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Public Health and Violence Prevention - Maintaining the Momentum

A position paper and resolutions adopted by the Ontario Public Health Association (OPHA)

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Executive Summary

The Ontario Public Health Association (OPHA) passed a resolution in 1997 which formally recognized violence as a Public Health issue. The OPHA Violence Prevention Workgroup was formed and has since been involved in many violence prevention activities. This paper builds on the position paper written by the OPHA Violence Prevention Workgroup in 1999. The achievements of the workgroup are briefly outlined. Despite the progress made by Public Health and other partners in violence prevention initiatives there remains some challenges which can be addressed utilizing a Public Health approach.

The definitions of violence for this paper were chosen from two sources. The first definition found in the paper is from the World Health Organization's document, "World Report on Violence and Health" (Krug et al., 2002) which provided a major foundation in the writing of this paper, the recommendations and the proposed resolutions. The other definition is from the Canadian Public Health Association issue paper (Canadian Public Health Association, 1994).

The impact of violence on individuals, families and communities are discussed as it relates to women, family violence, children, older adults, men and youth. It is important to note that data regarding violence should be interpreted with caution due to the complex nature of violence. This data reflects numerically the pervasiveness of violence in our society yet it falls short in describing the effects of violence from a human perspective. The limited research available regarding the cost of violence to our society indicate the staggering effects financially, yet again do not reflect the personal cost and pain to the individual or society which cannot be calculated.

A Public Health approach to violence prevention which is multi-faceted and multi-disciplinary that occurs at all levels of government and society with individuals, families and the community at large is encouraged. Research and evaluation into effective interventions is paramount to a Public Health approach to violence prevention. Pubic Health plays a key role in the documentation and dissemination of statistics that help to formulate practice and policy. Public Health needs to continue to focus on the primary prevention of violence with a view toward understanding the underlying causes of violence. The prerequisites for health outlined by the Ottawa Charter (World Health Organization, 1986) are important in the prevention of violence in our society and play a key role in the development of best practices in violence prevention.

Primary prevention and Public Health's continued work with community partners are important. Three areas that require more attention of Public Health are resiliency, early identification and harm reduction.

The conclusions and recommendations in the paper encourage maintaining the momentum of Public Health in partnership with other organizations in the prevention of violence. Highlights of these recommendations include:

- Advocate for the inclusion of Violence Prevention in the Mandatory Health Program and Services Guidelines through the Ministry of Health and Long Term Care.
- Advocate for a coordinated and comprehensive provincial and local approaches to violence prevention.
- OPHA will work with local and provincial bodies to ensure the development and adoption of policies that prevent and reduce violence in their own communities.
- Advocate for access to adequately funded, coordinated and appropriate services.
- There is a need for public awareness about the risks associated with physical punishment, universal and targeted education on effective discipline, and a need for organizations serving children and families to develop a clear position on the use of physical punishment.
- OPHA will advocate for the creation of a forum to share information and ideas and to develop violence prevention strategies at provincial and federal levels. OPHA will bring this issue to meetings with Canadian Public Health Association (CPHA) for discussion with public health bodies in other provinces.
- OPHA will support and participate in activities that enhance violence prevention surveillance, research, program implementation and evaluation.
- OPHA will foster communication, professional development, and the sharing of effective strategies among Public Health practitioners across Ontario.

References

Canadian Public Health Association. (1994). Violence in our society: a public health perspective. Ottawa: Canadian Public Health Association.

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Introduction

At its 1997 Annual Meeting, the Ontario Public Health Association (OPHA) passed a resolution formally recognizing violence as a public health issue. The resolution called upon the OPHA to initiate a Workgroup with the objectives below:

Furthering the work outlined by the Canadian Public Health Association (CPHA) in its 1994 issue paper Violence in Society: A Public Health Perspective

Providing direction regarding the implementation of violence prevention initiatives by:
Identifying best practices from existing violence prevention strategies.
Producing a position paper recommending effective strategies.
Informing OPHA members of relevant violence issues using available communications vehicles such as a web site or newsletter.

Achievements of the OPHA Violence Prevention Workgroup

Since 1997, the OPHA Violence Prevention Workgroup has been active in raising the awareness of public health professionals about the impact of violence on health. In 1999, a joint survey was conducted by the Centre for Research in Women's Health in partnership with the OPHA Violence Prevention Work Group. The results showed that, while 69% of responding health units had identified violence prevention as a need in their communities, violence prevention was not given a high priority and was often addressed as a secondary issue (Nanget, 1999). The Violence Prevention Work Group produced a position paper, "A Public Health Approach to Violence Prevention," that was adopted at the 1999 OPHA Annual General Meeting (Ontario Public Health Association Violence Prevention Workgroup, 1999). A resolution calling for the inclusion of violence prevention in the Mandatory Health Programs and Services Guidelines was passed at the same meeting. Further to this resolution, the Ministry of Health and Long Term Care engaged in a review of the Injury Prevention Including Substance Abuse Prevention Mandatory Health Program and Services Guidelines (Ontario Ministry of Health Public Health Branch,1997). With the establishment of a Technical Review Committee, including membership from the OPHA Violence Prevention Workgroup, members directly participated in the development of the revised guidelines and continue to advocate for their adoption.

