exposure to IPV may have short- and long-term health impacts on the child, especially mental health effects.

**Physical health problems** associated with IPV include death, a broad range of injuries, reproductive disorders, gastrointestinal disorders, chronic pain syndromes, fibromyalgia, poor physical functioning and lower health-related quality of life. Sexually transmitted diseases, unwanted pregnancies and physical inactivity are also increased. A 2017 Statistics Canada survey found women account for approximately eight in 10 victims of intimate partner homicide, a rate five times greater for females than males. Homicide rates are substantially lower than in the 1990s. This is thought to be attributable to rising divorce rates and more equitable employment rates, which offer women more options. Laws, law enforcement, shelters and advocacy may also contribute to declining homicide.

**Adverse outcomes for children exposed to IPV** include an increased risk of physical, psychological, social, emotional and behavioural problems, including mood and anxiety disorders, and substance use disorders and school-related problems in children and adolescents. These negative effects may continue into adulthood and become part of an intergenerational cycle of violence. Children who are exposed to IPV in the home are more likely to maltreat their own children and are more likely to have violent dating and intimate relationships as adults (either as victims or perpetrators). Children exposed to IPV are at increased risk of experiencing other forms of abuse by caregivers (e.g., physical and sexual abuse).

Perpetrators of IPV most frequently have personality disorders, but substance use disorders and other types of mental illness or brain dysfunction may also occur.

## Identifying IPV

There is **no evidence for universal screening for IPV**, based on three randomized controlled trials (RCTs), conducted in Canada New Zealand and the United States. Across these trials, IPV screening did not reduce IPV or improve health outcomes.

Instead, it is important for clinicians to remain alert to the signs and symptoms of IPV exposure and ask about IPV in the assessment of patients who present with a wide range of psychological signs or symptoms as discussed in the section above. Inquiring about current and past IPV victimization or perpetration should be part of the clinical assessment of all patients in mental health, addiction and perinatal care settings. Such inquiry is referred to as case finding because it involves including questions about exposure to and perpetration of violence within the diagnostic assessment; it does not involve screening—the use of standardized questions administered in the same way to all patients.

Certain **injury patterns** can differentiate people exposed to IPV, compared with other kinds of injurious events. Specifically, head, neck, dental or facial injuries that were not witnessed (i.e., as would likely occur with a motor vehicle injury) are indicators. In addition, multiple injuries are associated with IPV exposure, whereas thoracic or abdominal extremity injuries alone tend to not differentiate between abused and non-abused women.

## What we know works and the knowledge gaps

**Advocacy interventions** for people exposed to IPV aim to empower victims and link them to community resources such as shelters, housing, safety planning advice, informal counselling and legal services. A systematic review of all controlled studies of IPV advocacy interventions, including some in healthcare settings, found a reduction in abuse, increased social support, improved quality of life, increased safety behaviours and use of community resources. **Shelters** provide safety for women at moderate risk of IPV and their children.

Victims who receive **psychological interventions** for IPV report improvements in psychological outcomes, including depression, PTSD and self-esteem, with a wide range of psychological interventions, including individual or group cognitive trauma therapy. For victims of IPV with PTSD, studies have shown cognitive behaviour therapy (CBT), exposure and CBT-mixed treatments to be highly effective and cognitive processing therapy, cognitive therapy, eye movement desensitization and reprocessing (EMDR) therapy and narrative exposure therapy to be moderately effective at improving symptoms. With regards to **medication**, fluoxetine, paroxetine and venlafaxine have been found to be only moderately effective.

Couple-based interventions are not recommended. They are thought to pose safety risks to the victim and effectiveness is uncertain.

Children exposed to IPV have shown positive outcomes for specific interventions, such as child–parent psychotherapy, teaching child management skills combined with providing support to mothers, advocacy for mothers and their children, combined with a support and education group for children, and trauma-focused CBT, involving individual sessions for mothers and children as well as joint sessions. These interventions, focused on the mother–child dyad, have been shown to improve behaviour problems and (or) PTSD symptoms in children, as well as children’s competence and self-worth. They are promising in their level of evidence but require replication.

The prognosis for victims of IPV is uncertain, as intervention studies usually have small samples, short follow-up and high attrition. Cohort studies of the natural history of IPV are rare. There are numerous descriptive reports of women successfully leaving abusive partners and establishing healthy relationships with subsequent partners. However, one follow-up study of women who received an advocacy-based intervention after leaving a shelter found that 44 per cent had been assaulted by their original or a new partner 3.5 years after leaving the shelter.

In addition, despite significantly lower recurrence rates in the intervention group at two-year follow-up, this difference was not sustained at the three-year follow-up period. However, importantly, there was a significant improvement in quality of life and social support among women who participated in the advocacy-based intervention, compared with those who did not. There is a dearth of prognostic data about men or members of special population groups who are victims of IPV.