In partnership with the Effectiveness Public Health Project, the Workgroup participated in a systematic review of the effectiveness of Public Health Interventions to reduce or prevent spousal abuse toward women (Mueller & Thomas, 2001). In addition, a web site including information about available resources and website links, research findings, and projects on violence prevention has been created to facilitate access to the expertise of violence prevention advocates around the world. All of these activities have contributed to the creation of a network where public health practitioners across the province can share current literature and discuss as well as develop appropriate strategies, thereby enhancing the capacity of practitioners to effectively work within a violence prevention

framework. The Work Group has expanded its membership and, through the use of teleconferencing, is able to reach members across the province monthly to share information and discuss policy issues.

The OPHA Violence Prevention Workgroup has also worked to promote best practices with respect to violence prevention. For example, the Work Group has gathered and disseminated information about available resources designed to deal with such topics as bullying, building healthy relationships, and appropriate discipline methods. Work Group members who sit on other local, regional or provincial bodies, have shared information and fostered coordinated activities with other community partners, such as school boards, early childhood learning centres, community agencies, mental health and addiction services, and recreation providers.

The Work Group believes that it is essential to develop and deliver primary prevention programs that assist children and youth to acquire the skills and commitment necessary to adopt non-violent lifestyles. Out of interest in children and youth, workgroup members have facilitated the development of Public Health Partnership Against Bullying, a group of public health professionals who have developed bullying prevention interventions within their own communities so that they may share their ideas and foster the development of province wide bullying strategies.

The OPHA Violence Prevention Workgroup in 2000 endorsed the Routine Universal Comprehensive Screening (RUCS) Protocol for the identification of woman abuse developed by the Middlesex-London Health Unit's Task Force on the Health Effects of Woman Abuse (Task Force on the Health Effects of Woman Abuse, 2000). This protocol calls for an integrated multidisciplinary community-based approach to promote early identification by health care professionals of all forms of woman abuse, so that effective treatment, consistent documentation and appropriate referrals provide opportunities to reduce the incidence and the health consequences of woman abuse. Using the federally funded Early Child Development funds administered by the Ministry of Health and Long Term Care, a majority of health units in Ontario have begun to adapt the RUCS protocol for use in appropriate service areas. The OPHA Violence Prevention Work Group, in conjunction with the Middlesex-London Health Unit, is coordinating these efforts through the provision of educational resources, speakers, shared policies and experiences, teleconferencing and e-mail. At the same time, the Work Group is partnering with the Toronto Woman Abuse Council and the Ontario Hospital Association project on screening for abuse in the hospital setting. The Work Group has encouraged local health units to form partnerships with violence against women services, hospitals, community health clinics, and private practitioners to develop local practices and procedures to implement RUCS in their communities. In support of continued research, the workgroup has provided letters of support to investigators who submitted proposals to the Women's Health Council for a project to evaluate screening interventions in healthcare settings and continues to provide public health consultation to the investigators. All of the initiatives described above have resulted in many collaborative efforts with partners not previously working together on violence prevention.

Ongoing Challenges

- Despite these efforts and those of many other organizations, there continue to be limitations in the development of comprehensive violence prevention strategies:

- Communities throughout Ontario continue to identify violence as a threat to the public health and safety of their citizens. However, concerted community action, with a focus on prevention, is still in a developmental stage.

- Public Health is attempting to develop promising violence prevention strategies. However, these strategies tend to be under-funded and to lack the appropriate emphasis on research and evaluation.

- Despite work conducted in the field of violence prevention by Public Health over the past few years, community collaboration in conjunction with Public Health, although improving, continues to be limited in some parts of the province.

- Public Health is significantly contributing to the identification and reduction of many identified public health problems through methods of surveillance and data analysis. Similar methods need to be developed specifically for violence issues, possibly through such methods as the Rapid Risk Factor Surveillance System.

- There continues to be no specific Provincial mandate for violence prevention in public health programs, even though the province has supported program development through the federally funded Early Child Development initiative. Programs currently running continue to be insecure, as they have been funded through time-limited grants or by local initiatives.

- Violence prevention has been included in the draft revision of the Mandatory Health Programs and Services Guidelines, Injury and Substance Abuse Prevention Program; however, to date, the recommended guidelines have not been approved. OPHA and affiliated members have lobbied strongly with appropriate decision-makers to support adoption and implementation of these guidelines.

Public health practitioners in Ontario are playing a significant role in violence prevention. Thus, the purpose of this revised paper is to keep the momentum going in the area of violence prevention and to promote a strong Public Health presence in this significant public health issue. In order to move this commitment forward, research, surveillance, data analysis and dissemination of promising programs and best practices are essential.

Definition, Impact and Cost of Violence

Definition

The World Health Organization (WHO) defines violence as:

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (Krug et.al.,2002, p. 5).

The Canadian Public Health Association issue paper, produced in 1994, includes some observations that flesh out that definition in a helpful way:

> In the broadest terms, violence includes behaviour that is diminishing, damaging or destructive … it takes more forms than physical blows or wounds. It includes sexual assault, neglect, verbal attacks, insults, threats, harassment and other psychological abuses (CPHA, 1994).

Impact

In an effort to summarize the significant health effects of violence, the World Health Organization has produced the "World Report on Violence and Health" (Krug et al., 2002) as the first international report documenting the extent of violence among nations. Captured within the extensive documentation of the ravages of war, oppression and perhaps the less common daily occurrences is a thorough examination of the effects of violence on human health and human spirit.

In addition, the WHO Report (October 3, 2002) also identified corporal punishment as a violent act stating that physical punishment "is dangerous to children. In the short term it kills thousands of children each year and injures and handicaps many more. In the longer term, a large body of research has shown it to be a significant factor in the development of violent behavior, and is associated with other problems in childhood and later life" (Krug et. al., 2002, p. 64).

Violence has both direct and indirect impacts on the public health and safety of the citizens of Ontario. Research to date only provides us with some clues as to the extent and impact of violence on our society. Furthermore, usually such research focuses on one or another aspect using, for example, hospital room emergency statistics, criminal justice statistics, homicide or suicide rates, without considering the broad picture. Many incidents of violence are never reported, often because of the fear of repercussions both from the perpetrator and from society itself. Below is a sample of some of the key findings from various studies that have attempted to measure the impact of violence. These data should be interpreted with caution as methodologies between studies vary and these studies have not generally considered the complex nature of violence such as: the impact of early victimization, the community context in which violence occurs, the

correlation between the various forms of violence and the continuum of violence over time. Nevertheless, the selected data offered below reaffirm the long reaching effect of violence on physical and mental health.

Woman Abuse and Family Violence

The Canadian Panel on Violence Against Women (1993), the most extensive Canadian study available, reported that more than 50% of women had experienced some form of unwanted or intrusive sexual experience before reaching the age of 16; 24% of these cases of sexual abuse were at the level of forced or attempted forced sexual intercourse; 17% of these women reported at least one experience of incest. Using the criminal code definition of sexual assault, 66% of adult women studied reported at least one incident of sexual assault over their lifespan. Additionally, 27 % of these women experienced physical assault in an intimate relationship and 50% who had been physically assaulted were also sexually assaulted in the same relationship. In relation to suicide, 25% of female suicides occurred in the context of physical or sexual abuse (Canadian Panel on Violence Against Women, 1993).

Data captured by the criminal justice system show that women accounted for 88% of spousal violence victims. Although both men and women experience violence in spousal relationships, women were more likely to experience more severe forms of violence resulting in physical injury (Canadian Centre for Justice Statistics, 2002). Approximately 40% of women in violent spousal relationships experienced physical injury compared to 13% of men. 38% of women feared for their lives compared to 7% of men.

Intimate partner abuse is not limited to heterosexual couples; however, there is not much reliable data available on the incidence of intimate violence between homosexual couples. Because the power dynamic is similar in both types of relationships, there is no reason to believe that the incidence of violence in these relationships is any less. In fact, given the marginalization of homosexual people and their lack of support in many communities, the potential for intimate partner violence may be elevated (Champagne, Lapp & Lee, 1999).

The Violence Against Women Survey of 1993 found that 21% of all women who were abused by their partners had been assaulted during pregnancy—in terms of the Canadian population, this figure represents an estimated 560,000 women. Abuse began during pregnancy for 40% of these women. Of those who were physically injured by abusive partners during pregnancy, 10% reported suffering miscarriages and internal injuries as a result of the abuse. Battered pregnant women are twice as likely to miscarry and 4 times as likely to have low birth-weight infants (Canadian Panel on Violence Against Women, 1993).

Women who are psychologically abused by their partners have 5 times the risk of alcohol abuse while physically abused women have 8 times the risk (McFarlane et al, 1996).

Child Maltreatment

Changes to the Child and Family Services Act 2000, broadened the definition of children in need of protection to include patterns of neglect and emotional abuse including witnessing violence in the home (Ministry of Community and Social Services, 2000).