## The legislation proposed by [Bill S-249](#)

Overall, this is a good bill, but mandatory reporting to police by health professionals raises serious concerns and is not recommended. The Canadian Psychiatric Association suggests the legislation be strengthened in the following ways:

### **3(2) Consultations**

In addition to consulting on the national strategy with federal ministers and representatives of provincial governments who are responsible for social development, families and public safety, as well as representatives of groups who provide services to or advocate on behalf of victims of IPV, consider also consulting with public health and education. Training for health and social work professionals who support victims of IPV is essential. The [Violence, Evidence, Guidance, Action \(VEGA\) Project at McMaster University](#) has created evidence-based guidance and education resources to assist healthcare and social service providers (including students) in recognizing and responding safely to IPV and child maltreatment. With funding from the Public Health Agency of Canada (2015-2020) and in collaboration with organizations, the Project developed the ©VEGA Family Violence Education Resources – a freely available, bilingual, and accredited online platform. The use of the VEGA Resources could address the problem that currently, there is little IPV content in the Canadian medical curriculum or in the curricula for allied health professions such as nursing and social work. A national strategy should also consider developing a coordinated, evidence-based, pan-Canadian public health campaign.

**3(2)(a)** The assessment of the adequacy of current programs and strategies aimed at preventing IPV and protecting and assisting victims of IPV would benefit from specific reference to assessing the extent to which the prevention strategies employed and the treatments and services offered are *evidence-based* and *evidence-informed*. See, “What we know works” above.

CPA further recommends that consultations:

- Pay special attention to the adequacy of prevention strategies, treatments and services that target populations at greater risk of IPV (see, “Prevalence of IPV and populations at greater risk” above).
- Assess the adequacy of training among those providing services. Building on the foundation of the VEGA Resources referred to above, further research is needed to inform best-practice guidance for the continued communication and collaboration among health care providers and child welfare professionals following the initial mandatory report and among social workers and medical trainees working with specific populations.
- Identify the critical knowledge needed to improve services to establish research priorities.

While research has provided considerable descriptive information about IPV, especially in women, it is important to examine IPV against men perpetrated by women and IPV in special populations. Studies of effective interventions for the prevention and treatment of victims and perpetrators are still in their infancy and there are important knowledge gaps. Specifically, there is a need for rigorously designed studies comparing different psychological interventions, and which focus on people at different stages of the abuse trajectory, as well as studies testing the impact of interventions of differing durations and follow-up periods. Both patient- and system-centred interventions should use standardized or comparable outcome measures.

To aid in developing best guidance around mandatory reporting, research into the factors that preserve the safety of the victim is needed. It is also important to identify and evaluate evidence-informed interventions that will meet the mental and physical health needs of youth IPV victims as they transition out of child welfare services.

**3(2)(b)** The bill requires consulting about partnerships between police services, health care facilities, advocacy groups and shelters in the prevention of IPV and the protection of victims of intimate partner violence. Consider more explicitly naming schools, the legal profession and Indigenous organizations as partners.

**3(2)(c)** The legislation requires that information be gathered on the requirements for representatives of health care facilities, medical practitioners and nurse practitioners to provide information on access to legal assistance to patients who they suspect may be victims of IPV. CPA guidance to physicians to whom patients have disclosed IPV is to ask questions about the abuse, to listen and believe them, express concern, be nonjudgmental and supportive, and to refer to advocacy services who can provide legal information along with housing and other assistance. Clinicians need to provide information more generally on how to access services that include legal, but not focus on providing legal advice/information themselves. The CPA would support mandatory education of clinicians about how to refer to advocacy services.

**3(2)(d)** CPA does not support extending the requirement for mandatory reporting of IPV to the adult population. There is no research to date indicating the effectiveness of this approach as a preventive strategy and there is risk of potential harms (e.g. escalations of abuse, reluctance to seek care from clinicians) associated with mandatory reporting.

It is unclear if the requirement for health professionals to make a report to the police if they suspect that a patient is a victim of IPV refers to children, youth and adults.

While the specifics of legislation vary among provinces, it is clear that a disclosure that indicates that a child is being abused, or is at risk of harm related to IPV exposure among caregivers, requires mandatory reporting to provincial or territorial child protection services (CPS). In contrast, IPV among adults is not reportable to the police unless a practitioner is concerned about a serious imminent risk to the patient or someone else. Barring such a circumstance, the decision to involve legal authorities usually belongs to the abused patient alone.

Before extending such legislation to adult patients, it is important to understand that while mandatory reporting likely increases the reporting rates of reluctant reporter groups and increases the identification of children exposed to maltreatment, to date there is no prospective research examining if mandatory reporting reduces recurrence of maltreatment or improves the well-being of children.

Further, in general, studies exploring women's preferred responses after disclosing IPV suggest that women want clinicians to ask questions about the abuse, to listen and believe them, express concern, be nonjudgmental and supportive, and to make appropriate referrals to a shelter, and to social and legal services. Women do not want to be pressured to disclose IPV (or to leave their partner); they prefer to be asked about it in a way that is confident and comfortable, with assurance of confidentiality (with the potential exceptions regarding child welfare).

## About the CPA

Founded in 1951, the Canadian Psychiatric Association is the national voice of Canada's psychiatrists and psychiatrists-in-training and is the leading authority on psychiatric matters in Canada.

## Sources

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