The only national study on child abuse and neglect (Trocme et al., 2001) found that an estimated 135,573 child maltreatment investigations were carried out in 1998. The main reasons for child maltreatment investigations were neglect (40%), physical abuse (31%) emotional maltreatment (19%) and sexual abuse (10%).

There is a growing body of research indicating that physical punishment has detrimental effects on children; it places children at risk of physical injury, physical abuse, impaired mental health, a poor parent/child relationship, and increased childhood and adolescent aggression and antisocial behaviour (Gershoff, 2002). Physical punishment in childhood has also been associated with negative outcomes in adulthood such as increased aggression, poorer mental health, and an increased risk of abusing one's own child or partner (Gershoff, 2002).

The 1998 Ontario Incidence Study of Child Maltreatment reported that the estimated number of substantiated investigations of physical abuse increased significantly from 4,200 investigations in 1993 to 8,000 in 1998 (Trocme et al, 2002). Of these substantiated physical abuse investigations 71% involved inappropriate punishment. In 1998, 23% of *all* substantiated investigations of child maltreatment involved physical abuse due to inappropriate punishment.

Likewise, the 1998 Canadian Incidence Study of Child Maltreatment reported that 69% of substantiated physical abuse cases were a result of inappropriate punishment (Trocme et al, 2001). In 38% of these cases, the victim was an adolescent (Trocme & Durrant, in press).

In a Canada-wide study, abused women reported that their partners had also abused their children using physical abuse (26%), psychological abuse (48%) and sexual Abuse (7%) (Canadian Panel on Violence Against Women, 1993).

A survivor of child abuse is 7 times more likely to become dependent on alcohol and drugs and 10 times more likely to attempt suicide. (Canadian Panel on Violence Against Women, 1993)

It is estimated that one third of all children who are abused or witness abuse will be violent in their families as adults (CPHA, 1994). Fully 75% of men who abuse their wives observed violence between their parents when they were children. Sons of abusive men have intimate partner violence rates which are 100% higher than sons of non-violent fathers (Jaffe & Sudermann, 1996).

Children who witness violence at home often suffer from low self-esteem, lack self-confidence, and feel fearful and vulnerable (Jaffe & Sudermann, 1996).

One Ontario study on child physical and sexual abuse reports that the prevalence of adults disclosing a history of sexual abuse ranges from 2% to 62% for females and from 3% to 15% for males (Trocme, 1998).

Violence Against Older Adults
A great amount of information regarding violence against older adults is discussed in the document, "Abuse of Older Adults: A Fact Sheet From The Department of Justice Canada" (Department of Justice Canada, 2003). According to the Department of Justice Canada "abuse of older adults" refers to violence, mistreatment or neglect that older adults living in either private residences or institutions may experience at the hands of their spouses, children, other family members, caregivers, service providers or other individuals in situations of power or trust.

Abuse of older adults is still a hidden phenomenon but approximately 7% of the sample of more than 4,000 adults 65 years and older who responded to the 1999 General Social Survey on Victimization (GSS) reported that they had experienced some form of emotional or financial abuse by an adult child, spouse or caregiver in the 5 years prior to the survey (Department of Justice Canada, 2003).

The Incidence-based Uniform Crime Reporting Survey in 2000 indicated that the largest category of police-reported violence crime committed against older adults by family members was assault. Almost 65% of the older adult victims of family violence in 2000 (as reported to a subset of police agencies) were women (Department of Justice Canada, 2003).

Homicide data shows that between 1974 and 2000, older women were at higher risk of spousal homicide than older men. More than half (52%) of the older women who were victims of family homicide were killed by their spouses compared to 25% of older men victims of family homicide. Older men victims were twice as likely as older women victims to be killed by their adult sons (42% vs. 24%)(Department of Justice Canada, 2003).

Violence toward Men
The 1993 Ontario Incidence Study of Reported Child Abuse and Neglect found 49% of investigated children were male and in cases of sexual abuse, 35% were boys (Trocme, et al., 1994).

Boys are more likely to receive physical punishment than girls (CHEO, 2003).

Men are the most likely victims of non-intimate assault and homicide. Men who abuse or murder their intimate partners are at high risk for suicide (Statistics Canada, 2001).

Youth Violence

Youth violence extends beyond bullying and harassment to including violence among youth in dating relationships. Youth between the ages of 12 and 19 remain at the highest risk for victimization by violent crime (Ellickson & McGuigan, 2000).

Schools have often partnered with community agencies and services to offer a range of programs and services designed to reduce the incidence of violence and facilitate youth access to services. Adolescents aged14 years have the highest rate of calls to the Kid's Help Phone regarding abuse or violence at a rate of 430 calls per 100,000 children aged 14 in Canada (Canadian Centre for Justice Statistics, 1999).

A 1993 survey by the Central Toronto Youth Services found that 45-63% of students believe there is moderate to a lot of violence in schools, 80% of students reported being exposed to violence in schools as victims or seeing someone else being victimized (Toronto Public Health Violence Prevention Program for Youth, 1997).

A study conducted in Toronto revealed that 20% of students reported being involved in a bullying incident more than once over the school year. As well, an Alberta study of a rural secondary school found that of students in grade 7-12, 66% of students had been victims of bullying (Ziegler & Rosenstein-Manner, 1991).

Research conducted over time has found that there is a direct relationship between children who witness and/or experience violence and their subsequent levels of aggression (Song et al., 1998, Alksnis & Taylor, 2000).

Dating violence also continues to be an ongoing issue among adolescents. Although a number of youth-focused violence prevention initiatives exist, studies conducted exploring the prevalence of dating violence report that up to 25 % of adolescents report being a victim of dating violence (Foshee, 1998).

The Cost of Violence

There is no way to calculate the personal cost of pain and suffering caused by violence in our society. The World Health Organization observes that, "In addition to the toll of human misery, violence puts a massive burden on national economies." (WHO, 2002, p.8) There has been a significant amount of effort and some success in documenting the cost of *unintentional* injuries in Ontario (e.g. cost of hospitalizations, days lost work,

rehabilitation, treatment, medical services, and the loss of social productivity.) However, with respect to *intentional* injury, very little research exists and most of those efforts have focused on violence against women and maltreatment of children. For example, the only Canadian study conducted to determine the financial cost to society of violence against women estimates that amount to be approximately $4 billion annually in Canada (Day, 1995).

The World Health Organization states:

> In calculating the costs of violence to a nation's economy, a wide range of factors need to be taken into consideration besides the direct costs of medical care and criminal justice. Indirect costs may include, for example:
>
> - the provision of shelter or other places of safety and long-term care
> - lost productivity as a result of premature death, injury, absenteeism, long-term disability and lost potential
> - diminished quality of life and decreased ability to care for oneself or others
> - damage to public property and infrastructure leading to disruption of services such as health care, transport and food distribution
> - disruption of daily life as a result of fears for personal safety
> - disincentives to investment and tourism that hamper economic development
>
> The costs of violence are rarely evenly distributed. Those with the least options for protecting themselves against economic hardship will be most seriously affected (WHO, 2002, p. 8).

Addressing the Issue of Violence

The complexity of the issue of violence prevention can be overwhelming and effective interventions can only be achieved through collaborative interdisciplinary actions in which public health is a partner. Most importantly, change can only occur if action is taken at all levels of government and society, as well as with individuals, with families and with the community at large. Action to prevent violence requires a multi-faceted, multi-disciplinary approach.

Research and Documentation

A review of the documented statistics clearly indicates that violence has insinuated itself into the lives of all Ontarians; its pervasiveness causes a threat to families and communities across the province and leads to wide-ranging negative health effects. But despite the growing awareness of the reality, impact and costs of violence, we need to make a concerted effort to achieve more complete documentation to support the efforts of

those working to prevent violence. Some of the traditional methods of gathering statistics and calculating costs through hospital records or criminal justice data are inadequate to measure the true cost of violence to our society.

To reduce violence, it is necessary first to understand it epidemiologically, so that we can clearly know the underlying causes of violence and the major risk factors. Aspects such as race-based violence, homophobia, and violence against the mentally ill and the disabled require special attention.

In relation to youth violence, family violence and male violence, substance use and abuse is often identified as a confounding factor found when exploring violence-related injuries. Clearly, substance use and abuse are not the cause of violence; however, the use of substances has been documented to coexist with the occurrence of violence (McFarlane, Parker, Soeken et al, 1992; Farrokhazad, 2001).

All forms of violence need to be statistically described and targeted with appropriate prevention and intervention. The Provincial government needs to support the enhanced documentation of the effects of violence on the population of the province, as it has with respect to cancer, tobacco, heart disease and stroke.

Addressing the Societal Conditions that Foster Violence

It is essential to address societal conditions such as racism, poverty and inequality that foster violence.

Peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity are the prerequisites for health, as set out by the Ottawa Charter for Health Promotion (World Health Organization,1986). Violence is often fostered by the absence of these preconditions for health. As well, these fundamental prerequisites for health are threatened by the very existence of violence in our society.

Our society is becoming more diverse with each passing year; Ontario has become a refuge for individuals and families fleeing war and oppression. Differences in sex, race, language, religion, culture, ethnicity, ability and orientation often arouse fear and hostility that is expressed by violence and results in intentional injuries, both physical and psychological. Equity is disrupted when even one child is threatened by another, while attending school, or one person is denied employment on the basis of these differences.

Family violence can destroy a family's access to shelter and income, as well as shatter the trust that is essential to healthy human relationships.

The OPHA believes that to prevent violence it is essential to ameliorate the social conditions, such as racism, inequality and poverty than can foster violence.

Developing Healthy Public Policies to Address Violence Prevention

The greatest impact on societal change is through the development of healthy public policies that address the root causes of violence and foster a comprehensive, multifaceted approach to prevention and intervention.

To reduce violence, it is necessary to first understand the root causes of violence (Cohen & Swift, 1993). These causes are extremely difficult to change, requiring substantial reordering of political and social priorities. Violence emerges from multiple and complex personal, social and economic causes, and therefore, violence reduction necessitates a multi-faceted approach. An effective response requires the marshalling of resources on all levels. The health of a community is a composite of physical, psychological, social and economic variables. Consequently, the responsibility for overall community health resides in a number of systems, including family, education, health, work, criminal justice and social services.

The OPHA recognizes that violence prevention is a huge and complex social issue and that a comprehensive, multi-faceted approach, integrating the efforts of health, education, law enforcement, social services, employments services, criminal justice agencies, faith communities and all levels of government is necessary.

Ontario has begun to build a public policy base to support the integrated response to violence prevention and effective interventions. By supporting the role of government-based agencies, such as the Ontario Women's Directorate and the Victim Services Unit, the province has the means to foster a multi-faceted approach.

In recent years, the Coroner's office has taken a proactive roll in reviewing tragic deaths resulting from intimate partner violence, child neglect and abuse. The Iles-May and Hadley inquests looked in depth at two cases where intimate partner abuse led to the murder-suicide of two couples. The recommendations coming out of those inquests highlighted the requirement for health professionals to be active members of multidisciplinary teams working within their communities to prevent such tragedies. Public Health has a long history of working from a multi-disciplinary, community-based approach, similar to that advocated by these recommendations.

The trial in regards to the death of Randal Dooley highlighted many lessons we need to learn about how inappropriate discipline can result in severe child abuse and death. Public Health has taken action in the past in response to tragic events which have lead to the formulation of policies and programs.

The Ministry of the Attorney General has developed a five-year plan to deal with intimate partner abuse, based on recommendations from the inquests(Ministry of the Attorney General, 1999). The OPHA Violence Prevention Workgroup supports the multi-faceted approach of the plan and encourages the active participation of Public Health in its implementation.

There is increasing public concern about the apparent proliferation of weapons particularly among young people. The OPHA had a resolution in 1994 entitled Stricter Gun Control Regulation" (OPHA ,1994) which has since been archived. Public Health should work actively in efforts to reduce access to weapons used to perpetrate violence in the community.

Working with community and provincial partnerships, Public Health does have the levers to make changes through the useful role of documenting the impact of changing public policies, creating new ones, and, when policies have a negative impact on health, joining with other groups to advocate for change.

Developing Public Health Best Practices with Respect to Violence Prevention

Public Health can play a key role, based on practice and experience, in developing new best practices to deal with the extensive health effects of violence and to prevent future violence. Public Health's commitment to the development of primary prevention strategies that reduce violence is paramount to maintaining the momentum in violence prevention. Using an upstream view (Butterfield, 1990), multifaceted, comprehensive population based approaches with a focus on building healthy public policy, re-orienting health services, and community action need to be developed, successfully implemented and sustained over time. Extensive community partnerships with other sectors and agencies are essential for effective delivery of programs and services by Ontario Public Health Units. There are three particular areas that need attention.

A) ***Resiliency***
It is evident that individuals, faced with similar circumstances and challenges, respond differently and experience different health impacts depending on their resiliency. Resiliency is often cited in the ability of low birth weight infants to develop normally or for the disabled to overcome barriers to independent living. Public Health's role in building resiliency within individuals, families and communities needs to be implemented, evaluated and honoured. We need to examine how resiliency impacts on the response of different victims to the violence they experience. Public Health needs to work with other community partners to foster that resiliency and to establish best practices that can be seen to aid in preventing further violence and in dealing with the health effects of violence already experienced.

B) ***Early Identification***
Community partners who work with the victims of domestic abuse, including woman abuse, child maltreatment and elder abuse maintain that early identification of abuse is the first step to preventing ongoing violence and to assisting victims to survive and, eventually, to thrive, despite the impact violence may have had on their health and safety. While early identification of violence that has already occurred does not, in and of itself, prevent further violence, early identification has the potential to lead to appropriate differential diagnoses, effective treatments, helpful social interventions and criminal justice interventions

that may prevent any future violence to that victim and intervene in the pattern of intergenerational violence. When health care professionals identify violence as inappropriate, clearly state that violence causes serious health consequences, and make appropriate referrals for the victims of violence, they are acting as advocates for the victims of violence and providing support to those victims in their efforts to live free of violence.

A recent systematic review of public health interventions in intimate partner abuse shows that advocacy by public health professionals helps reduce violence. (Mueller & Thomas, 2001) Research clearly shows that children who are exposed to violence are at increased risk; assisting an abused parent to recognize the serious impact of witnessing abuse has on children may result in influencing the decision of that parent to end the violence for herself/himself as well as the children, (Jaffe& Sudermann,1996) Public Health in Ontario is deeply committed to screening parents of at risk infants for current and past abuse, recognizing that an experience of abuse by parents can increase risk factors for babies and children (Healthy Babies, Healthy Children Program). Public Health has an obvious role in researching the effectiveness of early identification, within the context of an integrated multidisciplinary approach to violence prevention; the Violence Prevention Workgroup of OPHA has pledged its assistance to a major three-year study, funded by the Women's Health Council, to determine the effectiveness of screening for violence in public health settings.

C) Harm Reduction

The ultimate and long-term goal of violence prevention is to create a society that does not tolerate violence in any form. Achieving that goal requires fundamental changes to behaviour and attitudes that are unlikely to happen in the short term. It may be helpful to look at violence prevention through a harm reduction lens. Public Health has expertise in the practice of harm reduction in its efforts to reduce smoking, encourage safer sex, stem substance abuse and prevent suicide. At present, most public policy efforts are directed at ending violence by separating the victim and the perpetrator and punishing the perpetrator, often precipitating additional problems for both parties that exacerbate the direct effects of the violence itself. Public Health needs to share its expertise and success with harm reduction methodology with other community members who are also working on violence prevention. Public Health needs to develop a best practice model of harm reduction with respect to violence prevention and needs to be an active partner in the research and analysis required to evaluate the relative effectiveness of a harm reduction approach to violence prevention.

Conclusions and Recommendations

- The Ontario Public Health Association (OPHA) will continue to advocate for inclusion of Violence Prevention in the Mandatory Health Program and Services Guidelines through the Ministry of Health and Long Term Care (Public Health Branch) and affiliated bodies. Once violence prevention is included, OPHA will work to ensure effective implementation.

- A coordinated and comprehensive provincial and local approaches to violence prevention is essential. OPHA will work with its members, other related ministry officials, public health units, provincial associations and other key partners to promote the development of the provincial/interministerial strategy aimed specifically at the prevention of violence through integrated multidisciplinary approaches.

- OPHA will work with local and provincial bodies (councillors, district health councils, municipal sectors) to ensure the development and adoption of policies that prevent and reduce violence within their own communities.

- Violence has far reaching implications and there is a need for continued advocacy for access to adequately funded, coordinated, and appropriate services. OPHA will advocate for these services at a local and provincial level.

- Physical punishment is still widely used and has serious consequences for children. There is a need for public awareness about the risks associated with physical punishment, universal and targeted education on effective discipline, and a need for organizations serving children and families to develop a clear position on the use of physical punishment. The OPHA will advocate for these actions at a local and provincial level.

- OPHA will advocate for the creation of a forum to share information and ideas and to develop violence prevention strategies at provincial and federal levels. OPHA will bring this issue to meetings with Canadian Public Health Association (CPHA) for discussion with public health bodies in other provinces.

- OPHA will support and participate in activities that enhance violence prevention surveillance, research, program implementation and evaluation.

- OPHA will foster communication, professional development, and the sharing of effective strategies among Public Health practitioners across Ontario.

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Resolution 1

WHEREAS violence is a pervasive problem in our society; and

WHEREAS violence prevention is a public health issue as described in the World Health Organization (WHO) document, "World Report on Violence and Health"; and

WHEREAS Public Health works collaboratively with many partners utilizing diverse strategies; and

WHEREAS Public Health provides solid leadership;

THEREFORE BE IT RESOLVED THAT OPHA advocate for the inclusion of Violence Prevention in the Mandatory Health Program and Services Guidelines.

Resolution 2

WHEREAS violence is a pervasive problem in our society; and

WHEREAS violence prevention is a public health issue as described in the World Health Organization's (WHO) document, "World Report on Violence and Health"; and

WHEREAS Public Health works collaboratively with many partners utilizing diverse strategies; and

WHEREAS Public Health provides solid leadership;

THEREFORE BE IT RESOLVED THAT the Ontario Public Health Association Position Paper on Violence Prevention, "Maintaining the Momentum" be distributed to the Canadian Public Health Association and other organizations and individuals who share a commitment to the prevention of violence.

BE IT FURTHER RESOLVED THAT the OPHA work with the CPHA to foster a national public health strategy on violence prevention.

Resolution 3

WHEREAS violence is a pervasive problem in our society; and

WHEREAS violence prevention is a public health issue as described in the World Health Organization's (WHO) document, "World Report on Violence and Health"; and

WHEREAS Public Health works collaboratively with many partners utilizing diverse strategies; and

WHEREAS Public Health provides solid leadership;

THEREFORE BE IT RESOLVED THAT the Ontario Public Health Association (OPHA) endorses the World Health Assembly (WHA) Resolution 49.25 25 (*Preventing Violence: a public health priority*);

BE IT FURTHER RESOLVED THAT the OPHA recommends the Canadian Public Health Association (CPHA) endorse the WHA Resolution 49.25;

BE IT FURTHER RESOLVED THAT the OPHA endorse the World Health Organization (WHO), "Global Campaign for Violence Prevention";

BE IT FURTHER RESOLVED THAT the OPHA recommends the CPHA endorse the WHO, "Global Campaign for Violence Prevention".

Please note that the information on the World Health Organization, "Global Campaign for Violence Prevention" can be found on-line at
http://www.who.int/violence_injury_prevention/violence/global_campaign/campaign/en/

Please see attached for the WHA Resolution 49.25

Preventing violence: a public health priority (Resolution WHA49.25)

The Forty-ninth World Health Assembly,

Noting with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children;

Endorsing the call made in the Declaration of the World Summit for Social Development for the introduction and implementation of specific policies and programmes of public health and social services to prevent violence in society and mitigate its effect;

Endorsing the recommendations made at the International Conference on Population and Development (Cairo,1994)and the Fourth World Conference on Women (Beijing,1995) urgently to tackle the problem of violence against women and girls and to understand its health consequences;

Recalling the United Nations Declaration on the elimination of violence against women;

Noting the call made by the scientific community in the Melbourne Declaration adopted at the Third International Conference on Injury Prevention and Control (1996)for increased international cooperation in ensuring the safety of the citizens of the world;

Recognizing the serious immediate and future long-term implications for health and psychological and social development that violence represents for individuals, families, communities and countries;

Recognizing the growing consequences of violence for health care services everywhere and its detrimental effect on scarce health care resources for countries and communities;

Recognizing that health workers are frequently among the first to see victims of violence, having a unique technical capacity and benefiting from a special position in the community to help those at risk;

Recognizing that WHO, the major agency for coordination of international work in public health, has the responsibility to provide leadership and guidance to Member States in developing public health programmes to prevent self-inflicted violence and violence against others;

1. DECLARES that violence is a leading worldwide public health problem;

2. URGES Member States to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it;

3. REQUESTS the Director-General, within available resources, to initiate public health activities to address the problem of violence that will:
   (1) characterize different types of violence, define their magnitude and assess the causes and the public health consequences of violence using also a ‘‘gender perspective ’’in the analysis;
   (2) assess the types and effectiveness of measures and programmes to prevent violence and mitigate its effects, with particular attention to community-based initiatives;
   (3) promote activities to tackle this problem at both international and country level including steps to:
      (a) improve the recognition, reporting and management of the consequences of violence;
      (b) promote greater intersectoral involvement in the prevention and management of violence;
      (c) promote research on violence as a priority for public health research;
      (d) prepare and disseminate recommendations for violence prevention programmes in nations, States and communities all over the world;
   (4) ensure the coordinated and active participation of appropriate WHO technical programmes;
   (5) strengthen the Organization ’s collaboration with governments, local authorities and other organizations of the United Nations system in the planning, implementation and monitoring of programmes of violence prevention and mitigation;

4. FURTHER REQUESTS the Director-General to present a report to the ninety-ninth session of the Executive Board describing the progress made so far and to present a plan of action for progress towards a science-based public health approach to violence prevention.

Krug EG et al.,eds.World report on violence and health.Geneva,World Health Organization,2002.

Resolution 4

WHEREAS Public Health has a goal to increase the percentage of children and youth who meet physical, cognitive, communicative and psychosocial development milestones; and

WHEREAS studies indicate the utilization of physical punishment is still widely used and may have serious consequences for children; and

WHEREAS Public Health has a role in conjunction with other community agencies educating potential and actual caregivers of children about the various forms of positive discipline; and

WHEREAS Public Health has a role in conjunction with other community agencies educating potential and actual caregivers of children about the potential negative consequences of physical punishment;

THEREFORE BE IT RESOLVED that the Ontario Public Health Association (OPHA) advocate locally and provincially for education initiatives with other community agencies educating potential and actual caregivers of children and youth about the potential negative consequences of physical punishment and the various forms of positive discipline, and

BE IT FURTHER RESOLVED that the OPHA advocate for organizations to develop clear positions on the use of physical punishment of children and youth.

Regarding resolutions, position papers and motions:

Status: Policy statements (resolutions, position papers and motions) are categorized as:
ACTIVE, if:
1. The activities outlined in the policy statement's implementation plan have not yet been completed; or
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

ARCHIVED, if:
1. The activities outlined in the policy statement's implementation plan have been completed; or
2. The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supersedes the latter

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